American Society of Clinical Oncology Position Statement
Out-of-Pocket Costs for Cancer Care

Approved by the ASCO Board of Directors December 18, 2024

INTRODUCTION

Health care costs continue to skyrocket in the United States with one estimate placing total medical expenditures at nearly 20% of current GDP.[1] Despite therapeutic advances that have improved the prognosis of millions of patients with cancer, **out-of-pocket (OOP) costs** remain a heavy burden on patients, placing them at greater risk for poorer health outcomes. Deductibles, copays, and coinsurance are all forms of out-of-pocket expenditures incorporated into most insurance plans—expenses that patients must pay themselves above and beyond their monthly premium. Intentionally or not, out-of-pocket costs are disincentives and barriers to care, both in terms of access to cancer care and compliance with treatment recommendations.

ASCO represents over 50,000 global physicians and other health care professionals specialized in cancer treatment, diagnosis, and prevention. ASCO members are dedicated to conducting research that leads to improved patient outcomes and are committed to ensuring that evidence-based practices for the prevention, diagnosis, and treatment of cancer are equitably available to all patients. ASCO is deeply concerned about rising out-of-pocket costs and their impact on individuals affected by cancer. The purpose of this ASCO Position Statement is to provide a summary of the different types of patient out-of-pocket costs and how financial toxicity and related monetary barriers compromise cancer outcomes and jeopardize overall population health. ASCO supports efforts to reduce the burden of out-of-pocket costs by advancing evidence-based policies that reduce financial barriers and allow patients to access timely oncology care without concern for their short and-long-term financial health.

BACKGROUND

A patient's first encounter with cost-sharing generally occurs with their deductible, a set amount patients agree to pay annually for covered health care services before their insurance plan begins contributing for subsequent care. For example, if a patient is on a health plan with a deductible of $1,000, they would have to pay this amount out of their own pocket before their insurer contributes to most health care costs for that year. These and other related cost-sharing measures first proliferated in the U.S. in the late 1940s under the belief that "first-dollar" health coverage, coverage where the insurance company covers costs on the first dollar claimed,[2] encouraged excessive, often unnecessary, medical care utilization (otherwise known as the "moral hazard" in

[1] Augustine, N. R., Madhavan, G., & Nass, S. J. (Eds.). (2018). *Making Medicines Affordable: A National Imperative*. National Academies Press. https://doi.org/10.17226/24946

[2] Mitchell C. First Dollar Coverage. Investopedia. https://www.investopedia.com/terms/f/first_dollar_coverage.asp

health insurance), which drove up the cost of coverage.[3] Opponents of cost-sharing countered that these provisions discouraged people from seeking basic health care. By the 1960s, despite 39 million Americans (over 20% of the population at the time) having some form of insurance that included cost-sharing, expenses were rising anyway. Cost-sharing did, as predicted, contribute to chronic underutilization of necessary care in the American population.[3] In one important study, the seminal RAND Health Insurance Experiment explored how different levels of cost-sharing affected utilization and outcomes, and confirmed that the use of appropriate or necessary care is reduced under cost-sharing arrangements.[4]

While deductibles have been in place for decades in response to concerns about moral hazard, high-deductible health plans (HDHPs) began proliferating following the implementation of the Affordable Care Act (ACA). Thresholds vary based on plan type, but the IRS defines HDHPs as employer plans that utilize deductibles of at least $1,600 for an individual in 2024.[5] ACA plans in 2024 contained an average deductible of $3,000.[6] Additionally, a 2022 employer survey indicated that approximately 30% of covered workers are enrolled in HDHPs, a figure which had increased by approximately 20% over the preceding decade.[7] The purported benefit of selecting an HDHP, lower monthly premiums, may benefit patients who do not expect to utilize much health care. However, individuals diagnosed with cancer can often be left facing a hefty initial bill before having their many tests and procedures covered, in part, by their insurer.

