



The Impact of Healthcare Cost Controls on the Patient-Caregiver Relationship

“The patient-physician relationship does not exist in a bubble— independent of the realities of the world. The cost of treatment shouldn’t be the focus of the relationship. But just like physicians need to look beyond the pure clinical situation of their patients and consider their social and personal needs, isn’t it more compassionate to patients and society if they also consider the cost of the treatment they’re prescribing?”

- Aran Ron, MD, Medical Director, Oscar Health Insurance



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INTRODUCTION

In an ideal world, physicians would make their clinical decisions based solely on what is best for patients. But in a country where healthcare spending consumes 18 percent of the gross domestic product—about \$3 trillion in 2014—issues of cost are beginning to penetrate the sanctity of the exam room. Prescription drugs, which account for nearly 10 percent of those expenditures, have become a key target.

At the Schwartz Center for Compassionate Healthcare's recent New York Thought Leadership Breakfast, in partnership with NewYorkBIO and held at the New York Genome Center, a panel of experts representing diverse perspectives came together to discuss the impact of healthcare cost containment on the patient-caregiver relationship, with a specific focus on so-called "step therapies" to contain prescription drug costs.

NewYorkBIO is the leading advocate for life science research and commercialization in New York State, and the New York Genome Center is a consortium of academic, medical and industry leaders focused on translating genomic research into clinical solutions for serious disease.

Among the major themes that emerged from the discussion were:

- The real consequences of cost containment policies like step therapy on patients and the patient-caregiver relationship
- Physicians' general lack of knowledge about cost issues, which impedes their ability to talk to patients about cost
- The need for more clinician training and more time in the exam room and at the bedside to talk to patients about these issues
- The need to teach medical students and trainees about the economics of healthcare and how to have compassionate conversations with patients and families about cost issues
- How price matters to patients and can affect their compliance with treatment recommendations and health outcomes

The Schwartz Center for Compassionate Healthcare is a national nonprofit leading the movement to bring compassion to every patient-caregiver interaction. Research shows that when caregivers are compassionate, patients do better and caregivers rediscover their passion for healing. The Center believes that a strong patient-caregiver relationship characterized by effective communication, emotional support, mutual trust and respect, and the involvement of patients and families in healthcare decisions is fundamental to high-quality healthcare. Visit us at theschwartzcenter.org and follow us on **Twitter** and **Facebook**.

OPENING REMARKS:

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PANELISTS:

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President and Founder, U.S. Pain Foundation

Tom Lynch, MD

Director, Yale Cancer Center; Physician-in-Chief, Smilow Cancer Hospital at Yale-New Haven

Aran Ron, MD

Chief Medical Officer, Oscar Health Insurance

J. Russell Teagarden

Member, Advisory Committee on Rare Diseases, Patient-Centered Outcomes Research Institute

Jane Wasman, JD

President, International and General Counsel, Acorda Therapeutics

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THE IMPACT ON PATIENTS

U.S. Pain Foundation President and Founder Paul Gileno kicked off the panel discussion by describing his experience with step therapy, a cost containment policy adopted by an estimated two-thirds of insurance plans. Step therapy requires physicians to prescribe proven lower-cost medications for a given condition before a patient can be approved for a higher-cost drug. The process is sometimes pejoratively referred to as “fail first.”

“I went through step therapy three times,” said Gileno, who broke his spine in a work-related accident in 2003 and has been living with chronic pain ever since. “The delays in getting the right care caused me a lot of time, a lot of pain, and it put me in a state of depression. It gave me the sense that no one was out there for me.” Through his work with the U.S. Pain Foundation, Gileno said he has learned that his experience is not an unusual one. “It [step therapy] is hurting a lot of patients,” he asserted.

Aran Ron, MD, chief medical officer of Oscar Health Insurance, argued that step therapy is no different than any other medical guideline that directs physician practice. “Current guidelines require a person with back pain to have rehabilitative therapy before surgery, and diet and exercise before gastric bypass surgery,” explained Ron. “I view this [step therapy] as no different than any other guideline a physician practicing first-class medicine would follow.”

He said guidelines created by medical societies and other medical groups routinely factor in cost. “Why wouldn’t we consider financial factors if there’s an equivalent alternative at one-tenth the cost?” Ron asked. “Wouldn’t it be logical, as well as ethically and financially appropriate, to use the less costly option?”

Ron pointed to a [study](#) published in the *Annals of Internal Medicine* in 2014, showing that patients who took generic statins were 6 percent more compliant than patients who were prescribed the brand name equivalent, leading to better overall health outcomes. “Price matters to patients and ignoring its impact is ill-advised,” he said.

Gileno said that when he refers to step therapy, he is not talking about substituting a generic equivalent for a more expensive brand name medication, but rather forcing doctors to prescribe a different drug altogether. “I understand the rationale, but as a patient, do you want to have to go through trial and error?” he asked.



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CONVERSATIONS ABOUT COST

J. Russell Teagarden, who serves on the federal government's Patient-Centered Outcomes Research Institute's Advisory Committee on Rare Diseases, said he agrees with the philosophy of step therapy, but exceptions must be made, for instance, when a specific rule runs contrary to a doctor's clinical judgment. "Where it falls apart is execution because these decisions are sometimes left to mindless bureaucrats," said Teagarden. But on the positive side, cost controls like step therapy enable insurers to cover extremely expensive medications like biologics to treat rheumatoid arthritis, which cost thousands of dollars a month.

Teagarden said he doesn't believe it is incumbent upon physicians to defend step therapy to their patients, "but they should be able to discuss with patients the general purpose—trying to lower costs when clinically possible so more expensive therapies are available when patients really need them."

