NAMCP Medical Directors Spotlight Guide: Oral Oncology Drug Management 2023

How Trends and Issues in Oral Oncology Management Can Affect Strategy for Medical Directors of Purchasers, Health Plans, and Providers

JOURNAL of MANAGED CARE MEDICINE

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TRANSFORM KNOWLEDGE
INTO IMPROVED OUTCOMES

Mission Statement

The mission of the National Association of Managed Care Physicians (NAMCP) Medical Directors Oncology Institute is to open the lines of communication between medical directors in managed care and practicing oncologists to help them jointly better navigate and understand what is happening in managed care and the daily management and practice of oncology. The NAMCP Medical Oncology Directors Institute brings resources and updates, strategic reviews, and key information to medical directors for insurers, employers, providers, and integrated delivery networks. Unique Executive Councils focus on emerging technologies, oncology and value-based contracting for manufacturers and managed market leaders.

This guide presents an overview of the growing trends and issues for oral oncology drugs, as they affect management strategy and policies of physicians and purchasers of health care. It discusses oral oncology treatment and policy in the context of the current landscape. Utilization management and evidence-based decision-making choices impact the total costs of care as well as patient access to needed care and well-being. Concerns and new legislative and market intervention will drive quality and payment reform. Issues and strategies for plans, patients and purchasers are leading to transformation of policy and strategy solutions for oral oncology management. This guide is part of a series of activities and initiatives within the NAMCP Oncology Institute to support medical directors from purchasers, plans, and provider systems, and to eventually achieve greater collaboration leading to improved patient outcomes in oncology.

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How Trends and Issues in Oral Oncology Management Can Affect Strategy for Medical Directors of Purchasers, Health Plans, and Providers

Dawn Holcombe, MBA, FACMPE, ACHE

Abstract

In just the last 50 years, oncology treatment has undergone a dramatic evolution that includes transitions from inpatient care – that usually became end of life care – to the targeted medicines of today, as well as a marked shift toward the use of oral antineoplastics and supportive care as part of combination therapies. Expansion in cancer care options and delivery methods has led to wide variation across providers, payers, and patients as to the utility, evidence, justification, and value of the use of oral treatments. This guide will illuminate key practice, policy, and strategies of oral treatments in cancer care, and suggest opportunities and challenges for enhanced evidence, utility, and value.

More and more Americans are being diagnosed with cancer during their working years. The majority of cancer survivors remain "on the job" during and after treatment. Only patients who are well-motivated, health-literate, have good oral food intake, good gut function, and minimal nausea and vomiting are likely to be able to manage and tolerate oral chemotherapy. Oral cancer coverage and management policies by health plans and employers need to recognize the advantages, but also the limitations of oral cancer and the reality that not all patients with the same disease will benefit from the same oral cancer care. In fact, poor management for a patient on oral therapy could lead to failure of the regimen, and ultimately higher costs for total care.

Traditional utilization management techniques under the pharmacy benefit for oral oncology medications are challenged by the unique demographics of each patient, their disease, their health, work, and life demographics. The Consolidated Appropriations Act of 2021 (CAA) will transform the health benefits industry much as the retirement benefit industry was impacted by earlier federal reform. Employers and those with whom they contract for administration and management of health benefits will be held accountable for the quality, value, and transparency of the services provided and covered. The perspective of the patient as to the value of their health benefits for the premium and out-of-pocket dollars they are paying will transform the insurance marketplace. If employees experience delays in care, higher out-of-pocket costs due to intermediary fees or internal service referrals, denials for standard of care treatments, and/or mandated service provision from other than their personal medical provider – all of which are frequently-voiced concerns under traditional oral utilization management processes – the potential for litigious employee action against their employer for allowing such practices for employee health benefits is staggering.

Pharmacy benefit programs will benefit from the inclusion of medically integrated dispensing (MID) providers in their preferred pharmacy networks. Patients and employers will appreciate the continuity of care and flexibility that MIDs can bring to their treatment regimens, which ultimately reduces both total cost of care and patient out-of-pocket costs. Under the new era of the CAA for health benefits, employers will seek quality assurances and comparisons for drug delivery options. The downstream consequences of specialty pharmacy referrals away from the treating provider include delays in prescription approval and fulfillment, shipping, lack of sourcing pedigree and cold chain verification, incomplete knowledge of the

patient and their disease and health status, and high drug waste and patient non-adherence. These adverse consequences all lead to higher costs, low patient satisfaction, and inadequate care management.

Pharmacy benefit strategy has not kept pace with the technology and opportunities for better, early care intervention with a targeted therapy that has been identified through precision medicine testing. If the standard of care treatment for a given diagnosed cancer does not yet include biomarker testing or molecular classification, it will not be long before it does. The more we can efficiently use precious tissue/blood samples to start with a good understanding of the disease, the better we can make sure the right treatment reaches the patient at the right time and that we can avoid treatments that will not be effective. Precision oncology should allow payer policy and provider treatment patterns to avoid long drawn out and costly lines of therapy that "might" work. More efficient care the first time will reduce the financial and medical burden of the disease on the patient and their family, and lower total costs of care.

Several cancer organizations have addressed the unintended consequences of traditional oral oncology medication management and offered suggestions for better collaboration with the treating medical community and recognition of the individual determinants of treatment for each patient and cancer. CancerCare's® guide called "Best Practices for Prescription Drug Benefit Design" explains some common utilization management practices and their unintended consequences and then offers recommendations for pharmacy benefit plans related to reform of these utilization management tools, including: pre-authorization, formulary design, step therapy, use of specialty pharmacies, co-pay accumulator programs, the denials and appeals process, and financial non-adherence issues resulting from unmanageable patient out-of-pocket costs and high-deductible health plans.

In a visionary 2013 article, Steven Stranne, MD, JD, stated that there are urgent needs for safeguards in order to protect patient access to oral oncology drugs across a diverse national landscape with multi-payer insurance systems. There are several mechanisms which leave individuals with health insurance unable to afford prescribed oral cancer drugs, and patient cost-sharing burdens for oral drugs that are much higher than for intravenous drugs administered by a healthcare professional. He suggested "the interests of patients are best served when policymakers collaborate with physician experts and other stakeholders in the cancer community to help ensure that individuals with cancer have meaningful and timely access to medically necessary and clinically appropriate services. As we face a period of ongoing change with respect to the agents available to treat cancer and the structure of the U.S. health insurance system, there remains much work to be done to monitor, identify, and remedy problems involving patient access and affordability to medically necessary cancer therapies, including oral cancer drugs."[1]

Benefit design and coverage rules that are perceived by covered employees to adversely affect their access to standards of care, or to target needed care under prior authorization denials and step edits, or lack of coverage of standard of care treatments that align with patient and physician medical necessity perspectives may well become the backbone for fiduciary responsibility lawsuits. Existing oral cancer care management by health plans that restrict standard of care access and prefer first generation to newer generation treatments may become more of a liability than an asset to managed care medical directors and employers.

Introduction

Cancer treatment started as inpatient care, with few treatment options and toxic side events that frequently left patients hospitalized until the inevitable end. Driven by inpatient payment reductions, hospital outpatient facilities and then community-based physician offices created cancer centers to treat patients outside of the inpatient setting. Pharmaceutical companies developed oral versions of existing administered drugs, and eventually more options. Uptake was not immediate for many reasons. Oral treatments in oncology now are part of the standard of care arsenal for treating cancer, but patient utilization is not easy, adherence is weak, and costs of oral cancer care can be unsustainably high for patients, employers, health plans and even physicians.

The costs of treating cancer are of rising concern to patients, payers, and physicians. The proliferation of oral cancer medications has exacerbated those concerns. A variety of tools and approaches have been developed to reduce costs of care, but most of these have involved utilization management (rules that may restrict or deny select therapies) practices

including authorizations, pricing limitations, stepped therapy, and drug formularies largely built on price.

Patients diagnosed with cancer present in varied ways impacted by social-demographic factors, diagnosis at the macroscopic and molecular level, and progression based on initial treatment selection(s). Access, utilization, and adherence to the right treatment (or choice not to treat) at the right time for the right patient at the right cost is not assured or consistent. The promise of oral treatments for cancer patients for convenience, integration into work and family life, and flexibility is being overshadowed by financial toxicity, restrictions on access to clinical advances and standard of care treatments, and intrusion of third parties into the healthcare process that adds costs, delays, and other challenges.

> "Of the estimated 40 percent of Americans that will develop cancer in their lifetimes, more and more are being diagnosed during their working years – due in part to the large baby boomer population and shifts in retirement age. Since work can be a primary source of support for people with cancer, offering a sense of normalcy and control, most want to keep working. In fact, nearly two-thirds of cancer survivors remain "on the job" during and after treatment.
>
> *The Employers' Prescription for Employee Protection Toolkit: Best Practices for Prescription Drug Benefit Design," CancerCare®, published 2021, Last accessed on 09/05/2023 at https://media.cancercare.org/publications/original/447-CancerCare-EmployeeProtection-Toolkit-digital-new.pdf"*

Perspectives on how to manage oral medications are notably different between managed care organizations and their subcontractors and the treating physicians/providers and the patients and their families. The intended impact of a management choice can be simultaneously praised and decried, depending upon the perspective of the beholder. There are upstream and downstream consequences of common oral management approaches, and opportunities for increased collaboration and communication between the treating provider, patients, and managed care. The ultimate payer, the employer or the federal or state government, have their own perspectives, as well as the ability to drive care. **The voice and perspective of the insured patient is rising in importance and may become a driver of change for employer benefit design, and in turn, drug management strategies by managed care for health plans and other intermediaries.**

The Consolidated Appropriations Act (CAA) of 2021[2] is forcing self-insured employers to assume new levels of fiduciary responsibility to their employees for the healthcare services they purchase and healthcare premiums they collect and manage. Brokers, vendors and health plans will increasingly have to answer to employers for patient access to care and restrictions, like step edits (requirements to use one or more specific drugs, and have it proven to be unsuccessful/fail before another drug is allowed to be covered) and formulary restrictions that are perceived by patients/employees as not responsible stewardship of their benefits and premiums.

Benefit design and coverage rules that are perceived by covered employees to adversely affect their access to standards of care, or delay needed care under prior authorization (requiring patients or prescribers to secure preapproval as a condition of payment or insurance coverage for their prescribed medication) denials and step edits, or lack of coverage of standard of care treatments that align with patient and physician medical necessity perspectives may become the backbone for health benefit-related fiduciary responsibility lawsuits. Existing oral cancer care management by health plans that restrict standard of care access and prefer less costly first generation to newer generation treatments may become more of a liability than an asset to managed care medical directors and employers.

This paper reviews the evolving story of oral drug management in oncology and looks at areas of challenge and opportunity under the emerging shift of power for reasonable patient access to medical services.

Why Does Strategy for Oral Care in Oncology Matter?

The general costs of healthcare continue to rise, past the level of sustainability. Cancer is one of the leading causes of death and a key cost component of healthcare. Cancer touches one in three people in the United States, and though often seen in the population aged over 65, it does affect those younger than 65 years of age, becoming a concern for employers and other purchasers of care. By 2022, almost $100 billion of U.S. healthcare spending is projected to be for oncology medications, many of which will be specialty drugs. About 30 percent of all oncology drugs in the research pipeline are oral chemotherapeutic agents.[3]

Oral oncology treatments are increasing as part of the standard of care as single agents, supportive care agents, or part of a combination regimen. In some cases, patients and their providers can choose between oral treatment or intravenous treatment.

ORAL CANCER CARE MAY GIVE AN ILLUSION OF FALSE EASE OF USE

Traditional chemotherapy drugs, whether oral or intravenous (IV), are intentionally toxic to human cells. As single agents or part of combination

regimens, these are toxic medicines, with symptoms and side events that, combined with the disease of cancer itself, can wreak havoc on a patient's health, quality of life, ability to work, family, finances, and emotional well-being. Sometimes the concept of taking "oral" drugs could raise a false sense of being an "easier" treatment than IV drugs, but the toll they take, although different, can be as significant as administered medications. In fact, battling cancer using oral drugs can be much harder than with IV drugs, because it becomes the patient's responsibility to follow tight dosing requirements and scheduling and handling instructions, and to take them as directed. Patients may feel reluctant to take a drug that they know will give them unpleasant side events or they may self-modify the dosage and timing for comfort or financial reasons. Mishandling oral drugs for cancer treatment or not taking them as directed can lead to serious consequences for the patient, their families, their treatment plan, and even aggravate the total costs of care due to unintended consequences.[4]

BENEFIT DESIGN AND COVERAGE POLICY FOR ORALS CAN HELP OR HURT PATIENTS

Just as physicians evaluate the advantages and disadvantages of oral treatments, employers and health plans, and their intermediary agents, are also considering their policies for coverage and reimbursement. The challenge is that what may be an advantage to patients and their physicians may be perceived as a disadvantage to those paying for the care. Oral treatments are now an option for many cancer types, including breast cancer, leukemia, colorectal cancer, multiple myeloma, lymphoma, prostate cancer, and renal cancer.[5] Clarity in benefit design is helpful but may be the beginning of a more complex conversation that could shape and improve benefit design decisions. Patients can feel forced into choices, buffeted by benefit design, financial responsibility, confusion, with the encroachment of alternative management and drug delivery outside of their physician relationship, which complicates more than enhances treatment. With unsustainable rising costs of care, better understanding of the drivers and perhaps unintended impact of health plan and employer policy choices could be useful in transforming traditional utilization management by removing or reducing barriers to cost-effective care alternatives.

