April 1, 2022

Joseph R. Biden
President of the United States
1600 Pennsylvania Ave. NW
Washington, DC 20500

Kamala Harris
Vice President of the Unites States
Old Executive Office Building
Washington, DC 20501

Dear President Biden and Vice President Harris,

On behalf of the Coalition to Improve Access to Cancer Care (CIACC), we would like to express our excitement and appreciation for the vision you have laid out for the continuation of the Cancer Moonshot. Specifically, we were encouraged to see the Moonshot's emphasis on improving the experience and of people and their families living with and surviving cancer.

The CIACC is a patient-focused organization representing patients, health care professionals, care centers, the life sciences industry, and other stakeholders serving cancer patients across the nation. Our coalition is committed to ensuring that lifesaving medicines are more affordable for the patients who need them.

As you know, advances in oncology practice have led to the development and proliferation of oral (or self-administered) anticancer drugs for many patients. Because these medications can be administered at home, they can be more accessible than intravenous (IV) cancer treatments, allowing patients to stay home, spend less time away from work, and save money traveling to cancer care facilities.

Unfortunately, these oral anticancer treatments are, in many cases, inaccessible to patients due to high out-of-pocket costs stemming from outdated insurance benefit design. Many cancer patients today are covered under insurance policies which require patients to pay higher out-of-pocket costs for anticancer treatments delivered orally instead of intravenously. Oral and self-administered drugs are covered under a plan's prescription drug benefit, whereas, IV therapies, are covered under the plan's medical benefit. Instead of paying a fixed copay, patients on oral and self-administered drugs pay coinsurance for their drugs, which results in high and often unpredictable patient out-of-pocket expenses. This unnecessary discrepancy in cost-sharing means that many cancer patients face significant financial barriers to oral therapies, which may be more appropriate for many patients, and could be the only viable option for others. The result of these high out-of-pocket costs is that 10% of patients choose not to fill their initial prescriptions for anticancer medicines taken orally[1]. The rates are much higher for therapies with the most-expensive co-pays.

[1] Street SB, Schwartzberg L, Husain N, and Johnsrud M, Patient and Plan Characteristics Affecting Abandonment of Oral Oncolytic Prescriptions. Journal of Oncology Practice. Vol. 7, Issue 3S: 46s-51s, 2011

The problem is exacerbated by the growth of patient-administered cancer therapies. It has become the standard of care for many types of cancer. Chemotherapy taken orally accounts for approximately 25% of the oncology development pipeline, according to a study by the *National Community Oncology Dispensing Association*. More importantly, many cancer medicines taken orally do not have an alternative that is injected or administered by IV. That means these oral medications are the only option for some cancer patients. As these treatments become more prevalent, we must ensure the out-of-pocket costs to patients are as affordable as their IV counterparts.

The lack of "oral parity" has only become more critical during the ongoing COVID-19 pandemic. Many cancer patients are uniquely at risk to contract COVID-19 due to their compromised immune systems. To help alleviate this burden, oncologists are regularly reexamining the best ways to treat patients during the pandemic while complying with social distancing and quarantine protocols. When medically appropriate, many medical professionals have tried transitioning patients onto oral anticancer drugs in order to help them stay at home as much as possible and reduce the risk of infection.

Access to oral treatments is also vital for patients in rural and other medically underserved areas. Cancer patients in such areas face a host of unique challenges that have the potential to limit their access to appropriate cancer treatments, putting them at risk for later diagnosis and more severe disease progression. Rural cancer patients and their caregivers must travel longer distances and take more time to access the same health care as those living in more urban areas. Rural residents may also be disproportionately disadvantaged financially, making it difficult to afford both the extra travel costs and the treatment costs themselves, especially when lost wages from treatment travel time are considered. Increased access to oral and self-administered treatments can make cancer treatment more manageable for rural patients, while also reducing overall health care system usage in areas that are already overstressed by the demands of the COVID-19 pandemic.

Our solution is the Cancer Drug Parity Act, legislation with has a history of overwhelming bipartisan support in both the House and the Senate. This builds on robust support at the state level. In fact, 43 states and the District of Columbia have taken action to solve this disparity for patients that are on state-regulated health plans.

The Cancer Drug Parity Act would ensure that federally-regulated group health plans provide coverage for cancer treatments, allows patients taking self-administered anticancer medicines to benefit from the same level of cost-sharing as they would have if they were administered an IV, port administered or injected cancer medication. This bill addresses the outdated insurance benefit designs and seeks to lower out-of-pocket costs for all cancer treatments, regardless of how they are administered. Health insurance cost-sharing designs should not create barriers for cancer patients to access potentially life-saving medicines or undermine the doctor-patient relationship by forcing physicians to place patients on less-effective treatments based solely on costs.

We hope that your Cancer Moonshot's approach "to target the right treatments to the right patients" will address all of the actors in the drug supply chain and that you will consider ways to address the disparities in costs of oral and IV administered anti-cancer drugs. As you know all too well, a cancer diagnosis is life-changing and brings with it an enormous set of challenges but determining how to pay for treatment should never be one.

Thank you again for your leadership and commitment to accelerating the rate of progress in the fight against cancer. We hope to be a resource for the administration. Should you or your staff wish to

contact us directly, please contact Robin Levy of the International Myeloma Foundation at RLevy@myeloma.org/201-220-9137 or Jeremy Scott at jscott@dc-crd.com/202-669-3534.

Respectfully,

Accessia Health
AIM at Melanoma
American Cancer Society Cancer Action Network
American Society of Hematology
Association of Community Cancer Centers
Association of American Cancer Institutes
Association of Pediatric Hematology/Oncology Nurses
Cancer and Careers
Cancer*Care*
Cancer Support Community
Colorectal Cancer Alliance
Community Oncology Alliance
Facing Our Risk of Cancer Empowered (FORCE)
Fight Colorectal Cancer
GO2 Foundation for Lung Cancer
Hematology/Oncology Pharmacy Association
International Myeloma Foundation
Leukemia & Lymphoma Society
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