

Robin's Messages for Testimony on SB50

Good Afternoon

I'm Robin Tuohy from Prospect, CT and I am Director of Support Groups for the International Myeloma Foundation. In addition to the letter that was submitted to you from Susie Novis, President and co-founder of the International Myeloma Foundation, I would like to add the following:

The IMF believes patients should be able to take advantage of the treatment that is best for them and not have to select their treatment based on insurance coverage. Hematologist-oncologists need the freedom to prescribe therapies based on their potential efficacy.

- We need an equitable, patient-oriented insurance system that acknowledges and covers 21st Century tests and treatments
- Currently although oral drugs cost the least to administer they have the highest out-of-pocket charges for patients.
- All treatments must be reimbursed at an equitable rate, regardless of how they are administered
- We question a system that reimburses the least for the most cost-effective treatments
- We are not promoting oral drugs; we are saying treatment should be based on medical assessment not insurance coverage. That is, based on what patients and physicians working together agree is the optimal treatment for their specific case
- Something is very wrong when the largest side effect of a drug is economic based upon inequitable and irrational differences in reimbursement.

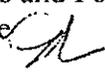
Oral drug Parity Legislation CT SB 50 is now being considered in CT that would require private insurance companies to cover oral anti-cancer drugs at the same rate they cover intravenous infusions in terms of patient out of pocket costs. This is a critical time to stand-up for the health issues that affect us directly.

Thank you.

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TO: Douglas A. Racine, Chair, Senate Committee on Health and Welfare
Stephen B. Maier, Chair, House Committee on Health Care

FROM: Sean Londergan, Assistant General Counsel, Director of Rates and Forms
Department of Banking, Insurance, Securities and Health Care
Administration 

DATE: January 15, 2009

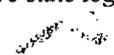
SUBJECT: Coverage of Oral Anticancer Medications – 8 V.S.A. § 4100h

Section 48 of Act 61 of 2009, An Act Relating to Health Care Reform directs the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) to study the impact of implementing a requirement for health insurance coverage of orally administered anticancer medication. In conducting the study, the Department was asked to consider: (1) projected impact on health insurance premiums; (2) options for mitigating the impact on premiums of the coverage requirement; (3) administrative complexities associated with the mandate; (4) public policy implications of expanding coverage for treatment-specific medications and procedures; (5) appropriate safeguards for accomplishing the purpose of the coverage requirement; and other factors that the Department deems appropriate. As directed, the Department is reporting its findings and recommendations.

I. Impact on Premiums

The Department has not received information indicating that mandating coverage for orally administered anticancer medications will significantly impact premiums. The Department's assessment is based on information received from three other states (IN, CA & OR), which have passed similar legislation and the Department's contracted actuary.¹ During last year's session, Senator Mullin provided an impact statement for premiums at .00144% for California. Indiana, which passed oral anticancer medication legislation last year, reported a "negligible" impact on premiums so far, although they did not have any hard data. Oregon does not have any information about whether their state's legislation increased premium rates because their insurance department does not track information about premium rate increases. For Vermont, the Department's actuary

¹ The Department notes that at least eight other states, in addition to Indiana, introduced cancer drug parity laws during the last year. In all eight states (Texas, Montana, Colorado, New Mexico, Oklahoma, Minnesota, Ohio and New York) the legislation remains pending in their respective state legislatures.

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has concluded that individuals without prescription drug coverage may experience a 0.5% increase in premiums. Approximately 95.0% of insured Vermonters have prescription drug coverage. The insurers contacted for this report provided no indication of significant rate increases as a result of the legislation. Therefore, the Department does not believe that the State's mandate for orally administered anticancer medication will significantly impact premiums for Vermonters.

II. Administrative Complexities

There may be administrative complexities associated with the mandate. For instance, a majority of Vermonters have Preferred Provider Organization (PPO) coverage that consists of a medical/surgical portion (administered by the insurer) and a freestanding prescription drug portion subcontracted to a Pharmacy Benefit Manager (PBM). Currently, the injectable chemotherapy drugs are provided under the medical/surgical portion; and the orally administered chemotherapy drugs are provided by the PBM. Each coverage type is administered differently with different patient payment rules.² As a result, there may be an administrative challenge to match the benefits of each coverage type to assure oral drug anticancer medication parity. In addition, for those consumers who have opted out of any freestanding prescription drug coverage, insurers will have to either have to administer the mandated benefits themselves; or negotiate with the PBMs to provide coverage only for orally administered chemotherapy drugs. The insurers contacted by the Department for this report did not identify any administrative complexities associated with the mandate.

