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When Innovation Outpaces Access:

Closing the Gap in Blood Cancer Care in New Jersey

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Kirsten Axelsen, Laura Jenkins, Michelle Pan, and Naomi Checoury-Taub

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Executive Summary



New Jersey offers a clear example of both the promise and the persistent access challenges shaping blood cancer care today. The state has a strong healthcare infrastructure, leading academic and community oncology providers, active patient advocacy organizations, and recent policy reforms intended to improve access to **biomarker testing**, telehealth, **step therapy** exceptions, and affordability protections. Yet these advances do not automatically translate into timely, accessible care for every patient. Across New Jersey, patients may still face regional variation in access to blood cancer expertise, transportation and financial barriers, inconsistent referrals to supportive cancer care, language and cultural barriers, and administrative hurdles that can delay clinically recommended treatment.

These challenges, while specific to New Jersey, reflect broader national trends in blood cancer care. In 2025, an estimated 175,000 adults were expected to be newly diagnosed with **leukemia, lymphoma,** or **myeloma,** representing roughly 1 in every 1,500 U.S. adults each year.[1] Survival rates for common blood cancers have increased significantly in recent decades with the five-year survival rates doubling from 34% in the late 1970s to 70% in the late 2010s for **leukemia**.[2] **Targeted therapies** are largely behind these survival improvements and have transformed treatment for some of the most common adult **leukemias**.[3] Today, clinicians can tailor treatment based on genetic risk factors, age, comorbidities, and treatment goals.

Yet despite innovative scientific progress, many blood cancer patients continue to face barriers that limit access to the latest advances in care. To better understand these challenges, we convened a roundtable of stakeholders from across New Jersey's blood cancer community, including patients, caregivers, advocates, providers, and healthcare leaders, to identify practical solutions that could help more patients receive the right care at the right time.

Access to high-quality blood cancer care depends not only on the availability and coverage of effective treatment, but also on timely access to supportive cancer care, including psychosocial support, navigation and education, practical and financial assistance, care partner support, palliative care, rehabilitation, and other services across the care continuum that help people access, adhere to, and benefit from treatment.

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1 "Blood cancer facts and statistics," Blood Cancer United, https://bloodcancerunited.org/blood-cancer/blood-cancer-facts-and-statistics.

2 "Blood cancer facts and statistics," Blood Cancer United, https://bloodcancerunited.org/blood-cancer/blood-cancer-facts-and-statistics.

3 "A Decade of Progress: Transformative Advances in Blood Cancer Research and Treatment," American Association for Cancer Research, https://cancerprogressreport.aacr.org/progress/cpr25-contents/cpr25-transformative-advances-in-blood-cancer-research-and-treatment/.

Drawing on policy evidence and stakeholder input, this report recommends five priorities for action in New Jersey that could help close the gap between innovation and access:



1. Provide education on the latest treatments and diagnostics.

Promote evidence-based care pathways, strengthen education and communication about **biomarker testing** and treatment options, increase access to blood cancer expertise, and provide patients with accessible information to support informed treatment decisions.



2. Improve care coordination, access to specialist expertise, and supportive cancer care.

Expand access to blood cancer expertise through telehealth, strengthen referral pathways for supportive and palliative care, rehabilitation, psychosocial support, financial counseling, and care partner resources, and reduce barriers to second opinions and coordinated care across academic, community, and Veterans Affairs (VA) settings. Improve interoperability among electronic health record systems so essential clinical information can follow patients across care settings, particularly those in underserved communities. Support reimbursement for clinician time spent coordinating between practices, communicating with patients, and completing care-management activities.



3. Reform utilization management practices.

Expand **step therapy** reforms to all state-regulated plans as **step therapy** can delay access to guideline-preferred therapies and create significant barriers for patients and providers.



4. Reduce financial and administrative barriers to care.

Close remaining patient access gaps by ensuring financial protections are fully implemented, limiting practices such as **alternative funding programs** that shift costs onto patients, engaging self-insured employers around oncology benefit design and carrier practices, and reducing administrative burdens associated with **prior authorization, utilization management (UM),** and appeals processes that can delay access to clinically recommended treatment.



5. Increase transparency and promote responsible artificial intelligence (AI) in cancer care.

Advance responsible use of AI to help patients access trusted, evidence-based education and resources, and require health plans to disclose when AI is used in coverage decisions and require qualified clinician oversight of care denial determinations.

Recent advances in medicine have created new opportunities for patients with blood cancer to live longer and healthier lives. Realizing the full benefits of these treatments will require addressing persistent barriers across the blood cancer treatment journey to ensure that more patients have access to personalized, evidence-based treatment.

1. Introduction

Leukemia, **lymphoma**, and **myeloma** are the most common blood cancers in the U.S.[4] **Leukemia** and **myeloma** are most frequently diagnosed among older people, ages 65 to 74 years old.[5] **Lymphoma** is most frequently diagnosed among both younger and older people, ages 15 to 40 years old and over 55 years old.[6] Blood cancer is not the same in every patient, with outcomes within each type of blood cancer influenced by patient-specific genetic risk factors, age, and comorbidities.[7] **Biomarker testing** can now be used to create personalized treatment plans based on how a patient's specific cancer subtype may respond to treatment.[8] Some blood cancer patients are initially managed under an "**active surveillance**" approach before requiring therapy, whereas others require immediate treatment.[9] Together, these factors make individualized, evidence-based treatment essential to improving patient outcomes, **overall survival** (**OS**) and quality of life.



Chronic lymphocytic leukemia (CLL), the most common adult **leukemia**, is a powerful example of how scientific advances have reshaped blood cancer care. **CLL** is primarily a disease of older adults with a median diagnosis age of 70 to 72 years old.[10] **CLL** patients can have multiple comorbidities, including cardiovascular disease, hypertension, renal impairment, and other chronic conditions, at the time of diagnosis that can complicate treatment selection and tolerability. **CLL** is not the same in every patient, with outcomes influenced by genetic risk factors such as immunoglobulin heavy chain variable region (IGHV) status and TP53 mutations.[11] Many patients are initially managed under an "**active surveillance**" approach before requiring therapy, adding further complexity.[12]

For decades, **CLL** treatment relied on chemotherapy, which was associated with severe side effects and produced lower efficacy relative to today's **targeted therapies**.[13] In the 2010s, the **standard of**

[4] "Blood Cancer," Cleveland Clinic, April 15, 2025, https://my.clevelandclinic.org/health/diseases/22883-blood-cancer.

[5] "Cancer Stat Facts: Leukemia," National Cancer Institute, https://seer.cancer.gov/statfacts/html/leuks.html; "Cancer Stat Facts: Myeloma," National Cancer Institute, https://seer.cancer.gov/statfacts/html/mulmy.html.

[6] "Lymphoma diagnosis, survival rate by age, prognosis, and treatment," Blood Cancer United, https://bloodcancerunited.org/resources/blog/lymphoma-diagnosis-survival-rate-age-prognosis-and-treatment.

[7] Stephan Stilgenbauer, "Selection of Initial Therapy for Symptomatic or Advanced Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma," *UpToDate*, April 23, 2026, 5–12; Feuer, Gerold, "Genetic Abnormality Spectrum in Hematologic Cancers," Crown Bioscience, July 22, 2024, https://blog.crownbio.com/genetic-abnormality-spectrum-in-hematologic-cancers.

