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Oncology Marketing Strategies™ U.S. 2008

Sixth Edition

Designing Physician Financial Incentives for Appropriate Care

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Key Questions

- Do “Buy and Bill” drugs create conflict between physicians’ financial interests and patients needs?
- What alternative approaches to physician reimbursement may mitigate potential conflicts?

Do “Buy and Bill” drugs create conflict between physicians’ financial interests and patients needs?

- Does the potential for conflict exist?
- What sort of conflict might arise?
  - Physician chooses more profitable of two equal alternatives?
  - Physician chooses more profitable but less effective alternative?
  - Physician over treats?
- Are there scenarios in which both patients and physicians’ economic interests conflict with payers?

Potential for Conflict:
Office-administered drugs deliver positive margins

Taxotere Monotherapy, mBC
Single Treatment, Q1 2007

	Medicare	Commercial
Drug revenue	$2,147	$2,765
Admin revenue	312	251
Total revenue	**2,459**	**3,015**
Drug cost	1,987	1,987
Labor cost	71	71
Total cost	**2,059**	**2,059**
Gross profit	400	957
Gross margin	*16.3%*	*31.7%*
Overhead	168	168
Net profit	**$232**	**$789**
Net Margin	*9.4%*	*26.2%*

Additional Anecdotes:

Remicade litigation documents indicate that rheumatologists earned from $1,590 to $2.350 per treatment

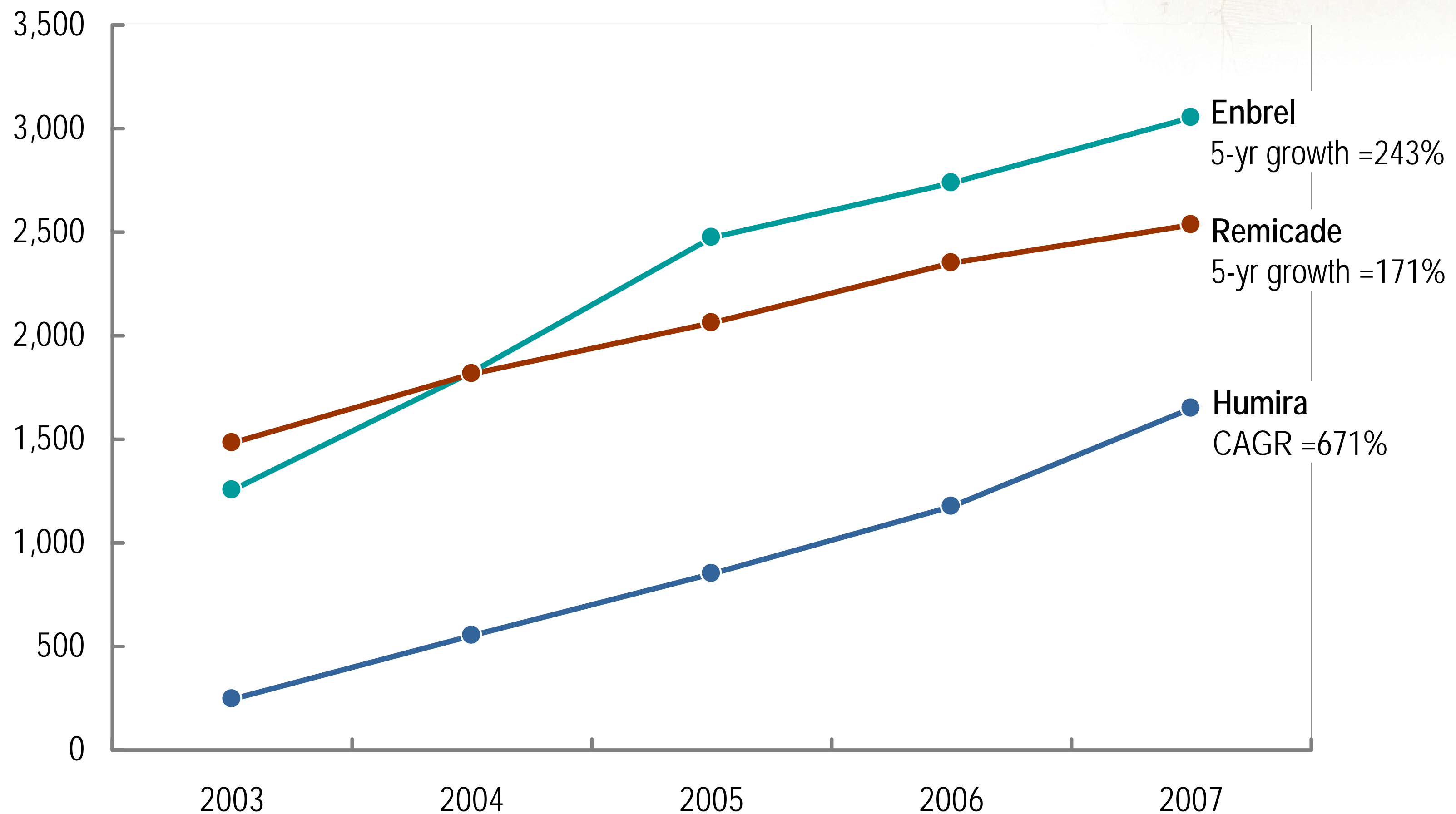
Source: SCDrecipe.com

Procrit and Aranesp/Neulasta margins averaged $90-150,000 per oncologist in 2006

Source: MattsonJack DaVinci, 2007

MattsonJack DaVinci Source: MattsonJack DaVinci, 2007

Evidence of Conflicts? Little systematic evidence of a preference for highest profit alternative (Remicade) in RA



Source: EvaluatePharma

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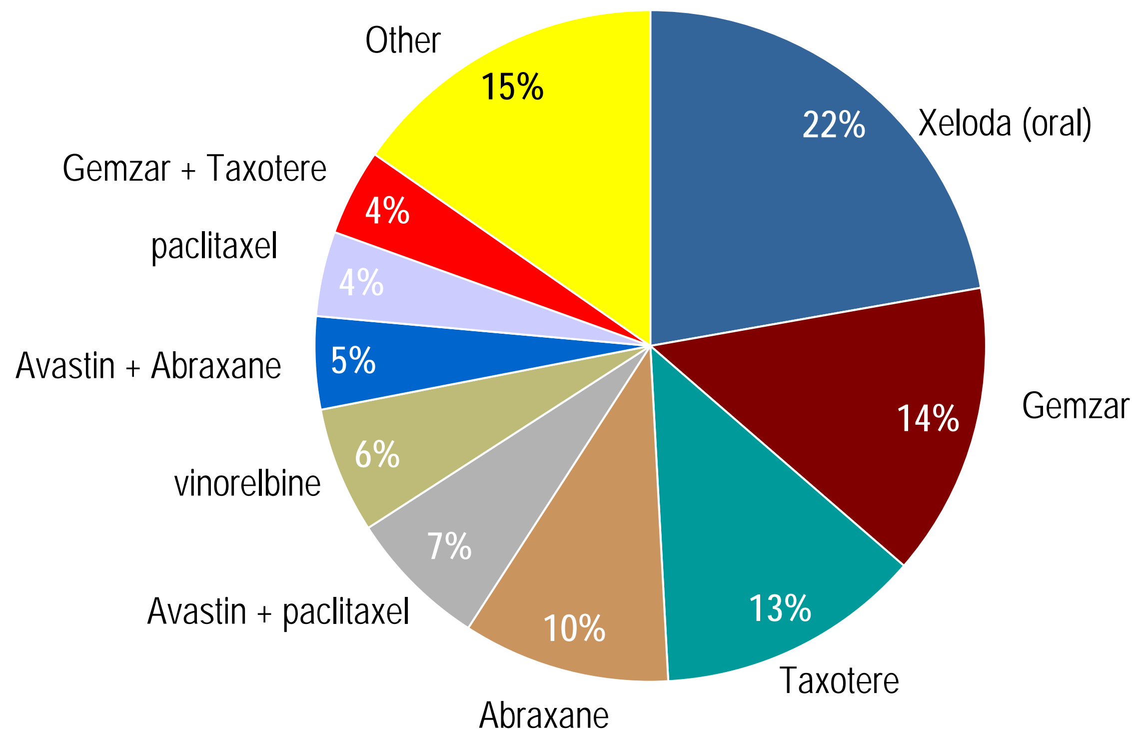
Evidence of Conflicts? Little systematic evidence of using lower efficacy, higher profit alternatives in cancer

