PAT STRACHOTA

STATE REPRESENTATIVE

AB 392 – Health Committee Testimony 11/13/13

Imagine you are diagnosed with cancer. While the news is devastating, you can still take some small comfort in knowing that the health insurance policy you selected covers chemotherapy treatments. You will be able to fight the cancer, and win.

Cancer treatment options should be a decision made by the patient and their doctor on what is the best possible treatment program available to help fight their form of cancer, not what is dictated to be covered by the insurance company. Cancer treatment options have changed so much in the past 20 years that many of the forms of chemotherapy target cells directly and are available in only a pill form. Many in the industry have stated that this is going to be the continuing trend.

Different cancers often require different types of treatments. If your health insurance plan covers chemotherapy, and you are diagnosed with a cancer that requires orally administered chemotherapy, you may be in for a surprise. Many Wisconsin residents are discovering that while their insurance plan covers injected or intravenous chemotherapy treatments, it does not cover orally administered forms equally. Since intravenous chemotherapy is done in the doctor's office or hospital, it is generally covered under a health plan's medical benefit. Oral chemotherapy however, is typically covered under a plan's pharmacy benefit, because it is in an orally administered form. This can lead to massively increased out-of-pocket costs. Instead of focusing on beating cancer, patients must then find a way to pay for a chemotherapy treatment that they thought was covered.

AB 392, the Cancer Treatment Fairness Act, is an important piece of legislation designed to ensure patients equal access to life-saving oral chemotherapy treatments. It would prohibit state-regulated health plans from requiring patients to pay higher co-payments, deductibles, or co-insurance for oral chemotherapy treatments than they do for injected or intravenous treatments. The bill essentially says that if you're going to cover chemotherapy, you must cover the injected, intravenous, and oral forms equally. It does not apply to those insurance plans that choose not to cover chemotherapy.

This type of legislation is not unique to Wisconsin. Twenty-seven states across the country, along with the District of Columbia, have passed similar bills, including: Indiana, Iowa, Minnesota, and Nebraska here in the Midwest. In 2013 alone, six states passed this type of legislation. I am happy to report that here in Wisconsin, both AB 392 and its companion bill SB 300, have the bipartisan support of over 53 co-sponsors in the Assembly and Senate.

Capitol: Post Office Box 8953 • Madison, Wisconsin 53708-8953
(608) 264-8486 • Fax: (608) 282-3658 • Toll-Free: (888) 534-0058 • Rep.Strachota@legis.wi.gov
District: 639 Ridge Road • West Bend, Wisconsin 53095 • (262) 338-3790

Nine states (including Washington, DC) that passed oral chemotherapy laws similar to this one looked at the results in terms of increased or decreased health insurance premium costs after the law was signed. Only two of the nine, Connecticut and Washington, saw an increase, and it was only 0.2 percent. The other states saw no increase.

Treatments used to battle serious conditions such as cancer are constantly evolving, and health insurance plans do not always keep pace. This can leave patients who need coverage without any support, simply because their only chemotherapy option is taken orally instead of intravenously. A Multiple Myeloma Society study has shown that 10% of cancer patients ultimately decide against following through with oral therapy, partly due to cost pressures.

The benefits of oral cancer treatments are many. Instead of spending hours hooked up to an IV, a patient can simply swallow a pill. This less invasive method provides for a better quality of life and has fewer negative side effects. Oftentimes, oral treatment is the only option a patient has to fight the form of cancer affecting them. This is why equitable coverage of oral chemotherapy is so important.

Intravenous chemotherapy continues to be the primary and most widely used form of treatment for cancer patients. However, more than 25% of chemotherapy drugs currently in oncology development are of the oral variety. Oncology treatment is very personal and individualized. Something that may work for one person may not work for another person. As the number of oral treatments increase in the future, it is important that insurance coverage of those treatments keeps pace.

