Approved: May 3, 2010
Date

MINUTES OF THE HOUSE INSURANCE COMMITTEE

The meeting was called to order by Vice-Chairman Virgil Peck at 3:33 p.m. on March 18, 2010, in Room 152-S of the Capitol. This meeting is a reschedule from Tuesday, March 16, 2010.

All members were present.

Committee staff present:
Bruce Kinzie, Office of the Revisor of Statutes
Sean Ostrow, Office of the Revisor of Statutes
Melissa Calderwood, Kansas Legislative Research Department
Amanda Nguyen, Kansas Legislative Research Department
Sue Fowler, Committee Assistant

Conferees appearing before the Committee:
Senator Susan Wagle, District 30
Linda Sheppard, Kansas Insurance Department
Chris Masoner, American Cancer Society
Kim Olson, Stormont Vail Cancer Center
Kaye Yarrington, Individual
William W. Sneed, America's Health Insurance Plans
Brad Smoot, Blue Cross/Blue Shield of Kansas and Kansas City

Others attending:
See attached list.

Hearing on:
SB 390 **Regulating the use of genetic testing by insurance and health care entities; providing reimbursement for orally administered anticancer medications**

Melissa Calderwood, Kansas Legislative Research Department, gave an overview on **SB 390**.

Proponents:
Senator Susan Wagle, District 30, (Attachment 1), gave testimony before the committee in support of **SB 390**.
Linda Sheppard, Kansas Insurance Department, (Attachment 2), appeared before the committee in support of **SB 390**.
Chris Masoner, American Cancer Society, (Attachment 3), appeared before the committee in support of **SB 390**.
Kaye Yarrington, Individual, (Attachment 3), appeared before the committee in support of **SB 390**.
Kim Olson, Stormont Vail Cancer Center, (Attachment 3), presented testimony before the committee in support of **SB 390**.
Dr. James Hamilton, American Cancer Society, (Attachment 3), presented written testimony in support of **SB 390**.
Dr. Mark Fesen, Physician, (Attachment 4), presented written testimony in support of **SB 390**.
Dr. Gary Doolittle, KS Cancer Center Partnership & Kansas University Cancer Center, (Attachment 5), presented written testimony in support of **SB 390**.
Peggy Johnson, Kansas Cancer Partnership, (Attachment 6), presented written testimony in support of **SB 390**.
Katie Linden, Susan G. Komen for the Cure – Greater Kansas City and Mid-Kansas Affiliates, (Attachment 7), presented written testimony in support of **SB 390**.
Harley Headings, Farmer, (Attachment 8), presented written testimony in support of **SB 390**.
Michele Krier, Individual, (Attachment 9), presented written testimony in support of **SB 390**.
Pat Graf, Individual, (Attachment 10), presented written testimony in support of **SB 390**.
Ben Steinmetz, GlaxoSmithKline, (Attachment 11), presented written testimony in support of **SB 390**.
John Peterson, GlaxoSmithKline, (Attachment 12), presented written testimony in support of **SB 390**.
Lisa Covington, Individual, (Attachment 13), presented written testimony in support of **SB 390**.

Minutes of the House Insurance Committee at 3:33 p.m. on March 18, 2010, in Room 152-S of the Capitol.

Opponents:
William W. Sneed, America's Health Insurance Plans, (Attachment 14), gave testimony before the committee in opposition to **SB 390**.
Brad Smoot, Blue Cross/Blue Shield of Kansas and Kansas City, (Attachment 15), presented testimony before the committee in opposition to **SB 390**.
Marlee Carpenter, Kansas Association of Health Plans, (Attachment 16), presented written testimony in opposition to **SB 390**.

Hearing closed on **SB 390**.

Minutes:
Representative Grant moved without objection to pass the March 11, 2010 committee minutes as written.

Discussion and action on:
SB 388 Changing the effective date for NAIC rules relating to risk-based capital

Representative Brown moved to remove **SB 388** from the table (the bill was tabled on March 11, 2010). Seconded by Representative DeGraaf. Motion carried.

Representative Brunk made a motion to move **SB 388** out favorable for passage, as amended. Seconded by Representative Swenson. Motion carried.

HB 2474 Establishing the on-line motor vehicle financial security verification and compliance system

Representative Brown moved to amend HB 2474 with a balloon amendment. Seconded by Representative Olson. After discussion, Representative Swenson made a motion to table HB 2474. A vote was taken and a division was called for with an outcome of 6 in favor and 6 in opposition. Motion failed.

Representative Brown made a substitute motion to amend his prior motion, by striking subsection (c) on p. 4 of the balloon amendment presented and make related technical amendments [deleting the $1 fee, financing of the system]. The second to the original motion agreed to the amended motion. Motion carried.

Representative Brown then moved to strike the content of SB 260 and insert HB 2474, as amended, and create a substitute bill. Seconded by Representative Olson. Motion carried.

Representative Brown moved House Substitute for SB 260 favorably for passage. Seconded by Representative Olson. Discussion continued on the substitute bill. Motion carried.

Representative Swenson made a conceptual amendment to New Section 1 (balloon amendment, adopted by previous committee action) to provide that costs associated with the verification system, including development and maintenance, would be borne by the vendor . Seconded by Representative Neighbor. Motion carried. Discussion continued on the substitute bill. Representative Swenson moved a second conceptual amendment to strike references to an on-line verification system [vendor-specific language] in the substitute bill. Seconded by Representative Neighbor. Motion carried.

The meeting was adjourned at 5:45 p.m.

House Insurance Committee
Guest Sign In Sheet
Thursday, March 18, 2010

Name	Representing
Kaye Yarrington	Self
Michelle Butler	Capitol Strategies
Bill Sneed	NAIIP
Jamal Jones	United Health Group
Kevin Robertson	KS Dental Assn
Doyle Hanson	KS Ins

State of Kansas
Senate Chamber

Susan Wagle

First of all, I want to thank Chairman Shultz and the committee for your time and this opportunity to express support for the section of S.B. 390 that requires payment parity for cancer medications. I'm going to try to be brief and to the point. I authored this bill because the way we treat Cancer is evolving and changing. Cancer treatment technology is advancing and I believe we are close to a cure. As you probably know, we have had to deal with reoccurring cancers in my family on several occasions. My son Paul went through 2 ½ years of chemotherapy for acute lymphocytic leukemia at age 10, he relapsed at age 14 and spent 9 months in a crowded transplant ward in Ft. Worth, Texas getting a stem cell transplant. Paul spent Christmas of 04 in the hospital, while previous patients who had survived the transplant process stopped by to give Paul encouragement and to drop off Christmas presents. Four years later, in Christmas of 08, Paul and I called the hospital to tell them we wanted to visit the transplant kids and bring them presents. We talked to his past health care team who told us there were only 3 kids in the ward. It really wasn't worth our time to make the drive to Texas. This was the same stem cell transplant ward that just 4 years earlier was spending significant dollars adding over 50 additional beds to accommodate new patients. When I asked the Doctors what had happened, they said there had been so many advances in treatment products that they are now curing childhood leukemia during the first round of treatment and stem cell transplants for childhood relapsed leukemia are no longer necessary.

In my case, after being diagnosed with stage 4 Non Hodgkins Lymphoma in 1995, had I not had a targeted cancer breakthrough treatment called Rituxan made available to me on numerous occasions, that only kills cancer cells, I would not be standing here today, before this committee.

I consider many of the new pharmaceutical drugs that are being developed today to treat cancer as miracle drugs. They are target drugs that only kill cancer cells, leaving the patient in a healthier state of being with a stronger immune system. The problem with these drugs is that they are often costly and are covered under a pharmacy benefits package rather than covered as a traditional medical benefit. Insurance benefit designs have evolved over time to where intravenous/injected chemotherapy drugs are typically covered through a medical benefits package where cost sharing is lower, while

SENATOR 30TH DISTRICT
SEDGWICK COUNTY
4 SAGEBRUSH
WICHITA, KANSAS 67230

ROOM 221-E
STATE CAPITOL
TOPEKA, KANSAS 66612
785 296-7386

oral chemotherapy drugs are often covered through pharmacy benefits, where cost sharing is much greater for the patients, and often times, unattainable.

S.B. 390 demands payment parity. If an insurance plan covers I.V. therapy similar to an office visit, then they must also treat oral therapy in the same manner with the same deductible.

I have some friends who are going to testify against this bill. While we have been in agreement on many bills that have crossed our paths in the years we have worked in the State Capitol, in this situation, we are going to agree to disagree. You might hear today that S.B. 195 is a mandate. And, I would like to challenge that premise. According to KSA 40-4248, 2249 and 2249a, an impact study must be conducted prior to the legislature considering mandates as defined by these statues. In addition, any changes must first be effective in the State health care benefit program for a period of at least one year. I am pleased to report to you that the State employees' health benefits plan currently provides parity between oral and IV therapies. In addition, the three specific provisions of these statutes basically cover three situations:

1) Any bill that mandates health insurance coverage for specific services
2) Any bill that mandates health insurance coverage for specific diseases
3) Any bill that mandates health insurance coverage for certain providers or health care services

S.B. 390 does not fall under any of these categories and the data we will present complies with the spirit of those impact requirements. This bill does not mandate health insurance coverage for specific services or specific disease. It creates no requirement that cancer be covered by an insurance policy. It does not require that a pharmaceutical product be covered under an insurance plan. And it certainly does not mandate that any particular provider of health care services be covered. S.B. 390 is clearly not a mandate as set forth in our Kansas statutes. It is merely an attempt to provide payer parity within the current policy structure. The bill doesn't tell the plans how to provide such parity. That is left up to each individual plan or policy.

I ask that you give S.B. 390 serious consideration and pass it favorably on to the floor of the Senate.

Kansas Insurance Department
Sandy Praeger, Commissioner of Insurance

TESTIMONY ON
SENATE BILL 390

INSURANCE COMMITTEE
March 16, 2010

Chairman Shultz and Members of the Committee:

Thank you for the opportunity to testify today in support of Section 4 of Senate Bill No. 390, which amends K.S.A. 40-2259, the statute that sets out rules for insurance companies related to genetic testing and test results for their insureds. My name is Linda Sheppard and I am the Director of the Department's Accident & Health Division.

The existing version of K.S.A. 40-2259 became law in 1997. In May 2008, Congress enacted H.R. 493, the Genetic Information Nondiscrimination Act of 2008, which became effective for plan years beginning after May 21, 2009. Regulations implementing the provisions of the Act were made public on October 1, 2009. After reviewing the provisions of the federal Act and the related regulations, the Department introduced this bill in order to update our Kansas law to include some of the new consumer protections that were a part of the federal Act.

The proposed changes to K.S.A. 40-2259 include the addition of new subsections (b) (5) and (6), which clarify that insurance companies may not condition an individual's enrollment or premiums or subsequently adjust an individual's premiums based on whether the individual or a member of the individual's family had obtained a genetic test or the results of such a test.

House Insurance
Date: 3-18-10
Attachment # 2

The Department has also added some additional wording in the first paragraph of subsection (b) to clarify that the provisions of the statute apply to group policies and certificates of coverage, and individual policies.

I would be happy to stand for any questions you may have regarding this testimony.

Linda J. Sheppard, Director
Accident & Health Division, Kansas Insurance Department

American Cancer Society®

THE OFFICIAL SPONSOR OF BIRTHDAYS.™

TO: HOUSE INSURANCE COMMITTEE
REPRESENTATIVE CLARK SCHULTZ, CHAIR

FROM: CHRISTOPHER J. MASONER,
AMERICAN CANCER SOCIETY

KAYE AND STEVE YARRINGTON,
CANCER SURVIVORS

JAMES J. HAMILTON, JR. MD, FACS
VOLUNTEER BOARD MEMBER,
AMERICAN CANCER SOCIETY
STATE CHAIR, COMMISSION ON CANCER

KIM OLSON,
COTTON-O'NEIL CANCER CENTER

DATE: MARCH 16, 2010

RE: SB 390 – INSURANCE PARITY FOR ORAL CHEMOTHERAPY

LEGISLATIVE TESTIMONY ON BEHALF OF THE
AMERICAN CANCER SOCIETY

Representative Schultz, Members of the Committee, thank you for the opportunity to testify today regarding the issue of insurance coverage parity for oral chemotherapy medication.

The American Cancer Society supports SB 390 and the goal of providing insurance coverage for oral chemotherapy that is not less favorable than the coverage provided for IV chemotherapy. For background, I have attached a copy of an article from Medscape Today, dated May 7, 2009, which summarizes the dilemma faced by many cancer patients due to the disparate coverage provided to oral chemotherapy treatment compared

House Insurance
Date: 3-18-10
Attachment # 3

to IV chemotherapy and other forms of treatment. The key components of the Society's position are as follows:

- Fifteen to twenty percent of cancer patients will be diagnosed with a type of cancer where oral chemotherapy is the best and sometimes the only form of treatment.
- The emergence of clinically safe and effective, orally administered anticancer medication has significantly increased the treatment options for cancer patients. Many researchers and physicians expect the emergence and utilization of such treatment regimens will increase in coming years.
- In spite of successes there is often a significant cost barrier to patients when using orally administered chemotherapy.
- Chemotherapy that is administered intravenously is typically covered as a medical benefit which requires the patient to pay an office visit fee after all deductible obligations are met. On the other hand, orally administered chemotherapy is typically covered under a plan's pharmacy benefit where many of these drugs are placed on a 4th tier or specialty tier of a prescription plan's formulary. Drugs placed on these specialty tiers often require a high out-of pocket co-insurance rate for the patient.
- The American Cancer Society Cancer supports SB 390 because it will make out-of pocket costs for cancer patients equitable. In many cases there is no intravenous chemotherapy option. No one should be financially penalized for getting the "wrong kind of cancer" or for which an oral chemotherapy would produce the best patient outcome.

