Senate Fiscal Agency
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BILL ANALYSIS

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Senate Bill 625 (Substitute S-2 as passed by the Senate)
Sponsor: Senator Goeff Hansen
Committee: Insurance

Date Completed: 7-12-16

RATIONALE

Over the years, advances in cancer treatment have been marked by the development of a number of oral alternatives to intravenous and injected chemotherapy drugs. Reportedly, these oral anticancer medications offer more convenience for patients and tend to have fewer side effects compared to traditional chemotherapy. Under many health insurance policies, however, the out-of-pocket cost to patients for the oral treatments is higher than the cost for intravenous treatments. This is because, typically, intravenous chemotherapy is covered under the medical portion of a policy, while orally administered medications are covered as prescription drugs under the policy's pharmacy benefit. To address this, it has been suggested that insurers should be required to provide comparable terms for intravenous and oral anticancer medications with regard to treatment limitations and patient financial requirements, or financial requirements for oral medications should otherwise be limited.

CONTENT

The bill would amend the Insurance Code to restrict treatment limitations and financial requirements applicable to prescribed orally administered anticancer medications under a policy, certificate, or contract that also covers intravenously administered or injected anticancer medications.

The bill would apply to an expense-incurred hospital, medical, or surgical policy or certificate delivered, issued for delivery, or renewed in this State, as well as a health maintenance organization (HMO) group or individual contract, that provided coverage for the medications described above. Except as otherwise provided, the bill's requirements would apply to policies, certificates, and contracts delivered, executed, issued, amended, adjusted, or renewed in Michigan, or outside of Michigan if covering Michigan residents, after December 31, 2016.

Specifically, the bill would require a policy, certificate, or contract to ensure that treatment limitations applicable to prescribed orally administered anticancer medications were not more restrictive than those applicable to intravenously administered or injected anticancer medications, and that there were no separate treatment limitations applicable only to the orally administered medication. Additionally, the policy, certificate, or contract would have to ensure either of the following:

-- That financial requirements applicable to prescribed orally administered anticancer medications were no more restrictive than those applicable to intravenously administered or injected medications, and that there were no separate cost-sharing requirements applicable only to the orally administered medications.
-- Beginning January 1, 2018, that the financial requirement for orally administered medication did not exceed $100 (adjusted annually for inflation by the Department of Insurance and Financial Services) per 30-day supply.

Beginning on the bill's effective date, an insurer or HMO could not achieve compliance with the bill's requirements by increasing financial requirements, reclassifying benefits with respect to anticancer medications, or imposing more restrictive treatment limitations on prescribed orally administered anticancer medications or intravenously administered or injected anticancer medications covered under the policy, certificate, or contract.

For a policy, certificate, or contract that was a high-deductible plan, the bill's requirements would apply only after the minimum annual deductible specified in 26 USC 223(c)(2) was reached. (Under that section of the U.S. Code, "high deductible health plan" means a plan with an annual deductible of at least $1,000 for self-only coverage or $2,000 for family coverage; and the sum of the annual deductible and other out-of-pocket expenses required to be paid under the plan (excluding premiums) for covered benefits does not exceed $5,000 for self-only coverage or $10,000 for family coverage.)

The bill would not prohibit an insurer or HMO from applying utilization management techniques, including prior authorization, step therapy, limits on quantity dispensed, and days' supply per fill for any administered anticancer medication.

The bill would not apply to a policy, certificate, or contract that provided coverage for specific diseases or accidents only, or to a hospital indemnity, Medicare supplement, long-term care, disability income, or one-time limited duration policy or certificate that had a term of six months or less.

The bill would define "financial requirement" as deductibles, copayments, coinsurance, out-of-pocket expenses, aggregate lifetime limits, and annual limits. "Treatment limitation" would mean limits on the frequency of treatment, days of coverage, or other similar limits on the scope or duration of treatment. "Anticancer medication" would mean a medication used to kill, slow, or prevent the growth of cancerous cells.

Proposed MCL 500.3406u

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

At present, oral medications constitute about 10% of all available chemotherapies. Of the anticancer medications in the development pipeline, however, oral medications make up 25%, indicating that they will become more prevalent in cancer treatment. Often, these modern medications represent the most effective, and in some cases, the only course of treatment, as some of the newest chemotherapies on the market are available only in pill form. Additionally, cancer patients may have a higher quality of life if they use oral treatment rather than intravenous chemotherapy. They may experience fewer and less severe side effects, save the time of traveling to appointments and receiving the treatments, and be able to continue working and otherwise maintain a normal routine.

