ASCO Rx for High Drug Costs: Doctors and Patients Need To Talk

By Joanne Nicholas

A special task force of the American Society of Clinical Oncology (ASCO) recently issued a Guidance Statement on the Cost of Care, which advises oncologists to speak with their patients about the cost of treatment. While urging ASCO to also address underlying economic factors that drive costs, the guidance focused on issues at the practice level.

“The task force tried to address the rising costs of cancer care and how it affects the practicing of quality medicine and the well-being of the patient,” said chair Lowell E. Schnipper, M.D., of Harvard Medical School in Boston.

The statement highlighted a recognized problem: Doctors and patients have difficulty broaching financial topics in the context of an office visit. But it did not offer specific suggestions on how to effect changes necessary for both sides to communicate. In fact, several large, entrenched roadblocks need to be overcome before this kind of communication can take place, according to oncologists and patient advocates.

Few dispute the importance of such discussions or the effect that costs can have on patient care. “Without a conversation about cost, there is no way for doctors to know how many patients are being forced to make decisions about treatment while weighing other demands such as supporting their families [and] children to be educated,” Schnipper said.

Timothy Moynihan, M.D., an oncologist and end-of-life specialist at the Mayo Clinic in Rochester, Minn., agreed: “The reality of it is, a prescription you don’t take because you can’t afford to has a zero response rate. If an aromatase inhibitor costs a patient $300 out of pocket versus $70 for tamoxifen, it is important for an oncologist to know if this expense will affect the patient’s compliance,” he said.

Moynihan is also concerned about prescribing a high-cost treatment without fully describing its risks and benefits to a patient near the end of life. “If someone is going to get a very expensive therapy, their doctor needs to explain that it may only change their outcome by 6 weeks, they may have to
mortgage the farm to pay for it, they will
die anyway, and it may prevent them from
leaving the farm to their children as a
legacy. If you don’t have this conversation,
patients can’t have a choice. You can liter-
ally break a family,” Moynihan said.

**Barriers to Discussion**

So why aren’t these conversations hap-
pening right now? Despite widespread
agreement on their potential usefulness,
experts said that many barriers exist.

One of the major issues is time. Most
oncologists have tightly scheduled clinic
appointments and no extra time to discuss
the cost of care, according to all the physi-
cians interviewed for this article.

A second roadblock is the current reim-
bursement system, which provides payment
only for the medical care provided. “A fair
question is how can we remodel the system
to assure that key issues such as a discussion
of a patient’s insur-
ance and personal
economic issues are
included among the
topics covered in the
course of patient’s
visit,” Schnipper said.

Third, even if
time and reimbursement were not prob-
lems, such discussions have inherent diffi-
culty. According to ASCO, only 37% of
oncologists surveyed said they were com-
fortable discussing costs of cancer treat-
ment with patients. And even fewer are
trained to conduct this type of conversa-
tion. “Most doctors are uncomfortable
discussing the topic and may not have
ready answers,” said Thomas J. Smith,
M.D., director of palliative care at Virginia
Commonwealth University–Massey Cancer
Center in Richmond.

The task force also recommended that
patients initiate discussions of costs, and
ASCO has created a guide for patients to
facilitate these discussions. But this scena-
rio presumes that patients want to have
that conversation with their oncologists,
and that is not always the case, according
to some experts.

Research led by Deborah Schrag, M.D.,
an oncologist at the Dana–Farber Cancer
Institute in Boston and a member of the
ASCO task force, found that 90% of patients
with advanced colorectal cancer starting
chemotherapy reported that they almost
never discussed the costs of prescription
drugs with their doctors. Their study, pre-
sented at the May 2009 ASCO meeting,
showed that even when participants were
worried about drug affordability, only 12%
of patients discussed these concerns with
their physicians either before beginning the
clinical trial or 3 months after.

“Our study corroborated what providers
see in clinic,” Schrag said. “When folks are
in crisis and have a new diagnosis or feel
immense pressure, they relegate costs to the
back burner. Ninety-nine percent of
patients and family members say, ‘I don’t
care what it costs. I just want the best care
for my loved one.’” She said that once
patients undergoing cancer treatment re-
alize they are in it “for the long haul and the
bills start piling up, people then turn their
attention to focus on the cost aspect.”