American Cancer Society®

THE OFFICIAL SPONSOR OF BIRTHDAYS.™

Testimony of Kaye and Steve Yarrington

My husband Steve was diagnosed with a glioblastoma, grade 4 tumor (malignant brain tumor) on March 2, 2009. He immediately had a craniotomy to remove the tumor and two weeks later his oncologist put him on Temadar, a chemo drug. He went to the pharmacy to pick up the prescription and was told that it cost $9,000 something for the 30 day supply, which he needed another 10 days worth, and it would be in later so that would cost several thousand more. Steve was so shocked that he told them to keep the drug and he would just go home and die. Our insurance coverage didn't cover the cost of this because it was a prescription drug, if it had been an IV chemo it would have been covered, but it was not available in IV form at that time. Our prescription coverage required us to pay the cost upfront and then be reimbursed for half the cost. There was no way we could pay this ungodly amount up front. Luckily for us the Cotton O'Neil Cancer Center worked very hard and was successful at finding funding to cover this drug and Steve was able to take his treatment.

American Cancer Society®

THE OFFICIAL SPONSOR OF BIRTHDAYS.™

Testimony of Dr. James Hamilton:

As another example, we provide the experience of Ms. Terry Henderson, a patient of Dr. Hamilton's. Terry has granted us permission to use her name and tell her story. She is working during committee testimony, and will not be able to attend the hearing.

Terry Henderson is a productive, working Kansan who has twice been diagnosed with breast cancer. She kept working through both of her mastectomies in order to keep her health insurance and support herself. She lost her husband to kidney failure several years ago. After her second diagnosis with breast cancer, her oncologist recommended therapy with an oral chemotherapy agent, Arimidex. Arimidex works by blocking the effects of estrogen on cancer cells. This agent was not covered by her insurance, and the cost of the drug was more than she could afford. Terry decided to have surgery to remove her ovaries (and their estrogen production) to decrease her risk that the cancer would come back, as this procedure was covered by her health insurance.

Terry underwent invasive surgery with attendant risks when insurance coverage for the oral chemotherapy agent, Arimidex, would have allowed her to afford the drug and avoid more surgery. Terry has already had both of her breasts removed as treatment of her cancer, and then decided to have her ovaries removed to reduce her risk of recurrence because her insurance would not cover the cost of oral chemotherapy that would have eliminated the need for surgery.

Oral chemotherapy treatments for cancer are lifesaving and often are cost-effective when compared to surgery or IV chemotherapy treatments. Insurance coverage for these drugs benefits all, and eliminates the need for patients to undergo more expensive surgeries and IV chemotherapy, when lower cost oral chemotherapy agents are safe and effective.

On behalf of all cancer patients with health insurance in Kansas, Terry Henderson, Dr. Hamilton, and the American Cancer Society strongly encourage your support for this Bill.

American Cancer Society®

THE OFFICIAL SPONSOR OF BIRTHDAYS.™

Testimony of Kim Olson:

My name is Kim Olson and I am a social worker at the Cotton O-Neil Cancer Center. I have been at the cancer center for 2 and a half years. I spend the majority of my time trying to help patient get their life-saving anti-cancer medications, which they cannot afford. When a patient is prescribed IV chemotherapy, there is usually no problem with cost or insurance coverage because the treatment is covered as a medical benefit. However, when the prescription is for oral chemotherapy medication, the patient faces a tremendous burden and significant costs—in addition to all of the familiar physical side effects of chemotherapy—because their insurance policy covers the treatment as a prescription drug benefit. Because of this distinction, patients often have a $200-2,000 out-of-pocket expense every month. There are programs to help patients with these expenses, but the requirements for obtaining assistance are complex and time-consuming. Meanwhile, the patient is waiting to get the medication they need to save their life. Ironically, for patients that do not have insurance, it is much easier because they will get free medicine and the process is much easier. It is the insured or underinsured where this is a problem.

Following is an example of the kind of story I deal with every day. Unfortunately, Ms. Gibbs is unable to attend today's hearing, but she does ask that you consider her written testimony:

> My name is Tammy Gibbs. On June 28th 2009, I was diagnosed with Stage IV Lung Cancer at the age of 46 with no signs or symptoms. I have 3 children ages 17, 22, & 30. At that time I had an in-home daycare business, which due to my health I had to close.
> Immediately I was started on a systemic treatment (IV treatment) for the first line of treatment. The IV treatment is covered under my major medical insurance, and I did not have any problems with the coverage or the payments. I went for treatment every 3 weeks for 6-8 hours at the Stormont Vail Cancer Center. After 6 months, my physician changed my treatment to Tarceva which is an oral prescription chemotherapy drug and not available in IV form. The up side of this chemotherapy drug is that I take it once a day, and not having to go every 3 weeks for IV treatment for 6-8 hours. The down side to this chemotherapy drug is my insurance prescription coverage only covers 50% and Tarceva is a very expensive drug. My monthly portion is something my family can't afford.

American Cancer Society®

THE OFFICIAL SPONSOR OF BIRTHDAYS.™

Myself along with the social worker at Stormont Vail Cancer Center has worked very hard for me to be able to get this drug, and we continue to work hard each month to be able to get my prescription.
Someone that is battling cancer that needs this type of treatment to possibly save their life should not have to battle to get their prescription filled each month.
Oral chemotherapy drugs should be covered under Major Medical just the same as chemotherapy IV infusions.
I ask you to consider a change to these guidelines of prescription coverage for oral chemotherapy drug treatment to be covered under major medical, the same way my IV treatment was covered.

Please consider all the families that are battling cancer and all that they have to go through without having to worry about getting their medication paid for each month.
Thank you for your time and consideration.

-Tammy Gibbs- Patient in need of coverage for Tarceva
785-273-1240

Mark R. Fesen M.D. F.A.C.P.
2609 N Linksland Dr.
Hutchinson, Kansas 67502

I have been practicing medical oncology in Hutchinson Kansas since 1993. I treat adult patients with all types of cancer from many counties in central and western Kansas. Patients who are fortunate enough to enjoy third party insurance are often surprised to learn the extent of their out of pocket share of the oral chemotherapy costs greatly exceeds their ability to pay.

Orally administered chemotherapy plays an increasingly crucial role in cancer treatment. Many of these agents have provided major advances in wide areas of cancer treatment. Oral chemotherapy agents, either alone or in combination with intravenous agents, are frequently used to treat many common cancers. These include lung cancer, breast cancer, chronic myelogenous leukemia (CML), colon cancer, pancreatic cancer, melanoma, brain tumors and others. Barriers exist to the adoption of oral chemotherapy agents.

Unlike costs associated with intravenous therapies, the expenses associated with oral chemotherapy need to be paid immediately, out of pocket, and before therapy starts. Furthermore these substantial costs can continue indefinitely. The cost of intravenous chemotherapy is covered by the outpatient portion of the insurance, while oral chemotherapy is covered under the prescription benefit.

Insurance policies where patients are required to pay a percentage of prescription drug costs can be the most challenging. Prescription plans where a patient pays 20-50% of the drug costs are prohibitive for most families. Oral chemotherapy agents frequently cost three to seven thousand dollars EACH month. Most patients are treated for an indefinite period of time. Other challenges are when patients are required to first pay the entire amount of the costs of the drug up front and then wait for reimbursement.

Cancer patients are immediately burdened with an overwhelming myriad of other out of pocket expenses including travel, many other prescriptions, deductibles and co-pay expenses. These expenses may occur at a time when the breadwinner can no longer work. Patients may be forced to consider other treatment options when resources are depleted.

Insurance policies create an artificial distinction between oral and intravenous chemotherapy that is absent in the reality of cancer treatment. To the cancer patient and physician, what matters is that the patient is able to receive the best, most effective treatment. My book is entitled: *Surviving the Cancer System*. Why have a system that develops world class oral chemotherapy drugs then allows families to buy insurance that doesn't help them receive it. Rarely, if ever, do employees think to ask: "How expensive is the co-pay for oral chemotherapy?", when they are contracting to buy the least expensive policy. Sadly, this loophole is only discovered when they are diagnosed. Patients who buy insurance that covers only 50% of a chemotherapy drug that costs $5000 per month will rarely receive any benefit.

I wrote a book that tries to allay the common fears that limit cancer treatment. Insurance policies that plan on high co-pays and up front charges for chemotherapy treatments worsen this cancer panic. Patients who are already upset about their cancer diagnosis are suddenly faced with a tragic decision. Try to imagine just being diagnosed with cancer, knowing that a medication is available that could help extend your survival, and being forced to decide between your health and life and your family's financial security. Patients have told me "I'm not worth that much money."

A recently released study, completed by researchers at Tufts Medical Center and at the University of Michigan found that 84% of oncologists considered their patients out of pocket expenses when recommending cancer treatment. Seventy nine percent of oncologists in the study said that they support further government research into the comparative effectiveness of different cancer drugs. Oncologists are also concerned that the professional payments associated with monitoring cancer treatment with oral chemotherapy agents fail to recognize the work that goes into monitoring the use of these complex drugs and are substantially underpaid.

One patient, a farmer suffering with metastatic melanoma, was initially successfully treated on a clinical trial. Later his cancer progressed. Temodar, an oral chemotherapy drug, was given by mouth at an out of pocket cost of six thousand dollars a month. Even though he and his wife both took out additional jobs, these monthly costs proved burdensome. The equivalent intravenous dose of Temodar that was later given costs two to three times as much. By using the oral version of Temodar the patient was able to limit his travel into the office and limit days off work.

The current bill starts the process to assist many Kansas residents afflicted with cancer. By creating parity between the reimbursement of oral and intravenous chemotherapy agents House Bill 390 will help many be able to start the treatment that they need.

KANSAS comprehensive cancer control & prevention

Kansas Senate Committee on Financial Institutions and Insurance

"SENATE BILL No. 390"

Testimony of
Gary C. Doolittle, MD
Chair, Kansas Cancer Partnership

Tuesday, March 16, 2010

Mr. Chairman and Members of the Committee, thank you for the opportunity to testify today about Senate Bill Number 390, which would require that insurance companies cover orally-administered anticancer medications on terms no less favorable than intravenously-administered or injected cancer medications. My name is Gary Doolittle. I come before you to offer several perspectives about this bill as chair of the Kansas Cancer Partnership, as a practicing medical oncologist, and as a cancer survivor.

The Kansas Cancer Partnership is a group that was tasked with developing a comprehensive cancer plan for Kansas, which was first published in 2005. One of the main goals of the Partnership is to provide access to care for all Kansans diagnosed with cancer. The bad news is that there are nearly 5,000 cancer deaths each year in our state; it is the second leading cause of death in Kansas. Fortunately, we know of many chemotherapy medicines that will cure or prolong life for patients diagnosed with cancer. Some of the newer oral chemotherapy agents result in a patient's cancer being cured or in his/her life being prolonged. Additionally, not only do these drugs generally afford patients prolonged lives, they typically offer them a better quality of life.

While most patients who are insured will be able to receive chemotherapy intravenously, we are still faced with a challenge. Many of these policies will not pay for oral chemotherapy agents, as the medical insurers often assert that it is the responsibility of the patient or the patient's prescription drug insurer to cover the cost of

such therapies. Some prescription drug policies pay for these oral agents, but many do not, primarily because these agents tend to be expensive.

For the cancer patient who does not have insurance coverage for these drugs, it is a struggle to get them. These patients either have to work with the drug company to provide the drug or find an alternative payer source. In the best-case scenario, the patient will ultimately be able to obtain the drug, but a delay in treatment remains inevitable, as it is a lengthy process to obtain these drugs without insurance coverage. Additionally, the process taxes the time and resources of the system. In the worst-case scenario, the patient will not get the drug, and he/she suffers an extended treatment delay.

I have talked about the perspective of the Kansas Cancer Partnership, and now I would like to address my perspective as a practicing oncologist. We are witnessing a change in the way we are developing drugs to combat cancer. Under the old model, we developed drugs that were designed to kill cancer cells. Under the new model, drugs are developed in a very different manner. Cancers are caused by genes that – when turned on/ off – will result in abnormal growth. These genes make proteins that actually cause the abnormal cancerous growth. Most of the modern day research in the cancer arena focuses on identifying these proteins and developing drugs to neutralize their activity, which essentially shuts down cell growth. Many of the new drugs – targeted drugs – work in this manner, and there has been a strong push to develop these agents in an oral formulation.

This is the wave of the future for the treatment of cancer. At the present time, over 125 new oral agents are in development or are being tested to treat cancer. Cancer patients need to have access to these medicines in the same way they have access to intravenous chemotherapies. In many cases, the oral agent is superior to the intravenous option. That leaves me, as a cancer doctor, in the position of prescribing a less than optimal treatment, which then leaves me asking, "Why?" The answer is because the oral agent is expensive, and intravenous medicine is paid for by the insurance company. Even more frustrating than that answer, is that sometimes the intravenous option is actually **MORE EXPENSIVE** than the oral preparation, but we forced to use the intravenous drug, since it is the only agent that the insurance company will cover.

As a cancer survivor myself, I can also speak on the perspective of the cancer patient. Patients living with cancer simply want to have the best treatment for their cancers. Again, sometimes oral agents **are the only FDA-approved treatments** for a given cancer. This is the case with both kidney cancer, which is what I was diagnosed with and treated for just last spring, and liver cancer.

The differences between intravenous drugs and oral agents also present a huge quality of life issue for patients. Oral agents can be administered at the patient's home, which results in no trips to the cancer center and no stays for intravenous infusions. Furthermore, side effects resulting from oral agents tend to be milder than those from

intravenous options. In addition to harsher side effects with intravenous therapies, patients are faced with challenges when having intravenous treatment; such treatment requires that an IV be established and that indwelling catheters be placed, and both procedures introduce risks for infection and clotting.

