

October 14, 2012

# In Cancer Care, Cost Matters

By PETER B. BACH, LEONARD B. SALTZ and ROBERT E. WITTES

AT Memorial Sloan-Kettering Cancer Center, we recently made a decision that should have been a no-brainer: we are not going to give a phenomenally expensive new cancer drug to our patients.

The reasons are simple: The drug, Zaltrap, has proved to be no better than a similar medicine we already have for advanced colorectal cancer, while its price — at \$11,063 on average for a month of treatment — is more than twice as high.

In most industries something that offers no advantage over its competitors and yet sells for twice the price would never even get on the market. But that is not how things work for drugs. The Food and Drug Administration approves drugs if they are shown to be “safe and effective.” It does not consider what the relative costs might be once the new medicine is marketed.

By law, Medicare must cover every cancer drug the F.D.A. approves. (A 2003 law, moreover, mandates payment at the price the manufacturers charge, plus a 6 percent cushion.) In most states private insurers are held to this same standard. Physician guideline-setting organizations likewise focus on whether or not a treatment is effective, and rarely factor in cost in their determinations.

Ignoring the cost of care, though, is no longer tenable. Soaring spending has presented the medical community with a new obligation. When choosing treatments for a patient, we have to consider the financial strains they may cause alongside the benefits they might deliver.

This is particularly the case with cancer, where the cost of drugs, and of care over all, has risen precipitously. The typical new cancer drug coming on the market a decade ago cost about \$4,500 per month (in 2012 dollars); since 2010 the median price has been around \$10,000. Two of the new cancer drugs cost more than \$35,000 each per month of treatment.

The burden of this cost is borne, increasingly, by patients themselves — and the effects can be devastating. In 2006, one-quarter of cancer patients reported that they had used up all or most of their savings paying for care; a study last year reported that 2 percent of cancer patients were driven into bankruptcy by their illness and its treatment. One in 10 cancer patients reports spending more than \$18,000 out of pocket on care.



OPEN

MORE IN OP  
**Op-Ed (**  
**Heartac**  
**Family**  
Read More :

---

Which brings us back to our decision on Zaltrap. In patients with advancing, metastatic colorectal cancer, the new drug, [approved](#) by the F.D.A. in August and jointly marketed by Sanofi and Regeneron, offers the same survival benefit as Genentech's [Avastin](#), which works through a similar molecular mechanism. When compared with the standard [chemotherapy](#) regimen alone, adding either medicine has been shown to prolong patient lives by a median of 1.4 months. Major clinical practice guidelines, like those from the [National Comprehensive Cancer Network](#), agree that Zaltrap is no better than Avastin in this setting. (Full disclosure: Two of us, Dr. Bach and Dr. Saltz, have been paid consulting fees by Genentech.)

But Avastin costs roughly \$5,000 a month: very expensive in its own right, yet less than half of Zaltrap's price tag. And while the side effects in both drugs are roughly equal, doses of Avastin generally take less time to administer than those of Zaltrap, which makes Avastin more convenient for patients.

Consider that colorectal cancer is typically diagnosed in older individuals and the cost issue becomes starker still. Many patients are on Medicare and living on fixed incomes. And because Medicare requires patients to co-pay for cancer drugs, 20 percent of the cost of drugs like Zaltrap and Avastin is passed on — absorbed either by supplemental insurance or by the patients themselves.

To put these percentages in perspective, an older colorectal cancer patient without extra insurance would have to pay more than \$2,200 out of pocket for a month's treatment with Zaltrap. That's greater than the monthly income for half of Medicare participants.

Once you take all this into account it may seem surprising that the decision to exclude Zaltrap from our hospital's formulary was a hard one to make. But because our medical culture equates "new" with "better" so unequivocally, a decision like this one can seem out of place at a leading cancer hospital

Political rhetoric today is similarly slanted. Our refusal to adopt this remarkably expensive therapy risks being labeled "rationing," not rational.

This political climate also helps explain why the Affordable Care Act precludes Medicare from changing its coverage or payment amounts based on cost comparisons like the one we have outlined, even when two drugs appear to work equally well. And it is probably why neither presidential candidate has addressed runaway cancer drug prices.

But if no one else will act, leading cancer centers and other research hospitals should. The future of our health care system, and of cancer care, depends on our using our limited resources wisely.

The current level of spending on health care, estimated to be \$2.8 trillion this year, is already too high. The [growth rate](#) in health spending is unsustainable.

Of course, we know our decision about Zaltrap will not meaningfully address these larger problems. Projected United States sales of Zaltrap in 2013 are less than \$150 million, or 0.005 percent of all dollars spent on health care. Our use would account for a very small percentage of even that number.

But it is a step in the right direction — one of many we need to take.

*The writers are doctors at Memorial Sloan-Kettering Cancer Center. [Peter B. Bach](#) is the director of the Center for Health Policy and Outcomes, [Leonard B. Saltz](#) is chief of the gastrointestinal oncology service and chairman of the pharmacy and therapeutics committee, and [Robert E. Wittes](#) is the physician in chief.*