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PUBLIC STATEMENT
Submitted to

HOUSE INSURANCE COMMITTEE
The Honorable Anthony DeLuca, Chairman
The Honorable Nicholas Micozzie, Republican Chairman

Oral Chemotherapy Parity
House Bill 1865, Printer's No. 2466

March 18, 2010
Hershey, PA

Blue Cross of Northeastern Pennsylvania (BCNEPA) respectfully submits the following statement on House Bill 1865, Printer's No. 2466 for purposes of the House Insurance Committee's March 18, 2010 public hearing. House Bill 1865 would amend the Insurance Company Law of 1921 by requiring an insurer to provide coverage for orally administered (pharmaceutical) cancer chemotherapy and intravenously (IV) administered cancer chemotherapy on equal terms under group and individual health insurance policies. House Bill 1865 seeks to equalize all co-payments, deductibles, coinsurance provisions and maximum out-of-pocket expenses for insureds using either orally administered or intravenously administered anti-cancer agents. BCNEPA opposes House Bill 1865 for the following overarching reasons:

1. **Increases Patient Costs while Eliminating Individual Choice** - House Bill 1865 would remove customer choice with regard to plan design, in many cases potentially necessitating the purchase of higher cost coverage that, for certain patients, may not offer any meaningful financial benefit compared to what they would otherwise have had access to.
2. **Drives up Health Care and Premium Costs** – House Bill 1865 effectively eliminates the ability to utilize formulary to encourage the use of proven, cost-effective therapies—including generics. Removing this mechanism will result in more rapid growth of care costs, leading to higher premiums for all plan members.
3. **Discriminates on the Basis of Medical Condition and Treatment** - By establishing a legislative protection for cancer patients that doesn't exist for people suffering from other medical conditions, House Bill 1865 confers special status to one group and, effectively, denies equal protection to other groups.
4. **Sets a Dangerous Precedent** – House Bill 1865 would establish the dangerous precedent for the equal treatment of all pharmaceutical benefits and medical benefits—which have historically and consistently been understood to be different—under benefit design.

Oral and infused treatments are often dispensed in different settings, and as a result, intravenously-administered drugs are typically covered under a policy's medical benefits while orally-administered treatments are covered through the pharmacy benefit. There is an ill-conceived perception that cancer chemotherapy treatment through medical benefits can be less financially burdensome to the patient because members' financial responsibility rests solely on an office co-payment and contains a maximum limit on out-of-pocket expenses. The other misperception—arguably the genesis of House Bill 1865—is that cancer pharmacy benefits are a higher out of pocket cost alternative for all policyholders.

The reality is that House Bill 1865 will do little to diminish members' out-of-pockets costs by simply mandating parity between the cancer treatment options. Due to the choices in cost-sharing strategies and varying product benefit designs to meet the needs of our members, there are a variety of affordable prescription drug benefit and medical benefit options available. In the case of prescription drug benefits for chemotherapy, the out-of-pocket financial responsibility for a typical member covered under an individual or group policy at BCNEPA is minimal.

For example, most group members carry an average 3-tier prescription drug benefit co-payment of $15/$30/$50 with no additional cost sharing. A small portion of our group members, approximately 5%, have purchased a policy with a 20% coinsurance for prescription medications (typically with a $2500 member limit on these plans' out of pocket costs). Of BCNEPA's group customers, less than 1% of members are responsible for co-insurance and have no limit on out-of-pocket costs when purchasing prescription drugs presumably because this design offers a premium that is manageable for that consumer. Individual policies have similar designs and variations.

Throughout 2009, BCNEPA group policy members using orally administered chemotherapy incurred an average of $329 in total out-of-pocket costs for these drugs. For individual policy members, the average out-of-pocket cost for oral chemotherapy was $444. While these are the averages for BCNEPA's customers, there could be a scenario in which a member(s) face greater out of pocket costs. For example, if an employer or individual chose a

plan design in which prescription drug coverage was subject to a 20% coinsurance and a $200,000 annual out of pocket maximum, the individual or employee of that group could be responsible for out of pocket charges up to the $200,000 maximum. However, if that same member had no prescription drug coverage because the individual or employer did not have an affordable option, the total out of pocket responsibility for pharmaceutical chemotherapy--***and any other pharmaceutical***--would have no limit. It is important to note that this same scenario could describe an individual or employee receiving IV chemotherapy under a medical benefits plan with a 20% coinsurance.

