**FAQs and POINT/COUNTERPOINT**

**Patient Cost-Sharing for Oral Anticancer Treatments**

**“What exactly does ‘no less favorable’ mean? How would this be implemented?”**

* + This means that when a patient fills a script for an oral medication, the required cost-share – that is, the amount of money the patient pays out-of-pocket – will be no higher than the cost-share required for a drug administered by IV or some other format.
  + “No less favorable” does not obligate insurers to apply the same exact cost-share to all cancer treatment medications. A health plan would be in compliance as long as the patient’s cost-share for an oral is the same or less than the cost-share for an IV medication.
* Sometimes referred to as “oral chemo 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.

**“Couldn’t this result in an increase in cost-sharing for an IV treatment, or in orals being shifted to the medical benefit where high deductibles must be satisfied?”**

* To protect against this, the bill includes language stating that payers cannot achieve compliance with the law by increasing the patient cost-share for any anticancer medication already covered by the plan.

**“As an alternative to parity, some states have imposed caps. What states are these?”**

* Studies show that prescription abandonment rates increase significantly when the patient cost-share exceeds $100. According to one study, patients facing a cost-share of $500 were four times more likely to abandon their oral oncology products than those with cost-sharing under $100.[[1]](#endnote-1) In light of this fact, patient and provider groups have worked closely with policymakers to ensure that caps do not exceed $100.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| STATE | YEAR | AMOUNT | STATE | YEAR | AMOUNT |
| California | 2013 | $ 200 | Nevada | 2013 | $ 100 |
| Florida | 2013 | $ 50 | New Hampshire | 2015 | $ 200 |
| Georgia | 2014 | $ 200 | Ohio | 2014 | $ 100 |
| Kentucky | 2014 | $ 100 | Oklahoma | 2013 | $ 100 |
| Louisiana | 2012 | $ 100 | Utah | 2013 | $ 300 |
| Missouri | 2014 | $ 75 | Wisconsin | 2014 | $ 100 |

**“Would this bill be considered a mandate?”**

* No. This bill applies only to health plans that already offer coverage for medications used to treat cancer. So, in other words, this bill does not require the coverage of a new benefit or service.
* With regard to the Affordable Care Act (ACA): the ACA permits a state to require qualified health plans (QHPs) to offer benefits that go above and beyond those already included in the essential health benefits package (EHB) selected by that state. However, if doing so, the state must defray the cost of these additional benefits, if those benefits were mandated in state laws enacted on or after January 1, 2012. Federal regulation specified that this requirement applies to state laws that require the coverage of NEW benefits and/or services. In 2013, CMS was asked if – in light of this requirement – a state would have to defray the cost of oral parity requirements enacted in 2012 and beyond. In reply, CMS wrote, “No. We do not consider such payment parity bills to create a requirement to cover a NEW benefit.”[[2]](#endnote-2) In other words, CMS does not consider oral parity to be a mandate and, as a result, a state would not have to defray the cost of oral parity.

**“Doesn’t the ACA’s out-of-pocket maximum address this problem?”**

* Under the ACA, health plans in the small group and individual market must comply with an annual out-of-pocket maximum for in-network expenses. In 2016, that amount is set at $6,850 for an individual and at $13,700 for a family. This cap is intended to limit the total out-of-pockets costs that a patient can be required to pay in the course of a single year. But an *annual* maximum offers little value to a patient facing a *monthly* financial hardship – for example, a $1,200 cost-share for one month’s supply of a single medication – which many patients encounter at the very start of their plan year.
* The value of the ACA’s out-of-pocket maximum is further limited by the fact that only certain costs count toward the maximum. There is no ceiling limiting the accumulation of any other costs. Further, grandfathered health plans (those in existence before March 23, 2010) do not have to comply with the ACA’s cost-sharing limitations. Bottom line: despite the ACA, many patients and their families may continue to face serious financial strain as a result of the cost of their care.

