Senate Bill 344 (Rubio):
California Cancer Registry

Summary:
Senate Bill 344 (Rubio) will support cancer research and advance the quality of care for cancer patients by improving the effectiveness of the California Cancer Registry, the statewide cancer surveillance system.

Need for bill:

- The California Cancer Registry was established in 1985 and is the largest cancer registry in the nation and is recognized as one of the leading cancer registries in the world.
- The CCR is an integrated surveillance program comprised of physicians and treatment facilities that collect and report cancer data, CCR staff who receive the data and ensure accuracy, and researchers who use CCR data to make new discoveries about cancer diagnosis, patterns, and treatment outcomes.
- The cancer data collected by the CCR helps researchers understand the causes of cancers and how to prevent and treat cancers.
- The CCR regularly publishes reports on the cancer burden and disparities among the diverse populations in California.
- Since 2019, California requires pathologists to report cancer data electronically to the CCR. Direct electronic pathology (e-Path) reporting into cancer registries has helped improve the completeness, timeliness, quality, and impact of cancer registry data. *However, changes are needed to update the CCR and make it more efficient.*

What will SB 496 do?
Senate Bill 344 will improve the effectiveness of the California Cancer Registry by shortening delays in research and streamlining ePath reporting. SB 344 will also align California data sharing requirements with national data sharing standards to reduce the duplication and administrative burdens.

ACS CAN Position: *Co-Sponsor. For more information regarding this position, please contact ACS CAN California's Director of State Legislation, Autumn Ogden at 916.206.9686 or autumn.ogden@cancer.org*

SB 344 (Rubio) California Cancer Registry

Bill Summary

SB 344 would support cancer research and advance the quality of care for cancer patients by improving the effectiveness of the California Cancer Registry, the statewide cancer surveillance system.

Existing Law

Section 103885 of the Health and Safety Code establishes the California Cancer Registry, a statewide repository of cancer data that provides vital information to public health officers and researchers.

Background

Established in 1985, the California Cancer Registry (CCR) is the largest cancer registry in the nation and is recognized as one of the leading cancer registries in the world.[1] The CCR is an integrated surveillance program comprised of physicians and treatment facilities that collect and report cancer data, CCR staff who receive the data and ensure accuracy, and researchers who use CCR data to make new discoveries about cancer diagnosis, patterns, and treatment outcomes.[2]

Since 2019, California requires pathologists to report cancer data electronically to the CCR. Direct electronic pathology (e-Path) reporting into cancer registries can improve the completeness, timeliness, quality, and impact of cancer registry data.[3] The more discrete cancer data that can be retrieved from the reporting source, the faster central registries can include the records in the final database. Leveraging available technology to improve the timeliness and completeness of data collection is a key objective for the CCR.

Cancer is a disease that too many Californians are familiar with. According to the federal Centers for Disease Control and Prevention, cancer was the second leading cause of death, after heart disease, in the United States in 2020.[4] This year, there will be an estimated 176,140 people diagnosed with cancer in California, the equivalent of more than 20 new cases every hour of every day.[5]

The cancer data collected by the CCR helps researchers understand the causes of cancers and how to prevent and treat cancers. Over the past 30 years, the CCR has collected 5.8 million cancer cases for research. CCR regularly publishes reports on the cancer burden and disparities among the diverse populations in California.[6] CCR data also serves as the launch pad for California's Comprehensive Cancer Control Plan to reduce the burden of cancer in the state.[7]

Details of the Bill

SB 344 would improve the effectiveness of the California Cancer Registry by shortening delays and streamlining ePath reporting. The bill would also allow researchers authorized by the California Department of Public Health to access data in the California Cancer Registry to share that data with federally-designated data repositories and other bona fide researchers so long as the data does not contain individually identifiable data.