[8] "Biomarker testing can lead to precise blood cancer care" PfizerForAll, https://www.pfizerforall.com/find-care/biomarker-testing/blood.

[9] "Watch and Wait for Leukemia," Leukemia Research Foundation, https://leukemiarf.org/patients/treatment/options/watch-and-wait/.

[10] Wierda, W. G., Brown, J. R., Abramson, J. S., et al., "NCCN Guidelines® Insights: Chronic lymphocytic leukemia/small lymphocytic lymphoma," *Journal of the National Comprehensive Cancer Network*, 20, 2022, 622–634; American Cancer Society, "Key Statistics for Chronic Lymphocytic Leukemia (**CLL**)," last modified January 13, 2026, https://www.cancer.org/cancer/types/chronic-lymphocytic-leukemia/about/key-statistics.html.

[11] Stephan Stilgenbauer, "Selection of Initial Therapy for Symptomatic or Advanced Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma," *UpToDate*, April 23, 2026, 5–12.

[12] Stephan Stilgenbauer, "Overview of the Treatment of Chronic Lymphocytic Leukemia," *UpToDate*, June 3, 2025, https://www.uptodate.com/contents/overview-of-the-treatment-of-chronic-lymphocytic-leukemia#H5.

[13] "Blood cancer research 2026: Meeting patients where they want to be," Blood Cancer United, https://bloodcancerunited.org/resources/blog/blood-cancer-research-2026-meeting-patients-where-they-want-be; "Innovative Therapies Shape the Future of Chronic Lymphocytic Leukemia Treatment," *Mayo Clinic*, December 9, 2025, https://www.mayoclinic.org/medical-professionals/cancer/news/innovative-therapies-shape-the-future-of-chronic-lymphocytic-leukemia-treatment/mac-20592646; Molica, Stefano and David Allsup, "Chronic Lymphocytic Leukemia Care and Beyond: Navigating the Needs of Long-Term Survivors," *Cancers*, 17:119, 2025, p. 2.

care evolved to early **immunotherapies** often used in combination with chemotherapy.[14] While these therapies improved survival, side effects (e.g., fatigue and immunosuppression) were profound and left patients vulnerable to infections.[15] There were few biomarker or risk-targeted options, especially if patients had comorbidities. Median **progression-free survival** (**PFS**) was four to five years, and only two to three years for high-risk patients.[16]

New, more efficacious **CLL** treatments compared to chemotherapy were introduced with the FDA approval of oral treatments: the first Bruton's tyrosine kinase inhibitor (**BTKi**) in 2014 and the first B-cell lymphoma 2 inhibitor (**BCL2i**) in 2016. These **targeted therapies** attack cancer cells while minimizing damage to healthy cells and have drastically improved patient outcomes.[17] First-generation **BTKis** extended **progression-free survival** (**PFS)** by 7.6 years compared to chemotherapy alone.[18] Second-generation **BTKis** built on these survival gains and improved selectivity and tolerability, increasing three-year **progression-free survival** (**PFS)** in **relapsed/refractory CLL** from 54 percent to 66 percent compared to first-generation **BTKis**.[19] Some next-gen treatments have demonstrated exceptional long-term survival benefits over chemotherapy, increasing 78-month **progression-free survival** (**PFS)** from 31 percent to 72 percent compared to **chemoimmunotherapy** alone, underscoring the importance of durable long-term data in treatment decision-making.[20] **Fixed-duration** treatments may offer the promise of treatment-free intervals for some patients, depending on the specific characteristics of their disease.[21]

The progress seen in **CLL** reflects a larger shift toward more personalized blood cancer care, allowing clinicians to tailor treatment based on a patient's unique risk factors and treatment goals, including: genetic risk, comorbidities, age factors, concomitant medications, and patient preferences.[22] However, not all blood cancer patients have access to the treatment options that may give them the greatest

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[14] "Innovative Therapies Shape the Future of Chronic Lymphocytic Leukemia Treatment," *Mayo Clinic*, December 9, 2025, https://www.mayoclinic.org/medical-professionals/cancer/news/innovative-therapies-shape-the-future-of-chronic-lymphocytic-leukemia-treatment/mac-20592646; Anna Lewandowska et al., "Quality of Life of Cancer Patients Treated with Chemotherapy," *International Journal of Environmental Research and Public Health* (2020): 1, Table 2; J. Bryan and G. Borthakur, "Role of Rituximab in First-Line Treatment of Chronic Lymphocytic Leukemia," *Therapeutics and Clinical Risk Management* 7, no. 1 (2010); Eugen Tausch et al., "Advances in Treating Chronic Lymphocytic Leukemia," *F1000 Prime Reports* 6, no. 65 (2014): 1; Jennifer A. Woyach and Amy J. Johnson, "Targeted Therapies in **CLL**: Mechanisms of Resistance and Strategies for Management," *Blood* 126, no. 4 (2015): 471; M. Ghielmini et al., "Panel Members of the 1st ESMO Consensus Conference on Malignant Lymphoma. ESMO Guidelines Consensus Conference on Malignant Lymphoma 2011 Part 1: Diffuse Large B-Cell Lymphoma (DLBCL), Follicular Lymphoma (FL) and Chronic Lymphocytic Leukemia (**CLL**)," *Annals of Oncology* 24, no. 3 (2013): 561–76.

[15] Molica, Stefano, "Progress in the treatment of chronic lymphocytic leukemia: results of the German **CLL**8 trial*," Expert Review of Anticancer Therapy*, 11:9, 2011, pp. 1333-1340; "New Combination Treatment to Show Improved Overall Survival in Patients with Chronic Lymphocytic Leukaemia," *ecancer*, October 1, 2010, https://ecancer.org/en/news/1250-new-combination-treatment-to-show-improved-overall-survival-in-patients-with-chronic-lymphocytic-leukaemia; Lisa Astor, "The Battle for the Front Line in **CLL** Moves Away from Chemoimmunotherapy," *Targeted Oncology*, October 14, 2020, https://www.targetedonc.com/view/the-battle-for-the-front-line-in-**CLL**-moves-away-from-chemoimmunotherapy.

[16] Collins, Sonya, "10 Years in **CLL**: Top Advances From 2012-2022," *Targeted Therapies in Oncology*, April 14, 2022, https://www.targetedonc.com/view/10-years-in-**CLL**-top-advances-from-2012-2022.

[17] "Innovative Therapies Shape the Future of Chronic Lymphocytic Leukemia Treatment," *Mayo Clinic*, December 9, 2025, https://www.mayoclinic.org/medical-professionals/cancer/news/innovative-therapies-shape-the-future-of-chronic-lymphocytic-leukemia-treatment/mac-20592646; Davids, Matthew S., et al., "First-line treatment for **CLL** in the era of targeted therapy," *Blood Cancer Journal*, 16:19, 2026, p. 9.

[18] "What's New in **CLL** Therapies at ASH 2024," ***CLL** Society*, January 24, 2025, https://**CLL**society.org/2025/01/whats-new-in-**CLL**-therapies-at-ash-2024/; Jan A. Burger et al., "Final Analysis of the RESONATE-2 Study: Up to 10 Years of Follow-Up of First-Line Ibrutinib Treatment for **CLL**/SLL," *Blood* 146, no. 18 (2025): 2168–2176.

