Approved: 2-16-10
Date

MINUTES OF THE SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

The meeting was called to order by Chairman Ruth Teichman at 9:30 a.m. on February 10, 2010, in Room 152-S of the Capitol.

All members were present.

Committee staff present:
Ken Wilke, Office of the Revisor of Statutes
Melissa Calderwood, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Beverly Beam, Committee Assistant

Conferees appearing before the Committee:
Bill Sneed, AHIP
Jarrod Forbes, UnitedHealthcare
Marlee Carpenter, KAHP
Brad Smoot, BCBS
Rachelle Colombo (written only), Chamber of Commerce
John Peterson (written only),

Others attending:
See attached list.

Bill Sneed, AHIP (Attachment 1)
Jarrod Forbes, UnitedHealthcare (Attachment 2)
Marlee Carpenter, KAHP (Attachment 3)
Brad Smoot, BCBS (Attachment 4)
Rachelle Colombo (written only), Chamber of Commerce (Attachment 5)
John Peterson (written only), (Attachment 6)

The Chair called the meeting to order.

Continued Hearing on

SB 195 - Providing insurance coverage for orally administered anti-cancer medications.

Bill Sneed, AHIP, testified in opposition to **SB 195.** Mr. Sneed said although the concept behind **SB 195** is admirable, the reality is such a proposal could possibly create unsafe situations and increase costs. He said treatments involving intravenous chemotherapy have a robust system of checks and balances; however, similar safeguards have not been adopted for oral agents. Additionally, he said mandatory coverage for oral chemotherapy drugs will increase costs at a time when businesses and families are struggling to maintain their health care coverage. He noted that all pharmaceutical coverages outside the hospital setting are covered by an insurance rider that accompanies one's major medical insurance. He said 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. He said by transposing drug coverages into a major medical policy, it will create a dramatic shift in the cost of that drug coverage, thus increasing the overall cost of the health care coverage. (Attachment 1)

Jarrod Forbes, UnitedHealthcare, testified in opposition to **SB 195.** Mr. Forbes said first, this bill is seen as mandating coverage and UnitedHealthcare opposes all mandates on the grounds of cost. He said it is the consumers of Kansas who end up paying the cost. Second, he said this bill is attempting to apply the rules of one type of policy (major medical) to another type (pharmaceutical). He said in other states where this law has passed, it has created unnecessary administrative burdens on carriers. He said additionally, we believe this bill has the potential of resulting in less coverage for Kansans. He added that also in other states where this law has passed, small employers have opted to not provide any pharmaceutical coverage at all simply because they cannot afford the additional cost. (Attachment 2)

Minutes of the Senate Financial Institutions and Insurance Committee at 9:30 a.m. on February 10, 2010, in Room 152-S of the Capitol.

Marlee Carpenter, Kansas Association of Health Plans, testified in opposition to **SB 195.** Ms. Carpenter stated that this bill would require insurance companies to pay the same amount for IV anti-cancer treatments and orally administered anti-cancer treatments. She said 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 cost plans they can offer. She said mandates place additional requirements on health insurance companies in Kansas and limit their ability to offer new, innovative and lower cost health insurance products. (Attachment 3)

Brad Smoot, Blue Cross and Blue Shield of Kansas and Kansas City, testified in opposition to **SB 195.** In summary, Mr. Smoot stated that **SB 195** is unnecessary for those insured Kansans who already have "Cadillac" coverage; inapplicable to those who have no pharmacy benefit at all; and very costly to those who choose or can only afford more modest drug coverage. While **SB 195** 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. He added that there are probably some good reasons only a handful of states have adopted this mandate. (Attachment 4)

Rachelle Colombo, Senior Director of Legislative Affairs, The Kansas Chamber of Commerce, presented written testimony only in opposition to **SB 195.** (Attachment 5)

John Peterson, Capitol Strategies, LLC, presented written testimony only in support of **SB 195.** (Attachment 6)

The Chair closed the hearing on **SB 195.**

Action on

SB 424 - Vehicle registrations; insufficient payments by credit card or other instrument.

Melissa Calderwood gave a brief overview for **SB 424.**

Senator Taddiken moved that SB 424 be passed out favorably. Senator Steineger seconded. Motion passed.