The Evolution of Oral Treatments for Cancer

Oral and IV-administered chemotherapy existed even before the establishment of medical oncology as a specialty in the early 1970s. Mercaptopurine and methotrexate were first approved by the Food and Drug Administration (FDA) in the 1950s. Many oral anticancer medications have been approved since then.[7] Whether a part of combination therapy or as

The Unintended Consequences of Traditional Cancer Utilization Management

The 2021 CancerCare® Employers' Prescription for Employee Protection Toolkit: Best Practices for Prescription Benefit Design worked with patients, physicians, nurses, patient advocacy personnel, employers, and health plans to understand the challenges for cancer utilization management and opportunities for transformation and improvement.

"Utilization management (UM) is an umbrella term for cost-containment techniques used to determine whether healthcare services are medically necessary and appropriate for patients, and ultimately, whether they should be covered by health insurance. UM sets the rules by which insurers restrict or deny coverage for care. At its best, UM helps to weed out unproven treatments, evaluate physicians' treatment recommendations, and reduce costs while still delivering quality care. At its worst, UM creates administrative snarls, delays, stress, costly out-of-pocket expenses for patients, and interferes with patient/physician decisions regarding the best personal course of treatment. Common UM practices are not only significant obstacles to time-sensitive, precise cancer care but put a tremendous burden on patients that can lead to worse outcomes, debilitating suffering, higher medical expenses, extreme financial pressures, relationship difficulties, lower productivity at work, increased absences and compromised presenteeism."

Benefits consultants often provide one-size fits all products that don't offer the customization necessary to meet a company's unique needs and employee demographics. Cancer coverage needs can vary widely for younger or older employee populations, or other geographic or socioeconomic differences. Recent benefit design trends have started to restrict benefits and shift out-of-pocket costs to employees.

"Restricting pharmacy benefits might seem to be a good idea as it can save the company money, may lower premiums for employees and, in theory, keeps coverage focused on drugs deemed both medically effective and cost effective. Importantly however, any short-term savings can have costly long-term consequences for employers and patients. Multiple studies on restrictive formularies have found that they are associated with increased medical costs and higher total healthcare spending. Under a restrictive benefits plan, employees may be unable to access medications that support a higher quality of life, or they may struggle under the financial burden of paying for these medications out of pocket. Restrictive benefits are linked to worse clinical outcomes, lower patient satisfaction, increased or extended hospital stays, increased pain and suffering, and even higher death rates."[6]

The Employers' Prescription for Employee Protection Toolkit: Best Practices for Prescription Drug Benefit Design," CancerCare®, Published 2021

single agents, oral drugs are now becoming standard of care treatments for many cancers.

Several key milestones in the journey of the business of oncology paved the way for the current strength of oral medicine as medical options.[8]

- President Nixon declared "War on Cancer" in 1971. At the time, cancer was primarily a hospital-based disease, with few options to manage toxic side events from cancer medications.
- In the late 1980s, **a new payment process for all physicians** was developed, after review of workflow in physician practices, called the Resource Based Relative Value System (RBRVS).
- In 1991, the FDA approval of ondansetron, an antiemetic, along with other drugs developed subsequently, made it **possible to better manage oncology in the physician/outpatient offices**.
- In the early 1990s, oncology trained physicians and nurses evolved the community practice model for cancer evaluation and infusion treatment in the **acute care office setting that quickly became the norm** for most cancer care delivered in the United States.
- The **original RBRVS rates were created exclusively for the outpatient care setting,** but they were created without evaluating professional services, workflow, and overhead of a present-day oncology practice, due to the rapid growth and complexity of care delivery that evolved in oncology practices following the RBRVS implementation.
- Acknowledging the **pricing imbalance** related to the work effort and professional services of an oncology practice, original RBRVS rates and actual office overhead, the **government created a provider reimbursement calculation for drugs** based upon a drug pricing benchmark commonly known as the **Average Wholesale Price (AWP)**. AWP, a variable number reported by drug manufacturers to publishers of drug pricing data, was widely accepted as a **provider reimbursement mechanism that allowed margins over the drug purchase costs. Those margins were then to be used to offset the growing gap caused by RBRVS based under-reimbursement of professional services and to cover the costs of running the acute care oncology offices**.[9]
- In 2003, the Medicare Modernization Act (MMA) passed, which in part changed federal reimbursement for drugs to the **Average Selling Price (ASP) model**. Under this model, Medicare reimbursement **dropped** for drugs and professional services resulting in **break-even or net losses for cancer practices.**
- The MMA reworked Medicare Part C to become the **Medicare Advantage (MA) Program**. Under MA, beneficiary plan choices were updated, and the way benefits were established and payments made, were changed. Commercial contractors could bid to manage MA plans for Medicare beneficiaries.[10]
- The MMA also established the **Medicare Part D prescription drug benefit** for traditional Medicare beneficiaries, also allowing the MA plans to offer prescription drug coverage to their MA beneficiaries.
- **Medicare Part B covers** a limited number of outpatient prescription drugs under certain conditions, including[11]:
    - **Most injectable and infused drugs** when a licensed medical provider gives them, because these types of drugs are not usually self-administered.
    - **Some oral cancer drugs** that patients take by mouth if the same drug is available in injectable form, or the drug is a prodrug or the injectable drug.
    - **Oral anti-nausea drugs** used as part of an anti-cancer chemotherapeutic regiment if they are administered before, at or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug.
- At the turn of the millennium, a new oral chemotherapy drug (imatinib – brand name Gleevec®) was introduced that revolutionized treatment for chronic myelogenous leukemia (CML) and established a paradigm shift in cancer care.

With the advent of the human genome project, new research and funding opportunities led to an explosion in the development and discovery of novel drugs. Expedited approval of anticancer drugs and biologics fueled further innovation in treatment options. Anticancer drugs are broadly described as chemotherapy, which encompasses both cytotoxic agents and biologic therapy (drugs targeting a biologic process).[12] Many of the new targeted treatments are oral drugs used in cancer treatment. These drugs include chemotherapy, immunotherapy, and supportive care.

The FDA's Center for Drug Evaluation and Research (CDER) summarized that from 2000 to 2008, 25 anticancer and 15 new biologics were approved, out of 209 total new drugs approved. Over the next nine years, through 2017, those numbers more than doubled (53 new anticancer drugs and 47 new biologics).[13] Contributing factors to this consistent innovation included steadily increasing new drug

applications, a noticeable shift toward submissions for first in class and orphan drug approvals, extensive discussions between CDER and drug developers that improved the availability of relevant information needed for complete reviews, multiple FDA expedited approval programs (fast track, breakthrough therapy, priority review and accelerated approval), and the attractiveness of cancer as a therapeutic area full of need. Drug approvals themselves fall into distinct categories which can impact coverage policy:[14]

- First in class – These are drugs with a first of its kind mechanism and which are totally different from already available drugs for a medical condition.
- Drugs for rare disease (orphan drugs) – Orphan drugs are approved for use on patients in small populations, i.e., less than 200,000 people. Patients with rare diseases often have very limited options for treatment.
- First cycle approval – Many drugs can achieve approval after only one cycle of review, which reflects the preparation and work done before entering that review.

New Medicare Benefits Expanded Access to Oral Cancer Drugs

The 2003 MMA created opportunities for patients to receive oral drugs under the Medicare Part B medical benefit **if** they were provided by their treating physician and were an oral version of a drug that was also administered via infusion or injection in their treating physician's office. The MMA also opened the door for Medicare patients to receive coverage and access to oral drugs under the new Medicare Part D pharmacy benefit.

Although oral drugs were covered, there were ongoing challenges for the successful integration of oral drugs into the patient care regimen, even if an oral medication may be the best clinical choice for a patient. The treating physician might offer an IV alternative to ensure that the patient can access the drug in a timely and affordable manner to maximize the effectiveness of the full cancer treatment. Some Medicare patients may have chosen not to enroll in the Medicare Part D program and have limited access to orals. Medicare did expand Medicare Part B coverage to eight oral oncolytics called prodrugs, an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable form. These eight oral oncolytics covered under Medicare Part B include ALKERAN® (melphalan), HYCAMTIN® (topotecan hydrochloride), MYLERAN® (busulfan), TEMODAR® (temozolomide), XELODA® (capecitabine), cyclophosphamide, etoposide, and methotrexate. Medicare also covers under Part B some oral anti-emetics prescribed for use within 48 hours of chemotherapy (within 24 hours of use for a few drugs).[15]

Oral Drugs Offer Unique Challenges in Comparison to IV Drugs

ORAL THERAPY AND IV THERAPY HAVE SIMILAR EFFECTIVENESS FOR PATIENTS, BUT NOT THE SAME PROTECTIONS

Oral chemotherapy can be as effective as IV chemotherapy but needs to be taken as indicated. No matter which delivery method is used - chemotherapy is designed to kill human cancer cells, to reduce tumor size, control disease progression, and improve both quality and quantity of life. Oral chemotherapy may have similar adverse side events on patients as traditional chemotherapy, including fatigue, nausea, constipation, or hair loss.

Oral supportive care medications may address symptoms and side events of toxic chemotherapy and hopefully help the patient be better able to continue with the full treatment dosing and plan for care, due to the ability for the patient to manage side events at home rather than go to the office to receive the equally effective IV supportive care.[16,17] But when cancer patients take oral drugs outside of the medical office setting, providers are not as easily able to monitor toxic side events, or to ensure that the patient actually takes the medication as planned.

MEDICAL BENEFIT VERSUS PHARMACY BENEFIT – BIG DIFFERENCES THAT AFFECT ACCESS AND COSTS

The employer or health plan makes decisions about whether patients will be allowed to access needed treatments through their medical or their pharmacy benefit – and, in some circumstances, particularly in oncology, through either. The management of drugs under each benefit structure varies widely, and the impact can affect the entity paying for the care positively or negatively, yet at the same time, have the exact opposite impact on the employee or beneficiary receiving care. Creating escalating levels of patient financial obligation may satisfy the employer or health plan because it may force patients to consider the financial impact of certain treatment options, but the danger is that it also could lead to patient financial hardship, and decisions to delay or restrict treatment that can later lead to higher uncontrollable costs of care.

PATIENT COMPLIANCE AND ADHERENCE IS NOT THE SAME BETWEEN ORAL AND IV TREATMENT

Paid under the medical benefit, IV treatments are administered in the cancer center, under the oversight of physicians and nurses. If a patient has an

adverse reaction (which is all too common), there is immediate medical care available. IV treatments are administered under medical supervision, so there is 100 percent confidence that the medication has gotten into the patient at the right time, and in the right concentrations to achieve its purpose, whether chemotherapy or supportive care. This is especially important when the treatment is in combination with other treatments since a careful balance is required to achieve the desired impact on the cancer.

Oral chemotherapy, which can be paid under the medical or pharmacy benefit depending on the situation, can be perceived as easier and more convenient for patients – not requiring travel to the office for infusions, more control of their treatment, and more portability to match active lifestyles. However, those advantages do not always materialize: patients on combination regimens still need to go to the office for infusions (which may then make more sense to receive the entire regimen parenterally); and the responsibility of managing the regimen and monitoring for dose accuracy and toxicity falls to the patient (which can be overwhelming or difficult for sick patients). Only patients who are well-motivated, health-literate, have good oral food intake, good gut function, and minimal nausea and vomiting are likely to be able to manage and tolerate oral chemotherapy.[18]

Oral cancer coverage and management policy by health plans and employers should recognize the advantages, but also the limitations of oral cancer treatments and the reality that not all patients with the same disease will benefit from them in the same way. Poor management, compliance, or adherence by a patient on oral therapy could lead to failure of the regimen, potentially medical harm to the patient, and ultimately higher costs for total care.

Pharmacy Benefit Oral Drugs Raise Concerns for Patient Access and Financial Burden

Oral treatments are prescribed by the physician. These drugs will most likely be billed under the pharmacy benefit of the patient's insurance and thus lead to several differences from physician-administered drugs in the office that are covered by medical benefits.