[19] Tam, Constantine and Philip A. Thompson, "BTK inhibitors in **CLL**: second-generation drugs and beyond," *Blood Advances*, 8:9, 2024, pp. 2300-2309; Koffman, Brian, "Zanubrutinib Extends Remission Time vs. Ibrutinib in **CLL** / SLL," **CLL** Society, https://**CLL**society.org/2024/02/zanubrutinib-extends-remission-time-vs-ibrutinib-in-**CLL**-sll/.

[20] "Long-Term Follow-Up of First-Line Zanubrutinib for CLL," *CLL Society*, May 5, 2025, https://cllsociety.org/2025/05/long-term-follow-up-of-first-line-zanubrutinib-for-cll/; Results presented by BeOne Medicines at American Society of Clinical Oncology (ASCO) 2026 Annual Meeting.

[21] *Venclexta (venetoclax) Product Insert*, Revised February 2026, https://www.rxabbvie.com/pdf/venclexta.pdf. Fixed duration treatments are administered for a definite period of time, and patients are monitored for signs or worsening disease after completing a fixed duration treatment course (Sara Youngblood Gregory, "Chronic Lymphocytic Leukemia (**CLL**): Understanding the Difference Between Fixed Duration and Continuous Treatment," *Mayo Clinic*, https://mcpress.mayoclinic.org/managing-**CLL**/chronic-lymphocytic-leukemia-**CLL**-understanding-the-difference-between-fixed-duration-and-continuous-treatment/).

[22] Stephan Stilgenbauer, "Selection of Initial Therapy for Symptomatic or Advanced Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma," *UpToDate*, April 23, 2026, 5–12; W. G. Wierda, J. R. Brown, J. S. Abramson, et al., "NCCN Guidelines® Insights: Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma, Version 3.2022," *Journal of the National Comprehensive Cancer Network* 20 (2022): 622–634; T. Baumann, J. Delgado, R. Santacruz, et al., "Chronic Lymphocytic Leukemia in the Elderly: Clinico-Biological Features, Outcomes, and Proposal of a Prognostic Model," *Haematologica* 99, no. 10 (2014): 1599–1604; Ravelo, Arliene, et al., "Patient preferences for chronic lymphocytic leukemia treatments: a discrete-choice experiment," *Future Oncology*, 20:28, 2024, p. 2063; Sylver, Adrienne, "The Future of Blood Cancers: How Advances Are Improving Care," Baptist Health, September 9, 2025, https://baptisthealth.net/baptist-health-news/the-future-of-blood-cancers-how-advances-are-improving-care.

opportunity for survival and the best quality of life.[23] **Clinical guidelines** can often lag behind innovative advances and may also not be consistently followed, with some blood cancer patients initiated on older therapies instead of newer, targeted oral therapies. Insurance coverage may also lag behind advances in care with **UM** practices like **step therapy** requiring patients to fail on less efficacious therapies before accessing newer therapies.[24] For example, one study found that in 2022 a quarter of new prescriptions for specialty oral blood cancer medications were rejected by insurers.[25]

In this report, we synthesize perspectives from the academic and policy literature and from the broader blood cancer community through interviews to assess the gaps between innovation and access in blood cancer care in New Jersey. Only when the impact of access barriers are understood and reduced can patients fully benefit from innovative medicines. **Glossary** describes the key definitions used in this report.

2. Key Access Gaps in Blood Cancer Treatment

Even with policies enacted in New Jersey to improve access, blood cancer patients in New Jersey can still face significant challenges in getting the right treatment at the right time throughout their care journey.

Biomarker Testing



Biomarker testing may provide important information on the expected disease course, treatment effectiveness, and changes in disease over time. However, **biomarker testing** is not consistently done for blood cancer patients, often resulting in suboptimal treatment selection.[26] In addition, the gaps in **biomarker testing** coverage can be significant. A recent American Cancer Society study found that 31% of New Jersey residents had health plans with more restrictive biomarker coverage than recommended by National Comprehensive Cancer Network (NCCN) guidelines for several common cancers.[27] To help address this gap, in 2025, state-regulated health plans in New Jersey were required to cover **biomarker testing** when its use is supported by FDA labeling, CMS coverage determinations, or nationally recognized clinical practice guidelines. State-regulated health plans are also required to provide coverage in a way that minimizes

[23] **CLL** Society, "Access," ***CLL*** *Society*, accessed May 18, 2026, https://**CLL**society.org/access-**CLL**-societys-policy-institute/; HealthTree Foundation, "What's Keeping Patients from the Best First-Line **CLL** Treatments?" *HealthTree Foundation*, June 16, 2025, https://healthtree.org/**CLL**/community/articles/eha25-disparities-recommended-first-**CLL**-treatments.

[24] See, for example, "UnitedHealthcare Pharmacy Clinical Pharmacy Programs," UnitedHealthcare, 2026, https://www.uhcprovider.com/content/dam/provider/docs/public/resources/pharmacy/step-therapy/Step-Therapy-Brukinsa.pdf.

[25] Koffman, Brian, "Insurers Reject One in Four Oral Blood Cancer Prescriptions," CLL Society, March 20, 2025, https://cllsociety.org/2025/03/insurers-reject-one-in-four-oral-blood-cancer-prescriptions/.

[26] Ackbarali, Tariqa, et al., "3662 Systems-Based Care Improvements to Optimize BTK Inhibitors in Chronic Lymphocytic Leukemia Vary in the Community Setting," American Society of Hematology, December 8, 2024; "Regional Disparities in Chronic Lymphocytic Leukemia: A GPS for Cancer Care," Association of Cancer Care Centers, June 22, 2023, https://www.accc-cancer.org/view/regional-disparities-in-chronic-lymphocytic-leukemia-a-gps-for-cancer-care.

[27] Calls to Improve Access to Biomarker Testing in NJ Bring Together Patients, Providers & Public Health Leaders across Disease Spectrum," American Cancer Society Cancer Action Network, December 4, 2024, https://www.fightcancer.org/releases/calls-improve-access-biomarker-testing-nj-bring-together-patients-providers-public-health.

disruptions to patients (e.g., coverage that allows patients to avoid repeat biopsies) and Medicaid recipients can receive **biomarker testing** at no out-of-pocket cost. Additionally, if a state-regulated insurer receives a **prior authorization** request for a biomarker test, the decision must be rendered within 72 hours for non-urgent requests and within 24 hours for urgent requests.[28]

During conversations with stakeholders, they indicated that education and awareness are the largest barriers to **biomarker testing** in New Jersey, rather than a lack of coverage. However, the experts cautioned that legislative reforms alone do not guarantee access. Several participants noted that despite recent **biomarker testing** coverage protections, implementation remains inconsistent, with some patients continuing to experience denials, delays, and administrative hurdles. Consequently, participants emphasized that improving patient and provider education must be accompanied with stronger enforcement of existing coverage requirements to ensure eligible patients receive timely **biomarker testing**.

