TESTIMONY ON HB 1865
Presented To

HOUSE INSURANCE COMMITTEE

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Presented by
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FOR

INDEPENDENCE BLUE CROSS

Good morning Chairman DeLuca, Chairman Micozzie and distinguished members of the House Insurance Committee. My name is Richard Snyder, M.D. I am the Senior Vice President and Chief Medical Officer for Independence Blue Cross (Independence).

Independence Blue Cross (Independence) provides health insurance coverage for over 2.6 million people in Southeastern Pennsylvania and has a longstanding history of providing individual and group health insurance policies with coverage for chemotherapy as described under the Act. While we understand the good intentions of H.B. 1856, we believe that the unintended impact of the "oncology parity bill" will be to raise the cost of care for our members suffering from cancer for the variety of reasons that we describe below.

While H.B. 1856 specifically addresses the member cost sharing features of individual and group health insurance policies it is important to also understand the relationship between medical and pharmacy benefits and how they are provided and used today.

Independence provides pharmacy benefits to nearly half of its members through a wholly owned pharmacy benefits management subsidiary, FutureScripts. Members with pharmacy benefits through FutureScripts have access to coverage for oral and self-injectible chemotherapeutic agents through their pharmacy benefits. Approximately half of the Independence members have pharmacy benefits through another independent pharmacy benefits management company, or do not have pharmacy benefits.

The medical benefits defined in the individual and group health insurance policies administered by Independence provide coverage to members for medically necessary covered services. For certain policies the benefits are filed with and approved by the Pennsylvania Insurance Department. The benefit design is selected by the individual or the group customer purchasing the coverage from Independence based on their selection criteria, which may include the need for affordability. Currently, the member cost sharing features of the individual or group health insurance policy, including the copayments, deductibles, coinsurance provisions and maximum out-of-pocket limits, vary based on the benefit design selected by the individual or group customer. In addition, the copayments, deductibles, coinsurance provisions and maximum out-of-pocket limits may vary based on the type of service, the place of service, whether or not the service is performed by a participating provider, and subject to the general limitations and exclusions of the policy.

Independence provides coverage for chemotherapy subject to medical policy and medical necessity based on the unique clinical circumstances of the member. The medical benefits defined in the individual or group health insurance policy purchased from Independence cover chemotherapy delivered by the provider regardless of the method of delivery.

However, oral and potentially self-injectible chemotherapeutic agents secured at a pharmacy are covered under the pharmacy benefit subject to the member cost sharing features of the pharmacy benefit contract, including the copayments, deductibles, coinsurance provisions and maximum out-of-pocket limits. As noted above, the pharmacy benefit contracts are separate from and cannot coordinate with the medical benefits on member cost sharing features including the copayments, deductibles, coinsurance provisions and maximum out-of-pocket limits.

Independence Blue Cross does not select or dictate the form of chemotherapy a patient is to receive. That decision is made by the prescribing physician. When a request for prior authorization for

chemotherapy is received from the ordering physician, Independence will first determine if the request is for a covered service under the terms of the individual or group health insurance policy. If the requested service is a covered service, then Independence will determine if the request is medically necessary. Independence will provide coverage under the individual or group health insurance policy for medically necessary covered services subject to the member cost sharing features of the medical benefit, including the copayments, deductibles, coinsurance provisions and maximum out-of-pocket limits.

If the ordering physician dispenses a prescription for an oral or a self-injectible chemotherapeutic agent, then the request will be considered under the pharmacy benefit by the applicable pharmacy benefit management company subject to the applicable member cost sharing features of the pharmacy benefit contract, including the copayments, deductibles, coinsurance provisions and maximum out-of-pocket limits. There is no coordination of member cost sharing with the medical benefit.

Individual and group health insurance policies have different member cost sharing features by type of service, place of service, and provider of service, for very good reasons. A well intended coordination of equalized member cost sharing features, including the copayments, deductibles, coinsurance provisions and maximum out-of-pocket limits might have the unintended consequence of raising the aggregate member out-of-pocket exposure.

H.B. 1856 as written will require significant time and cost to implement the necessary changes to existing systems and processes to administer the proposed benefit structure since this one condition will be managed differently from members with other similar chronic conditions that are not cancer. In some cases the same drugs will need to be handled differently when administered to a member with cancer than a member who has another chronic condition. Insurance premiums will increase to accommodate these transformational costs.

H.B. 1856 does not define whether "cancer chemotherapy" is inclusive of drugs needed to treat the potential side effects of cancer chemotherapy. Many of these drugs are very expensive and administered along with cancer chemotherapy. However, they are used for many unrelated conditions as well. If they are intended to be included, this will require additional system and process modifications, further inflating the cost of administering the mandate.

H.B. 1856 would increase insurance premiums by shifting costs from what were traditionally pharmacy benefit costs into the medical benefit. Pharmacy benefit management companies through their volume based purchasing power are able to provide medications at a lower cost than health plans. The potential unintended consequence of driving oral medication use from the pharmacy benefit to the medical benefit, initially for cancer and perhaps later for other conditions, will be to reduce the volume based negotiating power of pharmacy benefit management companies, ultimately leading to increased insurance premiums and increased profits for pharmaceutical manufacturers.

H.B. 1856 by requiring equal member cost sharing regardless of the method of delivery will likely increase the cost to the member. Today the copayments, deductibles and coinsurance are a reflection of the intensity and cost of services. Inpatient treatment often incorporates administration of chemotherapy in bundled rates subject to facility based cost sharing, which in the case of a participating facility may be minimal. Requiring an incremental "equalized" member cost share for the chemotherapy would subject members to copayments they do not have today. Outpatient facility based intravenous administration of chemotherapy frequently has greater costs and greater member cost sharing than

office based intravenous administration or oral administration. By requiring insurers to equalize member cost sharing, H.B. 1856 will result in a new "average" set of member cost sharing features including potential new incremental copayments for services delivered in a hospital inpatient setting; and definitely higher "average" member cost sharing in the form of copayments for oral chemotherapy.

H.B. 1856 by eliminating higher member cost sharing when care is provided by a non-participating provider could increase use of non-participating providers and would expose members to higher overall out-of-pocket costs related to the potentially large differences between actual charges and allowable charges on which member cost sharing is based. Non-participating providers may bill the member for the difference between the allowable charges and the actual charges, whereas participating providers agree not to bill the member for the difference.

In summary, the cost of care to our members will be adversely impacted by H.B. 1856, contrary to the intent of the authors.