**“Decreasing the cost-share for oral therapies will force an increase in the cost-share for a different benefit or service covered by the plan, in order for the plan to satisfy actuarial value (AV) requirements and avoid increases in premiums.”**

* Relative to the total number of covered lives, cancer patients are a statistically small population. For that reason, spending on cancer medicines – including both IVs and orals – represents less than 1% of overall health care spending[[3]](#endnote-3). Of that amount, a fraction applies to oral therapies.
* This low utilization of oral anticancer therapies – relative to the utilization of other covered benefits and services – means that parity will not trigger any significant increase in either AV or premiums. This can be observed in the forty states (plus the District of Columbia) where parity bills have been enacted: none of these states have documented a statistically significant increase in premiums as a result of these laws.

**“Implementing parity means forcing all policyholders to absorb the cost of cancer treatment. It’s not fair that cancer patients should receive preferential treatment.”**

* This policy change will not trigger a significant increase in costs for the average plan or consumer, given the relatively low utilization of oral anticancer therapies.
* Insurance is intended to spread risk across the total insured population, rather than singling out certain patients by forcing them to cover a disproportionate share of the cost of their care.

**“Oral therapies are more expensive. That’s why the cost-sharing is higher.”**

* There is variation in the cost of individual cancer treatment medications. Newer treatments are considered to have a higher cost than older therapies, but in general this higher cost is associated with all newer, innovative therapies, regardless of their administration format. Note that older therapies – together as a group – include some medications for which there is now a lower-cost, generic counterpart.
* In some cases, IV treatments involve higher total plan costs than an oral medication, as administering an IV drug requires health plans to cover the cost of other items and services in addition to the cost of the drug itself. This can include facility fees, nursing staff, and supplies. For example, a study published in 2013 in the *Journal of Medical Economics* compared the overall costs of IV and oral therapies used in the treatment of relapsed/refractory multiple myeloma. The study found that annual treatment costs for the IV regimen were more than $17,000 higher than the costs for the oral regimen, as the result of direct medical costs. (The costs of the drugs themselves were about the same.)[[4]](#endnote-4)

**“If a health care provider believes that it’s in a patient’s best interest to take an oral therapy that’s not covered by the patient’s health plan, then the provider can simply use the insurer’s exceptions process to request that the therapy be covered.”**

* An exceptions process may allow a health care provider to request that a product be considered on-formulary, but that determination doesn’t necessarily mean that coverage would be provided for the oral therapy under the same out-of-pocket cost as for an IV medication.
* Exceptions processes often lack transparency and can be time-consuming and difficult to follow for both patients and health care providers.

**“Only federal law can require all plans to implement parity. Patients would be better served if proponents of this bill would focus their efforts on Congress.”**

* + While some plans are not subject to state law, there remains a significant number of plans in our state that would be subject to – and improved by – this bill. Patients covered by those plans should have the benefit of affordable cancer treatment, as do patients in the states where parity has been enacted.
  + Oftentimes, the federal government does not take action on a particular issue until after a significant number of states has done so; in that way, state action is absolutely critical to achieving this policy change for plans that are subject only to federal law.
  + In some states where parity has been enacted, insurers have chosen to extend parity to their federally-regulated plans as well. Thus, establishing parity in state law can have a positive domino effect on other plans in the state.

**“Insurers have not heard from their customers that this is in fact a problem.”**

* + Every year, non-profit organizations receive a high volume of requests for financial assistance from cancer patients who need help paying the cost-share required for their treatment medications. This is clear evidence that patients are experiencing out-of-pocket costs that prohibit –rather than facilitate—access to treatment.
* The volume of complaints that insurers receive should not be interpreted as an accurate measure of the number of patients having trouble accessing a needed medication. Many patients—rather than contact their insurer—will simply turn down a medication at the pharmacy or ask their doctor to suggest treatment alternatives with a lower out-of-pocket cost, even if the alternative offers a lower potential medical benefit.