The next meeting is scheduled for February 11, 2010.

The meeting was adjourned at 10:30 a.m.

SENATE FINANCIAL INSTITUTIONS & INS. COMMITTEE
GUEST LIST

DATE: 2-10-10

NAME	REPRESENTING
Teresa Cueter	Susan G. Komen
Peggy Johnson	Kansas Cancer Partnership
Janet Neff	KDHE
Katie Lane	Susan G. Komen
Lisa Covington	Susan G Komen
Bill Snead	AHIP
Malee Carpenter	KAHP
Kaye Uppington	self
Kari Presley	Kerney & Associates
Lon Church	KS Life & Health Assoc.
Kerri Spielman	KAIA
James Jeter	United Health Group
[illegible] MITCHELL	CBA
Ron Coches	KAIA
Chad Austin	KHA
Brent Koops	Hein Law Firm
Anne Spiess	American Cancer Society
Mark Mauck	KCCI A
Brad Smoot	BCBS

Polsinelli Shughart PC

Memorandum

TO: The Honorable Ruth Teichman, Chair
Senate Financial Institutions and Insurance Committee

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

SUBJECT: S.B. 195

DATE: January 28, 2010

Madam Chair, 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 S.B. 195.

Although the concept behind S.B. 195 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 accompanies one's major medical insurance. This pharmaceutical, or drug benefit rider, has a

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FI&I Committee
2-10-10
Attachment 1

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 not to act favorably on S.B. 195 for the reasons listed above.

I am available for questions at your convenience.

Respectfully submitted,

William W. Sneed

WWS:kjb
cc:
/

Benchmark Communications

JANUARY 28, 2010

STATEMENT IN OPPOSITION TO SB 195
SENATE FINANCIAL INSTITUTIONS AND INSURANCE

Chairwoman Teichman and Members of the Committee:

Thank you for allowing me to appear before you today. My name is Jarrod Forbes and I represent UnitedHealthcare. While we understand the intent of the proponents of SB 195, we respectfully oppose this bill for a variety of reasons.

First, we see this as a bill mandating coverage. As you know, we oppose all mandates on the grounds of cost. It is important to note that when we say mandates increase the cost of health insurance, it is the consumers of Kansas that end up paying that cost.

Second, this bill is attempting to apply the rules of one type of policy (major medical) to another type (pharmaceutical). In simple terms you are asking the rules of football to apply to soccer. While they are similar games, they have very different rules. In the few other states this law has passed it has created unnecessary administrative burdens on carriers.

Additionally, we believe this bill has the potential of resulting in less coverage for Kansans. In the few other states that this language has passed we have seen small employers opt to not provide any pharmaceutical coverage at all—simply because they cannot afford the additional cost.

While I am sure that is not the intent of the proponents, I am sure that if it has happened in other states, it will happen here.

Chairwoman Teichman, we understand that the proponents simply want the best treatment for their constituencies. However, we do not believe the legislation is necessary since the vast majority of businesses in Kansas do purchase policies that have generous coverage for cancer treatment, including over a dozen anticancer oral prescriptions. This legislation is not needed in Kansas at a time when we are trying to find ways to reduce the cost of health care—not increase it.

With that, I would be happy to answer any questions the committee may have.

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FI&I Committee
2-10-10
Attachment 2

Kansas Association of Health Plans

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Topeka, Kansas 66612

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marlee@brightcarpenter.com

January 28, 2010

SB 195
Before the Senate Financial Institutions and Insurance Committee
Marlee Carpenter, Executive Director

Chairman Teichman 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 195. 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.

FI & I Committee
2-10-10
Attachment 3

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.

BRAD SMOOT
ATTORNEY AT LAW

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LEAWOOD, KANSAS 66206

Statement of Brad Smoot
Legislative Counsel
Blue Cross Blue Shield of Kansas and Kansas City
Senate Financial Institutions and Insurance Committee
Regarding Senate Bill 195
February 10, 2010

Madam Chairman:

On behalf of two independent Blue Plans (BCBSKS & BCBSKC) serving Kansas, I am pleased to appear today to discuss SB 195. 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.

Senate Bill 195 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 195 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 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 195 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.