Support

American Cancer Society Cancer Action Network (***Sponsor***)
City of Hope (***Sponsor***)
Public Health Institute (***Sponsor***)
University of Southern California (***Sponsor***)

For More Information

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[1] https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDSRB/Pages/California-Cancer-Registry.aspx
[2] https://www.ccrcal.org/learn-about-ccr/about-cancer-registries/
[3] https://www.cdc.gov/cancer/npcr/informatics/aerro/index.htm
[4] https://www.cdc.gov/cancer/dcpc/research/update-on-cancer-deaths/index.htm
[5] https://www.ccrcal.org/learn-about-ccr/about-cancer/
[6] https://www.ccrcal.org/retrieve-data/data-library/
[7] https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDSRB/Pages/California's-Comprehensive-Cancer-Control-Plan-.aspx

Senate Bill 421 (Limón):
Oral Chemotherapy Fairness Act

Summary:
SB 496 (Limón) will remove the sunset date on existing law that prohibits a health plan or insurer from charging more than $250 per month on oral chemotherapy prescriptions.

Need for bill:

- In California, there are 178,000 new cancer cases that are reported within a year.
- The emergence of safe, clinically-effective, orally-administered anticancer medications has dramatically improved the quality of life for cancer patients.
- Patients have been routinely charged significantly greater out-of-pocket costs for oral anticancer therapies than traditional IV therapies.
- Since 2013, state law has placed a $250 per month cap on the out-of-pocket costs for oral anticancer medication. This law is set to sunset on January 1, 2024.
- Since this cap was instituted in state law, 43 states and Washington, DC, have passed oral oncology fairness laws.
- Passage of these laws has made therapies more accessible and equitable to marginalized communities that face greater disparities.

What will SB 496 do?
Senate Bill 421 removes the sunset date, making the cap on out-of-pocket costs to $250 permanent and maintaining affordability for cancer patients.

ACS CAN Position: *Co-Sponsor. For more information regarding this position, please contact ACS CAN California's Director of State Legislation, Autumn Ogden at 916.206.9686 or autumn.ogden@cancer.org*

Senate Bill 421

Oral Chemotherapy

MONIQUE LIMÓN
REPRESENTING SENATE DISTRICT 19

THIS BILL

SB 421 removes the sunset date on existing law that prohibits a health plan or health insurer from requiring more than $250 per month in out-of-pocket costs for each prescription of up to a 30-day supply for a covered oral anticancer medication.

BACKGROUND

According to the CDC, in 2019, an estimated 1.7 million people in the United States were diagnosed with cancer.[1] In California alone, there are 178,000 new cancer cases that are reported within a year.[2]

The emergence of safe, clinically-effective, orally-administered anticancer medications has dramatically improved the quality of life for cancer patients. However, patients are routinely charged significantly greater out-of-pocket costs for oral anticancer therapies than traditional IV therapies.

Out-of-pocket costs become a *de facto* denial of access. According to a study by Prime Therapeutics, 1 in 4 patients who were faced with high costs ultimately abandoned treatment.[3] Most oral anticancer drugs do not have an equivalent IV drug. Thus, leaving patients without an alternative and forced to abandon treatment.

Since 2013, state law has placed a $250 per month cap on the out-of-pocket costs for oral anticancer medication. This law is set to sunset on January 1, 2024.

PURPOSE

Forty-three other states and D.C. have already enacted legislation to make oral anticancer medications more affordable and accessible, ensuring individuals can receive life-changing treatment.

SB 421 removes the sunset date, making the cap on out-of-pocket costs to $250 permanent.

Since this cap was instituted in state law, 43 states and Washington, DC, have passed oral oncology parity laws[4] Passage of these laws has made therapies more accessible and equitable to marginalized communities that face greater disparities.

SUPPORT

American Cancer Society Cancer Action Network - cosponsor
Association of Northern California Oncologists – cosponsor
Medical Oncology Association of Southern California – cosponsor

OPPOSE

None on file.

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[1] https://www.cdc.gov/cancer/dcpc/data/index.htm
[2] https://gis.cdc.gov/Cancer/USCS/#/AtAGlance/
[3] Washington State Department of Health (2010). Oral Chemotherapy Drug Coverage Mandated Benefit Sunrise Review. Retrieved from: https://www.doh.wa.gov/portals/1/Documents/Pubs/631014.pdf
[4] Andrews M. Some states mandate better coverage of oral cancer drugs. Kaiser Family Foundation website. https://khn.org/news/cancer-drugs-by-pill-instead-of-iv-michelle-andrews-051512/. Published May 14, 2012. Accessed January 24, 2020.

