



September 6, 2011

Oklahoma House of Representatives
Insurance Committee
2300 N. Lincoln Blvd
Oklahoma City, OK 73105

RE: IS11-044 Parity in health insurance coverage for oral and intravenous chemotherapy agents – Rep. Gary Banz

Honorable Members of the Oklahoma House of Representatives,

The Oklahoma Society of Clinical Oncology was founded on July 11, 1996 to address the legislative and fiscal challenges of our member jurisdiction and to establish a united front by sharing resources, information and common goals such as Parity of coverage in health insurance for oral and intravenous chemotherapy agents.

OSCO recognizes that health legislation is driven by the desire to improve health care services to the community. Our members are committed to the same ideal.

Anticancer therapy is broken down into three major categories. Anticancer drugs, surgery and radiation therapy.

Anticancer drugs can be given intravenously or orally. Historically, intravenous therapy has been the predominant route for administering anticancer drug therapy, however an increasing proportion of new cancer drugs are being developed in oral form, with 85% of those being targeted agents. Targeted agents block the growth of specific cancer cells and may be less harmful to normal cells. Experts estimate that more than one quarter of the 400 chemotherapy drugs now in the development pipeline are planned as oral drugs.

The issue that has surfaced is chemotherapy administered in a physician's office is generally covered under the major medical portion of an insurance benefit package and oral (self-administered) chemotherapy is generally covered under the prescription drug benefit. Because oral and injectable chemotherapy pricing is determined by two different formulas they are not reimbursed in the same way or at the same levels. We are starting to see patients with co-payments for oral drugs in excess of \$2,500 while if they received a chemotherapy infusion they might have incurred a \$50 office visit fee. If scenarios such as this are not challenged, it will be the families of cancer patients that will face catastrophic illness and financial ruin no matter what their earning power is. Sometimes there is not an IV equivalent to an oral chemo agent. Furthermore, oral drugs are being investigated as maintenance therapy, with an indefinite stopping time.

Medicare has already fixed this problem. Under Medicare Part D, any oral chemotherapy drug which is identical to an intravenous chemotherapy drug is covered under Medicare's medical benefit, commonly known as Part B. In the spirit of equitable treatment of cancer patients, we ask that you pass legislation that will reduce out of pocket costs to cancer patients.

According to the American Cancer Society, 18,670 people in Oklahoma were diagnosed with cancer in 2010.

The good news for these patients is that new oral therapies are extending lives and even allowing cancer to be treated as a chronic disease. The bad news is they may not be accessible to everyone. Large out of pocket expenses, high healthcare cost-sharing requirements, dollar limits on pharmacy benefits, and lifetime maximums on some policies are among the factors that can contribute to families being forced to choose between loved ones and financial ruin. Patients on oral chemotherapy drugs can face copayment disadvantages as compared to patients on infused agents. Some patients who cannot meet the co-pays and do not qualify for total assistance simply refuse therapy. Chemotherapy by any other name is still chemotherapy and must not be held hostage by an uncompromising insurance industry.

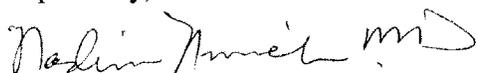
Clearly, there is a need for legislative updates to make emerging treatment and advances in oncology feasible for cancer patients.

We are requesting an interim study to analyze the disparity in patient copayments between orally and intravenously administered chemotherapies, the reasons for the disparity, and the patient benefits in establishing copayment parity between oral and infused chemotherapy agents. Based on a Texas study to quantify the cost of implementing chemotherapy parity the cost would be less than fifty cents, per member, per month for most plan designs. In cases where the medical benefit cost sharing percentage is currently low and the prescription benefit cost sharing percentage is currently high, implementing chemotherapy parity would cost between \$0.50 and \$1.30 per member per month.

A new era of personalized medicine is here and there is a need for legislative updates on the emerging treatment and advances in oncology. Four other states have passed legislation including New Mexico and Texas.

It is OSCO's opinion that oral drugs should be covered in the same manner as intravenous drugs for the treatment of cancer, regardless of the type of prescription drug plan cancer patients may have under their primary insurance policy.