FI&I Committee
2-10-10
Attachment 4

Although we often focus attention on the impact of insurance mandates on our customers, as I've done above, SB 195 also presents some interesting if not insurmountable technical issues. For example, one third of BCBSKS' customers receive their benefits from other carriers or PBM's. How will other insurers determine what is in each of our policies and set their benefit structure to be "no less favorable?" In addition, SB 195 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 195 is unnecessary for those insured Kansans who already have "Cadillac" coverage; inapplicable to those who have no pharmacy benefit at all; and very costly to those who choose or can only afford more modest "Chevy" drug coverage. While SB 195 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. Thank you for consideration of our views.

achieve more

Legislative Testimony

SB 195

February 10, 2010

Senate Financial Institutions and Insurance

Rachelle Colombo, Senior Director of Legislative Affairs

Chairman Teichman, members of the Committee:

We appreciate the opportunity to provide written testimony in opposition to SB 195 which mandates the provision of coverage for the orally administered anticancer medications. While this is an emotional subject that impacts many Kansans, it behooves the legislature to first consider the effectiveness and financial impact of mandating coverage.

The Kansas Chamber and its members believe that before we impose higher premiums on employers, additional mandates should meet the financial impact requirements laid out in statute so that their cost can be accurately determined.

Studies show that mandates increase the cost of health care and drive up premium price. Increasing premium price makes health care less affordable and results in a growing number of uninsured. In a recent study, the Pacific Research Institute found that if the cost of insurance premiums rises by 1 percent, the number of uninsured people increases by 0.5 percent. This illustrates the detrimental impact of even minor increases in premium price on the uninsured population.

Managing health care costs is a top issue affecting profitability as identified by Kansas CEOs surveyed in the Chamber's annual CEO poll. Kansas business owners tell us that they want to provide health insurance and remain competitive, but the cost is too high. Already the cost of health care put business owners at a competitive disadvantage. Until statutory financial impact studies are conducted additional coverage should not be mandated.

The Kansas Chamber opposes SB 195 because the exact cost of implementing the coverage required has not yet been determined, but we do know that mandates increase the cost of health care. Before employers are burdened with increasing premium costs fattened by mandates and forced to shoulder the cost of an even heftier health care bill, we should study the financial and physical impact of new mandates on the market and the health of individuals.

Thank you for the opportunity to offer these comments today.

The Kansas Chamber, with headquarters in Topeka, is the leading statewide pro-business advocacy group moving Kansas towards becoming the best state in America to do business. The Chamber represents small, medium and large employers all across Kansas.

THE KANSAS CHAMBER

FI & I Committee
2-10-10
Attachment 5

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February 10, 2010

Senator Ruth Teichman, Chair
Senate Committee on Financial Institutions and Insurance
Statehouse, Room 236-E
Topeka KS 66612

RE: Impact Study—SB 195

Dear Chair Teichman:

Thank you for the opportunity to have hearings on Senate Bill 195, 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.

Senator Wagle correctly pointed out that Senate Bill 195 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. Also, as was noted during the testimony, the State Employees Health Plan already provides coverage consistent with Senate Bill 195.

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

Respectfully submitted,

John C. Peterson
GlaxoSmithKline

Enclosures

FI&I Committee
2-10-10
Attachment 6

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

6-3

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.

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.

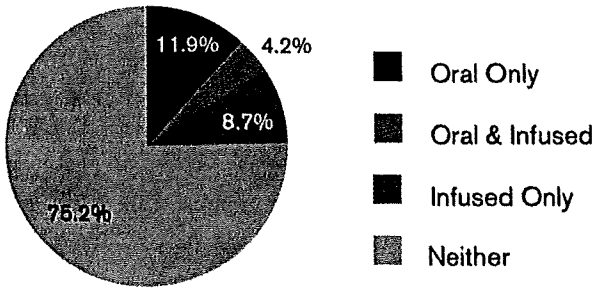
Many medical benefit designs offer some form of cap on member out-of-pocket costs. The trend toward prescription drug benefits with unlimited coinsurance, together with the introduction of often expensive oral agents, has made intravenous/injected-oral parity an issue.

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.

