

## HOT TOPIC

### Leveling the Paying Field

While oral anti-cancer agents currently make up about 10 percent of the oncology market, they are expected to make up 25 percent in the next decade.<sup>1</sup> Many attribute this market increase to patient preference. When given a choice, patients often prefer oral over IV therapy because of such benefits as fewer office visits, reduced burden on family members, and less time spent away from work and home. The downside: high costs that can run in the \$6,000 to \$8,000 range per patient each month and regimen adherence issues. (For more on the rewards, risks, and challenges oral agents have for community cancer centers, see “Keeping Pace with Oral Chemotherapy,” page 36.)

Clinical efficacy and patient safety play a major role in treatment choice; however, three additional influences can affect patient access to clinically appropriate oral therapies:

1. Patient cost-sharing responsibilities
2. Tightly managed pharmacy benefits that place increased administrative burdens on providers
3. The current reimbursement landscape.

#### Patient Cost-Sharing Responsibilities

Patient copays for oral anti-cancer therapies covered under a payer’s pharmacy benefit are often significantly higher than copays for comparable IV therapies. Most patients receiving oral drugs under the pharmacy benefit may pay less for IV therapies because they may be responsible only for an office visit copayment for each IV infusion. Most patients who receive oral drugs under the pharmacy benefit, however, have a separate cost-sharing

responsibility—a separate drug copayment.

In cancer treatment, these cost-sharing responsibilities can be significant. Payers assign many oral agents to the fourth tier or specialty tiers; the average copayment for fourth tier drugs is \$75 and the average coinsurance rate for fourth tier drugs is 28 percent.<sup>2</sup>

Another challenge for patients: low pharmacy benefit caps. In these situations, patients can rapidly exceed their pharmacy benefit limits, resulting in a significant financial burden. Even worse, monies that patients expend for prescription drug cost-sharing do not always count towards their out-of-pocket maximum, which would enable the patient to access catastrophic coverage.

Today, providers must consider a patient’s ability to afford his or her cost-sharing responsibilities when making treatment selections. In other words, a provider may choose an IV over an oral therapy based on knowledge of a patient’s ability to afford a specific treatment regimen.

#### Increased Administrative Burdens on Providers

Tightly managed pharmacy benefits are a burden to busy providers. For example, oral agents often require more prior authorizations than comparable IV therapies. Documentation requirements for oral therapies (e.g., letters of medical necessity, medical records, lab results) are resource intensive for practices. Time spent on documentation and pre-authorizations is also uncompensated.

#### The Current Reimbursement Landscape

How insurers pay for IV and oral therapies significantly impacts patient access to oral therapies. Often providers are under-reimbursed for oral therapies as compared to IV therapies. Under the “buy and bill” reimburse-

ment model for IV anti-cancer agents, providers are reimbursed for providing infusion services. Unfortunately, at this time, providers are not reimbursed for treatment counseling and management involved in prescribing comparable oral agents that are dispensed by external entities (e.g., specialty, retail, mail order pharmacies).

#### Oregon Senate Bill 8

In 2007 the state of Oregon passed legislation aimed at addressing payer benefit design disparity, specifically patient out-of-pocket differences between IV and oral anti-cancer therapies.

The issue of coverage disparity was first brought to the attention of the Oregon legislature by a constituent, Heather Kirk. In 2005 Kirk’s father was diagnosed with brain cancer and was prescribed an oral anti-cancer agent. As opposed to beneficiaries on his plan on IV therapy who were responsible for a \$500 deductible and a \$4,000 out-of-pocket maximum, Kirk’s father was responsible for a 50 percent coinsurance—with no out-of-pocket maximum. In addition to these out-of-pocket expenses amounting to over \$30,000 for a year’s worth of oral chemotherapy, Kirk’s father also had cost-sharing responsibilities for prescriptions to treat side effects such as inflammation, nausea, fatigue, and seizures.

After appeals to her healthcare plan were denied, Kirk took the issue to the Oregon legislature. She worked with her state representative, lobbyists from the American Cancer Society, and eventually her father’s healthcare plan. The result of this collaboration was Oregon Senate Bill 8 (SB 8), which required health benefit plans to equalize patient out-of-pocket responsibilities for oral and IV therapies regardless of the benefit. The exact language of SB 8 specifically states: *A health benefit plan that provides coverage for cancer*



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### The Private Payer Prognosis

On Saturday March 21, the final day of ACCC's 35<sup>th</sup> Annual National Meeting, Matt Farber, ACCC's Manager of Provider Economics and Public Policy, engaged attendees in an interactive discussion about recent reimbursement trends, particularly an increasing number of denials and difficulties associated with private payers. The lively forum, "Private Payer Prognosis: Identifying the Problems and Potential Solutions," elicited many responses from attendees. ACCC's goal going forward is to help its membership resolve a growing list of concerns.

