

Patient Cost Disparity between Orally and Intravenously Administered Chemotherapies

**Report on Senate Bill 1143, Section 3
81st Legislature, Regular Session, 2009**



**Submitted by the
Texas Department of Insurance**

August 2010



Texas Department of Insurance

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August 1, 2010

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Dear Governors, Speaker and Chairmen:

In accordance with section three of SB 1143, 81st Texas Legislature, Regular Session, TDI conducted a study to analyze the disparity in patient copayments between orally and intravenously administered chemotherapies, the reasons for the disparity, and the patient benefits in establishing copayment parity between oral and infused chemotherapy agents. As required by SB 1143, this letter conveys a report that contains the results of this study, as well as recommendations for legislation during the 82nd Texas Legislative Session.

Thank you for the opportunity to provide this information and for your consideration of this report. Should you have any questions about this report, please contact me; Carol Cates, Associate Commissioner of Government Relations, at 463-6123; or Katrina Daniel, Senior Associate Commissioner of Life, Health & Licensing, at 305-7342.

Sincerely,

A handwritten signature in cursive script that reads "Mike Geeslin".

Mike Geeslin
Commissioner of Insurance

C: Members, Senate Committee on State Affairs
Members, House Committee on Insurance
Members, Senate Committee on Health and Human Services
Members, House Committee on Public Health

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Patient Cost Disparity between Orally and Intravenously Administered Chemotherapies

Executive Summary

Senate Bill (SB) 1143, as enacted by the 81st Texas Legislature, directed the Texas Department of Insurance (TDI) to “study the disparity in patient copayments between orally and intravenously administered chemotherapies, the reasons for the disparity, and the patient benefits in establishing copayment parity between oral and infused chemotherapy agents.”

In conducting this study, TDI sought input from external stakeholders that included physicians, pharmaceutical manufacturers, health benefit plan issuers, and individual consumers of pharmaceutical products. TDI also reviewed existing literature and studies regarding the cost of anticancer medication treatment, as well as recent reports by Milliman, Inc. and the California Health Benefits Review Program (CHBRP) that addressed the costs and benefits of establishing patient cost sharing parity between oral and intravenous anticancer medications. Finally, TDI conducted a survey of selected insurance carriers and health maintenance organizations (HMOs) to gather data on the cost and utilization of oral and intravenous/injected anticancer medications for fully insured group health benefit plan enrollees in Texas. Following is a summary of key study findings:

- Recent technological advancements have increased the availability and effectiveness of oral medications for cancer treatment. To date, 40 oral anticancer medications have received approval from the U.S. Food and Drug Administration (FDA), and these medications are recommended for treatment of 54 different types of cancer.
- Oral treatments offer patients distinct advantages over traditional intravenous chemotherapy, including increased convenience; enhanced flexibility in the timing, duration and location of administration; the lack of complications associated with administration; and often reduced side effects.
- Overall, 28 percent of the oral anticancer medications approved by the FDA have intravenous/injected substitutes and 23 percent have generic equivalents. In these cases, the choice between oral and intravenous administration largely depends on the preferences of the patient and attending physician and the ability of the patient to properly adhere to the treatment regimen. Since oral anticancer medications are frequently very expensive, the patient’s health insurance coverage and cost sharing responsibility also often play a significant role in this decision.
- Intravenous anticancer medications and oral anticancer medications are usually covered by separate benefit plans; specifically, intravenous medications are typically covered under a medical benefit plan, while oral medications are typically covered under a

prescription drug plan. Medical and prescription drug plans are administered by separate and distinct entities, and these plans can vary significantly.

- The patient's cost burden for intravenous medications is determined by the copayment, coinsurance, deductible, maximum out-of-pocket, and annual/lifetime maximum benefit provisions of the patient's medical benefit plan, while the patient's cost burden for oral medications is determined by these features of the patient's prescription drug plan.
- Medical benefit plans usually contain a lower average cost sharing requirement as a percentage of total covered medical benefits, while prescription drug plans usually contain a higher average cost sharing requirement as a percentage of total covered pharmacy benefits.
- High patient out-of-pocket costs for prescription drug plans are most often driven by unlimited coinsurance provisions, and these provisions often require patients to meet higher cost sharing requirements to obtain oral medications than medical benefit plans require for intravenous medications. Enrollees in small group plans and enrollees in the individual market are the most likely to face unlimited coinsurance requirements for pharmacy benefits.
- In Texas, fully insured group health benefit plan enrollees facing unlimited coinsurance requirements for pharmacy benefits currently experience a higher average cost sharing requirement for outpatient oral anticancer medications than for outpatient intravenous/injected anticancer medications. This discrepancy is approximately 7.3 percent between the most frequently prescribed outpatient anticancer medications within each category, 2.1 percent between the most costly outpatient anticancer medications per service/prescription within each category, and 1.3 percent between the outpatient anticancer medications that account for the largest share of total costs for such medications within each category.
- To date, nine states and the District of Columbia have passed "chemotherapy parity" legislation that attempts to equalize the member cost sharing requirements of oral anticancer medications and intravenous anticancer medications. In addition, similar legislation has been introduced in the U.S. Congress and in 18 other states. Many of these statutes generally require state-regulated insurance companies and HMOs to cover orally administered anticancer medications "on a basis no less favorable than" intravenously administered anticancer medications.
- Health plans that are subject to chemotherapy parity legislation are expected to comply by reducing the current cost sharing requirements for oral anticancer medications to match the current cost sharing requirements for intravenous anticancer medications. However, legislation that simply requires plans to cover orally administered anticancer medications "on a basis no less favorable than" intravenously administered anticancer medications could allow health plans to implement this legislation without reducing patient cost sharing requirements for oral anticancer medications.
- The implication of reducing patient out-of-pocket costs for pharmacy benefits is that these costs are effectively shifted from the patient to the health plan. The cost of implementing chemotherapy parity is estimated to be less than \$0.50 per member per month in most cases, although this estimate can increase to \$1.30 per member per month in cases where an enrollee faces high cost sharing requirements for pharmacy benefits and low cost sharing requirements for medical benefits.

Introduction

Pursuant to the enactment of Senate Bill 1143, 81st Texas Legislature, Regular Session, the Texas Department of Insurance conducted an interim study to analyze the patient cost disparity between orally and intravenously administered chemotherapies. Section three of SB 1143, which added Section 32.0221 to the Texas Insurance Code, directed TDI to “study the disparity in patient copayments between orally and intravenously administered chemotherapies, the reasons for the disparity, and the patient benefits in establishing copayment parity between oral and infused chemotherapy agents.” The legislation also instructed TDI to prepare a summary report to address these issues and provide recommendations for future legislation.¹

Oral anticancer medications have been available for several decades, and they are becoming an increasingly common treatment alternative for cancer patients. While oral medications provide patients a more convenient and less invasive treatment option than their traditional intravenous counterparts, both private and public insurance plans often require enrollees to pay higher out-of-pocket costs for oral medications than for intravenous medications.

The inconsistency between patient cost sharing requirements for intravenous and oral anticancer medications can largely be attributed to the fact that intravenous medications are usually covered as a medical benefit, while oral medications are usually covered as a pharmacy benefit. Medical and pharmacy benefits are commonly provided by separate benefit plans that are administered by separate and distinct entities; specifically, medical benefit plans are typically administered by an insurer, health maintenance organization, or third party administrator (TPA), while prescription drug plans are typically administered by a pharmacy benefit manager (PBM). The patient’s cost burden for an intravenous medication is usually therefore determined by the cost sharing requirements of the patient’s medical benefit plan, while the patient’s cost burden for an oral medication is determined by the cost sharing requirements of the patient’s pharmacy benefit plan.^{2,3}

Cost sharing requirements are one of the primary administrative and utilization management strategies utilized by insurance plans to control costs. Cost sharing requirements are intended to limit unnecessary or inappropriate utilization by exposing the patient to a portion of the cost of therapy. Common cost sharing provisions include copayments, coinsurance, and deductibles, and these provisions often vary significantly between policies. As recent advancements in pharmaceutical research lead to the discovery of more sophisticated and often more expensive oral drugs, cost sharing requirements that include unlimited coinsurance can significantly impact the ability of cancer patients to afford these treatments.

To date, nine states and the District of Columbia have passed “chemotherapy parity” legislation that attempts to equalize the member cost sharing requirements of oral anticancer medications

¹ Senate Bill 1143, as Enrolled by the 81st Texas Legislature.

² Fitch, Kathryn; Iwasaki, Kosuke; and Pyenson, Bruce. *Parity for Oral and Intravenous/Injected Cancer Drugs*. Prepared by Milliman, Inc., NY for GlaxoSmithKline. January 25, 2010.

³ California Health Benefits Review Program (CHBRP). *Analysis of Senate Bill 161: Health Care Coverage: Chemotherapy Treatment*. Report to California State Legislature. Oakland, CA. 2009.

and intravenous anticancer medications.⁴ In addition, similar legislation has been introduced in the U.S. Congress and in 18 other states.⁵ Many of these statutes generally require state-regulated insurance companies and HMOs to cover orally administered anticancer medications “on a basis no less favorable than” intravenously administered anticancer medications. Other statutes specify that these drugs must be covered “at the same copayment percentage or relative coinsurance amount,” or prohibit a “higher copayment, deductible, or coinsurance amount” for oral chemotherapy drugs. Most of these statutes and bills are limited to drugs that are “used to kill or slow the growth of cancerous cells,” and thereby exclude medications that are prescribed to reduce the common side effects of anticancer medications. Summaries of these statutes and bills are provided in Attachments A and B of this report.

Overall, chemotherapy parity statutes provide the most benefit for enrollees in small group plans and enrollees in the individual market. These enrollees are much more likely to face unlimited coinsurance requirements for pharmacy benefits than enrollees in large group plans. The cost of implementing chemotherapy parity will also be highest for these groups, so they will ultimately experience the highest premium increases as a result of chemotherapy parity legislation. Prominent studies by Milliman, Inc. and the California Health Benefits Review Program indicate that the estimated cost of implementing chemotherapy parity for these groups will be \$1.30 per member per month. In most other cases, the cost of implementing chemotherapy parity is estimated to be less than \$0.50 per member per month.^{6,7}

In Texas, fully insured health benefit plan enrollees facing unlimited coinsurance requirements for pharmacy benefits currently experience a higher average cost sharing requirement for outpatient oral anticancer medications than for outpatient intravenous/injected anticancer medications. This discrepancy is approximately 7.3 percent between the most frequently prescribed outpatient anticancer medications within each category, 2.1 percent between the most costly outpatient anticancer medications per service/prescription within each category, and 1.3 percent between the outpatient anticancer medications that account for the largest share of total costs for such medications within each category. Since many outpatient oral anticancer medications can cost several thousand dollars per prescription, this increased cost sharing can potentially equate to several hundred dollars per month for these cancer patients.

In the following sections, TDI provides background information on the overall burden of cancer in Texas, the basic approaches of treating cancer, and a description of how physicians determine the most appropriate course of treatment. The report also compares the design and cost sharing requirements of medical and prescription drug plans and summarizes previous studies that analyzed the costs and benefits of establishing chemotherapy parity. The report then provides additional Texas-specific data on the cost of oral and intravenous anticancer medications under fully insured group health benefit plans issued in Texas. TDI collected this data by distributing a survey to 19 insurance carriers and seven HMOs that wrote over 85 percent of the fully insured

⁴ Fitch, Kathryn; Iwasaki, Kosuke; and Pyenson, Bruce. *Parity for Oral and Intravenous/Injected Cancer Drugs*. Prepared by Milliman, Inc., NY for GlaxoSmithKline. January 25, 2010.

⁵ <http://capwiz.com/myeloma/issues/> - Accessed 7/5/2010.

⁶ Fitch, Kathryn; Iwasaki, Kosuke; and Pyenson, Bruce. *Parity for Oral and Intravenous/Injected Cancer Drugs*. Prepared by Milliman, Inc., NY for GlaxoSmithKline. January 25, 2010.

⁷ California Health Benefits Review Program (CHBRP). *Analysis of Senate Bill 161: Health Care Coverage: Chemotherapy Treatment*. Report to California State Legislature. Oakland, CA. 2009.

major medical health insurance premiums in Texas in calendar year 2009, and a complete analysis of this information is provided in Attachment C of this report. Finally, the report analyzes the potential impact of federal health reform on chemotherapy parity and provides recommendations for legislation during the 82nd Texas Legislative Session.

Texas Cancer Statistics

According to the American Cancer Society, there were approximately 441,000 Texans living with cancer in 2007 that had been diagnosed within the previous 10 years. Approximately 97,000 new cancer diagnoses are made in Texas each year, and nearly two-thirds of these cases occur in patients 60 years of age or older. Cancer is currently the second leading cause of death in Texas and the leading cause of death for Texas adults under the age of 75. In 2008, over 38,000 Texans died as a result of cancer. As demonstrated in Exhibit 1, prostate cancer, female breast cancer, lung and bronchus cancer, and colorectal cancer accounted for 54.2 percent of all new cancer cases and 50.4 percent of the overall cancer deaths in Texas in 2008.⁸

Exhibit 1: Texas Cancer Cases and Deaths by Cancer Site

Cancer Site	Cancer Incidence		Cancer Mortality	
	Number of New Cases	Percent of New Cases	Number of Deaths	Percent of Deaths
Prostate	15,506	15.9%	1,895	5.0%
Female Breast	15,132	15.6%	2,780	7.3%
Lung and Bronchus	12,117	12.5%	10,822	28.5%
Colorectal	9,879	10.2%	3,646	9.6%
All Other Sites	44,647	45.8%	18,894	49.6%
Total	97,281	100.0%	38,037	100.0%

Source: American Cancer Society, High Plains Division: *Texas Cancer Facts & Figures, 2008*

A broad array of factors can directly or indirectly influence an individual's susceptibility to specific types of cancer, including demographic characteristics (age, gender, and race/ethnicity), population characteristics (income, geography, education/literacy, and poverty), and individual characteristics (family history/genetics, environmental factors, and lifestyle risk factors). Many of these demographic disparities occur because members of certain population groups do not have the same overall health status as other population groups.⁹

In addition, there are factors that significantly impact the ultimate outcome and overall cost of cancer treatment. These include access to appropriate early-detection screening, access to providers and treatment facilities, and access to the most effective treatment protocols.¹⁰ Individuals that lack health insurance coverage are especially susceptible to the least favorable outcomes, primarily because they are less likely to receive prompt medical care or appropriate preventive care such as mammograms, cervical cancer screenings, or prostate screenings.¹¹

⁸ American Cancer Society, High Plains Division, Inc. *Texas Cancer Facts & Figures 2008*. Austin, TX: American Cancer Society, High Plains Division, 2008.