Stakeholders also emphasized that communication, care coordination, and continuity during the **biomarker testing** process can create significant barriers for patients and families, including those facing language or cultural barriers. The discussion also highlighted the importance of connecting community oncology practices with disease-specific expertise at academic centers. These observations are consistent with published research, including an American Cancer Society Cancer Action Network study on health equity in **biomarker testing**, identifying communication and knowledge gaps, care-coordination challenges, and disparities between community and academic settings as barriers to **biomarker testing**.[29]

Accessing Clinically Recommended Treatments

Evidence-based treatment approaches are not always consistently followed, and some patients still may be initiated on chemotherapy instead of **targeted therapies**.[30] The gap between guidelines and clinical practice could be due to site of service differences where large hospitals have greater access and familiarity with the latest treatment options compared to smaller practices or rural treatment centers.[31] In interviews with patient advocates and providers in New Jersey, a lack of provider education on the latest treatments in blood cancers was identified as a potential contributor, with providers noting that physicians may have difficulty keeping pace with rapidly evolving evidence and clinical practice.

Access to the latest treatments can depend heavily on geography with patients in underserved areas often lacking access to blood cancer specialists and having to travel farther to receive treatment.[32] Newer, oral blood cancer treatments can significantly alleviate this burden on patients by enabling

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[28] New Jersey A4163 (P.L. 2025, c.49), "Biomarker Testing Coverage Law," LegiScan, https://legiscan.com/NJ/text/A4163/id/2980487; "P.L. 2025, c.49," State of New Jersey, https://www.nj.gov/treasury/pensions/documents/laws/ch49-2025.pdf.

[29] "Targeted therapy can improve survival and quality of life by connecting patients to the most beneficial treatment for their disease," American Cancer Society Cancer Action Network, https://www.fightcancer.org/sites/default/files/health_equity_in_biomarker_testing_and_targeted_therapy_.pdf.

[30] Julie Ehlers, "Many **CLL** Patients Are Not Receiving Recommended First-Line Treatment," *Hematology Advisor*, December 31, 2023, https://www.hematologyadvisor.com/reports/chronic-leukemia-**CLL**-patients-not-receiving-recommended-first-line-treatment/; Jacob D. Soumerai et al., "Consensus Recommendations from the 2024 Lymphoma Research Foundation Workshop on Treatment Selection and Sequencing in **CLL** or SLL," *Blood Advances* 9, no. 5 (2025), https://ashpublications.org/bloodadvances/article/9/5/1213/526014/Consensus-recommendations-from-the-2024-Lymphoma.

[31] Soumerai, Jacob D., et al., "Consensus recommendations from the 2024 Lymphoma Research Foundation workshop on treatment selection and sequencing in **CLL** or SLL," *Blood Advances*, 9:5, 2025, https://ashpublications.org/bloodadvances/article/9/5/1213/526014/Consensus-recommendations-from-the-2024-Lymphoma; National Comprehensive Cancer Network, "Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma," December 22, 2025, pp. CSLL-1, CSLL-4, CSLL-5, CSLL-D; Jacob D. Soumerai et al., "Consensus Recommendations from the 2024 Lymphoma Research Foundation Workshop on Treatment Selection and Sequencing in **CLL** or SLL," *Blood Advances* 9, no. 5 (2025), Figure 2; Mayo Clinic Laboratories, "Complex Testing Offers Answers and Guidance About a Lifelong Illness," accessed May 18, 2026, https://news.mayocliniclabs.com/2021/06/14/complex-testing-offers-answers-and-guidance-about-a-lifelong-illness/.

[32] "Regional Disparities in Chronic Lymphocytic Leukemia: A GPS for Cancer Care," Association of Cancer Care Centers, June 22, 2023, https://www.accc-cancer.org/view/regional-disparities-in-chronic-lymphocytic-leukemia-a-gps-for-cancer-care; "Dr. Burke on **CLL** Treatment Challenges in Community vs Academic Health Care Settings," OncLive, May 30, 2025, https://www.onclive.com/view/dr-burke-on-**CLL**-treatment-challenges-in-community-vs-academic-health-care-settings.

patients to take their treatments at home.[33] In 2011, New Jersey was one of the first states to pass an oral parity law that required state-regulated plans, excluding Medicaid, to cover oral cancer medicines on a "no less favorable" basis than infusion-based therapies, such as chemotherapy. The law prohibits insurers from imposing **prior authorization**, deductibles, or cost-sharing requirements on oral cancer drugs that do not also apply to infusion-based therapies. [34]

Insurance Barriers and UM

Even when clinicians prescribe evidence-based therapies, insurance coverage policies can create significant barriers to treatment. Insurance companies and **pharmacy benefit managers (PBMs)** often require **prior authorization** on treatments and force patients to go through **step therapy** policies where patients are required to demonstrate intolerance, have a contraindication, or otherwise be an inappropriate candidate for older, potentially less efficacious treatments first before accessing newer, clinically recommended treatments.[35]

To help address the burden caused by **UM** practices, in January 2026, New Jersey implemented **step therapy** reform laws that required Medicaid, State Health Benefit Programs (SHBP), and School Employees' Health Benefits Programs (SEHBP) to grant **step therapy** exceptions if the drug required to be stepped through is contraindicated, likely to cause harm, or expected to be ineffective. The law requires that these exception decisions be made within 72 hours for non-urgent requests and within 24 hours for urgent requests. When a **step therapy** exception is granted, coverage must be authorized for at least 180 days.[36] However, as **step therapy** reform in New Jersey does not apply to all state-regulated commercial plans, significant gaps still remain as patients in these plans can face **step therapy** hurdles, as can patients with health plans outside of state regulation such as employer-sponsored insurance.

Geographic and Socioeconomic Barriers

Blood cancer patients in New Jersey often face limited access to blood cancer specialists. In interviews with patients and providers, they discussed how it can be difficult to find hematopathologists or other blood cancer specialists outside of a small number of institutions in New Jersey, with regional access gaps compounded by transportation and financial barriers. These challenges can disproportionately affect underserved communities, where limited specialist availability, fewer local resources, and fragmented coordination among community providers, specialists, and systems such as the VA can make it more difficult to obtain timely, continuous care.[37]

For example, **CLL** patients in New Jersey have limited access to **CLL** specialists as there are only two **CLL**-specialized institutions in New Jersey, the Rutgers Cancer Institute and the Hackensack University Medical Center. Additionally, many counties in the state are also facing a physician

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[33] George, S., Thibault, S., Stephen, M., Owen, C., Hamilton, M., Vuong, V., and Cheung, W., "Real-world treatment patterns, clinical outcomes, and healthcare resource utilization of patients with Chronic Lymphocytic Leukemia treated with Fixed Duration Therapy in a 1L Setting in Alberta, Canada," AstraZeneca Canada, Oncology Outcomes, and University of Calgary; Rifkin, Bell, DasMahapatra, et al., "Treatment Satisfaction and Burden of Illness in Patients with Newly Diagnosed Multiple Myeloma," *PharmacoEconomics Open*, 4:3, 2020, pp. 473–483. Free full text: https://pmc.ncbi.nlm.nih.gov/articles/PMC7426337/; "Oral Therapy," Lymphoma Research Foundation. https://lymphoma.org/understanding-lymphoma/treatment-planning-and-options/treatments/oraltherapy/. Paulson, R. Steve, et al., "Front-line treatment approaches in multiple myeloma: real-world data from a community-based oncology network," *Frontiers in Oncology*, 16, 2026; Stienen, Jozette, et al., "Variation in guideline adherence in non-Hodgkin's lymphoma care: impact of patient and hospital characteristics," *BMC Cancer*, 15, 2015.

