

An Advocate's Guide to Patient Out-of-Pocket Costs for Oral Anticancer Treatments

For many years, intravenous (IV) delivery was the primary method for administering the medicines used to treat cancer. In recent years, self-administered medicines, including oral therapies, have become much more prevalent. In fact, for many cancers, an oral treatment is the standard of care and, in some cases, an oral therapy is the only available treatment option. But because many insurance plans' benefit designs treat these benefits differently, some patients can't afford the treatment their physicians have prescribed.

Background and Issue Overview

Most insurance plans include two different types of coverage:

Medical Benefit: A patient's medical benefit or medical coverage applies to health care services and treatments administered in a health care setting. This can include things like doctor's appointments, laboratory tests, hospital inpatient care, and outpatient services like IV infusions.

Pharmacy Benefit: Typically, a patient's prescription drug coverage applies only to prescription drugs that are self-administered, like oral medications.

For IV therapies – which traditionally have been covered under a health plan's medical benefit – the patient's share of the cost is typically a flat copay of a moderate amount. Oral therapies, however, are usually covered under a plan's pharmacy benefit, where patients are commonly required to pay coinsurance.

Copay: The patient pays a fixed dollar amount, and the health plan pays for the remainder of the cost.

Coinsurance: The patient pays a percentage of the total cost, and the health plan pays for the remainder of the cost.

Because coinsurance is calculated as a percentage (of up to 50%) of the actual price of a medication, patients can be required to pay hundreds or thousands of dollars a month to access their physician-prescribed treatments.

The Impact on Patients

The high cost of accessing oral anticancer medications has forced some patients to make the impossible choice of paying for a medically necessary treatment and risking their families' financial stability, or forgoing the treatment prescribed by their doctors and putting their health in jeopardy. Here's just one example: Imatinib is a medication that is commonly prescribed to treat chronic myeloid leukemia (CML). Many CML patients must take this medication daily, for the rest of their lives. Given the price for an average monthly supply of imatinib, a coinsurance of just 20% generates an out-of-pocket expense of at least \$1,200 for a month's supply.

Costs like these drive many patients to alter the prescribed treatment regimen or abandon treatment all together. According to one recent study, when a patient's cost-share (the portion of the total cost that the patient pays) exceeds \$500, nearly 25% of patients abandon their treatment regimen.ⁱⁱ Abandonment can lead to costly hospitalizations, the need for additional treatment, and disease progression.

Our Proposed Solution

The Leukemia & Lymphoma Society (LLS) seeks to ensure that all blood cancer patients have access to quality and affordable treatment. LLS advocates for implementation of policies at both the state and federal level to prohibit health plans from requiring cancer patients to pay a higher out-of-pocket cost for an oral drug versus an intravenous drug. Often referred to as "oral parity," this solution is intended to prevent health plans from forcing a subset of cancer patients to shoulder a disproportionate share of the cost of their treatment.

Health plans should not be permitted to meet this requirement by simply increasing the patient's cost-share for a cancer treatment medication already covered by the plan, regardless of that treatment's administration format. So for example, a health plan could not comply with new laws by raising the patient's cost-share for IV treatments to match their existing cost-sharing formula for oral medications.

Is this Feasible?

Legislation that is similar to our proposal has been enacted in forty states plus the District of Columbia have enacted legislation addressing "oral parity". None of these states have documented a significant increase in premiums as a result of this legislation. This proposal is not considered a mandate because it applies only to health plans that already offer coverage for medications used to treat cancer -- it does not require the coverage of a new benefit or service.

ⁱ Imatinib carries a retail price in the \$6,000 to \$7,500 range for an average monthly supply.

ⁱⁱ Streeter, SB, Schwartzberg, L, and Johnsrud, M. "Patient and Plan Characteristics Affecting Abandonment of Oral Oncolytic Prescriptions." *American Journal of Managed Care*, 2011: 175, 5 spec no: SP38-SP44.