HB 243

Department of Legislative Services

Maryland General Assembly
2012 Session

FISCAL AND POLICY NOTE
Revised

House Bill 243 (Delegate Nathan-Pulliam, *et al.*)
Health and Government Operations Finance

Kathleen A. Mathias Chemotherapy Parity Act of 2012

This bill prohibits insurers, nonprofit health service plans, and health maintenance organizations (carriers) that provide coverage for both orally administered cancer chemotherapy and cancer chemotherapy administered intravenously or by injection from imposing dollar limits, copayments, deductibles, or coinsurance requirements on coverage for orally administered cancer chemotherapy that are less favorable to an enrollee than those that apply to cancer chemotherapy administered intravenously or by injection.

The bill applies to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after October 1, 2012.

Fiscal Summary

State Effect: To the extent that the bill applies to the State Employee and Retiree Health and Welfare Benefits Program (State plan), State plan expenditures increase by at least $51,500 and as much as $368,000 in FY 2014 due to decreased enrollee cost sharing for oral anti-cancer drugs. Growth in expenditures is anticipated in future years but cannot be reliably estimated at this time. Minimal special fund revenue increase for the Maryland Insurance Administration (MIA) from the $125 rate and form filing fee in FY 2013. Review of filings can be handled with existing budgeted MIA resources.

(in dollars)	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
SF Revenue	-	$0	$0	$0	$0
GF/SF/FF Exp.	$0	$51,500	-	-	-
Net Effect	$0	($51,500)	$0	$0	$0

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate effect

Local Effect: Expenditures increase for some local governments due to decreased enrollee cost sharing for oral anti-cancer drugs.

Small Business Effect: None. The bill does not apply to the small group market.

Analysis

Bill Summary: Carriers may not reclassify cancer chemotherapy or increase a copayment, deductible, coinsurance requirement, or other out-of-pocket expense imposed on cancer chemotherapy to achieve compliance with the bill.

The bill does not apply to a policy or contract issued or delivered by an entity subject to the bill that provides the essential health benefits required under the federal Patient Protection and Affordable Care Act.

Current Law: Statute includes 45 mandated health insurance benefits that certain carriers must provide to their enrollees. Chemotherapy is not one of the mandated benefits.

Background: The number of oral anti-cancer drugs is growing rapidly, accounting for 25% of cancer drugs under development. Insurance companies typically cover intravenous or injected chemotherapy as a medical benefit, while orally administered chemotherapy drugs are provided under a prescription plan (many of which are administered by third-party pharmacy benefits managers). Cost-sharing arrangements for medical benefits and prescription benefits are often very different. Oral administration of cancer chemotherapy has the potential for cost savings over therapeutically similar intravenous or infused therapies due to a reduction in costs associated with intravenous administration.

To date, 15 states (Colorado, Connecticut, Hawaii, Illinois, Indiana, Iowa, Kansas, Minnesota, New Jersey, New Mexico, New York, Oregon, Texas, Vermont, and Washington) and the District of Columbia have passed legislation that would require carriers to cover orally administered chemotherapy drugs with the same (or no less favorable) cost-sharing arrangements as intravenously or injected chemotherapy.

As shown in **Exhibit 1**, under the current benefit design in the State plan, intravenous or injected chemotherapy is covered with no cost sharing under a medical plan, whereas orally administered chemotherapy is covered under the prescription plan with specified cost sharing. To comply with the bill *at this time*, the State plan would have to waive copayments for oral chemotherapy under the prescription plan in order to have parity with the 100% coverage provided under the medical plans.

Exhibit 1
Estimated Out-of-pocket Expenditures for Cancer Chemotherapy Under the State Employee and Retiree Health and Welfare Benefits Program

Drug Administration Method	Covered By	Cost Sharing for In-network Services Fiscal 2012	Cost Sharing for In-network Services Fiscal 2013
IV/Injected	Medical Plan (PPO, POS, & EPO)	PPO/POS: 0%	PPO/POS: 10% (maximum of $1,000 per individual per year or $2,000 per family)
		EPO: 0%	EPO: 0%
Oral	Prescription Plan	Maximum copayment of $25 for a nonpreferred brand name drug (1-45 day supply)	Maximum copayment of $25 for a nonpreferred brand name drug (1-45 day supply)

Note: EPO = exclusive provider organization; POS = point of service; PPO = preferred provider organization

Source: Department of Budget and Management

Beginning in fiscal 2013, cost-sharing changes will be made to the State plan. POS and PPO plans will require 10% coinsurance on the covered amount for in-network covered expenses (except for office visits subject to a copayment) and 30% coinsurance for out-of-network covered expenses (after a $250 deductible). EPO plans will continue to cover in-network covered medical expenses at 100%. Under this revised benefit design, cost-sharing arrangements for intravenous or injected chemotherapy for enrollees in the POS/PPO plans will not be less favorable than the copayment required for orally administered chemotherapy and would be in compliance with the bill. However, cost sharing for EPO enrollees would not be compliant. Therefore, the Department of Budget and Management (DBM) indicates that the State plan would have to waive copayments for EPO enrollees who are also enrolled in the prescription drug plan for oral anti-cancer drugs.

State Expenditures: According to DBM, there is some doubt as to whether the State plan is subject to the bill's requirements given that medical coverage and prescription coverage are provided separately within the State plan. As the State plan contract runs on a fiscal-year basis, the cost sharing specified under the bill would not be included until the fiscal 2014 plan year.

To the extent that the State plan is subject to the bill, State plan expenditures increase by at least $51,516 and as much as $367,973 in fiscal 2014. This estimate is based on the following information and assumptions:

- in fiscal 2011, copayments paid by State plan enrollees for oral anti-cancer drugs totaled $367,973;
- in fiscal 2011, 14% of State plan participants were enrolled in the EPO; and
- the State plan will cover the copayments for oral anti-cancer drugs for individuals enrolled in the EPO plan in fiscal 2014.

The exact amount of State plan expenditures will depend on a number of factors including the number of individuals who enroll in the EPO plan and utilization of oral anti-cancer drugs among enrollees. Based on anticipated changes in benefit design, potentially significant migration of enrollees to the EPO plan is anticipated beginning in fiscal 2013. Furthermore, both the prevalence and utilization of oral anti-cancer drugs are expected to increase. While future year State plan expenditures are anticipated to increase due to these assumptions, they cannot be reliably estimated at this time.

State plan expenditures are split 59% general funds, 30% special funds, and 11% federal funds.

Local Expenditures: Local government expenditures (for those that purchase fully insured plans from an insurance company) may increase for some local governments beginning in fiscal 2013 due to decreased enrollee cost sharing for oral anti-cancer drugs.

Additional Comments: CareFirst BlueCross BlueShield indicates that there will be no significant fiscal impact on its business as a result of the bill.

Additional Information

Prior Introductions: Similar legislation, SB 524/HB 626 of 2010 received hearings from the Senate Finance and House Health and Government Operations committees, respectively. Both bills were later withdrawn.

Cross File: SB 179 (Senator Pugh, *et al.*) - Finance.

Information Source(s): CareFirst BlueCross BlueShield, Department of Budget and Management, Department of Health and Mental Hygiene, Maryland Insurance Administration, Department of Legislative Services

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