Respectfully,



Nadim Nimeh, M.D., President
Oklahoma Society of Clinical Oncology

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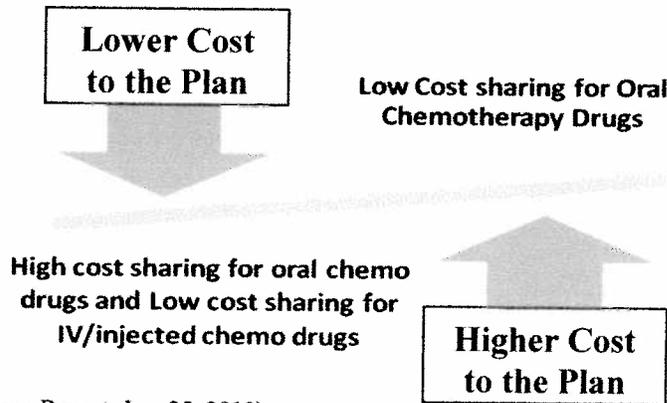
Daron Street, M.D.
Cancer Care Associates

several states including California, Vermont, and Texas, have reported on the estimated costs of implementing chemotherapy parity legislation. A sample of the results from these studies follows.

A. Milliman's Report

The expected result of reducing patient out-of-pocket costs for pharmacy benefits is that insurance companies will shoulder a larger portion of these expenses. If cost sharing for oral chemotherapy medications is already low, as is the case with traditional prescription drug benefit plans with copays only, the mandate will have a negligible cost impact.⁶³ But for policies with unlimited coinsurance for costly anticancer medications, the mandate could slightly increase the cost of the plan. See Figure 5.

Figure 5. Relationship between Pre-Parity Benefits and Cost of Introducing Parity



(Adapted from Milliman Report, Jan. 25, 2010)

To quantify this amount, Milliman, Inc., calculated that the cost of implementing chemotherapy parity would be less than fifty cents, per member, per month for most plan designs. In cases where the medical benefit cost sharing percentage is currently low and the prescription benefit cost sharing percentage is currently high, implementing chemotherapy parity would cost between \$0.50 and \$1.30 per member per month.⁶⁴ See Table 4.

Medical Benefit Cost Sharing Percentage	Oral Chemotherapy Cost Sharing Percentage		
	Low	Medium	High
Low			\$0.50 to \$1.30
Medium	\$0.05 to \$0.10	\$0.15 to \$0.20	\$0.25 to \$0.35
High			\$0.20 to \$0.30

*Per Member Per Month (PMPM). Costs trended to 2009. Figures do not include plan administrative costs. Source: Milliman. Parity for Oral and Intravenous/Injected Cancer Drugs⁶⁵

⁶³Milliman, Inc., NY, *supra* note 24.

⁶⁴*Id.*

⁶⁵*Id.* at 9.

Milliman Analysis of State Parity Legislation

The emergence of oral chemotherapy agents represents a significant scientific advancement that is changing the nature of medical treatment, giving patients access to a number of innovative and convenient therapies for serious diseases, such as cancer. While new oral anticancer agents have become increasingly available, differences in benefit design may be inappropriately influencing physicians to select the best therapy for patients.

- Because of how benefit designs have evolved, intravenous/injected chemotherapy drugs are typically covered through medical benefits where patient cost sharing is typically lower. Oral chemotherapy drugs, however, are more often covered through pharmacy benefits, where patient cost sharing is greater. This evolution has caused a disparity in coverage, resulting in higher patient out-of-pocket costs for orals than for intravenous/injected formulations in some health plans.

To solve this disparity, Oregon enacted legislation¹ in 2007 requiring state-regulated health plans to cover oral drugs on parity with intravenous/injected drugs. Hawaii, Indiana, Iowa, Vermont and the District of Columbia enacted similar parity legislation in 2009. Some health insurers have opposed the bills, arguing that such legislation will increase patient premiums.

Milliman Findings:

To address these issues, GlaxoSmithKline commissioned Milliman, Inc., an independent actuarial business consulting firm with 60 years experience in the healthcare arena, to analyze disparities in health plan benefit design and evaluate how much state parity legislation would cost state-regulated health plans to implement. The following are Milliman's key findings:

- **For most benefit plans, parity will cost under \$0.50 Per Member Per Month (PMPM), which compares to a typical plan cost of over \$300 PMPM for all benefits.**
- However, there are literally thousands of variations of benefit design, and some of the plan design features can affect parity costs.
- Parity for plans with very high cost sharing for specialty drugs and low cost sharing for medical benefits could cost about \$1.00 PMPM, or, in unusual circumstances, more.
- Parity for other plan designs with low cost sharing could cost as little as \$0.05 to \$0.10 PMPM.

Milliman defined "parity" to mean that "the percent cost sharing for an oral chemotherapy drug will be no more than that of an intravenous/injected chemotherapy drug."

