Paying for Cancer Drugs: Federal Entitlement Creates Better Access, Limits Moral Hazard

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Cancer care is one of the largest components of patient medical care costs in the U.S., rivaled in overall expenditures only by cardiovascular disease.\(^1\) Off-label use of chemotherapy drugs is a major driving force behind the costs of cancer care. One reason for this is because prescription of FDA-approved cancer drugs for unapproved (i.e. off-label) and untested uses is the rule, not the exception, in the care of pediatric and adult cancer patients. A second reason is that some of the newest cancer therapies are very expensive, often running into many thousands of dollars per month, which raises additional questions about their proper use.\(^2\)

Because Medicare patients tend to be older and more likely to develop cancer, the issue of cancer drug costs and containment of health care spending for beneficiaries of federal entitlement programs is of enormous concern for health economists and current and future patients alike. Although the spiraling costs of paying for cancer therapy for an aging patient population did not make the “Top Ten Health Law Issues for 2009” for the American Health Lawyers Association\(^3\) (losing out to electronic health records, health care reform and the uninsured, and hospital/physician relations among others), it probably should have. Despite the enormous uncertainty voiced over even the short-term viability of health entitlement programs such as Medicare, recent federal announcements reveal that little effort is being made to hit the brakes on the runaway train of cancer drug costs. The issue of controlling health care costs, and how paying for therapy is justified, is now a major concern for all U.S. citizens. All signs point to the fact that expanding coverage for off-label uses of cancer drugs will only make the cost problem worse.

Cancer Chemotherapy Economics: Tiers of Care

Any approach to understanding the problems of paying for cancer chemotherapy must acknowledge some unpleasant truths: (1) some of these cancer drugs are not only costly but of demonstrably marginal clinical value even for the indications they have undergone formal clinical testing for;\(^4\) (2) once a drug has an established off-label use there is little incentive for pharmaceutical or biotechnology companies to ever perform the large clinical trials to establish efficacy and safety or to risk going through the U.S. Food and Drug Administration (FDA) approval process;\(^5\) (3) off-label use of medications is not regulated by FDA at all but rather is controlled only by clinical practice preferences of

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the medical profession,⁶ tort law, and administrative law; (4) there isn’t enough money in the U.S. healthcare system anymore to pay for every drug every patient wants or every physician might prescribe for every clinical condition;⁷ (5) unregulated medical technology is a major driving force behind rising health care costs;⁸ and (6) the U.S. government has in the past consistently shown an unwillingness to make a serious effort to control CMS (Center for Medicare and Medicaid Services) payments for pharmaceuticals, including off-label use of expensive cancer drugs,⁹ even though private insurers and HMO routinely deny payment¹⁰ for some of this therapy because of the lack of substantive data showing it is either effective or cost-effective.

This difference in payment for off-label use of chemotherapeutic agents has created a bifurcated system of cancer care, with those individuals who are eligible for Medicare receiving greater access to cancer drugs than many others who have not yet retired and whose tax dollars go directly to fund Medicare. The recent federal rule makes this discrepancy worse.¹¹

CMS’s New Rule

As recently reported in The New York Times,¹² Medicare has dramatically expanded its coverage for cancer chemotherapy for off-label uses. This change in policy, which took effect this past November without any real public debate,¹³ will certainly have dramatic financial repercussions for a federal entitlement program that currently spends more than $2.5 billion a year on cancer drugs¹⁴ and is already slated for cost-review by the Obama administration. Because cancer chemotherapy is one of those areas in medicine where federal government reimbursement policy truly incentivizes physicians to persist in treating patients even when they have little or no chance of having a significant