III. Public Policy Implications

The mandate has public policy implications. By requiring coverage of oral anticancer medications, the State is opening itself up to questions about whether other promising drugs for other serious illnesses should also be covered.

IV. Safeguards

The Department has received anecdotal evidence from both Oregon and Indiana suggesting that insurers will choose to move coverage for all chemotherapy drugs to whichever coverage type (medical or pharmacy) provides the least comprehensive coverage and requires the most consumer cost-sharing. Thus, there is the potential that the enacted legislation will be harmful to some consumers because they may end up with

² In commissioning the Louisiana Department of Insurance to study the disparities in the amounts of co-payments between orally and intravenously administered chemotherapy medications, the Louisiana Legislature stated that "while traditional intravenous chemotherapy is typically covered under a health plan's medical benefits and requires only an office visit co-payment, oral chemotherapy medications are typically covered by the plan's drug benefit and require significant co-payments or co-insurance to fill the prescription at a pharmacy." The Louisiana Department of Insurance is to report its findings by February 15, 2010.

less coverage and more cost sharing.³ In both Oregon and Indiana, the potential harm to the consumer was reportedly due to imprecise statutory language, which is very similar to that of 8 V.S.A. § 4100h.⁴ However, the Department has been unable to determine how extensive the problem has been due to lack of data in both states.

Indiana at one point considered proposing that coverage for cancer chemotherapy be treated as a non-pharmacy benefit.⁵ Ultimately, however, Indiana policymakers, concluded that they would be unable to ensure that all consumers would benefit in every instance and decided not to require a specific coverage type.⁶ Indiana's contention that their mandate would be better for consumers if it were covered as a non-pharmacy benefit may have merit.⁷ However, the Department's actuary estimated that for Vermonters who have PPO coverage with freestanding prescription drug coverage, consumer payments under their pharmacy benefit would be lower for orally administered anticancer medications in most instances (80 to 85% of the time) than if coverage was provided under the medical portion. Similar to the experience of Indiana and Oregon, the Department is hesitant to recommend that coverage for all cancer chemotherapy be treated as a non-pharmacy or as a pharmacy benefit, because there is no guarantee that in so doing the consumer will benefit in each instance.

V. Conclusion

Despite possible administrative complexities associated with the requirement for health insurance coverage for orally administered anticancer medication, the Department does

³ Oregon also reported that its legislation did not fix the problem of affordability for oral cancer medications because consumers were still paying high copays and coinsurance for the medications.

⁴ Oregon's statute reads as follows: "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." 56 O.R.S. §743.068. Indiana statute reads as follows: "Coverage for orally administered cancer chemotherapy under an individual contract or a group contract must not be subject to dollar limits, copayments, deductibles, or coinsurance provisions that are less favorable to an enrollee than the dollar limits, copayments, deductibles, or coinsurance provisions that apply to coverage for cancer chemotherapy that is administered intravenously or by injection under the individual contract or group contract." I.C. 27-13-7-20.

⁵ In an attempt to make the Indiana legislation more precise the following language was recommended "A policy of accident and sickness insurance that provides coverage for cancer chemotherapy, regardless of the method of administration, may not be issued, amended, or delivered or renewed in Indiana unless the policy treats chemotherapy as a non-pharmacy benefit."

⁶ Indiana's conclusion on this matter was the same as Oregon's. The Oregon Legislature requested that their Department of Insurance recommend a type of coverage (either a pharmacy or major medical) for the mandated benefits. The Department of Insurance was unable to make a recommendation because the answer was inconclusive depending on the individual or group health plan.

⁷ It must be noted that since the passage of Indiana's mandate some consumers have reportedly experienced greater cost sharing as a result of insurers moving oral anticancer medication from a pharmacy benefit to a major medical benefit.

not believe that the Vermont's mandate will significantly impact premiums for Vermonters. A greater concern is anecdotal evidence from states with similar legislation stating that insurers will choose to move coverage for all chemotherapy drugs to whichever coverage type (medical or pharmacy) that provides the least comprehensive coverage and greatest cost sharing. The Department was unable to determine whether there is a legislative solution that eliminates this concern without adversely impacting some consumers.

VI. Recommendations

1. The Legislature should consider articulating the rationale for mandating coverage of oral anticancer medication and consider establishing criteria to be used for the analysis of additional requests in order to avoid future controversies.
2. The Department should monitor the implementation of the oral anticancer medication mandate for unintended consequences and report to the legislature with a recommended solution if problems arise.