tain clinical excellence with optimal cost effectiveness. Successful change will only grow from a thorough understanding of the many drivers of rising cost. The task force will explore possible approaches to payment reform that promote unimpeded access, excellence in care delivery, efficiency, and social responsibility.

Research needs. The task force is fully behind expansion of research into the cost effectiveness of various experimental therapies. The cooperative group mechanism is one ideal setting in which to accomplish this goal. Much remains to be learned about how to encourage improvements in clinical decision making and how oncologists and their patients value various clinical benefits associated with therapeutic interventions. Although not a funding agency, ASCO is in a favorable position to stimulate such research. For example, the society could include the topic of cost in its list of high-priority research areas when calling for research proposals. Furthermore, in its regular meetings with the leadership of the National Cancer Institute, cost effectiveness and comparative effectiveness of treatment

regimens and techniques must be emphasized as essential goals of funded clinical research.

We will be communicating about these and other aspects of the work of the task force in the weeks ahead. I hope you will participate in this important conversation, with the task force, with your colleagues, and with your patients. Our future depends on it.

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Three Changes for Affordable Care: One Payer's Wish List

By Lee Newcomer, MD

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Any oncologist's first reaction to the issue of cost is likely to be: "Haven't I heard all of this before, and haven't we always found a way to fund more care? What is different this time?" Ever since the discovery of mechlorethamine, vincristine, procarbazine, and prednisone (MOPP) chemotherapy, payers have paid oncologists directly for cancer chemotherapy.

This time, we have reached a tipping point. When MOPP was discovered in the 1970s, a minimum-wage worker in California could provide coverage for his or her family of four with a standard Blue Cross/Blue Shield health plan for 15% of his or her annual income. In 2005, the same worker would have had to spend 101% of his or her annual income for such coverage.¹ The cost of medical care has been accelerating far faster than the growth of wages for decades, and the impact is now stunning. Workers at the low end of the pay scale face the choice of forgoing food, shelter, and clothing to afford health care coverage. The current economic crisis is driving that same choice into the middle class as well. The debate is much larger than the cost

of an individual drug; society is struggling to keep employees insured. If readers have any doubt about this statement, their business managers can confirm dramatic changes in the numbers of insured and underinsured.

Oncology has taken center stage in this debate. The cost trend in oncology is approximately two times higher than the overall medical cost trend. Patients with cancer had previously received amnesty in the debate on cost because of their desperate situation, but the new economic reality has forced policymakers to look at every branch of medicine to cut cost. How can we accomplish that while still serving patients with quality care?

Adhering to existing evidence is the starting point. UnitedHealthcare (Minnetonka, MN) studies on claims have shown that 35% of all erythropoietins were administered to patients whose hemoglobin levels were in excess of the 12 g/dL maximum recommended by the US Food and Drug Administration and ASCO.² Of women receiving trastuzumab ther-

apy, 12% had an underexpressed *HER2* gene. Approximately 15% of all chemotherapy claims in 2007 were for drugs that were not recommended by the National Cancer Center Network Compendium for patients with cancer. These treatments were not necessary, and in many cases, they had the potential to cause harm.

The profession needs to raise its evidence standards. It has been a scientific principle since Jenner treated smallpox that discoveries must be replicated by others to be considered valid. Every June, my office is flooded for requests to deviate from National Cancer Center Network standards on the basis of an abstract presented at the ASCO annual meeting. Those making the requests are unfazed by the fact that the work has not been replicated at another center, that the study has not been published, or that the work has been presented as an interim report before final analysis is complete. Physicians are treating patients with drugs that provided only 1 month of additional freedom from progression in a select group of study patients with good performance status, assuming that their own patients will fare as well, despite their comorbid conditions and lower performance status.

Failing to use the evidence that exists and accepting incomplete evidence are wastes of precious resources. These practices have another toxic effect. They create variability. Variability makes any valid evaluation of current practices almost impossible. Variability is the basis of my second wish for the oncology profession: Create formal learning and improvement structures that will accelerate the identification of best practices in cancer care.

I recently had a discussion with the medical director of a large 50-oncologist group who was trying to determine the most effective way to use fluorouracil for colorectal carcinoma in the practice. To his dismay, he discovered that his group had 18 different regimens in use for this single drug, making measurement of responses and toxicities impossible. Every partner produced an article to defend his or her preferred approach. But no partner could identify the best approach for the practice regarding real patients. Practices must standardize treatment of their patients the same way a treatment protocol of a clinical study mandates standard care. Obviously, some patients will require modification for their unique personal issues; clinical trial protocols also make such allowances. However, it is highly unlikely that those personalized adjustments would require 18 methods for fluorouracil therapy.

