Importance of Robust Coverage for Cancer Medicines

Cancer patients require access to critical life-saving and symptom-managing medications. In recent years, more cancer patients have had the opportunity to use newer, targeted oral oncolytics to treat their cancer. Alongside more traditional intravenously administered (IV) chemotherapy, oral oncolytics offer physicians additional options to meet their patients' individual needs. Cancer treatment options will likely further expand as new cancer medicines enter the market. Each class of medicines used to treat cancer patients often includes a diverse range of therapies that may target a specific type of cancer, making it crucial that patients have access to a range of therapies within each class. Additionally, physicians need to be able to select from a wide array of therapies because cancer medicines are often used in combination to prevent resistance and improve outcomes. Cancer patients also need access to a broad range of therapies because medicines work differently and patients have various responses to them.

Benchmark Coverage for Cancer Therapies

Meaningful access to medicines requires both broad formularies and affordable cost sharing. Information on cost sharing and the use of utilization management techniques such as prior authorization will be available starting in October 2013 when open enrollment begins. Currently, it is only possible to directly assess the required number of medicines to be included in the formularies in each state through an analysis of Essential Health Benefit (EHB) coverage requirements. For this analysis, requirements for coverage of three of the many classes of medicines used to treat patients with cancer highlights the risk that plan formularies may provide poor coverage of cancer medicines in some states. To comply with EHB requirements, plans must cover at least the number of medicines in each USP category and class as the state-selected benchmark plan. However, benchmark plan coverage differs widely, leaving patients in some states vulnerable to limited formularies. For example:

- EHB plans in all states would be permitted to cover fewer than 75% of therapies in the molecular target inhibitor class (see appendix).
- EHB plans in all states would be permitted to cover fewer than 50% of therapies in the alkylating agents class.
- EHB plans in 9 states would be permitted to cover fewer than 75% of therapies in the antiemetics class.
- All EHB plans may have limited coverage in at least one these three classes (molecular target inhibitors, alkylating agents, or antiemetics).
- Coverage of molecular target inhibitors (a class that includes several breakthrough therapies that have revolutionized cancer treatments) is particularly vulnerable because of inconsistencies in the way that therapies typically covered through the medical benefit are counted.

Formulary Standards and Counting Rules

The EHB counting standards ignore some key distinctions between medicines, potentially leading to Exchange plans having narrower formularies than the benchmark plans. For example, the standards do not recognize the importance of newly approved medicines and products typically covered under health plans' medical benefits instead of the pharmacy benefits. While the current standards may help plans manage costs, they may fail to protect patient access to critical cancer medications.

Therapies Covered Under the Medical Benefit. The Centers for Medicare and Medicaid Services (CMS) did not specifically mention medical benefit therapies in their EHB coverage requirements.

- There is no explicit standard for coverage of therapies covered through the medical benefit in EHB plans, beyond the general requirement to provide coverage comparable to what employers typically provide.
- Lack of clarity on counting medical benefit therapies may result in inconsistencies across EHB plans that may lead to less generous coverage for oral medicines than is typical in employer plans.