⁹ Ibid.

¹⁰ Ibid.

¹¹ State Health Access Data Assistance Center. *Characteristics of the Uninsured: A View from the States*. Prepared for the Robert Wood Johnson Foundation. 2005.

Since over one-fourth of the Texas population was uninsured in 2008,¹² these factors significantly impact the overall economic burden of cancer in Texas.

The Texas Cancer Registry estimates that the total cost of cancer in Texas was \$21.875 billion in 2007. This amount includes the direct costs of cancer screening, cancer treatment, and retail pharmaceuticals; the indirect costs of morbidity and mortality; and the related costs incurred by state agencies, non-profit organizations and foundations. Of this amount, almost \$7.7 billion resulted from the direct cost of cancer care, and \$334.5 million resulted from the direct cost of retail pharmaceuticals. The full results of this cost analysis are demonstrated in Exhibit 2.¹³

Exhibit 2: The Cost of Cancer in Texas

Cost Component	Estimated Total Cost of Cancer in Texas
Direct Costs	
Cancer Care	\$7,699,400,000
Cancer Screening	\$1,963,500,000
Retail Pharmaceuticals	\$334,500,000
Total Direct Costs	\$9,997,400,000
Indirect Costs	
Morbidity (Loss of productivity)	\$3,757,500,000
Mortality (Future wages, fringe benefits, etc.)	\$8,042,000,000
Total Indirect Costs	\$11,799,500,000
Related Costs	
State Agency Budgets	\$26,100,000
Nonprofits and Foundations	\$52,400,000
Total Related Costs	\$78,500,000
Total	\$21,875,400,000

Source: Texas Cancer Registry: The Cost of Cancer in Texas, 2007.

¹² U.S. Census Bureau. March 2009 Current Population Survey (Texas Sample).

¹³ Tan, A.; Freeman, D.H.; Freeman, J.L.; Zhang, D.D.; Dayal, H.; and Philips, B.U. *The Cost of Cancer in Texas, 2007*. Texas Cancer Registry, Texas Department of State Health Services. Publication No. 10-13121. March 2009.

Cancer Treatment Alternatives

The primary approaches to cancer treatment include anticancer drug therapy, surgical treatment, and radiation therapy. These approaches can be used individually or in combination depending on the type of cancer present, the stage of the disease, and the individual characteristics of the patient.

Over 100 anticancer medications are currently in use, and these medications are administered to patients using a variety of approaches. Traditional chemotherapy treatments are usually administered intravenously to allow the drug to travel throughout the body to reach cancer cells wherever they exist. Additional common techniques include oral administration of pills and liquids, as well as injections made either into the muscle or under the skin. Numerous alternative methods of administration have been developed as well, including topical application of creams or lotions, arterial injections, and infusions made into a specific organ or area of the body.^{14,15}

While most anticancer medications are administered using only one approach, it is becoming increasingly common for medications to be available both in both oral and intravenous forms. This recent increase in the prevalence of oral medications is largely the result of a noted shift in the research and development efforts of pharmaceutical companies. Of the estimated 400 new chemotherapy drugs that are currently under development, approximately 100 are anticipated to be released as oral drugs.^{16,17}

To date, 40 oral anticancer medications have received approval from the U.S. Food and Drug Administration, and these medications are recommended for treatment of 54 different types of cancer.^{18,19} Their uses include preventing cancer cell growth, preventing recurrence for patients who have already received treatment, treating inoperable cancers, and treating advanced or metastatic cancers. Overall, 28 percent of the oral anticancer medications approved by the FDA have intravenous/injected substitutes and 23 percent have generic equivalents.²⁰

Anticancer medications vary widely in their chemical makeup, the types of cancer they target, and their side effects to patients. There are three primary categories of anticancer drug therapy: cytotoxic agents, biologic/targeted agents, and hormonal agents.²¹

¹⁴ American Cancer Society. *Chemotherapy Principles: An Indepth Discussion of the Techniques and Its Role in Cancer Treatment*. 2009.

¹⁵ California Health Benefits Review Program (CHBRP). *Analysis of Senate Bill 161: Health Care Coverage: Chemotherapy Treatment*. Report to California State Legislature. Oakland, CA. 2009.

¹⁶ Fitch, Kathryn; Iwasaki, Kosuke; and Pyenson, Bruce. *Parity for Oral and Intravenous/Injected Cancer Drugs*. Prepared by Milliman, Inc., NY for GlaxoSmithKline. January 25, 2010.

¹⁷ California Health Benefits Review Program (CHBRP). *Analysis of Senate Bill 161: Health Care Coverage: Chemotherapy Treatment*. Report to California State Legislature. Oakland, CA. 2009.

¹⁸ Ibid.

¹⁹ <http://www.centerwatch.com/drug-information/fda-approvals/> - Accessed 7/22/2010.

²⁰ California Health Benefits Review Program (CHBRP). *Analysis of Senate Bill 161: Health Care Coverage: Chemotherapy Treatment*. Report to California State Legislature. Oakland, CA. 2009.

²¹ American Cancer Society. *Chemotherapy Principles: An Indepth Discussion of the Techniques and Its Role in Cancer Treatment*. 2009.

- Cytotoxic agents are intended to kill cancer cells by impairing cell division in rapidly dividing cells. As an unintended consequence, these agents harm cells that divide rapidly under normal circumstances, including bone marrow, the intestinal lining, and hair follicles.²² These agents are usually administered intravenously in the maximum dose that can be tolerated by the patient to maximize their effectiveness. They are also usually administered in specific treatment cycles to allow the patient to recover from side effects.²³ Cytotoxic drugs include alkylating agents, which damage cancer cell DNA to impede cell reproduction; antimetabolites, which interfere with DNA and RNA growth; antitumor antibiotics, which block certain enzymes to impede DNA replication; and plant alkaloids, which stop cell division or inhibit cell reproduction.²⁴
- Biologic/targeted agents are directed at specific biologic pathways in cancer cells, and they are currently a primary focus for cancer research. These medications often either attack cells that contain mutated genes or cells that contain duplications of a particular gene. Since these agents specifically target cancer cells, they often have less severe side effects than traditional chemotherapy.²⁵ Targeted agents are often administered orally, because these agents are most effective when administered on a frequent, recurring basis to allow continuous exposure of the cancer cells to the drug therapy.²⁶
- Hormonal agents alter the action or production of hormones to slow the growth cancers which normally grow in response to natural hormones in the body, such as breast, prostate, and uterine cancers. These cancer treatments either prevent the body from making certain hormones or prevent cancer cells from using the hormones that facilitate cell growth.²⁷ Hormonal agents can generally be obtained at a lower cost than cytotoxic or targeted anticancer medications,²⁸ and they can be administered orally, as an infusion, or as an injection.

²² <http://en.wikipedia.org/wiki/Chemotherapy>- Accessed 7/11/2010.

²³ Fitch, Kathryn; Iwasaki, Kosuke; and Pyenson, Bruce. *Parity for Oral and Intravenous/Injected Cancer Drugs*. Prepared by Milliman, Inc., NY for GlaxoSmithKline. January 25, 2010.

²⁴ American Cancer Society. *Chemotherapy Principles: An Indepth Discussion of the Techniques and Its Role in Cancer Treatment*. 2009.

²⁵ Ibid.

²⁶ Fitch, Kathryn; Iwasaki, Kosuke; and Pyenson, Bruce. *Parity for Oral and Intravenous/Injected Cancer Drugs*. Prepared by Milliman, Inc., NY for GlaxoSmithKline. January 25, 2010.

²⁷ American Cancer Society. *Chemotherapy Principles: An Indepth Discussion of the Techniques and Its Role in Cancer Treatment*. 2009.

²⁸ Fitch, Kathryn; Iwasaki, Kosuke; and Pyenson, Bruce. *Parity for Oral and Intravenous/Injected Cancer Drugs*. Prepared by Milliman, Inc., NY for GlaxoSmithKline. January 25, 2010.

Choice of Therapy

The National Comprehensive Cancer Network (NCCN) publishes evidence-based treatment guidelines that are designed to assist physicians in the diagnosis, treatment, management and monitoring of cancer patients. NCCN guidelines represent the most comprehensive and most frequently updated clinical practice guidelines available in the medical field, and they are recognized as the clinical standard for cancer treatment.²⁹ These guidelines provide recommended cancer treatment protocols that are driven by the type of cancer present and the stage of the disease. Depending on these variables, the overall goal of cancer treatment can be to eliminate the presence of cancer cells entirely, to stop the cancer from growing and spreading, or, in advanced stages of the disease, to simply relieve cancer symptoms and improve the quality of the patient's life.³⁰

Some NCCN guidelines recommend the administration of a single intravenous anticancer medication or a single oral anticancer medication. Other recommended protocols suggest various combinations of anticancer medication treatments, which can include multiple intravenous medications or a combination of intravenous and oral medications. When a drug is available in both intravenous and oral form, the guidelines also indicate that these drugs can potentially be substituted for one another.³¹

The choice between oral and intravenous administration largely depends on the preferences of the patient and attending physician and the ability of the patient to properly adhere to the treatment regimen.³² However, additional factors that contribute to this decision include the age and general health of the patient; the presence of other serious health problems, including heart, liver, or kidney diseases; and the type and effectiveness of past anticancer treatments. The patient's health insurance coverage and cost sharing responsibility often play a significant role in this decision as well.³³

When selecting a course of treatment, patients and providers must consider additional advantages and disadvantages of oral anticancer medications. Patients usually require fewer office visits when they are exclusively taking an oral treatment regimen, and oral drugs often lead to fewer undesirable side effects.³⁴ They allow the patient to avoid numerous complications that may occur with intravenous administration, which include pain at the intravenous site, infection, and damage to the vein. Oral medications are less costly to administer than intravenous medications, as they do not require the associated costs of an office visit or nursing staff supervision for each

²⁹ <http://www.nccn.com/NCCN-Clinical-Practice-Guidelines/> - Accessed 7/13/2010.

³⁰ American Cancer Society. *Chemotherapy Principles: An In-depth Discussion of the Techniques and Its Role in Cancer Treatment*. 2009.

³¹ Fitch, Kathryn; Iwasaki, Kosuke; and Pyenson, Bruce. *Parity for Oral and Intravenous/Injected Cancer Drugs*. Prepared by Milliman, Inc., NY for GlaxoSmithKline. January 25, 2010.

³² Weingart, Saul; Brown, Elizabeth; Bach, Peter et al. *NCCN Task Force Report: Oral Chemotherapy*. Journal of the National Comprehensive Cancer Network. Volume 6, Supplement 3. March 2008.

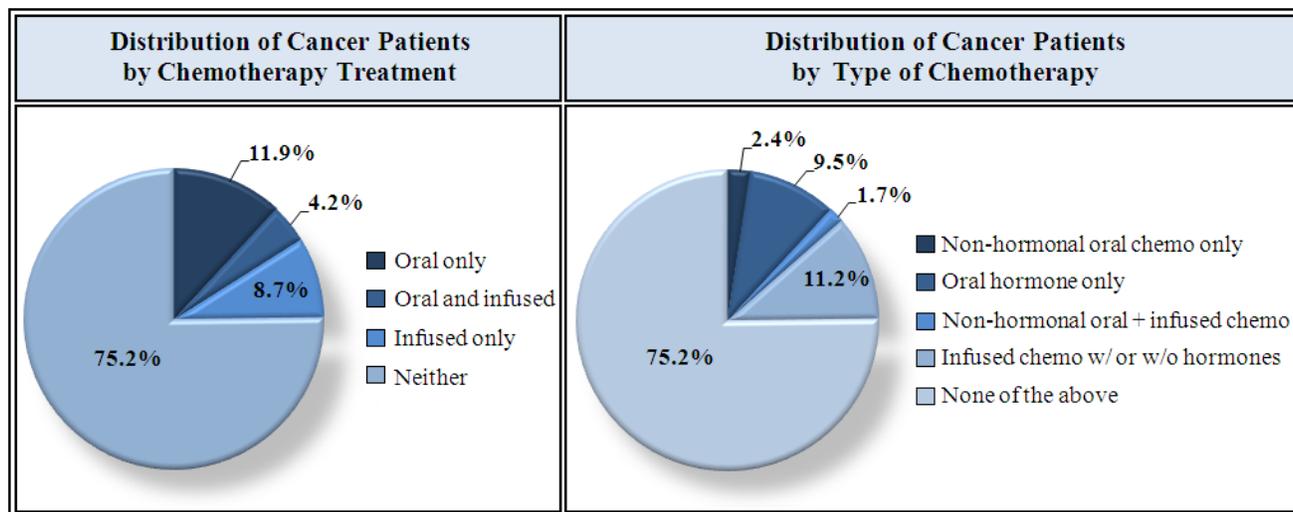
³³ American Cancer Society. *Chemotherapy Principles: An In-depth Discussion of the Techniques and Its Role in Cancer Treatment*. 2009.

