AJMC Panel Explores Immuno-oncology, and What Making Cancer a Chronic Condition Means for Payers

Immuno-oncology, in which the patient’s own immune system is engaged to fight cancer, has shown potential but also presents challenges, including the cost of treatment. Last month, The American Journal of Managed Care convened an expert panel to discuss the value of current therapies and how payers make policy calls.

Plainsboro, N.J. (PRWEB) October 07, 2014 -- The emergence of immuno-oncology, in which a patient’s own immune system is activated to fight the cancer, has shown promise in some diseases, notably in the therapies such as ipilimumab which has been approved for metastatic melanoma.

But immuno-oncology presents certain challenges, too. Patients may not be “cured” in the conventional sense; rather, the disease may be converted to a chronic condition. In some cases, the person can return to work but in others, that’s not possible. This raises important policy choices when employers pay for healthcare. How payers and providers are balancing these opportunities and costs was the topic of a panel discussion convened last month by The American Journal of Managed Care.

Surabhi Dangi-Garimella, PhD, managing editor of Evidence-Based Oncology, a publication of The American Journal of Managed Care, served as moderator of the September 4, 2014, panel, which featured Michael Kolodziej, MD, a medical oncologist and the national medical director for Oncology Solutions at Aetna; Kimberly Shafer-Weaver, PhD, a tumor immunologist who is program director for immunology, oncology, and metabolic disease at Health Analytics; and Jianda Yuan, MD, PhD, a tumor immunologist at the Memorial Sloan Kettering Cancer Center.

The discussion involved checkpoint inhibitors on the market and those under development, including the CTLA-4, PD-1, and PD-L1 inhibitors. To hear the full discussion, click here.

Matching the Therapy to the Patient

Dangi-Garimella asked the panelists whether there are good biomarkers to help clinicians decide whether a specific drug will work in a patient, and how to measure patient response.

This issue is important to payers; as Kolodziej would explain, cost is not the first thing payers examine; instead, it’s the evidence of whether a therapy works and for whom it works. If the evidence supports using the therapy in a particular patient, payers then look into how to fund it.

As Shafer-Weaver discussed, the field is challenged by the lack of consistency in the way clinicians test for how well some immunotherapies will work in a given patient. But both she and Yuan said this is changing, and Yuan said that the technology is improving to make things more cost-effective. “It would be ideal to find good immune biomarkers (that) could predict the patient’s initial response to the immunotherapies,” he said, which would improve clinical response.

The Right Amount of Therapy

Kolodziej said that today, approval from the US Food and Drug Administration (FDA), along with appearance
on the guidelines of the National Comprehensive Cancer Network, typically guides commercial payers. That said, immunotherapies are very expensive.

“Because of the high cost, there is a lot of scrutiny in managed care to make sure that the right patient gets the treatment,” he said.

Development of better biomarkers is encouraging, Kolodziej said, because when therapies can be better matched to patients who will see a response, everyone benefits. All this will become increasingly important to payers as decisions are made about how to sequence different therapies, or whether to use them in combination.

“There is a great deal of desperation in patients with advanced malignancy,” he said, speaking from years of experience. “In an era when we did not have anything that worked, we wanted to try everything. Those days are over.”

How Do We Measure Benefits?

Dangi-Garimella asked how much patient-reported outcomes should be weighed in deciding the value of immunotherapy. This raised another issue: who should pay for these therapies?

Kolodziej said more is being done to include patient-reported outcomes, but the approach is in its “infancy.” Shafer-Weaver agreed, and said that “quality of life” is defined differently by different people. One question that will arise is whether a patient’s employer should continue to pay for therapy if the cancer has become a chronic condition, but there is no possibility the person will return to work.

The old way of measuring response — reduced tumor size on a scan — may no longer apply. “We are looking at a progression-free, stable disease as almost a win,” Shafer-Weaver said.

About the Journal

The American Journal of Managed Care, now in its 20th year of publication, is the leading peer-reviewed journal dedicated to issues in managed care. Other titles are The American Journal of Pharmacy Benefits, which provides pharmacy and formulary decision makers with information to improve the efficiency and health outcomes in managing pharmaceutical care. In December 2013, AJMC introduced The American Journal of Accountable Care, which publishes research and commentary devoted to understanding changes to the healthcare system due to the 2010 Affordable Care Act. AJMC’s news publications, the Evidence-Based series, bring together stakeholder views from payers, providers, policymakers and pharmaceutical leaders in oncology and diabetes management. To order reprints of articles appearing in AJMC publications, please call (609) 716-7777, x 131.

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