Insurers maintain that cost-sharing keeps overall insurance costs manageable and ensures patients are utilizing health care services judiciously. However, many patients, especially those on public insurance programs such as Medicaid, struggle to afford additional medical expenses on top of essential goods such as food and shelter. According to one estimate, the average total cost of medical care and pharmaceuticals exceeds $42,000 in the year following a cancer diagnosis.[8] Another review examined an individual patient's monthly out-of-pocket burden for cancer care among different nations and estimated these costs in the U.S. to be between $180 and $2,600.[9]

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[3] Hoffman B. Restraining the Health Care Consumer: The History of Deductibles and Co-payments in U.S. Health Insurance. *Social Science History*. 2006;30:501-528. doi:10.1215/01455532-2006-007

[4] Aron-Dine A, Einav L, Finkelstein A. The RAND Health Insurance Experiment, three decades later. *J Econ Perspect*. 2013;27(1):197-222. doi:10.1257/jep.27.1.197

[5] IRS.gov. Corrections to High Deductible Health Plan eligibility and employer contribution limits in the 2024 Publication 15-B | Internal Revenue Service. https://www.irs.gov/about-irs/corrections-to-high-deductible-health-plan-eligibility-and-employer-contribution-limits-in-the-2024-publication-15-b

[6] Kaiser Family Foundation. Deductibles in ACA Marketplace Plans, 2014-2024. 2023. https://www.kff.org/affordable-care-act/issue-brief/deductibles-in-aca-marketplace-plans/

[7] Kaiser Family Foundation. 2022 Employer Health Benefits Survey. Section 8: High-Deductible Health Plans with Savings Option. KFF. 2022. https://www.kff.org/report-section/ehbs-2022-section-8-high-deductible-health-plans-with-savings-option/

[8] Mariotto, A. B., Enewold, L., Zhao, J., Zeruto, C. A., & Yabroff, K. R. (2020). Medical Care Costs Associated with Cancer Survivorship in the United States. *Cancer Epidemiology, Biomarkers & Prevention: A Publication of the American Association for Cancer Research, Cosponsored by the American Society of Preventive Oncology*, *29*(7), 1304–1312. https://doi.org/10.1158/1055-9965.EPI-19-1534

[9] Iragorri N, de Oliveira C, Fitzgerald N, Essue B. The Out-of-Pocket Cost Burden of Cancer Care—A Systematic Literature Review. *Curr Oncol*. 2021;28(2):1216-1248. doi:10.3390/curroncol28020117

An additional financial concern for patients with cancer is lengthy or indefinite leave from the workforce, which can quickly deplete their entire life savings once they begin undergoing treatment for cancer. While there are safety net programs available to patients who are unable to work due to disability caused by their diagnosis, qualifying as "disabled" for these programs is not guaranteed and can depend on a variety of factors.

Social Security Disability Insurance (SSDI) applications have a built-in five-month waiting period before entitlement can begin[10] (though some cancers qualify for expedited processing by Social Security under its Compassionate Allowances program)[11] and those who wish to qualify for Medicare as a disabled adult must be earning SSDI income for 24 consecutive months.[12] For many patients, waiting half a year without earning any income is simply not an option. According to the U.S. Federal Reserve Board's 2022 Economic Well-Being of U.S. Households survey, approximately one-in-three American households do not have the funds to cover a $400 emergency expense.[13] In this context, current levels of out-of-pocket costs do not allow health insurance to serve as an effective safety net to avoid financial insolvency in the face of a serious medical diagnosis.

Cancer treatment is often expensive and disruptive, lasting months or years, with a complex array of clinician visits, tests, surgeries, radiation treatments, drugs, and other services required for optimal outcomes.[14] A Health Affairs survey found that 30% of Americans with a cancer history reported having difficulty paying off medical bills, borrowing money, or filing for bankruptcy.[15] Moreover, those patients with cancer who are forced to declare bankruptcy possessed a nearly 80% greater relative mortality risk,[16] an unacceptably high figure that underscores the severity of financial toxicity, which refers to the detrimental effects of the excess financial strain caused by the diagnosis of cancer on the well-being of patients, their families, and society.[17]

It must be emphasized that many of the reported adverse impacts are coming from those who *do* have health insurance. Despite being insured, many patients face high deductibles, copayments, and

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[10] The Social Security Administration. When Your Benefits Start. https://www.ssa.gov/benefits/disability/approval.html

[11] The Social Security Administration. Diagnosed with Cancer? Social Security and Triage Cancer Can Help. 2021. https://blog.ssa.gov/diagnosed-with-cancer-social-security-and-triage-cancer-can-help/

[12] The Social Security Administration. Medicare Information. https://www.ssa.gov/disabilityresearch/wi/medicare.htm

[13] Federal Reserve Board. Economic Well-Being of U.S. Households in 2022 Fact Sheet. Published online 2023. https://www.federalreserve.gov/newsevents/pressreleases/files/other20230522a1.pdf

[14] *Out-of-Pocket Spending Limits Are Crucial for Cancer Patients & Survivors*. (2022). American Cancer Society Cancer Action Network. https://www.fightcancer.org/policy-resources/out-pocket-spending-limits-are-crucial-cancer-patients-survivors