Utilization Among Oral, Generic, and Brands Relatively Even

Metastatic Breast, HER-2 Negative, Second Line

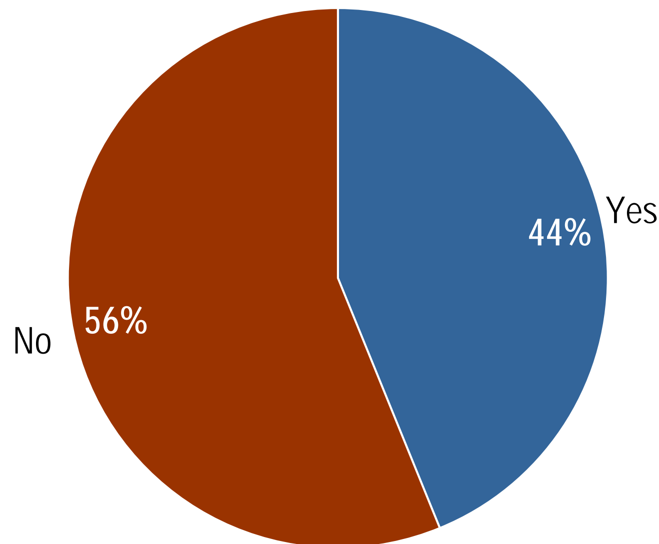


MattsonJack DaVinci Source: MattsonJack DaVinci, CancerImpact, 2007

Conflict with Payers: Medicare patient and provider interests more likely to conflict than commercial

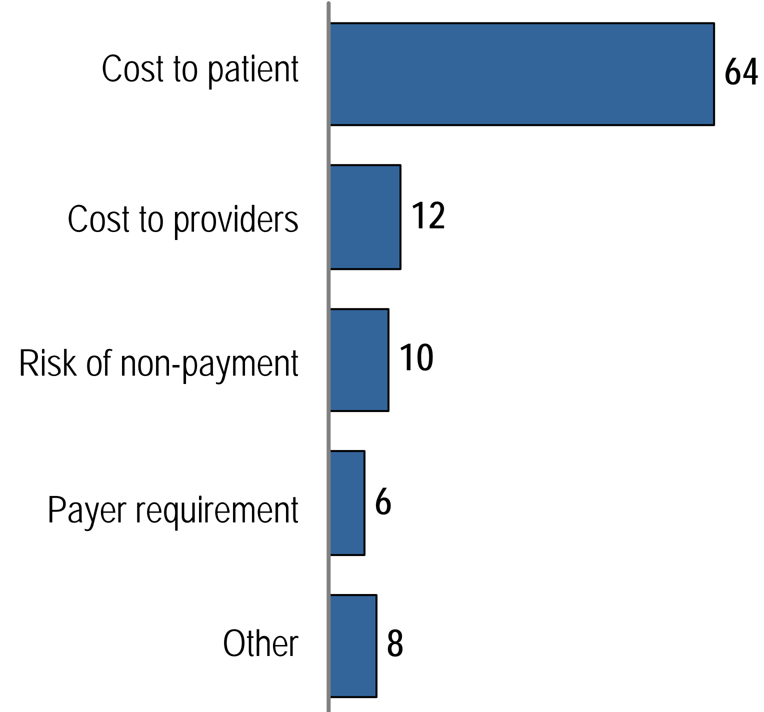
Physicians Deciding to Not Prescribe a Cancer Drug Due Solely to Cost

(n = 104 Community Oncologists and 30 Hospital-based Oncologists)



Reasons for Not Prescribing

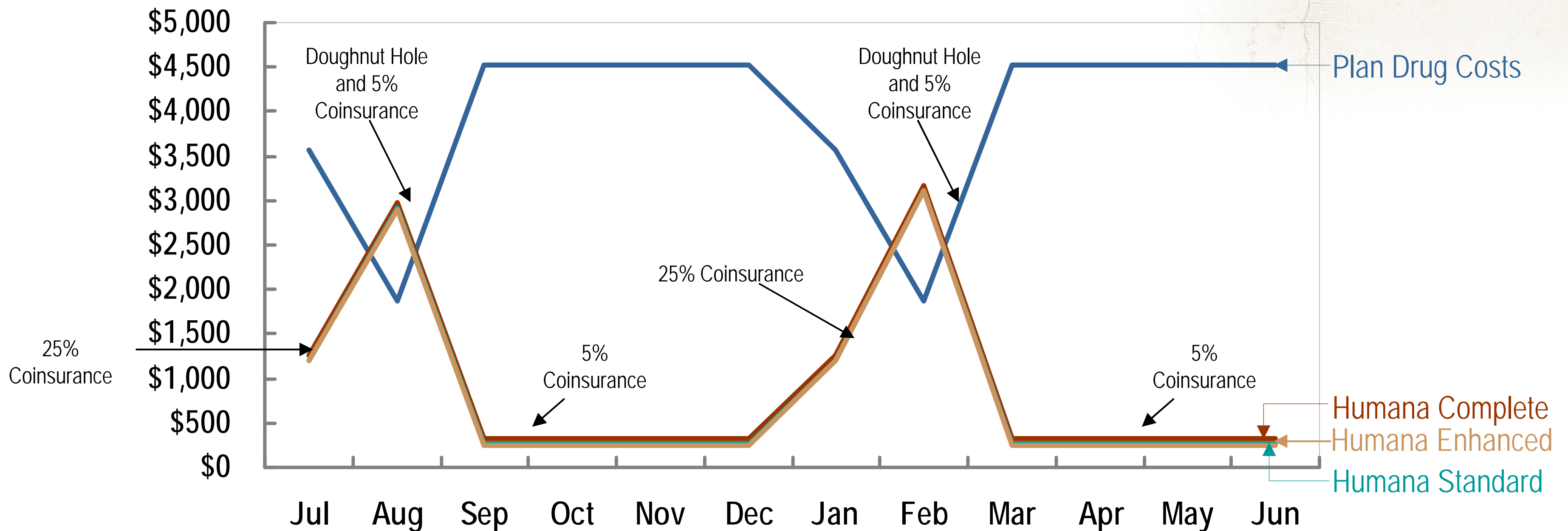
100 Points Allocated (n = 59)



MattsonJack DaVinci Source: Oncology Marketing Strategies US 2007 Oncologist Study, April 2007.

