Cancer Drug Coverage in Health Insurance Marketplace Plans

Background

An estimated 1.7 million Americans will be diagnosed with cancer in 2014, and approximately one-half of all American men and one-third of all American women will develop cancer at some point in their lifetime. In 2009, direct medical spending for cancer in the US was $86.6 billion. While private or public insurance provides coverage for many cancer patients, these patients often face high out-of-pocket costs due to their plans' cost-sharing requirements or coverage limitations. Therefore, it is critically important for cancer patients to be able to access clear, consistent, and comparable information on prescription drug coverage, including coverage of physician-administered drugs, in order to choose a health plan. Prior to the Affordable Care Act (ACA), such information was not widely available, but various ACA provisions aim to improve the comprehensiveness, comparability, and transparency of health plan benefits.

The ACA provides for a standardized set of benefits in plans sold in the Marketplace and an out-of-pocket maximum that must take into account prescription drug spending. However, health insurance companies have created a wide variety of Marketplace plan designs. To determine what kind of prescription drug coverage is available to cancer patients and survivors, we examined the prescription drug formularies of 62 health insurance issuers in California, the District of Columbia, Florida, New York, Ohio, and Texas to determine:

- How accessible, comparable, and complete is the publicly-available information on prescription drug coverage in Marketplace plans?
- Are cancer drugs generally covered?
- What are the cost-sharing requirements for cancer drugs?
- How common is prior authorization for cancer drugs?

Findings

- **The inconsistency and incompleteness of formulary information available from health insurance companies in the Marketplace poses a significant problem for cancer patients**. It is simply not possible for patients with significant prescription drug needs to make an apples-to-apples comparison of Marketplace plans in the six states we examined. The essential health benefits policy requires only that a particular number of drugs to be covered in each class without regard to cost-sharing, and health insurance companies have created a wide variety of Marketplace plan designs. **Without clear, consistent, complete, and up-to-date formulary information, patients will be unable to determine the best plan for them.**
- **Across all six states, the 14 oral cancer medications we examined were generally covered, but there are gaps in some plans.** Coverage of intravenous drugs was more unclear, potentially because those drugs are covered under the medical plan.
    - 95 percent of plans covered both drugs in the antiangiogenic class, which includes drugs that slow cancer growth by preventing blood vessel formation.
    - 77 percent of plans covered all 12 drugs in the molecular target inhibitor class, which includes drugs that interfere with specific molecules involved in cancer growth and progression.
- **Many cancer drugs are covered on the highest cost-sharing tier, and plans frequently use coinsurance, rather than copays, for these drugs**. There is a great deal of variation among plans in cost-sharing designs, making it difficult for patients to choose the best plan for them.

- **Prior authorization is required for nearly all cancer medications in most plans.**

Recommendations

- **Transparency**
  A major goal of the Affordable Care Act is to increase insurance market competition by enabling consumers to more completely and accurately compare plans. That goal is undermined by the inconsistent formulary information posted by plans and the lack of tools to help consumers understand their out-of-pocket costs. Therefore, HHS, State Exchange Boards, and State Insurance Commissioners should:
    - Develop a tool similar to the Medicare Plan Finder that allows patients to enter their drugs and see projected out-of-pocket costs for each plan option.
    - Immediately pursue formulary display requirements for plans. Plans should, at a minimum, provide a list of all covered drugs, including those covered under the medical benefit; use a standard organizational structure that includes the cost-sharing for each drug; update formularies frequently; and provide a description of the process to request a non-formulary drug.
    - Develop a cost calculator tool that allows for a variety of consumer entries and includes both premiums and out-of-pocket costs. Without such a tool, patients will be unable to navigate the wide variety of cost-sharing structures and choose the best plan for them.
    - Release formulary and cost-sharing data collected for display and oversight purposes to allow third parties to develop tools to help consumers compare plans.
- **Standardized Benefits**
  Some states have chosen to create standardized plans at each metal level to allow enrollees to more easily compare plans. HHS and State-based Marketplaces should pursue plan standardization, with a particular focus on the use of copays rather that coinsurance for prescription drugs. Standardized benefits reduce the number of factors patients must consider when choosing a plan, and copays are more predictable for patients.
- **Robust Oversight**
  Currently, the approach to prescription drug benefits in the Marketplaces focuses on the number of drugs covered, rather than on the quality of the benefit provided. In addition, the standard used to determine the number of drugs covered is does not include newly approved drugs. Therefore State Insurance Commissioners, State Exchange Boards, and HHS should:
    - Use the new United States Pharmacopeia Medicare Model Guidelines (USP MMG) version 6.0 to determine the number of drugs covered for the 2015 plan year. The UPS MMG version 6.0 includes a new class of anti-cancer drugs, as well as additional drugs across other cancer classes. Updating to the USP MMG version 6.0 will help ensure coverage of newly approved, targeted cancer therapies.
    - Undertake in-depth reviews of formularies for clinical appropriateness, coverage gaps, and non-discrimination to inform qualified health plan certification and updates to essential health benefit requirements.