One of the concerns with oral chemotherapy equality legislation was whether or not it would increase costs. Here in the Midwest, three states – Iowa, Minnesota, and Indiana – have passed this type of legislation and seen no significant increase in premium or insurance costs. The Indiana Department of Insurance stated that despite initial concerns by some insurance carriers that costs would increase to accommodate the new coverage, no increases have materialized. It is reasonable to assume that the results here in Wisconsin would be similar. A study by the Leukemia & Lymphoma Society found that over the last decade, the average monthly wholesale cost of oral chemotherapy agents were roughly half the cost of their intravenous counterparts. On the whole, oral treatments are similar or cheaper in cost when compared to intravenous treatments.

In addition to cheaper acquisition costs, oral treatments require less hospital resources to administer. Intravenous treatments must be administered in a doctor's office or at the hospital, requiring additional costs for staffing, office, and supplies. In fact, a study of the costs to provide intravenous chemotherapy for lung cancer patients found that administration and other visit related services accounted for nearly half the total treatment costs. Oral chemotherapy does not require these additional costs. Since they are less invasive than intravenous treatments, oral chemotherapy requires fewer visits to the hospital. Fewer visits mean fewer hospital staff and administration costs, and most importantly, fewer complications and risks of infection.

This legislation allows cancer patients whose insurance plan covers chemotherapy, to make the best treatment choices possible in order to fight their disease. Certain oral treatments target specific types of cancer where no comparable injected or intravenous chemotherapy treatments exist. AB 392 keeps the decision on whether or not to use these important drugs between the doctor and patient, and not simply with the insurance company.

I would like to address the concerns and attacks that have been brought up regarding the Cancer Treatment Fairness Act, such as: this bill dictates the structure of medical benefits, the ACA covers oral chemo, there is a separation between medical benefits and pharmaceuticals, that this adds another wrinkle to the other pressures that insurers are facing from ACA, that pharmaceuticals are very expensive and have nothing to do with the insurance company, and the out of pocket cost maximums associated with ACA cover the extreme cost that many now face.

This bill is not a mandate, it is parity issue. It simply states that if chemotherapy is being offered by the insurer, all forms of chemotherapy must be covered. This bill does not dispute the fact that the oral form of chemotherapy has not always been covered by insurers. This is about the high costs associated through the plan design of a person's plan, and the Affordable Care Act does not fix this. Even with the maximum out of pocket cost caps, many families cannot afford $6,500 to $12,500 in out of pocket costs at the beginning of the year. Additionally, the ACA only addresses the total yearly out of pocket maximums, and does nothing with monthly costs. One example of how these caps are meaningless would be a person diagnosed and put on oral chemotherapy in November or December. They would still have to pay these maximums, and then be hit with them again once the new year began in January. That is a potential $13,000-$25,000 over the course of only a couple months. Many whose insurance plans who have been grandfathered will not have caps on their pharmaceutical coverage or the amount of out of pocket expenses they are liable for. These added costs would be on top of the drastic insurance premium increases here in Wisconsin due to implementation of the ACA.

If this bill is passed, it would not go into effect until Jan 1, 2015, which gives insurers the time to complete the implementation of the ACA. This also provides time for insurers to further understand and negotiate with the pharmaceuticals for lower drug coverage costs. The oral and IV forms of chemotherapy cost about the same, however oral agents require smaller administrative costs than those associated with the IV agents.

As the federal health care law continues to roll out, it has been marred with delays, confusion, and uncertainty. One aspect of the law that is certain however, is the fact that it is silent on the coverage parity for chemotherapy addressed in this bill before the committee today.

The out-of-pocket expense cap put in the ACA has been delayed by the President. However, if and when the cap is put back into place it still means the average Wisconsin cancer patient would be forced to pay thousands and thousands of dollars more for things like oral chemotherapy treatment. It provides no "fix" for this disparity in coverage.

There are some who see this type of legislation as a mandate, when in fact, it is not. Most health insurance plans in Wisconsin already include chemotherapy coverage. The ones that do not provide coverage will not be mandated to do so; this bill does not apply to them. The Wisconsin Commissioner of Insurance stated, "Since AB 151 (now AB 392) does not require coverage, it does not meet the definition of health insurance mandate under s. 601.423."