³⁴ Weingart, Saul; Brown, Elizabeth; Bach, Peter et al. *NCCN Task Force Report: Oral Chemotherapy*. Journal of the National Comprehensive Cancer Network. Volume 6, Supplement 3. March 2008.

treatment. Oral medications also allow the patient to feel a sense of empowerment by taking an active role in their cancer treatment. This comes with a significant amount of responsibility, because the physician is no longer able to strictly monitor adherence to the treatment regimen, side effects, toxicity, or dosage accuracy. Since many oral treatment regimens can be highly complex, oral treatment also requires the physician or physician’s nursing staff to invest a significant amount of time educating the patient and providing ongoing consultation and support. Oral treatment also requires the physician to coordinate with specialty pharmacies, hospital pharmacies, free-standing clinics, and mid-level providers to implement and oversee patient care.³⁵ Finally, oral anticancer medications are frequently very expensive, and patients must pay for these medications up front when they are received from a pharmacy. Conversely, patients taking intravenous medications typically satisfy their copayment at the time of service and then pay any remaining balance due after the insurance claim has been processed.³⁶

To quantify the prevalence of oral chemotherapy treatment, Milliman, Inc. performed a detailed analysis of data from the Thompson Reuters MedStat database. Milliman determined that about 1.5 percent of the population with commercial insurance has a medical claim for cancer each year, and 24.8 percent of cancer patients receive chemotherapy. Further, they found that 48.0 percent of chemotherapy patients receive oral treatment only; 35.1 percent receive intravenous treatment only; and 16.9 percent receive both oral and intravenous treatment. The charts below demonstrate the full results of Milliman’s analysis, which excludes basal cell skin cancer.³⁷

Exhibit 3: Cancer Patients by Chemotherapy Treatment and Type of Chemotherapy



Source: Milliman, Inc: Parity for Oral and Intravenous/Injected Cancer Drugs

When the California legislature introduced chemotherapy parity legislation in 2009, the California Health Benefits Review Program performed a similar analysis relating to enrollees in

³⁵ Weingart, Saul; Brown, Elizabeth; Bach, Peter et al. *NCCN Task Force Report: Oral Chemotherapy*. Journal of the National Comprehensive Cancer Network. Volume 6, Supplement 3. March 2008.

³⁶ Mahay, Heidi. *Oral Chemotherapy: Patient Advantages and Challenges*. August 15, 2009.

³⁷ Fitch, Kathryn; Iwasaki, Kosuke; and Pyenson, Bruce. *Parity for Oral and Intravenous/Injected Cancer Drugs*. Prepared by Milliman, Inc., NY for GlaxoSmithKline. January 25, 2010.

insurance plans that are regulated by the California Department of Insurance (CDI) and enrollees in HMO plans that are regulated by the California Department of Managed Health Care (CDMHC). While this population includes plans and policies in the large employer, small employer and individual insurance markets, it does not include enrollees in self-insured employer plans. CHBRP estimates that 0.4 percent of the enrollees in this population will use outpatient oral anticancer medications in 2010. CHBRP also estimates that 69.5 percent of the people using anticancer medications will use oral drugs only; 20.2 percent will use injected or intravenous drugs only; and 10.3 percent will use both oral and injected/intravenous drugs.³⁸

³⁸ California Health Benefits Review Program (CHBRP). *Analysis of Senate Bill 161: Health Care Coverage: Chemotherapy Treatment*. Report to California State Legislature. Oakland, CA. 2009.

Anticancer Medication Coverage and Cost Sharing

Most benefit plans use the dispensing site of the medication to determine whether it will be covered as a medical benefit or a pharmacy benefit. Intravenous anticancer medications are most commonly administered in a hospital, outpatient treatment facility, or physician's office, so they are usually covered as a medical benefit. Conversely, oral anticancer medications are most commonly dispensed by a pharmacist, so they are usually covered as a pharmacy benefit.^{39,40} In cases where oral anticancer medications are administered in an inpatient facility such as a hospital, these medications are covered as a medical benefit.

For injected anticancer medications, the source of coverage is dependent on the drug. Some injected medications can only be administered by a physician, and these drugs are therefore covered as a medical benefit. Other injected medications can be directly obtained from a pharmacy and self-administered by the patient, so they are covered as a pharmacy benefit.⁴¹

Medical and pharmacy benefits are typically provided by benefit plans that are administered by separate and distinct entities. Specifically, medical benefit plans are typically administered by an insurer, health maintenance organization, or third party administrator, while prescription drug plans are typically administered by a pharmacy benefit manager.

Benefit plans utilize a variety of administration and utilization management strategies to control costs, including patient cost sharing, prior authorization, and pharmacy formularies. Cost sharing requirements are intended to limit unnecessary or inappropriate utilization by exposing the patient to a portion of the cost of therapy. Common cost sharing provisions include the following:

- Deductible: a fixed dollar amount that the enrollee must pay out of pocket during each policy period before the insurer will cover any expenses;
- Copayment: a fixed dollar amount that the enrollee must pay at the time of receiving a health care service or prescription; and
- Coinsurance: a fixed percentage of covered health care costs for which the enrollee is responsible after the enrollee satisfies any applicable deductible.

Some contracts and policies also include provisions that limit the total amount that the plan will pay toward the cost of care. These include the following:

- Annual maximum benefit: the maximum dollar amount a plan will pay toward the cost of care incurred by an enrollee during each annual policy period; and
- Lifetime maximum benefit: the total maximum dollar amount a plan will pay toward the cost of care incurred by an enrollee during the enrollee's lifetime.

³⁹ Ibid.

⁴⁰ Fitch, Kathryn; Iwasaki, Kosuke; and Pyenson, Bruce. *Parity for Oral and Intravenous/Injected Cancer Drugs*. Prepared by Milliman, Inc., NY for GlaxoSmithKline. January 25, 2010.

⁴¹ California Health Benefits Review Program (CHBRP). *Analysis of Senate Bill 161: Health Care Coverage: Chemotherapy Treatment*. Report to California State Legislature. Oakland, CA. 2009.

Medical benefit plans and prescription drug plans can vary widely, and the patient's applicable contract or policy will ultimately determine whether a medication is covered and what cost sharing requirements apply. The patient's overall cost sharing requirement for intravenous medications is usually determined by the deductible, copayment and coinsurance requirements of the patient's medical benefit plan, while the patient's cost sharing requirement for oral medications is usually determined by these features of the patient's pharmacy benefit plan.^{42,43} According to Milliman, Inc., medical benefit plans usually contain a lower average cost sharing requirement as a percentage of total covered medical benefits, while prescription drug plans usually contain a higher average cost sharing requirement as a percentage of total covered pharmacy benefits.⁴⁴

For benefit plans that do not include coinsurance requirements, annual maximum benefits or lifetime maximum benefits, the patient faces a minimal risk of incurring high out-of-pocket costs.⁴⁵ In these cases, the patient will only be required to meet the copayment and/or deductible requirements of their benefit plan. While this would be the ideal scenario for a cancer patient who is facing high-cost medical care or prescription drugs, these plans are usually quite expensive. Therefore, employers and individuals often select plans with enhanced cost sharing requirements to make the plans more affordable.

The patient's exposure to high cost sharing is often reduced in medical benefit plans that include a maximum out-of-pocket limit.⁴⁶ When this feature is included in a contract or policy, the benefit plan will cover 100 percent of claim costs after the patient reaches this limit.

While prescription drug plans usually do not provide a maximum out-of-pocket limit, traditional plan designs limit the patient's potential cost burden by requiring only a fixed copayment for each prescription.⁴⁷ These plans often group medications into three or more formulary tiers, and this pricing structure further complicates the cost sharing requirements for prescription drugs.⁴⁸ In tiered formularies, the first tier usually contains inexpensive generic medications and requires the lowest copayment. The second formulary tier usually contains preferred brand name medications and requires a higher copayment than the first tier. In many cases, a health plan or pharmacy benefit manager will place a drug in the preferred tier when it is able to negotiate a discounted price with the drug manufacturer. The third formulary tier usually includes non-preferred brand name medications and requires the highest copayment. A drug may be placed on the third tier because it is new and unproven, or because there is a similar drug on a lower tier of the formulary that may provide the same benefit at a lower cost.

⁴² Ibid.

⁴³ Fitch, Kathryn; Iwasaki, Kosuke; and Pyenson, Bruce. *Parity for Oral and Intravenous/Injected Cancer Drugs*. Prepared by Milliman, Inc., NY for GlaxoSmithKline. January 25, 2010.

⁴⁴ Ibid.

⁴⁵ Ibid.

⁴⁶ Ibid.

⁴⁷ Ibid.

⁴⁸ California Health Benefits Review Program (CHBRP). *Analysis of Senate Bill 161: Health Care Coverage: Chemotherapy Treatment*. Report to California State Legislature. Oakland, CA. 2009.

Many prescription drug formularies have recently implemented a fourth formulary tier that includes only very expensive “specialty” medications. Oral anticancer medications, especially targeted therapies, are often placed on this tier. This specialty tier commonly contains an unlimited coinsurance provision that requires the patient to pay a set percentage, often 20 to 40 percent or more, of each prescription drug claim. The patient will incur a significantly higher cost to obtain specialty drugs when an unlimited copayment provision is in place.

Chemotherapy Parity

To date, nine states and the District of Columbia have passed “chemotherapy parity” legislation that attempts to equalize the member cost sharing requirements of oral and intravenous anticancer medications.⁴⁹ In addition, similar legislation has been introduced in 18 other states.⁵⁰ Many of these statutes generally require state-regulated insurance companies and HMOs to cover orally administered anticancer medications “on a basis no less favorable than” intravenously administered anticancer medications. Other statutes specify that these drugs must be covered “at the same copayment percentage or relative coinsurance amount,” or prohibit a “higher co-payment, deductible, or coinsurance amount” for oral chemotherapy drugs. Most of these statutes and bills are limited to drugs that are “used to kill or slow the growth of cancerous cells,” and thereby exclude medications that are prescribed to reduce the common side effects of anticancer medications. Summaries of these statutes and bills are provided in Attachments A and B of this report.

In addition, Representative Brian Higgins introduced legislation in the U.S. Congress in 2009 to address chemotherapy parity in self-insured health benefit plans. This legislation, the Cancer Drug Coverage Parity Act of 2009, would “amend the Employee Retirement Income Security Act of 1974, the Public Health Service Act, and the Internal Revenue Code of 1986 to 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.”⁵¹

Health plans that are subject to chemotherapy parity legislation are expected to comply by reducing the current cost sharing requirements for oral anticancer medications to match the current cost sharing requirements for intravenous anticancer medications. However, legislation that simply requires plans to cover orally administered anticancer medications “on a basis no less favorable than” intravenously administered anticancer medications could allow health plans to *increase* the cost sharing requirements for intravenous medications.⁵² For this reason, the recently enacted chemotherapy parity statute in Minnesota stipulates that, “A health plan company must not achieve compliance by imposing an increase in co-payment, deductible, or coinsurance amount for an intravenously administered or injected cancer chemotherapy agent covered under the health plan.”⁵³

The National Patient Advocate Foundation (NPAF) suggests that states broaden this restriction, because anticancer medications “could be moved from requiring a relatively low copay from the patient to a classification as a medical benefit or to a specialty tier classification requiring higher coinsurance rates for the patient.” Specifically, NPAF recommends that states include language

⁴⁹ Fitch, Kathryn; Iwasaki, Kosuke; and Pyenson, Bruce. *Parity for Oral and Intravenous/Injected Cancer Drugs*. Prepared by Milliman, Inc., NY for GlaxoSmithKline. January 25, 2010.

⁵⁰ <http://capwiz.com/myeloma/issues/> - Accessed 7/5/2010

⁵¹ H.R. 2366, 111th U.S. Congress.

⁵² California Health Benefits Review Program (CHBRP). *Analysis of Senate Bill 161: Health Care Coverage: Chemotherapy Treatment*. Report to California State Legislature. Oakland, CA. 2009.

⁵³ SF 1761, 86th Minnesota Legislative Session.

from the Massachusetts bill, which states, "An increase in patient cost sharing for anticancer medications is not allowed to achieve compliance with this provision."⁵⁴

The anticipated result of chemotherapy parity statutes is to lower the patient’s out-of-pocket costs for oral anticancer medications. While this reduction would have a minimal impact on enrollees in traditional pharmacy benefit plan designs that only require copayments, enrollees facing unlimited coinsurance requirements for specialty drugs, as in the four tier plans described above, could receive a notable benefit.^{55,56}

The implication of reducing patient out-of-pocket costs for pharmacy benefits, however, is that these costs are effectively shifted from the patient to the health plan. To quantify this amount, Milliman, Inc. calculated that the cost of implementing chemotherapy parity would be less than \$0.50 per member per month for most plan designs. In cases where the medical benefit cost sharing percentage is currently low and the prescription benefit cost sharing percentage is currently high, implementing chemotherapy parity would cost between \$0.50 and \$1.30 per member per month. Exhibit 4 demonstrates the full results of Milliman’s analysis, which excludes administrative costs.⁵⁷

Exhibit 4: Milliman’s PMPM Cost Estimates of Implementing Chemotherapy Parity

		Current Oral Chemotherapy Cost Sharing Percentage		
		Low	Medium	High
Current 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

Source: Milliman, Inc.: Parity for Oral and Intravenous/Injected Cancer Drugs

The California Health Benefits Review Program performed a similar analysis of the cost of implementing chemotherapy parity, but their analysis provided additional insight on the impact to regulated plans by plan type and market segment. As demonstrated in Exhibit 5, CHBRP found that large group enrollees are expected to experience the lowest PMPM cost of implementation for both insurance carriers and HMOs, while individual enrollees are expected to experience the highest PMPM cost of implementation.⁵⁸ Overall, individual and small group

⁵⁴ National Patient Advocate Foundation - 2010 State Principles & Priorities. <http://www.npaf.org/state/2007-principles-priorities.html#Oral%20Chemo> – Accessed 7/19/2010.

