Making Cost-Sharing Affordable for Prescription Drugs

New break-throughs in cancer research are making more life-saving drug therapies available to cancer patients and survivors. Keeping these therapies affordable for patients is imperative. Costs for the prescription drugs used by cancer patients and survivors amount to hundreds of thousands of dollars in the United States each year; cost-sharing for these therapies can often be unaffordable. Insurance plans are increasingly requiring co-insurance (a percentage of the cost of the drug) instead of co-pays (a flat fee) for certain drugs. In dollar terms, co-insurance generally costs a consumer more than a flat co-pay, and provides less transparency to the consumer insofar as her portion of the cost of the drug is not known until the drug has been dispensed. Further, many cancer drugs must be taken over the course of many years – or indefinitely – as part of maintenance therapy and the cumulative costs for the patient can be significant.

Prohibitive cost-sharing for prescription drugs can cause patients to skip dosages, split pills, stop taking their medications entirely, or not follow their doctors' recommendations, which reduces the effectiveness of their treatment. These behaviors are known as "medication non-adherence." Several recent studies have shown that higher cost-sharing is associated with cancer patients becoming non-adherent on their medications.[1,2] The problem only worsens when patients also need medications for other chronic conditions such as diabetes.[3] Young adult cancer survivors are particularly likely to become non-adherent to the medications they need to further treatment, prevent re-occurrence and address side effects because of problems affording their medications.[4]

Capping Co-Pay Legislation

Several states are considering or have passed legislation that limits the amount of cost-sharing patients have to pay each month for their prescription drugs. Some state proposals apply the cap only to drugs on the highest tier of the plan's formulary. Other proposals apply the cap to all prescription drugs on the plan's formulary, regardless of the tier. Most of the proposals cap patient cost-sharing at a specific dollar amount (such as a limit of $100 per drug per month). It is also common for proposals to limit caps to drugs covered under a plan's pharmacy benefit and not drugs covered under the plan's medical benefit. To date, no similar federal legislation has been enacted. These policies apply to co-pays and co-insurance, although they are commonly referred to as "co-pay caps."

Supporters of co-pay caps argue that the caps help keep necessary drug treatments affordable for cancer patients and survivors. Opponents argue caps remove insurer flexibility to design marketable insurance plans. Opponents also claim that insurers might compensate for the limited drug cost-sharing by increasing premiums or cost-sharing for other types of benefits. For example, if a plan compensates for co-pay caps by increasing cost-sharing for surgery, the cancer patient may end up paying just as much out-of-pocket. This is of particular concern for cancer patients who use the medical benefit, which includes physician and hospital services, as much as the pharmacy benefit.

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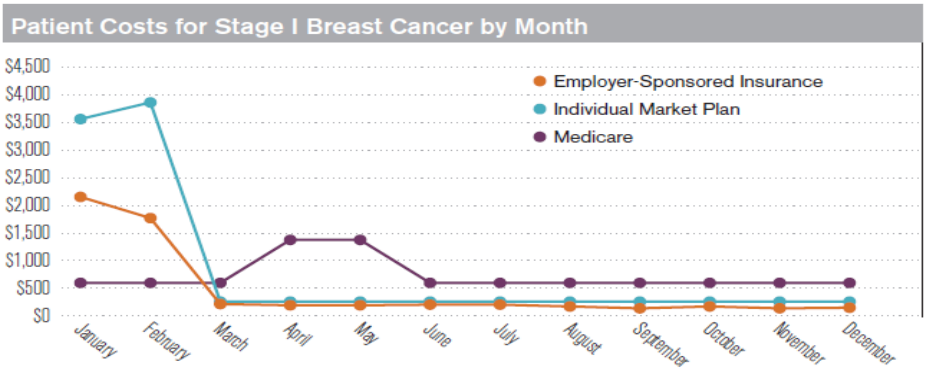
ACS CAN Position

- ACS CAN supports state co-pay cap legislation that limits the co-pay or co-insurance amount the patient has to pay per drug per month.
- ACS CAN does not support proposals that also include plan deductibles in the cap because of the potential for plans to significantly increase premiums.

Limiting Deductibles or Out-of-Pocket Costs by Month

Patients in active cancer treatment are high utilizers of high-cost care, including prescription drugs. Because of the nature of cancer and its treatment, treatment timelines are often aggressive, leading to a high volume of treatment in a short amount of time. This can result in the cancer patient being required to pay multiple large medical bills in a short timeframe, causing their monthly costs to spike dramatically. According to the ACS CAN *Costs of Cancer* report, non-Medicare patients in active cancer treatment can expect to pay their entire deductible and out-of-pocket maximum in one-to-three months.[5] The graph below shows this monthly spending trend for a breast cancer patient in three different insurance scenarios.



Source: American Cancer Society Cancer Action Network. The Costs of Cancer. April 2017. www.acscan.org/costsofcancer

This spending pattern for cancer patients is particularly concerning, as nearly half of Americans report being unable to cover a $400 emergency medical expense without having to borrow or sell something.[6]

While the Affordable Care Act requires all commercial insurance plans to have a limit on covered patient out-of-pocket expenses of at least $7,150 (in 2017),[7] this limit is applied to the whole year of costs and does not require any limits on monthly expenses. A patient could be required to pay all $7,150 in one month – a difficult task for most anyone, especially if the expense is unexpected. Cancer patients have the same cash-flow problems with deductibles, which function much the same way, on an annual basis instead of monthly. Some plans have deductibles of multiple thousands of dollars – even matching the maximum out-of-pocket amount of $7,150.

While several states have passed legislation capping cost-sharing per-drug per-month, as discussed above, no state has enacted a proposal to cap plan deductibles or maximum out-of-pocket limits per month.

ACS CAN Position

- ACS CAN believes that plan designs using a monthly deductible and/or maximum out-of-pocket limit are worth exploring, and would support a pilot project doing so. The program should be rigorously evaluated, including an analysis of patient expenses for all benefits, potential changes to healthcare utilization, and any changes to plan design or benefit generosity.

[1] Dusetzina, SB, Winn, AN, Abel GA, Huskamp, HA, & Keating, NL. Cost Sharing and Adherence to Tyrosine Kinase Inhibitors for Patients with Chronic Myeloid Leukemia. *J Clin Oncol.* 2014;32;4: 306-11.

[2] Farias, AJ & Du, XL. Association Between Out-Of-Pocket Costs, Race/Ethnicity, and Adjuvant Endocrine Therapy Adherence Among Medicare Patients with Breast Cancer. *J Clin Oncol.* 2017; 35;1: 86-95.

[3] Neugut, AI, Zhong, X, Wright, JD, et al. Nonadherence to Medications for Chronic Conditions and Nonadherence to Adjuvant Hormonal Therapy in Women with Breast Cancer. *JAMA.* 2016;2;10: 1326-1332.

[4] Kaul, S, Avila, JC, Mehta, HB, et al. Cost-Related Medication Nonadherence Among Adolescent and Young Adult Cancer Survivors. *Cancer;* 123;14: 2726-2734.

[5] American Cancer Society Cancer Action Network. The Costs of Cancer. Washington, DC: American Cancer Society Cancer Action Network, 2017.

[6] Board of Governors of the Federal Reserve System. Report on the Economic Well-Being of U.S. Households in 2015. 2016. Available at https://www.federalreserve.gov/2015-report-economic-well-being-us-households-201605.pdf.

[7] 42 U.S. Code § 1302(c) (2012).