DRUG DELIVERY CHANGES CAN ADVERSELY IMPACT PATIENT ACCESS TO CARE

Although many cancer centers are capable of dispensing oral treatments through either the medical benefit or pharmacy benefit, many pharmacy benefit managers (PBMs), health plans, benefit designs, and employers may try to route oral treatments through other dispensing sites, such as specialty pharmacies or commercial infusion centers. Inserting a delivery model outside of the traditional physician patient relationship instantly adds compliance and adherence complications for that treatment.

DIFFERENCES BETWEEN MEDICAL BENEFIT AND PHARMACY BENEFIT FOR THE PATIENT

Most benefit designs include medical benefits (hospital visits and physician services, including physician administered drugs) and pharmacy benefits (drugs that a patient would self-administer, mostly orals). Prescription drug plan copays and co-insurance for specialty cancer drugs are vastly different and much higher for pharmacy benefit drugs than for drugs billed within the medical benefit.

Commercially insured patients are covered under a variety of benefit designs, with variations in co-pays, co-insurance, and deductible financial obligations. Health plans and self-insured employers set their own parameters for coverage and benefit design, often with variation down to specific drugs. When selecting insurance plan choices each year, many individuals are not able to understand or anticipate coverage down to every drug they may need.

Traditional Medicare patients are responsible for up to a 20 percent co-insurance for Part B services and any drugs delivered under Part B. Traditional Medicare enrollees have no catastrophic threshold or out-of-pocket maximums, but most (almost 90%) have supplemental coverage that reduces or eliminates the co-insurance. In comparison, commercial and Medicare Advantage patients are subject to varied benefit design packages, including co-pays that can rise to 30 percent and higher, formulary restrictions on which drugs can be obtained and often mandate the delivery source.

Medicare Advantage patients are prohibited by law from purchasing supplemental insurance to offset their financial obligations under their benefit design, since Medicare Advantage plans are administered by private insurers who are responsible to Medicare for achieving savings (patient financial obligations are often considered a utilization management tool to control medical spending). Medicare Part D drug plans, like commercial pharmacy benefit plans, include a co-payment for prescriptions, a deductible, and an ongoing co-payment when they reach the catastrophic level of their benefit plan, as well as formulary tiers.[19]

WHEN PATIENT OUT-OF-POCKET COSTS RISE, ADHERENCE TO ORAL DRUGS FALLS

For both commercial and Medicare Advantage enrollees, most oral cancer drugs are placed on the higher formulary tiers, where patients pay a larger portion of the drugs' cost out-of-pocket, which can

amount to thousands of dollars. With no patient option for purchasing supplemental insurance to assist with out-of-pocket costs, a 2010 Avalere health study indicated that Medicare Advantage patients on oral drugs frequently shoulder a larger financial burden compared to what they might have paid under traditional Medicare, which may even lead some patients to decline care.[20]

Higher patient out of pocket costs can adversely affect patient compliance and adherence, even for cancer treatments. A 2022 University of Rhode Island College of Pharmacy study found that close to half (48.2%) of almost 38,000 patients with cancer in their study were nonadherent to oral cancer treatments.[21] A similarly-sized University of Pennsylvania study looked at utilization of 38 oral therapies from a 2014–2015 Medicare and private health insurance claims database, finding that overall, 18 percent of the patients did not fill an oral drug prescription after their insurance approved it. The out-of-pocket patient cost drove adherence variation among these patients. Almost half of the patients who were charged more than $2,000, and almost one-third of the patients who owed $100 to $500 did not fill their prescription, but only 10 percent of those who were charged less than $10 skipped their prescribed drug. The patients facing the highest out-of-pocket costs (over $2,000) also were more likely to delay the start of oral treatments, and less likely to switch to alternative oral or IV options.[22]

IMPACT OF PBM AND SPECIALTY PHARMACY INVOLVEMENT ON PATIENTS FOR ORAL DRUGS

Managing the growth in oral cancer treatments is a challenge for employers and health plans. In addition to supportive oncology care and chemotherapy, new treatment advances are likely to include cell, gene and RNA therapy, and immuno-oncology drugs. These medicines are costly to develop and will be costly to manufacture and deliver. Payers are likely to use tight management and cautious coverage to ensure that only the most appropriate therapies are provided to covered patients. That caution for coverage and reimbursement often conflicts with the hope that providers and patients hold for these therapies in cancer treatment and prevention.[23]

Health plans and employers continue to turn to outside vendors, such as PBMs and specialty pharmacies, to understand the medical drugs and their applications. Not all the new specialty drugs may be covered, which may then set up conflicts with employees and their physicians who feel such coverage is appropriate under their health benefit plan for the premiums they pay. Employers, health plans and payers may seek to work more closely with oncology providers or third-party vendors for specific guidance in specialty diseases.

PBMs and specialty pharmacies have a strong history of managing and supporting high-cost, high-touch chronic conditions including hemophilia, hyperlipidemia, hyperglycemia, and hypertension. PBMs initially started as third-party administrators of pharmacy claims but have expanded their role into leveraging market power for rebates, lower prices on drugs, preferred market positions for products, and self-referral to wholly owned or affiliated specialty pharmacies.[24]

Typical leverage and cost containment provided by PBMs, and specialty pharmacies is linked to market positioning of drugs against competing alternatives and multi-month fills of prescriptions. Prior authorization, formulary positioning and step edit policies, as well as algorithms for care decisions, deepen control and management of oral drugs for health plans and employers. Extensive mergers and acquisitions mean that PBMs and specialty pharmacies are highly likely to be affiliates of health insurers and other organizations.

The challenge is that cancer patients, their disease and the treatment options are not easily standardized. Different patients with the same disease diagnosis will have vastly different medical histories, health and socioeconomic disparities, work and family responsibilities and financial resources. Those patients are not going to benefit from templated universal therapy approval and coverage.

Site of Dispensing Impact for Oral Drugs

Cancer patients may obtain their oral drugs from several sources, depending on the design of their health benefit and policies set by the health plan or employer. Where and how the drug is obtained (if the patient can afford to pay the cost required by their benefit design and delivery source) can be nearly as important to the success of treatment as the drug itself. There are many variables between those sources that can affect:

1. The patient's timely access to the drug
2. Their out-of-pocket cost
3. The total cost to the employer or payer
4. The quality and stability of the drug
5. The patient's own choices to self-manage their individual administration of the drug (or not to take it even if it was prescribed).

DISPENSING DRUGS BY THE TREATING PHYSICIAN IN A PRIVATE OFFICE

Physicians may administer or dispense drugs to cancer patients in their acute medical clinics under the scope of their medical license, and thus are

not required to employ pharmacists or to license a pharmacy in their state. In most states, patients are able to have their oral prescriptions filled directly from their own physician's clinic. This option is known as "Medically Integrated Dispensing (MID)" and is offered as a clinical advantage to cancer patients. The prescription is verified immediately, and filled, often before the patient leaves the clinic.

The clinic staff has **access to all the patient's medical information** and, with the doctor, can review and **make rapid dosing adjustments in response to adverse reactions, patient health status changes, or other medical issues.** Drugs dispensed through a treating physician's clinic are **often dispensed before the final patient financial obligation is met for continuity of care**, because of the ongoing nature of the care journey and interaction between the patient and their care team. **The medical practice usually does not delay care if the patient is not immediately able to provide payment in full before receiving the needed oral drugs, in contrast to other drug delivery models.**

Physicians can write a **prescription for a limited initial fill and consider the impact of that drug on the patient and their disease or combination regimens before committing to a longer fill time frame.** This is particularly important for oral drugs that can cost hundreds or thousands of dollars per month. Patient compliance and adherence to orals as part of their single or combination treatment regimen is essential. **Physician clinics stay in close contact with their patients and can even double check for compliance by having the patient bring in their meds during office visits so that remaining pills can be counted and verified.** Texas Oncology, a large private practice with multiple locations across Texas, tracks patient adherence, with their lowest rate being 93 percent.

Cancer patients are in a vulnerable health and personal position and have an established relationship with the staff and physicians caring for them, which provides strong opportunities for education, outreach, communication, and follow-up. With direct knowledge of and involvement with their patients, **clinics seek – with no charge to the patient or health insurance – prior authorizations, patient support, and patient assistance programs, and ensure that administered or dispensed drugs meet all stability and temperature handling parameters**. Many physician clinics and networks fund their own patient assistance programs, usually for support of patient needs for transportation, childcare, food insecurity and other non-medical issues.

Physicians utilize secure drug distributors that are trusted sources for quality drugs from within the United States. **Because physicians operate under a "Buy and Bill" model (they buy the drugs they expect to need, and only bill patients and their insurance for the drugs actually administered or dispensed), there is very little waste resulting from unused prescribed drugs.** Cancer patients often have health status changes or reactions to drugs that require regimen dosing adjustments or quick switches to another drug. MID allows for smaller initial dosing units (usually as little as a week, but no more than 30 days) and great flexibility when the inevitable regimen changes arise.[25]

DISPENSING DRUGS THROUGH THE HOSPITAL OUTPATIENT FACILITY OR HOSPITAL-OWNED ONCOLOGY GROUP

Hospital based cancer facilities can offer a broad range of clinical services related to cancer care, including clinical services, imaging, radiation oncology and surgical services. They often have their own internal state-licensed pharmacy and employ pharmacists and pharmacy personnel that can be based in the pharmacy or in the outpatient facilities or practice groups. Hospital based organizations rely on different preferred secure drug distribution organizations than those used by private physician groups, but still basically use a closed drug acquisition system as a trusted source.

As treating facilities, the physicians and staff enjoy full access to the patient medical records and patient history, can be flexible in the drug quantity being dispensed, and sensitive to rapid changes for patient reactions, health status, and financial needs. Hospital staff are able to **support and enroll patients for no charge in patient assistance and financial programs for which the patient is eligible**.

One challenge with hospital-based cancer centers is that **hospital billing contract rates differ from the contract rates negotiated by insurers with private physician groups**. There **can be significant variation for costs of services and drugs billed** to both the patient and the insurer/employer. Facility fees charged by health systems are often billed in addition to the services and drugs provided.

Over the last decade, consolidation in the delivery of medical services, driven partly by increasing financial pressures on private practice from health plans, PBMs and specialty pharmacies, (followed by medical practices being acquired by hospitals) has reduced the market presence of the most cost-effective site of care setting, which is the private medical oncology practice. The growing importance of the voice of the patient in responsible management of their health benefit premiums may lead to pushback on medical benefit

design, including the impact of network contracts that limit site of care and drug delivery options.

DISPENSING DRUGS THROUGH THE SPECIALTY PHARMACY

The specialty pharmacy cannot provide oral drugs to a patient unless they receive a physician prescription. In most states, they cannot substitute the ordered drug for another without first consulting with the prescribing physician.

Specialty pharmacies may request medical information from the prescribing physician, but their staff does not see the patient clinically and does not have direct medical knowledge of each individual patient. Specialty pharmacies are physically distant from the patient, with no knowledge of:

1. The patient's health status, clinical history, IV drug history
2. The patient needs for home, work, and family functionality
3. Financial resources
4. Caregiver availability
5. Other patient support for medication adherence.

Each of these components are as essential as the labs, imaging, and clinical presentation of the patient's cancer in determining appropriateness, potential compliance and adherence factors, and drivers of success for the cancer treatment.[26]

Specialty pharmacies and the PBMs that own or contract with them manage drug volumes, market share, and cost. Their tools include negotiated rebates, step edits, non-medical switching, utilization management, formularies with preferred and non-preferred drugs as well as specialty tiering, prior authorizations, and patient financial obligations, such as co-pays, co-insurance, and deductibles.

To gain patient and prescription market share, PBMs and health plans may mandate preferred specialty pharmacies that they own or have an affiliation with, rather than allowing physician or hospital clinics to fill oral prescriptions. However, the push for payer or PBM preferred-specialty pharmacies to dispense oral drugs rather than the physician or hospital-based provider creates a risk for the patient and provider. Using external entities to dispense oral drugs:

1. Adds delays in patient care
2. Disrupts access to prescribed drugs determined by the physician to best suit the patient's needs
3. Adds additional costs of unused drug due to the multiple-month fills
4. Holds up medication dispensing until the prescribed drug is paid for in full
5. Increases delays between the prescription and changed regimen needs, all of which are not issues that arise with provider dispensing, as noted above.[27]

Brown-bagging and White-bagging from Specialty Pharmacy

When specialty pharmacies seek to fill the prescription and ship the drug to the provider's office for administration, that is termed as "white-bagging." When specialty pharmacies fill the prescription and ship the drug directly to the patient for self-administration, that is called "brown-bagging." Both white-bagging and brown-bagging practices are of great concern to both physician and hospital-based providers because the drugs are being sourced from a distributor that is unknown and unvetted by the provider. There is little control over the timeliness and accuracy of delivery, or how hazardous or unstable medications are stored and handled prior to use by the physician or the patient.