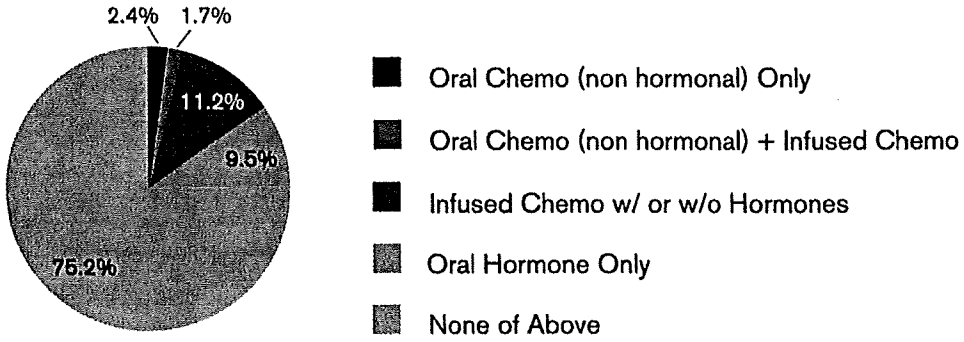
Figure 1: Distribution of Cancer Patients by Chemotherapy Treatment



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



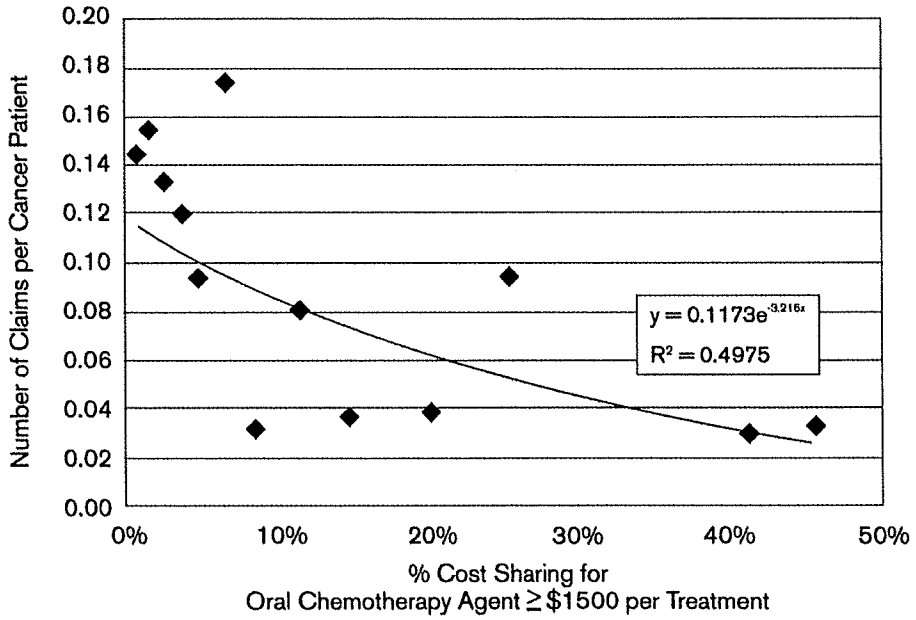
N = 172,547 cancer patients. Excludes basal cell skin cancer
Source: Milliman's work on MedStat Commercial 2007

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



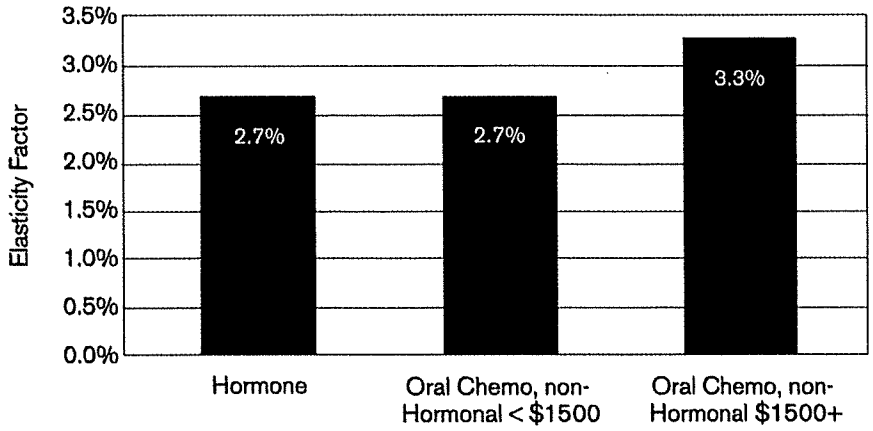
N = 24,474 cancer patients spread among 13 cost-sharing categories. Source: Milliman's analysis of MedStat Commercial 2007, 2008Q1-3 and Milliman proprietary data from 2007. Oral chemotherapy category does not include hormonal therapies. The box shows the best fit of a typical elasticity curve.