I hope to see this bipartisan legislation signed into law in the future. It will bring Wisconsin in line with the numerous other states who have successfully implemented equitable insurance coverage of chemotherapy without any significant cost increases. Oral chemotherapy is cheaper to acquire and cheaper to administer. There is no reason it should be covered any differently than other forms of treatment. Decisions on the best cancer treatment options available to help fight their form of cancer should be made by the patient and their doctor, not dictated by the insurance company.

Alberta Darling
Wisconsin State Senator
Member, Joint Committee on Finance

Assembly Bill 392: The Cancer Treatment Fairness Act Testimony

Thank you Representative Severson and committee members.

The Cancer Treatment Fairness Act will simply mean that if you have been paying for cancer treatment in your health insurance, you will be covered for cancer treatment.

It's not fair for people to pay decades of premiums for health insurance to suddenly find out that the treatments have improved, but the insurance they've invested in didn't keep pace.

When we plan out our family budget, we all prioritize what we can afford each month. But what if you had to sit down with your spouse and budget how long you could afford to keep your loved one alive? For too many people in Wisconsin, that is a discussion that must have because their insurance doesn't cover the type of cancer they have.

The Cancer Treatment Fairness Act will make sure patients have access to the cancer treatment their doctor prescribes. If a health care plan regulated by the state covers chemotherapy, then the out-of-pocket costs for patients must be the same. Twenty-seven states and the District of Columbia have already approved similar legislation.

Most health care plans cover chemotherapy treatments for cancer, but many have not kept up with advancements in the science. Most patients rightly assume they are covered, only to find out that they have the "wrong type of cancer."

Doctors are increasingly using an oral form of chemotherapy treatment. In some cases doctors use a combination of traditional intravenous chemotherapy and in other cases they will prescribe an oral chemotherapy because it is the only effective way to combat certain types of cancer. Because of the disparity in access, doctors are more likely to prescribe treatments that aren't as effective and likely cost insurance companies even more.

Oral chemotherapy is more convenient because it doesn't require a trip to the doctor's office. The pills only target the cancer cells, which means fewer side effects for patients. Patients on oral chemotherapy treatments don't suffer hair loss or nausea, and that means they will be able to continue to work and care for their families while they fight their disease. Many of the latest advances in anti-cancer drugs are coming in pill form. That means in the future, more types of cancers will be treatable with oral chemotherapy which means not passing this bill will impact more and more people.

Both intravenous and oral chemotherapies are expensive. Oral chemotherapy treatments can save some money because patients avoid costly office visits and can continue

working. After the state of Indiana passed this legislation, no evidence was found that it increased health care costs.

Some people have tried to say that the Affordable Care Act will take care of this problem. I'm pretty sure we all heard that we could keep our plan if we wanted it too.

Given that thousands, maybe millions of people throughout the country are losing their insurance and only a handful are able to log in to the new marketplace - the only certainty in health care is that it's going to cost a lot more under the ACA. The Cancer Treatment Fairness Act will give patients and their families some certainty.

The ACA will eventually install maximum out of pocket caps for patients. The maximum out of pocket costs will eventually be well over $6,000 per year, per patient. If the health insurance lobby believes that the average Wisconsin cancer patient has $6,000 readily available to cover the cost of cancer medications, they are truly out of touch with consumers. In fact, research shows that the patient abandonment rate---patients going to the pharmacy to fill their prescription, but leaving without filling the prescription---drastically increases when the out-of-pocket cost exceeds $100. In addition, the Obama Administration has delayed this cap for 2014---and who knows whether this Administration will delay it again.

The beauty of SB 300 is that it does not tell health plans how to operate. If insurance companies want to make sure patients have some skin in the game, SB 300 does nothing to deter that. It provides health plans flexibility in how they provide coverage for cancer therapies. The only thing SB 300 does is ensure that cancer patients who need medications that are only available in pill form can truly access their medications. These consumers paid their premiums. They signed on the dotted line and purchased health care coverage. Chemotherapy is a covered service. They should not be discriminated against simply because they drug they need to survive comes in pill form, as opposed to IV.

SB 300 respects the doctor-patient relationship to choose the best therapy for that individual patient. It ensures that all of us---those of us who have battled cancer, those us fighting it right now and those of us who will hear those dreaded words at some time in the future---can access the medication that offers us the best chance at survival.