Some brown-bagging models may require a home-health nurse to administer the drug in the patient's home. There are many quality risks related to treatment timing, nurse availability and reliability when home-health staff with no expertise in oncology are expected to administer cancer medications safely. Physicians maintain professional liability for these toxic and dangerous drugs, and the risk of accepting these products through unknown sources is opposed by the physician and a danger to the patient themselves. Patients may forget to take brown-bagged drugs in advance, store and handle them within safety parameters, or fail to bring brown-bagged drugs needed for combination regimens with them to their appointments, thus disrupting the treatment regimen.

Bagging of medications needed for cancer treatments leads to fragmentation of care while adding cost, risk, and liability for the cancer patient. Providers frequently disallow brown- or white-bagged drugs into their clinics, despite payer or employer mandates.[28] The National Association of Boards of Pharmacy reviewed the practices of brown- and white-bagging in 2018, determining that there is a legitimate patient protection issue and a potential for compromised domestic contents or the inclusion of imported foreign drugs that may have been manufactured abroad and not appropriately FDA inspected. Serious questions need to be considered including where, when, and from whom do the medications originate when considering pharmacy benefit policy that includes brown- or white-bagging.[29]

OBTAINING DRUGS THROUGH ALTERNATE FUNDING PROGRAMS (AFPS)

These recent programs are sold to self-insured employers as ways to reduce specialty pharmacy costs

for the employer and the employee. They provide a list of up to a few hundred oral drugs that they deem to be "non-essential" despite the fact that prescription drugs are one of ten essential health benefits that are protected under the Affordable Care Act as services that health insurance plans must cover.[30]

When an employee is diagnosed as needing a drug on that list, the PBM (often affiliated with the AFP) notifies the employee that they are not covered for that drug. The employee is referred to the AFP, which then tries to sign them up for patient assistance programs (free drug set aside for needy and uninsured patients) from manufacturers, or other patient financial assistance as a patient with no insurance, or imports substitute drug from other countries at lower rates. The AFP program promises drugs at zero or reduced cost to the employer and promises the employee their drugs with zero or little co-pay. If the AFP is unable to sign the employee into the free drug or patient support programs, or to import product, the employee faces significant financial risk of paying for the drug fully on their own or being placed back into their pre-existing insurance coverage after weeks of delayed care.

On the surface, this seems to be an attractive model that provides free or discounted drug to employers and employees and provides a profit to the AFP vendor and others in the drug management chain. In reality, AFP involvement:

1. Disrupts patient care
2. Drains drug support intended for truly needy patients
3. Can eliminate access to support and drugs employees used to receive before the AFP came along
4. Charges employers for up to 35 percent of the retail price of the drugs when oncology offices seek assistance for eligible patients at no charge
5. Confuses vulnerable employees trying to deal with their cancer diagnosis
6. Mandates provision of the drug through (often affiliated) specialty pharmacies or foreign imports.

AFP intrusions increase risk and liability for both patients and physicians, and, by extension, for those employers choosing to allocate employee benefit dollars for these adverse programs. Drugs are shipped from sources unknown to the physician or the patient, adding risk for handling mishaps in the delivery process outside of the stability or temperature requirements of the drug, or delays in delivery, all of which put the patient at risk, and expose the treating physicians to medical liability beyond their control.

In addition, since otherwise insured patients are often presented as uninsured for the purpose of obtaining manufacturer drugs set aside for needy patients, or funds intended for needy patients, those programs and resources are not limitless, and become unavailable to the truly needy patients for whom they were designed.

Patients and providers are put at risk for the source and danger of these unknown drugs, and employers and employees deal with disruption and delays in essential cancer treatments, as well as the costs of the AFP fees and increased health costs from untreated disease. **Rising concern from patients, physicians, and several state and national based patient advocate organizations are putting the AFP programs under legal and public review for their actions and interference with patient access to essential benefits and care**.[31-33]

Step Edits Lead to Unintended Higher Total Costs of Care – Including Much-Needed Treatments for Iron Deficiency

Iron Deficiency and Anemia Are Significant Issues for Cancer Care

Iron deficiency is reported in 32 percent to 60 percent of patients with cancer, most of whom are also anemic.[34] Anemia is extremely common for cancer patients undergoing treatment. Anemia in patients with cancer may be attributed to multiple causes and underlying comorbidities such as bleeding, hemolysis, nutritional deficiencies, hereditary disease, renal insufficiency, hormone dysfunction, chronic inflammation, or a combination of these factors. Anemia is prevalent among patients with cancer at initial presentation, especially in patients with lung cancer. Common complaints are syncope, exercise dyspnea, headache, vertigo, chest pain, fatigue that is disruptive to work and daily activities, and abnormal menstruation in female patients. Cancer-related fatigue, unlike fatigue in healthy individuals, is less likely to be ameliorated by rest.[35] There are oral and IV drugs available for iron replacement for patients with cancer who develop chemotherapy induced anemia (CIA).

Oral Iron Drugs are Not Recommended for Cancer Patients
Available oral iron treatments are often viewed as front-line therapy and given preference as such in managed care formularies, prior authorization algorithms and step edits, but that is contradictory to established medical guidance for cancer patients in the U.S., and contrary to standard of care in Europe.

The National Comprehensive Cancer Network (NCCN) has cited that: "Although oral iron is appropriate for most iron-deficient anemias, many patients with CIA either do not respond to oral iron, may be intolerant of oral iron, or may require higher iron doses than achievable with oral iron, making IV iron therapy a valuable option. Since the majority of studies show that IV iron is superior to oral iron in improving hemoglobin response rates in patients with CIA, the NCCN medical advisory panel recommends that IV iron supplementation be used in most clinical circumstances. Low-molecular-weight iron dextran, ferric gluconate, iron sucrose, ferric carboxymaltose, and ferumoxytol are the recommended IV iron preparations."[36]

IV Iron Drugs Vary Widely, Older Drugs have Notable Limitations
Most of the older iron drugs are infusions that can only be given in small doses at a time, over periods of weeks with significant potential side events (anaphylaxis) and a total iron load that is less than full replacement. Newer generation IV drugs offer faster uptake of an appropriate iron load (1 or 2 doses versus weeks of oral dosing), and higher final iron load with improved adverse event profiles.

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In Contrast – U.S. Payer Coverage and Step Edit Policies Still Rely on Older IV Iron and Step Edits Following Oral Drug Failures

Commonly, U.S. payer coverage and step edit policies for iron replacement, especially for chemotherapy-induced anemia, indicate only older generation oral/IV iron drugs as preferred and/or require failure on older iron drugs for periods of weeks or months before the newer IV iron products may be even requested.[37-39]

Oral Iron and Older IV Iron Cost Less per Dose, but More in Total Costs of Care

Most health plans and PBMs seem to believe that older IV or oral iron treatments will save money over newer, more expensive drugs. Successful management of iron deficiency involves more than simply taking a pill or receiving an infusion. The load of replaced iron is important. Lower iron replacement levels that do not bring patients up to appropriate iron levels leave patients weak, unable to perform duties of daily life or work, and with limited physical or emotional resources to tolerate concomitant cancer treatments or the ongoing side events from those treatments. Oral iron drugs engage the gastrointestinal system of a patient, leading to further complications and potential adverse reactions.

In 2023, a claims data review of approximately 25,000 patients demonstrated lower discordance – receiving less than 1,000 mg of iron (the standard of care dose prescribed for patients not receiving hemodialysis) over a course of therapy – to treatment and lower overall cost of care from newer-generation IV iron products compared to older products. Discordance to IV iron therapy overall was 33 percent. Patients who received newer-generation products were less discordant to therapy (16%) than patients who received older-generation products (55%). Overall total costs of care were $36,552. Patients who were concordant to therapy and on a newer-generation product had the lowest mean total cost of care ($35,353), compared to patients on older-generation, less expensive, iron products ($38,164) suggesting that overall cost of care is not necessarily proportional to the purchase price of the chosen iron replacement therapy. Optimizing concordance to IV iron therapy may lead to lower total cost of care for patients with iron deficiency anemia.[40]

Futile Oral Step Edit Mandates Waste Drugs, Dollars, and Patient Health

The disadvantages of oral iron for cancer patients have already been identified, but we need to also consider the futility of forcing patients to fail first on oral and/or older IV iron treatments for weeks and months (sometimes coverage can require failure on more than one oral option). Cancer patients with CIA need immediate iron replenishment to be able to function at work and at home, to tolerate and even continue with their cancer treatments. The waste of weeks and months of oral treatments that patients with CIA will already be expected to fail, plus the costs of their worsening disease status will lead to increased financial and patient health costs.

Second Generation IV Iron Lower in Total Costs Than First Generation – Key Payer Strategy

Older generation IV and oral iron products were formulated and approved for lower doses, which are administered over more than two treatments. Multiple IV infusions place a higher burden on patients, which can lead to discordance between the actual IV dose given and the required/prescribed dose, and lead to ultimate higher total costs of care. Understanding the impact on patient health, total overall costs, and the importance of recovery to full iron replacement levels for cancer patients can inform and transform health plan and employer strategy regarding the timing and need for iron deficiency anemia. Total overall costs tell a much different picture than solely looking at the dosing cost of older-generation products compared to newer-generation products. Oral or older iron replacement regimens may lead to patients not receiving recommended IV iron treatment per label. **New data is available to inform payer policy decision-making processes suggesting that restricting use of newer standard of care IV irons by step edits through older low-dose IV/oral irons ultimately results in increased total costs of care despite the higher average sales price of the newer drug**.[41]

Oral Cancer Drugs Are Complicated to Self-Administer

Cancer drugs, whether oral or administered intravenously, are designed to kill human cells, albeit malignant ones. Parenteral IV therapies are straightforward to administer. Unlike oral therapies, they bypass the gastrointestinal tract – avoiding the low pH environment of the stomach, liver breakdown of drug before it can reach therapeutic levels, and the variable absorption in the small intestine. The parenteral delivery method is well suited to cytotoxic treatment regimens that allow the maximal tolerated dose of chemotherapy to optimize cell kill in a single episode, or for several numbers of cycles of treatment and breaks. Cancer centers have been designed around the acute care and monitoring needs of chemotherapy infusion.[42]

Oral chemotherapy is changing those models. Many current oral treatments target very specific cellular processes that require prolonged treatment and often obtain significant benefits over IV therapy. One example is life-long imatinib therapy that has become an oral alternative to allogeneic stem cell transplantation. These daily low dose schedules may not have the same dose-limiting side events seen with personal IV treatment, removing the need to cycle regimens with weeks of breaks for marrow recovery. With the prolonged duration of therapy, some cancers are now considered chronic diseases requiring chronic therapy, a new mindset for cancer. As more oral therapies are approved, a perception of generally lower toxicity plus ease of administration may lead to increased use as clinicians add them to other cytotoxic regimens or use them as monotherapies where there may be fewer alternate treatment options available.[43]

PATIENT COMPLIANCE FOR ORAL CANCER DRUGS IS LOW FOR SPECIALTY PHARMACY DISPENSED, HIGH FOR MD DISPENSED

Not every cancer patient is a suitable candidate for oral medication. Cancer patients, like any patient population, vary in their levels of health literacy and comprehension, living environment, social determinants of health, and self-sufficiency. Dispensing toxic oral medications in channels outside of the physician/patient relationship can lead to significant disadvantages to the patient and their payer in terms of costly wasted product and incomplete treatment for a disease that continues

to progress. Restricted formularies or mandated external supply chains can result in delayed treatment initiation, lead to miscommunication of essential information about safe administration, drug-drug, or drug-food interactions, identifying serious adverse events and how to manage them, and unfamiliarity with proper storage and disposal techniques in the home setting.[44]

When the specialty pharmacy Express Scripts® reported on patient adherence for oral cancer drugs dispensed by the specialty pharmacy, the numbers were consistently low: for 2015 – 38.4 percent[45] and 2016 – 35.2 percent.[46] A specialty pharmacy does not have direct access to the patient and their medical care. They receive an oral prescription from the physician, need to request any additional information they need regarding the patient's medical record to process the prescription. This includes taking steps to require that payment be received in full before filling the order, fill the prescription under their operational formats, which usually includes a multi-month dispensing, and ship the drug to the patient.