Double Doughnut Holes: Mid-year starts cross 2 coverage gaps in 12 months

Humana Part D Cost Share for Nexavar (RCC)



	Humana Standard	Humana Enhanced	Humana Complete
Monthly Premium*	$12.70	$19.80	$76.60
Total 12-Month Beneficiary Costs	$10,435.90	$10,521.10	$11,202.70
12-Month Drug Costs to Plan	$46,920.14	$46,920.14	$46,920.14

* Texas Zip Code 77030. Monthly patient cost share = $238.35 w/5% coinsurance

Source: Medicare.gov March 27, 2007

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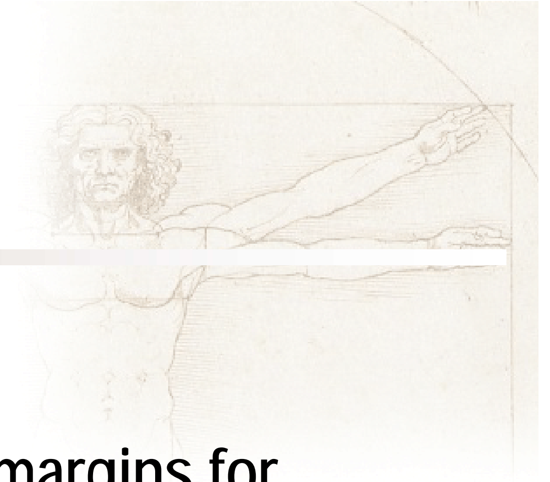
Conclusions

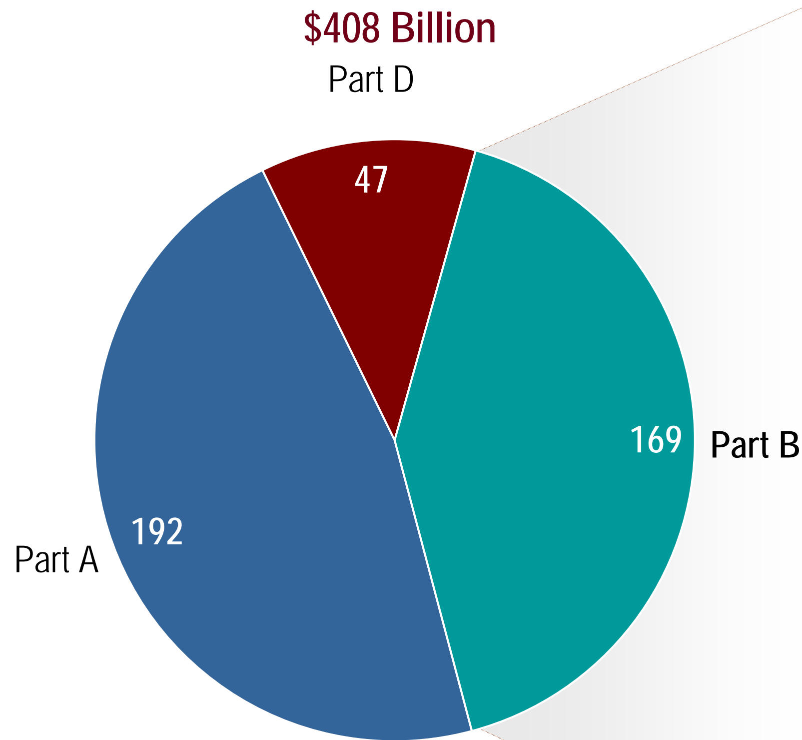


- In-office IV treatment does generate positive margins for many drugs
- Little or no evidence that physicians are allowing profit motive to conflict with patients' best interest
- Part D oral coverage encourages oncologists and Medicare patients to seek treatments covered under Part B

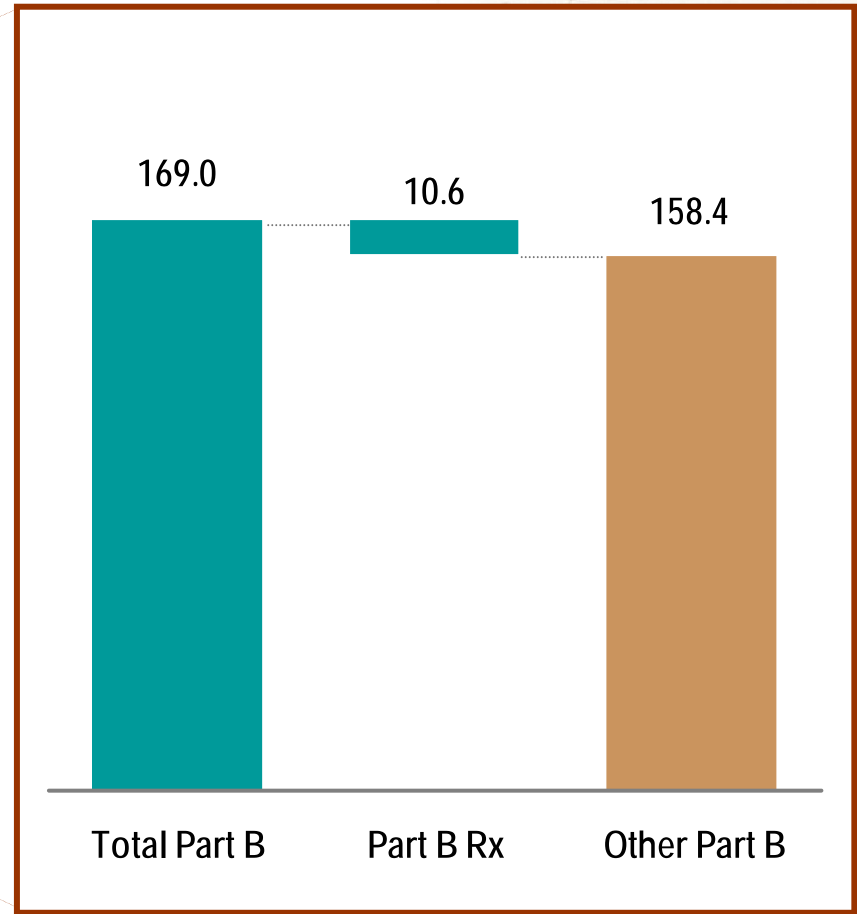
Alternative Reimbursement Schemes

Worth the Worry? Part B drugs accounted for only 2.6% of total Medicare spend in 2006 - below 2004's level

Medicare Expenditures, 2006
$ Billions



Source: 2007 CMS Trustees Report



Source: MedPAC 2008 Data Book

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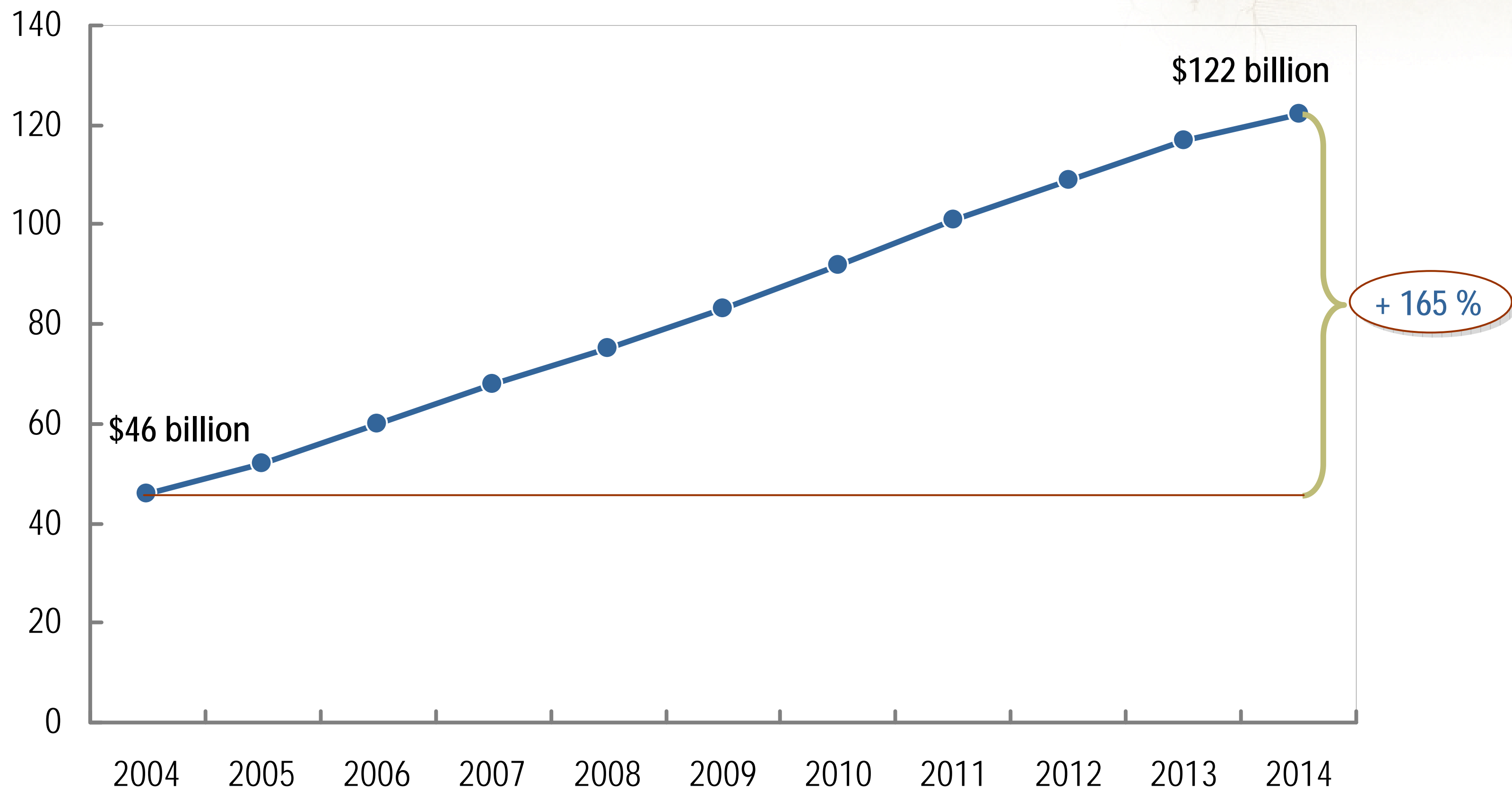
The Trend: Concern based upon forward expectations? Equity forecasts probably overstate clinical development successes.