[34] Oral Anticancer Medication Coverage Law," Horizon Blue Cross Blue Shield of New Jersey (N.J. P.L. 2011, c.188), https://www.horizonblue.com/marlabs/plans/horizon-pharmacy/drug-lists/oral-anticancer-medication-coverage-law.

[35] "Step Therapy (Fail First)," National Organization for Rare Disorders, https://rarediseases.org/policy-issues/step-therapy-fail-first/; "UnitedHealthcare Pharmacy Clinical Pharmacy Programs Brukinsa (Zanubrutinib)" UnitedHealthcare, https://www.uhcprovider.com/content/dam/provider/docs/public/resources/pharmacy/step-therapy/Step-Therapy-Brukinsa.pdf.

[36] P.L. 2025, c.50 (A1825)," New Jersey Legislature, https://pub.njleg.gov/Bills/2024/AL25/50_.HTM; "New Jersey's Step Therapy Reform: What A1825 Means for New Jersey Hospitals," Frier Levitt, https://www.frierlevitt.com/articles/new-jerseys-step-therapy-reform-what-a1825-means-for-new-jersey-hospitals/.

37 "Addressing Cancer Disparities: Challenges and Creating Change," RWJ Barnabas Health Rutgers Cancer Institute, https://cinj.org/addressing-cancer-disparities-challenges-and-creating-change.

shortage, with access gaps being the most severe in the southern part of the state.[38] These access gaps are particularly acute when considering that New Jersey has the second highest rate of new cancer diagnoses in the U.S. and the cancer rate in the southern part of New Jersey is 18% higher than in other regions of the state.[39] In interviews with providers in New Jersey, telehealth was recognized as one potential way to address this gap in care. In 2026, New Jersey extended telehealth payment parity, requiring state-regulated health plans to provide equal reimbursement for in-person and virtual care, until December 31, 2027.[40]

New Jersey is demonstrating innovative approaches to patient support through community-based efforts such as the blood cancer-focused programs convened by Crossroads4Hope, an organization that offers people impacted by cancer free resources, information, and support.[41] Stakeholders emphasized that access to high-quality blood cancer care depends not only on treatment availability but also on education, navigation, psychosocial support, financial guidance, and caregiver resources. Models that bring together patients, providers, advocacy organizations, and community resources can help address fragmentation in the care journey, improve patient engagement, and ensure individuals receive the information and support needed to navigate increasingly complex treatment decisions. The New Jersey roundtable highlighted the value of expanding and sustaining these coordinated support networks as part of a comprehensive approach to blood cancer care.

Certain populations may experience multiple overlapping barriers to blood cancer care. Veterans, for example, may face geographic and rural access challenges, financial hardship, co-occurring conditions such as PTSD or traumatic brain injury, and the complexity of navigating Veterans Affairs, Department of Defense, and civilian healthcare systems. Other patients may encounter compounded barriers related to language, culture, transportation, trust, insurance coverage, or concerns about disrupting existing care relationships when seeking second opinions or specialist input.

Patient Affordability Barriers

Blood cancer patients often face high insurance **copays** or **coinsurance** for treatment and can face significant travel costs to receive treatment.[42] Many pharmaceutical manufacturers provide **copay** assistance, which has traditionally counted toward a patient's annual out of pocket maximums or deductibles, but under insurer **copay accumulator programs**, this **copay** assistance does not count toward a patient's annual out of pocket maximums or deductibles.[43]

New Jersey has prohibited **copay accumulator programs** and requires insurers and **PBMs** through enactment of the Ensuring Fairness in Cost-Sharing Amounts Act to credit third-party assistance toward deductibles, **copays**, **coinsurance**, and out-of-pocket maximums. The **copay accumulator** ban in New Jersey applies to state-regulated commercial plans and does not apply to SHBP, SEHBP, or Employee Retirement Income Security Act (ERISA) plans.[44] New Jersey has also closed potential loopholes to **copay accumulator program** bans by prohibiting insurers and **PBMs** from altering

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[38] Regional CLL Heat Maps," Association of Community Cancer Centers (ACCC), https://www.accc-cancer.org/education-and-resources/cancer-types/hematologic-malignancies/chronic-lymphocytic-leukemia-(cll)-resources/regional-cll-heatmap; 2025 Access to Care Report," New Jersey Collaborating Center for Nursing, March 2025, https://njccn.org/wp-content/uploads/2025/03/2025-Access-to-Care-Final.pdf; Bridging the Gap: Addressing Health Disparities and Advancing Equity in South Jersey," South Jersey Institute for Population Health, January 2025, https://sjiph.org/wp-content/uploads/2025/01/Bridging-the-Gap-Addressing-Health-Disparities-and-Advancing-Equity-in-South-Jersey.pdf.

[39] New Jersey Comprehensive Cancer Control Plan 2021–2025," New Jersey Department of Health, https://www.nj.gov/health/ces/documents/nj-comprehensive-cancer-control-plan-2021-2025.pdf; Mobin, T., Weaver, R., Herrberg, E., and Vaughn, N., "Bridging the Gap: Addressing Health Disparities and Advancing Equity in South Jersey," South Jersey Institute for Population Health.

[40] "New Jersey Telemedicine and Telehealth Update," McCarter & English, https://www.mccarter.com/insights/new-jersey-telemedicine-and-telehealth-update/.

[41] "Frequently Asked Questions," Crossroads4Hope, https://crossroads4hope.org/faqs/.

[42] Conti, Rena M. et al, "Observational survey of financial difficulties among patients with multiple myeloma and chronic lymphocytic leukemia treated at U.S. community oncology clinics (Alliance A231602CD)," *BMJ Open,* 2025.

[43] "Senate, No. 3818 State of New Jersey 221st Legislature," New Jersey Legislature, Cantrell, Joseph, "State Copay Accumulator Legislation: An Overview," The Rheumatologist, June 25, 2024, https://www.the-rheumatologist.org/article/state-copay-accumulator-legislation-an-overview/.

[44] New Jersey Legislature, Office of Legislative Services, *Legislative Fiscal Estimate [First Reprint]: Senate, No. 3818*, 221st Legislature (June 16, 2025), https://njleg.state.nj.us/bill-search/2024/S3818/bill-text?f=S4000&n=3818_E3.

benefit designs, such as using **alternative funding programs**, based on availability of patient assistance.[45]

However, in interviews with patients, advocates, and providers, stakeholders reported that implementation challenges remain. Several participants described instances in which insurers appeared not to apply the law as intended, requiring advocates to educate plans on the legislation and challenge coverage determinations on behalf of patients. These experiences underscore a broader theme raised throughout the interviews: while legislative reforms can remove important barriers to care, ongoing education, oversight, and enforcement may be necessary to ensure patients realize the full benefits of those protections.

Blood cancer patients, like other oncology patients, tend to experience financial hardship that can lead to debt, bankruptcy, and property foreclosures due to medical bills, with 42% of oncology patients depleting their life savings within two years of diagnosis.[46] In structured interviews with patient advocates in New Jersey, financial hardship was frequently cited as one of the most critical unmet needs still facing blood cancer patients today.

