Legislative Analysis

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ORALLY ADMINISTERED ANTICANCER MEDICATIONS

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House Bill 4071 as enacted
Public Act 170 of 2023
Sponsor: Rep. Samantha Steckloff
House Committee: Health Policy
Senate Committee: Health Policy
Complete to 2-15-24

SUMMARY:

House Bill 4071 amends the Insurance Code to prohibit a health insurance policy from applying financial requirements to orally administered (by mouth) anticancer medications that are more restrictive than the requirements it applies to anticancer medications that are administered or injected intravenously (into a vein). However, the above prohibition only applies if the co-pay or coinsurance for orally administered anticancer medications under the policy is more than $250 for a 30-day supply.

Under the bill, a health insurance policy delivered, issued, or renewed in Michigan after December 31, 2025, that provides coverage for prescribed orally administered antineoplastic[1] medications and intravenously administered or injected antineoplastic medications must ensure *either* of the following:

- Financial requirements that apply to prescribed orally administered antineoplastic medications are not more restrictive than those that apply to intravenously administered or injected antineoplastic medications covered by the policy.
- The co-pay or coinsurance for orally administered antineoplastic medication does not exceed $250 per 30-day supply.[2]

An insurer cannot comply with these requirements by increasing ***cost-sharing requirements***, by reclassifying benefits with respect to antineoplastic medications, or by imposing more restrictive ***treatment limitations*** on prescribed orally administered antineoplastic medications or intravenously administered or injected antineoplastic medications covered under the policy. However, the bill does not prohibit an insurer from applying ***utilization management techniques***.

Cost-sharing requirement means deductibles, copayments, coinsurance, out-of-pocket expenses, aggregate lifetime limits, and annual limits.

Treatment limitation means limits on the frequency of treatment, days of coverage, or other similar limits on the scope or duration of treatment. Treatment limitation does *not* include the application of ***utilization management techniques***.

[1] *Antineoplastic* means inhibiting or preventing the growth and spread of tumors (*neoplasms*).
[2] Beginning January 1, 2026, this dollar amount must be adjusted annually to reflect the cumulative annual change in the prescription drug index of the medical care component of the U.S. Consumer Price Index.

Utilization management techniques includes prior authorization, step therapy (i.e., requiring certain drugs to be tried to treat a medical condition before other drugs are covered), limits on quantity dispensed, and days' supply per fill for any administered antineoplastic medication.

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BACKGROUND:

House Bill 4071 is a reintroduction of HB 4354 of the 2021-22 legislative session, as passed by the House of Representatives. Similar bills have been introduced each session beginning with the 2009-10 legislative session.

BRIEF DISCUSSION:

House Bill 4071 addresses what some see as unfairness in how health insurers provide coverage for oral anticancer medications and medications that are infused or injected. Anticancer medications that are infused or injected fall under the medical benefits of a health plan, while oral medications fall under the pharmacy benefits. In some health plans, the cost-sharing structure—the amount a beneficiary pays in deductibles, co-pays, co-insurance, and maximum out-of-pocket costs—can differ greatly between medical and pharmacy benefits. For example, many medical policies set a flat co-pay or, after an annual deductible is met, require a small percentage of the cost of an office visit or medical test, with an annual maximum cap on out-of-pocket expenses. On the pharmacy side, however, a plan may require coinsurance as high as 50% per drug with no annual out-of-pocket maximum. In the case of oral anticancer drugs, which can run in the tens of thousands each month, paying 20%, 30%, or 50% of a life-saving treatment per month is unattainable for many. Even if a plan does have a cap on annual drug costs, due to the high cost of anticancer medications, even one month's cost share may be too much for a patient to afford.

The bill would provide parity in how anticancer medications are treated. If a policy offered anticancer medications as a covered benefit, cost-sharing would have to be the same whether the medication was an infused or injected drug or one taken by mouth. The bill would thus refocus cancer treatment on the best therapy for the patient and the type of cancer the patient has, not on which anticancer medication the patient's health insurance covers is the most affordable.

Forty-three states and the District of Columbia offer some sort of cancer-drug parity. According to committee testimony, those states have seen negligible impacts on the cost of premiums while at the same time making oral cancer drugs more accessible. In many cases, oral cancer medications are less costly, and in some cases, an oral cancer drug may be the only treatment for a particular cancer or may be the standard treatment of care, being more effective than a more costly infused or injected drug. In addition, infused or injected chemo drugs can be harsh, with such debilitating side effects that patients may lose their jobs due to absenteeism. Because oral cancer drugs tend to be less toxic, patients often report fewer side effects than with the infused counterparts, meaning cancer patients are able to have a higher quality of life and can continue to work, care for their families, and live productive lives.

Not all believe that the bill is the right path to establish cancer-drug parity. For example, few Michigan residents would benefit under the bill. This is because most people with insurance are covered under large employer-sponsored health plans that are self-funded and therefore regulated under the federal Employee Retirement Income Security Act (ERISA) rather than the state Insurance Code. In addition, Medicaid, Medicare, and Tricare (health insurance for members of the military, retirees, and their dependents) are also not subject to Michigan's insurance laws. Reportedly, 65% of cancer patients are covered by Medicaid. With so few likely to benefit from the bill, opponents say a better approach would be to tackle the underlying structure of drug pricing and the way federal law first defined drugs as a medical benefit or a drug benefit when designing Part D for Medicare enrollees. Moreover, with drug prices across the board increasing annually, restricting how an insurer sets cost-sharing may have the greatest impact on small employers and individuals buying health insurance. Small employers are more likely than large employers to eliminate insurance for their employees, and individuals may find it difficult to maintain quality health insurance if premiums do eventually rise.

FISCAL IMPACT:

House Bill 4071 would not have any noteworthy direct fiscal impact on the Department of Insurance and Financial Services, which would be responsible under the bill for annually adjusting the maximum allowable co-pay or coinsurance for orally administered anticancer medication. This activity would likely be sufficiently supported by existing appropriations.

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