Response Memo to Oral Chemotherapy Copayment Parity Backgrounder

Statement: This is a matter of convenience & preference for the patient: if they can only afford an IV therapy, they should just choose that therapy.

Response: In most cases, a cancer patient will not have a choice between an IV or oral therapy. Their doctor will prescribe the treatment which is the standard of care for their specific cancer, regardless of how the treatment is administered. Additionally, given the prevalent use of combination therapy, which includes both oral and IV treatments in a course of treatment, affordable access to both is essential. As more cancers are treated with these targeted therapies, it is important to ensure that patients have affordable access. Of the approximately 1,000 cancer medicines in the pipeline, nearly 80% are first in class medications that take a novel approach to treating a specific type of cancer. Oral parity merely creates fairness in the benefit design for patients who rely on oral medications to treat their cancer and only applies to insurers that already offer coverage of oral medications.

Statement: This is going to be an additional driver of increased healthcare costs as providers have more incentive to prescribe oral therapies.

Response: Specialty medications are not a primary driver of the growth in overall healthcare costs. This legislation simply brings fundamental fairness to insurance benefit designs and does not incentivize prescribing habits. Furthermore, patients treated with oral chemotherapy have the ease of taking their medication at home, have limited travel requirements for treatment, reduced medical cost associated with infusion centers and less risk of complication associated with IV therapy.

Statement: Doesn't the Affordable Care Act (ACA) fix the problem of high out-of-pocket costs for patients?

Response: The ACA put in place annual out-of-pocket maximums for patients and provide important protections. Unfortunately, this does not help those who have cancer that may be required to pay thousands of dollars in coinsurance per prescription each month until they reach their out-of-pocket maximum. In fact, since the passage of the ACA, the number of plans charging high coinsurances for specialty drugs has increased dramatically. For example, in 2015, approximately 41% of Silver Plans had co-insurance greater than 30% on specialty tier drugs.

Statement: Isn't this a coverage mandate? Won't the state have to pick up these costs under the ACA?

Response: No. CMS has clearly stated in a FAQ document that an oral parity law is a cost-sharing requirement, not a coverage benefit. This distinction is essential, as states are only required to defray the cost of additional coverage benefits. [1]

Statement: This legislation will result in significant premium increases.

---

[1] http://bewv.wvinsurance.gov/Portals/2/pdf/QHP%20FAQ%2012%20-%20June%202013.pdf

Response: Fifteen states have proactively studied the premium impacts of oral chemotherapy parity and demonstrated insignificant increases in premiums. In 2012, Massachusetts estimated the impact to be between 4 cents and 23 cents per member per month.[2]

In California, the 2011-2012 CHBRP analysis estimated the impact to be between 1 cent and 3 cents per member per month.[3] In a 2010 study, Milliman consulting estimated that the impact of oral parity in most benefit designs would be less than 50 cents per member per month.[4]

Statement: This bill is too difficult to implement because of the distinctions between the pharmacy and medical benefit.

Response: Oral parity has been successfully implemented in 40 states and the District of Columbia, and flexibility has been provided for plans to implement the bill in a way that fits best with their business model while still creating parity in out-of-pocket costs for oral and IV medications. In a focus group conducted of 13 health plans that Avalere health found that plans implemented the bill through a number of different types of cost-sharing adjustments in order to achieve compliance with the parity laws.

Statement: Despite new ways of administering chemotherapy, it continues to require direct oversight by qualified medical professionals, to ensure patient safety.

Response: It is true that physicians and other medical professionals have gone to great lengths to protect patients receiving any cancer killing treatment and patients have benefited tremendously, as a result.

In 2008, the American Society of Clinical Oncology (ASCO) and the Oncology Nursing Society (ONS) convened a meeting with a broad range of stakeholder organizations and created a set of 31 standards for the administration of chemotherapy in outpatient settings for cancer centers, oncologists and other providers to follow. These standards encompass seven domains: (1) review of clinical information and selection of a treatment regimen; (2) treatment planning and informed consent; (3) ordering of treatment; (4) drug preparation; (5) assessment of treatment compliance; (6) administration and monitoring; (7) assessment of response and toxicity monitoring.

Moreover, the Occupational Health and Safety Administration (OSHA) and the American Society of Health-System Pharmacists (ASHP) have strict guidelines on how oral chemotherapy should be handled and administered by practitioners. Additionally, cancer centers and oncology practices have procedures to help reduce patient safety risks associated with oral chemotherapy and to better monitor adherence. For example, centers and practices have incorporated telephone outreach into their methodologies for gauging adherence to oral therapy and monitoring for potential adverse events.

---

[2] http://www.chiamass.gov/assets/docs/r/pubs/12/mb-oral-cancer-therapy-actuarial.pdf

[3] http://chbrp.ucop.edu/index.php?action=read&bill_id=125&doc_type=2

[4] http://us.milliman.com/uploadedFiles/insight/research/health-rr/parity-oral-intravenous-injected.pdf