Administrative Burden

Cancer care is becoming increasingly specialized at the same time that many community oncologists are managing growing patient volumes. In interviews and roundtable discussions with providers and stakeholders across New Jersey, participants noted that patient volumes continue to rise while advances in precision medicine require physicians to stay current with an expanding body of evidence, biomarker-driven treatment decisions, and rapidly evolving clinical practice that may be updated multiple times in a single year. These observations are consistent with findings from a recent survey of U.S. hematologists and oncologists, in which clinicians reported seeing a median of 18 patients on clinic days and 71% reported seeing moderately to significantly more patients than they did five years earlier. Respondents identified increasing cancer incidence (42%), provider turnover or departures (32%), and higher patient quotas (28%) as the leading contributors to growing patient loads.[47]

Providers also face a growing administrative burden associated with delivering evidence-based blood cancer care. **Prior authorization** requirements, **UM** policies, **step therapy** protocols, and payer appeals consume substantial physician and staff resources. In a national physician survey, respondents reported completing an average of 39 **prior authorizations** per week and spending approximately 13 hours per week on **prior authorization**-related activities.[48]

In oncology, these requirements can delay treatment, diagnostic imaging, and access to preferred therapies. As treatment decisions increasingly depend on **biomarker testing**, molecular diagnostics, and specialized clinical expertise, these clinical and administrative demands may further strain community oncology practices and complicate efforts to ensure timely access to evidence-based care.[49]

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[45] New Jersey A5217 (P.L. 2025, c.199), Ensuring Fairness in Cost-Sharing Amounts Act," LegiScan, January 9, 2026, https://legiscan.com/NJ/bill/A5217/2024; "HealthCare Institute of New Jersey Statement on Enactment of the Copay Accumulator Law," HealthCare Institute of New Jersey, January 9, 2026, https://hinj.org/healthcare-institute-of-new-jersey-statement-on-enactment-of-the-copay-accumulator-law/.

[46] "Financial Toxicity (Financial Distress) and Cancer Treatment (PDQ®)–Patient Version," National Cancer Institute, https://www.cancer.gov/about-cancer/managing-care/track-care-costs/financial-toxicity-pdq; "42% of cancer patients spent entire life savings in 2 years after diagnosis, study finds," Advisory Board, https://www.advisory.com/daily-briefing/2018/11/01/financial-toxicity.

[47] Boone, Robert N., et al., "Perceptions of work stress, burnout, and burnout management strategies among Oncologists," *Journal of Clinical Oncology*, 43:16, 2025.

[48] Henry, Tanya Albert, "Fixing prior auth: Nearly 40 prior authorizations a week is way too many," *AMA*, April 24, 2025, https://www.ama-assn.org/practice-management/prior-authorization/fixing-prior-auth-nearly-40-prior-authorizations-week-way.

[49] "Prior Authorization," ASCO, https://www.asco.org/news-initiatives/current-initiatives/cancer-care-initiatives/prior-authorization.

Artificial Intelligence, Transparency, and Care Denials

Cancer patients, including those with blood cancer, are increasingly turning to AI for information about their diagnosis and treatment. While AI can help patients better understand their diagnosis and treatment options in accessible language, patient advocates have raised concerns that patients may receive outdated or inaccurate treatment recommendations, potentially influencing them to pursue treatments that are not recommended by their physicians. To help blood cancer patients and their physicians navigate treatment decisions, organizations have developed digital tools that use AI-powered search capabilities to make evidence-based cancer information more accessible. While disease-specific resources can help patients navigate a blood cancer diagnosis, additional tools and safeguards are needed because patients often turn to general AI chatbots before seeking out trusted, blood cancer-specific information.

Insurers are also increasingly using AI in the **UM** process, including evaluating **prior authorization** requests. Patient advocates and physicians have voiced concerns that patients may be inappropriately denied recommended treatments through AI-assisted review of **prior authorization** requests, without ever knowing that AI contributed to the decision.[50] States are increasingly prohibiting the use of AI as the sole basis for care denials (with seven states enacting such laws in 2026), and at least four states also require insurers to disclose the use of AI in care decisions.[51] Under New Jersey's Ensuring Transparency in Prior Authorization Act, state-regulated health plans can only issue a care denial decision when it has been authorized by a physician of the same specialty as the patient's healthcare provider.[52]

During stakeholder interviews, New Jersey-based participants observed, "AI will help in two ways: first, by synthesizing information in complex patients, and second, by providing an algorithm of what to do with that information. This will be an answer to a lot of our problems. AI, done well and in a focused manner, will help really complex patients." Stakeholders expressed optimism that AI could support clinical decision-making, particularly as cancer care becomes increasingly specialized and data intensive.

3. Targeted Recommendations to Help Every Blood Cancer Patient Get the Right Treatment at the Right Time

Drawing on the gaps noted above, in addition to existing proposals and suggestions from the blood cancer community, this report recommends five actions that could help ensure that treatment decisions are driven by clinical evidence and patient needs, helping more patients receive the right treatment at the right time in New Jersey.

While these recommendations are tailored to New Jersey's policy environment and stakeholder discussion, several themes—including provider education, navigation, supportive cancer care access, biomarker testing communication, and responsible AI use—are relevant across states and may create opportunities for cross-state learning and collaboration.

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[50] Littrell, Austin, "Physicians Warn That AI Will Undermine Judgment, Increase Prior Authorization Denials," *Medical Economics*, February 26, 2025, https://www.medicaleconomics.com/view/physicians-warn-that-ai-will-undermine-judgement-increase-prior-authorization-denials

[51] Emerson, Jakob, "7 AI health insurance state laws passed in 2026," Becker's Payer Issues, July 28th, 2026, https://www.beckerspayer.com/policy-updates/7-ai-health-insurance-state-laws-passed-in-2026/; Makhene, Tshedimoso, "Which states require disclosure of AI use in treatment?" Paubox, https://www.paubox.com/blog/which-states-require-disclosure-of-ai-use-in-treatment.

[52] "New Jersey signs prior authorization reform bill into law," Becker's Payer Issues, https://www.beckerspayer.com/policy-updates/new-jersey-signs-prior-authorization-reform-bill-into-law/.

1. Provide education on the latest treatments and diagnostics.



a. Healthcare systems should implement an evidence-based blood cancer care pathway that keeps pace with emerging data and evolving clinical practice, including requiring **biomarker testing** before treatment decisions and access to blood cancer expertise at key decision points, potentially facilitated by continued telehealth payment parity.

2. Improve care coordination, access to specialist expertise, and supportive cancer care.



a. New Jersey should strengthen care coordination so patients can access blood cancer expertise, supportive cancer care, and community-based resources at the right time. This includes improving referral pathways for supportive and palliative care, rehabilitation, psychosocial support, financial counseling, and care partner resources; expanding navigation models that help patients move between academic and community settings; and preserving access to second opinions without disrupting the patient's relationship with their treating oncologist.

b. Expand and scale community-based blood cancer navigation and support models. New Jersey should support collaboration among patient advocacy organizations, healthcare systems, community organizations, and providers to strengthen education, navigation, psychosocial support, and financial counseling services throughout the blood cancer care continuum.

c. Continue to extend telehealth payment parity and other models that expand access to specialist expertise, multidisciplinary supportive care, and community-based services, particularly for patients in underserved communities or those facing transportation, caregiver, or geographic barriers.