With a consistent, standardized approach to patient care, we can measure results and improve them. Imagine a world in which small groups of oncology practices met on an annual basis to compare results in common cancers facilitated by a payer, a professional society, or any other sponsoring body. Each group could compare the results of its consistent approach with different approaches of other groups. Best practices would emerge. One does not have to belong to a cooperative clinical trial group to learn about new advances in cancer therapy.

My final wish is for a realigned payment system. Chemotherapy drugs account for a majority of the income of an oncology practice, and this situation creates unhealthy incentive. The current payment method encourages too much treatment and penalizes physicians who seek less expensive approaches to clinical problems. It is exactly the wrong incentive for cost reduction. In one study,³ researchers at Harvard University (Cambridge, MA) and the University of Michigan (Ann Arbor, MI) documented that when multiple options are available for a clinical situation, the oncologist will often select the drug with the maximum profit margin. The same study showed that payers are billed \$23 for every \$1 of increased income for the oncologist. Simply reducing the payment for drugs only aggravates the problem, because oncologists are left with no method to support today's complex practice.

UnitedHealthcare is piloting an episode payment method that may preserve physician income at current levels by changing the focus of payment to patient care and may eliminate the effect of drug selection on income. The groups in the pilot are part of a performance measurement program to identify best practices. Income increases come from better outcomes. This program is a pilot, and its success is not guaranteed. Other payers must try other innovative approaches. Eventually, a program will emerge that blends cost effectiveness and quality with higher payment to physicians.

These three changes—using evidence strictly, becoming more consistent and improving care with results measurement, and developing a new payment system—will not be easy. However, we have no choice. Failure to change will ensure that even fewer are insured.

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Penny Wise, Dollar Foolish Approach to Antiemetic Use May Compromise Patient Care

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A number of surveys have consistently shown that among the potential adverse effects of cancer treatment, patients rate chemotherapy-induced nausea and vomiting (CINV) as one of the most feared problems.^{1,2} Over the past 20 years, substantial progress has been made in developing more effective and better tolerated means to prevent CINV. With appropriate application of evidence-based antiemetic treatment, nausea and vomiting can be completely prevented in the majority of patients with cancer receiving chemotherapy.³

A recent coverage determination by National Government Services (NGS)—a Part A/Part B Medicare Administrative Contractor—threatens to compromise the ability of patients to achieve complete control of CINV by limiting the discretion of oncologists in prescribing antiemetics. In a directive issued on January 13, 2009, NGS indicated that “the use of injectable medications when an oral form is available must meet medical necessity requirements for use of the drug, and for the route of administration. Documentation should indicate that the patient was unable to tolerate the oral preparation before initiation of the intravenous form of the medication. An example is a failed course of the oral antiemetic before starting an intravenous form of the same antiemetic.”⁴⁻⁶

In a perfect world, this policy directive would appear to be quite reasonable. There is no evidence that when dosed appropriately, oral formulations are any less effective than parenteral formulations of the same antiemetics, and this is reflected in various evidence-based guidelines. Oral antiemetics are effective, safe, and, in many instances, the preferred antiemetic treatment. However, when one attempts to apply the new NGS policy in the real world of daily cancer care, a number of problems emerge. In most private practices and many hospital-based practices in the United States, providers do not dispense oral drugs. This means that patients with cancer must obtain their oral antiemetics from pharmacies and bring them to their sites of care on treatment days. Depending on their type of Medicare

coverage, patients may encounter a number of hardships and inconveniences. With Part B coverage, physicians are not permitted to write prescriptions for antiemetics that cover entire courses of chemotherapy. Rather, they are only permitted to prescribe coverage for single cycles at a time. With Part D plans, patients must deal with prior authorizations and quantity limitations.

Compliance with care recommendations is a challenge for a significant segment of patients. Limiting the discretion of providers to administer intravenous formulations of antiemetics when there is concern about patients' ability to comply with treatment recommendations could compromise outcomes. Consistently adhering to oral medication schedules can be difficult even for the most astute patients when supportive care medications are added to the often lengthy lists of other chronic medications. Every provider has encountered the situation in which a patient has not brought his or her prescribed oral antiemetic medications on the scheduled day of treatment. Having the ability to provide intravenous antiemetics in such situations is essential.

One could argue that withholding the intravenous formulation of an antiemetic until failure of the oral form of the same antiemetic has been demonstrated is a cost-effective and prudent policy given the bioequivalence of the different formulations. Nevertheless, for many of the reasons noted, actually ensuring that oral antiemetics are taken as prescribed can be much more problematic than doing the same for intravenous formulations. The policy of withholding one form of antiemetic treatment until another less costly alternative has been demonstrated to be ineffective has historical precedent. This practice was followed in a number of settings when the 5-hydroxytryptamine-3 receptor antagonists were first used and, more recently, after the introduction of aprepitant, the first neurokinin-1 receptor antagonist. Unfortunately, the adverse consequences of such an approach are not limited to an unacceptable antiemetic out-