This bill isn't just about the people battling cancer today. It's about putting protections in place so that as more and more promising anticancer medications are approved, access to HOPE isn't contingent on an outdated health insurance benefit design.

Thank you for your time on this important matter.

Peter W.
BARCA
Minority Leader – Wisconsin State Assembly

November 13, 2013

Testimony on AB 392: WI Cancer Treatment Fairness Act

Chairman Severson, members of the Assembly Health Committee, thank you for holding a hearing on Assembly Bill 392, the Wisconsin Cancer Fairness Act.

As the original bill author in 2009, I have closely tracked this legislation over the last few sessions and believe we should follow the example of 27 states and allow our cancer patients fair treatment in their choice of chemotherapy. All of us have friends and relatives who suffered through grueling cancer treatments and understand the immense comfort and value in taking a pill at home rather than receiving IV treatment for hours a week in a hospital or clinic.

Issue background

- This proposal requires parity in health insurance cost coverage of oral and intravenous chemotherapies for health plans that cover these treatments. Currently, many plans offer far more generous coverage for intravenous drugs, which are billed as medical costs, than oral drugs, which are considered pharmaceutical costs. This legislation does not require insurance companies to cover oral chemotherapy; however if coverage already exists, it seeks to level the playing field between the out-of-pocket costs for oral and IV/injectable chemotherapies.

- Oral chemotherapy has been developing at an increasing rate in recent years and more than a quarter of the 400 anti-cancer agents in the pipeline today are intended as oral drugs. Patients often prefer oral chemotherapy because it is a more comfortable, effective way to treat cancer with fewer adverse reactions and has turned once incurable cancers such as myeloma and breast cancer into manageable diseases.

- Unfortunately, health insurance practices lag behind the state of the science. For example, there is a significant difference in the amount cancer patients in the U.S. must pay out of pocket for an oral drug and how much they pay for an intravenous product. Intravenous therapies are traditionally covered under a medical benefit, under which most patients are only responsible for an office copayment for each visit and are not required to pay a separate fee for the intravenous drug. By contrast, oral chemotherapy is generally covered under a prescription drug benefit, which tends to have higher copayments.

State Capitol, P.O. Box 8952, Madison, WI 53708 • (608) 266-5504 • Toll-Free: (888) 534-0064
64th Assembly District • rep.barca@legis.wi.gov • http://barca.assembly.wi.gov

Oral chemo parity has widespread support

- AB 392 has strong bi-partisan support (over 40 Assembly and 15 Senate co-sponsors).
- Oral chemo parity has passed in 27 states and District of Columbia and there is no evidence of premium increases or issues complying with the Affordable Care Act.
- Patient advocacy organizations which have advocated for the legislation include the American Cancer Society Cancer Action Network, Susan G. Komen for the Cure, the International Myeloma Foundation and the Leukemia & Lymphoma Society.
- Oral chemo parity has strong support from major Wisconsin cancer centers including Children's Hospital of Wisconsin, Aurora Health Care, and Marshfield Clinic.

Oral chemotherapy benefits

- improve patients' quality of life
- provide a more convenient and less invasive method of therapy
- offer a more effective alternative with less adverse reactions for patients who have failed to respond to IV treatments
- reduce resource utilization and health care system costs, improve drug safety, and enhance patient satisfaction.

AB 392 is not a mandate

This legislation does not mandate coverage of oral therapies or require health plans to have a pharmacy benefit; it simply establishes parity in patients' out of pocket costs.

Evidence suggests oral chemotherapy costs less than IV chemotherapy

A study in the Journal of Medical Economics, focused on multiple myeloma patients, recently found that total treatment costs for IV therapy were higher than oral therapy even though the drugs cost about the same. It showed annual treatment costs of IV therapy are approximately $17,000 more per year due to additional costs such as nursing, medical staff and facility fees which can total hundreds of dollars for every treatment. Also, there are lost wages to consider.

The way we treat cancer is changing. Oral cancer therapies are the wave of the future. To the benefit of patients, exciting advancements are being made in cancer treatment and care. Advancements are allowing us to selectively target cancer cells and deliver agents that directly interfere with the cancer cells' survival. These targeted agents generally require continuous exposure to the medication, for which oral therapies are well-suited.