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⁶ Statement of Janet Woodcock, Director of the Center for Drug Evaluation and Research, Before the House Subcommittee on Oversight & Investigations, 106th Cong. (1999), “FDA does not generally regulate the practice of pharmacy or the practice of medicine – the States traditionally have regulated both the prescribing and dispensing of drugs.” See also Peter Barton Hutt, Regulation of the Practice of Medicine Under the Pure Food and Drug Laws, 33 J. A. FOOD AND DRUG OFFICIALS 3 (1969).
¹¹ DEPARTMENT OF HEALTH & HUMAN SERVICES, CENTERS FOR MEDICARE AND MEDICAID SERVICES, CMS MANUAL SYSTEM, PUB 100-02 MEDICARE BENEFIT POLICY, COMPENDIA AS AUTHORITATIVE SOURCES FOR USE IN THE DETERMINATION OF A “MEDICALLY ACCEPTED CONDITION” OF DRUGS AND BIOLOGICALS USED OFF-LABEL IN AN ANTI-CANCER CHEMOTHERAPEUTIC REGIMEN, OCTOBER 24, 2008 [hereafter New CMS Rule].
¹² Abelson, supra note 9.
¹³ Id.
¹⁴ Id.
prolongation of their lives, Medicare reimbursement policy inevitably creates a situation which has no meaningful cost-control mechanism.\textsuperscript{15}

The new rule\textsuperscript{16} expands coverage for more off-label uses of cancer drugs by expanding the number of reference guides – known as Compendia – that CMS relies upon to make off-label coverage decisions.\textsuperscript{17} The problem is that the new prescription drug approval decision which FDA makes is generally based on well-designed, mutually agreed-upon, large, randomized, prospective clinical trials with well-defined endpoints that must achieve a certain level of statistical significance, while the compendia which CMS uses to base its off-label coverage and reimbursement decisions on contain clinical trial data which is much less robust and which is potentially derived from multiple sources.\textsuperscript{18} Anyone, including manufacturers or sponsors, may get small, non-dispositive clinical investigations on off-label uses of approved drugs into the medical literature;\textsuperscript{19} it is this less-reliable, industry-sponsored medical data which is routinely used to support listing of off-label uses of drugs in the Compendia.

Anyone, including pharmaceutical manufacturers or sponsors, may request that unapproved indications for drugs be added to compendia based on this less substantive clinical information. Once an off-label use for a drug is listed in the compendia it becomes eligible for coverage by Medicare and Medicaid.\textsuperscript{20} What this split between FDA and CMS decision-making does is provide an incentive to manufacturers to get the most narrow clinical indication possible approved by FDA, and to then turn to the CMS compendia as the avenue to get reimbursement coverage for the desired off-label indications. In so doing, this approach avoids the need to submit costly and time-consuming New Drug Applications (NDAs) for off-label uses of already approved cancer drugs.\textsuperscript{21}

Another Proposed Medicare Rule Goes Beyond Just Off-Label Use

As serious as this change in federal policy is, recent announcements from CMS also indicate that one of the other remaining cost-constraints on prescription drug use for Medicare beneficiaries may also be lifted; this concerns the substitution of generic for brand name drugs, whether cancer chemotherapy or any other prescription drug.

\textsuperscript{15} John Z. Ayanian, \textit{The Elusive Quest for Quality and Cost Savings in the Medicare Program}, 301 JAMA 668 (2009).
\textsuperscript{16} New CMS Rule, \textit{supra} note 11.
\textsuperscript{17} Id.
\textsuperscript{18} Food and Drug Law Institute, Conference on Better Understanding CMS and Its Relationship to FDA: The Regulation of, and Payment for, Drugs and Medical Devices, November 19, 2008, Washington, D.C. Topic VI: How Important is An Indication? Off Label Uses and Compendia. Comments by Jeffrey A. Kelman, M.D., Chief Medical Officer, Center for Beneficiary Choices, Center for Medicare and Medicaid Services; and comments by Daniel Meron, Partner, Latham & Watkins.
\textsuperscript{19} Id.
\textsuperscript{20} Id.
\textsuperscript{21} Id.
Until recently under what is termed “reference-based” pricing, Medicare beneficiaries faced a penalty for insisting on a brand-name drug (often the difference in price between the brand-name drug and the generic plus a co-payment). This Medicare drug coverage policy proved to be a useful mechanism for steering Medicare beneficiaries towards lower-cost generics. Even though there is virtually no difference in the safety or effectiveness of an adult brand-name drug when compared to its generic equivalents and pharmacists will routinely substitute a generic for a brand-name drug unless the physician prescription indicates otherwise, there is invariably a significant cost savings for the use of the generic. Recent proposals by the outgoing Bush administration have sought to ban the financial penalties for Medicare beneficiaries for picking brand-name drugs instead of the generic versions of those drugs for prescription drug plans that insurers will offer for 2010. This federal action is a classic study in the moral hazards which are present when individuals are heavily shielded from the financial consequences of their actions.

