Key Findings:

Analysis of California Assembly Bill 1860 Cancer Treatment

Summary to the 2017–2018 California State Legislature, April 20, 2018

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

AT A GLANCE

The version of California Assembly Bill (AB) 1860 analyzed by CHBRP would repeal the sunset date for provisions of the current law that prohibit plans and policies from requiring an enrollee or insured to pay, notwithstanding any deductible, a total amount of copayments and coinsurance that exceeds $200 for an individual prescription of up to a 30-day supply of a prescribed orally administered anticancer medication.

1. CHBRP estimates that, in 2019, of the 23.4 million Californians enrolled in state-regulated health insurance, 15.9 million of them will have insurance subject to AB 1860.
2. **Benefit coverage.** 100% of enrollees have health insurance fully compliant with AB 1860, because the provisions are included in current law. AB 1860 would not exceed the essential health benefits (EHBs).
3. **Utilization.** Utilization is not expected to increase in the first year post implementation due to the passage of AB 1860.
4. **Expenditures.** Expenditures are not expected to increase due to the passage of AB 1860.
5. **Medical effectiveness.** There is a preponderance of evidence that lower cost-sharing is associated with greater likelihood of initiating treatment with oral anticancer medications, adherence to treatment, and persistence with treatment.
6. **Public health.** There is no short-term public health impact.
7. **Long-term impacts.** The $200 out-of-pocket cost-sharing limits are fixed; therefore, as drug costs increase, more drugs and enrollees will get closer to the out-of-pocket cost-sharing limit.

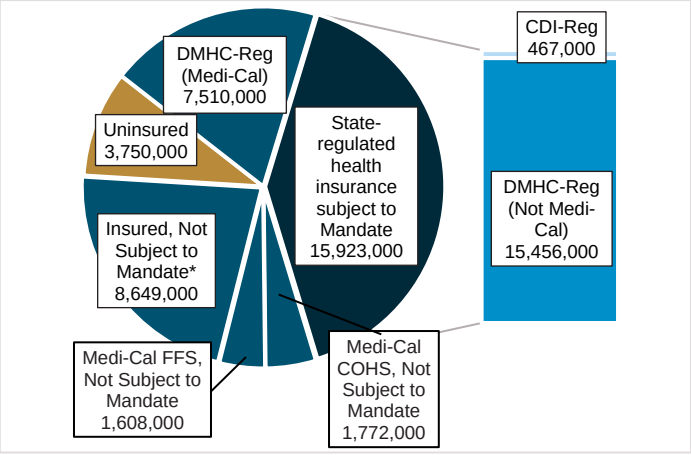
CONTEXT

To date, the Food and Drug Administration (FDA) has approved 83 oral anticancer medications used to kill or slow the growth of cancerous cells. These medications are used to treat more than 62 different of types of cancers and play a variety of roles in cancer treatment.[1] Oral anticancer medications are used to treat frequently diagnosed cancers, such as breast, lung, prostate, and colorectal cancers. They are also used for rare cancers, such as adrenocortical cancer (cancer of the adrenal gland), dermatofibrosarcoma protuberans (a cancer of the dermis layer of skin), and retinoblastoma (an eye cancer).

BILL SUMMARY

AB 1860 would repeal the sunset date for provisions of current law that prohibit Department of Managed Health Care (DMHC)-regulated plans and California Department of Insurance (CDI)-regulated policies from requiring an enrollee or insured to pay, notwithstanding any deductible, a total amount of copayments and coinsurance that exceeds $200 for an individual prescription of up to a 30-day supply of a prescribed orally administered anticancer medication. Figure 1 notes how many Californians have health insurance that would be subject to AB 1860.

Figure 1. Health Insurance in CA and AB 1860



Source: California Health Benefits Review Program, 2018.
Note: * Medicare beneficiaries, enrollees in self-insured products, etc.

[1] Refer to CHBRP's full report for full citations and references.

IMPACTS

Benefit Coverage, Utilization, and Cost

Current law limits copayments or coinsurance to $250 for *all* individual prescriptions for up to a 30-day supply. If the $200 limit on copayments and coinsurance for oral anticancer prescription drugs sunsets on January 1, 2019, enrollees filling oral anticancer prescriptions would have their copayments and coinsurance limited to $250 per 30-day supply at least through January 1, 2020.

Benefit Coverage

All enrollees with health insurance that would be subject to AB 1860 have fully compliant coverage due to existing law.