Thank you again for your time today in reviewing these very important fairness issues for Wisconsin cancer patients.

LEUKEMIA &
LYMPHOMA
SOCIETY®
fighting blood cancers

www.LLS.org

Testimony of the Leukemia and Lymphoma Society on AB 392

The Leukemia & Lymphoma Society is the world's largest voluntary health agency dedicated to curing leukemia, lymphoma, Hodgkin's disease and myeloma, while improving the quality of life of patients and their families.

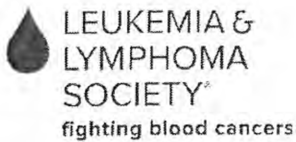
Innovative, targeted, patient-administered medicines have become more prevalent in cancer treatment and are now the recognized standard of care for many types of cancers. Unfortunately, the insurance industry has not caught up with the technological advancements in therapy and continues to treat patients differently based upon whether they receive their care in a provider setting, such as IV Chemotherapy, or in a pharmacy setting, such as an orally-administered anti-cancer product.

By allowing insurance plans to continue to charge patients high co-insurances for these oral medications, rather than the flat co-payments typically charged for treatments delivered in a provider setting, cancer patients continue to be discriminated against based upon the site of service where they receive their treatment.

Oral Products Are Often the Only Option for Patients
In many cases, the only option for patients is an oral anti-cancer therapy, and for these patients outdated benefit designs will often require the patient to absorb a disproportionate share of those costs. For example, Gleevec (Imatinib), an oral treatment for Chronic Myeloid Leukemia (CML), carries a retail price for an average monthly (supply) of 400mg tablets in the $6,000 to $7,500 range. Many CML patients are dependent upon this oral therapy to keep them alive, yet a 20% co-insurance requirement generates an out-of-pocket expense of at least $1,200 per month.

This Bill Does Not Require Coverage of Oral Forms of Treatment
This bill simply eliminates the current discrimination caused by outdated health benefit designs, it does not require an insurance company to provide coverage of any kind, or create new insurance benefits. The bill states that, if a health plan already covers cancer treatment, the plan must apply the same cost sharing rules to drugs that are self-administered and drugs that are administered by an IV. In other words, coverage for oral drugs may not be less favorable than coverage for IV drugs. In addition, included in your packet is a memo from the Office of the Commissioner of Insurance indicating this bill does not meet the definition of a mandate since it does not require coverage.

No Statistically Relevant Premium Increases Have Been Seen
To date, 27 other states plus the District of Columbia have passed similar bills and implemented the law. Included in your packet is an Oral Oncology Access Legislative Landscape map indicating the states which have enacted laws to ensure access to oral anti-cancer therapies. Since 2008, states have been leveling the playing field for cancer patients ensuring that no matter how dispensed, they have access to the best



www.LLS.org

treatment for them.

We chose to summarize a peer group of this committee – included in your packet is a summary of the eight states and the District of Columbia who responded to a request from the Tennessee Health and Human Resources Committee asking their Departments of Insurance if "...any health plans operating in your State raised specific concerns about the oral chemotherapy parity requirement and/or claimed that the new requirement has resulted in an increase in health insurance premiums?" Only two states (Connecticut and the state of Washington) reported a 0.2% increase and no states reported their health plans raised any concerns.

The Affordable Care Act Does Not Fix This Challenge Facing Patients

Another common question is how the Affordable Care Act affects parity - a guideline to address frequently asked questions is included in your packet. By supporting this bill, you will help solve the monthly out-of-pocket financial burden for patients. Although the ACA does place an annual out-of-pocket maximum for in-network expenses of $6,350 per individual, this does nothing to address a patient's struggle with the cost of their anti-cancer treatment each month.