Medical clinics in many states run medically integrated dispensing (MID) models that are outcome-based, collaborative, and comprehensive models that involve oncology healthcare professionals and other stakeholders who focus on the continuity of coordinated quality care in a patient-centered manner with full access to the electronic health records of the clinic. The MID models provide real-time counseling and follow-up with patients, leading to a seamless system of support.[47] At one oncology clinic, Texas Oncology, their lowest patient adherence rate is 93 percent. That practice reported that the best specialty pharmacy rate they have seen presented is 85 percent.[48]

Many oral equivalents of cytotoxic therapies will, like their parenteral counterparts, require vigilant monitoring for side events. Patients may minimize growing toxicity and wait days or over a weekend to consult their physician, until they suddenly are at a life-threatening level of toxicity. Oral therapies depend on the patient to follow often complex directions for self-administration. Failure to follow these instructions could make the costly treatment ineffectual, or worse, dangerous for the patient. One example of such complex instructions for capecitabine includes:

- Take with water within 30 minutes of a meal.
- If a dose is missed, do not take the drug when remembered and do not take a double dose.
- Stop taking capecitabine and contact the doctor if experiencing four or more bowel movements than usual per day, diarrhea at night, loss of appetite or large reduction in fluid intake, more than one vomiting episode in 24 hours, mouth sores, temperature greater than 100.5°F, or pain, redness, or swelling of hands or feet that prevents normal activity.[49]

Benefit Design Can Lead to Higher Total Cost of Cancer Care and Danger to Patients

WHEN FORMULARIES, STEP EDITS AND PRIOR AUTHORIZATION REQUIREMENTS CAN HURT, NOT HELP PATIENTS

Collaboration with the oncology community would benefit health plans and employers regarding effective oral drug use for cancer. Utilization management policies that mandate alternative drug delivery from a source other than the physician's office, and use blanket assumptions or algorithms for formularies, step edits, or prior authorization coverage for oral cancer treatments (chemotherapy, biologics, immunotherapy, or supportive care) can lead to unintended additional costs and danger to patients.

Adverse Impact of Network Delays, Specialty Pharmacy Mandates, Prior Authorizations, Step Edits, Interceptions and Foreign Imports on Patients for Oral Drugs

Network Delays

A 68-year-old multiple myeloma patient in Georgia recently underwent a stem-cell transplant and was prescribed medication to ensure he stayed in remission. Nearly three weeks later, when the patient came in for his follow-up, the doctor asked how he was doing on the medication. "I haven't received it yet," he told her. Opening his chart, she found a notification from the pharmacy, dated nearly two weeks later, saying that the patient's insurance plan would not allow them to join his pharmacy network and that they could therefore not supply the medication, but were transferring his prescription to the relevant pharmacy in his network.

Another week went by, and it was now four weeks since the prescription was made, but the patient had still not received his medication, even though it is an important part of his regimen to stay in remission. Ironically, the oncologist's in-house pharmacy had the drug available on the shelf, however, the patient's PBM would not let them dispense it. According to the physician, it is far from being an uncommon drug, and as 90 percent of multiple myeloma patients go on this medication, it should be in stock everywhere.[50]

Specialty Pharmacy Inhouse Referrals Not Requested by Doctor or Patient

A 71-year-old New Yorker with ovarian cancer was prescribed a new medication. While her Medicare Part D plan allows her to fill her prescriptions wherever she desires, in this case the on-site pharmacy at her community oncologist's practice was unable to provide the drug.

Upon receiving prior authorization, the practice forwarded the prescription to a local pharmacy they work with in such cases. When that pharmacy was also unable to provide the drug, they sent it out to

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a third pharmacy. That same day, the patient received a phone call from a PBM mail-order pharmacy, saying they had received the prescription from her doctor and that it had been approved. This was not true – no one in the doctor's office had sent them the prescription. Four days later, this mysterious pharmacy contacted the patient again, stating that the medication still required authorization and that they needed her doctor to resend it. The patient contacted her oncologist's office in concern, saying that she was very confused as to why this pharmacy was contacting her, first saying the medicine was approved, then saying it wasn't, and finally – asking her to call the doctor to get a new prescription.

Gathering the pieces of the puzzle together, the pharmacist at her oncologist's clinic tried to get a picture of what was happening. He surmised that the moment the initial prescription had been sent out to the insurance company for authorization, their PBM contacted its own mail-order pharmacy to see if they could get that prescription filled in-house. That specialty pharmacy then probably started outreach to the patient, causing confusion.

The pharmacist at the oncology clinic kept the patient on the line, added the local pharmacy of their choice to the conversation, and arranged for delivery. Since then, the patient has received no other calls from the mystery pharmacy to solicit her business.[51]

Prior Authorization Denials and Delays

In May 2022, a 33-year-old mother in Texas was diagnosed with stage 3C low-grade serous ovarian carcinoma (LGSOC), so rare it accounts for just 3 to 4 percent of all ovarian cancers. LGSOC is highly resistant to chemotherapy, failing 90 percent of the time, so oncologists usually start with surgery to remove as much tumor as possible, and follow with drug-combination therapies. Her pelvis, however, had such a high volume of tumors that she was deemed inoperable, unless an innovative way could be found to first shrink the tumors.

She was being treated in Houston at the world's top-ranked cancer center, by a renowned oncologist and a team of gynecological oncologists specializing in her disease and which had recently had good results in a clinical trial using an FDA-approved breast cancer medication to treat Stage 3/4 inoperable LGSOC. Her insurance company approved treatment and she began in June 2022. Over the next half a year, the tumors slowly shrank and by January 2023, one lung nodule had entirely disappeared, while other tumors had shrunk by up to 1cm.

In January 2023, having left her job, the patient had to relinquish her insurance policy and accept coverage through her husband's policy. His insurance company used a different PBM. When she tried to refill her medication that month, they denied her request.

After rejecting two appeals, the insurance company sent it out for external review by an oncologist who had no knowledge of LGSOC. His lack of understanding of the drug combination she had been prescribed extended to the point at which he called one of her medicines "experimental," and said that there had been no supporting studies published - despite this medication being FDA-approved and the standard treatment to shut down ovary function in pre-menopausal women, having achieved positive results in published clinical trials. All of this was explained in an 11-page document submitted by her oncologist, along with the fact that there were no other treatment options for her and that positive results had been achieved in her case after seven months. He nevertheless was denied the claim, as well.

Her third appeal was also denied, and yet she persisted, calling the insurance company daily between January 5 and January 27, with every 'no' reverberating in her mind as 'you should die,' since she was unable to pay out-of-pocket the $15,000 a month cost of the drug. She became clinically depressed and was put on anti-depressants. Finally, in the second week of February, and only after intense advocacy and pressure from the United States Congress, the PBM granted her the life-saving medication she needed. Unfortunately, there are thousands of others in the same position who are not so lucky to break through.[52]

Step Edit Delays for Non-Standard of Care Treatment

Gordon, a retired FBI agent with a distinguished record of security service on behalf of the United States, was diagnosed with an aggressive form of lung cancer. Proving resistant to the drug regimen his oncologist initially prescribed, the cancer metastasized to his brain and he immediately started radiation therapy. It was at that point that his doctors made an important discovery – Gordon's cancer had the EGFR mutation, which indicated he would do better with oral medication than infusion chemotherapy. More importantly, there was a new drug that had just been approved by the FDA as the first-line treatment for EGFR-mutated non-small cell lung cancer. This gave Gordon and his cancer care team a window of hope.

Gordon's oncologist prescribed the new medication, but the PBM denied authorization, providing the name of an alternative drug they wanted him to try first. His doctor argued that his original prescription would be better for the patient as it had been shown to have far higher efficacy for patients whose cancer had metastasized to the brain. The PBM argued back that it had been initially approved for a different EGFR mutation than the one Gordon had. His doctor argued back that this was irrelevant, as it was effective for Gordon's mutation as well, and was now FDA approved.

Back and forth, the fight went on for an entire month, with the doctor providing data and rationale to support his clinical decision-making. Meanwhile, cancer grew inside Gordon, unchecked. He began to feel increasingly fatigued, and a man who had remained very active throughout his cancer battle began to deteriorate.

Ultimately, after more than 30 days of wasted time, the PBM approved the doctor's original prescription. Upon beginning the regimen, Gordon's condition began to slowly improve, but it never should have been allowed to reach such a low state.[53]

Interception and Referral to PBM's Affiliated Specialty Pharmacy

A community oncology clinic in New York with an in-house pharmacy has seen a disturbing trend recently with patients whose insurance company is associated with a particular PBM. A 70-year-old man with prostate cancer… a 63-year-old woman with breast cancer… a 69-year-old woman with anemia – these are examples of patients with different illnesses but near-identical stories.

Each situation begins with their physician prescribing medication for their illness and obtaining prior authorization from the PBM to dispense the drug in their own in-house pharmacy. Next, the patients each received a phone call from the PBM's mail-order pharmacy requesting that they have their physician's office send them the prescription to fill the medication.

According to the practice's pharmacist: "I believe that the PBM specialty pharmacy is flagging patients during the process of obtaining prior authorization, and this leads them to contact patients and providers and to request that the prescriptions be sent out to them."[54]

Switching to Foreign Drug Sources

According to the in-house pharmacy of a community oncology practice in Utah, several of their patients have been contacted directly this past year by their insurance provider and told to have their prescriptions sent to a pharmacy in Canada. The prescriptions are always for two particular drugs used for blood clots. The pharmacy in question has no U.S. locations and is not licensed to sell drugs in Utah.

After the first two occurrences, the practice's pharmacist became suspicious and contacted the State Board of Utah. They reviewed the insurance company's prescription transfer request and determined that ordering medicine by mail from an unlicensed pharmacy was an illegal practice and potentially unsafe for patients.

The practice informed the patients that the request was illegal and then convinced the PBM to provide a prior authorization for a local pharmacy. "We caught it and stopped it," said the pharmacist. "However, how many more cases like this are out there? This was just one of 40 of the payors we deal with."[55]

Excerpted from the Community Oncology Pharmacy Association website

Traditional Utilization Management Tools for Cancer Oral Drugs Have Significant Downstream Patient Impact, Whether or Not Intended

Downstream consequences of changes in delivery models or non-medical switching of products or patient delays or restricted access to care through formularies or step edits often have an unintended health, quality of life, work and life productivity, and progression of disease and adverse events impact on patients, which could turn into patient pushback on employers, and, by extension, the health plans administering the benefit design and use of employee premium dollars.

- **Oral Supportive Care Drugs Not Received or Purchased** – Supportive care agents used in combination with chemotherapy are intended to manage side events that could lead to costly care or adversely impact the intended chemotherapy but must be administered in the prescribed time frame and manner to be effective. If patients have not received the needed oral supportive drug in time for the IV regimen or decided not to fill that oral from an alternate drug delivery source for any reason, the entire combination drug treatment becomes compromised. Supportive oral drugs not received or purchased from an external source mean the entire treatment plan could be compromised, with likely looming cost escalation for managing that cancer.
- **Standard of Care Drugs Not Allowed** – When standard of care treatment (whether for supportive care or chemotherapy) is not allowed on a formulary, or because of a step edit or prior authorization denial, the whole patient care regimen becomes compromised. Newer generations of drugs constantly replace older generations, but misguided advice to health plans and employers that older generations are sufficient leads to care delays, reduced access to care, and significant costs added for patients and those paying for the treatment.
- **Restrictive Formularies, Step Edits, and Non-Medical Switching** – Cancer drugs within a class may not be interchangeable. The exclusion of certain drugs from coverage could negatively affect outcomes. In the growing field of precision therapy, it is plausible that a targeted agent's effectiveness could be compromised by requiring first use of step therapy-dictated, less preferred medications. Nonmedical switching that requires (for no medically advantageous reasons) that patients be switched from a prescribed therapy to a different but less expensive therapy could impede patient access to optimal cancer care.[56]

Precision Medicine Benefit Coverage Policies Affect Oral Treatment

Cancer is, by definition, the alteration (or mutation) of one or more cellular processes leading to abnormal growth. Early traditional treatment relied on non-specific chemotherapy, surgery and radiation given uniformly to all patients with the same disease, with varying success. Understanding the tumor genome and cellular biology is an essential first step. However, understanding the molecular signature of cancer is not the key to success in and of itself. There are many additional layers of cellular biology and the tumor micro-environment that must be recognized.

To truly understand cancer and personalized treatment options requires understanding the multiple mutations that result in every cancer being unique and exploiting those mutations unique to cancer cells in a targeted precision oncology cancer regimen. Next Generation Sequencing (NGS) technologies have now emerged as cost-effective tools capable of high-dimensional and parallel genomic sequencing at an industrial scale. NGS allows sequencing of many genes at once, allowing up to whole exome (WES), or even the entire genome (WGS) of the host or tumor. NGS has transformed the ability to understand the molecular basis of cancer.[57]

APPLYING PRECISION ONCOLOGY TO CANCER CARE CAN IMPROVE OUTCOMES AND REDUCE TOTAL COSTS, IF COVERAGE POLICIES MAINTAIN PACE WITH ADVANCES

Many molecular findings have paved the way for novel targeted treatments that are able to prolong both quality and quantity of life. Most molecularly targeted drugs in precision medicine have led to better treatments in patients with specific mutations, increased survival rates, and improved quality of life – at work and at home – for patients.