⁵⁵ California Health Benefits Review Program (CHBRP). *Analysis of Senate Bill 161: Health Care Coverage: Chemotherapy Treatment*. Report to California State Legislature. Oakland, CA. 2009.

⁵⁶ Fitch, Kathryn; Iwasaki, Kosuke; and Pyenson, Bruce. *Parity for Oral and Intravenous/Injected Cancer Drugs*. Prepared by Milliman, Inc., NY for GlaxoSmithKline. January 25, 2010.

⁵⁷ Ibid.

⁵⁸ California Health Benefits Review Program (CHBRP). *Analysis of Senate Bill 161: Health Care Coverage: Chemotherapy Treatment*. Report to California State Legislature. Oakland, CA. 2009.

enrollees are much more likely to face unlimited coinsurance requirements for pharmacy benefits than large group enrollees.⁵⁹

Exhibit 5: CHBRP’s PMPM Cost Estimates of Implementing Chemotherapy Parity

	Market Segment		
	Large Group	Small Group	Individual
Insurance plans regulated by CDI	\$0.0527	\$0.2818	\$0.7958
HMO plans regulated by CDMHC	\$0.0324	\$0.0356	\$0.0421

Source: California Health Benefits Review Program: Analysis of Senate Bill 161: Health Care Coverage: Chemotherapy Treatment.

One significant difference between the Milliman and CHBRP studies involves the relationship between out-of-pocket costs and the utilization of high-cost anticancer medications. Economists analyze how the quantity demanded of a good or service will respond to a change in price, and this measure is referred to as the price elasticity of demand. Utilization for a product will increase when the cost of the product decreases in the vast majority of cases, and Milliman determined that this relationship holds true for anticancer medications. Specifically, utilization for non-hormonal oral anticancer medications costing over \$1,500 will increase by 3.3 percent with each one percent reduction in the patient’s cost sharing requirement. Further, utilization for all hormonal medications, as well as non-hormonal oral anticancer medications costing under \$1,500, will increase by 2.7 percent with each one percent reduction in cost sharing.⁶⁰

In contrast, CHBRP determined that there would be “no increase in the number of users and no increase in the units of oral anticancer medication or utilization of oral anticancer medications among existing users of anticancer medications.” CHBRP cited several factors that contributed to this conclusion, which include the following:

- Nearly 98 percent of enrollees in plans that are subject to the chemotherapy parity legislation in California already have some oral anticancer medication coverage.
- The price elasticity of demand is significantly lower for anticancer medications than for other prescription drugs.
- Due to the nature of the disease, cancer patients will make every effort to comply with their treatment regimen and will seek alternative funding sources if necessary.
- A number of public and private programs provide financial assistance to some patients, including charitable efforts by drug manufacturers.
- Physicians are unlikely to change their prescribing practices as a result of chemotherapy parity legislation.⁶¹

⁵⁹ Fitch, Kathryn; Iwasaki, Kosuke; and Pyenson, Bruce. *Parity for Oral and Intravenous/Injected Cancer Drugs*. Prepared by Milliman, Inc., NY for GlaxoSmithKline. January 25, 2010.

⁶⁰ Fitch, Kathryn; Iwasaki, Kosuke; and Pyenson, Bruce. *Parity for Oral and Intravenous/Injected Cancer Drugs*. Prepared by Milliman, Inc., NY for GlaxoSmithKline. January 25, 2010.

⁶¹ California Health Benefits Review Program (CHBRP). *Analysis of Senate Bill 161: Health Care Coverage: Chemotherapy Treatment*. Report to California State Legislature. Oakland, CA. 2009.

TDI Survey Results

To gather Texas-specific data on the cost of oral and intravenous/injected chemotherapy, TDI distributed a survey to selected insurance carriers and HMOs that wrote over 85 percent of the fully insured major medical health insurance premiums in Texas in calendar year 2009.

The questions on the survey related only to fully insured group health benefit plan coverage written by responding companies in Texas during calendar year 2009. As defined in Section 1501.002 (5) of the Texas Insurance Code, a health benefit plan is a “group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services.” The complete statutory definition of this term is provided on page A-26 of this report.

It is important to note that data was not collected for self-funded benefit plans or individual benefit plans. Self-funded plans were excluded from the survey population because they are exempt from state regulation under the federal Employee Retirement Income Security Act. Self-funded plans are usually provided by large companies, and these plans represent approximately 60 percent of employer-based coverage in Texas. Individual or “direct purchase” plans vary widely, and many of these are limited benefit plans. Only 29 percent of the fully insured benefit plans sold in Texas are direct purchase plans, and the remaining 71 percent are group plans.

Overall, 19 insurance carriers and seven HMOs responded to the survey; however, one of these responses was removed from this analysis because it contained materially incomplete data. The remaining 25 responses are summarized below, and a complete analysis is provided in Attachment C of this report.

Background Information

- Survey respondents had a total of 3,038,037 fully insured health benefit plan enrollees.
- A total of 2,485,960 enrollees (81.83 percent) were also covered by pharmacy benefits, which indicates that 552,077 enrollees were not covered by pharmacy benefits.
- Respondents indicated that 100 percent of enrollees with pharmacy coverage had at least some coverage for the following:
 - Inpatient intravenous and injected anticancer medications,
 - Outpatient intravenous and injected anticancer medications, and
 - Inpatient oral anticancer medications.
- Respondents indicated that 99.996 percent of enrollees with pharmacy coverage had at least some coverage for outpatient oral anticancer medications.

Outpatient Intravenous/Injected Anticancer Medications

- 14 companies (56 percent) indicated that outpatient intravenous/injected anticancer medications are covered through medical benefits, while 11 companies (44 percent) indicated that these medications can be covered through either medical benefits or pharmacy benefits depending on the medication.
- 10,195 enrollees had at least one outpatient intravenous/injected anticancer medication claim, which represents 0.336 percent of total enrollees.
- 1,544 of the enrollees with at least one outpatient intravenous/injected anticancer medication claim reached their annual maximum medical benefit. This represents 15.14 percent of enrollees with at least one intravenous/injected anticancer medication claim, and 0.051 percent of total enrollees.
- These companies performed a total of 96,402 outpatient intravenous/injected anticancer medication services. (For the purpose of this survey, each unique anticancer medication treatment is considered a service.) This represents 9.46 outpatient intravenous/injected anticancer medication services paid per enrollee with at least one outpatient intravenous/injected anticancer medication claim, and 0.032 services per enrollee overall.
- Exhibit 6 summarizes the total dollar value of outpatient intravenous/injected anticancer medication services paid by these companies in Texas, as well as average claims cost measures per claim and per enrollee. Please note that two companies did not provide this information on the survey, so the results below exclude the enrollees from those companies.

Exhibit 6: Outpatient Intravenous/injected Anticancer Medication Services Paid

	Medication Only	Administration Only	Medication Plus Administration
Cost of services paid	\$95,638,597	\$15,101,064	\$110,739,661
Average cost per service	\$1,032.76	\$163.07	\$1,195.83
Average cost per enrollee with at least one outpatient intravenous/injected anticancer medication claim	\$9,891.26	\$1,561.80	\$11,453.06
Average cost per enrollee	\$32.43	\$5.12	\$37.55

- Survey respondents were asked to provide information on their five *most frequently administered* outpatient intravenous/injected anticancer medications, their five *most expensive* outpatient intravenous/injected anticancer medications for a single treatment, and the five outpatient intravenous/injected anticancer medications *that accounted for the largest share of total costs for such medications*.

- Overall, the five *most frequently administered* outpatient intravenous/injected anticancer medications were Fluorouracil, Bevacizumab, Trastuzumab, Paclitaxel, and Docetaxel.
- Overall, the five *most expensive* outpatient intravenous/injected anticancer medications for a single treatment were Gemtuzumab Ozogamicin, Melphalan Hydrochloride, Paclitaxel, Pegaspargase, and Ixabepilone.
- The five outpatient intravenous/injected anticancer medications *that accounted for the largest share of total costs for such medications* were Bevacizumab, Trastuzumab, Oxaliplatin, Docetaxel, and Rituximab.

Outpatient Oral Anticancer Medications

- One company (4 percent) indicated that outpatient oral anticancer medications are covered through medical benefits; 14 companies (56 percent) indicated that these medications are covered through pharmacy benefits; 9 companies (36 percent) indicated that these medications can be covered through either medical benefits or pharmacy benefits depending on the medication; and one company (4 percent) indicated that these medications can be covered through either medical benefits or pharmacy benefits depending on the specific group policy coverage.
- 16,767 enrollees had at least one outpatient oral anticancer medication claim. This represents 0.552 percent of total enrollees, and 0.674 percent of total enrollees with pharmacy benefits.
- 338 of the enrollees with at least one outpatient oral anticancer medication claim reached their annual maximum pharmacy benefit. This represents 2.016 percent of enrollees with at least one oral anticancer medication claim, 0.011 percent of total enrollees, and 0.014 percent of total enrollees with pharmacy benefits.
- These companies paid a total of 79,789 outpatient oral anticancer medication claims. This represents 4.76 outpatient oral anticancer medication claims paid per enrollee with at least one outpatient oral anticancer medication claim, 0.026 claims per enrollee overall, and 0.032 claims per enrollee with pharmacy benefits. (It is important to note that there were also exactly 0.032 outpatient intravenous/injected anticancer medication services paid per enrollee overall.)
- Exhibit 7 summarizes the total dollar value of outpatient oral anticancer medication claims paid by these companies in Texas, as well as average claims cost measures per claim and per enrollee.

Exhibit 7: Outpatient Oral Anticancer Medication Claims Paid

	Total Cost
Cost of claims paid	\$37,046,082
Average cost per claim	\$464.30
Average claims cost per enrollee with at least one outpatient oral anticancer medication claim	\$2,209.46
Average claims cost per enrollee	\$12.19
Average claims cost per enrollee with pharmacy benefits	\$14.90

- Survey respondents were asked to identify the tiers of their most popular formulary and provide the cost sharing requirements of each tier. (For the purpose of this survey, the formulary with the highest number of enrollees is considered the most popular formulary.) Exhibit 8 summarizes the responses from the 21 companies that responded to this question. Please note that four companies did not provide this information on the survey, so the results below exclude the enrollees from those companies.

Exhibit 8: Outpatient Oral Anticancer Medication Analysis by Formulary Design

	All Companies Submitting Formulary Information	Companies with Coinsurance Requirement in Highest Tier of Most Popular Formulary	Companies without Coinsurance Requirement in Highest Tier of Most Popular Formulary
Number of Companies	21	10	11
Average number of formulary tiers	3.4	3.6	3.2
Number of companies that require a deductible	4	4	0
Average deductible	\$43	\$90	\$0
Average copayment for highest formulary tier	\$36.67	\$17.50	\$54.09
Average coinsurance requirement for highest formulary tier	16.4%	34.5%	0.0%
Total enrollees with pharmacy benefits	2,394,947	395,861	1,999,086
Average claims cost per enrollee with at least one outpatient oral anticancer medication claim	\$2,217.71	\$2,317.60	\$2,196.11
Average cost per claim	\$463.63	\$474.28	\$461.26
Average claims cost per enrollee	\$12.10	\$15.27	\$11.55
Average claims cost per enrollee with pharmacy benefits	\$14.87	\$16.72	\$14.51

- Survey respondents were asked to provide information on their five *most frequently administered* outpatient oral anticancer medications, their five *most expensive* outpatient oral anticancer medications for a single treatment, and the five outpatient oral anticancer medications *that accounted for the largest share of total costs for such medications*.
 - Overall, the five *most frequently administered* outpatient oral anticancer medications were Methotrexate, tamoxifen citrate, Arimidex, Femara, and Anastrozole.
 - Overall, the five *most expensive* outpatient oral anticancer medications for a single treatment were Tarceva, Thalomid, Vorinostate, Lenalidomide, and Nilotinib.
 - The five outpatient oral anticancer medications *that accounted for the largest share of total costs for such medications* were Gleevec, Arimidex, Temodar, Xeloda, and Femara.

- All 25 respondents (100 percent) indicated that they do not have any policies or formulary limitations that are intended to limit the availability of oral anticancer medications when a comparable intravenous medication is available.

- Eight respondents (32 percent) indicated that they make exceptions for individuals who have to travel a long distance to obtain intravenous treatments, while 12 respondents (48 percent) indicated that they do not make such exceptions. Five companies (20 percent) did not respond to this question.

- 23 respondents (92 percent) indicated that their company has a process for individuals to request an appeal of a denied claim for an oral anticancer medication. Two companies (8 percent) did not respond to this question.
 - These respondents indicated that a total of 3,394 oral anticancer medications claims were denied.
 - These respondents indicated that a total of six appeals were filed after an oral anticancer medication claim was denied, and two of these appeals were decided in favor of the insured.

