LEUKEMIA & LYMPHOMA SOCIETY®
fighting blood cancers

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Statement in Support of SB 142/HB 272 (Giessel/Saddler)
Patient Cost-Sharing for Oral Anti-Cancer Treatments

Oral therapies: a cornerstone in cancer treatment

For many years, intravenous (IV) delivery was the primary method for administering the medicines used to treat cancer but, in recent years, orally-administered medicines have increased in prevalence. 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. This marks a major trend in cancer treatment: of the cancer drugs currently under development, estimates project that up to 35% will be available in pill format only.[i]

Disparities in coverage for oral therapies limit patient access

Unfortunately, health plans have not kept pace with this development, as high cost-sharing requirements prohibit many patients from accessing oral therapies. This contrasts sharply with the cost-sharing rules that have typically applied to IV-administered cancer treatments. For IV therapies – which traditionally have been covered under a plan's medical benefit – the typical cost-share is a flat co-pay of a moderate amount. Oral therapies, however, are usually covered under a plan's pharmacy benefit, where patients are commonly required to pay coinsurance. A percentage of the actual price of a medication, coinsurance can range as high as 40%, leading to a potential cost-share in the thousands of dollars for a single month's supply of a medication.

Such high cost-sharing forces patients to make impossible choices between paying for a medically necessary treatment or risking the family's financial stability. High cost-sharing also drives many patients to alter the prescribed treatment regimen: three out of seven cancer patients report skipping doses or cutting pills, as a result of financial pressures.[ii] In other cases, patients have stopped taking their pills altogether. According to one recent study, when a cost-share exceeds $500, nearly 25% of patients abandon their treatment regimen.[iii] Abandonment can lead to costly hospitalizations, the need for additional treatment, and disease progression.

A fair and balanced solution: ***SB 142/HB 272***

The Leukemia & Lymphoma Society (LLS) applauds Senator Cathy Giessel and Representative Dan Saddler for their introduction of SB 142 and HB 272 respectively, which would prohibit health plans from requiring cancer patients to pay an out-of-pocket cost for an oral therapy that is higher than the out-of-pocket required for an IV-administered cancer treatment. It is a simple solution, intended to ensure that patients can reliably expect fair and consistent coverage for cancer treatment, even when those treatments happen to come in the form of pill.

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As of today, forty states and the District of Columbia have enacted a similar law, as governors and legislators on both sides of the aisle and all across the country have come to recognize the very real barrier that this issue imposes on patients living with cancer. The existence of forty very similar laws also indicates that policymakers view the approach captured in this bill as the ***right*** solution. LLS is hopeful that lawmakers in Alaska will similarly embrace SB 142 and HB 272, not only because it offers meaningful improvements in access to care but also because it adopts an approach that is fair and balanced:

- **This bill is expected to have little-to-no impact on premiums.** This can be observed already 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.
- **This bill will make tremendous improvements in access to care.** Under the Affordable Care Act, certain health plans must comply with an annual out-of-pocket maximum. This cap (set at $6,850 for an individual in 2016) 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 cancer patients often encounter at the very start of their plan year. Thus many cancer patients continue to face serious financial strain as a result of the cost-share for their care. This bill would address that problem for many patients in Alaska.
- **This bill is not a mandate.** SB 142 and HB 272 would apply only to health plans that already offer coverage for medications used to treat cancer – meaning, this bill does not require the coverage of a new benefit or service.

At LLS, our mission is to find cures for leukemia, lymphoma, Hodgkin's disease, and myeloma, and to ensure that blood cancer patients have sustainable access to quality, affordable, coordinated healthcare. We urge the committee to help advance that mission by supporting SB 142 and HB 272.

With questions or concerns, please contact:

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[i] Geynissman, DM and Wickersham, KE. "Adherence to Targeted Oral Anticancer Medications." *Discovery Medicine*, 2014: 17, no. 095.

[ii] Zullig, LL, Peppercorn, JM, et al. "Financial Distress, Use of Cost-Coping Strategies, and Adherence to Prescription Medication Among Patients With Cancer." *Journal of Oncology Practice*, 2013: vol. 9, issue 6s.

[iii] 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.