Patients are also oftentimes faced with a huge financial burden related to their cancer treatment. Some of these agents cost thousands of dollars a month. Some of the associated co-pays force patients to choose between receiving the treatment they need or impoverishing their families, and that's a choice no one should have to make.

Another key point to keep in mind is that patients are vulnerable! The diagnosis of cancer is devastating. I have seen – both on the giving and receiving end – that a diagnosis of cancer can be extremely frightening and extremely isolating for the patient. After receiving such a diagnosis, people do not function at their best. By making it difficult to access the drugs they need, we add to the tremendous strain with which patients are already trying to cope. Furthermore, the majority of patients do not know much about their personal insurance policies; they generally have no idea about what is covered and what is not covered. As a physician, one would think I would be informed about my personal policy, right? Wrong! When I was diagnosed last spring, I had to look up to see what was covered and what was not. Fortunately, I have great insurance and was not faced with many of the challenges facing other cancer patients these days. While I was fortunate, it is not alright that so many other cancer patients are not. We must do something right now to change the way the system currently covers anticancer medications, specifically orally-administered ones.

Thank you for allowing me the opportunity to share these three perspectives with you. In my opinion – as chair of the Kansas Cancer Partnership, as a practicing medical oncologist, and as a cancer survivor – it is imperative that insurance companies be required to cover orally-administered anticancer medications on terms no less favorable than intravenously-administered or injected cancer medications.

Kansas House of Representatives
Insurance Committee

Testimony Provided by
Peggy L Johnson
Public Policy Chair
Kansas Cancer Partnership

Tuesday, March 16, 2010
Written Testimony for SB 390

Chairman Shultz and other members of this committee, my name is Peggy Johnson, I am Executive Director/COO for the Wichita Medical Research and Education Foundation located in Wichita. I am here today representing the Kansas Cancer Partnership for whom I serve as the Public Policy Chair. The Kansas Cancer Partnership supports the passage of Senate Bill 390.

The Kansas Cancer Partnership is a group of approximately 200 individuals from institutions, clinics, county health departments, large and small hospitals, organizations and advocacy groups who have worked together to develop a coordinated and comprehensive plan, the Kansas Comprehensive Cancer Control and Prevention Plan. The plan addresses the burden of cancer on Kansas citizens, families, communities and the government and provides the framework to reduce cancer incidence, morbidity and mortality in the state through prevention, early detection, screening, treatment and survivorship. The Plan was completed and published in March 2005.

According to the Kansas Cancer Registry for 2006 more than 13,000 Kansans were diagnosed with invasive cancer. One very important part of the Kansas Comp Cancer Plan is access to quality cancer care in Kansas. This sounds reasonable; unless you live in the northwest, the southwest, the north central or the southeastern regions of Kansas. I am sure each of you, but especially those of you from rural districts, understand the uphill struggle rural Kansans have in finding health care in their home communities. If you compound that difficulty with a diagnosis of cancer the burden can become exhausting.

Access is a multi-layered subject. Access is the ability to determine with your oncologist the best possible treatment option for your cancer diagnosis. But it is also access to the treatment option of your choice and not limited by your health care coverage. Making access to oral chemotherapy drugs equal to the access to intravenously injected drugs by your healthcare insurer is very important. It becomes not just an issue of access but a financial one. It can be a two layered problem.

If you are a farmer living outside Canton, Kansas and you are diagnosed with brain cancer, what are your options? Today one of the best treatments for your type of cancer is an oral chemotherapy drug. It has few side effects and you take it at home.

There are no daily or weekly long drives to a treatment center, no four hour treatment regiments, and none of the other side effects associated with intravenous chemotherapy. But more than likely this oral drug will not be covered by your health insurance. Or if it is your portion of the cost will be staggering.

I believe most of us don't really understand what our health insurance will cover until there is a crisis. I ask you, all of you, do you know what will be covered by your health care policy if you are diagnosed with cancer tomorrow?

I took the test. I have good insurance, not great, but good. I am the Executive Director and I make those decisions about our insurance. In preparing this testimony, I took out my policy and I tried to figure out how I would be covered for cancer. I read the whole thing.

Here is what I found. Under Covered services, part b. Chemotherapy (chemical treatment) for malignant conditions. (1) Your Doctor's services for administering chemotherapy. (2) The chemotherapy drugs that are injected or given intravenously or taken by mouth and under the direct supervision of Your Doctor. Prescription Drugs for chemotherapy are covered under the health benefits section of this coverage only if **You** are ***not enrolled*** in prescription drug coverage.

I called my carrier and asked some questions. They couldn't tell me if most chemotherapy drugs were included in my prescription rider, they also told me the list is constantly changing. I then asked, 'What if my drug isn't on the list?' The polite young man hesitated and then answered 'we won't pay for it.' I asked 'any of it?' To which he answered 'no.'

When I made the decisions about our health care coverage for this year, I guess I decided not to have cancer this year, and none of my employees can have cancer. We need the prescription drug coverage because I have two diabetics working for me and they need the prescription coverage. We can't have cancer.

Equal access to oral medications for the treatment of cancer shouldn't be a financial decision. It should be the decision of the patient and their physician based on the best treatment options for their cancer.

If you talk to any cancer researcher their dream is to develop a pill to deliver all future cancer drugs. They have less toxicity, easier to administer, less follow up, and less patient morbidity. The cancer pill of the future is finally showing up. We need to be able to make these new therapies available to patients.

Medical debt is the number one cause of bankruptcy in Kansas. We can't allow more of our hard working citizens to face decisions about their cancer treatment based on their ability to travel for treatment or the financial burden it will place on their family.

The Kansas Cancer Partnership strongly encourages you the fill in this loop hole and take access to treatment and financial concerns out of what is an already stressful situation for your constituents. Please support Senate Bill 390.

On behalf of the 200 members of the Kansas Cancer Partnership I thank you for this important opportunity to provide this testimony.

Respectfully yours,
Peggy L Johnson
Public Policy Chair
The Kansas Cancer Partnership

SUSAN G. KOMEN FOR THE CURE® **Kansas Affiliates**

Kansas House Committee on Insurance

"SENATE BILL No. 390"

Testimony of
Katie M Linden
Board Member
Greater Kansas City Affiliate Susan G. Komen for the Cure®

Tuesday, March 16, 2010

Mr. Chairman and Members of the Committee, thank you for the opportunity to testify today about Senate Bill No. 390, which would require that insurance companies cover orally-administered anticancer medications on terms no less favorable than intravenously-administered or injected cancer medications. My name is Katie Linden, and I am a Board Member of the Greater Kansas City Affiliate of Susan G. Komen for the Cure®. I testify today on behalf of both the Greater Kansas City and Mid-Kansas Affiliates, which together represent the entire state.

Cancer is a national and state epidemic. In 2009 alone, almost 1.5 million people in the U.S. were diagnosed with cancer and 560,000 died. In Kansas, more than 13,000 new cancers were detected and more than 5,000 people died. Some 2,200 women in Kansas are diagnosed with breast cancer each year, and 370 lose their battle with the disease.

Komen for the Cure is the world's largest grassroots network of breast cancer survivors and activists fighting to save lives, empower people, ensure quality care for all and energize science to find the cures. Thanks to events like the Susan G. Komen Race for the Cure® Series, Komen has invested almost $1.5 billion to fulfill our promise, becoming the largest source of nonprofit funds dedicated to the fight against breast cancer in the world, and Komen will invest another $2 billion over the next decade into cutting-edge research and community programs.

In Kansas, the Greater Kansas City and Mid-Kansas Affiliates have granted over $6.1 million into Kansas communities to cover local breast health education and breast cancer screening and treatment programs. This includes over $2 million in grant funds to the State of Kansas' Early Detection Works program — which provides potentially life-saving breast and cervical cancer screening and diagnostics to the state's low-income and uninsured and underinsured women — equaling over 26,000 mammograms for uninsured and underinsured women in Kansas.

SENATE BILL No. 390

The Komen Kansas Affiliates support Senate Bill No. 390. We believe health decisions should be made between a patient and her doctor. These decisions will depend on many factors such as age, type of cancer and the characteristics of the cancer; deciding on a particular treatment option is as much a personal matter as it is a medical one. Treatment decisions should not have to be based on financial factors; the decision should always be based on what is best for the patient. In addition, persons with

1148 S Hillside, Suite 11 Wichita, KS 67211
316-683-8510 | www.komenmidks.org and www.komenkansascity.org

cancer should be protected from high out-of-pocket medical costs that could lead to financial hardship and even bankruptcy. Medical debt is the number one cause of bankruptcy in the state of Kansas.

Chemotherapy is the use of anti-cancer drugs to kill or disable cancer cells. It is a treatment option for many types of cancer, but it is used differently depending on how advanced the cancer is. Chemotherapy drugs can be taken orally by pill or capsule, or injected intravenously. Typically, a combination of two or three chemotherapy drugs is used. Intravenous drugs must be given in a hospital or physician's office.

The emergence of safe, clinically effective oral chemotherapy has significantly increased the treatment options for cancer patients. According to the National Comprehensive Cancer Network, some 400 anticancer medications are currently under development and about 25 percent of them are intended as oral anticancer medications, which will be used to treat 52 different types of cancer. The most frequently prescribed oral medications are used to treat breast, ovarian, endometrial, and uterine cancers. In discussions with local researchers, we also have learned that oral chemotherapy drugs are expected to be the main source of anti-cancer drug in the future. While oral chemotherapy is available and will become an even more prevalent treatment option in the near future, there are many barriers that impede the use of this treatment option.

There can be a significant difference in the amount cancer patients pay out of pocket for an oral drug and how much they pay for an intravenous product. Intravenous therapies are traditionally covered under a medical benefit, under which most patients are only responsible for an office copayment for each visit and are not required to pay a separate fee for the intravenous drug. By contrast, oral chemotherapy is generally covered under a prescription drug benefit, which tends to have higher copayments or no coverage at all.

Oral chemotherapy drugs can be extremely expensive. And because of oral chemotherapy's higher levels of cost sharing, patients may be exposed to very high out-of-pocket costs. While some copayments have remained low, particularly for generic drugs, some cancer patients face out-of-pocket costs of hundreds or even thousands of dollars a month.

We strongly believe that a health plan that provides coverage for cancer chemotherapy treatment should not require a higher co-payment, deductible, or coinsurance amount for a prescribed, orally administered anticancer medication than what is required for an intravenously administered or injected cancer medication, regardless of formulation or benefit category determination by the health plan. We support efforts by the state to require health insurance plans to provide coverage for oral cancer drugs on terms no less favorable than the coverage provided for intravenously-administered chemotherapy. At the same time, we must ensure that in adopting this policy, health insurers are not allowed to reduce benefits for intravenous therapies.

Other states are leading the way. Already, Oregon, Indiana, Iowa and Vermont passed oral chemotherapy parity legislation, and legislation is pending in a number of other states.

Access to Quality Cancer Care and Quality of Life for Cancer Patients

Eighty-eight of the 105 counties in the state of Kansas are considered Rural or Frontier. Individuals in Rural and Frontiers areas experience significant barriers to accessing healthcare, let alone quality healthcare. The American Academy of Family Physicians, states, "At least two in five residents in Alabama, Alaska, Florida, Kansas, Mississippi, Missouri, Oregon, South Carolina and Utah have inadequate access to basic health care".

Provider surveys conducted by the Mid-Kansas Affiliate provide a fair overview of programs and services available throughout our service area. The size of the Affiliate's service area made this a difficult task as many of the communities and counties had few, if any, services available for breast cancer screening and treatment. Many communities rely on small county health departments, local clinics, civic

organizations and churches as their only resource for breast health awareness activities. Through the provider surveys and previous grant applications, the Affiliate recognized there are services available, but the distance between services and number of services available creates a significant barrier to Kansans trying to gain access to quality healthcare.

Oral chemotherapy provides several benefits to cancer patients resulting in an overall increase in quality of life; it may allow administration of the medication on a daily basis, may be more convenient for patients (takes away the need to drive long distances and/or schedule time away from work/family) and may reduce the risk of infection or other infiltration complications.

Conclusion

The Greater Kansas City and Mid-Kansas Affiliates of Susan G. Komen for the Cure support Senate Bill No. 390. We support efforts at the state and federal level to require group and individual health insurance coverage and group health plans to provide coverage for oral cancer drugs on terms no less favorable than the coverage provided for intravenously-administered chemotherapy. At the same time, we must ensure that in adopting this policy, health insurers are not allowed to reduce coverage for intravenous therapies.

For more information, contact Christina Osbourn (Mid-Kansas) at 316-683-8510 or cosbourn@komenmidks.org OR Lori Maris (Greater Kansas City) at 816-842-0410 *or lmaris@komenkansascity.org.*

hutchinson CLINIC
Setting a gold standard for 50 years.

March 15, 2010

Do Whom It May Concern:

I, Harley Headings, as a 59 year old farmer with melanoma cancer.

I purchased KHIA insurance in January 2009. I was started on Temador intravenously at a cost of $20,000 plus clinic costs for the infusion. In June we switched to oral Temador, same strength, so I could take the pills at home rather than 5 daily trips per week to the clinic.

The oral chemotherapy cost $3,200 for the 5 day treatment, which was every 4 weeks. I was required to pay up front for this medication and then get reimbursed by KHIA. I feel the oral chemotherapy should be covered by insurance because it is cheaper and much more convenient to take at home.