[15] Banegas, M. P., Guy, G. P., de Moor, J. S., Ekwueme, D. U., Virgo, K. S., Kent, E. E., Nutt, S., Zheng, Z., Rechis, R., & Yabroff, K. R. (2016). For Working-Age Cancer Survivors, Medical Debt And Bankruptcy Create Financial Hardships. *Health Affairs*, *35*(1), 54–61. https://doi.org/10.1377/hlthaff.2015.0830

[16] Ramsey, S. D., Bansal, A., Fedorenko, C. R., Blough, D. K., Overstreet, K. A., Shankaran, V., & Newcomb, P. (2016). Financial Insolvency as a Risk Factor for Early Mortality Among Patients With Cancer. *Journal of Clinical Oncology: Official Journal of the American Society of Clinical Oncology*, *34*(9), 980–986. https://doi.org/10.1200/JCO.2015.64.6620

[17] Desai A, Gyawali B. Financial toxicity of cancer treatment: Moving the discussion from acknowledgement of the problem to identifying solutions. *eClinicalMedicine*. 2020;20. doi:10.1016/j.eclinm.2020.100269

cost-sharing when obtaining essential tests, treatment, or specialty drugs. For example, patients can find themselves contending with the out-of-pocket costs for oral anticancer drugs, which in the past have exceeded $10,000 annually--even for patients covered by Medicare.[18]

Despite some safeguards that do place limits on out-of-pocket costs,[19] many patients still decide to delay or forgo care due to exceedingly high drug prices, which will only leave them facing more dire long-term prognoses and continued financial hardship.[20] In fact, patients with cancer are more likely than individuals without a cancer history to modify their health care behaviors and are more likely to report cost-related delays in prescription filling, use of less medication, or skipped medication doses.[20] A recent study published by the American Cancer Society found that over three-fourths of men who possessed elevated prostate specific antigen levels faced additional out-of-pocket costs for any further testing. By opting to skip follow-up procedures such as biopsies and MRI imaging in the interest of avoiding these expenses, many men could be left unable to receive accurate diagnoses and begin appropriate treatment regimens.[21]

Consistent delivery of evidence-based cancer screening and treatment is critical to achieving progress in prevention, quality of life and survival. Cost-sharing introduces a barrier to care, compromises outcomes, may lead to more expensive care later, and jeopardizes overall patient population health. Because meaningful moral hazard does not exist for oncology care, cost-sharing provisions are inappropriate for patients receiving cancer treatment.

COPAYMENTS AND COINSURANCE

One of the most common cost-sharing methods is the collection of copayments. Copayments, or copays, are a fixed amount of money a patient pays for a covered health care service. Copays can vary for different services within the same plan, such as drugs, lab tests, screenings, and visits to specialists. Depending on the insurance plan and the provider, copays can range from as low as $10 to as high as thousands of dollars and are collected per visit, leaving patients undergoing treatment for cancer responsible for dozens of different copays over a short period of time from diagnostics, imaging, labs, and medical radiation and surgical treatments.

Additionally, due to the vagaries of U.S. pharmaceutical supply chains, copays for drugs can sometimes exceed the cash price of the prescription. This discrepancy in pricing has been attributed, in part, towards the role pharmacy benefit managers (PBMs) play in determining which drugs are covered as well as working with payers to set the price of copays.[22] These drug

[18] Arora, N., Hussaini, S. M. Q., Sedhom, R., Blaes, A. H., Dusetzina, S. B., & Gupta, A. (2022). Out-of-pocket costs for oral anticancer drugs. *Journal of Clinical Oncology*, *40*(28_suppl), 14–14. https://doi.org/10.1200/JCO.2022.40.28_suppl.014

[19] *2022 Employer Health Benefits Survey*. Kaiser Family Foundation; 2022. https://www.kff.org/report-section/ehbs-2022-section-7-employee-cost-sharing/

[20] Szabo, L. (2017). *Cancer patients skipping meds, delaying treatment due to high drug prices*. STAT. https://www.statnews.com/2017/03/15/cancer-patients-drug-prices/

[21] Srivastava A, Tilea A, Kim DD, Dalton VK, Fendrick AM. Out-of-pocket costs for diagnostic testing following abnormal prostate cancer screening among privately insured men. *Cancer*. Published online July 15, 2024. doi:10.1002/cncr.35392