The rational for this proposed new rule was that it was “very difficult to accurately convey the extent of expected out-of-pocket spending for prescription drugs” to Medicare beneficiaries. This explanation seems to suggest that a federal program which effectively cuts drug-related medical expenses will not be kept if the economics behind it are complicated. Because this second, proposed CMS rule does not take effect until March, the Obama administration has only a short amount of time to change this policy.

The Medical Profession Could Help More

Recent medical literature suggests that the way physicians practice medicine, and the manner in which medical journals treat generic substitution, isn’t going to make this problem any easier. As reported this month in the Journal of the American Medical Association by Kesselheim and others, a review of editorials in major medical journals revealed that a substantial number of editorials written by presumed medical experts routinely counseled against the interchangeability of generic drugs even when there was no evidence to support the use of brand-name drugs. Although this comprehensive study was focused on cardiovascular disease, there is no medical literature demonstrating physician prescribing patterns which are any different in other areas of medicine. And, importantly, the authors were quick to point out that the findings of this study support the concept of formulary designs employing generic drugs as a means of achieving significant cost savings. When it comes to cancer care, recent surveys of medical oncologists have shown that the majority of academic oncologists believe that drug costs

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22 Ayanian, supra note 15.
24 Id.
25 Id.
27 Id.
28 Id.
do not influence their practice nor that it should limit access to “effective” care. There is also the problem that the meaning of “effective” remains fluid, even at the federal level.

Financial constraints aside, the penultimate bottom line for all parties concerned should be that there should be some definitive, or at least substantive, demonstration that pharmaceuticals work for the condition they are being prescribed for before the U.S. government agrees to pay for them. Given the ubiquity of off-label drug use in cancer care and the use of Compendia by CMS to justify compensation for off-label prescribing even though there is a lack of definitive efficacy data in the Compendia, pharmaceutical manufacturers need only focus on get a drug approved for one disease before the medical profession can use the drug for virtually anything.

The new CMS rule on coverage for off-label chemotherapy has serious implications, particularly in conjunction with the second, proposed new rule on generic substitution. There is no data proving that removing cost constraints on physician behavior or federal entitlement programs actually improve cancer patient care. Nor is there any evidence that serious effort to demonstrate therapeutic benefit of investigational therapy will occur when there is reimbursement without any requirement to establish efficacy. The 1938 Federal Food, Drug and Cosmetic Act was modified by the 1962 Kefauver-Harris Amendment to require that pharmaceutical manufacturers must provide evidence to prove that their drugs were effective as well as safe. In 1962 cancer care, and off-label drug use, were in their infancy, and federal health care entitlement programs such as Medicare did not exist. The situation has changed too much to be ignored. “The solution – and an essential component of health care reform – is to establish centers for comparing the effectiveness of drugs and treatments and the cost-effectiveness of using them. That would help make coverage decisions rational for all patients.”


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30 Peter B. Bach, Limits on Medicare’s Ability to Control Rising Spending on Cancer Drugs, 360 N. ENGL. J. MED. 626 (2009).
31 Id.