Utilization

CHBRP estimates that enrollees utilize 33.1 prescriptions of oral anticancer medication per year per 1,000 enrollees and that 0.64%, or 102,000, of enrollees with coverage subject to AB 1860 will use oral anticancer medications in 2019. Overall utilization, the number of users, and the number of units of oral anticancer medications will not change within the first year postmandate due to the passage of AB 1860, because the cost-sharing limitations are included in current law.

Expenditures

The estimated average cost per prescription for 2019 is $1,362, an increase from $856 in 2014, which may be due to the availability and price of new drugs. The three most frequently prescribed oral anticancer medications represent 62.1% of all oral anticancer medication prescriptions, but account for only 1.5% of total cost. The three most expensive oral anticancer medications represent 0.5% of prescriptions, but account for 6.1% of total cost. The top three oral anticancer medications as a percentage of total cost represent 32.4% of total cost, but account for 3.4% of total prescriptions.

No changes in total premiums would be expected due to the passage of AB 1860 in the short term, because AB 1860 extends current law indefinitely. However, were AB 1860 not to pass, the maximum cost-sharing paid by enrollees using oral anticancer medications may increase by $50 per prescription given the current law that limits cost-sharing to $250 for *all* prescriptions.

Medi-Cal

Medi-Cal is not subject to the provisions of AB 1860, and therefore, no impact is projected.

CalPERS

No measureable impact is projected.

Number of Uninsured in California

No measureable impact is projected.

Medical Effectiveness

This analysis examines studies of the effects of cost-sharing for oral anticancer mediations on measures of medication use, such as abandonment of prescriptions, initiation of treatment, persistence with treatment, and adherence to treatment for oral anticancer medications. There is a preponderance of evidence that lower cost-sharing is associated with greater likelihood of initiating treatment with oral anticancer medications, adherence to treatment, and persistence with treatment.

Public Health

CHBRP concludes that passage of AB 1860 would have no short-term[2] public health impact because it would extend current coinsurance/copayment limitations for oral anticancer medications. However, were AB 1860 to fail to pass, CHBRP still does not project a public health impact in 2019 because another existing law limits copayments and coinsurance to no more than $250 per 30-day supply of any prescription medication.

Long-Term Impacts

Long-term impacts on overall health care costs as a result of the elimination of the sunset that limits cost-sharing for oral anticancer medications to $200 per prescription for up

[2] CHBRP defines short-term impacts as changes occurring within 12 months of bill implementation.

to a 30-day supply are unknown. However, it is expected that the overall utilization and cost of premiums in the long term will increase due to increased availability of new and expensive oral medications.

The $200 out-of-pocket cost-sharing limit is fixed [assuming plans and policies continue to not increase the cost-sharing limit by the Consumer Price Index (CPI)]; therefore, as drug costs increase, more enrollees will reach the out of pocket cost-sharing limit. CHBRP completed a 3 year projection of the maximum number of enrollees hitting the cost-sharing limit of $200 per prescription for up to a 30-day supply, assuming all else remains constant (i.e., number of approved drugs and utilization).

Table 1. Projected Maximum Number and Percentage of Enrollees Who Will Hit the Cost-Sharing Limitation of AB 1860

Year	Maximum Number of Enrollees	Maximum Percentage of Enrollees
2019	13,800	0.087%
2020	14,500	0.091%
2021	15,100	0.095%

Source: California Health Benefits Review Program, 2018.

Note: Based on MarketScan claims database sample data. The cost-sharing limit of $200 per individual prescription is for up to a 30-day supply of outpatient oral anticancer medications.

CHBRP estimates that approximately 85% of the 102,000 patients using oral anticancer medications will not reach the $200 cost-sharing limit. On the basis of the evidence that lower cost-sharing for oral anticancer medications is associated with a greater likelihood of medication initiation and adherence, CHBRP assumes medication utilization and health outcomes for these enrollees would remain the same regardless of the presence of the cost-sharing provision(s). However, for some portion of the 15% of enrollees who may reach the $200 cost-sharing limit, especially those in high deductible health plans, there could be significant financial and health benefits associated with the passage of AB 1860.

Essential Health Benefits and the Affordable Care Act

AB 1860 would not require coverage for a new state benefit mandate, but instead, specifies cost-sharing limits, and therefore appears not to exceed the definition of EHBs in California.