In addition to evaluating the cost of implementing state parity legislation, Milliman also studied elasticity for oral chemotherapy drugs – demonstrating that higher cost sharing for oral chemotherapy agents is associated with lower utilization of these drugs. This elasticity for chemotherapy drugs is a finding that has not previously been published and was not included in previous analyses of state parity legislation.²

Note: In partnering with Milliman, GlaxoSmithKline, a pharmaceutical company that manufactures, markets, and is developing intravenous/injected and oral chemotherapy drugs, provided oncology disease state and treatment expertise, background information on iv/oral chemotherapy treatment paradigms, information on the current status of oral/iv parity legislation, and general editing.

¹ Under the Oregon law (S.B. 8), "[a] health benefit plan that provides coverage for cancer chemotherapy treatment must provide coverage for a prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected cancer medications that are covered as medical benefits."

² Analysis of Senate Bill 161 Health Care Coverage: Chemotherapy Treatment. California Health Benefits Review Program, Apr 17, 2009.

September 14, 2009

The Honorable Mary Jane Garcia
New Mexico State Senate
Box 22
Doña Ana, NM 88032

Dear Senator Garcia:

I am writing in regards to Senate Memorial 89, which asks the Department of Health to study the disparities in copayments between orally and intravenously administered chemotherapy.

As with many disease treatments, cancer therapy methods have improved greatly. In the past, chemotherapy was mainly administered intravenously (IV). Today many cancer treatments can be administered orally and taken at home. Oral chemotherapy medications have become a safe and effective treatment for several types of cancer, including breast, colorectal, lung and several types of leukemia.

The disparity in copayments between oral chemotherapy medications and IV chemotherapy is largely the result of the way most insurance plans offer benefits. Oral chemotherapies are covered by the prescription plan and generally have high co-payments. Patients receiving IV chemotherapy treatments go to a doctor's office or outpatient clinic. This is considered to be a part of the medical benefit and has a lower co-pay.

Also, chemotherapy medications are either not covered by a prescription plan or are placed on a multi-tier formulary. For example, a four-tier formulary would require the patient to pay 28% of the cost of the medication. Data from a bill analysis from the State of California (SB161 2009) shows a fourth-tier medication, with a total cost of \$3,000 a month, would cost a patient \$840 out-of-pocket each month, or \$10,080 a year in out-of-pocket expenses. In many types of cancer, a patient may be on several oral chemotherapy medications.

Along with tiered formularies, many health plans have a maximum benefit for medications. This is variable from plan to plan and from medication to medication. In many cases, once patients reach the maximum benefit for their prescription plan, they must choose between paying full price or discontinuing treatment.

Patients treated exclusively with oral chemotherapy medication tend to fall into debt more quickly than those who receive it intravenously. A Kaiser Foundation report, *Spending to Survive: Cancer Patients Confront Holes in the Health Insurance System*, February 5, 2009, looked into how many patients face debt due to higher co-pay for oral chemotherapy medication and the other reasons discussed above.

September 14, 2009

In a recent article (Drug Topics: Oral and IV drug coverage gains attention, May 29, 2009), oncologist Brian G.M. Durie, MD, asserts that the higher costs of oral chemotherapies interferes with a doctor's ability to choose the best course of treatment of his patients. "Some [cancer medications] are intravenous drugs and some can be taken by mouth. As a practicing hematologist-oncologist, I need the freedom to prescribe therapies based on their potential efficacy. Something is very wrong when the largest side effect is economic, based upon inequitable and irrational differences in reimbursement."

Indiana and Oregon have passed laws that protect against this disparity in price. Six other states – Texas, Washington, Hawaii, New York, Ohio and Oklahoma – have introduced or will introduce similar legislation. At the federal level, the Cancer Drug Coverage Parity Act of 2009 (HR 2366), introduced by Rep. Brian Higgins (D-NY) is currently in the House Ways and Means Committee. It would require group and individual health insurance coverage and group health plans to provide for coverage of oral cancer drugs on terms no less favorable than the coverage provided for intravenously administered anticancer medications. The intent is very similar to the state bills that have passed or are being considered in these six states.

Thank you for your interest in such an important topic. I am happy to follow up with any additional information you may need.

Sincerely,

A handwritten signature in black ink, appearing to read "Alfredo Vigil, MD". The signature is written in a cursive, flowing style with some loops and flourishes.

Alfredo Vigil, MD
Secretary

2011 Chemotherapy Parity