Injectable Drugs Sales (Projected)*

US only, All Drugs, All Payers; $ Billions



* Includes all injectable classes; subcutaneous, intramuscular, intravenous

Source: Evaluate Pharma

Some proposed goals for a new approach

- **Avoid perverse incentives**
  - Right patient, right drug, right time
  - Care in community medical office/cancer center
  - Support, followup and care coordination provided to patients
- **Render decision makers "formulation agnostic"**
- **Implementation practical: via existing IT and organizational structures**

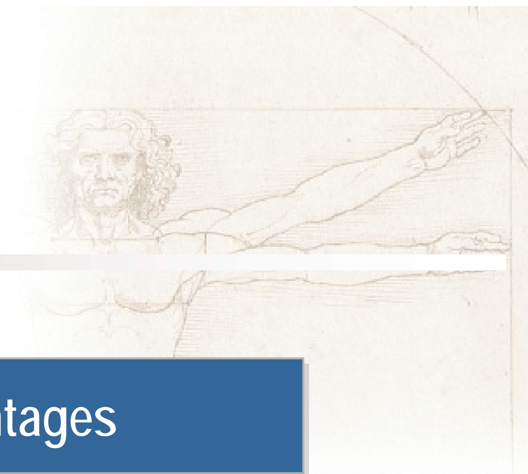
? **Restrain growth trend in costs**

Caveat: reimbursement only, no benefit changes addressed

Alternative One: Maintain the Status Quo

Continue reimbursing physician-administered drugs via “buy and bill”

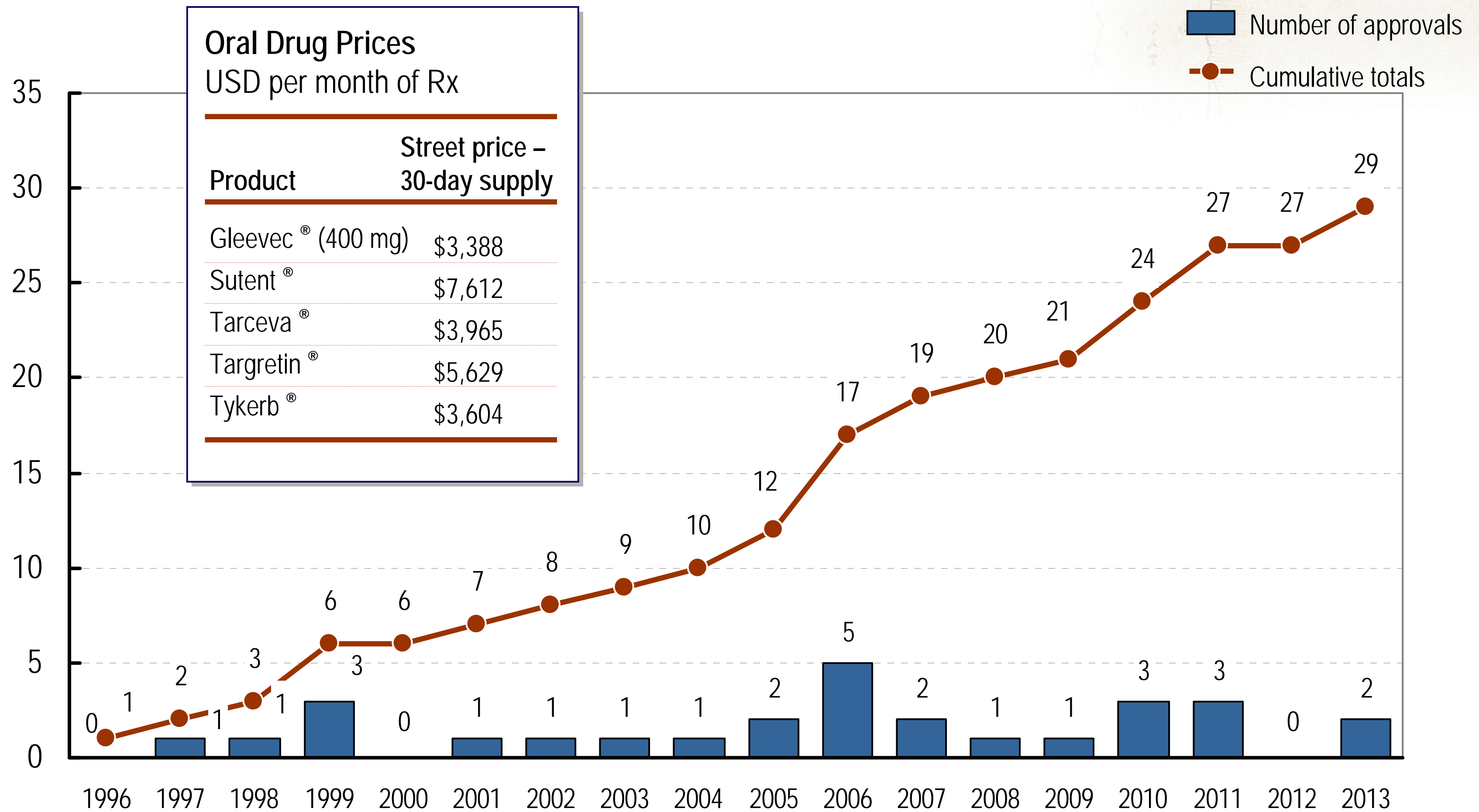
Considerations



Advantages	Disadvantages
• Easy operational implementation • Good physician acceptance (or at least well-understood) • Growth trend already faces downward pressure – Pipeline orals – Generics – Follow on biologics – Commercial plans switching away from AWP-based contracts	• Growth trend continues • Current approach already driving consolidation and likely shift in site of care • Access for orals remains weak for many Part D patients • Physician carries most risk of non-reimbursement

Riding the Wave: Orals may account for 35% of pipeline

Oral Cancer Drug Launches by Year, 1996-2013 (Projected)