Sincerely

Harley Headings

2101 N. Waldron Hutchinson, Kansas 67502 620.669.2500
TOLL FREE: 1.800.779.6979 FAX: 620.669.2501

House Insurance
Date: 3-18-10
Attachment # 8

Written Testimony for Kansas House of Representatives
Insurance Committee
in Support of Senate Bill No. 390

Michele Krier
Ashland, Kansas
620-635-2241

Chairman Shultz and Members of the Committee:

Good morning. My name is Michele Krier, and I live in Ashland, Kansas. Thank you for taking the time today to read my testimony in support of Senate Bill No. 390. Unfortunately, due to my current health condition and work schedule I was unable to make the five hour drive to Topeka to testify before you in person, so I thank you again for taking the time to read my story.

At the age of 47, I was doing a self-breast exam when I found a lump. After a mammogram and MRI, three spots of cancer were found, including the 2.5 cm lump I felt. On November 2, 2009, at the age of 48, I was diagnosed with breast cancer (Happy Birthday, Michele). I had a bi-lateral mastectomy and am currently undergoing intravenous chemotherapy treatments. I drive approximately 80 miles (1.5 hours) to Pratt, KS for all of my cancer-related appointments and treatments. I drive the three hours (round-trip) to get chemotherapy every two weeks and am having to the drive every couple of weeks for additional appointments, as well, including a CT scan in upcoming months.

Without talking with my doctor, I am unsure if oral chemotherapy would have been the appropriate treatment option for me, but I strongly believe that this should be an equal option for all cancer patients, especially those living in rural communities like myself.

If I were able to take oral chemotherapy (vs intravenous chemotherapy) there are several burdens that could be lifted. Due to having to drive three hours to get treatment, I am unable to finish my workday. I actually feel pretty decent the day I receive treatment, so if I were able to take treatment locally, possibly even in the form of a pill, I wouldn't have to take so much time off work. Driving 80 miles just about weekly is financially burdensome, as well. While I am not extremely strapped for cash, I am having to pay for very expensive medications such as Neulasta ($5,300), which is absolutely necessary. I HAVE to pay for this, so I'd rather not have to be wasting money on gasoline. (Neulasta is a prescription medication used to prevent infections in people undergoing certain kinds of chemotherapy. Many types of chemotherapy increase the risk of dangerous infections, and Neulasta can help prevent such infections). I believe the biggest burden is when I have to burden others. When going to receive my Taxol (chemotherapy) treatments I am not going to be able to drive myself. Therefore, I am going to have to ask others to take a full day to drive me to treatment, stay with me, and drive me home from treatment. Almost everyone I know works, so not only am I having to take off work, but they are as well. I am very blessed that I have such a great support system, but I don't know what others would do if they didn't have the same community I do.

The reason I wanted to share my story was for you to hear directly from someone battling breast cancer and undergoing intravenous chemotherapy to help you understand that there is a true access to care barrier in so many Kansas communities, including my own. The idea of all of the time, money, and anxiety I could save from being able to take a pill [oral chemotherapy] is extremely appealing; however, I do not think it is fair to us cancer patients that insurance companies do not treat it equally as intravenous chemotherapy. I feel very strongly that insurance companies should be required to have chemotherapy options on a level playing field so that patients in situations like myself aren't forced to make treatment and quality of life decisions based on our health plan or the cost of the alternative choice.

Testimony before the Kansas House of Representative
Insurance Committee
in Support of Senate Bill No. 390

Pat Graf
Ashland, Kansas
620-635-0582

Chairman Shultz and Members of the Committee:

Hello and thank you for taking the time today to read my testimony in support of Senate Bill No. 390. Unfortunately, I am currently undergoing chemotherapy, so I was not able to make the drive to Topeka to testify before you in person today. I appreciate you taking the time to read my written testimony in place of a verbal testimony.

My name is Pat Graf. I have lived in Ashland, Kansas for about thirty years. I am happily married and am the proud mother of four boys.

One day I found myself having pain in my right breast. At first I thought that maybe I had just bruised myself somehow but after a little while it became very apparent that it must be something more. It was at that point that I actually gave myself a breast exam and found a noticeable lump- probably about the size of a quarter. I immediately made an appointment with a local women's health physician who recommended I go to Oklahoma City (four hours away) for testing. After several images and a biopsy, on March 7, 2009, at the age of 64, I was diagnosed with breast cancer. I was in complete denial and shock. Usually pain in the breast is actually not associated with cancer, so I really didn't think I was going to have cancer. I didn't even want to tell my husband; I thought I was going to be fine. That was obviously not the case.

The closest oncologist was an hour and half away- either in Pratt or Dodge City. I chose to see an oncologist in Pratt and have been going there ever since for my cancer-related appointments and treatment. I had a lumpectomy and had 11 sentinel nodes removed (three of them cancerous which was not good news). For the past nine months I have been receiving intravenous chemotherapy every Wednesday in Pratt, and I have yet to know when it will end. I am sick of it.

Every Wednesday, I have a three hour round trip drive to Pratt to receive my treatment. The minimum amount of time taken out of a day for treatment and travel has been about four hours and the maximum about eleven hours. At first I didn't have any problems driving myself but that didn't last long. Now I need someone with me all the time. My husband (City Manager) has to take off work every Wednesday to take me to get my treatment. And, my work situation, well that's another story. The chemotherapy has caused issues with the nerve endings in my feet and hands so I have had to stop working. Luckily, I work for an attorney in town who has been extremely kind and has let me take the time I need, so I haven't technically lost my job... but that's definitely not helping our financial situation.

Learning more about oral chemotherapy, I would be extremely interested in this treatment option, if I were to go through this all over again. It is so financially and time burdensome to have to drive so far to get treatment, especially since I can't work right now. Gas is expensive these days! However, I am very concerned that even if I wanted to chose oral chemotherapy for my treatment, I might not be able to because of the extreme out of pocket costs I have heard about. I believe that IV chemotherapy and pills (chemotherapy) should be equal options in all regards. This must be changed so that cancer patients like myself aren't making quality of life decisions based on the cost of treatment due to our health plans.

I hope my story has given you some insight into what it is like to be living with cancer in southwest Kansas. It's not easy battling cancer, and it makes it even worse when you having to travel to get care, burdening others in the process. Thank you for taking the time to read my story. I hope you are able to make a difference in how health insurance plans are structured so that this great new opportunity can be taken advantage of by all.

House Insurance Committee
Testimony in Support of SB 390
Ben Steinmetz's Testimony on Oncology Parity
March 16, 2010

Good afternoon, I'm Ben Steinmetz, VP Policy and Payer Insights for GlaxoSmithKline's oncology area. I have been involved in oncology R&D and commercialization for over 20 years.

GlaxoSmithKline is a pharmaceutical company that manufactures, markets, and is developing intravenous/injected and oral chemotherapy drugs.

I want to speak to you today about:

1. A brief overview of cancer treatment and new advancements such as targeted therapies
2. Contrast medical versus pharmacy coverage
3. Financial considerations of parity for patient oral/iv out-of-pocket

The central objective of patient out-of-pocket parity for anticancer agents is about access to the most beneficial agent(s) as determined by physician and patient, taking into account efficacy, safety, compliance and other factors; but eliminating the patient out-of pocket disparity between formulations.

- Parity is less about the relatively few agents that have both intravenous and oral forms;
- Parity is about access to (oral) medications for which there may be no equally appropriate or clear clinical substitute.

Cytotoxic chemotherapy is generally regarded as the administration of cytotoxic "poisons" which, unfortunately, indiscriminately affect both normal and tumor cells with the hope that the drug kills more of the rapidly dividing cancer cells than the normal healthy cells.

- Cytotoxic chemotherapy is administered in doses which, can lead to substantial toxicities including life-threatening infections, heart failure, nerve damage, mucositis, and sometimes death
- Following administration of cytotoxic chemotherapy, it generally takes a patient 1-3 weeks to recover from the toxicities before beginning a new cycle.
- This episodic administration of cytotoxic chemotherapy lends itself to intravenously administered agents, although some of these agents are available for oral administration.

Scientific advances are helping us selectively target tumor cells and deliver agents that interfere with cell survival and/or reproduction in a different way than cytotoxics, these are the so called "targeted agents."

- These targeted agents generally require continuous exposure to the medication for which oral administration is well suited,
- It is important to recognize that these targeted agents are not themselves devoid of toxicity and toxicity associated with orals can also be substantial.

Often a pharmaceutical manufacturer has no/little choice in formulation, e.g. IV or oral. For example, large protein agents must be given by infusion or injection, if taken orally they get destroyed in the stomach. Other agents are just not practical to make as IV given their pharmaceutical properties.

- There are very few anticancer agents where both oral and intravenous forms are available.

- Nevertheless, with the scientific advances in targeted therapy, we can anticipate an increase in the number of oral anti-cancer agents becoming available.

Unfortunately, there can be a notable disparity in the patient out-of-pocket cost (coverage) as a function of whether a treatment is administered by infusion and covered as a medical benefit with typically an office visit co-pay or co-insurance with a cap, or taken as oral medication at home and covered as a pharmacy benefit, where there can, in some circumstances, be co-insurance costs of 25%-33% or more, often without an out of pocket cap that many plans have for medical costs.

A bill calling for parity in patient out-of-pocket costs regardless of route of administration was passed in Oregon and several other states. As a result of these laws, many have asked what is the "cost of parity?"

There are a number of considerations for determining the cost of parity, including:

1. Shifting of patient out-of-pocket (OOP) costs back to the plan
2. Potential for increased utilization of oral anti-cancers as consequence of lower patient OOP
3. Potential for decreased utilization of IV therapies (and administration fees) if replaced by orals
4. Plan administration costs to implement parity.

GlaxoSmithKline commissioned Milliman to develop and author a whitepaper to help quantify the cost of parity in a commercial population.

GlaxoSmithKline provided oncology disease state and treatment expertise, background information on iv/oral chemotherapy treatment paradigms, information on the current status of oral/iv parity legislation, and the general editing of these sections in the whitepaper. I think Ken was ok with us putting a period after "paradigms." This language really does imply that we wrote the report which is not true.

Milliman, Inc. is a leading source of health actuarial expertise to insurance industry and is well-respected among State Insurance Departments and State Health Departments.

Milliman's analysis concluded that for most benefit plans, parity will cost under $0.50 Per Member Per Month (PMPM), which compares to a typical commercial plan cost of over $300 PMPM for all benefits.

- However, there are literally thousands of benefit design variations, and plan design features can affect parity costs. Milliman found that parity for some plan designs with very high cost sharing for oral specialty drugs and low cost sharing for medical benefits could cost about $1.00 PMPM, or, in unusual circumstances, more.
- Parity for other plan designs that have low overall cost sharing could cost as little as $0.05 to $0.10 PMPM.
- These figures did not include plan administrative costs.
- Importantly, Milliman estimates also include elasticity in demand, -- that as out-of-pocket costs become lower for oral anti-cancer agents, there will be increased usage.

A remaining question is that of the relative cost of IV and oral anti-cancer agents. The FDA has approved 41 new anticancer drugs between January 2000 and January 2010 including 18 IV and 13 oral medicines. Because these agents rarely have identical indications, a direct drug-to-drug comparison is difficult. Another approach is to look at the cost in aggregate, meaning, the average monthly cost of the 18 IV agents compared to the average monthly cost of the orals. This comparison, using the wholesale

acquisition cost[i] indicates a monthly cost of the 18 branded IV drugs of $12,830. The average monthly cost of the 13 branded oral drugs is $5,699.

I hope I have left you with an appreciation of the potential advances in systemic cancer therapy and that many anticancer drugs are available as either an oral or an iv but rarely both, an understanding of the "disparity" in patient out-of-pocket costs as a function of where treatment is administered, and a better appreciation of the financial implications of parity.

---

[i] Wholesale Acquisition Cost (WAC) is the listed price to wholesalers and warehousing chains, not including prompt pay, stocking or distribution allowances, or other discounts, rebates or chargebacks. Listed price may not represent prices charged to other customers, including specialty distributors.

JOHN C. PETERSON
CAPITOL STRATEGIES, LLC
SUITE 200, 212 SW 8TH AVENUE • TOPEKA, KANSAS 66603-3939 • (785) 233-1903 • FAX (785) 233-3518 • john@kansasstatehouse.com

March 16, 2010

Representative Clark Shultz, Chair
House Committee on Insurance
Statehouse
Topeka KS 66612

RE: Impact Study—SB 390

Dear Chair Shultz:

Thank you for the opportunity to have hearings on Senate Bill 390, legislation that would provide for the availability and reimbursement for oral anti-cancer drugs under terms no less favorable than those that are covered for IV and injected cancer medications.

Senate Bill 390 does not propose any mandate as specified in those laws, K.S.A. 40-2248 et seq. (see attached). Nevertheless, in the spirit of that legislation, I am attaching for you and for each Committee member a study of the recently released Milliman impact study regarding Parity for Oral and Intravenous/Injected Cancer Drugs.

Again, thank you for the opportunity to provide information concerning this important legislation.

Respectfully submitted,

John C. Peterson
GlaxoSmithKline

Enclosures

House Insurance
Date: 3-18-10
Attachment # 12

40-2248

Chapter 40.–INSURANCE

Article 22.–UNIFORM POLICY PROVISIONS

40-2248. Mandated health benefits; impact report to be submitted prior to legislative consideration. Prior to the legislature's consideration of any bill that mandates health insurance coverage for specific health services, specific diseases, or for certain providers of health care services as part of individual, group or blanket health insurance policies, the person or organization which seeks sponsorship of such proposal shall submit to the legislative committees to which the proposal is assigned an impact report that assesses both the social and financial effects of the proposed mandated coverage. For purposes of this act, mandated health insurance coverage shall include mandated optional benefits. It shall be the duty of the commissioner of insurance to cooperate with, assist and provide information to any person or organization required to submit an impact report under the provisions of this act.

