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ORAL/IV PARITY AND THE AFFORDABLE CARE ACT:

Legislative Action Needed to Ensure Patient Access to Self-Administered Anti-Cancer Therapies

Discrimination in cost sharing is a barrier to life-saving cancer treatment for patients.

Cancer patients can face significantly higher out-of-pocket costs if their treatment is self-administered rather than administered by a health care professional. The problem is out-of-date insurance benefit design. Intravenous or infused cancer medications are typically covered under a health plan's medical benefit. In this situation, patients are usually required to pay an office visit co-payment and are not required to pay a separate fee for the drug. However, orally-administered cancer medications are generally covered under a health plan's pharmacy benefit. Traditional prescription drug programs, with fixed co-pays of $25 or $40 per prescription, do not impose large cost-sharing. However, some plans require patients to pay a coinsurance for certain drugs, of as much as 25%, 40% or higher. For patients facing cancer – a life-changing diagnosis that causes a great deal of disruption and uncertainty in their lives – having to also face exorbitant cost-sharing requirements amounting to thousands of dollars in prescription drug costs can prove overwhelming.

How this legislation relates to the Affordable Care Act (ACA):

The ACA does nothing to address a patient's monthly out-of-pocket burden.

Under the ACA, health plans in the small group and individual market must comply with a total annual out-of-pocket maximum that, starting January 1, 2015, is set at $6,600 (self-only) for in-network expenses.

There is a misconception that this annual out-of-pocket limit solves the problem of high out-of-pocket costs for cancer patients. In reality, an annual maximum does nothing to solve the problem of the monthly financial hardship that patients encounter when filling their prescriptions. This legislation tries to solve that problem.

Here are three more reasons why the ACA does not fix this problem:

#1 – With High Percentage Co-Insurances, Some Patients Will Never Fill Their Prescriptions

In a study in the *American Journal of Managed Care*, the authors found that patients with cost-sharing of over $500 were four times more likely to abandon their oral oncology products than those with cost-sharing under $100.[1] The total out-of-pocket cap, while helpful in some regards, does little to address the "sticker shock" that comes with high patient cost sharing on oral oncology products.

[1] Streeter, Sonya. "Patient and Plan Characteristics Affecting Abandonment of Oral Oncolytic Prescriptions". American Journal of Managed Care, 2011.

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In short, while the $6,600 cap is designed to provide a ceiling on a patient's total out-of-pocket expenses, the **evidence suggests that an exorbitant coinsurance requirement will likely prevent many patients from ever filling even their first prescription because they cannot afford the cost**. **The out-of-pocket maximum simply does not protect against the barriers created by excessive patient coinsurance requirements.**

#2 – Only In-network Services and Products On the Prescription Drug Formulary Count Toward the Annual Out-of-Pocket Maximum

Only certain costs associated with "covered" services and products count toward a patient's annual out-of-pocket maximum, including in-network services and prescription drugs that are on a plan's formulary. There is significant risk that fewer drugs will be covered in these new plans and a greater risk that costs can accumulate for patients without counting toward the out-of-pocket maximum.

#3 – Grandfathered Health Plans Still Leave Patients Exposed

Grandfathered Health Plans are those that were in existence before March 23, 2010 in the small group and individual markets. These health plans do not have to comply with the cost-sharing limitations in the ACA and still leave large numbers of cancer patients exposed. There are only rough estimates regarding the number of grandfathered plans in the small group and individual markets, but some estimates have it as high as 30% of the small group and individual plans.

Several states have passed and implemented this law after passage of the ACA because these changes are still needed!

The following 34 states and the District of Columbia have enacted oral parity access laws: (2008) Oregon; (2009) Indiana, Iowa, Hawaii, District of Columbia; (2010) Vermont, Connecticut, Kansas, Colorado, Minnesota; (2011) Illinois, New Mexico, Texas, New York, Washington; (2012) New Jersey, Virginia, Maryland, Nebraska, Delaware, Louisiana; (2013) Massachusetts, Oklahoma, Utah, Nevada, Florida, Rhode Island, California; (2014) Maine, Missouri, Wisconsin, Georgia, Arizona, Ohio