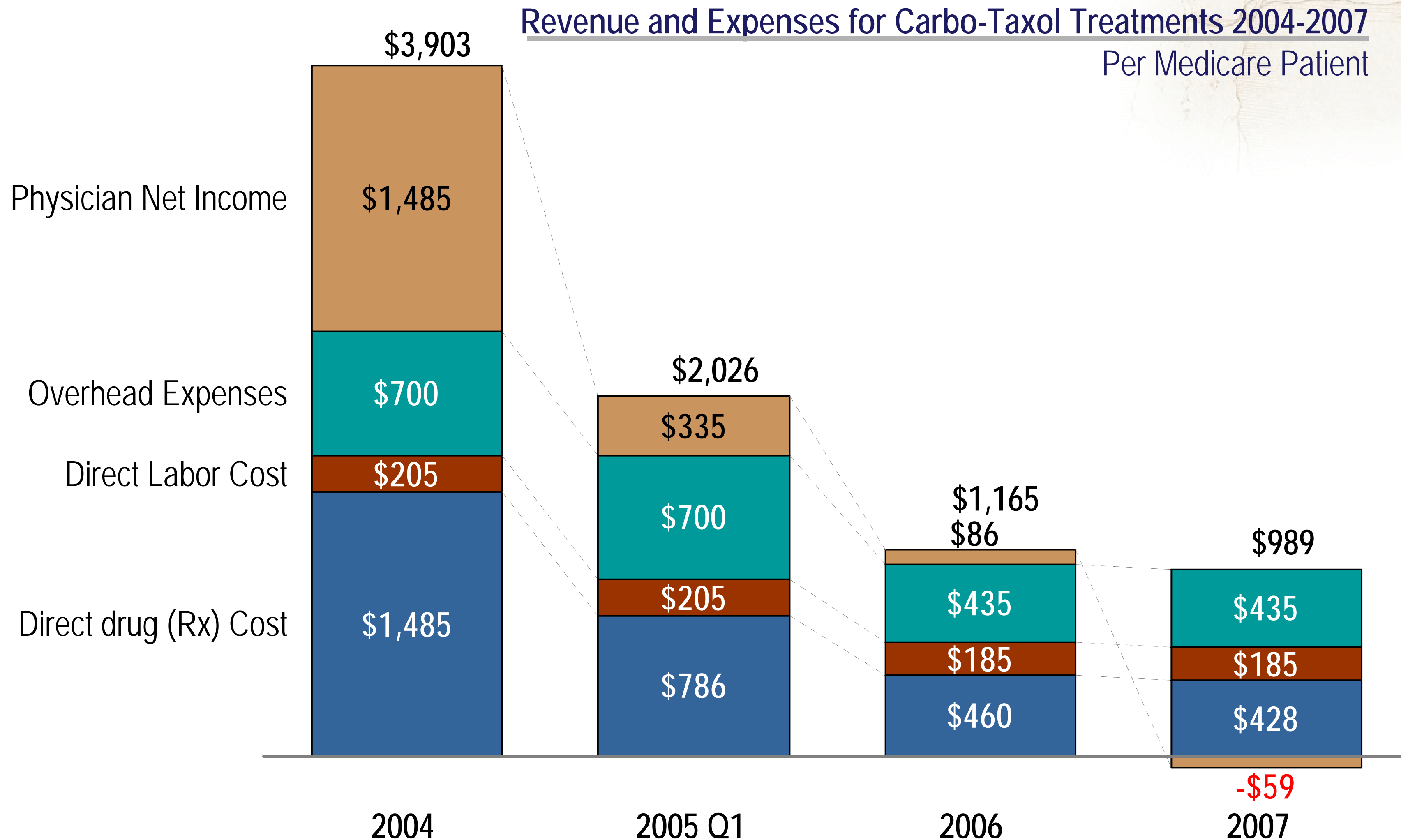


Oral Drug Prices
USD per month of Rx

Product	Street price – 30-day supply
Gleevec ® (400 mg)	$3,388
Sutent ®	$7,612
Tarceva ®	$3,965
Targretin ®	$5,629
Tykerb ®	$3,604

Source: Drugstore.com; MattsonJack DaVinci, Cancer!MPact, Emerging Technologies, July 2008

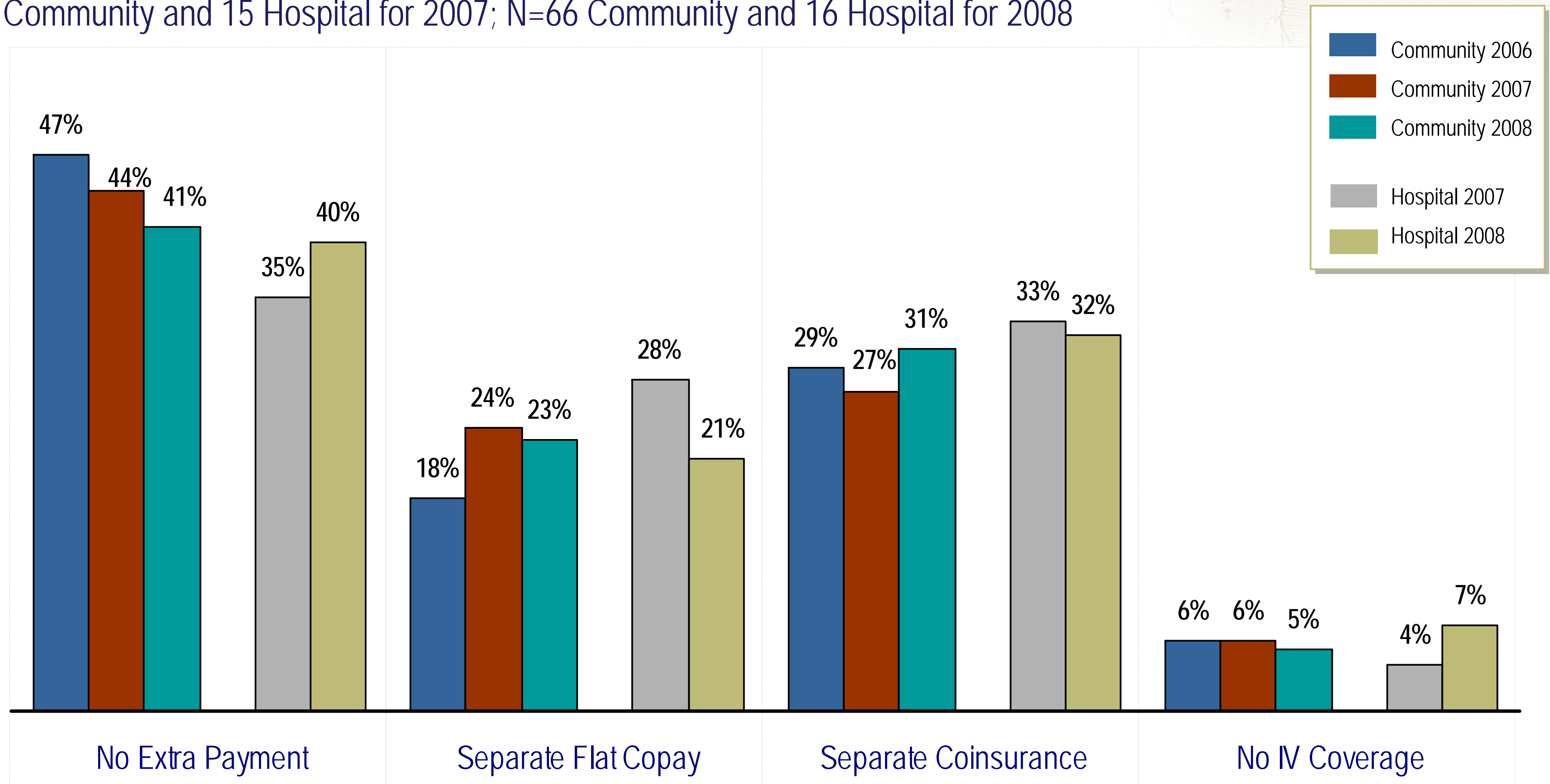
Unintended Consequences: Medicare's ASP-based IV drug reimbursement plunges MDs below break even on chemo