History: L. 1990, ch. 162, § 1; July 1.

40-2249a

Chapter 40.–INSURANCE

Article 22.–UNIFORM POLICY PROVISIONS

40-2249a. Same; state employee group pilot project for new mandated health benefits. (a) After July 1, 1999, in addition to the requirements of K.S.A. 40-2248 and 40-2249, and amendments thereto, any new mandated health insurance coverage for specific health services, specific diseases or for certain providers of health care services approved by the legislature shall apply only to the state health care benefits program, K.S.A. 75-6501, *et seq.*, and amendments thereto, for a period of at least one year beginning with the first anniversary date of the state health care benefits program subsequent to approval of the mandate by the legislature. On or before March 1, after the one year period for which the mandate has been applied, the Kansas state employees health care commission shall submit to the president of the senate and to the speaker of the house of representatives, a report indicating the impact such mandated coverage has had on the state health care benefits program, including data on the utilization and costs of such mandated coverage. Such report shall also include a recommendation whether such mandated coverage should continue for the state health care benefits program or whether additional utilization and cost data is required.

(b) The legislature shall periodically review all health insurance coverages mandated by state law.

History: L. 1999, ch. 162, § 5; July 1.

Milliman Client Report

Milliman

Parity for Oral and Intravenous/Injected Cancer Drugs

Prepared by
Milliman, Inc., NY

Kathryn Fitch, RN, MEd
Principal and Healthcare Management Consultant

Kosuke Iwasaki, FIAJ, MAAA, MBA
Consulting Actuary

Bruce Pyenson, FSA, MAAA
Principal and Consulting Actuary

Commissioned by GlaxoSmithKline

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Technology continues to change the nature of medical treatment, and a number of new, innovative, and often costlier treatments have emerged for serious diseases such as cancer. However, these new treatments may be viewed skeptically by those who ultimately shoulder the costs, payers and employers, who need to control healthcare costs. Payers use a variety of techniques to control costs including utilization management and increased member cost sharing. Employers have increased patient out of pocket responsibilities or required higher employee contributions; the former has the member pay more for care received, while the latter reduces net wages.

In certain instances, technology has outpaced payer and employer management of healthcare benefits. This issue has become evident with the emergence of orally-administered anticancer agents. Because of how benefit designs have evolved, intravenous/injected chemotherapy drugs are typically covered through medical benefits, while oral chemotherapy drugs are most often covered through pharmacy benefits. Medical benefits often bring relatively low cost burdens to patients for chemotherapy because they may require only an office visit copay or have a cap on out-of-pocket expenditures. In contrast, pharmacy benefits can be more burdensome for patients as some designs require unlimited cost sharing, for example, 25% of the drug price with no cap on out of pocket expenses. Such pharmacy benefit structures can make high cost oral anticancer medications unaffordable.

This research report examines the concept of "parity" between oral and infused drugs – in particular, equalizing patient cost-sharing for all chemotherapy drugs regardless of formulation. Treatment choice is, of course, complex. In addition to medical effectiveness and safety, financial considerations figure prominently for the provider, payer and patient. The cost sharing inequity in some plan designs for intravenous/injected and oral chemotherapy products is becoming more apparent as high-cost oral products come to market with many more under development. The benefit design issue we address here will likely continue to grow in importance.

Several state legislatures have passed or are considering "parity" legislation that would require state-regulated payers to cover oral chemotherapy drugs with the same cost sharing as intravenous/injected chemotherapy drugs. This paper addresses a particular benefits issue – how much parity legislation might cost a payer.

As described in the body of the text, for most benefit plans, parity will cost under $0.50 Per Member Per Month (PMPM), which compares to a typical commercial plan cost of over $300 PMPM for all benefits. However, there are literally thousands of benefit design variations, and plan design features can affect parity costs. Parity for some plan designs with very high cost sharing for oral specialty drugs and low cost sharing for medical benefits could cost about $1.00 PMPM, or, in unusual circumstances, more. Parity for other plan designs that have low overall cost sharing could cost as little as $0.05 to $0.10 PMPM.

In addition to our parity cost estimates, significant new findings presented here include estimates of elasticity for oral chemotherapy drugs – how increasing cost sharing reduces the consumption of higher cost oral chemotherapy drugs. This elasticity for chemotherapy drugs is a finding that hasn't previously been published and raises the question of whether treatment quality or choice is affected in plans with high cost sharing.

This paper presents models and assumptions that a payer can consider to estimate the impact of parity for oral and intravenous/injected chemotherapy. We do not address administrative costs associated with parity. Development of insurance rates is, of course, the domain of actuaries, and actuaries with appropriate expertise should be involved in any rate calculation.

We note that our assumptions and analysis are general and do not presume any particular therapy. Similarly, we do not address the efficacy or safety of different therapies. In authoring this paper, the authors and Milliman are making no endorsement of any product or policy.

GlaxoSmithKline, a pharmaceutical company that manufactures, markets, and is developing intravenous/injected and oral chemotherapy drugs, commissioned Milliman to develop and author this paper. GlaxoSmithKline provided oncology disease state and treatment expertise, background information on iv/oral chemotherapy treatment paradigms, information on the current status of oral/iv parity legislation, and the general editing of these sections.

12-6

BASICS OF CANCER DRUGS FROM THE STANDPOINT OF BENEFIT DESIGN

Primer on Cancer Chemotherapy

Anticancer drug therapy is one of the three pillars of cancer treatment along with surgical treatment and radiation therapy. Anticancer drug therapy is generally categorized into three types; cytotoxic agents, biologic agents and hormonal agents. These categories include both oral and intravenous/injectable products. Treatment recommendations depend on the type and stage of cancer, along with patient characteristics.

Cytotoxic agents are the traditional therapies that damage cancer cells by interfering with cellular division but have the drawback of killing healthy cells along with cancer cells. Major types of cytotoxic agents include alkylating agents, antimetabolites, and plant alkyloids. Biologic agents, also called targeted agents, target specific cancer biologic pathways. Hormonal therapy interferes with hormone dependent pathways that promote the development or growth of cancer cells and plays an important role in treating breast and prostate cancers.

Historically, intravenous therapies have been the predominant route for administering anticancer drug therapy. Although oral cytotoxic and hormone products have been available for decades, the past 10 years has seen accelerated development of oral anticancer drugs, particularly biologics. Experts estimate that more than one quarter of the 400 chemotherapy drugs now in the development pipeline are planned as oral drugs.[1]

Evidence based treatment guidelines, including those issued by the National Comprehensive Cancer Network (NCCN)[2], recommend various combinations of chemotherapy depending on the particular cancer and stage. These recommendations are made without regard to the route of administration. Protocols may recommend a single oral or single infused treatment protocol, a combination of infused products only, and oral and infused product combinations. For a few treatment protocols, NCCN guidelines indicate an oral product or an infused product as being potentially substitutable.

Cytotoxic products, which are predominantly given by intravenous infusion, are generally administered episodically to deliver the maximum tolerated dose to optimize cell kill in a single episode. The interval between doses allows for recovery from potential side effects. Biologic products are optimally effective when taken chronically, often daily, to continuously expose the tumor cells and tumor microenvironment to the drug therapy. This goal of chronic administration is consistent with the convenience of oral administration when available. There are pros and cons to each option, cytotoxic or biologic, intravenous or oral, which need to be weighed by patients and healthcare providers.[3] [4]

Overview of Cancer Drug Coverage and Benefit Designs

Infused and oral medications typically have different dispensing sites, and the dispensing site often defines which portion of a health benefit applies. Intravenous medication, most often administered in a physician's office or hospital outpatient infusion center, is generally covered as a physician service or hospital outpatient service and defined as medical benefits. Oral anticancer medication is typically dispensed by a pharmacy and covered under a pharmacy benefit. Injectable anticancer medication may be self administered and covered under a pharmacy benefit or administered in a physician's office or outpatient hospital setting and covered under a medical benefit. On average, as a percent of all covered medical benefits, average patient cost sharing for a typical medical benefit is lower, and cost sharing for the prescription benefit as a percent of covered prescription benefits is higher.

THE COST AND UTILIZATION IMPACT OF PARITY FOR ORAL CANCER DRUGS

Defining Parity

The term "parity" for health benefits has most prominently referred to requiring coverage for mental health and substance abuse services on the same basis as medical benefits. Traditional benefit designs covered mental health and substance abuse services with higher cost sharing (for example, 50% coinsurance) and "inside" limits (for example, 20 visit annual maximum) that meant less coverage than for other services.[5] Parity legislation passed in the 1990s applied only to benefit maximums, and full parity was signed into law in October 2008.[6] [7]

State parity legislation for oral chemotherapy drug coverage typically requires that insurance coverage for orally administered chemotherapy medications shall be provided on a basis no less favorable than coverage for injected or intravenously administered chemotherapy medications. For the purpose of this report, we define oral/intravenous/injected chemotherapy parity to mean that the percent patient cost sharing for an oral chemotherapy drug will be no more than that of an intravenous/injected chemotherapy drug. We apply the following algorithm:

Definition of Oral/Intravenous/Injected Chemotherapy Parity

For an individual who receives both oral and intravenous/injected chemotherapy drugs, the percent cost sharing for the oral chemotherapy drugs will be no more than the percent cost sharing for their intravenous/injected chemotherapy drugs.

For an individual who receives only oral chemotherapy drugs, the percent cost sharing for the oral chemotherapy drugs will be no more than the average percent cost sharing for the intravenous/injected drugs as administered by their benefit plan.

Traditional prescription drug designs, with fixed copays, such as $25 or $40 per script, do not impose large cost sharing for expensive drugs. However, some plan designs with unlimited coinsurance, for example 25% or 33% or higher, can impose a significant cost sharing burden when the prescription costs thousands of dollars, which is not an unusual cost for a chemotherapy product whether it is intravenous/injected or oral.

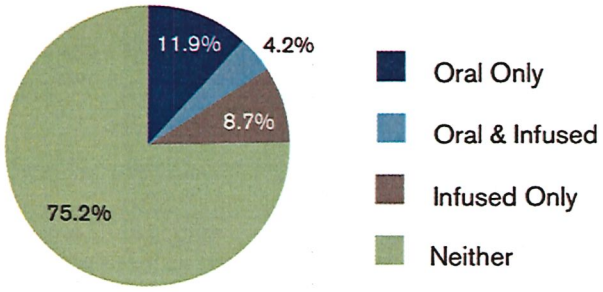
Many medical benefit designs offer some form of cap on member out-of-pocket costs. The trend toward prescription drug benefits with unlimited coinsurance, together with the introduction of often expensive oral agents, has made intravenous/injected-oral parity an issue.

In our analysis, we do not address administrative costs and assume parity does not affect utilization management strategies such as prior authorization, quantity limits and restricted formularies.

Cancer Patients and Utilization of Chemotherapy

Using the approach described in the Methodology section, we estimate approximately 1.5% of a commercially insured population has medical claims for cancer in a one year period. Although chemotherapy is a significant treatment option for cancer patients, most patients with a cancer diagnosis do not receive chemotherapy in a year. Figure 1 provides the distribution of cancer patients by chemotherapy treatment showing about 25% of cancer patients receive chemotherapy during a year. The remaining three-quarters of patients may be treated using a variety of other non-chemotherapeutic treatment modalities, such as surgery, radiation therapy or monitoring.

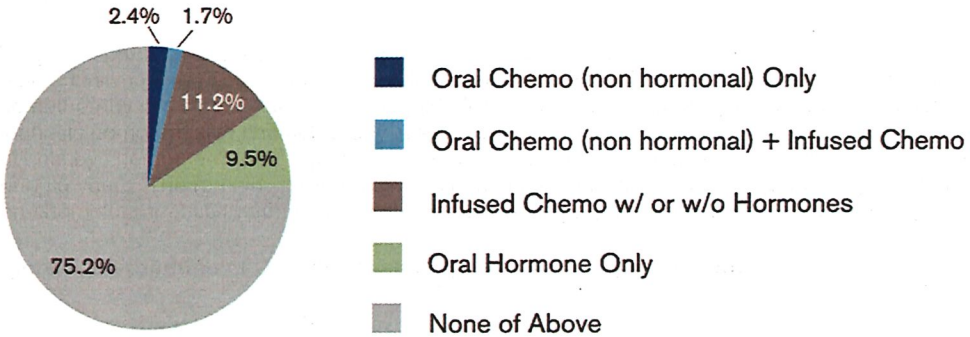
Figure 1: Distribution of Cancer Patients by Chemotherapy Treatment



N = 172,547 cancer patients. Excludes basal cell skin cancer
Source: Milliman's work on MedStat Commercial 2007

Figure 2 shows the distribution of patients by the kinds of cancer drugs (hormonal, non-hormonal, oral, infused) they take in one year. Almost half of patients receiving chemotherapy use oral products only, and most of that usage is hormonal agents which are generally low cost. Of those cancer patients receiving chemotherapy treatment, only 17% (2.4% plus 1.7% out of 24.8%) receive chemotherapy that does not include hormonal treatment.