While the annual cap is designed to provide a ceiling on a patient's total out-of-pocket expenses, the evidence published in the American Journal of Managed Care found that patients with cost-sharing over $500 were four times more likely to abandon their oral oncology products than those with cost-sharing under $100. This suggests that an exorbitant co-insurance requirement will likely prevent many patients from ever filling even their first prescription because they cannot afford the cost, which can mean a choice between living with their cancer or dying because of it. An annual out-of-pocket maximum simply does not protect against the barriers created by excessive patient co-insurance requirements. In short, this bill creates equity and affordability on a per prescription basis, while an annual maximum does not help make a prescription affordable if a patient needs to make a decision that month whether or not they can afford it.

Equitable access to oral therapies will allow patients and their doctors to decide the most clinically appropriate treatment; prevent patients from making a choice whether or not to fill their prescription; and bring parity to a patient's out-of-pocket expense no matter which setting they receive their care in. We are not asking health plans to provide cancer treatment coverage, only to apply equality to a patient's cost sharing. We know from the other states that have enacted this law that insurance premiums have not increased. And we also know an annual out-of-pocket does nothing to address the monthly burden patients face.

AB 392 provides critical patient protections for those suffering from cancer – on behalf of the estimated 31,590 Wisconsinites who will be newly diagnosed with a cancer in 2013, The Leukemia & Lymphoma Society urges your support to remove barriers to access for our patients and their families.

ALLIANCE OF HEALTH INSURERS, U.A.
Post Office Box 308
Madison, WI 53701
608-630-9293
info@allianceofhealthinsurers.com

To: Members, Assembly Health Committee

From: Alliance of Health Insurers, U. A. (AHI)

Date: November 13, 2013

Re: Assembly Bill 392, Oral Chemotherapy Parity Legislation

The Alliance of Health Insurers, or AHI, is a health insurance trade association comprised of nine member health insurance companies engaged in providing a broad range of health care coverage services in Wisconsin.

Collectively, AHI member companies provide health insurance coverage to about 70% of the commercial health insurance market and insure approximately 60% of the population enrolled in the State's Medicaid program. The companies are all major employers in the state and strong partners in our communities.

AHI is opposed to AB 392, the oral chemotherapy parity legislation that aims to require insurers to charge the same copays, coinsurance and deductibles for oral chemotherapy prescription drugs as IV chemotherapy treatments.

This legislation is not about providing oral chemotherapy prescription drug coverage. All AHI member companies provide coverage of oral chemotherapy treatments. There are more than two dozen oral anticancer medications that are currently covered under the typical pharmacy rider. Also, new federal laws will soon require all insurance companies to cover oral chemotherapy if they do not currently. Wisconsin is well known for its high levels of insurance coverage and a competitive health insurance marketplace. A report highlighting the historic competitive nature of the health insurance industry in Wisconsin and its importance to Wisconsin's economy is included with this memo for Committee members.

Oral chemotherapy is generally covered by health insurance plans as a specialty pharmaceutical subject to various co-pays, deductibles and out-of-pocket limits applicable to pharmaceutical benefit plans. Traditional intravenous treatment, which is delivered in a clinical setting, is considered a medical benefit. To treat them the same would be mixing apples and oranges, requiring a unique and expensive redesign that would increase costs for everyone covered under health a insurance policy.

This legislation does not address the root cause of the aforability problem: the high costs of these treatments, which can run $10,000 a month or more. Because many of the treatments that would be subject to this requirement have no generic or therapeutic alternative, it is difficult for health plans to negotiate more favorable prices from manufacturers. Separating the cost of medical and pharmacy helps to better manage those costs. **Reduced cost- sharing does not lower the overall cost of the prescription drug. Instead, it simply shifts those costs back to the health plan.**

This could have the unintended consequence of actually increasing costs, not only for patients receiving treatment for cancer, but for all of the patients covered by the pharmacy benefit.

On a practical level, this type of legislation presents difficulties in processing claims; for example:

- Medical and pharmacy claims process under different systems and use different reimbursement code sets. It would not be possible at the point of sale in a retail pharmacy to compare how the claim would process under each benefit and apply the lower cost. This is especially true in cases where the health plan processes medical claims while pharmacy claims are processed by a contracted pharmacy benefit manager, which would have no access to the medical benefit information.

- Cancer agents paid under the medical benefits are incorporated into deductibles, office co-pays and other charges that extend beyond just the drug cost. It is not feasible to compare the member share of cost in an in-office setting to that paid for oral cancer drugs through the retail pharmacy benefit, which has a copayment or coinsurance amount for the drug only.