Comparison of Cost Sharing Requirements

Exhibit 9 quantifies the patient cost sharing disparity between outpatient oral anticancer medications and outpatient intravenous/injected anticancer medications for fully insured health benefit plan enrollees in Texas during calendar year 2009. This data confirms that enrollees facing unlimited coinsurance requirements in their prescription drug plans are required to meet a higher average cost sharing percentage for outpatient oral anticancer medications than for outpatient intravenous/injected anticancer medications. This discrepancy is approximately 7.3 percent between the most frequently prescribed outpatient anticancer medications in each category, 2.1 percent between the most costly outpatient anticancer medications per service/

prescription in each category, and 1.3 percent between the outpatient anticancer medications that accounted for the largest share of total costs for such medications in each category. Since many outpatient oral anticancer medications can cost several thousand dollars per prescription, this increased cost sharing can potentially equate to several hundred dollars per month for these cancer patients.

Exhibit 9: Comparison of Average Cost Sharing Requirements for Outpatient Oral Anticancer Medications and Outpatient Intravenous / Injected Anticancer Medications

Medication Category	Outpatient Oral Anticancer Medications		Outpatient Intravenous / Injected Anticancer Medications – All Companies
	Companies <u>with</u> Coinsurance Requirement in Highest Tier of Most Popular Formulary	Companies <u>without</u> Coinsurance Requirement in Highest Tier of Most Popular Formulary	
Most frequently prescribed medications	15.90%	12.86%	8.59%
Medications with the highest cost per service/prescription	6.64%	1.75%	4.56%
Medications that accounted for the largest share of total costs	9.36%	5.77%	8.05%

Additional Analysis

The following analysis demonstrates that up to 17.4 percent of fully insured group health benefit plan enrollees in Texas could lack coverage for outpatient oral anticancer medications. Since TDI did not ask respondents to indicate what percent of total enrollees had at least some coverage for oral anticancer medications, TDI cannot definitively state this number. However, using the information from the survey, TDI can provide the number of enrollees that did not have any oral anticancer medication coverage through the responding company. Some of these enrollees could have purchased prescription drug coverage separately, but that is outside the scope of this analysis.

Given that survey respondents had a total of 3,038,037 fully insured group health benefit plan enrollees in Texas, TDI can state the following:

- 2,485,960 of these enrollees were also covered by pharmacy benefits.
 - Of these, 18,000 enrollees did not have at least some coverage for oral anticancer medications through the responding company.
- The remaining 552,077 enrollees were not covered by pharmacy benefits.
 - Of these, 51,302 enrollees were enrolled in companies that indicated oral anticancer medications can be covered through medical benefits or pharmacy benefits.

- Therefore, these enrollees likely had some coverage for oral anticancer medications through the responding company.
- The remaining 510,775 enrollees were enrolled in companies that indicated oral anticancer medications are covered through pharmacy benefits only.
 - Therefore, none of these enrollees had any oral anticancer medication coverage through the responding company.
- A minimum of 528,775 enrollees (18,000 + 510,775) did not have any coverage for oral anticancer medications through the responding company. Therefore, up to 17.4 percent of fully insured group health benefit plan enrollees in Texas could lack coverage for outpatient oral anticancer medications.

Federal Health Reform

The Patient Protection and Affordable Care Act (PPACA) generally prohibits group health plans from placing annual or lifetime limits on the dollar value of health benefits. The Departments of Labor, Treasury and Health and Human Services recently released an Interim Final Rule stating that this provision applies only to "essential health benefits." While these agencies have not yet released regulatory guidance to further define this term, section 1302(b) of the PPACA does include prescription drugs in its definition.

For plan years beginning before January 1, 2014, group health plans may establish annual limits on the total dollar value of essential health benefits for any individual, so long as those limits are not below the following dollar amounts:

- \$750,000 for plan years beginning between September 23, 2010 and September 23, 2011;
- \$1.25 million for plan years beginning between September 23, 2011 and September 23, 2012; and
- \$2 million for plan years beginning between September 23, 2012 and January 1, 2014.

For plan years beginning on or after January 1, 2014, group health plans may not establish any annual limits on essential health benefits. In addition, for plan years beginning on or after September 23, 2010, group health plans may not establish any lifetime limits on essential health benefits.

In addition, PPACA includes several provisions that will limit an individual's cost-sharing requirements (applicable to deductibles, coinsurance, copayments or other similar charges) under qualified health plans issued beginning January 1, 2014.

Though a final analysis of the impact of these provisions cannot be made until additional federal rules are issued, these requirements are likely to affect health plan benefits for all prescription drugs, including both oral and applicable injected anticancer medications.

Summary / Recommendations

Recent technological advancements have increased the availability and effectiveness of oral medications for cancer treatment. These medications offer patients distinct advantages over traditional intravenous chemotherapy, including increased convenience; enhanced flexibility in the timing, duration and location of administration; the lack of complications associated with administration; and often reduced side effects. However, to be successful, oral anticancer medication treatment requires strict adherence, careful dosage management and maintenance, patient education enhancements, and effective coordination with providers.

Oral anticancer medications are frequently very expensive, and prescription drug plans that include unlimited coinsurance provisions often require patients to meet higher cost sharing requirements to obtain these medications than medical benefit plans require for intravenous medications. This disparity most commonly impacts enrollees with individual or small group coverage, and it can significantly hinder the ability of these cancer patients to afford oral anticancer medications. Members of the 82nd Texas Legislature may therefore wish to consider introducing legislation that will equalize the cost sharing requirements between oral and intravenous anticancer medications.

Several other states, with the support of the National Patient Advocate Foundation and the American Cancer Society, have enacted similar legislation within the past three years. Many of these statutes generally require state-regulated insurance companies and HMOs to cover orally administered anticancer medications “on a basis no less favorable than” intravenously administered anticancer medications, and this imprecise wording could potentially allow health plans to implement this legislation without reducing the cost sharing requirements for oral anticancer medications to match the cost sharing requirements for intravenous anticancer medications. For this reason, TDI encourages the Legislature to include language in any proposed chemotherapy parity legislation that will specifically prohibit any increase in the copayment, deductible, or coinsurance requirements for an oral, intravenous or injected anticancer medication to comply with the statute.

Attachment A: Enacted Chemotherapy Parity Legislation

Colorado – HB 1202 (2010)

Requires a health benefit plan that covers cancer chemotherapy treatment to provide coverage for prescribed, orally administered anticancer medication at a cost to the patient at the same copayment percentage or relative coinsurance amount as is applied to the cost of other cancer medications.

Connecticut – SB 50 (2010)

Requires orally-administered anticancer medications to be covered on the same basis as intravenously administered or injected anticancer medications; and prohibits the reclassification of such anticancer medications or increases in the coinsurance, copayment, deductible or other out-of-pocket expenses to achieve compliance.

District of Columbia - Bill 18-278 (2009)

Requires an individual health plan or group health plan, and a health insurer offering health insurance coverage that provides coverage for prescription drugs, to provide health insurance coverage for prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells and the person receiving such prescribed medication shall have the option of having it dispensed at any appropriately licensed pharmacy. The health insurance coverage provided shall be on a basis no less favorable than coverage provided for intravenously administered or injected cancer medications, for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayments and coinsurance factors.

Hawaii – SB 166 (2009)

Individual and group accident and health or sickness insurance policies that include coverage or benefits for the treatment of cancer shall provide payment or reimbursement for all chemotherapy that is considered medically necessary, including orally administered chemotherapy, at the same copayment percentage or relative coinsurance amount as is applied to intravenously administered chemotherapy. This statute does not apply to an accident only, specified disease, hospital indemnity, long-term care, or other limited benefit health insurance policy.

Indiana – SB 0437 (2009)

Coverage for orally administered cancer chemotherapy under an individual contract or a group contract must not be subject to dollar limits, copayments, deductibles, or coinsurance provisions that are less favorable to an enrollee than the dollar limits, copayments, deductibles, or coinsurance provisions that apply to coverage for cancer chemotherapy that is administered intravenously or by injection under the individual contract or group contract.

Iowa – SF 478 (2009)

A contract, policy, or plan providing for third-party payment or prepayment for cancer treatment shall not discriminate between coverage benefits for prescribed, orally administered anticancer

medication used to kill or slow the growth of cancerous cells and intravenously administered or injected cancer medications that are covered, regardless of formulation or benefit category determination by the contract, policy, or plan.

Kansas – HB 2160 (2010)

Any individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization, municipal group-funded pool and the state employee health care benefits plan which provides coverage for prescription drugs and which is delivered, issued for delivery, amended or renewed on and after July 1, 2011, shall 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.

Minnesota – SF 1761 (2010)

A health plan company that provides coverage under a health plan for cancer chemotherapy treatment shall not require a higher co-payment, deductible, or coinsurance amount for a prescribed, orally administered anticancer medication that is used to kill or slow the growth of cancerous cells than what the health plan requires for an intravenously administered or injected cancer medication that is provided, regardless of formulation or benefit category determination by the health plan company. A health plan company must not achieve compliance with this section by imposing an increase in co-payment, deductible, or coinsurance amount for an intravenously administered or injected cancer chemotherapy agent covered under the health plan. Nothing in this section shall be interpreted to prohibit a health plan company from requiring prior authorization or imposing other appropriate utilization controls in approving coverage for any chemotherapy.

New Hampshire - SB 510 – (2010)

This Act establishes a commission to evaluate the parity between oral and intravenous chemotherapy. It instructs the commission to collect, compile, and analyze data to determine whether a disparity between coverage for chemotherapy treatments exists; receive, if applicable, testimony from patients, providers, and other persons deemed necessary by the commission; determine, to the extent possible, the cost to insurers of requiring parity; and survey how other jurisdictions have addressed this issue.

Oregon – SB 8 (2007)

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.

Vermont – H. 444 (2009)

A health insurer that provides coverage for cancer chemotherapy treatment shall provide coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells that is no less favorable on a financial basis than intravenously administered or injected anticancer medications covered under the insured's plan.

Attachment B: Introduced Chemotherapy Parity Legislation

U.S. Congress

HR 2366 - Introduced 5/12/2009

Amends the Employee Retirement Income Security Act of 1974, the Public Health Service Act, and the Internal Revenue Code of 1986 to require a group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides benefits with respect to intravenously administered or injected cancer medications to provide for no less favorable coverage for prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells. The coverage for such medication may be subject to annual deductibles and coinsurance provisions as may be applicable to intravenously administered or injected cancer medications under the plan or coverage. Written notice of the availability of such coverage shall be delivered to participants upon enrollment and annually thereafter.

Arizona

SB 1216 - Introduced 1/27/2010.

States that a health insurance plan that provides coverage for cancer chemotherapy treatment and coverage for prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells shall not impose any additional limitations or financial requirements for the use of prescribed, orally administered anticancer medication than those applicable to intravenously administered or injected chemotherapy agents that are covered under the contract.

California

SB 961 - Introduced 2/5/2010.

Prohibits health care service plan contracts and health insurance policies that provide coverage for cancer chemotherapy treatment that is taken orally from charging or otherwise requiring a copayment or other charge for each of those dispensed prescriptions in excess of a certain unspecified amount.

SB 161 – Introduced 2/14/09, ultimately vetoed 10/11/09

A health care service plan contract or insurance policy issued, amended, or renewed on or after January 1, 2010, that provides coverage for cancer chemotherapy treatment shall provide coverage for a prescribed, orally administered cancer medication used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected cancer medications covered under the contract or policy.

Georgia

SB 245 - Introduced 3/5/2009

Provides coverage for cancer chemotherapy shall provide coverage for orally administered cancer medication.

HB 1263 - Introduced 3/8/2010

Provides for payment or reimbursement of orally administered chemotherapy at the same reimbursement rate as intravenously administered chemotherapy.

Illinois

HB 5085 - Introduced 1/26/2010

Requires that accident and health insurance policies that provide coverage for prescription drugs or cancer chemotherapy treatment must provide coverage for prescribed orally-administered cancer medication used to kill or slow the growth of cancerous cells. Also requires that an insurer shall ensure that the financial requirements and treatment limitations for orally-administered cancer medication coverage are no more restrictive than the requirements and limitations applied to intravenously administered cancer medications.

Kentucky

HB 460 - Introduced 2/18/2010.

Requires coverage of oral anti-cancer medication on the same basis as intravenously administered or injected cancer medications.

Maine

LD 1040 - Introduced 3/17/2009

Requires that, if a health insurance carrier provides coverage for cancer chemotherapy, the carrier shall provide coverage for a prescribed orally administered cancer medication on a basis no less favorable than intravenously administered or injected cancer medications that are covered benefits.

Maryland

SB 524 and HB 626 - Introduced 2/3/2010

Prohibits insurers, nonprofit health service plans, and health maintenance organizations that provide coverage for cancer chemotherapy from imposing limits or cost sharing on coverage for orally administered cancer chemotherapy that are less favorable to an insured or enrollee than the limits or cost sharing on coverage for cancer chemotherapy that is administered intravenously or by injection.

Massachusetts

S 2271 - Introduced 9/22/2009

Requires 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. An increase in patient cost sharing for anticancer medications is not allowed to achieve compliance with this provision.

Michigan

SB 481 and SB 482 - Introduced 4/28/2009; HB 4842 and HB 4843 - Introduced 4/29/2009

A health care corporation group or nongroup certificate that provides coverage for chemotherapy treatment of cancer shall include coverage for a prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells. Coverage shall not be subject to any prior authorization, dollar limit, copayment, deductible, or coinsurance provision that does not apply to intravenously administered or injected anticancer medications used to kill or slow the growth of cancerous cells.