Figure 2: Distribution of Cancer Patients by Type of Chemotherapy



N = 172,547 cancer patients. Excludes basal cell skin cancer
Source: Milliman's work on MedStat Commercial 2007

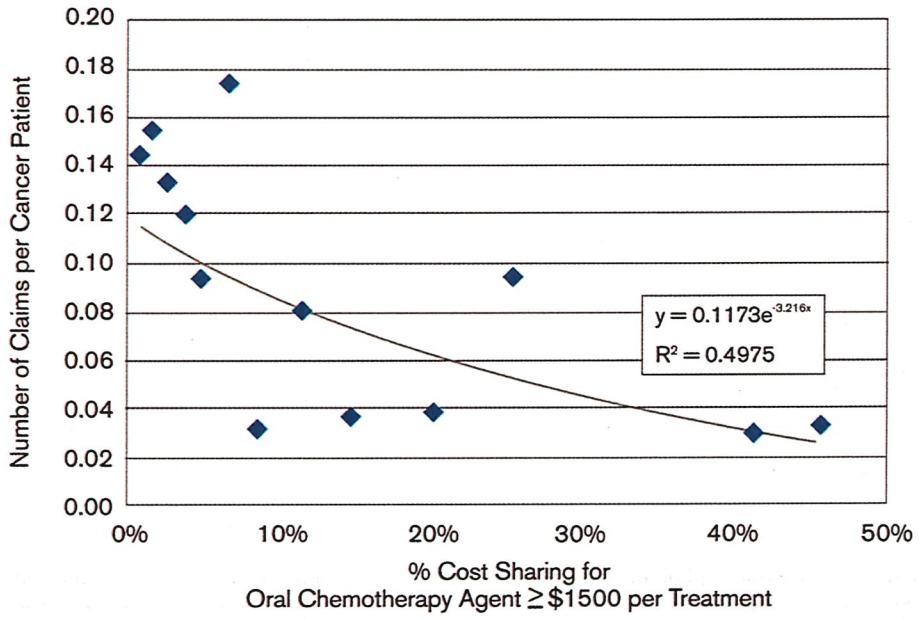
12-9

How Benefit Cost Sharing Impacts Cancer Drug Use: Elasticity

Higher out-of-pocket costs discourage the use of medical services and products, and this has been shown for high-cost pharmaceuticals.[8] In particular, we demonstrate that higher cost sharing for oral chemotherapy agents is associated with lower utilization of these drugs. This is shown in Figure 3 below, which is based on examination of the medical claims of thousands of cancer patients. Our finding contrasts with other studies, which have assumed no price elasticity.[9]

The diamonds in Figure 3 correspond to different plan designs, each diamond representing a distinct percent cost share for oral chemotherapy drugs. The chart shows an inverse relationship between the percent cost sharing, and number of claims per patient. In other words, higher percent cost sharing leads to fewer claims per patient for oral chemotherapy. The formula in the chart shows the elasticity function fitted to the data points, along with the corresponding R^2 value. The data sources and approach we used is described in the Methodology section.

Figure 3: Relationship Between % Cost Share or Oral Cytotoxic Rx and Number of Oral Cytotoxic Claims Per Cancer Patient Age 20-69



N = 24,474 cancer patients spread among 13 cost-sharing categories. Source: Milliman's analysis of MedStat Commercial 2007, 2008Q1-3 and Milliman proprietary data from 2007. Oral chemotherapy category does not include hormonal therapies. The box shows the best fit of a typical elasticity curve.

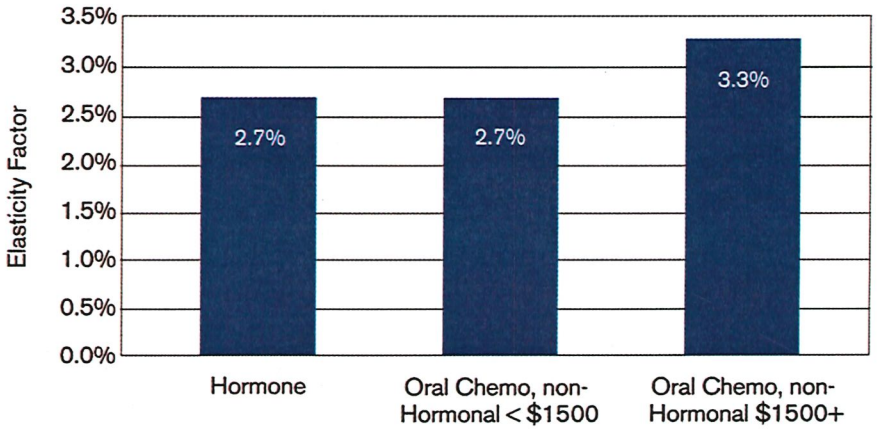
These data suggest that oral/intravenous/injected chemotherapy parity will increase drug utilization, which will increase cost.

In economics, elasticity measures the sensitivity of one variable to another, which is the percentage change that will occur in one variable in response to a 1-percent increase in another variable[10]. Actuaries have long recognized that higher cost sharing reduces utilization, and typical actuarial practice recognizes this phenomenon in setting premium rates for health insurance products.

12-10

In Figure 4, we show the elasticity factors of three types of oral chemotherapy drugs: hormonal agents, less expensive non-hormonal agents (under $1500 per claim), and more expensive non-hormonal agents ($1500 or more per claim).

Figure 4: Elasticity: % Utilization Caused by 1 Percentage Decrease in % Cost Share for Oral Cancer Drugs



Source: Milliman analysis of MedStat Commercial 2007, 2008Q1-3
Milliman Health Cost Guideline 2009

In Figure 4, elasticity means the percent increase in utilization caused by a 1 percentage point decrease in cost sharing. For example, the elasticity factor of 3.3% applies to oral chemotherapy, non hormonal drugs costing $1500 or more. The 3.3% elasticity factor shown means if the percent cost sharing for the drug goes down from 20% to 19%, the utilization of these drugs will increase by 3.3%. The 3.3% elasticity factor is consistent with Figure 3 and further described in the Methodology section. For the hormones and lower cost oral chemotherapy drugs, we used standard actuarial elasticity factors.

Cost Impact of Parity for Oral Cancer Drugs for Various Benefit Designs

We applied the elasticity relationships described above to estimate the additional drug cost of parity. It is impossible to define one cost for parity that will apply to all benefit designs, because variations in plan design have a significant impact. Plans vary in the amount of cost sharing for medical and pharmacy benefits, and they vary in how that cost sharing is arranged – copays, coinsurance, deductibles, out-of-pocket maximums, etc. Therefore, to show the additional costs of oral/intravenous/injected parity, we developed ranges and characterizations of health benefit designs.

To put plan cost sharing into perspective, we offer the following:

- A typical PPO benefit design has average cost sharing of 17% across all benefits[11]
- A typical, 3-tier drug benefit, $10/$25/$40 has average cost sharing of 25% across all drugs[12]

Oral/intravenous/injected parity costs depend on both the oral chemotherapy drug cost sharing and the intravenous/injected drug cost sharing, because parity reduces the oral cost sharing to the level

12-11

of the intravenous/injected cost sharing. In general, the cost of parity follows the relationships below:

Pre-Parity Benefits	Cost of Introducing Parity
Low cost sharing for oral chemotherapy drugs	Lower Cost to Plan
High cost sharing for oral drugs and Low cost sharing for intravenous/injected chemotherapy drugs	Higher Cost to Plan

If cost sharing for oral chemotherapy drugs is already low, as is the case with traditional prescription drug benefit designs with copays, parity will have only a small cost impact. However, for plans with unlimited coinsurance for expensive drugs, parity can add modest amounts to plan costs.

To present concrete examples of the impact of parity, the authors simulated the impact of oral/intravenous/injected parity for a variety of benefit designs using the definition of oral/Intravenous/Injected chemotherapy parity stated at the beginning of this section. The simulation was done for each patient taking oral chemotherapy, including hormonal agents. We simulated parity for over 60 benefit designs which comprised over 32 million member months and 43,000 cancer patients. We segmented the benefit designs into three categories, with the medium category typical of traditional PPO designs[13] and the high category including Consumer Driver Health Plans:[14]

Cost Sharing	Average Cost Sharing for Medical Benefits	Cost Sharing for Oral Chemotherapy Drugs
Low	Under 12%	Under 5%
Medium	12% to 17%*	5% to 10%
High	Above 17%	Above 10%**

*Close to a typical PPO benefit.
**Typical for coinsurance programs in a 3rd or 4th tier or specialty tier

We used the average cost sharing for medical benefits as an indicator of intravenous/injected drug cost sharing, because the deductible and coinsurance and out-of-pocket limits typically apply to intravenous/injected drugs.

The extra plan costs for parity are relatively small, as shown in the following table. The extra costs are shown Per Member Per Month (PMPM):

Extra Plan Cost of Parity Benefits in $PMPM (Costs Trended to 2009)

		Oral Chemotherapy Cost Sharing Percentage		
		Low	Medium	High
Medical Benefit Cost Sharing Percentage	Low			$0.50 to $1.30
	Medium	$0.05 to $0.10	$0.15 to $0.20	$0.25 to $0.35
	High			$0.20 to $0.30

These figures do not include plan administrative costs. These figures compare to a PMPM claim cost of $319 for a typical commercially insured individual based on Milliman's 2008 Group Health Insurance Survey, trended to 2009 dollars.

12-12

Decreased cost sharing will increase the cost of oral chemotherapy in several ways. We list these with the estimated most expensive listed first:

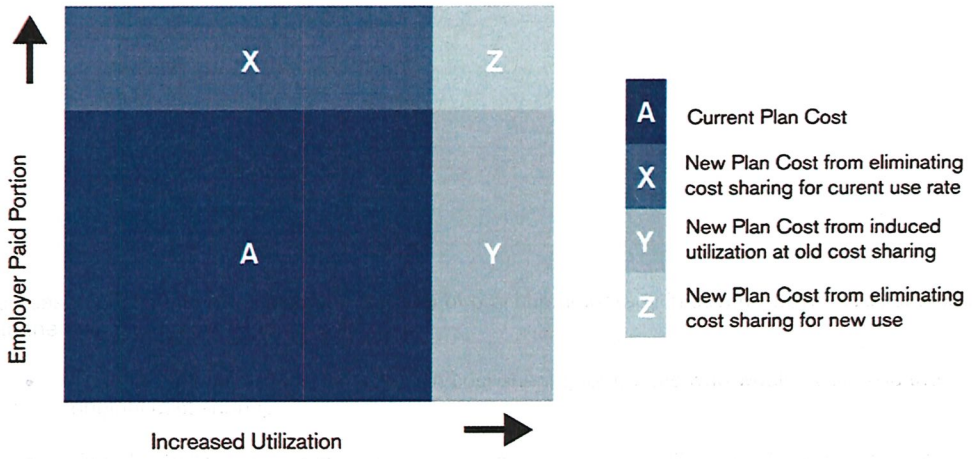
- The plan will pay for the difference in cost sharing for people who would have paid the original cost sharing.
- The plan will pay for the new utilization (induced utilization) that members would have avoided because of the original cost sharing. We divide this into two pieces:
  - The new services at the old price assuming cost sharing
  - The reduced cost sharing for the new services

In addition, there may be reduced recoveries through coordination of benefits (COB). Reduced cost sharing may encourage some employed spouses or dependents to obtain coverage from the plan with lower cost sharing. We did not attempt to quantify these two factors as they vary greatly with each employer's particular situation.

We also made no adjustment for changes in the utilization of intravenous/injected chemotherapy, as our analysis did not indicate an impact on intravenous/injected chemotherapy associated with increased utilization of oral chemotherapy.

Figure 5 shows the elements of increased costs (other than COB).

Figure 5: How Reducing Cost Sharing Increases Payer Cost (Elasticity)



The relative contribution of each component will vary with benefit design details.

Case Study Cost Comparison: Injectable versus Oral Chemotherapy

In general, care rendered in less intensive settings (such as home) is less expensive than care rendered in facilities or physician offices, which has led to widespread promotion of outpatient services as an alternative to inpatient services.[15] The possibility that some chemotherapy can be administered orally instead of intravenous/injected raises the potential for cost reduction in cases where oral or infused products are therapeutically similar. For many services, facility or physician office sites can involve services and costs beyond the particular drug, its acquisition cost, or the principle services being rendered.

12-13

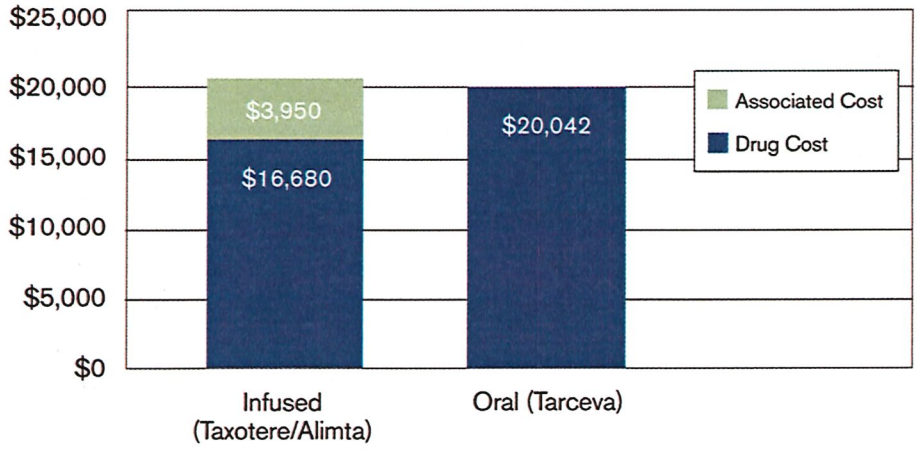
Although both oral and infused treatment options require close monitoring and follow up, infused therapies incur costs associated with IV administration. Several studies report costs associated with infused chemotherapy, although the reported costs vary. A study of the costs of IV administration in a metastatic breast cancer population identified chemotherapy per visit costs of $2,477, with IV administration accounting for approximately 10% ($252); the study drug accounting for 59% ($1,463); and other drugs and services accounting for 31% ($763).[16] Another study of chemotherapy cost for small cell lung cancer patients reported a cost per chemotherapy visit of $787, with 50% of the cost for the IV chemotherapy drug ($395); 12% of the cost for IV chemotherapy administration procedures ($93); and 38% for other visit related drugs and services ($300).[17]

Currently, there are only a handful of cancer treatments with oral or infused chemotherapy options, although a number of oral chemotherapy drugs are in development. To compare the costs of oral and intravenous/injectable administration in a case where there are oral or intravenous/injectable options, we examine the case of non small cell lung cancer where NCCN guidelines recommend treatment with one of infused Taxotere or infused Alimta or oral Tarceva.[18]

Using Medstat 2007 and Q1-Q3 2008, we identified members coded with lung cancer and having one or more claims for Taxotere, Alimta or Tarceva. We identified the average number of treatment claims per patient and the average drug cost per treatment to calculate a course of therapy drug cost. The average number of claims was 4.8/patient for Taxotere and Alimta and 4.9/patient for Tarceva. The intravenous/injected drugs accounted for 63% of the claims while the oral accounted for 37% of the claims. We identified the associated infusion costs incurred on the day of infusion administration by performing a claim line examination and determined costs that would go away if the infusion did not occur.