3. Reform UM practices.



a. Expand **step therapy** reforms to all state-regulated plans as **step therapy** can delay access to clinically recommended therapies and create significant barriers for patients and providers.

b. Building on existing **step therapy** reforms in New Jersey, consider expanding **step therapy** reforms to all state-regulated plans by 1) ensuring plans offer a process for **step therapy** exceptions so patients with a history of prior failures or adverse events can access newer therapies without having to fail on older, less efficacious ones first, 2) requiring plans to respond within 72 hours to an exception request, and 3) establishing circumstances where exceptions should be granted.[53]

4. Reduce financial and administrative barriers to care.



a. Close remaining patient access gaps by ensuring affordability protections are fully implemented, limiting practices such as **alternative funding programs** that shift costs onto patients, and reducing administrative burdens associated with **prior authorization**, **UM**, and appeals processes that can delay access to clinically recommended treatment.

b. New Jersey should monitor and evaluate implementation of the Ensuring Fairness in Cost-Sharing Amounts Act to ensure patients receive the protections intended under the law. Stakeholders reported that some patients continue to encounter challenges having third-party financial assistance applied toward deductibles and out-of-pocket obligations, despite enactment of the law. Increased education for patients, providers, insurers, and **PBMs,** coupled with oversight and compliance monitoring, could help ensure that eligible

[53] P.L. 2025, c.50 (A1825)," New Jersey Legislature, https://pub.njleg.gov/Bills/2024/AL25/50_.HTM; "New Jersey's Step Therapy Reform: What A1825 Means for New Jersey Hospitals," Frier Levitt, https://www.frierlevitt.com/articles/new-jerseys-step-therapy-reform-what-a1825-means-for-new-jersey-hospitals/.

patients fully benefit from the state's **copay accumulator** protections and avoid unnecessary financial barriers to treatment.

c. Engage self-insured employers as important purchasers and designers of health benefits. Employers can influence oncology benefit design, carrier practices, UM requirements, access to supportive cancer care, and the employee experience for people living with cancer.

5. Increase transparency and promote responsible AI in cancer care.



a. Advance policies that promote responsible use of AI to help patients access trusted, evidence-based education and resources, and require health plans to disclose when AI is used at various stages within coverage decisions. Policies should also ensure qualified clinician oversight of care denial determinations.

4. Conclusion

Innovation has transformed the outlook for patients with blood cancer, offering more personalized, effective, and tolerable treatment options than ever before. Yet too many patients remain unable to fully benefit from these advances because of barriers that limit consistent access to comprehensive **biomarker testing,** evidence-based treatment, supportive cancer care, specialist expertise, and affordable coverage.



The recommendations outlined in this report provide a practical roadmap for addressing these barriers. By strengthening education and communication, expanding navigation and supportive cancer care, improving access to blood cancer expertise, modernizing UM practices, engaging employers and payers around benefit design, and ensuring affordability protections are fully implemented, New Jersey can better align healthcare policy and care delivery with today's standard of care for blood cancer.

Ensuring that treatment decisions are guided by clinical evidence and patient needs, rather than administrative barriers or insurance design, geography, or gaps in support, is essential to improving outcomes for people living with blood cancer. Meanwhile, as technology continues to advance, stakeholders and policymakers must also promote responsible AI use that improves access to trusted information and supports clinical decision-making while preserving transparency and clinician oversight. By acting on these recommendations, payers, providers, patient advocates, employers, and policymakers can help strengthen a healthcare ecosystem that matches innovation with access—where every patient has timely access to the right treatment, the right expertise, and the right support at the right time, regardless of where they live or the type of insurance they have.

GLOSSARY

Active surveillance: Period of time after a CLL diagnosis before symptoms develop and treatment is necessary in which patients are monitored for symptoms.[54]

Alternative funding programs: Strategies used by plan sponsors to lower prescription drug costs by excluding specialty medications from the plan's formulary and requiring patients to seek alternative means, such as manufacturer assistance programs, to secure medications.[55]

Biomarker testing: Lab tests that look for certain genes, proteins, hormones, etc. to provide detailed information about an individual's cancer.[56] Clinical guidelines recommend that biomarker testing be used to inform treatment decisions.[57]

Chronic lymphocytic leukemia (CLL): The most common type of blood cancer in adults, which often progresses slowly, and occurs when white blood cells change into cancer cells.[58] As CLL is largely incurable, CLL treatment focuses on managing symptoms, extending survival, and improving quality of life.[59] Many patients can live with CLL for years.[60]

Clinical guidelines: Systematically developed recommendations issued by organizations on the diagnosis and treatment of specific clinical circumstances.[61] Clinical guidelines often describe the level of evidence for each recommendation and provide additional details on the line of therapy (e.g., first-line, second-line, etc.) and considerations for specific patient risk factors.[62]

Coinsurance: When a patient's out-of-pocket expense is based on a percentage of a drug's list price.[63] Coinsurance typically only applied to high-cost specialty drugs but is increasingly being used for non-specialty drugs.[64]

Copay accumulator programs: When an insurer does not count patient assistance programs towards patient deductibles or out of pocket maximums.[65]

Copay: A fixed fee paid by a patient for a covered medical expense.[66] A patient's copay may vary based on the formulary tier of a prescription drug, with drugs on higher formulary tiers having higher patient copayments.[67]

54 "Watch and Wait (Active Observation), CLL Society, https://cllsociety.org/cll-sll-patient-education-toolkit/watch-and-wait-active-observation/.

55 "Alternative Funding Programs: Short-Term Savings, Long-Term Consequences," MMIT, https://www.mmitnetwork.com/thought-leadership/alternative-funding-programs-short-term-savings-long-term-consequences/.

56 "Biomarker and Tumor Marker Tests," American Cancer Society, https://www.cancer.org/cancer/diagnosis-staging/tests/biomarker-tests.html.

57 "Chronic Lymphocytic Leukemia NCCN Guidelines for Patients," NCCN, October 10, 2026, https://www.nccn.org/patients/guidelines/content/PDF/cll-patient.pdf, p. 12.

58 "Chronic Lymphocytic Leukemia (CLL)," Cleveland Clinic, https://my.clevelandclinic.org/health/diseases/6210-chronic-lymphocytic-leukemia.

59 Gerlach, Alexandra, "Targeted Therapies Transform CLL Care: Inside the Era of BTK and BCL2 Inhibitors," *Pharmacy Times*, April 29, 2025, https://www.pharmacytimes.com/view/targeted-therapies-transform-cll-care-inside-the-era-of-btk-and-bcl-2-inhibitors.

60 Modglin, Lindsay, "CLL Prognosis By Age: Information for Patients and Caregivers," Patient Power, https://www.patientpower.info/chronic-lymphocytic-leukemia/cll-prognosis-by-age; "Living as a Chronic Lymphocytic Leukemia Survivor," American Cancer Society, https://www.cancer.org/cancer/types/chronic-lymphocytic-leukemia/after-treatment/follow-up.html.

61 "Clinical Practice Guidelines," National Center for Complementary and Integrative Health, https://www.nccih.nih.gov/health/providers/clinicalpractice.

62 Wierda, W. G., Brown, J. R., Abramson, J. S., et al., "NCCN Guidelines® Insights: Chronic lymphocytic leukemia/small lymphocytic lymphoma," Journal of the National Comprehensive Cancer Network, 20, 2022, 622–634.