Missouri

SB 786 - Introduced 1/14/2010

Provides that every health benefit plan must provide 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 under the health benefit plan

New York

A 7355 - Introduced 3/31/2009; and S 5864 - Introduced 6/15/2009

Requires every policy delivered in this state that provides medical, major medical or similar comprehensive-type coverage and provides coverage for cancer chemotherapy treatment shall 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.

Ohio

HB 237 and SB 133 - Introduced 6/23/2009

States that no individual or group health insuring corporation policy, contract, or agreement providing basic health care services or prescription drug services that is delivered, issued for delivery, or renewed in this state on or after the effective date of this section and that provides coverage for cancer chemotherapy treatment shall provide coverage for a prescribed, orally administered cancer medication on a less favorable basis than coverage for intravenously administered or injected cancer medications. The bill includes a prohibition on imposing a coverage limit, copayment, or deductible that is greater, or a prior authorization requirement that is more stringent, than any coverage limit, copayment, deductible, or prior authorization requirement in the policy, contract, or agreement that applies to coverage for intravenously administered or injected cancer medications.

Oklahoma

SB 839 - Introduced 2/2/2009

Requires coverage for orally administered anticancer medications on a basis no less favorable than IV or injected medications.

Pennsylvania

SB1006- Introduced 7/9/2009; and HB1865 - Introduced 7/16/2009

All individual or group health insurance policies offered by an insurer that provides coverage for intravenously administered cancer chemotherapy that also provides coverage for orally administered cancer chemotherapy shall provide such coverage on equal terms to the insured. This shall include equalizing the copayments, deductibles, coinsurance provisions and maximum out-of-pocket limits without regard as to how the chemotherapy is administered.

Tennessee

HB3322 - Introduced 1/27/2010; and SB3166 - Introduced 1/28/2010

A contract or policy of an insurer that provides health insurance coverage or benefits for chemotherapy must provide benefits and coverage for a patient's out of pocket costs related to

coverage for orally administered chemotherapy on a basis no less favorable than coverage provided for intravenously administered or injected chemotherapy under the policy. A health insurer cannot achieve compliance with this bill by imposing an increase in patient out of pocket costs with respect to intravenously administered or injected chemotherapy agents covered under the policy on the effective date of this bill. SB 3166 does not prohibit a health insurer from requiring prior authorization or imposing other appropriate utilization controls in approving coverage for any chemotherapy.

Utah

SB 101 - Introduced 1/25/2010

Prohibits an insurer from requiring a cancer patient to pay more for chemotherapy treatment that is administered orally rather than intravenously.

Vermont

S81 - Introduced 2/13/2009; and H230 - Introduced 2/17/2009

Requires health insurers to provide coverage for orally administered anticancer medications to at least the same extent that they provide coverage for traditional chemotherapy.

Washington

SB5512 - Introduced 1/26/2009.

Requires coverage of orally administered cancer medications on a basis not less favorable than IV or injected medications.

Primary Source: <http://capwiz.com/myeloma/issues/> - Accessed 7/5/2010.

Attachment C: 2010 Chemotherapy Survey for Insurance Companies and HMOs

TDI distributed the *2010 Chemotherapy Survey for Insurance Companies and HMOs* to gather Texas-specific data on the cost disparity between orally and intravenously administered chemotherapies as required by Senate Bill 1143. Companies were instructed to complete this survey as it relates only to fully insured health benefit plan coverage written in Texas during calendar year 2009.

Section 1: Background Information

1. *Please provide the total number of enrollees covered by your company under fully insured health benefit plans in Texas.*

Summary of Responses	
Grand total enrollees (All companies)	3,038,037
Average enrollees per company	121,521.5
Number of responses to Q1	25

2. *Please provide the number of enrollees covered by your company under fully insured health benefit plans in Texas who were also covered by pharmacy benefits.*

Summary of Responses	
Total enrollees with pharmacy benefits (All companies)	2,485,960
Average enrollees per company	99,438.4
Percent of grand total enrollees (from Q1) with pharmacy benefits	81.83%
Number of responses to Q2	25

3. *Please indicate what percentage of these enrollees (from question 2) had at least some coverage for the following:*

- a. *Inpatient intravenous and injected anticancer medications*

Summary of Responses	
Average percent of enrollees	100.00%
Number of responses to Q3a	25

- b. *Outpatient intravenous and injected anticancer medications*

Summary of Responses	
Average percent of enrollees	100.00%
Number of responses to Q3b	25

c. *Inpatient oral anticancer medications*

Summary of Responses	
Average percent of enrollees	100.00%
Number of responses to Q3c	25

d. *Outpatient oral anticancer medications*

Summary of Responses	
Average percent of enrollees	99.996%
Number of responses to Q3d	25

4. *Please specify how pharmacy benefit management services are performed for the fully insured health benefit plans issued by your company in Texas.*

Summary of Responses	
A division, subsidiary or affiliate of the company performs these functions.	11
A contracted third-party vendor performs these functions.	13
Not applicable	1
Number of responses to Q4	25

5. *Please provide the name of the division, subsidiary, affiliate, or contracted third-party vendor that provides pharmacy benefit management services for the fully insured health benefit plans issued by your company in Texas (if applicable).*

Summary of Responses	
Aetna Pharmacy Management	2
Caremark	2
Express Scripts Inc.	3
Humana Pharmacy Services	2
Medco Health Solutions, Inc.	6
Prescription Solutions, Inc.	2
Prime Therapeutics, LLP	1
Scott and White Prescription Services	1
United Health Pharmaceutical Solutions	1
WellPoint	1
Medco, Scriptcare, Express Scripts	1
All plans have coverage for inpatient /outpatient chemotherapy under the major medical portion of the plan. For other retail scripts, enrollees had a Prescription discount card offered through Express Scripts	1
Number of responses to Q5	23

Section 2: Outpatient Intravenous / Injected Anticancer Medications

6. Please indicate which statement below best describes how outpatient intravenous/injected anticancer medications are covered under the fully insured health benefit plans issued by your company in Texas.

Summary of Responses	
These medications are covered through medical benefits.	14
These medications are covered through pharmacy benefits.	0
These medications can be covered through either medical benefits or pharmacy benefits, depending on the medication.	11
Other	0
Number of responses to Q6	25

7. Please provide the number of fully insured health benefit plan enrollees in Texas who had at least one claim for an outpatient intravenous/injected anticancer medication.

Summary of Responses	
Total enrollees with at least one outpatient intravenous/injected anticancer medication claim (All companies)	10,195
Average enrollees per company with at least one outpatient intravenous/injected anticancer medication claim	407.8
Percent of grand total enrollees (from Q1) that had at least one outpatient intravenous/injected anticancer medication claim	0.336%
Number of responses to Q7	25

8. Of the enrollees who had at least one claim for an outpatient intravenous/injected anticancer medication, please provide the number of enrollees who reached their annual maximum medical benefit limit.

Summary of Responses	
Total enrollees that reached annual maximum medical benefit (All companies)	1,544
Average enrollees per company that reached annual maximum medical benefit	61.8
Percent of grand total enrollees (from Q1) that reached annual maximum medical benefit	0.051%
Percent of total enrollees with at least one outpatient intravenous/injected anticancer medication claim (from Q7) that reached annual maximum medical benefit	15.14%
Number of responses to Q8	25

9. Please provide the total number of outpatient intravenous/injected anticancer medication services paid by your company under fully insured health benefit plans in Texas. **For the purpose of this survey, each unique anticancer medication treatment is considered a service.**

Summary of Responses	
Total number of outpatient intravenous/injected anticancer medication services paid (All companies)	96,402
Average outpatient intravenous/injected anticancer medication services paid per company	3,856.1
Average number of outpatient intravenous/injected anticancer medication services paid per enrollee (from Q1)	0.032
Average number of outpatient intravenous/injected anticancer medication services paid per enrollee with at least one outpatient intravenous/injected medication claim (from Q7)	9.46
Number of responses to Q9	25

10. Please provide the total dollar value of outpatient intravenous/injected anticancer medication services paid by your company under fully insured health benefit plans in Texas, excluding the associated cost of administering the drugs (i.e., medication only).

Summary of Responses – Medication Only	
Total dollar value of outpatient intravenous/injected anticancer medication services paid for medication only (All companies)	\$95,638,597
Average dollar value of outpatient intravenous/injected anticancer medication services paid for medication only per company	\$4,158,200
Average dollar value of outpatient intravenous/injected anticancer medication services paid for medication only (from Q9, excluding the services reported by two companies that did not respond to Q10)	\$1,032.76
Average dollar value of outpatient intravenous/injected anticancer medication services paid for medication only per enrollee with at least one outpatient intravenous/injected anticancer medication claim (from Q7, excluding the enrollees reported by two companies that did not respond to Q10)	\$9,891.26
Average dollar value of outpatient intravenous/injected anticancer medication services paid for medication only per enrollee (from Q1, excluding the enrollees reported by two companies that did not respond to Q10)	\$32.43
Number of responses to Q10	23

11. Please provide the total dollar value of outpatient intravenous/injected anticancer medication services paid by your company under fully insured health benefit plans in Texas, including the associated cost of administering the drugs (i.e., medication plus administration).

Summary of Responses – Medication Plus Administration	
Total dollar value of outpatient intravenous/injected anticancer medication services paid for medication and administration (All companies)	\$110,739,661
Average dollar value of outpatient intravenous/injected anticancer medication services paid for medication and administration per company	\$4,814,768
Average dollar value of outpatient intravenous/injected anticancer medication services paid for medication and administration (from Q9, excluding the services reported by two companies that did not respond to Q11)	\$1,195.83
Average dollar value of outpatient intravenous/injected anticancer medication services paid for medication and administration per enrollee with at least one outpatient intravenous/injected anticancer medication claim (from Q7, excluding the enrollees reported by two companies that did not respond to Q11)	\$11,453.06
Average dollar value of outpatient intravenous/injected anticancer medication services paid for medication and administration per enrollee (from Q1, excluding the enrollees reported by two companies that did not respond to Q11)	\$37.55
Number of Responses to Q11	23

Additional Analysis – Administration Only	
Total dollar value of outpatient intravenous/injected anticancer medication services paid for administration only (All companies – implied by subtracting Q10 from Q11)	\$15,101,064
Average dollar value of outpatient intravenous/injected anticancer medication services paid for administration only per company	\$656,568
Average dollar value of outpatient intravenous/injected anticancer medication services paid for administration only (from Q9, excluding the services reported by two companies that did not respond to Q10 and Q11)	\$163.07
Average dollar value of outpatient intravenous/injected anticancer medication services paid for administration only per enrollee with at least one outpatient intravenous/injected anticancer medication claim (from Q7, excluding the enrollees reported by two companies that did not respond to Q10 and Q11)	\$1,561.80
Average dollar value of outpatient intravenous/injected anticancer medication services paid for administration only per enrollee (from Q1, excluding the enrollees reported by two companies that did not respond to Q10 and Q11)	\$5.12

12. Please provide following information for the five (5) **most frequently administered** outpatient intravenous/injected anticancer medications under fully insured health benefit plans in Texas. When completing this table, please combine all available dosages for a single drug.

TDI combined the “top 5” lists from all responding companies, and the following 10 outpatient intravenous/injected anticancer medications accounted for the highest number of total services provided. Since all companies were not asked to provide a comprehensive list of outpatient intravenous/injected anticancer medications, the numbers provided below do not represent the total number of services provided for each medication by these respondents in Texas.

Top 10 Outpatient Intravenous/ Injected Anticancer Medications by Total Number of Services Provided – All Companies					
Medication	Total Number of Services Provided	Total Average Cost Per Service	Implied Total Cost (# of Services * Avg. Cost)	Average Cost to Patient Per Service	Average Patient Cost Share Percentage
Fluorouracil	5,952	\$59.19	\$352,324.08	\$7.46	12.59%
Bevacizumab	4,783	\$4,104.96	\$19,634,037.65	\$214.14	5.22%
Trastuzumab	4,173	\$2,617.31	\$10,922,044.34	\$291.07	11.12%
Paclitaxel	3,488	\$764.10	\$2,665,188.00	\$24.49	3.20%
Docetaxel	1,294	\$3,211.99	\$4,156,315.84	\$239.31	7.45%
Leucovorin Calcium	1,285	\$25.14	\$32,303.69	\$1.03	4.09%
Dexamethasone Sodium Phosphate	1,244	\$939.72	\$1,169,011.68	\$230.80	24.56%
Cyclophosphamide	758	\$135.14	\$102,438.58	\$20.79	15.38%
Carboplatin	754	\$626.66	\$472,498.62	\$73.40	11.71%
Unclassified Drugs	728	\$372.67	\$271,303.76	\$71.64	19.22%
All Medications Reported on Q12	26,560	\$1,673.41	\$44,445,746.10	\$143.67	8.59%

Medication	Number of Companies that Included Drug in “Top 5” Most Frequently Administered Outpatient Intravenous/Injected Anticancer Medications
Fluorouracil	18
Bevacizumab	20
Trastuzumab	14
Paclitaxel	12
Docetaxel	6
Leucovorin Calcium	2
Dexamethasone Sodium Phosphate	1
Cyclophosphamide	4
Carboplatin	6
Unclassified Drugs	1

13. Please provide the following information for the five (5) **most expensive** outpatient intravenous/injected anticancer medications for a single treatment under fully insured health benefit plans in Texas. When completing this table, please combine all available dosages for a single drug.

