Michigan Association of Health Plans

House Committee on Health Policy
December 3, 2013

Testimony of Michigan Association of Health Plans in opposition of HB 4751

Good morning Madam Chair and members of the committee, my name is Christine Shearer, Deputy Director, of Legislation and Advocacy for the Michigan Association of Health Plans. With me today is Dr. Vanita Pindolia, VP Ambulatory Clinical Pharmacy Programs, Health Alliance Plan and Dave Bilardello, Executive Director, Public Policy, Priority Health, who has a background in underwriting.

As many of you already know, we are opposed to House Bill 4751. However, we don't want anyone to misinterpret our position as one of insensitivity. I bet if we asked everyone in this room to raise their hands if they personally (either themselves or a loved one) have been impacted by cancer, we would have an overwhelming demonstration that illustrates the scope and prevalence of this disease.

As health plans, we understand the physical, emotional and financial toll that cancer can have on people. That is why we provide coverage for all FDA-approved antineoplastic drugs – including the oral chemotherapy treatments that are the focus of House Bill 4751. That's also why we encourage, financially incentivize and, at times, require members to pursue healthy behaviors, seek preventive care and see their doctor for regular checkups and screenings. In other words, we are just as focused on preventing cancer as we are to treating it.

The purpose of our testimony is not questioning the benefits or efficacy of orally-administered chemotherapy treatments. Instead, we hope to provide some background on high-cost specialty drugs and the unintended consequences that may result if House Bill 4751 were effectuated into law.

Oral enzyme targeted chemotherapy is significantly more expensive than traditional intravenous treatment. Oral enzyme-targeted chemotherapy medications cost as much as $10,000 per month. Co-pays and other forms of cost sharing are substantially higher for oral chemotherapy to account for the high cost of these medications. Unlike traditional intravenous treatment, which is considered an established medical benefit, oral chemotherapy is reimbursed under the specialty prescription benefit tier. Specialty pharmaceuticals, targeted to small populations of the public, are among the most expensive pharmaceuticals in the market, contributing to explosive growth in costs that is making health care more expensive for everyone.

Cost sharing is a crucial part of controlling health care costs, whether it is to mitigate overutilization of prescription drugs (traditionally done to decrease inappropriate use of high cost brand drugs) OR offset the expense of costly prescription drugs (outcome of specialty drugs entering the market at $50,000-$80,000+/patient/year) . Establishing an arbitrary cost sharing limit for those who are using these expensive medications means more of the cost for oral chemotherapy medication will need to be borne by the other enrollees and insured in the form of higher premiums and/or higher out-of-pocket cost for other services.

I will now turn it over to Dr. Vanita Pindolia.

Proponents of House Bill 4751 would like to make this about the disparity between IV-administered and orally-administered cancer treatments. Biologic drugs are cutting edge medicines used by a number of patients for chronic conditions such as cancer, multiple sclerosis, rheumatoid arthritis, HIV/AIDS, epilepsy and hepatitis. Why is cancer the only disease that is under consideration in HB 4751? They can be vastly more expensive than traditional agents I will highlight how HB 4751 actually creates and/or exacerbates any disparity. Ms. Shearer asked me to address committee members concerns that have been raised thus far through previous testimony and meetings, including;

1. What is the definition of a specialty Drug?
2. Why are specialty drugs so expensive?
3. Are there generic alternative?
4. What percentage of drugs in the pipeline will be specialty drugs?
5. What kind of copay assistance is available for patients receiving specialty drugs?
6. What patient population would NOT be affected by this bill; thus continue to pay specialty drug copays/co-insurances?

Oral chemotherapy medications that have an equivalent intravenous (iv) formulation can be interchanged and used in the same manner. This involves taking the pill for a few days and then being off of them for a few days (normally) and then this gets repeated every 2-4 weeks. Each time it gets repeated it is called a cycle of treatment. Cancer treatment requiring chemotherapy includes a set number of cycles (e.g. 6 cycles or 6 courses of chemotherapy) and then chemotherapy treatment ends. Whether the oral or equivalent iv formulation is used, there is a set end date. Examples of these types of oral chemotherapy agents include: Xeloda and Temodar.

Another type of oral chemotherapy medications include the biologics (commonly associated with tyrosine kinase inhibition). These oral chemotherapy agents do NOT have an equivalent IV formulation available. Unlike traditional chemotherapy, these agents need to be taken daily for life or until resistance occurs. With these drugs, the patient basically lives with cancer cells kept at bay through enzyme inhibition vs with traditional chemotherapy actually killing the cancer cells. These oral biologic chemotherapy agents have turned cancer treatment into a type of chronic disease treatment. Oncologists in the past never had to worry about unknown non-adherence to therapy – the patients came in every 2-4 weeks for each cycle of treatment and follow-up care in between, as needed. With the oral biologic chemotherapy treatment, patients can go months in between

oncologist appointments and previously unknown non-adherence to therapy, as seen with other chronic diseases, appeared with cancer care. Therefore, treatment and management of patients with oral biologic chemotherapy is more like treatment and management of patients with chronic disease.