Source: MattsonJack DaVinci, 2007

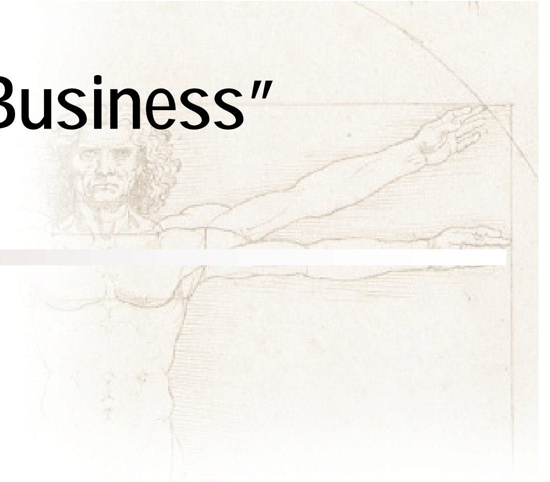
* Overhead expenses exclude physician salary

Unintended Consequences: Rising hospital shares no longer limited to patients with "Grade 4 Financial Toxicity"



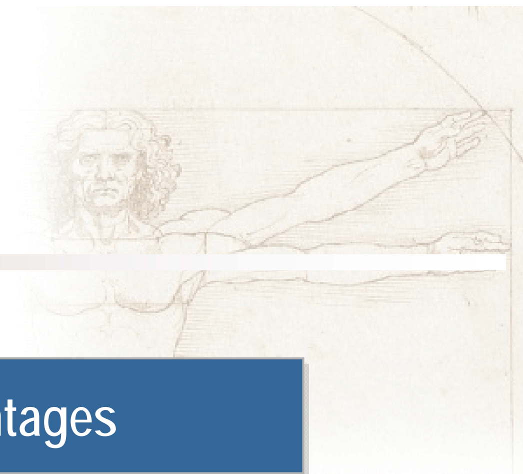
MATTSONJACK DAVINCI Source: MattsonJack DaVinci, Oncology Marketing Strategies™, Oncologist Studies, October 2006, April 2007, and April 2008

Alternative Two: "Get Docs Out of the Drug Business"



Move to zero or low margin on drugs;
Increase administration fees

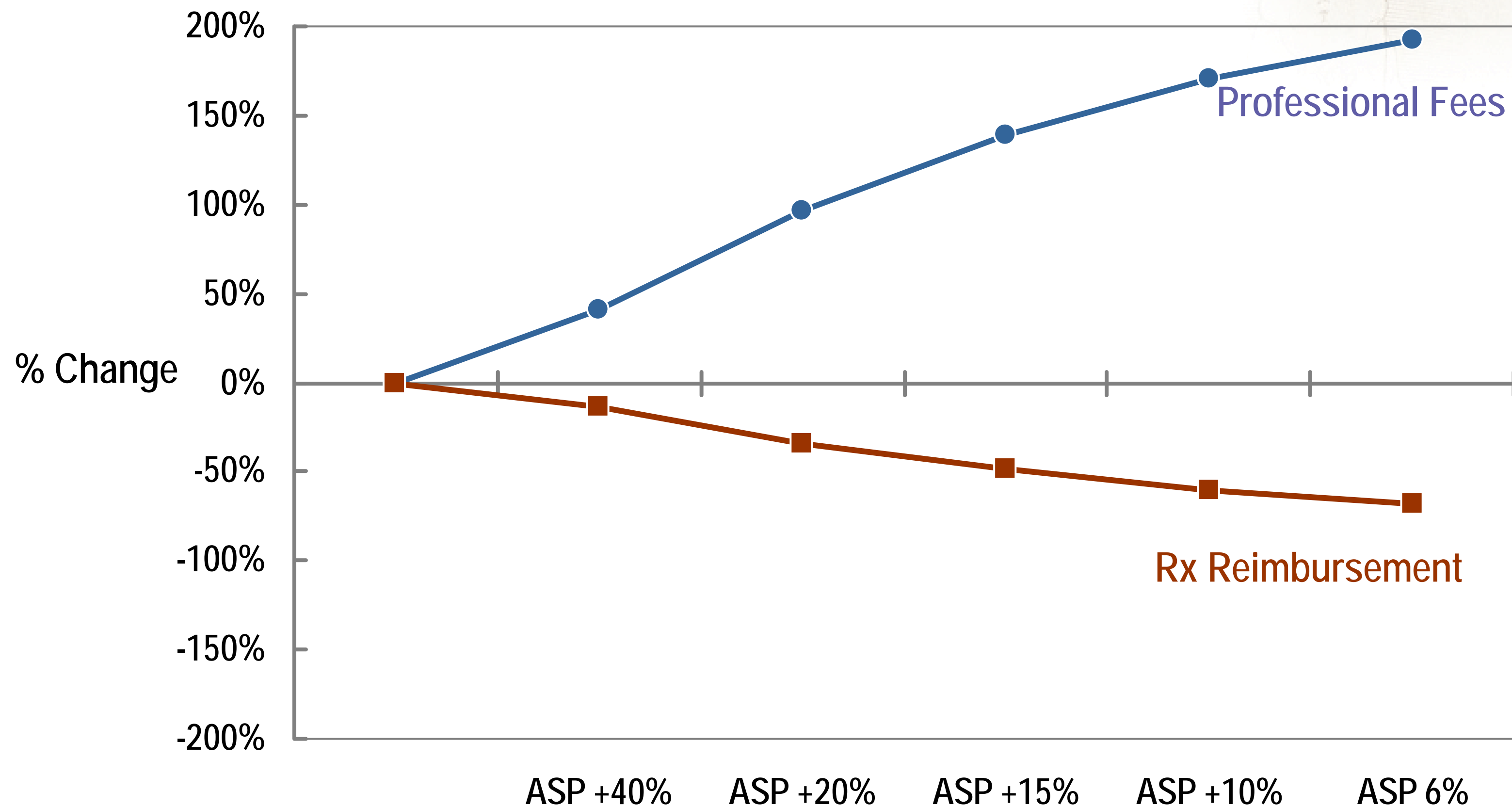
Considerations



Advantages	Disadvantages
• Eliminates profit as a physician selection criterion for "buy and bill" drugs • Re-establishes equality of access for Medicare and commercial patients	• Operationally complex for commercial payers to implement – Contracting structure (IPAs, etc.) – Confirming "cost" of Rx • Magnitude of pro fee shift politically challenging • Reduces $ margin/treatment, may lead to rising treatment volumes • Physicians' inaccurate view of true Rx costs may limit gains • Physician retains risk of non-payment for Rx, but loses margin

Physician Payment Politics: Pro fees need to rise 200% to maintain oncologist income levels at ASP +6%