[22] Appleby J. Filling A Prescription? You Might Be Better Off Paying Cash. KFF Health News. 2016. https://kffhealthnews.org/news/filling-a-prescription-you-might-be-better-off-paying-cash/

overpayments, sometimes referred to as "clawbacks," occur when a patient's copay exceeds the total cost of the drug, and the insurer or pharmacy benefit manager ends up pocketing the difference.[23] ASCO has previously voiced opposition to clawbacks as part of their position statement on pharmacy benefit managers and their impact on cancer care.[24] One examination of copayment data found that, among a sample of 9.5 million claims, approximately 23% of these claims involved overpayments.[25]

Coinsurance is yet another common expenditure faced by patients with cancer. Rather than copays' fixed rate, coinsurance is a percentage of a medical bill one pays after reaching their deductible and before hitting their annual out-of-pocket maximum. Depending on the type of insurance and provider, coinsurance may be calculated based on a percentage of charge or on a percentage of negotiated payment rates, not necessarily reflective of the actual cost to the insurer—the existence of back-end rebates from manufacturers to insurers can expose patients to higher coinsurance amounts.[26] Potentially priced in the thousands of dollars, coinsurance can quickly overwhelm a patient's financial resources. Regarding cancer health equity, an adverse consequence of copays and coinsurance requirements is that low-income patients are more likely to skip medications and forgo preventive screenings for common cancers such as breast and cervical cancer. This is especially unfortunate as these malignancies are far easier and cheaper to treat when pre-cancerous lesions are detected earlier rather than later.[27]

In response to exorbitant coinsurance costs, the Centers for Medicare and Medicaid Services (CMS) announced, as part of the recently passed Inflation Reduction Act, that Medicare Part D (the portion of Medicare that helps patients pay for prescription drugs) out-of-pocket spending will be capped at $2,000 beginning in 2025.[28] Prior to this ruling, many patients who relied on Part D coverage for oral anticancer medications were faced with ever-rising costs for their drugs. One analysis illustrated that Medicare beneficiaries who relied on Part D to access these medications upon a cancer diagnosis were often left paying thousands of dollars due to the previously high cap on patient out-of-pocket costs and a coinsurance rate of 25% during the initial coverage period.[29] With some estimates placing medication costs at nearly $14,000 on average, repeated coinsurance payments for a prolonged treatment regimen held the capacity to economically devastate Medicare

[23] Van Nuys, K., Joyce, G., Ribero, R., & Goldman, D. P. Overpaying for Prescription Drugs: The Copay Clawback Phenomenon. *USC School of Pharmacy and the USC Schaeffer Center for Health Policy & Economics*. Published online 2018. https://healthpolicy.usc.edu/research/overpaying-for-prescription-drugs/ https://healthpolicy.usc.edu/research/overpaying-for-prescription-drugs/

[24] *American Society of Clinical Oncology Position Statement: Pharmacy Benefit Managers and Their Impact on Cancer Care*. (2018). https://society.asco.org/sites/new-www.asco.org/files/content-files/advocacy-and-policy/ASCO-Position-Statement-PBMs-Aug.-2018.pdf

[25] Van Nuys, K., Joyce, G., Ribero, R., & Goldman, D. P. (2018). Frequency and Magnitude of Co-payments Exceeding Prescription Drug Costs. *JAMA*, *319*(10), 1045–1047. https://doi.org/10.1001/jama.2018.0102

[26] Lakdawalla D, Li M. Association of Drug Rebates and Competition With Out-of-Pocket Coinsurance in Medicare Part D, 2014 to 2018. *JAMA Network Open*. 2021;4(5):e219030. doi:10.1001/jamanetworkopen.2021.9030

[27] Sabik LM, Vichare AM, Dahman B, Bradley CJ. Co-Payment Policies and Breast and Cervical Cancer Screening in Medicaid. *Am J Manag Care*. 2020;26(2):69-74. doi:10.37765/ajmc.2020.42395

[28] Centers for Medicare & Medicaid Services. CMS Releases 2025 Medicare Part D Bid Information and Announces Premium Stabilization Demonstration | CMS.gov. 2024. https://www.cms.gov/newsroom/fact-sheets/cms-releases-2025-medicare-part-d-bid-information-and-announces-premium-stabilization-demonstration

patients, and high maximums for out-of-pocket costs continue to be an issue for prescription drugs in some commercial or ACA plans.[29] Medicare Part B, which covers outpatient infusions of anticancer therapy and carries a coinsurance rate of 20%--and no cap on these expenses--remains a huge source of financial toxicity in cancer care. Looking to the future of highly sophisticated therapies such as CAR-T cell administration, which can be administered in the outpatient setting, such coinsurance rates and lack of out-of-pocket maximums would be expected to preclude the majority of patients from being able to afford treatment.[30]. Similar to the need to contain costs for infused anticancer drugs, ASCO has previously called for cost parity for oral anticancer drugs to protect patients from financial toxicity in those cases where infused version of a drug is the cheaper option.[31]