Basically oral biologic chemo agents are not used in the same manner as the IV chemotherapy agents.

Oral biologic chemo agents administered daily for life. IV chemotherapy agents given only for a few days every 2-4 weeks for a certain number of cycles. As you can see in our attached Chart the prices can vary tremendously between oral and IV drug treatments. (review chart)

I will now turn it over to Dave Bilardello.

Passing HB 4751 will have the potential to help less than $1/10^{th}$ of 1% of Michigan citizens. In Michigan 53% of all cancer diagnosis are to those over 65 years of age, and covered by Medicare. Of those remaining, only 35% of those could have the potential to be affected by this legislation. When we remove those covered by ERISA plans, Medicaid and the uninsurerd, this equates to 0.09% of Michigan population. In doing so would provide an unfair competitive advantage for non-MAHP members. Furthermore, surveying members and reporting the result could certainly be considered a violation of state and federal antitrust laws.

Let's review the Milliman study – which estimates that premiums will increase $0.05 to $1.00 PMPM – that way we are not totally dodging the cost question. However, if we do use the Milliman study, we'll want to point out some of the limitations, including:
a. The Milliman analysis was distributed two months **before** the PPACA was enacted into law. As such, it didn't take account for the AV requirements, OOP maximum and cost-sharing credits now available.
b. Biologic specialty drugs represent 50% of the forthcoming drugs that are expected to hit the market in the next few years. Of those, almost half are cancer treatments. The Milliman study did somewhat recognize this trend. However, it did not quantify, factor nor forecast how the increased treatment introductions will impact the PMPM cost as these medications are released into the market.
c. The Milliman study did not consider the effects of additional specialty drugs being classified under the medical benefit for non-cancer disease states. While that is outside the scope of HB 4751, such legislative initiatives will undoubtedly be introduced, considered and possibly effectuated if HB 4751 is signed into law. In other words, the intent of HB 4751 is to standardize cost-sharing for chemotherapy treatments. However, doing so will create a whole new disparity – one that could prove to be much, much costlier if addressed in the same manner.

As stated earlier "Michigan is unique" and in keeping with that premise, maybe we should commission our own actuarial study that considers the current regulatory requirements to adopt best practices that result in better patient outcomes in a cost-effective manner and use actual Michigan benefit designs that are offered on the federal Marketplace?

The PPACA includes provisions that are set to effectuate as early as January 1, 2014 that will provide new/enhanced benefits and cost reductions/protections. Thus this bill is unnecessary

because the ACA already sets out of pocket limits for consumers, which apply for all prescription and medical out-of-pocket costs combined.

a. OOP expenses will be capped at $6,350/individual and $12,700/family for all plans in all markets

Lowering cost sharing for oral chemotherapy affects the actuarial value under the ACA. Between the comprehensive essential health benefits package and restrictions on benefit limits, it is proving extremely difficult to meet the actuarial value requirements for these new plans. Limiting cost sharing for oral chemotherapy exacerbates the problem. In order to keep the actuarial value in balance, there will need to be an adjustment made to some other type of cost sharing in the benefit design.

b. Cost-sharing credits will have the effect of increasing the actuarial value and limiting the OOP expenses for those who need it most – individuals and families making 250% or less than the federal poverty level

The bottom line is:

- Health plans ALREADY cover these medications and treatments to help patients battle cancer.
- Chemotherapy drugs are expensive and oral chemotherapy drugs are very expensive compared to IV treatment.
- Chemo treatments are covered in different ways depending on where it's received
- This bill could actually result in patients paying more out-of-pocket
- Regardless of the intent of the bill an untended consequence would be to place upward pressure on premiums.

Christine Shearer

Health insurance plans have taken important steps over the last decade to address the critical issues of increasing access to innovative, quality health care products and cost control mechanisms that would better allow individuals and small businesses to obtain coverage in the private market. The adoption of benefit mandates that do not promote evidence-based medicine may lead to lower quality of care, over-utilization, and high costs for possibly non-effective treatments. HB 4751 threatens the efforts of all healthcare stakeholders to provide consumers with meaningful health care choices and affordable coverage options.

MAHP believes this bill doesn't solve the problem but it shifts the problem and it shifts it to the employer and individual premiums.

For these reasons, MAHP respectfully opposes HB 4571.

Thank you for the opportunity to testify. We are happy to answer any questions.