High Drug Prices and Prior Authorization Are Barriers to Cancer Care

People who paid more money out-of-pocket filled fewer prescriptions and had shorter overall survival.

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The cost of medication and policies that require providers to obtain prior authorization for treatment plans from insurers impose barriers to treatment and may negatively affect outcomes, according to a pair of studies presented at the American Society of Clinical Oncology (ASCO) Quality Care Symposium this month in San Diego.

“The high costs of cancer care have many facets that often result in barriers to accessing timely and consistent care,” ASCO expert Neeraj Agarwal, MD, of the University of Utah Huntsman Cancer Institute, said in a press release.

Drug Cost

In the first study, Bernardo Goulart, MD, and colleagues from Fred Hutchinson Cancer Research Center in Seattle looked at the impact of high out-of-pocket costs for oral tyrosine kinase inhibitors (TKIs) on survival of people with Stage IV (metastatic) non-small-cell lung cancer (NSCLC).

Tyrosine kinase inhibitors are targeted therapies that work against cancer with specific genetic characteristics. Around 15% of people with advanced NSCLC have epidermal growth factor receptor mutations (EGFR+), making them potentially eligible for EFGR inhibitors, such as Iressa (efitinib) or Tagrisso (osimertinib). Around 7% have anaplastic lymphoma kinase mutations (ALK+), rendering them eligible for ALK inhibitors, such as Alecensa (alectinib) or Xalkori (crizotinib).

The researchers evaluated outcomes among 105 people with EGFR+ or ALK+ lung cancer. They had insurance coverage for at least a year after their diagnosis, had made at least one pharmacy claim for a TKI medication and were still alive three months after starting TKIs. People in the highest-cost quartile were older on average than those in the three lower quartiles combined (74 versus 67 years) and had a higher median household income (about $31,000 versus $26,000). They were more likely to be on Medicare (93% versus 58%) but less likely to have commercial

insurance (7% versus 42%).

Patient data were linked to commercial insurance and Medicare claims databases. Average out-of-pocket cost was estimated for the first three months of therapy by subtracting the total amount paid from the maximum allowable pharmacy claim amount. Participants were divided into four quartiles depending on the median monthly amount they paid for their TKIs: Quartile 1, $0; Q2, $1,432; Q3, $1,778; and Q4, $2,888.

The researchers found that higher out-of-pocket cost was associated with filling fewer prescriptions and a shorter total duration of TKI therapy. People in the quartile with the highest cost stayed on treatment half as long as those in the three lower-cost quartiles (4 months versus 8 months).

What's more, higher personal cost was associated with poorer survival. People in the highest-cost quartile had a shorter median overall survival time than those in the lower quartiles (9 months versus 22 months). After adjusting for other factors, the highest-cost group was more than twice as likely to die by the third month on TKIs.

However, the researchers saw a difference according to type of insurance. Among the 70 people on Medicare, the median overall survival was just 6 months in the highest-cost group, compared with 25 months in the lower-cost groups. Among the 35 people with commercial insurance, however, the highest-cost group lived longer: 25 months versus 18 months, respectively.

"Patients paying the highest out-of-pocket costs for TKIs have a greater risk of death," Goulart said. "If we can confirm the results with a larger nationwide sample, the findings help to make the case for a review of Medicare coverage for these effective medications."

Prior Authorization

In the second study, Mallika Sharma, MPH, and colleagues with the Seattle Cancer Care Alliance (SCCA) described findings from a program designed to eliminate prior authorizations.

Commercial insurance plans often require prior authorization for specific services such as imaging scans. Though intended to ensure medical necessity, this can cause delays in care, anxiety for patients and added administrative burden, the researchers noted as background.

At SCCA, an analysis of approximately 4,500 prior authorization requests found that 95% were approved instantly or after providing more documentation, showing that the process did not save money or add value. Another 2% were approved after peer review, which involves added administrative burden and delays in care. Only 3% ultimately did not meet medical necessity criteria.

Based on these findings, SCCA and a large regional commercial payer agreed to eliminate prior authorizations. This required providers to complete training on the National Comprehensive Cancer Network's Imaging Appropriate Use Criteria, and quarterly audits were instituted to

monitor compliance with the guidelines for ordering imaging tests. SCCA achieved a 100% provider training completion rate and 100% compliance with guidelines in the first three internal audits.

“A strong partnership and shared vision with a [payer] enabled us to eliminate wasteful prior authorizations,” the researchers concluded. “Our high training completion rate and compliance rate implies strong support from our providers and leadership to provide value-based care to our patients.”

Summarizing the results, Agarwal said that this study shows that “a vast majority of prior authorizations are redundant, and a close collaboration between hospitals and insurers can help eliminate them and improve efficiencies in health care systems.”

Click here to read the drug cost abstract.

Click here to read the prior authorization abstract.