**“This bill is focused on nothing more than forcing insurers to cover more ‘convenient’ treatment options.”**

* A patient’s treatment plan is determined by medical necessity – not ‘choice’ or ‘convenience.’ What’s more, nearly all of the oral anticancer drugs currently in use do not have an IV equivalent. In other words, then, a so-called ‘choice’ in treatment does not even exist for the vast majority of patients.

**“Does the bill ensure that patients who take oral anticancer medications at home are correctly taking those medications?”**

* The concern behind this bill is prohibitive cost-sharing, not patient skill or awareness. It’s within the scope of practice of a health care professional – not a legislator or insurer – to determine if/how patient skill and awareness should influence treatment decisions.
* High cost-sharing has been shown by many studies to be a primary driver in poor adherence. According to one recent study, when a cost-share exceeds $500, nearly 25% of patients abandon their treatment regimen.[[5]](#endnote-5) Abandonment can lead to costly hospitalizations, the need for additional treatment, and disease progression.

[top](http://kff.org/health-reform/faq/health-reform-frequently-asked-questions/#faq-wrapper)

KFF

###### [Can I buy or change private health plan coverage outside of Open Enrollment?](http://kff.org/health-reform/faq/health-reform-frequently-asked-questions/#question-can-i-buy-or-change-private-health-plan-coverage-outside-of-open-enrollment)

In general, you can have a special enrollment opportunity to sign up for private, non-group coverage during the year, other than during Open Enrollment period, if you have a qualifying life event. Events that trigger a special enrollment opportunity are:

* + Loss of eligibility for other coverage (for example if you quit your job or were laid off or if your hours were reduced, or if you lose student health coverage when you graduate) Note that loss of eligibility for other coverage because you didn’t pay premiums does not trigger a special enrollment opportunity
  + Gaining a dependent (for example, if you get married or give birth to or adopt a child). Note that pregnancy does NOT trigger a special enrollment opportunity.
  + Loss of coverage due to divorce or legal separation
  + Loss of dependent status (for example, “aging off” a parents’ plan when you turn 26)
  + Moving to another state or within a state if you move outside of your health plan service area
  + Exhaustion of COBRA coverage
  + Losing eligibility for Medicaid or the Children’s Health Insurance Program
  + For people enrolled in a Marketplace plan, income increases or decreases enough to change your eligibility for subsidies
  + Change in immigration status
  + Enrollment or eligibility error made by the Marketplace or another government agency or somebody, such as an assister, acting on their behalf.
* Note that some triggering events will only qualify you for a special enrollment opportunity in the health insurance Marketplace; they do not apply in the outside market. For example, if you gain citizenship or lawfully present status, the Marketplace must provide you with a special enrollment opportunity.
* When you experience a qualifying event, your special enrollment opportunity will last 60 days from the date of that triggering event. If you can foresee a qualifying event (for example, you know the date when you will graduate and lose student health coverage) you can ask the Marketplace for a special enrollment opportunity up to 60 days in advance so new coverage will take effect right after your old coverage runs out.
* States have flexibility to expand special enrollment opportunities for consumers. Check with your State Marketplace for more information.

1. Streeter, et al. “Patient and Plan Characteristics Affecting Abandonment of Oral Oncolytic Prescriptions.”*American Journal of Managed Care, SP 38,* May 2011 [↑](#endnote-ref-1)
2. QHP Webinar Series. Frequently Asked Questions #10. April 30, 2013 [↑](#endnote-ref-2)
3. PhRMA. “Cancer Medicines: Value in Context.” Cancer Chart Pack. Spring 2014. [↑](#endnote-ref-3)
4. Durie, BGM, Binder, G, Pashos CL, Khan, ZM, Hussein, MA, Borrello I. “Total cost comparison in relapsed/refractory multiple myeloma.” *Journal of Medical Economics*. Epub 2013 Jan 3. [↑](#endnote-ref-4)
5. Streeter et al. [↑](#endnote-ref-5)