Although the average acquisition cost of Taxotere/Alimta is lower than Tarceva, the associated infusion costs move the total average costs somewhat higher than for patients on the oral product Tarceva (see Figure 6). We did not factor in nonpayer costs that may be incurred with oral administration including additional education on drug administration, compliance and side effects. In this case, the costs of infused and oral therapy appear to be very close. Because oral chemotherapy is sometimes combined with infused agents, and because oral and infused agents are not often directly substitutable, we believe the hypothesis of cost reduction by avoiding infusion-related costs is unproved through this example. We did not attempt to compare clinical outcomes for this case. Figure 6 summarizes our findings.

Figure 6: Allowed Cost Comparison Per Course of Therapy
(Total cost paid by payer and member)
(Average Number of Claims/Patient)



N= 270 patients; Infused Taxotere and Alimta
N =154 patients; Oral Tarceva
Source: Milliman's work on MedStat 2007, 2008Q1-3
Costs trended to 2009
Lung cancer patients identified with one IP, one ER or 1 physician claim coded with ICD-9 162.xx

12-15

IMPLICATIONS FOR PAYERS AND EMPLOYERS

Oral/Infused Parity Legislation

In 2007, Oregon was the first state to pass oral/intravenous/injectable chemotherapy parity legislation - Senate Bill 8 (SB 8). This legislation requires that:

> "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."

Several advocacy organizations, including the National Patient Advocate Foundation[19] and the American Cancer Society[20], have taken an active role in supporting similar legislation in other states. Since the beginning of 2009, oral/infused chemotherapy parity legislation has passed in five states (Indiana, Hawaii, Vermont, Iowa, and the District of Columbia) and has been introduced in 20 other states.

State insurance legislation typically amends insurance laws. The state Insurance Commissioner is usually required to convert the intent of an Act into rules and regulations that can be put into practice by insurers and used by the regulators to test insurers for compliance. Seemingly simple parity language like, "no less favorable to an insured," can be interpreted by regulators in different ways. For example, if a patient receives both infused and oral drugs, parity could mean the insured should pay the same percent cost sharing or the same dollar cost sharing. Suppose the infused drug cost $1000 with 5% cost sharing ($50), and the oral drug cost $2000. Parity could mean the same 5% cost sharing or $100 for the oral drug (the same percent), or it could mean $50 cost sharing (the same dollar amount). As with other features of state insurance regulation, mandates for oral/infused parity are likely to be implemented in ways that vary by state.

Federal legislation to amend the Employee Retirement Income Security Act (ERISA) and other acts has been introduced by Representative Brian Higgins (NY) in May 2009.[21] HR 2366 would require "group and individual health insurance coverage and group health plans to provide for coverage of oral cancer drugs on terms no less favorable than the coverage provided for intravenously administered anticancer medications." ERISA, not states, governs self-insured health benefit plans, which is why this proposal and other federal mandates are structured as amending ERISA.

Impact on Large Employers

Most benefit designs will have low parity costs, especially for programs sponsored by large employers. The member cost burden challenge with oral/infused cost sharing is most pronounced when specialty or high-cost drugs are subject to coinsurance. A 25% coinsurance for a $100 drug is $25, which is a typical cost sharing amount for a brand prescription. However, 25% for a drug that costs $10,000 is $2,500, and such cost sharing can quickly become unaffordable for many people. Such high cost-sharing for expensive prescription drugs is today relatively uncommon among large employer-sponsored programs. According to a recent survey, only 14% of large employers have drug programs with coinsurance.[22] For large employers this information may be most relevant to those considering shifting to a specialty tier design.

Conclusion

The expected continued growth of specialty pharmaceutical products, some of which are very expensive, has prompted an array of benefit design and benefit management techniques.[23] Some insurers and employers are responding to this increasing cost pressure by increasing member cost share through benefit designs with unlimited coinsurance for expensive products, sometimes called

12-16

a specialty tier.[24] While such benefit designs may be lower cost to the payer, they can impose a significant cost burden on members and may limit the physician and patient choice of treatment. Oral/infused parity will increase costs the most for payers with benefit designs that include such a specialty tier.

The costs and methodology shown in this paper should be used as guides for employers or insurers who want to calculate parity costs for their own programs. Under reasonable scenarios, the additional costs of oral/infused parity are minimal -- an increase estimated at well below $1.00 PMPM for typical benefit plans that cost over $300 PMPM (claims costs only). Actual costs will, of course, fluctuate from year to year and employer to employer depending on the therapies individuals receive and the treatments that become available.

If oral/infused parity legislation follows the same pattern as mental health parity, medical management and contract management will continue[25] which is our assumption in estimating costs. Typically, for specialty pharmacy, this includes prior authorization, concurrent review, and medical appropriateness reviews as well as encouraging use of preferred providers or contracted specialty pharmacies.[26] Such techniques may become more important because of parity legislation. Managing oncology treatment overall is the subject of increasing payer attention.

12-17

APPENDIX A: DESCRIPTION OF KEY DATA SOURCES AND THEIR APPLICATION

Thompson Reuters Medstat database. This dataset contains all paid claims generated by over 20 million commercially insured lives. Member identification codes are consistent from year-to-year and allow for multi-year longitudinal studies. Information includes diagnosis codes, procedure codes and DRG codes, NDC codes along with site of service information, and the amounts paid by commercial insurers. For this study, we used Medstat 2007 through 3rd Quarter 2008.

Milliman's 2009 Health Cost Guidelines. The Guidelines provide a flexible but consistent basis for the determination of health claim costs and premium rates for a wide variety of health plans. The Guidelines are developed as a result of Milliman's continuing research on health care costs. First developed in 1954, the Guidelines have been updated and expanded annually since that time. The Guidelines are continually monitored as they are used in measuring the experience or evaluating the rates of health plans, and as they are compared to other data sources. The Standard Demographics in the Guidelines were developed to be representative of the age and sex distribution for a typical large insured group. The Standard Demographics were developed using data from large insurers combined with Department of Labor Sources. We use the Guidelines to demographically adjust our target population to a typical working age population.

Milliman Medical Index (MMI). The MMI examines key components of medical spending and the changes in these components over time. The MMI incorporates proprietary Milliman studies to determine representative provider-reimbursement levels over time, as well as other reliable sources, including the Kaiser Family Foundation/Health Research and Educational Trust 2007, *Annual Employer Health Benefit Survey* (Kaiser/HRET), to assess changes in health plan benefit level by year. The MMI includes the cost of services paid under an employer health-benefit program, as well as costs paid by employees in the form of deductibles, coinsurance, and copayments. The MMI represents the total cost of payments to healthcare providers, the most significant component of health insurance program costs, and excludes the non-medical administrative component of health plan premiums. The MMI includes detail by provider type (e.g., hospitals, physicians, and pharmacies), for utilization, negotiated charges, and per capita costs, as well as how much of these costs are absorbed by employees in the form of cost sharing. We used the annual MMI cost trends to trend the MedStat cost data to 2008 dollars.

Milliman Group Insurance Survey™ (GIS). The GIS measures premiums and experience of HMOs and PPOs based on a uniform population and benefit design. The Survey provides statistics on fully insured HMOs and PPOs that serve the commercial large or midgroup market. Companies use the Survey to benchmark their financials to the competition. HMO and PPO results are presented separately by metropolitan statistical area (MSA), state, region, and nationwide. The results are based on questions answered by at least three companies. Company identities are kept strictly confidential.

APPENDIX B: METHODOLOGY

Cancer Identification

We identified an individual as having cancer if they had one inpatient, one ER or 2 or more physician claims on separate days coded with the following ICD-9 codes in any position of the claim:

140.xx through 172.xx
174.xx through 208.9x

Of people identified with cancer claims, we identified patients receiving one or more oral and/or intravenous/infused chemotherapy drug using NDC and J codes. The complete list of chemotherapy drugs is available upon request to the authors.

Methodology for Elasticity Calculation

Data Sources

The following data sources were used in this research:

- Milliman *Health Cost Guideline 2009* for Hormonal drugs and Oral Chemo drugs costing less than $1500 per claim
- MedStat Commercial 2007 and 2008Q1-3 for Oral Chemo drugs more than $1500 per claim

Hormonal drugs and Oral Chemo drugs costing less than $1500 per claim

We used standard actuarial coefficients and the average allowed and cost share for both Hormonal drugs and Oral Chemotherapy drugs with allowed amounts less than $1500 per claim. These factors, which are not specific to hormonal drugs or oral chemotherapy drugs show that a 1 percentage point reduction in cost sharing produces a 2.7% increase in utilization. The following table shows the average allowed amounts for these two categories.

	Hormone	Oral Cytotoxic <$1500
Average Allowed Amount per Claim	$307	$400

The average allowed are from our analysis of MedStat for 2007 and 1Q-3Q 2008.

Oral Chemotherapy drugs more than $1500 per claim

We developed the elasticity factor for oral chemotherapy drugs costing more than $1500 per claim using MedStat Commercial 2007, 2008Q1-3 and Milliman's proprietary database with 2007 data. For purposes of calculating elasticity, we selected benefit designs with relatively low intravenous/injected drug cost sharing (greater than 2.5% and less than 5.5%") and grouped benefit designs based on similar ranges of oral chemotherapy cost sharing. We then used regression analysis to develop a best fit elasticity curve between,

y : Number of oral non-hormonal chemo claims per cancer patient

x : % Cost Share of oral non-hormonal chemo claims

We found

$$y = 0.0117e^{-3.2\ 1x6}$$, with R^2 = .4975

Base on the formula above, the elasticity, which is % utilization increase caused by 1 percentage point decrease in % cost share, is calculated as,

$$\frac{0.01173e^{-3.216(x-1\%)}}{0.01173e^{-3.216x}}-1=e^{3.216\times 1\%}-1=3.3\%$$

12-20

REFERENCES

[1] Weingart SN, Bach PB, Johnson SA et al. NCCN task force report: oral chemotherapy. Journal of the National comprehensive Cancer Network. 2008;6: S1-S17.

[2] NCCN guidelines available at http://www.nccn.org/professionals/physician_gls/f_guidelines.asp

[3] Weingart SN, Bach PB, Johnson SA et al. NCCN task force report: oral chemotherapy. Journal of the National comprehensive Cancer Network. 2008;6: S1-S17.

[4] Goodin S. Advancing the safe and appropriate use of oral chemotherapy agents supplement. American Journal of Health System Pharmacy. 2007;64:S1-S35.

[5] Mechanic D, McAlpine DD, Mission Unfulfilled: Potholes On The Road To Mental Health Parity, Hlth Aff, 18. 5, Sep/Oct 1999.

[6] Health Insurance Reform for Consumers. http://www.cms.hhs.gov/healthinsreformforconsume/04_thementalhealthparityact.asp

[7] Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. http://www.govtrack.us/congress/bill.xpd?bill=h110-6983 .

[8] Gleason PP, Starner, CI Gunderson BW, et al. Association of Prescription Abandonment with Cost Share for High-Cost Specialty Pharmacy Medications. JMCP, Oct 2009

[9] Analysis of Senate Bill 161 Health Care Coverage: Chemotherapy Treatment. California Health Benefits Review Program, Apr 17, 2009. http://www.chbrp.org/documents/sb_161final.pdf

[10] Robert S. Pindyck, Daniel L. Rubinfeld, Microeconomics (6th Edition), Princeton Hall, 2004

[11] Milliman Medical Index, http://www.milliman.com/expertise/healthcare/products-tools/mmi/pdfs/milliman-medical-index-2009.pdf. For 2009, the MMI average benefits are an in-network deductible of $473, various copays (e.g., $75 for ER visits, $19 for physician OV, 14% coinsurance for non-copay services, etc.).

[12] Milliman 2009 Health Cost Guidelines Rating Structures. Private Communication.

[13] Milliman Medical Index 2009, op cit.

[14] Burke J, Pipich R, Consumer Driven Impact Study. Milliman Research Report. Apr 2008. Available at, http://www.milliman.com/expertise/healthcare/publications/rr/pdfs/consumer-driven-impact-studyRR-04-01-08.pdf

[15] Pyenson B, Zenner P, Chye P, Silver bullets for outpatient cost increases? The Actuary, Nov 2002. http://www.soa.org/library/newsletters/the-actuary/2000-09/2002/november/act0211.pdf

[16] Kruse GB, Amonker MM, Smith G et al. Analysis of costs associated with administration of intravenous single-drug therapies in metastatic breast cancer in a U.S. population. J Manag Care Pharm. 2008;14:1-14.