ASCO maintains that cost-sharing in the context of evidence-based cancer care is an inappropriate application of moral hazard to health insurance, and the primary contributor to financial toxicity. With copays and coinsurance serving as some of the most common and repeated expenditures, patients receiving treatment for cancer are often at risk of financial toxicity related to the cost of their care. Non-adherence with recommended, evidence-based therapy can lead to severe stress upon patients and their families and can have a critical impact on overall quality of care.[20]

EFFORTS TO REDUCE OUT-OF-POCKET COSTS

Recognizing these harms, there have been efforts aimed at shielding patients from the full burden of copayments. Apart from the $2,000 cap on Part D out-of-pocket costs, CMS has also allowed for deductibles to be paid out monthly over the course of a year, smoothing out the expenditure and helping preserve a patient's finances. Both of these policies are supported by ASCO. Another effort to reduce patient costs takes the form of copay assistance programs, which provide financial assistance to patients with insurance who are nonetheless faced with burdensome out-of-pocket costs. Medicare beneficiaries, however, are unable to access many copay and drug assistance programs as those on federally funded insurance programs are often ineligible for manufacturer assistance.

Unfortunately, a proliferation of payer programs in response has compromised these copay assistance programs in recent years. In 2018, ASCO highlighted a new and harmful strategy imposed by pharmacy benefit managers and insurers known as copay accumulator adjustment programs.[32] Copay accumulator adjustment programs prevent assistance program funds (usually distributed via coupons or vouchers) from applying to a patient's out-of-pocket maximum or

[29] Williams CP, Rocque GB, Caston NE, et al. Health insurance and financial hardship in cancer survivors during the COVID-19 pandemic. *PLOS ONE*. 2022;17(8):e0272740. doi:10.1371/journal.pone.0272740

[30] Wu J, Ghobadi A, Maziarz R, et al. Medicare Utilization and Cost Trends for CAR T Cell Therapies Across Settings of Care in the Treatment of Diffuse Large B-Cell Lymphoma. *Adv Ther*. 2024;41(8):3232-3246. doi:10.1007/s12325-024-02917-7

[31] ASCO. Issue Brief: Parity in Anticancer Drugs. 2016. https://society.asco.org/sites/new-www.asco.org/files/content-files/about-asco/pdf/2016-oral-parity-issue-brief.pdf

[32] *American Society of Clinical Oncology Position Statement: Copay Accumulators and Copay Maximizers*. (2021). https://old-prod.asco.org/sites/new-www.asco.org/files/content-files/advocacy-and-policy/documents/2021-CopayAccumulatorsStatement.pdf

deductible. Hence, while the patient's out of pocket expense is reduced for that particular expense, they receive no annual personal credit and remain at risk over the long term.

Further, copay accumulator adjustment programs have often been put in place without even notifying plan enrollees.[32] Then, once the coupon is fully utilized, patient out-of-pocket costs resume counting toward their individual annual deductible and out-of-pocket maximum. As a result, insurers and PBMs are allowed to "double dip," receiving their full copay through the copay assistance program and also through the subsequent duration of a patient's deductible.[32] Paradoxically, this results in patients experiencing increased out-of-pocket costs and a delay in reaching their annual required deductible/out-of-pocket limits.[32]

Copay assistance programs are effectively neutered by copay accumulators, removing an essential safety net for patients who need expensive specialty medications but cannot afford them on their own. This has the effect of both compromising health outcomes and increasing overall costs to the health care system. ASCO volunteers have previously reported increasing concerns with copay accumulator adjustment programs preventing their patients from leveraging the full value of copay and drug assistance programs, and ASCO has voiced strong opposition to the use of these programs for patients with cancer to federal agencies, Congress, and current and past administrations as a result.[32]

With concerns about copay accumulator programs mounting, the U.S. District Court for the District of Columbia vacated a 2021 rule that allowed insurers to exclude drug manufacturer copay support coupons and assistance from a patient's annual cost-sharing caps.[33] As of June 2023, 19 states have implemented copay accumulator program bans.[33]

RATIONALE TO ELIMINATE COST-SHARING FOR CANCER CARE

Recent polling conducted by the Kaiser Family Foundation examined registered voters' top health care priorities and found that nearly half of all respondents (48%) stated lowering out of pocket costs for people was most important to them, with little partisan divide between Republicans and Democrats.[34] The authors [34]argue that, while polling items that are titled "health" or "health care" rank as a low priority issue, asking constituents about their economic concerns would elicit "health care costs" and "drug costs" as a common refrain and better demonstrate the salience of out-of-pocket spending as a public concern.