Jane Wasman of Acorda Therapeutics, a biotechnology company focused on multiple sclerosis (MS) and spinal cord injury treatments, said that patients' unprecedented access to medical information has also exerted pressure on the patient-caregiver relationship.

"Patients are very well educated," said Wasman. "MS patients know about drugs before they're on the market because they've been following the clinical trials. They're walking into their doctors' offices and saying, 'This is the drug I want.'" She pointed out that this is much different from the past "when physicians could control costs merely by not mentioning the more expensive drug option and patients assumed they were getting what the doctor thought was best."

Time is the enemy when trying to sort out issues of efficacy vs. cost with patients, said Wasman. "Lots of physicians talk about how they already don't have enough time to spend with patients, especially those with complex conditions. Then in the middle of a complex discussion about patient care, they have to insert another discussion about whether the patient can afford therapy. It's very challenging."

COVERAGE CALCULATIONS

How do insurance companies make these kinds of coverage decisions? How are clinical and other benefits weighed? The panelists agreed that one important consideration for insurers is cost avoidance—whether the selected drug will keep patients out of the hospital and ER. Otherwise, Teagarden said, there is no standard methodology used by insurers and pharmacy benefit managers to judge the worth of a medication. "What happens is a group of expert clinicians reviews the literature and strives to reach a reasonable consensus," he explained. "Is it standardized? No. Should we be better at this? Yes."



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Wasman said that one of Acorda’s drugs is the only medication on the market that helps patients with MS walk better. While most MS patients can look forward to a normal or close-to-normal life span, their lives can be significantly impacted. “We’ve had to work with insurers and other payers to educate them about the value of the drug—being able to cross the street before the light changes or walking your daughter down the aisle at her wedding,” she said. “It can be hard to quantify the value of things like this. We want a system that does place value on patients, and not just the dollars and cents issues.”

Teagarden said that clinical value can be relative. He gave the example of cystinosis, a rare genetic disorder that leads to problems with renal function. The traditional drug used to treat it, at an annual cost of \$10,000, must be taken every six hours and causes the patient to smell bad. A new drug, with an annual price tag of \$250,000, doesn’t cause the same odor problem and can be administered every 12 hours.

“A quarter of a million dollars sounds ridiculous until you learn that the majority of patients with this condition are teenagers,” said Teagarden. “And what’s more important to an adolescent than not smelling bad and sleeping through the night?”

Teagarden said that when he worked for Medco, a pharmacy benefits management firm now called Express Scripts, he gained insight into the coverage calculations payers must make. “Without policies like step therapy, insurers wouldn’t be able to foot the bill for high-cost therapies like biologics for rheumatoid arthritis. In some ways, these programs enable coverage,” he explained.

LESSONS FROM END-OF-LIFE CARE

Tom Lynch, MD, director of the Yale Cancer Center and physician-in-chief at the Smilow Cancer Hospital at Yale-New Haven, asked how the healthcare system can rein in costs without threatening the sanctity of the patient-caregiver relationship. “How do we [contain costs] in a way that doesn’t threaten the essential interactions between healthcare providers and patients?” he asked. “How do we do it in way that trains healthcare workers to become better at connecting with patients?”

Lynch described a Centers for Medicare and Medicaid Services [pilot project](#) that has the potential to contain costs and improve the patient-caregiver relationship. The Oncology Care Model gives oncologists treating Medicare patients with chemotherapy an additional monthly payment of \$1,000 per patient for six months plus retrospective performance-based payments if they are able to meet 10 key quality measures.

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“For the first time, [the quality metrics] resonate with me,” said Lynch. They include keeping patients out of the ER, giving them earlier access to a palliative care doctor, and discussing hospice care earlier in the course of illness.

Lynch pointed to a [2010 study](#) by Massachusetts General Hospital oncologist Jennifer Temel, MD, showing that lung cancer patients who received palliative care earlier in their disease trajectory not only had a better quality of life, but also lived longer. “Cost containment will force doctors and nurse practitioners to get better at having these difficult discussions,” said Lynch. “The Schwartz Center teaches us the importance of that connection. If we are to save money with the Oncology Care Model, we need to improve our ability to have those conversations.”

PHYSICIANS’ LACK OF KNOWLEDGE ABOUT COSTS

All of the panelists agreed that physicians need to be better informed about the cost of treatment. “I run a major cancer center and hospital, and until six months ago, I couldn’t have told you how much our most common lung cancer regimen costs,” Lynch said. “*The New England Journal of Medicine* doesn’t include cost calculations in their articles about new drugs coming out.”

Teagarden said some physicians are becoming more cognizant of the cost of drugs and are becoming patient advocates. The most recent example, he said, was a physician group upset about the high cost of a cystic fibrosis drug. “There’s more access to information and physicians are trying to affect things,” he added.

According to Lynch, discussions of resource utilization are now mandatory when teaching residents and medical students. At his hospital, cost guidelines are integrated into the electronic medical record (EMR) and when a treatment regimen is chosen, the cost is presented. The ordering clinician, however, is not privy to how much of the cost the patient is responsible for. “This is a brave new world,” he said. “We can’t teach this just through EMRs. Incorporating it into the medical curriculum is becoming even more important.”

Ron said he teaches fourth year medical students and is always “amazed and shocked” at how little they know about the economics of healthcare. “They think it’s not really their issue, that it’s the managed care guys—the bad guys—who are imposing this.” He added that future physicians will need to learn that cost is their concern as well.

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