Percent Increase in Professional Fees Required to Offset Declining Rx Margin

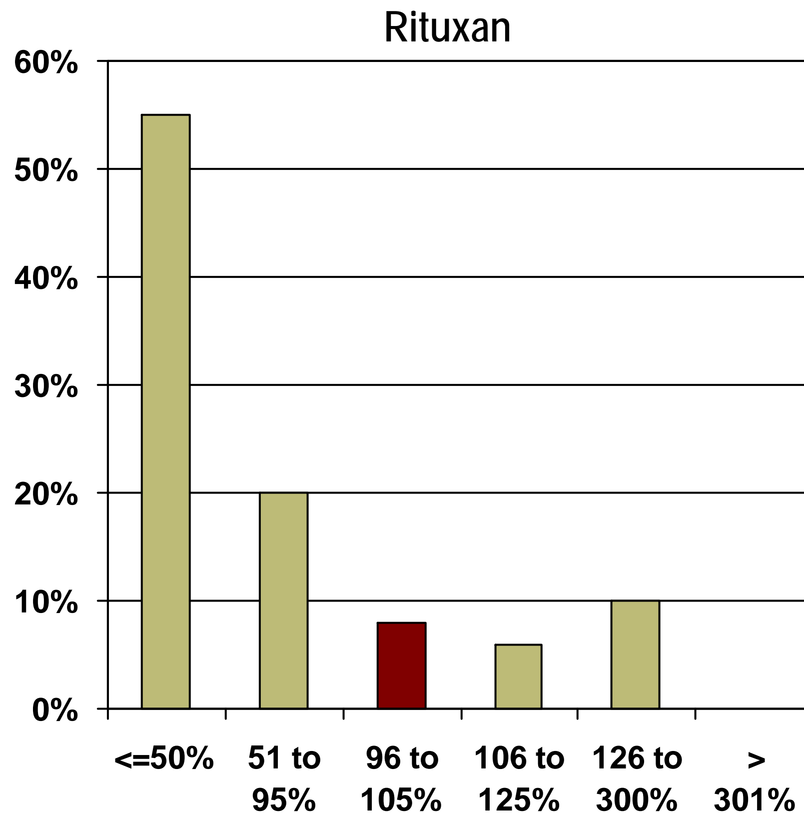


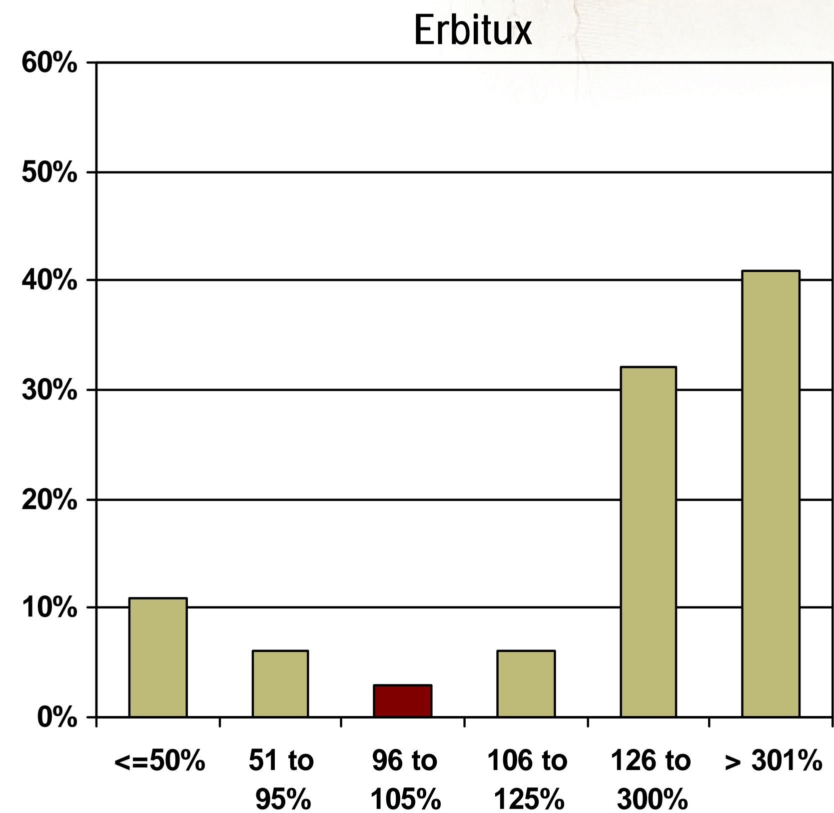
MATTSONJACK DAVINCI Source: MattsonJack DaVinci; OMS 2008; pro bono client analysis

MD Cost Awareness: Significant variation in knowledge of drug costs per treatment

Oncologists' Estimates, 2008

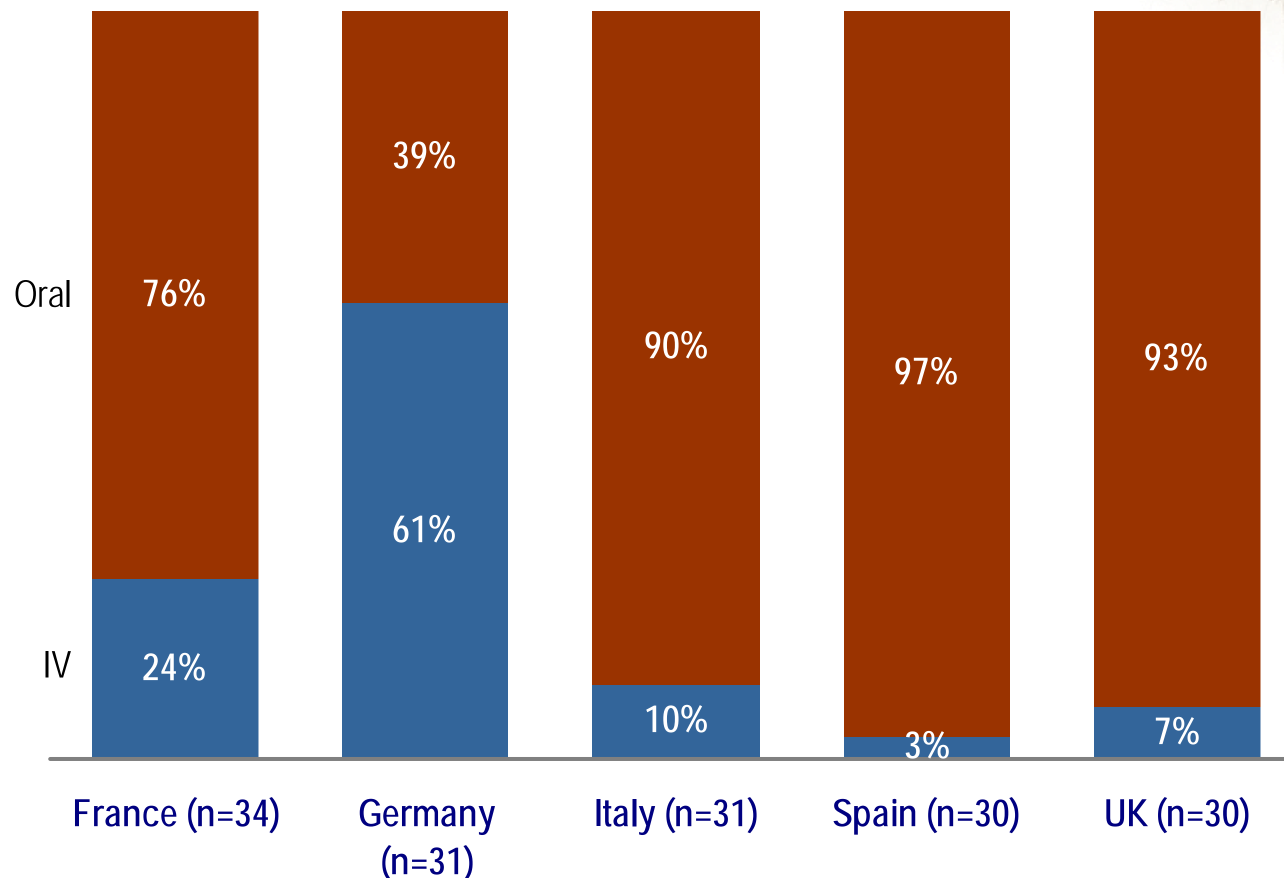
Estimated Cost per Administration; n = 110





MATTSONJACK DAVINCI Source: MattsonJack DaVinci, Oncology Marketing Strategies™, Oncologist Studies, April 2008

Incentives Lower but Remain: German IV admin payments are sufficient to maintain physician preference for IV cancer drugs



Source: MattsonJack DaVinci survey of ~30 oncologists in each country shown. Oncology Marketing Strategies, Western Europe, MattsonJack DaVinci, The Mattson Jack Group, Inc., 2008.