Patricia Goldsmith, Chief Executive Officer of CancerCare® notes "In recent years, drug discoveries have turned fatal cancers into chronic diseases, giving people longer and better lives. It's clear that the next generation of game changing cancer care will come from the pharmaceutical industry. And yet, we're seeing insurers use more and more strategies to restrict access to medications and shrink what they will pay for drugs. They're looking only at cost per dose and not the total costs of care or the consequences for patients." When oral drug management strategies focus just on drug cost and restrict access to these new treatment options, they miss what health economists call "the societal perspective," referring to those factors that are life enhancing to patients and their families, employers, and communities.[58]

Without testing that allows broad molecular profiling and data collection tied to treatment, it is going to be impossible to really unlock precision medicine. The payer community needs to decide how to work with providers and the scientific community to ensure that patients receive not only testing that is valuable today but also testing that could be invaluable in creating a better tomorrow.

TIMELY TEST RESULTS ARE KEY FOR INFORMED THERAPY DECISIONS

If a test doesn't deliver results in time to help physicians make informed treatment decisions, it is a lost opportunity, with significant adverse impact on patient quality of life, health status, access to appropriate care, and costs of care. There are many hurdles affecting timely test delivery, and payer policy can play a significant role in both causing and breaking down those hurdles.

Many of the reasons why a cancer patient may not receive testing or results in time to affect therapy decisions (which are often for oral drugs) may be influenced by payer policy under pharmacy benefits and the resulting impact on physician choice of test or source for test.

- If payers require preferred networks for biopsy, sampling or testing facilities that are not familiar to the providers, disconnects can occur that can lead to any of the above challenges.
- Prior authorization processes can contribute to delays in patients being sent for needed testing or biopsies.
- Step edits for allowed tests or treatment options could not only result in delays for results and needed care, but also require multiple tests over time that could deplete tissue samples

Other factors can include testing facility delays, miscommunication around tissue requisition and handling, and even patient challenges from health status or access to testing or treatment facilities (transportation, caregiver support, costs, loss of work, etc.)

COSTS OF TESTING VERSUS VALUE ARE STILL A CONCERN

Understanding the specific molecular signature of a patient and their tumor is central to achieving personalized cancer care. Yet, the complexity of cellular processes can lead to testing that may not directly impact cost or value.

The costs of testing to achieve precision oncology can multiply quickly. Factors may include[59]

- Multiple biomarkers for a disease state – many of which do not change treatment.
- Repeated molecular testing as disease progresses.
- Testing that did not lead to a specific targeted treatment.
- Stacked codes billing for individual biomarker tests because coverage/payment was not available for a gene panel test that may have cost less than the sum of the billed codes.
- More testing to reveal altered genes is now available than there are effective treatments (but that can change quickly with new discoveries).
- Lack of appropriate tissue samples. Metastatic disease that cannot be accessed through biopsy or surgery cannot generate the tissue samples needed for most NGS gene-based panel tests.

DESPITE APPREHENSION, ADVANCED PRECISION ONCOLOGY BENEFIT DESIGN CAN YIELD HIGH VALUE

Payers, employers, providers, and patients all may have opposing perspectives and fears about the technology and speed of precision oncology, leading to some of the following dichotomies:

- Genetic testing may drive up costs – *But it may be more efficient.*
- Oncology disease is complicated, and difficult to pigeonhole for treatment – *The growing body of knowledge and ability to test for tumors and mutations provides hitherto unavailable knowledge to better target what may work as well as what may not work.*
- Payer could spend thousands of dollars on panels with limited actionable targets to show for it – *Well-designed panels may catch important information using just one tissue sample that could fuel management of the cancer both now and in the future as targets and treatments rapidly evolve.*
- Broad genetics testing may cause patient confusion and fear – *Appropriate, credentialed counseling could engage and empower patients.*
- Specific targeted tests may be covered while gene panel tests are not covered under current payer policy, adversely affecting patients, providers, and ultimately the employer and payer – *Gene panel testing would have been the more efficient approach.*
- Rapid proliferation of oncology biomarkers and targeted testing may tax the limits of scarce and costly tissue sampling. – *Further tissue samples may not be possible and may be used up too quickly before individual targeted testing is completed.*
- Cancer is terrifying and can advance rapidly. Traditional coverage policy requiring cascading treatment and step edits, or denial of some kinds of testing but not others might delay needed knowledge for timely treatment – *Precision oncology offers streamlined cancer management*

and decision-making.

Older coverage policy and benefit design that is not aligned with the opportunities afforded by precision oncology may cause adverse financial, medical, and quality of life issues for the payer, employer, providers and most of all, the patient.

PAYERS CAN HELP ADVANCE ACCOUNTABILITY AND EFFECTIVENESS IN PRECISION MEDICINE THROUGH DATA COLLECTION TIED TO TREATMENT COVERAGE

Quality data collection that tracks details about the testing, patient response, physician decision-making, and outcomes to provide real-world evidence related to utility of the testing and treatment could be one of the most powerful tools to unlock the promise and value of precision medicine. Current traditional clinical trials or real-world data analytics from existing data sources are crucial for certain purposes but are unrealistic to provide the scientific rigor or transparency specifically needed to answer the questions of benefit of treatment tied to molecular testing.

One of the few working examples of rigorous data collection in oncology is the novel Master Observational Trial® (MOT), being led by a Public Benefit Corporation, Taproot Health®. They are spearheading a pre-competitive national (and eventually international) observational trial called the Registry of Oncology Outcomes Associated to Testing and Treatment (ROOT). ROOT collects standardized prospective, real-world data from consenting patients at the point of treatment across the country tied to molecular testing. ROOT will provide quality data for advancing drug discovery, personalizing treatments, and help all stakeholders work together to advance care.[60] The ROOT trial, although in its infancy, has been adopted by several National Cancer Institute-designated cancer centers and community oncology clinics to prospectively collect regulatory grade, real-world data from consented patients. The ability to merge community clinics with academic medical centers both nationally and internationally demonstrates that the MOT can be adopted in a variety of clinical settings.[61]

> *"Precision oncology is stunted when critical patient data is not broadly shared. The ROOT [Master Observational Trial] will serve as the foundational effort to collect and share the standardized and quality data that is needed to rapidly advance precision oncology," Jennifer Johnson, director of precision medicine at Thomas Jefferson University Hospital and a principal investigator for the trial.*[62]

ROOT allows payers, employers, and providers to come together in a unified effort to build a perpetually advancing evidence base of precision medicine. ROOT gathers prospective data at the point of care in a manner compliant with emerging FDA guidance on real-world data that can drive actionable coverage policy. Collaborative efforts can link data collection through ROOT to early coverage policy and lead to informed evidence-based clinical understanding for both medical decision-making and real-world data-based support for coverage for the right treatment at the right time for the right patient.

IMPROVING CANCER CARE VALUE VIA ENHANCED DATA FOCUSED POLICIES

Done correctly and to the height of its promise, precision oncology testing will allow providers to understand the specific and unique characteristics of a patient's tumor, and to target therapy and treatment (or decide not to treat) before numerous other traditional lines of treatment are used. This earlier intervention could save money and the burden of toxic and/or futile medical drugs for the patient and the payer.

Unfortunately, since the technology for testing of precision oncology is outpacing policy and coverage, there is great potential for outdated policy to inadvertently do more harm than good, both financially and medically. Older payer policies may focus narrowly on concerns regarding cost, variability in testing sources, limited information on the impact of biomarkers and testing on medical decision-making, as well as the emerging large gene panel assays that collect more gene data than the count of actionable targets now in existence.

Data is the missing link, and payers now have at least one vehicle to use with providers to jointly embark upon a new approach for both evidence-based care and real-world data –such as the ROOT trial. The new era of precision oncology has outpaced the traditional patterns for care and coverage that rely on traditional clinical trials, prior authorizations, step edits, and claims management. Updated payer testing policies that include novel data collection at the point of care are likely to achieve the goal of more effective care delivered the first time and better control of total care costs.

Traditional Oral Cancer Utilization Management Strategies Are Now Under a Growing Spotlight for Adverse Impact on Patients and Quality of Care

THE MEDICAL COMMUNITY CHALLENGES POLICIES FOR SAFETY, RISK, DELAYS AND QUALITY

PBM Intrusions Delay Care and Harms Oncology Patients

Once PBMs and specialty pharmacy began focusing on oncology care and became part of the drug approval and delivery process between treating

physicians and patients, the medical community has been very vocal about the adverse consequences of this new role for PBMs, particularly as oral drugs have become increasingly important in the treatment options for cancer.

The oncology medical community has some of the most complete patient care guidelines among all specialties, the National Comprehensive Cancer Network Clinical Practice Guidelines in Oncology (NCCN Guidelines®). These are a comprehensive database of evidence-based, consensus-driven guidelines detailing the sequential preventive, diagnostic, treatment and supportive care management decisions and interventions that currently apply to 97 percent of cancers affecting patients in the United States.[63]

As health plans used PBMs and turned their sights to oral oncology treatments, conflicts quickly arose between the medical community and the PBMs, specialty pharmacies, and other intermediaries as to standards of care for cancer. Delays in authorizations, costly patient financial burdens, non-medical-switching of prescribed treatment choices, differences in opinion as to whether compliance with the NCCN Guidelines constituted appropriate care decision-making, differences as to who ultimately is the arbiter of medical decision-making – the physician or the PBM – and whether patients were to be covered for specific cancer regimens ordered by their treating physician, have all raised significant concerns for patient emotional, health, financial and mental harm by these external entities.

PBMs now dominate the pharmacy benefit space. The three largest PBM companies (each of which is affiliated with major health plans) are Express Scripts®, OptumRX® and CVS Caremark®. These three PBMs exhibit broad horizontal consolidation as they process around 85 percent of all prescription claims and administer drug benefits for more than 266 million Americans in public and private plans. Vertical consolidation is just as pronounced – due to growth through PBM ownership of mail-order and specialty pharmacies, as well as insurer affiliation – which has resulted in market concerns about conflict-of-interest incentives that may lead to patients being switched to owned pharmacies and drugs that yield better margins for those aligned entities. Both types of consolidation have further increased both market share and the leverage that PBMs have in contract negotiation with payers, manufacturers, and pharmacies, which the White House Council of Economic Advisors linked to rising drug prices in a 2018 report.[64]

As part of the use case for PBMs, PBMs claim that they successfully achieve drastic price reductions on medications from negotiating with competing drug companies and "encouraging consumers to use the most cost-effective drug." However, in a 2018 example of the needs of the patient setting precedent for legislative transformation of pharmacy practice, the Patient Right to Know Drug Prices Act makes "gag clauses" in PBM and health plan contracts with pharmacies illegal. If the patient could pay less in cash for an oral drug than they would using their insurance and paying the pharmacy benefit co-pay, pharmacists are now required to tell the patient, rather than hiding it and financially benefitting from running the drug through the insurance benefit. The Know the Lowest Price Act of 2018 provides the same protection to patients insured through Medicare Advantage and Medicare Part D plans.[65]

The Community Oncology Alliance (COA) and the Community Oncology Pharmacy Association (COPA) challenge the idea that PBMs are cost effective interventions in the cancer patient's journey. "How exactly does a PBM 'encourage' a treating physician to use cost-effective but life-saving drugs? How do they know what is right for each individual patient and disease? What tactics or methods do PBMs use to do this? And are the changes in the patients' best interests, or simply to save money for PBM profit margins?[66] COA and COPA have published eight volumes entitled "The Real-Life Patient Impact of PBMs", chronicling their findings on when they feel that the PBM has overstepped its boundaries and caused harm to patients rather than serving as a problem-solver to make the process of patient's receiving their prescriptions more cost-effective and timely.[67]

Direct patient care and oral drug oversight save money and avoid costly adverse events. PBMs and specialty pharmacies have proven their ability to leverage and dispense oral drugs. However, oral drugs used in cancer care are being used for acute, severe, and often life-threatening conditions. Adverse reactions and rapid dosing refinements related to patient health and disease status, and management of patient compliance and adherence in the face of the challenges of coping with cancer all require full and rapid access to patient medical records, as well as familiarity with the 50-plus oral anticancer agents, the most frequent and expected reactions, and the most prompt and effective responses. Treating providers know their patients and the drugs in ways that PBMs and specialty pharmacies do not.[68]

Employees are starting to recognize their ability to raise their voices with employers and request fiduciary responsibility for the value of care delivered under their medical and pharmacy benefits. Delays, denials, non-provider pharmacy referrals, step edits, and formulary switching outside of standard of care are all common utilization management tools exercised by

PBMs and specialty pharmacies against the patient's pharmacy benefit options. Those concerned and vocal patients/employees are likely to create the platform for significant health benefit reform, transforming the current healthcare paradigm.