63 "Coinsurance vs. Copay: What's the Difference?" MetLife, February 5, 2026, https://www.metlife.com/stories/benefits/coinsurance-vs-copay/.

64 Fein, Adam J., "Employer Pharmacy Benefits 2021: Patient Specialty Costs Rise with Coinsurance and Accumulators," Drug Channels, https://www.drugchannels.net/2021/12/employer-pharmacy-benefits-2021-patient.html; "Medicare Beneficiaries Face Much Higher Drug Costs as Plans Quickly Shift to Coinsurance," USC Alfred Schaeffer Center, February 14, 2025, https://mann.usc.edu/news/medicare-beneficiaries-face-much-higher-drug-costs-as-plans-quickly-shift-to-coinsurance/.

65 "Copay Accumulator & Maximizer Programs," Crohn's & Colitis Foundation, https://www.crohnscolitisfoundation.org/patientsandcaregivers/managing-the-cost-of-ibd/copay-accumulator-maximizer-programs.

66 "Coinsurance vs. Copay: What's the Difference?" MetLife, February 5, 2026, https://www.metlife.com/stories/benefits/coinsurance-vs-copay/.

67 "What is a tiered formulary and what does it mean for me?" United Healthcare, https://www.uhc.com/news-articles/medicare-articles/what-is-a-tiered-formulary-and-what-does-it-mean-for-me.

Immunotherapies: Therapies that stimulate or suppress the immune system by targeting certain cells or the immune system in general to help the body fight cancer or other diseases.[68]

Leukemia: Cancer of blood-forming tissues, including bone marrow and lymphatic system, with various forms classified by the speed of progression and the type of white blood cell affected.[69] Treatments include chemotherapy, targeted therapy, radiation therapy, bone marrow transplant, immunotherapy, and CAR-T cell therapy.[70] The five-year survival rate in the U.S. is almost 70%.[71]

Lymphoma: Cancer that starts in lymphocytes and affects the lymphatic system. The main types of lymphoma are Hodgkin lymphoma and non-Hodgkin lymphoma.[72] Treatments include chemotherapy, immunotherapy, radiation therapy, targeted therapy, CAR-T cell therapy, and bone marrow transplant.[73] The five-year survival rate in the U.S. is between 74 to 89%.[74]

Myeloma: Cancer that results in plasma cells crowding out normal cells that make red blood cells, platelets, and other white blood cells.[75] Treatments include targeted therapy, immunotherapy, CAR-T cell therapy, chemotherapy, corticosteroids, bone marrow transplant, and radiation therapy.[76] The five-year survival rate in the U.S. is over 60%.[77]

Overall survival (OS): The amount of time that a patient is still alive after a cancer diagnosis or treatment initiation.[78]

Pharmacy benefit manager (PBM): Organizations that manage prescription drug plan benefits for insurers and employers. PBMs' functions include negotiating rebates with drug manufacturers, managing formularies, adjudicating claims, and assembling retail pharmacy networks.[79]

Prior authorization: A UM practice where a payor must review and approve a prescribed treatment, service, or medicine before coverage is granted.[80]

Progression-free survival (PFS): The amount of time during and after treatment that a cancer does not get worse in a patient.[81]

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68 "Immunotherapy," National Cancer Institute, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/immunotherapy.

69 "Leukemia," Mayo Clinic, https://www.mayoclinic.org/diseases-conditions/leukemia/symptoms-causes/syc-20374373.

70 "Leukemia," Mayo Clinic, https://www.mayoclinic.org/diseases-conditions/leukemia/symptoms-causes/syc-20374373.

71 "Blood Cancer," Cleveland Clinic, https://my.clevelandclinic.org/health/diseases/22883-blood-cancer.

72 "Lymphoma," Mayo Clinic, https://www.mayoclinic.org/diseases-conditions/lymphoma/symptoms-causes/syc-20352638.

73 "Lymphoma," Mayo Clinic, https://www.mayoclinic.org/diseases-conditions/lymphoma/symptoms-causes/syc-20352638.

74 "Blood Cancer," Cleveland Clinic, https://my.clevelandclinic.org/health/diseases/22883-blood-cancer.

75 "Myeloma Basics," CDC, https://www.cdc.gov/myeloma/about/index.html.

76 "Myeloma Basics," CDC, https://www.cdc.gov/myeloma/about/index.html.

77 "Blood Cancer," Cleveland Clinic, https://my.clevelandclinic.org/health/diseases/22883-blood-cancer.

78 "Overall Survival," National Cancer Institute, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/overall-survival.

79 "What are pharmacy benefit managers (PBMs) and why we need reform?" American Medical Association, February 4, 2026, https://www.ama-assn.org/health-care-advocacy/access-care/what-are-pharmacy-benefit-managers-pbms-and-why-we-need-reform.

80 Levine, Hallie, "Prior authorization: What is it, when might you need it, and how do you get it?" *Harvard Health Publishing*, August 5, 2024, https://www.health.harvard.edu/healthy-aging-and-longevity/prior-authorization-what-is-it-when-might-you-need-it-and-how-do-you-get-it.

81 "Progression-free Survival," National Cancer Institute, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/progression-free-survival.

Refractory CLL: CLL that does not have a lasting response to treatment.[82] One study found the overall survival of CLL patients who are refractory to both BTKis and BCL2is was 2.2 years.[83]

Relapsed CLL: CLL that reappears after a period of remission.[84] Patients often relapse multiple times.[85]

Step therapy: A UM practice, sometimes known as the "fail first" approach, in which a payor requires a patient to try a specific medicine (that is often lower-cost and older) before covering a higher-priced medicine.[86]

Targeted therapies: Medicine that treats cancer by targeting specific genes or molecules, such as molecules on the surface of cancer cells.[87]

Utilization management (UM): Tools used by payers to manage health care costs and utilization by steering patient care decisions through assessments of the necessity and appropriateness of care, including prior authorization, step therapy, quantity limits, formulary restrictions or tiering, and mandatory generic substitution.[88]

82 "Relapsed/Refractory," Lymphoma Research Foundation, https://lymphoma.org/understanding-lymphoma/aboutlymphoma/cll/relapsedcll/.

83 Frustaci, Anna Maria, et al., "Chronic Lymphocytic Leukemia Through the Spectrum: Frontline Therapy, Sequencing With Subsequent Therapy, and Treatment of Double-Refractory Patients," *Hematologic Malignancies*, 46:3, 2026, pp. 1-17.

84 "Relapsed/Refractory," Lymphoma Research Foundation, https://lymphoma.org/understanding-lymphoma/aboutlymphoma/cll/relapsedcll/.

85 Modglin, Lindsay, "Can CLL Go Into Remission?" Patient Power, October 1, 2024, https://www.patientpower.info/chronic-lymphocytic-leukemia/cll-remission.

86 "Step Therapy for Medicine," UMass Memorial Health, https://www.ummhealth.org/health-library/step-therapy-for-medicine.

87 "Targeted Therapy (Precision Medicine)," UT MD Anderson, https://www.mdanderson.org/treatment-options/targeted-therapy.html.

88 Walker, John, "Primer: What Is Utilization Management and How Is It Used?" American Action Forum, August 28, 2025, https://www.americanactionforum.org/insight/primer-what-is-utilization-management-and-how-is-it-used/.

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