Recent advancements in pharmaceutical research have led to innovative treatments for serious diseases, such as cancer, which are being used aggressively in clinical practice. This changing dynamic requires the health care industry to adapt to these ever changing treatment modalities. Particularly for the insurance industry, this means developing and structuring benefit designs to address both the medical and financial needs of customers. When considering cost sharing options, consumers evaluate the pros and cons associated with plans that have lower vs. higher cost sharing options. Generally, higher cost sharing translates into lower premiums while lower cost sharing requires higher premiums. Stated differently, the consumer makes the decision that a certain level of prescription drug coverage is appropriate for their particular circumstance.

BCNEPA's medical policies provide coverage for IV chemotherapy and most prescription drug benefit plans provide coverage for many of the chemotherapy pharmaceuticals. Depending on the policy—***chosen by the customer***—the cost sharing for IV chemotherapy and pharmaceutical chemotherapy will differ, just like any other medical benefit and pharmaceutical benefit differs. House Bill 1865 is troubling because the legislation is based on the misperception that individuals receiving chemotherapy in one setting pay exorbitantly greater out of pocket costs than individuals receiving chemotherapy in another. For BCNEPA customers, this is not true in most cases.

Although House Bill 1865 only pertains to chemotherapy treatment, the rationale of parity between medical and prescription benefits applies to any prescription drug coverage. For example, a person who receives a transplant must adhere to a strict prescription medication regimen post the transplant surgery. Using the rationale of House Bill 1865, the government is saying that all transplant medications should be subject to the same cost sharing as the surgery. Arguably, the rationale applies to any surgical procedure, disease, or other medical condition in which pharmaceuticals are prescribed. This is a dangerous precedent, but the alternative, as constructed under the proposed legislation, results in the equally undesirable outcome of effectively discriminating against those consumers who are not being treated for cancer, regardless of how equally serious their medical condition may be.

The unintended consequence of this public policy would to eliminate consumer choice. For instance, some customers will choose a low cost sharing medical benefits policy because the ***customer*** financially chooses to assume more risk for prescription drug coverage in order to at least obtain some level of coverage. In some cases, customers will choose such a model for economic reasons; i.e. it allows the customer to afford both a medical benefits and a prescription drug benefits policy. In many cases, customers choose high cost sharing alternatives because the premium is more affordable and the customer is able to secure coverage.

House Bill 1865 begs the larger public policy question of how medical benefits and prescription drug benefits are—and perhaps should be—structured. The market has evolved in such a manner that prescription drug policies are separate from medical benefit policies. Such a model provides for more consumer choice, but does create an environment in which some consumers may only have medical coverage or have medical coverage that is not "on par" with prescription drug coverage because of the various designs. While less than one percent of BCNEPA's group customers choose a prescription drug benefit with co-insurance and no limit on out pocket expenses, BCNEPA would prefer that the government, via House Bill 1865, not eliminate such an

option for these customers because of a misperception regarding the way oral chemotherapy and IV chemotherapy are treated.

BCNEPA applauds Chairman DeLuca and Chairman Micozzie for taking the time to hold a public hearing on this issue and encourages such diligence in further researching House Bill 1865. It is important that public policy makers take the necessary time to explore the issues—both intended and unintended—related to pharmaceutical oncology treatment, including an investigation into why such medication is so expensive creating a financial burden for individuals living with cancer. To that end, BCNEPA believes more research and discussion needs to take place on House Bill 1865. Based on BCNEPA's data demonstrating that most customers have minimal cost sharing for prescription chemotherapy, the problem that the legislation seeks to resolve appears to be overstated and the "quick fix" offered by House Bill 1865 is likely to have unintended consequences to the detriment of the consumer.