



Michigan Association of Health Plans

House Committee on Insurance

March 22, 2012

Testimony of Michigan Association of Health Plans in opposition of SB 540

PRESIDENT

Kathy Kendall
McLaren Health Plan

PRESIDENT-ELECT

Bruce Hill
HealthPlus of Michigan

SECRETARY

Randy Narowitz
Total Health Care.

TREASURER

Beverly A. Allen
OmniCare Health Plan, Inc

EXECUTIVE COMMITTEE

MEMBERS-AT-LARGE

William R. Alvin
Health Alliance Plan

Kimberly K Horn
Priority Health

Dennis H. Smith
Upper Peninsula Health Plan

BOARD MEMBERS

Ellen Anderson
ProCare Health Plan

Craig Bass
Molina Healthcare of Michigan

David Cotton
Health Plan of Michigan

David Livingston
UHC- Great Lakes

Roland Palmer
Grand Valley Health Plan

John Randolph
Paramount Care of Michigan

Mark Saffer
Midwest Health Plan

Scott Wilkerson
Physicians Health Plan-MM

Sharon Williams
CareSource Michigan

EXECUTIVE DIRECTOR

Richard B. Murdock
*Michigan Association of
Health Plans*

Good morning Madam Chair and members of the committee, my name is Christine Shearer, Legislative Director of the Michigan Association of Health Plans. With me today is Dr. Vanita Pindolia, VP Ambulatory Clinical Pharmacy Programs, Health Alliance Plan and Doctor Keith Tarter, Medical Director CareSource Michigan. We respectfully urge members to oppose this costly and unnecessary legislation.

Employers are demanding more affordable health insurance products. Today many health insurance products are designed to share the cost of coverage with enrollees as a way to keep the cost of coverage more affordable for the employer's entire group. Rx drugs make up a significant portion of the cost of health care coverage and high cost specialty drugs make up a fast-growing component of overall health care costs.

Because their cost is so high, these specialty drugs are often categorized into a third or fourth tier pharmacy benefit, where the enrollee pays a higher co-pay for these medications limited by an out-of-pocket (OOP) maximum. This bill mandates a cap on co-pays, but it does nothing to address the high cost of these drugs. It simply shifts the cost of these drugs to the employers' premium. The majority of MAHP members have these drugs in the second tier of their pharmacy benefit.

It is important to note that under Chapter 34 of the Insurance Code, section 3406e mandates coverage for all antineoplastic drugs. The language states "an insurer shall provide coverage in each policy for a drug used in antineoplastic therapy and the reasonable cost of its administration. Coverage shall be provided for any FDA approved drug." Thus ALL chemotherapy drugs – either oral or intravenous – are already covered benefits by health plans. What this bill does is to impose limits on how the benefit is administered, which could result in higher premiums for employers.

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

Biologic drugs are cutting edge medicines used by a number of patients for chronic conditions such as cancer, multiple sclerosis and rheumatoid arthritis. They can be vastly more expensive than traditional agents. Currently, there are no

generic equivalents of biologic drugs on the market that could save consumers billions of dollars over the years.

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.

Therefore, moving these oral biologic chemotherapy agents to a medical benefit raises questions on all other drugs used to treat chronic diseases (e.g. epilepsy, HIV, etc.). Unfortunately shifting all chronic disease oral therapy to medical benefit, no out-of-pocket costs to patients, could not be financially sustained and costs would need to be passed on to employer groups.

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 Doctor Tarter

Oral chemotherapy regimens typically require a patient to take the medication exactly as prescribed by the doctor, with the average regimen consisting of 10 - 20 pills each day. The regimens may be complex and rely upon the consumer to police his or her own medication without the direct supervision of a licensed and trained medical professional.

Inadequate patient adherence to medications is highly prevalent in clinical practice focusing on chronic illness. Until recently, non-adherence to cancer therapies was deemed a relatively small problem because most medications were delivered intravenously. Although oral antineoplastic therapies offer patients many advantages, including greater convenience, patient adherence to oral agents is more difficult to assess than adherence to IV medications and is relatively unstudied and could become a significant problem. (*Enhancing Patient Adherence to Improve Outcomes With Oral Chemotherapy, " Proceedings from a Symposium at the 2007 Hematology/Oncology Pharmacy Association Annual Conference, October 18, 2007*)

The bottom line is:

- Health plans ALREADY cover these medications 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 unintended consequence would be to place upward pressure on premiums.

Christine Shearer

In today's economy, employers are struggling to balance the cost of premiums against out-of-pocket costs. Employers make these choices as to which plans they can afford based on many factors, including whether they can afford more upfront costs in their premium that comes with lower out-of-pocket costs or a lower premium with higher out-of-pocket costs.

Premiums reflect the cost of health care and increased costs lead directly to increased premiums. Employers typically choose the plan design for their employees based on the most comprehensive health insurance coverage they can afford to purchase as well as how they want to share the cost with their employees. Different coverage and/or enrollee cost sharing for different classifications of benefits is a standard method of controlling costs in health care coverage.

Enactment of this bill will ultimately shift more of the cost of the premium onto employers. The cost of these drugs doesn't change as a result of this bill; instead, the portion of costs now paid by the enrollee are shifted onto the premiums paid by employers in the fully-insured market.

Health insurance plans offer competitively-priced, quality products to consumers by striving to provide access to medical care that is both medically necessary and adherent to evidence-based principles of patient safety. When a state passes a benefit mandate, the mandate remains static and often does not reflect changes in the practice of medicine, new medical technology, or other medical advances or knowledge that may make the mandate obsolete – or even harmful – to patients. 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.

MAHP believes these bills are a solution to a problem that doesn't exist.

For these reasons, MAHP must respectfully oppose SB 450.

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