Oral Drug Access Safety and Pedigree – Very Real Issues for Cancer Patients and their Physicians

The white-bagging of drugs to medical clinics and the brown-bagging of drugs to patients are perceived by PBMs as a positive element of oral oncology management, and a profit center to the specialty pharmacies shipping the drugs. However, the growing role of the patient voice on how their benefit dollars are handled, and the impact of benefit design choices is likely to spur patients and employers to put a spotlight on the adverse events of such management tools. Trust and quality are key to patient compliance and adherence with oral drugs, even orals that are used in the treatment of cancer. **Source, pedigree, cold chain management and distribution, whether the drug has been imported from outside the U.S. supply chain, timing, reliability and method of delivery, all lead to crucial aspects of whether a drug will be trusted and able to be used by the patient and the treating physician (who holds the liability for the drug treatment despite its source). If patients are forced to receive drugs from foreign or sources not trusted by their treating physician, the likely rise of employees questioning the fiduciary responsibility of the benefit design chosen by their employer would lead to upstream consequences for those providing guidance and services to the employer for those oral drugs.**

Benefit Design Dictating How Oral Cancer Prescriptions Are Filled Affects Patient Timely Access, Adherence, Waste and Costs

The way the oral prescription is filled – directly in the treating clinic or filled by entities outside of the treating physician's clinic – can lead to significant delays in care and wasted drug. They are also subject to a number of delays that affect patients. Cancer patients are fragile and vulnerable to variation in health status and tolerance to anticancer treatments. Additional costs are created for unused shipped drugs that have already been billed by the specialty pharmacy to the health plan and the employer, plus any charges for management fees (brokers, specialty pharmacies, health plans, PBMs, etc.) related to the billed retail costs of those unused drugs. Those costs are not incurred if the prescription is filled in the medical clinic, due to smaller dose packaging, and tighter patient management for tolerance and effectiveness.

Direct Fill by the Treating Physician – Patients are seen by the physician, who assesses them and writes an original prescription that meets the patient's needs at the time. If that prescription is filled in the treating physician's clinic, the patient receives it without delay, and any authorization questions are promptly handled by the clinic staff, which has full access to the patient's medical records and the treating physician. Many drugs may not be well tolerated by the patient, or for some other reason may not lead to planned success. Physicians can modulate dosing in small amounts until patient tolerance or reaction issues are revealed and can adjust medicines and dosages on the fly as needed, without waste, by using small prescription quantities until the right solution is found.

Fill by Outside Specialty Pharmacy – Patients are seen by the physician, who assesses them and writes an original prescription that meets the patient's needs at the time. The physician's clinic may prepare to fill the prescription, only to find during the authorization process that the benefit plan, the PBM, the health plan, or the employer may have mandated that any prescriptions be filled by another entity. At this point, the communications between the other specialty pharmacy and the physician office start. The specialty pharmacy requests information on the patient and their diagnosis and prescription and starts a back-and-forth process that can take days or weeks before the patient receives the needed oral medication. Specialty pharmacies rely on 90-day fill rates for economies of scale and bill the insurance plan once the drug is shipped (not when it is received by or ingested by the patient). Oral oncology drugs are costly, and both patients and physicians receive from days to months' worth of filled prescriptions (totaling from tens to hundreds of thousands of dollars) for drugs that cannot be used because the patient's health status changed, or the patient was unable to tolerate the originally prescribed drug dose. The patient cannot afford to pay thousands of dollars on co-pays and coinsurance for drugs that went unused, nor can the employer pay for those medical bills from the specialty pharmacy.

A 2017 study by St. Luke's Mountain States Tumor Institute in Boise, Idaho, monitored 2,262 prescriptions filled over a six-month period. Monetary waste was defined as filled prescriptions not used by the patient, while cost avoidance was characterized as timely interventions that prevented unnecessary prescriptions from being filled. Prescriptions filled through the MID in-office dispensing averaged $144,201 in monthly cost avoidance, and $4,305 in wasted drug. In the same time period, prescriptions filled through outside

specialty pharmacies averaged $5,124 in monthly cost avoidance and $9,982 in wasted drug. Almost half of the MD prescription interventions were related to unscheduled discontinuations and withholding or returning of a prescription refill. Patients generally are seen by their physician before starting their next drug cycle, so interventions were identified instead of just relying on automatic refills.[69]

The patient of a community oncology office in Minnesota recently brought in four bottles of cancer medication to the in-house pharmacy, asking if they could give them to somebody that needed them. When asked why he had so much, he stated that the specialty pharmacy kept sending the bottles to him even though he had contacted them on two occasions, asking that they stop shipment, since he had been taken off the medication. At ~$12,000 per bottle, this came to nearly $50,000 worth of wasted medicine for this patient alone.[70]

THE LEGISLATIVE ENVIRONMENT IS HEEDING PATIENT CONCERNS AND NOW INCREASING CONTROL

The issues around management of oral cancer drugs are under a spotlight at both the state and national level. In 2023, there are an unprecedented number of hearings and planned actions to intervene on behalf of the patient for access to standard of care treatments and to manage out of pocket burdens on both patients and employers.

The rise of the patient voice in cancer benefit design and medical-decision-making will focus and change the perspectives of providers, employers, health plans, brokers, PBMs and other intermediaries, and specialty pharmacies, as well as the legislative and regulatory communities. These actions will affect step edits, prior authorizations, PBMs, specialty pharmacies, intermediary fees, and ultimately benefit design options that will change the traditional oral management patterns. Close collaboration with the medical and employer communities to understand and integrate the unintended downstream consequences of policy, regulations and legislation will ensure that access to standard of care treatments and evidence-based medical decision-making will lead to cost-effective care without extraneous costs.

State and National Oral Parity Pricing Backlash

Patient drugs paid under the medical benefit are often different from the pharmacy benefit which are paid by insurers at different contracted rates, and with vastly different patient obligations for co-payments, co-insurances, and deductibles. As more oral drugs became available for cancer patient use, patients and providers have appealed for parity in the patient obligations for drugs, out of a desire for patients to have access to the most appropriate care for their disease without being financially penalized for the method of delivery.

Oral parity laws, intended to protect patients from higher out-of-pocket costs for oral drugs, began as early as 2010. Thirteen states had passed versions of oral parity laws by 2010, and more than 40 states plus the District of Columbia did so by 2023. The laws evolved over the years, and most laws passed since 2013 included out-of-pocket spending caps. However, protections under those state laws vary widely.

The bipartisan Cancer Drug Parity Act S.2039 was introduced in the U.S. Senate on June 15, 2023 by Senators Tina Smith (D-MN) and Jerry Moran (R-KS) with 14 co-sponsors (7 Democrat, 6 Republican and 1 Independent). This legislation would nationalize patient protections and empower the voice of the patient over inconsistent benefit designs. It would amend the Employee Retirement Income Security Act of 1974 to require a group health plan (or health insurance coverage offered in connection with such a plan) to provide for cost-sharing for oral anticancer drugs on terms no less favorable than the cost-sharing provided for anticancer medications administered by a healthcare provider.[71]

The impact of a national oral parity law on benefit design will affect tier placement, financial obligations on patients for oral drugs, and the positioning of clinically appropriate oral drugs on formularies. Such a national law will likely also affect more restrictive current parameters on prescribed oral drugs that could include:

1. limitations on access of oral drugs from the treating physician's office
2. standard of care oral drugs being denied by step edits favoring older IV treatments
3. benefit changes denying access to oral drugs solely on price
4. other edits or authorization denials that may be used by group health plans to impose higher financial costs on patients for use of clinically appropriate oral drugs rather than IV or infused anti-cancer drugs.

Financial parity and protection of the patient for clinically appropriate use of oral cancer medications has become a groundswell issue at the state level, and is now reaching the national level, and will continue to affect benefit design on an ongoing basis.

Legislative Hearings on How PBMs Impact Patients for Oral Oncology Drugs

Every time an entity is inserted between the patient and provider and the employer or payer, the total costs of care rise. Every additional step between the manufacturer of a drug and the physician that

orders it for a patient and the patient taking it adds fees and delays. Congress recognizes the role of intermediaries in drug prices and is focusing on PBMs and their impact on drug prices. PBMs have come under review for their role in the distribution chain, how they are compensated, and their potential involvement in anticompetitive behavior. More than eight pieces of legislation have already been prepared in 2023, including:

1. S. 1339 The Pharmacy Benefit Manager Reform Act
2. H.R. 3561 the PATIENT Act of 2023
3. S. 127 the PBM Transparency Act of 2023
4. The Senate Finance Committee PBM Legislative Framework
5. The Patients Before Middlemen (PBM) Act
6. J.R. 2816 the PBM Sunshine and Accountability Act
7. H.R. 830 and S. 1375 the Help Ensure Lower Patient (HELP) Copays Act
8. H.R. 2880 Protecting Patients Against PBM Abuses Act.[72]

SELF-INSURED EMPLOYERS WITH NEW LEGAL RISK FOR HEALTH CARE COSTS AND FIDUCIARY RESPONSIBILITY TO THEIR EMPLOYEES FOR HEALTH BENEFITS: SOLUTIONS ARE LIKELY TO TRANSFORM THE HEALTH BENEFITS MARKET

Self-insured employers represent about 65 percent of the almost 160 million U.S. individuals with employer-sponsored healthcare coverage. More than three quarters (82%) of workers in large firms (200 or more workers) and 20 percent of workers in small firms (between 3 and 199 workers) are in health benefit plans funded in part or whole by their employers.[73] Employees of self-insured employers may face rising healthcare costs and confusing health benefit alternatives. Premiums and deductibles can vary widely, and actual coverage may also vary significantly from year to year, even if premium costs appear consistent.

Both self-insured and fully insured employers review what they spent for healthcare costs previously, what they are projected to spend in the future, and then consider programs and options to mitigate increases in costs for themselves and their employees. These mitigation options may be proposed by a third-party administrator, broker, or other external entities. Some of these mitigation options, including step edits, formulary changes, benefit design changes, and prior authorizations directly impact oral drugs used for cancer care. There is growing concern on the part of providers and patients that recent management policy changes for oral cancer medications are harming patient access, treatment of disease, and quality of life in the quest to mitigate costs or to improve the financial position for those outside of the treating provider and the patient.

Self-insured employers face new fiduciary responsibilities in 2023. They will be given more data and transparency from their brokers, third party administrators and others, and have more responsibility to ensure that their employees get the best health coverage for a reasonable price. **As employees grow to understand that policy or coverage that could adversely impact their access to standard of care or NCCN Guideline recommended cancer treatments, they will challenge those benefit or coverage limitations, with the support of their healthcare providers.**[74]

CHALLENGES TO HEALTH BENEFIT DESIGN, MANAGEMENT AND CONTRACTING LOOM UNDER THE CAA OF 2021

After the Employee Retirement Income Security Act (ERISA was passed into law in 1974), class-action lawsuits were brought against large employers, alleging lack of responsible supervision of service providers who were charging excessive fees for retirement plan administration. This review of responsible supervision of retirement benefits eventually dropped retirement plan fees from 7 percent to less than 1 percent.[75] The CAA of 2021 sought to add more transparency and accountability for the protection of employees and their health benefits. Employers will be required to show the healthcare services they purchase are cost-effective, high quality, and align with mental health parity and pharmacy benefit requirements. Employers will also be required to evaluate broker and consultant compensation for reasonableness.[76] This should lead to similar scrutiny of the fiduciary responsibility of large employers and the health plans, brokers, PBMs, specialty pharmacies, and other entities with whom they contract to supervise, provide quality care and provide transparency for employees related to management of health benefits.

Class-action lawsuits are already underway in relation to the CAA fiduciary responsibility and transparency laws. A December 2022 class-action lawsuit accused UnitedHealthcare Group of systematically underpaying benefits for care received from out-of-network healthcare providers.[77] One noted retirement plan litigator, a St. Louis-based law firm called Schlichter & Bogard, has been advertising via its LinkedIn page to find potential employee plaintiffs covered by healthcare plans funded by Target, State Farm® and PetSmart®. One of these posts reads "Are you a current State Farm® employee who has participated in the company's healthcare plan? You may have a legal claim – and we'd like to speak

to you."[78] The rules of CAA will affect both health plan sponsors and service providers.

Benefit design and coverage rules that are perceived by covered employees to adversely affect their access to standards of care, or to target needed care under prior authorization denials and step edits, or lack of coverage of standard of care treatments that align with patient and physician medical necessity perspectives may well become the backbone for fiduciary responsibility lawsuits. Existing oral cancer care management by health plans that restrict standard of care access and prefer first generation to newer generation treatments may become more of a liability than an asset to managed care medical directors and employers.