- As drug prices change per market conditions, what percentage of the total drug cost a copayment equals would change month-to-month, meaning members would not have a steady, predictable share of cost. Also cancer treatment can oftentimes consist of both oral and intravenous treatment. Intravenous treatment is generally administered bi-weekly or monthly as opposed to oral, which is daily. This can make parity in cost-sharing very difficult.

- The extent of coverage under the medical benefits could also change depending on whether or not deductibles have been met and whether or not out-of-pocket maximums have been reached.

The issues of access and the affordability of oral chemotherapy have largely been addressed by the Affordable Care Act (ACA), which requires insurers to provide drug coverage and establishes specific out-of-pocket limits for consumers. These limits - $6,400 for individuals and $12,800 for families- apply to the combined total, prescription and medical out-of-pocket costs, under a health insurance plan and they are generally lower than one month's supply of oral chemotherapy medication. Also, lower income individuals can get assistance with insurance premiums, copayments and coinsurance if coverage is received through the Federally Facilitated Marketplace. As a result, AB 392 is no longer necessary since federal law now addresses the problem that this legislation was intended to solve.

The ACA is also expected to substantially increase the cost of health insurance for consumers and businesses alike. This is because the ACA establishes new coverage mandates, requires guaranteed issue, regardless of health status, imposes new taxes on health insurers and imposes a host of new regulations governing how health insurance is structured and sold. Together, these changes will substantially increase the cost of coverage for all consumers and the business that generally pay the premiums.

Finally, this mandate, as with all other state mandates, increases the cost of health insurance only for the thirty percent of consumers and small business that are in the state-regulated, private insurance market.

AHI members would welcome a conversation about the problems and costs associated with benefit design mandates and the need to find an appropriate balance between access and affordability. Because the cost of prescription drugs can be extremely high, the health insurance market has created a variety of benefit designs to meet the needs and budgets of consumers. **However, parity legislation would simply provide a perverse disincentive for drug companies to find ways to bring down the cost of these drugs.**

Thank you for considering our perspective on this issue.

PROTECTION & PROSPERITY

THE HEALTH INSURANCE INDUSTRY'S IMPACT ON WISCONSIN

EXECUTIVE SUMMARY

In November 2012, officials from the Wisconsin health insurance industry asked the Wisconsin Taxpayers Alliance (WISTAX) to study the impact that health insurers have on Wisconsin's economy.

The value of Wisconsin's health insurance industry can be seen in the way it improves access to health care services, coordinates care, and drives quality improvement and cost control. WISTAX looked at the industry's broader role, compiling state and national data on employment, wages, premiums, taxes, and financial holdings. The figures show Wisconsin's health insurance industry contributes significantly to the state economy by providing a large number of high-paying jobs, paying business and personal taxes, holding significant amounts of municipal securities, and helping to keep Wisconsin's uninsured rate among the lowest in the nation.

Hundreds of Companies

In 2011, Wisconsin had 534 companies authorized to sell health insurance in the state, with 73 of them domestic (Wisconsin-based) firms. Wisconsin ranks among the top 10 states in the number of health insurers offering coverage.

Millions in Taxes Paid

In addition to property taxes, Wisconsin's overall insurance industry paid $148 million in premiums taxes and another $28 million in corporate income taxes in 2011 (data specific to the health insurance industry were not available). Health insurance employees paid an estimated $75 million in individual income taxes.

Thousands of Jobs

In addition to the 18,172 residents employed by health insurers, the industry also generates between 4,900 and 6,300 agency and brokerage jobs. And, through its economic activity, it supports other jobs throughout the state economy. Thus, directly and indirectly, the health insurance industry supports between 63,800 and 67,100 jobs in Wisconsin.

Strong Job Growth

Job growth has outpaced other industries over the last 10 years. From 2001 through 2010, a period that includes the "Great Recession," life and health insurance jobs were up 19.4%, compared to a decline of 0.3% for all jobs statewide. Nationally, life/health insurance jobs dropped 3.3%.