Coverage for Cancer Medicines Under Essential Health Benefits

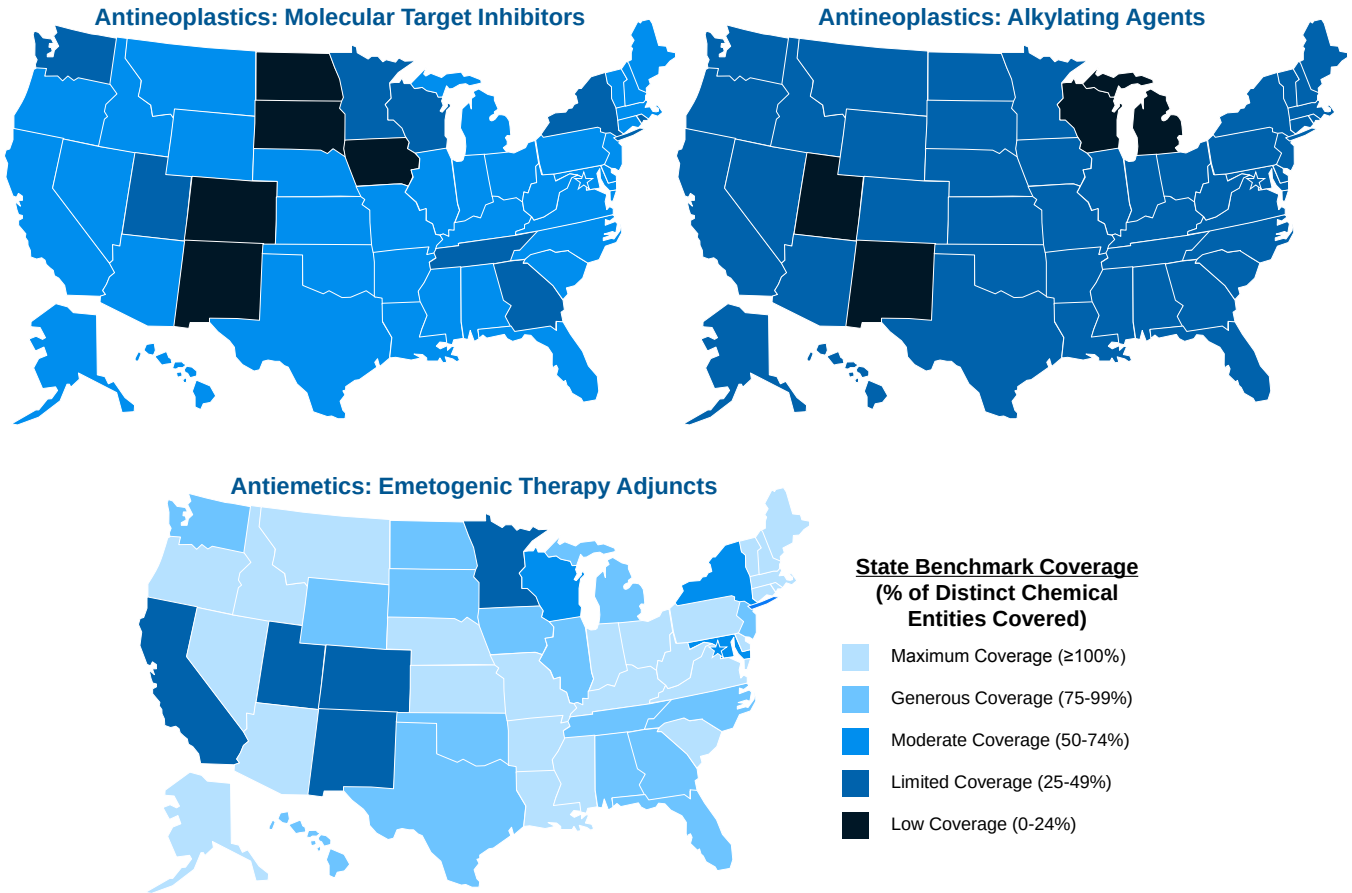
Newly Approved Medicines. The Department of Health and Human Services has not released guidance related to coverage of newly approved medicines or coverage of medicines that are FDA-approved in the middle of the benefit year.

- While plans have flexibility to add new medicines to their formulary mid-year, it is not required.
- Plans also could remove a medicine when adding a new medicine to the formulary, as long as they cover the required number of medicines in the class.

Role for States in Ensuring Good Coverage

The Affordable Care Act (ACA) requires EHB plans to offer coverage typical of the employer market that does not discriminate against individuals because of their age, disability, degree of medical dependency, or expected length of life. States play a critical role in meeting these standards by choosing a benchmark plan, reviewing plan formularies, and providing oversight to ensure that plans meet non-discrimination standards. There are several options for states to minimize the risk for discrimination. First, states can undertake non-discrimination reviews that encompass medication tier placement, cost sharing and utilization management. Non-discrimination reviews should ensure that EHB plan formularies enable patients to receive the standard of care for cancer. Second, states can incorporate other oversight activities, such as distribution of a class of medicines across formulary tiers. Third, states can provide oversight to ensure a timely and fair appeals process for individuals seeking access to a medication that is not on their plan's formulary. These activities could limit the potential for plans to discriminate against patients with specific chronic conditions and could also help prevent plans from providing a much narrower benefit package than is typically seen in the employer market.

Appendix: Benchmark Coverage by State



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