Reportedly, however, the insurance cost-sharing requirements and treatment limitations typically associated with oral medications can present a significant barrier to patient access. Patients might have to choose between compliance with their prescribed treatment and their families' financial stability. When faced with prescription co-pays totaling hundreds or thousands of dollars every month, people may skip or ration doses or stop taking their medication altogether.

Cost should not compel cancer patients to deviate from their physicians' recommended treatment regimen or deter doctors from prescribing the evidence-based chemotherapy options that offer their patients the greatest hope for survival. Insurance parity between intravenous and oral drugs would ensure that people with cancer had access to all available treatments and enable them to choose the best options for their individual circumstances within the context of the physician-patient relationship. By requiring equivalent coverage of these medications, the bill would reduce

suffering for cancer patients and could save lives. In addition, the bill would update Michigan's insurance laws to reflect that oral chemotherapy is replacing injected chemotherapy as the standard of care.

Opposing Argument

The oral anticancer medications replacing traditional intravenous chemotherapy generally are classified as specialty drugs: large-molecule drugs used to manage especially complex, serious conditions. Typically, these drugs require close monitoring for safety and efficacy, and the market price is much higher than the price for traditional medications. Additionally, the price usually increases over the course of the drugs' patent protection. Reportedly, even though specialty drugs made up only 1% of the prescriptions written in the United States in 2014, they constituted 32% of total prescription drug spending. The use of specialty drugs is expected to continue increasing. On an annual basis, approvals of new specialty drugs by the U.S. Food and Drug Administration now outnumber approvals of traditional drugs.

Rather than addressing the underlying problem of high prescription drug costs, the bill merely would shift some of the costs of oral anticancer medications from patients to insurance companies. Ultimately, these costs could be passed on to employers and individual subscribers in the form of higher premiums or widespread increases in cost-sharing requirements and reductions in coverage. Additionally, the bill would open the door for patients with other conditions treated with expensive specialty drugs to request statutory limits on their cost-sharing obligations. Thus, contrary to the bill's aim, these insurance mandates cumulatively could make health care less, rather than more, affordable for consumers. Additionally, whether the legislation is necessary is questionable, as many drug companies and charitable entities have financial assistance programs to help people with their prescription drug expenses.

Also, the insurance policies that would be affected by the bill cover only about one-third of the State's insured population. The bill would not apply to those covered by private entities that self-insure under the Employee Retirement Income Security Act (ERISA) or Medicare (which covers a disproportionate share of cancer patients, as cancer is more prevalent among the elderly). With regard to high-deductible plans, the bill's requirements would apply only once the deductible was reached; thus, people covered under such policies would experience little benefit from the bill's enactment.

Instead of establishing price controls in health plans, legislation should require more transparency from pharmaceutical manufacturers with regard to the prices of their anticancer drugs, including their periodic price increases and the reasons these drugs cost more in the United States than they do in other countries.

Response: As of October 2015, 40 states had enacted oral chemotherapy insurance parity laws. Overall, the experience in these states has shown little to no impact on health insurance premiums. A study by Milliman, an actuarial consulting firm, estimated an average increase of only 50 cents per subscriber per month connected to parity legislation. Additionally, in some cases, oral chemotherapy actually is a less expensive treatment option once the costs for supplies, facility overhead, and staff associated with traditional injected chemotherapy are taken into account. Moreover, insurance benefit designs that discourage people from using the most effective treatments can lead to disease progression that must be treated with costly medical procedures and hospitalizations in the future. Overall, it would be more cost effective to make the best proven treatments more affordable for patients from the beginning.

While pharmaceutical companies do provide financial assistance for expensive drugs, eligibility requirements can be restrictive and assistance might be provided to a limited population. Furthermore, these programs generally require patients to reapply every year, so access to affordable chemotherapy is not guaranteed. Cancer patients should be able to expect fair and consistent coverage for their treatment, regardless of the way it is administered.

Legislative Analyst: Julie Cassidy

FISCAL IMPACT

The bill would result in very minor increases in the cost of insurance for State and local government and would have no impact on Medicaid costs.

To the extent that copayments and other out-of-pocket costs are greater for orally administered anticancer medications, the bill would reduce such costs for patients. The reduced costs would effectively be picked up by a small increase in the cost of insurance. Given the limited range of medications affected by this legislation relative to the overall cost of pharmaceuticals and health care in general, the cost increase would be nominal.

The State's Medicaid program has tight limits on cost sharing for pharmaceuticals, so the legislation would have no impact on Medicaid spending.

Fiscal Analyst: Steve Angelotti

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