Managed Care Opportunities for Oral Drug Management Strategy

THE CAA EMPOWERS EMPLOYEES TO DRIVE CHANGE FOR EMPLOYERS, HEALTH PLANS, PBMS, SPECIALTY PHARMACY, AND BROKERS

With the passage of the CAA, the world has shifted. Patients (employees) are now fully empowered by the federal government to hold employers accountable for the quality of their health benefits and value for the premium dollars they pay. We already watched such a seismic shift play out in the management of retirement benefits years ago with the passage of the Employee Retirement Income Security Act (ERISA). The CAA may allow employees to sue employers if they don't effectively manage their healthcare benefits. A future where employers become proactive and take steps to protect their employees and optimize healthcare spend is likely to be good for employees and healthcare providers, but likely to create great change for intermediaries between the patients and providers and the employers as ultimate payers.[79]

The image of new employer accountability is already engendering class-action lawsuits, and lawyers are on the hunt for more. When healthcare benefit design leaves cancer patients frustrated, feeling as though they:

1. are paying high premiums but seeing delays from prior authorizations
2. have lack of access to standard of care drugs
3. are pushed to endure step edits that leave them predictably sick
4. face hurdles such as high co-pays, restrictive formularies, and intermediaries jumping in between the patient and their physician, they will take advantage of their new power to demand reasonable and timely access to quality care.

That empowered patient population and the CAA requirements will drive change with self-insured and even fully insured employers, and cascade to changes in employer contracts with third parties for healthcare benefits and administration.

Employers are likely to start this new post CAA era by becoming more pro-active, shopping around for brokers and benefits consultants, seeking new transparency for contracts related to fees and total costs, also reviewing their satisfaction with self-funded or fully-funded options and third-party administrators and balancing benefits structures against the impact of quality, access, and cost to their employees.

Employee satisfaction and communication regarding health benefits is likely become more important to employers, restricting blanket use of utilization management tools that adversely impact patients. The fees paid to intermediaries within the health benefits structure will become more exposed, and probably lead to restructuring of consolidated entities, shopping for less costly service options, and shine light on vertical and horizontal consolidation that may have been adversely affecting patients and their perspectives on value within their health benefits.[80]

Oral cancer drugs managed under the pharmacy benefit have grown rapidly, and the pipeline is strong. **Traditional oral cancer drug management strategies will be challenged based on how they directly impact patient (employee) access to care, and the hurdles, delays and complications that arise. This patient-centric strategic future will be a different accountability for the health plans and other intermediaries that have developed a payer-centric strategy.**

As healthcare benefits shift focus from price management to total cost of care and awareness of the adverse health, life, and financial impact on patients, there will be increased opportunities for health plans, brokers, employers, providers, and patient advocacy groups to more tightly align covered health services and benefit design with evidence-based care. The new alignment is likely to include timely access to standard of care options, while preserving the sanctity of the physician patient relationship and medical decision making.

OPPORTUNITIES FOR BETTER COLLABORATION AND IMPROVED CANCER ORALS MANAGEMENT BETWEEN PATIENTS, PROVIDERS AND EMPLOYERS (THE DIRECT PAYERS) AND HEALTH PLANS

In response to patient and provider concerns generated about the role of traditional oral management tools, including step edits, PBMs, prior authorizations, algorithms, non-medical switching, and alternate funding programs, several entities have suggested to both health plans and employers different paths

to collaboration and more mutually successful oral drug management with patients and providers.

CancerCare® offers Best Practices for Prescription Drug Benefit Design

CancerCare® is a leading national organization providing free professional support services and information to help people manage their emotional, practical, and financial challenges of cancer. They have recently created an employer and health plan toolkit to address health benefit design reform. Many cost-saving measures used in cancer benefit management may seem benign but can cause great harm from unintended consequences. Some cost-saving measures can increase overall healthcare costs and absenteeism, while reducing productivity and causing other adverse consequences. The ideal goal of employer-provided health coverage is to help employees receive swift and effective treatment, to resolve symptoms and to prevent poor outcomes. Swift and effective treatment is likely to mean a timely return to better health and productive life and work. However, restrictive oral drug plans can prevent access to medications that support a higher quality of life or cause employees/patients to struggle under less than standard of care treatment or unaffordable financial burdens. This toolkit offers recommendations on how to structure prescription drug benefits to protect employees who need access to these medications. Several of these recommendations have become law in many states, which would support the case for these measures.

CancerCare's® guide, called "Best Practices for Prescription Drug Benefit Design," explains some common utilization management practices and their unintended consequences. It then offers recommendations for pharmacy benefit plans related to reform of these utilization management tools, including:

1. Pre-authorization
2. Formulary design
3. Step therapy
4. Use of specialty pharmacies
5. Co-pay accumulator programs
6. The denials and appeals process
7. Financial non-adherence issues resulting from unmanageable patient out-of-pocket costs and high-deductible health plans.

The guide offers a template for a Request for Proposal (RFP) for those who seek to contract for pharmacy benefits for their employees, and those who intend to bid for pharmacy benefits for covered lives. This very detailed guide covers "Questions to Ask" on the details of:

- Formulary Design
- Pre-Authorization
- Appeals
- Step Therapy
- Specialty Pharmacy Programs
- Cost sharing, and
- High Deductible Health Plans (HDHPs)[81]

Avalere Health® Observations and Recommendations

Avalere Health® identified numerous challenges regarding oncology patient access, for example, the bifurcated insurance benefit design and its effect on disparate patient cost-sharing. As a result, Avalere® has suggested four existing best practices that oncology offices and payers can implement to ensure patient access to oral oncolytics:

- In-Office Pharmacy
- Health Plan Consultation with Practicing Oncologist
- Dedicated Financial Counselor
- Health Information Technology and Electronic Medical Record Usage

Avalere® also identified several potential areas of engagement and utilized several evaluation criteria to select seven areas of engagement for stakeholders to consider when addressing access barriers to oral oncolytics. The seven areas of engagement are:

- Create one universal enrollment form for all patient assistance programs.
- Engage with private payers to improve access to oral oncolytics, streamline administrative processes, and equalize coverage between formulations.
- Move all oral oncolytics under the medical benefit.
- Establish provider reimbursement for oncology treatment planning.
- Create an oncology-specific benefit.
- Expand access to oncology in-office pharmacies and ensure that private payers contract with such pharmacies.
- Develop payer messages regarding the potential issues surrounding the use of episode-of-care (EOC) payment models in oncology.

ASCO Position Statement on PBM's Role in Oncology

ASCO published a 2018 position statement on the role of PBMs in oncology. The intent of the position statement is to provide a summary of issues ASCO members have raised regarding firstly the role of PBMs in oncology, secondly PBM practices and their impact on physicians and patients, and lastly to highlight areas of concern for future policy efforts. The recommendations put forth in this statement include:

- PBMs and the payers with whom they work

should take immediate steps to address quality of care concerns related to the cancer patients they serve, including assuring that changes to prescribed therapy for patients with cancer are made only in the context of prior consultation and approval of their physician.

- Pharmacies should not be prevented from sharing with patients their most cost-effective option for purchasing needed medications (i.e., gag clauses). To this end, CMS should eliminate contractual requirements that prevent pharmacists from sharing with patients their most cost-effective option for purchasing required medications.
- CMS should leverage its regulatory authority to firstly require that PBMs provide detailed accounting of DIR fees, and secondly instruct contractors and PBMs to discontinue application of current Star performance ratings and related DIR claw backs on oncology dispensing physicians and practice-based pharmacies, instead relying on measures and standards that are more appropriate to the specialty.
- CMS should enforce its "Any Willing Provider" provision in Medicare Part D, preventing PBMs from excluding qualified in-office dispensing or provider led pharmacies from its networks.
- CMS should consider extending use of the JW modifier to better identify sources and cost of waste related to chemotherapy drugs in both Part B and Part D. Such data should be made public. Private payers should consider similar strategies.
- Pharmacy and Therapeutics committees should include full and meaningful participation by oncology specialists.[82]

Inclusion of Medically Integrated Dispensing Providers in the Pharmacy Benefit Network

Pharmacy benefit programs will benefit from the inclusion of medically integrated dispensing providers in their preferred pharmacy networks. Patients and employers will appreciate the continuity of care and flexibility that MIDs can bring to their treatment regimens, which ultimately reduces both total cost of care and patient out-of-pocket costs. Under the new era of the CAA regarding health benefits, employers will seek quality assurances and comparisons for drug delivery models. The downstream consequences of specialty pharmacy referrals away from the treating provider result in:

1. delays in prescription approval and fulfillment
2. shipping and handling complications
3. lack of pedigree and cold chain verification
4. incomplete knowledge of the patient and their disease and health status
5. high drug waste
6. patient non-adherence

All the above lead to higher costs, low patient satisfaction, and inadequate care management. Strong pharmacy benefit management programs that seek success under the new era of the CAA oversight of health benefits will want to include predictive markers of successful management of cancer patients on oral drugs (that require MID programs for success – which are not found in specialty pharmacies external to the patient/provider dynamic) such as:[83]

- Enrollment into a medically integrated patient management program under joint medical pharmacy supervision.
- Minimal time to first fill.
- Medication possession ratios and proportion of days covered used as measurements of continuous fills.
- Persistence on therapy.
- Patient satisfaction.
- Drug waste management (limited fills, tolerance/toxicity monitoring, regimen flexibility).

Precision Medicine and Precision Oncology of the Future – New Coverage Strategies

The most effective and cost-efficient cancer care is cancer that never materializes or is caught early. Payer and employer policy that supports and invests in providers and tools that create better healthcare management opportunities will lead the field in more successful and cost-effective healthcare for their customers and society.

Genetic Screening and Liquid Biopsies Should Become Part of Basic Wellness and Preventative Healthcare

Precision oncology will lead to a new era where employers and patients will demand genetic screening for proactive and directed awareness of disease risk. Patient education and awareness of cancer and other disease issues will begin at home, supported by primary care. Both health plans and employers should plan to incorporate digital behavioral engagement, screening, and appropriate genetic counseling to manage patient understanding and awareness for their members and employees.

Cancer Management Should Include Strategic Use of Larger Gene Panels, Proactive Liquid Biopsy, and Tissue Sampling

Given the rapid growth of targeted biomarkers and targeted therapy in the cancer drug pipeline, it only makes sense that if a gene or mutation can be identified in a panel, that a standard workup of a patient with cancer should include a broad panel. Of course, the testing facility and the analytics and results reporting of that broad panel should be

verified and trusted by both the provider and the payer, as well as compliant with current FDA (and other key organizations) guidance and standards.

If standard of care treatment for a given diagnosed cancer does not yet include biomarker testing or mutation clarity, it will not be long before it does. The more we can efficiently use precious tissue samples to start with a good understanding of the disease, the better we can make sure the right treatment reaches the patient at the right time, or the more we can avoid treatments that will not be effective. Precision oncology should allow payer policy and provider treatment patterns to avoid long drawn out and costly lines of therapy that "might" work. More efficient care the first time will reduce the financial and medical burden of the disease on the patient and their family, and lower total costs of care.

Precompetitive National Data Collection Efforts Can Lead the Way to Payer and Provider Management of Oncology Under Precision Oncology

Payer policy could remove barriers to efficient panel testing while encouraging patients and providers to participate in innovative precompetitive national data collection through models such as the Master Observational Trial® called ROOT. This will move oncology care to the next level, where real-world data becomes routine and the relationships between diagnostics, treatments and outcomes are routinely tracked in a longitudinal fashion.

Utilizing a national MOT could also create a flexible platform for understanding the impact of not only DNA-based treatments and testing for oncology, but also the emerging messenger (mRNA) landscape. Retrospective claims data and medical record analytics, although important, will be unable to handle the complexity of knowledge that will be needed to power precision oncology by themselves.

Summary - Pharmacy Benefit Strategies for Oral Cancer Drugs Will Soon Face Dramatic Changes

With the passage of the CAA of 2021, a seismic change was started for the management and contracting of health benefits. Most of the components did not start to take effect until early 2023, and understanding and uptake has been fairly slow to date. But the changes are coming. Every time an employee runs up against a benefit design coverage policy, or cost-sharing that seems unreasonable, or a treatment plan that goes against the medical community and patient community expectations for standards of care, change is likely to be affected.

Managed care medical directors and employer benefit managers will start to look at contracted health benefits from a different perspective. What harms employees or creates unreasonable hurdles will now likely be called out and may be the source for class-action lawsuits.

This creates a new opportunity for better collaboration between medical providers, patients and managed care and employers. There is likely to be less of a role for intermediary programs, and those that are engaged will have higher accountability for proof of added value benefitting the employee's health benefits as well as disclosure of fees that add on to the total cost of care.

Ultimately these changes will foster greater access to appropriate care in a clinically effective setting, and through a medically efficient, cost-effective process, with medical decision-making at the patient/provider level at the heart of the plan design. Innovative employers, health plans, providers and some intermediaries will embrace the opportunity to redesign the traditional health benefit design to meet the new health care paradigm. Oral drugs used for the treatment of cancer will continue to evolve and innovate for new targeted care options. Total costs of care will be reduced, and we will regain value in the American healthcare system.

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