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.

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

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.

6-12

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

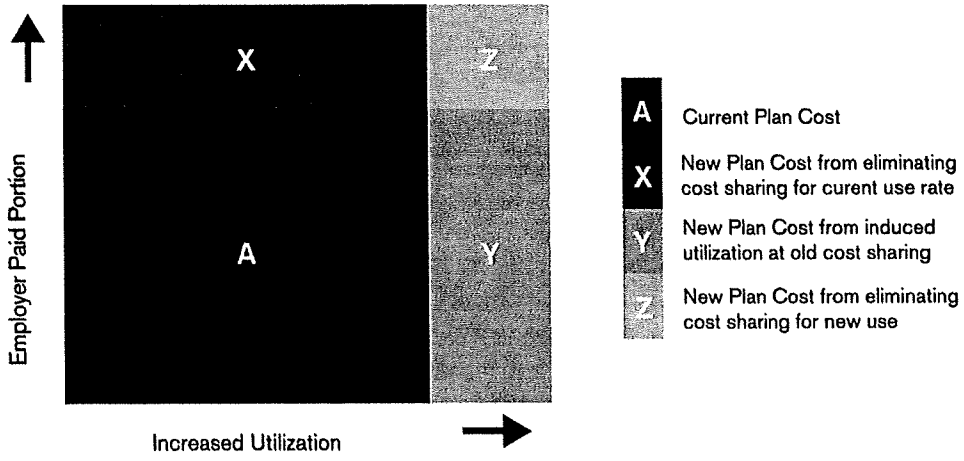
- The plan will pay for the difference in cost sharing for people who would have paid the original cost sharing.
- The plan will pay for the new utilization (induced utilization) that members would have avoided because of the original cost sharing. We divide this into two pieces:
    - The new services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

6-13

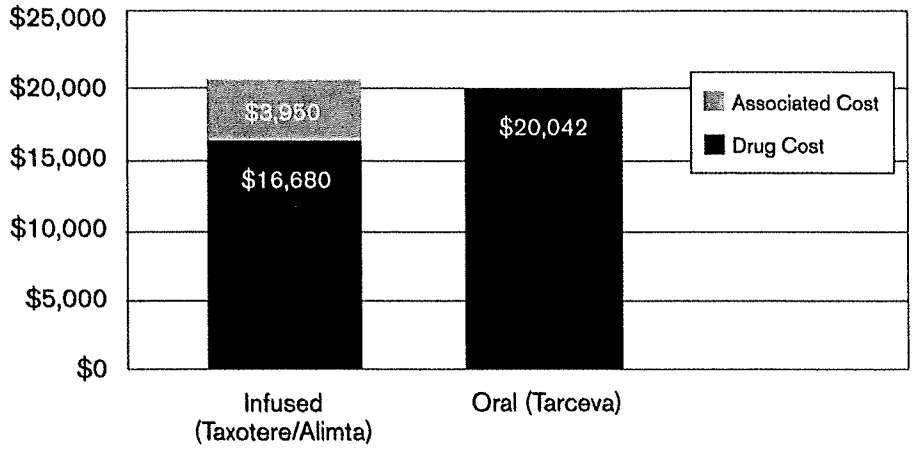
Although both oral and infused treatment options require close monitoring and follow up, infused therapies incur costs associated with IV administration. Several studies report costs associated with infused chemotherapy, although the reported costs vary. A study of the costs of IV administration in a 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

6-15

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

6-16

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.

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

$y = 0.0117e^{-3.21x}$, 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,

$$\frac{0.01173e^{-3.216(x-1\%)}}{0.01173e^{-3.216x}}-1=e^{3.216\times1\%}-1=3.3\%$$

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