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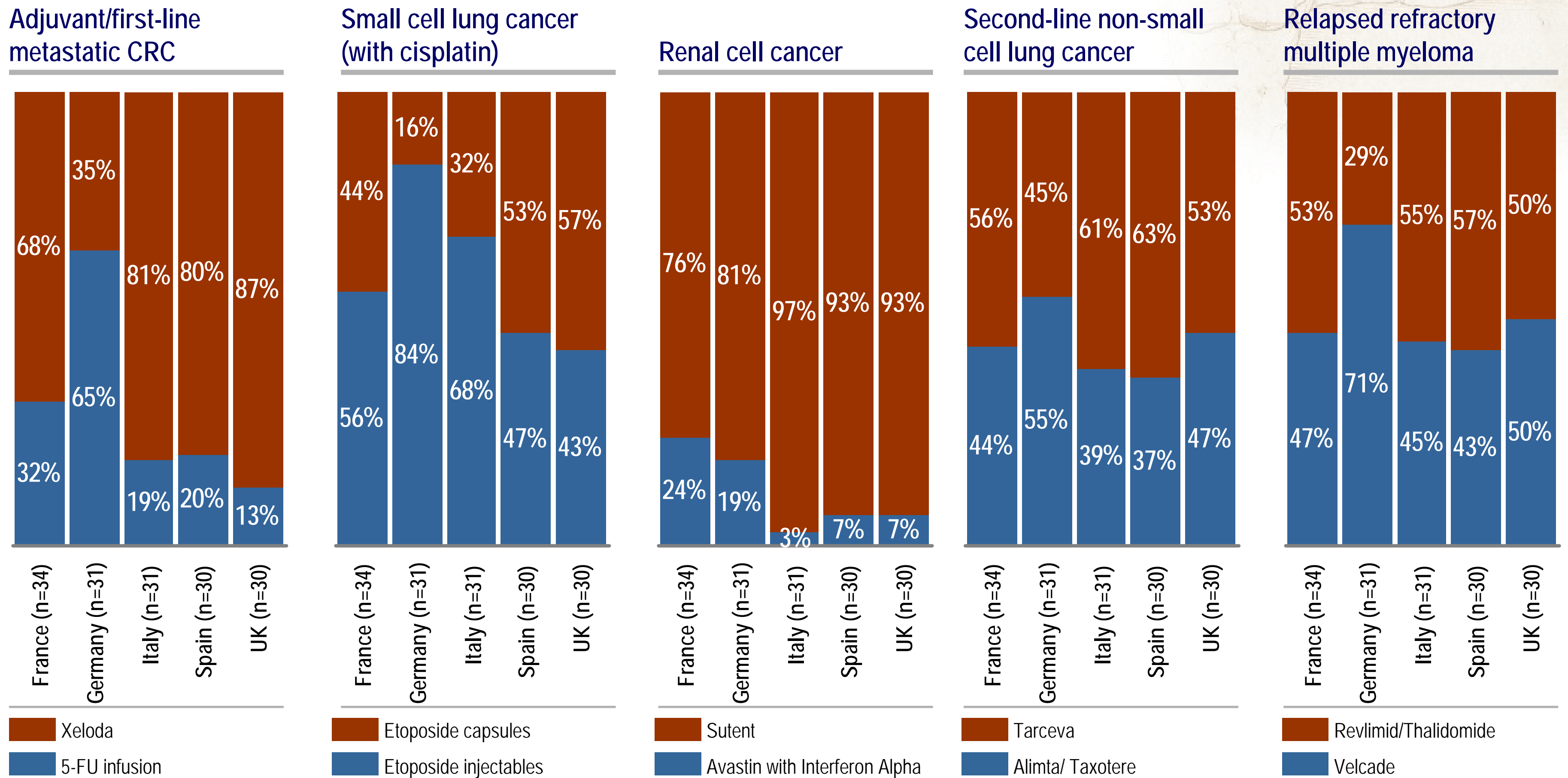
What does zero margin accomplish? Oral vs. IV regimen preference by cancer type



- There is a strong preference in Germany for IV therapies; 61% indicated a preference for IV therapies even at a price premium (slide 18)
- The fact that German oncologists collect a fee for IV administration likely plays into their preference.

Source: MattsonJack DaVinci survey of ~30 oncologists in each country shown. Oncology Marketing Strategies, Western Europe, MattsonJack DaVinci, The Mattson Jack Group, Inc., 2008.

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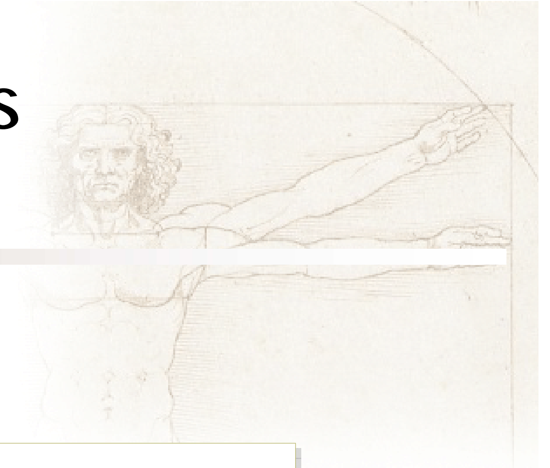
Alternative Three: Management/Episode Fees



Provide margin through episode fees

- Maintain viability of community-based IV infusion through ASP +4-6%
- Add monthly patient management fee for each cycle or line of therapy

Considerations

Advantages	Disadvantages
• Eliminates profit as a physician selection criterion for drug therapies • Pays physician office for managing and overseeing care delivered by multiple providers • Reduces attraction of "conglomerate" strategies, reducing potential for new utilization conflicts	• Operationally complex for commercial payers to implement – Contracting structure (IPAs, etc.) – Confirming "cost" of Rx • Determining terms and size of episode payments will be challenging • Some risk for encouraging undertreatment; requires QA and UM systems to change focus of monitoring

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Incentive Arises from Patient Management: Office-administered drugs deliver positive margins

Taxotere Monotherapy, mBC
Single Treatment, Q1 2007

	Commercial IV Status Quo	IV w/ Mgmt	Oral w/Mgt
Drug revenue	$2,765	$1,987	0
Admin revenue	251	251	0
Total revenue	**3,016**	**2,238**	**0**
Drug cost	1,987	1,987	0
Labor cost	71	71	0
Total cost	**2,058**	**2,058**	**0**
Gross profit	958	180	0
Overhead	168	168	84
Net profit before episode payment	**790**	**12**	
Episode payment	**0**	**778**	**778**
Final Net Profit	**$790**	**$790**	**$694**

MattsonJack DaVinci Source: MattsonJack DaVinci, pro bono client, 2007

Wrapping Up

	Alternative		
	Status Quo	Pro Fees	Management Fee
Avoids perverse incentives		✔	✔ ✔
Maintains community setting		✔	✔ ✔
Funds support, follow up		✔	✔ ✔
Formulation agnostic			✔
Practical implementation	✔ ✔	✔	
Restrains expenditure growth		?	?

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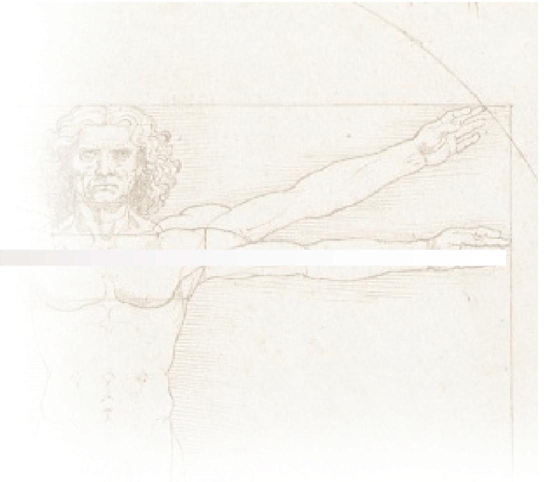

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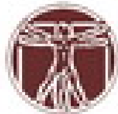

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