TDI combined the “top 5” lists from all responding companies, and the following 10 outpatient intravenous/injected anticancer medications accounted for the highest total average cost per service (calculated as average cost to plan per service plus average cost to patient per service). Since all companies were not asked to provide a comprehensive list of outpatient intravenous/injected anticancer medication services, the numbers provided below do not represent the total average cost per service for each medication by these respondents in Texas.

Top 10 Outpatient Intravenous/ Injected Anticancer Medications by Total Average Cost per Service – All Companies					
Medication	Total Number of Services Provided	Total Average Cost Per Service	Implied Total Cost (# of Services * Avg. Cost)	Average Cost to Patient Per Service	Average Patient Cost Share Percentage
Gemtuzumab Ozogamicin	2	\$42,601.23	\$85,202.46	\$0.00	0.00%
Melphalan Hydrochloride	2	\$25,264.00	\$50,528.00	\$109.00	0.43%
Paclitaxel	32	\$12,955.96	\$414,590.85	\$69.64	0.54%
Pegaspargase	31	\$9,801.57	\$303,848.55	\$33.87	0.35%
Ixabepilone	39	\$8,040.43	\$313,576.96	\$59.23	0.74%
Not Otherwise Classified Antineoplastic Drugs	7	\$6,016.71	\$42,117.00	\$4,734.86	78.70%
Pemetrexed	318	\$5,756.29	\$1,830,500.36	\$190.29	3.31%
Rituximab	582	\$5,469.92	\$3,183,494.46	\$663.09	12.12%
Cetuximab	142	\$5,236.56	\$743,591.39	\$167.21	3.19%
Oxaliplatin	1,194	\$4,994.40	\$5,963,314.59	\$125.01	2.50%
All Medications Reported on Q13	5,486	\$4,266.95	\$23,408,508.29	\$194.53	4.56%

Medication	Number of Companies that Included Drug in “Top 5” Most Expensive Outpatient Intravenous/Injected Anticancer Medications
Gemtuzumab Ozogamicin	1
Melphalan Hydrochloride	2
Paclitaxel	5
Pegaspargase	3
Ixabepilone	4
Not Otherwise Classified Antineoplastic Drugs	2
Pemetrexed	11
Rituximab	13
Cetuximab	9
Oxaliplatin	14

14. Please provide the following information for the five (5) outpatient intravenous/injected anticancer medications that accounted for the largest share of total costs for such medications under fully insured health benefit plans in Texas. When completing this table, please combine all available dosages for a single drug.

TDI combined the “top 5” lists from all responding companies, and the following 10 outpatient intravenous/injected anticancer medications accounted for the highest share of total costs (calculated as total average cost per service times total number of services provided). Since all companies were not asked to provide a comprehensive list of outpatient intravenous/injected anticancer medication services, the numbers provided below do not represent the total cost for each medication by these respondents in Texas.

Top 10 Outpatient Intravenous/ Injected Anticancer Medications by Implied Total Cost– All Companies					
Medication	Total Number of Services Provided	Total Average Cost Per Service	Implied Total Cost (# of Services * Avg. Cost)	Average Cost to Patient Per Service	Average Patient Cost Share Percentage
Bevacizumab	3,745	\$4,457.15	\$16,692,041.52	\$308.66	6.92%
Trastuzumab	4,087	\$2,604.24	\$10,643,523.60	\$278.97	10.71%
Oxaliplatin	2,548	\$4,097.12	\$10,439,467.67	\$182.66	4.46%
Docetaxel	2,745	\$3,145.53	\$8,634,470.41	\$241.75	7.69%
Rituximab	1,356	\$5,239.49	\$7,104,747.00	\$641.78	12.25%
Paclitaxel	1,176	\$1,266.79	\$1,489,745.81	\$25.16	1.99%
Gemcitabine Hydrochloride	921	\$1,566.66	\$1,442,892.29	\$166.77	10.65%
Cetuximab	344	\$3,849.63	\$1,324,272.85	\$56.16	1.46%
Topotecan	195	\$2,989.58	\$582,968.00	\$227.78	7.62%
Zoledronic Acid	209	\$2,393.11	\$500,159.99	\$779.68	32.58%
All Medications Reported on Q14	17,484	\$3,409.46	\$59,610,927.65	\$274.46	8.05%

Medication	Number of Companies that Included Drug in “Top 5” Outpatient Intravenous/Injected Anticancer Medications that Accounted for the Largest Share of Total Costs
Bevacizumab	21
Trastuzumab	13
Oxaliplatin	20
Docetaxel	14
Rituximab	16
Paclitaxel	7
Gemcitabine Hydrochloride	8
Cetuximab	6
Topotecan	3
Zoledronic Acid	1

Section 3: Outpatient Oral Anticancer Medications

15. Please indicate which statement below best describes how outpatient oral anticancer medications are covered under the fully insured health benefit plans issued by your company in Texas.

Summary of Responses	
These medications are covered through medical benefits.	1
These medications are covered through pharmacy benefits.	14
These medications can be covered through either medical benefits or pharmacy benefits, depending on the medication.	9
These medications can be covered through either medical benefits or pharmacy benefits, depending on the specific group policy coverage.	1
Number of responses to Q15	25

16. Please provide the number of fully insured health benefit plan enrollees in Texas who had at least one claim for an outpatient oral anticancer medication.

Summary of Responses	
Total enrollees with at least one outpatient oral anticancer medication claim (All companies)	16,767
Average enrollees per company with at least one outpatient oral anticancer medication claim	670.7
Percent of grand total enrollees (from Q1) that had at least one outpatient oral anticancer medication claim	0.552%
Percent of total enrollees with pharmacy benefits (from Q2) that had at least one outpatient oral anticancer medication claim	0.674%
Number of responses to Q16	25

17. Of the enrollees who had at least one claim for an outpatient oral anticancer medication, please provide the number of enrollees who reached their annual maximum prescription benefit limit.

Summary of Responses	
Total enrollees that reached annual maximum prescription benefit (All companies)	338
Average enrollees per company that reached annual maximum prescription benefit	13.5
Percent of grand total enrollees (from Q1) that reached annual maximum prescription benefit	0.011%
Percent of total enrollees with pharmacy benefits (from Q2) that reached annual maximum prescription benefit	0.014%
Percent of total enrollees with at least one outpatient oral anticancer medication claim (from Q16) that reached annual maximum prescription benefit	2.016%
Number of responses to Q17	25

18. Please provide the total number of outpatient oral anticancer medication claims paid by your company under fully insured health benefit plans in Texas.

Summary of Responses	
Total number of outpatient oral anticancer medication claims paid (All companies)	79,789
Average outpatient oral anticancer medication claims paid per company	3,191.6
Average number of outpatient oral anticancer medication claims paid per enrollee (from Q1)	0.026
Average number of outpatient oral anticancer medication claims paid per enrollee with pharmacy benefits (from Q2)	0.032
Average number of outpatient oral anticancer medication claims paid per enrollee with at least one outpatient oral anticancer medication claim (from Q16)	4.76
Number of responses to Q18	25

19. Please provide the total dollar value of outpatient oral anticancer medication claims paid by your company under fully insured health benefit plans in Texas.

Summary of Responses	
Total dollar value of outpatient oral anticancer medication claims paid (All companies)	\$37,046,082
Average dollar value of outpatient oral anticancer medication claims paid per company	\$1,481,843
Average dollar value of outpatient oral anticancer medication claims (from Q18)	\$464.30
Average dollar value of outpatient oral anticancer medication claims paid per enrollee with at least one outpatient oral anticancer medication claim (from Q16)	\$2,209.46
Average dollar value of outpatient oral anticancer medication claims paid per enrollee (from Q1)	\$12.19
Average dollar value of outpatient oral anticancer medication claims paid per enrollee with pharmacy benefits (from Q2)	\$14.90
Number of Responses to Q19	25

20. Please...identify the tiers of your company's most popular formulary and provide the cost sharing requirements of each tier. For the purpose of this survey, the formulary with the highest number of enrollees is considered the most popular formulary.

Summary of Responses for Companies that Submitted Formulary Information			
Formulary Information	All Companies Submitting Formulary Information	Companies with Coinsurance Requirement in Highest Tier of Most Popular Formulary	Companies without Coinsurance Requirement in Highest Tier of Most Popular Formulary
Number of Companies	21	10	11
Average number of formulary tiers	3.4	3.6	3.2
Number of companies that require a deductible	4	4	0
Average deductible	\$43	\$90	0
Average copayment for highest formulary tier	\$36.67	\$17.50	\$54.09
Average coinsurance requirement for highest formulary tier	16.42%	34.50%	0.0%
Grand total enrollees (from Q1)	2,944,080*	433,478	2,510,602
Total enrollees with pharmacy benefits (from Q2)	2,394,947*	395,861	1,999,086
Total enrollees with at least one outpatient oral anticancer medication claim (from Q16)	16,062*	2,856	13,206
Total enrollees that reached annual maximum prescription benefit (from Q17)	338*	6	332
Total number of outpatient oral anticancer medication claims paid (from Q18)	76,831*	13,956	62,875
Total dollar value of outpatient oral anticancer medication claims paid (from Q19)	\$35,620,879*	\$6,619,072	\$29,001,807
Average dollar value of outpatient oral anticancer medication claims (from Qs 18 and 19)	\$463.63	\$474.28	\$461.26
Dollar value of oral anticancer medication claims paid per enrollee with at least one oral anticancer medication claim (Qs 16 and 19)	\$2,217.71	\$2,317.60	\$2,196.11
Dollar value of outpatient oral anticancer medication claims paid per enrollee (from Qs 1 and 19)	\$12.10	\$15.27	\$11.55
Dollar value of oral anticancer medication claims paid per enrollee with pharmacy benefits (from Qs 2 and 19)	\$14.87	\$16.72	\$14.51

* These totals exclude the numbers reported by the four companies that did not respond to question 20.

21. Please provide following information for the five (5) **most frequently prescribed** outpatient oral anticancer medications under fully insured health benefit plans in Texas. When completing this table, please combine all available dosages for a single drug.

TDI combined the “top 5” lists from all responding companies, and the following 10 outpatient oral anticancer medications accounted for the highest number of total claims. Since all companies were not asked to provide a comprehensive list of outpatient oral anticancer medications, the numbers provided below do not represent the total number of prescriptions for each medication by these respondents in Texas.

Top 10 Outpatient Oral Anticancer Medications By Total Number of Prescriptions– All Companies					
Medication	Total Number of Prescriptions	Total Average Cost Per Prescription	Implied Total Cost (# of Prescriptions * Avg. Cost)	Average Cost to Patient Per Prescription	Average Patient Cost Share Percentage
Methotrexate	28,730	\$14.22	\$408,571.61	\$11.26	79.14%
Tamoxifen Citrate	11,415	\$22.77	\$259,950.48	\$15.88	69.75%
Arimidex	9,490	\$358.08	\$3,398,150.10	\$56.28	15.72%
Femara	6,259	\$371.23	\$2,323,525.70	\$55.47	14.94%
Anastrozole	2,490	\$392.33	\$976,907.29	\$46.32	11.81%
Letrozole	1,928	\$392.16	\$756,081.89	\$43.92	11.20%
Mercaptopurine	1,648	\$102.82	\$169,451.94	\$22.63	22.01%
Tretinoin	1,505	\$56.55	\$85,101.54	\$11.05	19.55%
Megestrol Acetate	1,495	\$45.70	\$68,327.23	\$14.10	30.84%
Xeloda	582	\$1,689.29	\$983,166.50	\$83.59	4.95%
All Medications Reported on Q21	67,352	\$196.37	\$13,225,582.35	\$26.77	13.63%

Medication	Number of Companies that Included Drug in “Top 5” Most Frequently Prescribed Outpatient Oral Anticancer Medications	Number of These Companies that Place Drug in the Highest Tier of Their Most Popular Formulary	Number of These Companies that Have Coinsurance Requirements for Their Most Popular Formulary
Methotrexate	14	0	N/A
Tamoxifen Citrate	14	0	N/A
Arimidex	11	6	3
Femara	11	6	2
Anastrozole	4	0	N/A
Letrozole	4	0	N/A
Mercaptopurine	11	0	N/A
Tretinoin	3	0	N/A
Megestrol Acetate	3	0	N/A
Xeloda	8	3	2

22. Please provide the following information for the five (5) **most expensive** outpatient oral anticancer medications (for a single prescription) under fully insured health benefit plans in Texas. When completing this table, please combine all available dosages for a single drug.

TDI combined the “top 5” lists from all responding companies, and the following 10 outpatient oral anticancer medications accounted for the highest total average cost per prescription (calculated as average cost to plan per prescription plus average cost to patient per prescription). Since all companies were not asked to provide a comprehensive list of outpatient oral anticancer medication prescriptions, the numbers provided below do not represent the total average cost per prescription for each medication by these respondents in Texas.