[17] Duh MS, Weiner JR, Lefebvre P et al. Costs associated with intravenous chemotherapy administration in patients with small cell lung cancer. A retrospective calims database analysis. Curr Med Res Opin. 2008;24:967-64.

[18] NCCN guidelines available at http://www.nccn.org/professionals/physician_gls/f_guidelines.asp

[19] National Patient Advocacy Foundation, Statement of Principles on Access to Oral Chemotherapy Drugs. Available at, http://www.npaf.org/state/2007-principles-priorities.html#oral%20chemo

[20] Staff Analysis of 161, Alaska Senate, Hearing date: Apr 29, 2009. Available at, http://info.sen.ca.gov/pub/09-10/bill/sen/sb_0151-0200/sb_161_cfa_20090428_105319_sen_comm.html

[21] Cancer Drug Coverage Parity Act of 2009, HR 2366. http://thomas.loc.gov/cgi-bin/query/z?c111:H.R.2366.IH:

[22] Prescription Drug Benefit Cost and Plan Design Report, 2008–09 edition, The Pharmacy Benefit Management Institute, http://www.pbmi.com/2008_report/index.html

[23] Sullivan SD, The Promise of Specialty Pharmaceuticals: Are They Worth the Price? J Manag Care Pharm. 2008;14(4):S3-S6. Available at http://www.amcp.org/data/jmcp/JMCPSupp_May08.pdf

[24] Gleason PP, Starner, CI Gunderson BW, et al. Association of Prescription Abandonment with Cost Share for High-Cost Specialty Pharmacy Medications. JMCP, Oct 2009

[25] Melek SP., Pyenson BS, Fitch, KF. An actuarial analysis of the impact of HR 1424 "The Paul Wellstone Mental Health and Addiction Equity Act of 2007." Milliman, Inc. http://edlabor.house.gov/testimony/071007SteveMelekTestimony.pdf

[26] Stern D, Benefit Design Innovations to Manage Specialty Pharmaceuticals. J Manag Care Pharm. 2008;14(4):S12-S16. Available at http://www.amcp.org/data/jmcp/JMCPSupp_May08.pdf

12-22

Testimony before the Kansas House Committee on Insurance
in Support of Senate Bill No. 390

Lisa Covington
Lenexa, KS
913-982-8230

Mr. Chairman and Members of the Committee:

My name is Lisa Covington, and I live in Lenexa, Kansas. Thank you for taking the time today to read my testimony in support of Senate Bill No.390. I wish I could be there in person to share my story; however, due to my obligations at work I am not able to get away.

I am a 40-year-old wife and mother of 2 boys (ages 12 & 16). I am also a Stage 4 Breast Cancer Survivor living with advanced disease. I was originally diagnosed 9 years ago with stage 2 Ductal Carcinoma. I had a mastectomy and four months of intense (IV) chemotherapy. I was told I had an 8% chance of recurrence and put on an oral hormone therapy drug called Tamoxifen, which worked for 2 years. Unfortunately in 2003, my disease metastasized to my lungs and bone. During the next 15 months, I underwent intense treatment, which included both IV and oral chemotherapy. I was given 6-12 months to live.

One of the drugs I was prescribed during that 15 month period was an oral Chemotherapy called XELODA. XELODA has been on the market since 1998, and was the first oral chemotherapy approved by the FDA for the treatment of metastatic Breast Cancer. Because XELODA can be taken by mouth, it was more convenient than intravenous (IV) chemotherapy. With XELODA, I was able to make fewer visits to the doctor/hospital, which saved me valuable time (4 hours/treatment) and money spent on co-pays ($40/visit). I took the drug on my own from home, and even while traveling. I was able to carry on somewhat of a normal life while taking this oral drug. Thankfully XELODA was covered by my health insurance plan.

After a brief time in remission, my disease surfaced again in 2006. I had a hysterectomy and the disease was discovered in my ovaries. Since my disease is estrogen positive, my oncology team has been able to keep it under control with oral hormone therapy drugs like Aromasin. This oral drug is used to treat advanced breast cancer in post-menopausal women whose disease has progressed following Tamoxifen therapy. Again, thanks to this oral drug, I did not have to make monthly trips to the Cancer Center for treatment or pay co-pays. I was only responsible for the minimal prescription drug cost required by my plan. This drug kept me alive for another year.

In 2007, they found a small spot on my liver. I was switched to another hormone therapy drug called Faslodex. Unfortunately this one is **not** oral therapy. I receive treatments at the hospital every 30 days. This means I have to take time off work once a month and endure the pain of having 2 nurses inject syringes of a thick gel into my hips. This therapy costs $7,000/month and is not fully covered by my insurance plan.

In October of 2008, my husband and I were forced to file for medical bankruptcy. We have had medical coverage throughout my illness, but unfortunately the high cost of treatment to keep me alive is not covered at 100%. I depend on these drugs to stay alive and will continue to do so for the rest of my life. I need to know that if the next drug I am prescribed happens to be an oral drug, which I pray it is, will be

covered by my insurance plan. If it is not, I don't want to have to make a life impacting decision to decline it to save money.

I hope my testimony will help you and committee realize how important oral therapy is to me and so many others in our state.

Thank you for your time.

Polsinelli Shughart PC

Memorandum

TO: The Honorable Clark Shultz, Chair
House Insurance Committee

FROM: William W. Sneed, Legislative Counsel
America's Health Insurance Plans

SUBJECT: S.B. 390

DATE: March 16, 2010

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I am Legislative Counsel for America's Health Insurance Plans ("AHIP"). AHIP is a trade association representing nearly 1,300 member companies providing health insurance coverage to more than two million Americans. Our member companies offer medical expense insurance, long-term care insurance, disability income insurance, dental insurance, supplemental insurance, stop-loss insurance and reinsurance to consumers, employers and public purchasers. We appreciate the opportunity to present testimony in opposition to the Senate floor amendment to S.B. 390. My client is not opposed to the original language of S.B. 390.

Although the concept behind the amendment is admirable, the reality is such a proposal could possibly create unsafe situations and increase costs.

Chemotherapy drugs have historically been administered intravenously in a doctor's office or hospital. However, the emergence of orally-administered anti-cancer medications has dramatically increased the consumer's options and changed the way in which the medical profession treats cancer. Oral chemotherapy regimens typically require a patient to take the medication exactly as prescribed by the doctor, with an average regime consisting of ten to twenty pills each day. The regimes may be complex and rely upon the consumer to police his or her own medication without the direct supervision of a licensed and trained medical professional. This raises safety concerns as, without direct supervision, side effects can be missed; patients may not take all of their medicine, which raises the risk their cancer will worsen; or patients may take too many pills, risking toxic reaction.

Treatments involving intravenous chemotherapy have a robust system of checks and balances; however, similar safeguards have not been adopted for oral agents.

There are numerous studies that discuss this area, and if the Committee wishes to receive copies of those studies, we would be happy to provide them to you.

Additionally, mandatory coverage for oral chemotherapy drugs will increase costs at a time when businesses and families are struggling to maintain their health care coverage. All pharmaceutical coverages outsides the hospital setting are covered by an insurance rider that

555 South Kansas Avenue, Suite 101
Topeka, KS 66603
Telephone: (785) 233-1446
Fax: (785) 233-1939

accompanies one's major medical insurance. This pharmaceutical, or drug benefit rider, has a distinct advent of coverages and is priced completely differently from that of a major medical insurance policy. By transposing drug coverages into a major medical policy, you will create a dramatic shift in the cost of that drug coverage, thus increasing the overall cost of the health care coverage.

Again, we certainly understand the issues raised by the proponents of the bill, but we would urge the Committee to remove the Senate floor amendment to S.B. 390 for the reasons listed above.

I am available for questions at your convenience.

Respectfully submitted,

William W. Sneed

WWS:kjb
cc:
/

BRAD SMOOT
ATTORNEY AT LAW

800 SW JACKSON, SUITE 808
TOPEKA, KANSAS 66612
(785) 233-0016
(785) 234-3687 (fax)
bsmoot@nomb.com

10200 STATE LINE ROAD
SUITE 230
LEAWOOD, KANSAS 66206

Statement of Brad Smoot
Legislative Counsel
Blue Cross Blue Shield of Kansas and Kansas City
House Insurance Committee
Regarding Senate Bill 390
March 16, 2010

Mr. Chairman and members:

On behalf of two independent Blue Plans (BCBSKS & BCBSKC) serving Kansas, I am pleased to appear today to discuss SB 390. BCBSKS is a mutual life insurance company (meaning it is owned by its policyholders) serving nearly 900,000 Kansans in 103 counties and BCBSKC is a not-for-profit hospital and medical service corporation serving nearly 300,000 in the counties of Johnson and Wyandotte.

The Senate floor amendment to SB 390 imposing an oral chemo drug mandate is obviously well-intentioned. All of us have friends and families who have or might benefit from these very expensive oral medications now available for the treatment of cancer. It would be nice if health insurance took care of all or most of these product costs. In fact, for many of our customers, such products are covered under the generous benefits of larger employers who purchase "Cadillac" pharmacy benefits. The state of Kansas employees health care plan, for instance, provides coverage for such oral cancer drugs, as do numerous other large employers. For these premium payers and their fortunate employees, SB 390 creates no additional expense and is, in fact, unnecessary since it doesn't change anything.

Unfortunately, a lot of individuals and small employer groups who purchase pharmacy coverage have elected more affordable but lesser benefits. BCBSKS offers a plan where the coverage is paid 50/50. BCBSKC offers a plan for generics only. Since out patient pharmacy benefits are not mandated by law, insurance purchasers buy these more limited coverages because they believe it is a benefit to their family or employees and because they can afford them. Clearly the structure for pharmacy benefits is different than major medical and to increase benefits for these limited pharmacy or major medical plans will require policy restructuring and additional cost.

There isn't a day that goes by that some lawmaker doesn't approach me to inquire why we can't offer a less expensive health insurance policy – one with lesser but affordable benefits. Or another will ask about a "mandate lite" policy. Then someone else will suggest we move to HSA's or other high deductible products. Unfortunately SB 390 flies in the face of all these concepts. It would force your constituents to purchase "Cadillac" pharmacy benefits for some drugs when all they may really want or can afford is "Chevy" coverage.

Although we often focus attention on the impact of insurance mandates on our customers, as I've done above, SB 390 also presents some interesting technical issues. One third of BCBSKS' customers receive their benefits from other carriers or PBM's. Does SB 390 command that the major medical policy be changed to cover the oral cancer drugs or that the pharmacy benefit be increased? How will other insurers determine what is in each others' policies and set their benefit structures to be "no less favorable" or determine which plan must pay? In addition, SB 390 begs the question: Why just cancer drugs? Why not mandate better coverage for drugs used to treat heart disease, kidney failure, HIV, mental illness, etc? Where will you be asked to draw the line next year?

We think SB 390 is unnecessary for those insured Kansans who already have "Cadillac" coverage but costly to those who choose or can only afford more modest "Chevy" drug coverage. While SB 390 no doubt means more people could afford the high cost of the advanced oral pharmaceuticals, it also means those same people will have less choice in selecting a pharmacy benefit, even causing some families and employers to drop this optional benefit altogether. There are probably some good reasons only a handful of states have adopted this mandate while most have elected not to enact it. Thank you for consideration of our views.

Kansas Association of Health Plans

815 SW Topeka Boulevard, Suite 2C
Topeka, Kansas 66612

(785) 213-0185
marlee@brightcarpenter.com

March 16, 2010

SB 390
Before the House Insurance Committee
Marlee Carpenter, Executive Director

Chairman Shultz and members of the Committee;

I am Marlee Carpenter, Executive Director of the Kansas Association of Health Plans (KAHP). The KAHP is a nonprofit association dedicated to providing the public information on managed care health plans. Members of the KAHP are Kansas licensed health maintenance organizations, preferred provider organizations and other entities that are associated with managed care. KAHP members serve the majority of Kansans enrolled in private health insurance. KAHP members also serve the Kansans enrolled in HealthWave and Medicaid managed care. We appreciate the opportunity to provide comments to this committee.

KAHP is here today to oppose SB 390. KAHP did not oppose the underlying bill in the Senate and we still do not have a position on the base provisions of SB 390. We are here today to oppose the orally administered anti-cancer drug mandate that was attached to the bill on the floor of the Senate. This measure would require insurance companies to pay the same amount for IV anti-cancer treatments and orally administered anti-cancer treatments. Even though the state employee health plan currently follow rules set out in this bill, health insurance companies wanting to offer lower cost options cannot offer similar benefits. This is one example of the state employee health plan offering benefits above and beyond the private marketplace.

Health insurance plans typically contract with a pharmacy benefits manager (PBM) to manage prescription drug costs. As PBM's manage prescription drug costs, they may not offer similar or identical benefits as is offered on the health side, but offer benefits that will help keep insurance prices low and affordable. KAHP members want to offer low cost products and enacting this mandate will increase costs. Drugs that are covered by this mandate are very expensive, will increase drug costs and in turn, the costs of health insurance plans for Kansans.

Every health insurance mandate is brought to the legislature with good intention, but as additional mandates have been enacted, health insurance companies have become limited in the types of lower costs plans they can offer. Mandates place additional

requirements upon health insurance companies in Kansas and limit their ability to offer new, innovative and lower costs health insurance products.

Finally, during the 2009/2010 Legislative Session, more than 15 health insurance mandates have been proposed. Every health insurance mandate is brought to the legislature with good intentions but if all were passed, the cost of health insurance would skyrocket. How do you choose which should be enacted and which should not?

The KAHP requests that as you look at newly proposed health insurance mandates that you consider the impact they will have on the health insurance market and ability to offer cost effective insurance products to Kansas citizens.

Thank you for your time and I will be happy to stand for questions.