"We are seeing prior authorizations on both on- and off-label indications for many commonly used oncology drugs," said one attendee at the presentation. Her concern was echoed by many others in attendance.

A host of other examples of increasing friction between providers and private payers was brought forward:

- "Voluntary" prior authorization that is actually mandatory. (If pre-authorizations are not submitted with every dose the practice

- has to submit medical records.)
- Uncertain and random payments
- Disclaimers that state authorization is no guarantee of payment, despite the pre-authorization
- Mandates for specialty pharmacy reimbursement
- Diagnostic imaging denials or delays in authorization
- Difficulties with contract negotiations.

Another area of concern is refusal by some private payers to pay for related routine and customary care costs of clinical trials. One attendee noted that a patient had been denied future care because of having once been on an experimental regimen. Attendees agreed that such restrictive private payer policies would make accruing patients to clinical trials, as well as developing new therapies, more difficult.

The consensus among participants seemed to be that private payers are putting up more and more hurdles, thereby blocking or slowing access to anti-cancer therapies.

In the past ACCC has effectively addressed many of these issues with the Medicare program, and the Association would like to do the same with private payers. To that end, the focus of the final segment of the forum shifted to a discussion of what ACCC could do to *help* member providers.

One request was for ACCC to

meet or contact private payers about reimbursement policies since some providers may be hesitant to do so on their own. Although such interactions typically deal with specific patients or specific treatment regimens, ACCC has written letters to private payers on behalf of members, and is certainly willing to do so again in the future.

ACCC has working relationships with certain private payers through their medical directors and will attempt to strengthen these relationships and build new ones with other payers. Attendees and ACCC staff agreed that mutual respect between ACCC and the payers is necessary to move forward productively.

Other requests for action centered on getting in touch with local officials, including state insurance commissioners, governors, and state legislators. At the federal level, Senators and Representatives were identified as the best advocates to work on their constituents' behalf. ACCC has a long history of working with elected officials at both state and federal levels and will continue to do so.

In the end, all these efforts are dependent on hearing from ACCC members. We need your help to identify problems with private payers. Please contact Matt Farber at: [mfarber@acc-cancer.org](mailto:mfarber@acc-cancer.org) if you are experiencing difficulties with private payers and have information you would like to share. 📧

*chemotherapy treatment must provide coverage for a prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected cancer medications that are covered as medical benefits.*

Upon enactment of the bill, Oregon plans subject to the legislation changed their coverage policies accordingly. (This legislation only impacted individual health plans, small group plans that are not self insured, and state employee plans. It did not impact Medicare Part D plans and self-insured group plans which are regulated by ERISA.)

In general, Oregon SB 8 has been positive for beneficiaries. The top state plans eliminated their high coinsurance rates, some established a

separate three-tier oral chemotherapy structure under their pharmacy benefit, and, most notably, patients in some plans with no pharmacy benefit now have coverage for oral anti-cancer agents through their medical benefit. It could be said that Oregon SB 8 effectively leveled the "paying field" for oral anti-cancer therapies between a plan's pharmacy and medical benefit and has significantly increased access to life-saving therapies.

### 2009 State Legislation

Following the passage and implementation of Oregon SB 8, numerous states are actively looking into enacting similar legislation in 2009. Bills addressing the disparity in patient out-of-pocket responsibilities for oral anti-cancer therapies have been intro-

duced in several states and many have heard testimony from stakeholder organizations on the benefit of this legislation, including the American Cancer Society, the Susan G. Komen Foundation, and members of the provider community. If you would like to get involved in such an effort in your state, contact ACCC's Manager of Provider Economics and Public Policy at: [mfarber@acc-cancer.org](mailto:mfarber@acc-cancer.org). 📧

### References

<sup>1</sup>Weingart MD, et al. NCCN task force report: oral chemotherapy. *J NCCN*. 2008;6(3):S1-S14.

<sup>2</sup>Kaiser Family Foundation and Health Research & Educational Trust. 2008 Employer-Sponsored Health Benefits Report. Available online at: <http://ehbs.kff.org/pdf/7790.pdf>. Last accessed April 7, 2009.