Senate Bill 496 (Limón): Biomarker Testing

Summary:
SB 496 (Limón) will increase access to biomarker testing, ensuring patients receive the right treatment at the right time.

Need for bill:

- Precision medicine is dramatically improving cancer outcomes by using information about a person's own genes or proteins (biomarkers) to prevent, diagnose, or treat disease.
- Advances in biomarker testing and cancer treatments now allow for targeted cancer therapies that can improve patient survival and quality of life.
- Testing patients for specific biomarkers is integral to precision medicine in cancer care, but despite evidence pointing to the benefits, testing rates lag behind clinical guideline recommendations.
- Research shows that there are socioeconomic inequalities in biomarker testing and targeted therapy utilization across cancer types.
- In a 2021 survey, 66% of oncology providers reported that insurance coverage for biomarker testing is a barrier to biomarker testing.
- Health care coverage for biomarker testing is failing to keep pace with scientific advancements.
- Timely access to appropriate biomarker testing will result in better health outcomes, advance health equity, and reduce costs by connecting all patients to the most effective treatments.

What will SB 496 do?
Senate Bill 496 will require state-regulated plans, including Medi-Cal, to cover comprehensive biomarker testing when supported by medical and scientific evidence, including nationally recognized clinical practice guidelines.

ACS CAN Position: *Co-Sponsor. For more information regarding this position, please contact ACS CAN California's Director of State Legislation, Autumn Ogden at 916.206.9686 or autumn.ogden@cancer.org*

Senate Bill 496 (Limón): Biomarker Testing

Summary:
SB 496 (Limón) will increase access to biomarker testing, ensuring patients receive the right treatment at the right time.

Background:
Precision medicine is dramatically improving cancer outcomes by using information about a person's own genes or proteins (biomarkers) to prevent, diagnose, or treat disease.[i] When used in the treatment of cancer, precision medicine incorporates specific information about a person's cancer to inform diagnosis, prognosis, therapy selection, and to monitor how well therapy works.

Advances in biomarker testing and cancer treatments now allow for targeted cancer therapies that can improve patient survival and quality of life. Testing patients for specific biomarkers is integral to precision medicine in cancer care, but despite evidence pointing to the benefits, testing rates lag behind clinical guideline recommendations. Research shows that there are socioeconomic inequalities in biomarker testing and targeted therapy utilization across cancer types. For example:

- In metastatic non-small cell lung cancer (NSCLC), eligible Black patients are less likely to receive biomarker testing compared to White patients.
- Patients with advanced NSCLC who were Black, older, or Medicaid-insured had lower odds of next-generation sequencing biomarker testing compared to patients who were White, younger, or commercially insured, respectively.
- Patients who are older, Black, uninsured, or Medicaid-insured are less likely to be tested for certain guideline indicated biomarkers for colorectal cancer.

In a 2021 survey, 66% of oncology providers reported that insurance coverage for biomarker testing is a barrier to biomarker testing.[ii]

What will SB 496 do?
Health care coverage for biomarker testing is failing to keep pace with scientific advancements. Senate Bill 496 will require state-regulated plans, including Medi-Cal, to cover comprehensive biomarker testing when supported by medical and scientific evidence, including nationally recognized clinical practice guidelines. **Timely access to appropriate biomarker testing will result in better health outcomes, advance health equity and reduce costs** by connecting all patients to the most effective treatments.

ACS CAN Position: *Support. For more information regarding this position, please contact ACS CAN California's Director of State Legislation at Ogden at 916.504.2475 or Autumn.Ogden@cancer.org.*

[i] NCI Dictionary of Cancer Terms. https://www.cancer.gov/publications/dictionaries/cancer-terms/def/precision-medicine. Accessed September 7, 2020.

[ii] ACS CAN. "Survey Findings Summary: Understanding Provider Utilization of Cancer Biomarker Testing Across Cancers." December 2021. https://www.fightcancer.org/sites/default/files/national_documents/provider_utilization_of_biomarker_testing_polling_memo_dec_2021.pdf

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