Top 10 Outpatient Oral Anticancer Medications By Total Average Cost Per Prescription – All Companies					
Medication	Total Number of Prescriptions	Total Average Cost Per Prescription	Implied Total Cost (# of Prescriptions * Avg. Cost)	Average Cost to Patient Per Prescription	Average Patient Cost Share Percentage
Tarceva	29	\$10,779.88	\$312,616.41	\$23.27	0.22%
Thalomid	30	\$9,090.59	\$272,717.66	\$39.17	0.43%
Vorinostate	2	\$8,736.95	\$17,473.90	\$35.00	0.40%
Lenalidomide	222	\$7,223.46	\$1,603,608.53	\$132.83	1.84%
Nilotinib	8	\$7,049.60	\$56,396.80	\$232.15	3.29%
Revlimid	312	\$7,001.43	\$2,184,446.86	\$229.99	3.28%
Targretin	11	\$6,879.44	\$75,673.84	\$45.00	0.65%
Sunitinib Malate	83	\$6,630.16	\$550,303.51	\$102.59	1.55%
Dasatinib	23	\$6,385.08	\$146,856.84	\$54.78	0.86%
Zolanza	2	\$5,956.87	\$11,913.74	\$40.00	0.67%
All Medications Reported on Q22	3,605	\$3,723.99	\$13,424,984.96	\$104.04	2.79%

Medication	Number of Companies that Included Drug in “Top 5” Most Expensive Outpatient Oral Anticancer Medications	Number of These Companies that Place Drug in the Highest Tier of Their Most Popular Formulary	Number of These Companies that Have Coinsurance Requirements for Their Most Popular Formulary
Tarceva	6	2	1
Thalomid	3	1	0
Vorinostate	1	1	0
Lenalidomide	4	2	0
Nilotinib	1	1	0
Revlimid	8	4	2
Targretin	1	1	0
Sunitinib Malate	2	0	N/A
Dasatinib	1	1	0
Zolanza	1	1	0

23. Please provide the following information for the five (5) outpatient oral anticancer medications that accounted for the largest share of total costs for such medications under fully insured health benefit plans in Texas. When completing this table, please combine all available dosages for a single drug.

TDI combined the “top 5” lists from all responding companies, and the following 10 outpatient oral anticancer medications accounted for the highest share of total costs (calculated as total average cost per prescription times total number of prescriptions). Since all companies were not asked to provide a comprehensive list of outpatient oral anticancer medication prescriptions, the numbers provided below do not represent the total cost for each medication by these respondents in Texas.

Top 10 Outpatient Oral Anticancer Medications by Implied Total Cost – All Companies					
Medication	Total Number of Prescriptions	Total Average Cost Per Prescription	Implied Total Cost (# of Prescriptions * Avg. Cost)	Average Cost to Patient Per Prescription	Average Patient Cost Share Percentage
Gleevec	1,567	\$4,243.40	\$6,649,413.05	\$114.86	2.71%
Arimidex	9,490	\$359.13	\$3,408,101.78	\$56.28	15.67%
Temodar	1,069	\$2,726.00	\$2,914,093.89	\$133.12	4.88%
Xeloda	1,456	\$1,697.16	\$2,471,070.06	\$106.28	6.26%
Femara	6,055	\$371.18	\$2,247,501.02	\$55.48	14.95%
Revlimid	303	\$6,989.19	\$2,117,724.82	\$235.50	3.37%
Imatinib Mesylate	378	\$4,618.45	\$1,745,773.66	\$97.19	2.10%
Lenalidomide	222	\$7,223.46	\$1,603,608.53	\$132.83	1.84%
Anastrozole	2,405	\$393.35	\$946,013.19	\$47.04	11.96%
Sutent	150	\$6,236.43	\$935,464.83	\$108.78	1.74%
All Medications Reported on Q23	25,573	\$1,070.12	\$27,366,206.42	\$67.79	6.33%

Medication	Number of Companies that Included Drug in “Top 5” Outpatient Oral Anticancer Medications that Accounted for the Largest Share of Total Costs	Number of These Companies that Place Drug in the Highest Tier of Their Most Popular Formulary	Number of These Companies that Have Coinsurance Requirements for Their Most Popular Formulary
Gleevec	11	5	4
Arimidex	11	6	3
Temodar	10	3	3
Xeloda	14	6	4
Femara	10	5	2
Revlimid	7	4	3
Imatinib Mesylate	3	0	N/A
Lenalidomide	4	2	0
Anastrozole	3	0	N/A
Sutent	7	5	3

Additional Analysis – The Impact of Coinsurance Requirements on the Patient Cost Share for Outpatient Oral Anticancer Medications					
Medication	Total Number of Prescriptions	Total Average Cost Per Prescription	Implied Total Cost (# of Prescriptions * Avg. Cost)	Average Cost to Patient Per Prescription	Average Patient Cost Share Percentage
Companies with Coinsurance Requirement in Highest Tier of Most Popular Formulary					
Most frequently prescribed medications (Q21)	11,902	\$239.16	\$2,846,495.29	\$38.02	15.90%
Medications with the highest cost per prescription (Q22)	1,496	\$1,938.15	\$2,899,478.06	\$128.68	6.64%
Medications that accounted for the largest share of total costs (Q23)	5,580	\$890.13	\$4,966,909.56	\$83.35	9.36%
Companies without Coinsurance Requirement in Highest Tier of Most Popular Formulary					
Most frequently prescribed medications (Q21)	53,088	\$187.99	\$9,980,241.59	\$24.18	12.86%
Medications with the highest cost per prescription (Q22)	1,978	\$5,004.92	\$9,899,731.58	\$87.43	1.75%
Medications that accounted for the largest share of total costs (Q23)	19,454	\$1,099.26	\$21,384,944.23	\$63.43	5.77%

	Average Patient Cost Share Percentage for Companies <u>with</u> Coinsurance Requirement in Highest Tier of Most Popular Formulary	Average Patient Cost Share Percentage for Companies <u>without</u> Coinsurance Requirement in Highest Tier of Most Popular Formulary	Difference
Most frequently prescribed medications (Q21)	15.90%	12.86%	3.04%
Medications with the highest cost per prescription (Q22)	6.64%	1.75%	4.89%
Medications that accounted for the largest share of total costs (Q23)	9.36%	5.77%	3.59%

24. Does your company have any policies or formulary limitations that are intended to limit the availability of oral anticancer medications when a comparable intravenous medication is available?

Summary of Responses	
Yes	0
No	25
Number of responses to Q24	25

25. Does your company make any exceptions for individuals who have to travel a long distance to obtain intravenous treatments?

Summary of Responses	
Yes	8
No	12
Number of responses to Q25	20

If yes, please describe.

Summary of Responses	
<ul style="list-style-type: none"> • Need additional information does "exceptions" mean coverage for travel or out of network access? 	
<ul style="list-style-type: none"> • Only on Preferred Provider plans if there is not a preferred provider within 30 miles. If so, benefits are paid at the in-network level. 	
<ul style="list-style-type: none"> • If the service is performed outside the member's PPO network, and there are no in-network providers available, then we consider the claim at the in-network benefit level. Many patients with whom have been diagnosed with cancer are handled thru our Large Case Mgmt department and if needed, charges are given agreed upon discounts. 	
<ul style="list-style-type: none"> • These are reviewed on an individual basis. We may provide via home health. 	

26. Does your company have a process for individuals to request an appeal of a denied claim for an oral anticancer medication?

Summary of Responses	
Yes	23
No	0
Number of responses to Q26	23

If yes, please describe.

Summary of Responses
<ul style="list-style-type: none"> • An appeal for a denied claim of an oral anti-cancer medication would follow our standard pharmacy appeals process.
<ul style="list-style-type: none"> • An appeal may be requested by the patient, physician, or any authorized person on behalf of the patient and may be requested verbally or in writing. All appeals are forwarded to our company's Pharmacy Team. Our Pharmacy Team contacts the physician for clinical information. Once the clinical information is received our Pharmacy Team reviews our established clinical criteria for the medication. If there is not sufficient information in the established clinical criteria for the medication which would allow approval, the appeal is referred to the medical reviewer. If the appeal results in approval of benefits notification is sent to the Pharmacy Benefit Manager to restart the order. If the appeal results in a denial a letter is sent to both the patient and physician advising them of the denial.
<ul style="list-style-type: none"> • Appeals can be sent to our company.
<ul style="list-style-type: none"> • Individuals have the right to a standard or expedited appeal process in the event of a denied claim for an oral anticancer medication. Individuals are sent written instructions pertaining to the appeals process with explanation to provide written comments, documents, records, or other information about their denied claim. All available information relevant to the claim is considered in making an appeal decision. The individual, their health care provider, or authorized representative may file an oral or written appeal.
<ul style="list-style-type: none"> • Member and/or physician can request an appeal to a denied claim but all oral anticancer medications are covered for our fully insured plans
<ul style="list-style-type: none"> • Member can appeal to the carrier or third party administrator. Claim will be referred to a medical review agency for medical necessity/experimental/investigational review. Carrier will make decision to cover or not cover the treatment based on the consultant's review and plan provisions.
<ul style="list-style-type: none"> • Notification of these rights and appeal procedure are documented in the Evidence of Coverage or Standard Plan Document.
<ul style="list-style-type: none"> • Our standard appeals process.
<ul style="list-style-type: none"> • They have access to appeal in writing through established grievance procedures
<ul style="list-style-type: none"> • The individual would follow the appeal process that is available for any adverse benefit determination. For medical necessity or experimental/investigational denials, the TX Appeal Policy offers a single level review by a same or similar specialist not previously involved, nor a subordinate of the previous reviewer. If the appeal is denied, the member is offered an external review by an independent review organization. For administrative denials, the TX Appeal Policy offers a two level appeal internal review, by someone not previously involved nor a subordinate of the previous reviewer(s), with a committee panel at the second level. Member has right to attend the second level panel hearing.
<ul style="list-style-type: none"> • We can take the appeal via telephone or written. If denied due to medical necessity, these would be reviewed by a different physician. Patient/physician can appeal up to an IRO/independent review organization
<ul style="list-style-type: none"> • Yes, members are sent a communication explaining that the drug has been denied with their appeals rights and the process to follow to open an appeal case.

27. Please provide the number of oral anticancer medication claims that were denied by your company for patients covered under fully insured health benefit plans in Texas.

Summary of Responses	
Total claims denied (All companies)	3,394
Average claims denied per company	135.76
Total companies reporting denied claims	11
Average claims denied for companies reporting denials	308.55
Maximum claims denied for a single company	986
Number of responses to Q27	25

28. Please provide the number of appeals filed by these patients after an oral anticancer medication claim was denied.

Summary of Responses	
Total appeals filed (All companies)	6
Average appeals filed per company	0.24
Total companies reporting filed appeals	3
Average appeals filed for companies reporting appeals	2.00
Maximum appeals filed for a single company	4
Number of responses to Q28	25

29. Please provide the number of these appeals that were decided in favor of the insured.

Summary of Responses	
Total appeals decided in favor of the insured (All companies)	2
Average appeals decided in favor of the insured per company	0.08
Total companies reporting appeals decided in favor of the insured	1
Number of responses to Q29	25

Section 4: Additional Information

30. *Please provide any additional information regarding the availability of oral anticancer medications that may be helpful to TDI in conducting this study.*

Summary of Responses
<ul style="list-style-type: none">• The following study performed might be of some interest to the Department: California Health Benefits Review Program Analysis of SB 161, Health coverage: Chemotherapy Treatment - www.chbrp.org
<ul style="list-style-type: none">• All commercially available oral anticancer medications are included on our drug formularies. Our Pharmacy & Therapeutics Committee is responsible for the review of drugs approved by the FDA and their inclusion/exclusion on the formulary and associated tier placement, at least on an annual basis. An evidence-based review of pharmaceuticals and pharmaceutical classes is conducted for consideration to be included a formulary for our members. The evidence based review includes a review of peer reviewed medical literature, consideration of published practice guidelines, and reviewing medically accepted indications. Appropriate tier placement is achieved through this evidence based review and includes a review of safety, efficacy (solely and in comparison to current formulary agents), place in therapy (solely and in comparison to current formulary agents), side effect profile, adverse drug reaction reports, current utilization trends, and cost versus clinical benefit.
<ul style="list-style-type: none">• We provide access to all oral anticancer medications and the majority of these drugs are in their Tier 2 category on the preferred drug list with an average copay of \$30. Additionally, there is very good access to anti-hormone medications, which are typically available on Tier 1, with an average copay of \$15. These drugs are low cost and comparable to cholesterol, high-blood pressure and diabetic medications.

31. *Please provide any additional information regarding the cost of oral anticancer medications that may be helpful to TDI in conducting this study. This information may include, but is not limited to, the cost comparability of oral anticancer treatment and intravenous anticancer treatment, and the incremental PMPM cost of implementing anticancer medication parity.*

TDI did not receive any responses to this question.

Section 1501.002 (5) of the Texas Insurance Code provides the following definition of a health benefit plan:

“Health benefit plan” means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include the following:

- (A) *accident-only or disability income insurance coverage or a combination of accident-only and disability income insurance coverage;*
- (B) *credit-only insurance coverage;*
- (C) *disability insurance coverage;*
- (D) *coverage for a specified disease or illness;*
- (E) *Medicare services under a federal contract;*
- (F) *Medicare supplement and Medicare Select benefit plans regulated in accordance with federal law;*
- (G) *long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;*
- (H) *coverage that provides limited-scope dental or vision benefits;*
- (I) *coverage provided by a single service health maintenance organization;*
- (J) *workers' compensation insurance coverage or similar insurance coverage;*
- (K) *coverage provided through a jointly managed trust authorized under 29 U.S.C. Section 141 et seq. that contains a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 U.S.C. Section 157;*
- (L) *hospital indemnity or other fixed indemnity insurance coverage;*
- (M) *reinsurance contracts issued on a stop-loss, quota-share, or similar basis;*
- (N) *short-term major medical contracts;*
- (O) *liability insurance coverage, including general liability insurance coverage and automobile liability insurance coverage, and coverage issued as a supplement to liability insurance coverage, including automobile medical payment insurance coverage;*
- (P) *coverage for on-site medical clinics;*
- (Q) *coverage that provides other limited benefits specified by federal regulations; or*
- (R) *other coverage that:*
 - i. *is similar to the coverage described by this subdivision under which benefits for medical care are secondary or incidental to other coverage benefits; and*
 - ii. *is specified by federal regulations.*