Desire for the best
care can present an-
other barrier to dis-
cussion if patients fear
their financial problems may affect their
care, said Diane Blum, executive director of
CancerCare, a nonprofit organization that
assists cancer patients with financial prob-
lems. “Patients are concerned that physi-
cians might not do all the necessary treatment
for an illness that will require a lot of care if
cost is an issue,” said Blum, another member
of the ASCO task force. “And every patient
wants to receive the best care.”

Blum believes that doctors should take
the initiative. “Physicians don’t need to be
financial experts, but when patients are
given choices for treatment, as they often
are, cost should be presented to them as
part of the decision they need to make, in-
cluding how it might affect their patients’
ability to comply.”

Health insurance may be another reason
patients don’t pursue discussions about
costs, according to Leonard Saltz, M.D., an
oncologist at Memorial Sloan–Kettering
Cancer Center in New York. “Human
nature is such that if I say to a patient a drug
will cost $4,000 a month, he or she wants to
know ‘What will it cost me . . . what are my
out-of-pocket costs?’” said Saltz. “If the
answer is nothing, or a small amount, he or
she will most likely be happy to have such
good insurance and is not going to be very
concerned about the actual cost.”

Saltz believes that to be relevant, a dis-
cussion of cost must be personalized to
reflect each patient’s insurance coverage
and immediate financial concerns.

**Delegating the Dialogue**

Confronted with the many barriers to this
kind of conversation, some larger medical
centers and private practices routinely
schedule patients for a meeting with a
financial representative to discuss costs.

At the Mayo Clinic, a financial represen-
tative speaks with the patient before the
first visit to arrange
for insurance approvals
and HMO authoriza-
tions and to refer the
patient for charity care
or other financial as-
sistance, if needed.

US Oncology, a
network of private,
for-profit practices
that reportedly treats more than 600,000
patients every year, begins the dialogue at
the first visit. After the patient sees an
oncologist to discuss the treatment plan,
he or she meets with a financial service
representative to review the plan’s costs,
what their insurance will pay, and what
they will owe out of pocket. To monitor
any change in treatment or financial is-
issues, a representative speaks with the
patient every 30 days to discuss potential
problems, said Roy Beveridge, M.D.,
medical director of US Oncology and a
medical oncologist at Fairfax Northern
Virginia Hematology–Oncology.

In smaller community practices, it is
impossible to generalize whether or how
such communication takes place. But the
lack of time and reimbursement for discus-
sions of cost negatively affects practices
with just a few oncologists. “Some small
practices are in danger and some are going
under,” Schnipper said. He recommends (and ASCO supports) an approach that provides information in waiting rooms and clinics to help patients understand what resources are available and advise them on the optimal way to begin a discussion of costs.

**The Bigger Picture**

In addition to urging dialogue on costs between oncologists and patients, the ASCO task force emphasized the need to “address the underlying factors contributing to the increasing cost of cancer care.” Some experts believe that these factors are what matter most.

Peter B. Bach, M.D., a physician at Memorial Sloan–Kettering, emphasized the potential role for evidence-based medicine. A major driver of cost, he said, is patients’ insistence on, and oncologists’ prescribing, expensive therapeutics and imaging that may have little or no evidence of benefit.

“The challenge that we have in holding down spending is there is no reasonable structure for inserting price into the patient–doctor relationship,” said Bach. “Putting spending decisions either on the patient or on the doctor gives the task to a party that is totally unequipped. The problem isn’t that drugs like Tarceva are expensive but that doctors are giving them to patients without a specific [biomarker that predicts response], so it is unlikely to work. If there is a solution, it is to make sure that
patients receive treatments that are evidence-based and valuable.”

Saltz, another Sloan-Kettering physician who speaks often about the cost of drugs, points to the current insurance system as one of the major underlying factors. “Health care has spun out of control due to programs like Medicaid and Medicare and third-party payers that pay six-figure prices for treatments that provide only incremental advantages but are priced like a cure,” he said. “We have taken what economists call the ‘moral hazard’ out of health care, because so many patients no longer need to make an economic decision when it comes to their treatment—to consider, ‘If I buy this, what do I have to give up?’”

Saltz said that “two separate and directly antithetical issues” need to be addressed—what society pays for health care and what individuals pay. “The only realistic way to lower the former is to increase the latter,” he said, “yet to lower or eliminate the latter will necessarily increase the former.”