Proponents who wish to eliminate the pernicious effects of financial toxicity argue for the elimination of high deductibles and copayments for cancer patients altogether, noting that these cost-related barriers are uniquely American.[35] For example, Germany has a model that limits out-of-pocket costs for chronic diseases to 1% of a patient's income (2% is the limit for non-chronic

[33] Wetzel, M., & Ingram R., H. (2023). *Federal Court Strikes Down Copay Accumulator Programs*. https://www.goodwinlaw.com/en/insights/blogs/2023/10/federal-court-strikes-down-copay-accumulator-programs

[34] Altman D. Why Affordability Is the Big Tent. Kaiser Family Foundation. Published February 20, 2024. https://www.kff.org/other/perspective/why-affordability-is-the-big-tent/

[35] Emanuel, E. J. (2023). Cancer patients shouldn't be responsible for out-of-pocket costs. *STAT*. https://www.statnews.com/2023/05/23/financial-toxicity-cancer-costs-cost-sharing/

conditions).[35] For comparison, in Medicaid, similar income-related caps are placed at 5%, and this is for the most financially vulnerable subpopulation in America. When annual limits are present outside Medicaid, these are fixed dollar amounts, generally priced in the thousands or tens of thousands, rather than a percentage of total income, which is inherently regressive. A 2021 report found that American patients with cancer and survivors paid $16 billion in out-of-pocket costs for cancer care in 2019, which amounts to approximately 8% of all costs for cancer care as estimated by the National Cancer Institute.[36-37] If copays, coinsurance, and deductibles were eliminated for cancer treatment delivered within the first year after a diagnosis, it is estimated that annual out-of-pocket costs would drop by 30% ($4.8 billion) for patients with cancer overall, or around $2,500 less per person, which amounts to approximately 2.4% of cancer spending. This makes a compelling case for targeted reductions in out-of-pocket costs because the ability for patients to better afford their treatment seems like a reasonable tradeoff in exchange for payers taking on this relatively small additional share of cancer costs.

CONCLUSION

ASCO remains firm on the need to contain rising out-of-pocket cancer care costs, to emphasize high-quality care, and to ensure no individual suffers financial harm from seeking recommended treatment. Copays and coinsurance have functioned as barriers to evidence-based care for many patients with cancer, even those who are insured. ASCO believes removing such fees for patients undergoing active cancer treatment would effectively reduce their out-of-pocket costs and meaningfully improve adherence and health outcomes. However, reaching that desired goal is likely to take time and patients will continue to suffer in the interim. As we work toward that outcome, ASCO makes the following recommendations to stakeholders and Congress to provide relief from inappropriate out-of-pocket costs tied to evidence-based cancer care:

- Health care stakeholders should strive towards the elimination of out-of-pocket costs for active cancer care
- Eliminate copay accumulator adjustment programs in public and private insurance plans
- Require a patient's cost-sharing for a prescription drug be based on the same rebated cost that their payer utilizes
- Implement a cap on Medicare Part B coinsurance, similar to what is in place for Medicare Part D, for patients undergoing active cancer treatment
- Provide increased cost-sharing reductions for patients enrolled in ACA Marketplace plans while undergoing active cancer treatment

[36] Yabroff KR, Mariotto A, Tangka F, et al. Annual Report to the Nation on the Status of Cancer, Part 2: Patient Economic Burden Associated With Cancer Care. *JNCI: Journal of the National Cancer Institute*. 2021;113(12):1670-1682. doi:10.1093/jnci/djab192

[37] National Cancer Institute. Financial Burden of Cancer Care. NIH. 2024. https://progressreport.cancer.gov/after/economic_burden

- Direct the Centers for Medicare and Medicaid Services (CMS) to adjust the maximum out-of-pocket limit for ACA covered plans to prevent cost-sharing for patients undergoing active cancer treatment

- Continue to support patient assistance programs that help facilitate access to high-cost anticancer therapies and ensure these programs are unfettered by payer arrangements that undermine these initiatives and drive up patient costs

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