Closer Scrutiny Advocated for Cancer Drug Use

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WASHINGTON — Payments for drugs to treat cancer deserve more scrutiny, Dr. Lee Newcomer, an Oncology Services for United Healthcare executive, said at a conference sponsored by Elsevier Oncology.

For example, he said, United Healthcare decided to take a closer look at 180 breast cancer patients who were prescribed trastuzumab (Herceptin), a drug indicated only for patients who have a HER2/neu gene. "I asked the oncology office to send us the report; 12% of patients who were getting Herceptin did not have a HER2/neu gene anywhere in their medical records," he said. "That's a dangerous drug. It's got a high incidence of heart failure."

As a result, Dr. Newcomer said he had no choice but to require physicians who prescribed the drug to staple a report showing the patient had the gene to their first Herceptin prescription claim. After the first prescription, "the rest will go straight through," he added.

Another issue is how to make chemotherapy more cost effective. "Right now, in the world of oncology, you have every incentive to use the most expensive chemotherapy regimen that works" because there is more profit in the expensive drugs, said Dr. Newcomer, formerly an oncologist in private practice. "That is part of how you make your practice income. I used to make my income that way."

Dr. Newcomer is considering a program in which United pays physicians the same profit they used to get from each chemotherapy regimen—in the form of a disease-management fee—but the plan also buys the drugs instead of having the physicians buy them. "You let me go out and get the best possible price for that drug, because as United Healthcare, I've got a little more clout than your office does," he said, noting that he spent $1.1 billion on drugs last year.

Under that plan, "[oncologists] win—you still keep the margins at your office," he continued. "I win because patients are going to get a lower premium. [Large pharmaceutical companies] lose, but that's going to happen."

The idea behind the proposal is that "I want to pay you a lung cancer management fee, but have you be indifferent to which drug gives you the best margin, because we're going to go out and purchase it directly from the manufacturers," Dr. Newcomer said. "Your money doesn't come any more from which drug you choose. It comes from the disease-management fee."

Dr. Newcomer also wants to look more closely at off-label use of cancer drugs. This issue came to his attention when he looked at prescriptions for bevacizumab (Avastin), a colorectal cancer drug, and found that over a 4-month period, 80% of the prescriptions were for colorectal cancer, but the other 20% were for "every other cancer you can imagine—head and neck cancer, pancreas, bone, you name it. Every cancer was on that list, and I have to ask, why? Where's the evidence? Who really benefits from that?" One way to find out the results of off-label use of cancer drugs is to enroll the patient in a clinical trial of an off-label drug. United already pays patient expenses in clinical trials that are approved by the National Cancer Institute, according to Dr. Newcomer.

The other option, he continued, is to create registries—possibly in conjunction with the Centers for Medicare and Medicaid Services, "and start finding out whether this stuff works [off-label] or not, instead of having every single office in the country try one or two patients and we never gain any knowledge from that endeavor."

Another area Dr. Newcomer's office is examining is rationalizing end-of-life care for cancer patients. "This is of personal interest to me because in my six-man [oncology] group, three of us had almost 90% of our patients die in the hospital, and the other three, where I was, had 90% of our patients die in hospice," he said. "As we had discussions about that, it was a difference in philosophy, but we couldn't quite figure out how we would approach what the right number was." Dr. Newcomer referred to a study by the Quality Oncology Practice Initiative that looked at end-of-life chemotherapy in about 30 oncology practices. The study found that in some practices, patients got no chemotherapy in the last few weeks of life, and in other practices, 40%-50% of terminally ill patients were getting chemotherapy.

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