Good Paying Jobs

In 2010, the average wage in the health insurance industry was $53,691, or nearly 40% above the state average. The industry's payroll totaled $1.24 billion, or about 1.4% of the state total.

Partners in Community Development

The insurance industry supports community development by buying and holding large amounts of municipal bonds. In 2011, the insurance industry nationwide held $452 billion in municipal securities, more than double what it held in 2002.

Leaders in Providing Health Insurance

Wisconsin's uninsured rate is among the lowest in the nation. In 2011, only 10.4% of state residents had no health insurance, compared to 15.7% nationally. Among the 50 states, Wisconsin ranked 10th.

Wisconsin Taxpayers Alliance
401 North Lawn Avenue • Madison, WI 53704
www.wistax.org

INTRODUCTION

Insurance plays an important role in today's society. Property and casualty insurance provides protection from financial losses due to fire, storms, vehicle accidents, and other unexpected events. Life insurance provides the comfort that comes from knowing survivors will be provided for when a policyholder dies. And health insurance provides access to quality health care and protects against the high cost of medical bills. In 2011, Wisconsin's health insurers paid claims totaling almost $6.5 billion.

But the health insurance industry also plays a broader role in Wisconsin and elsewhere by:

- providing high-paying jobs,
- paying significant state and local taxes,
- supporting local charities and nonprofits; and
- investing in public infrastructure by purchasing government bonds.

Nationally, the health insurance industry accounts for about 0.41% of all jobs and 0.63% of all salaries and wages. In addition to paying federal income taxes, the industry pays millions more in state and local taxes, including those on premiums, property, and income.

Just as it is important to the national economy, the health insurance industry is a critical part of Wisconsin's economy. The health insurance industry provides multiple economic benefits to Wisconsin individuals, families, and state government by promoting access to preventive care, helping people manage their chronic health conditions, driving improvements in health care quality and controlling costs. Managed health care, in particular, helps state government save millions of dollars in health care costs each year.

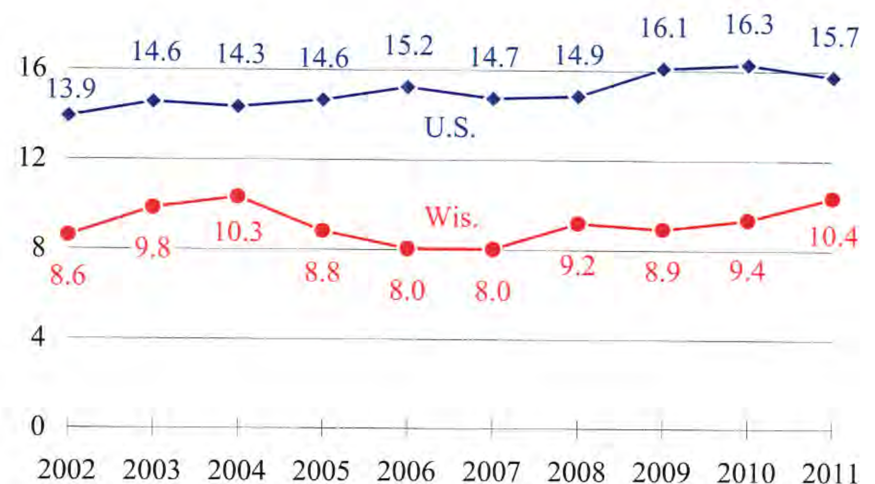
As Wisconsin's Legislative Audit Bureau concluded in its 2011 study, "Health plans serving the Medicaid Program are more likely to provide cost-effective health care while directing recipients to medically appropriate services." A 2012 Deloitte analysis showed health plans serving Wisconsin's state employees kept the program's cost trend an average of 4.1% lower than national averages, providing strong evidence the model used by the state has been a successful approach. And the commercial market provides further evidence of health plans' cost control. In 2010, the average cost of coverage in Wisconsin's individual market was 7% lower than the national average and lower than the average of 34 other states.

In addition, the industry employs more than 23,000 state residents in jobs that pay significantly more than the state average. In addition to its economic impact, Wisconsin's health insurers have helped Wisconsin attain one of the highest rates of health insurance coverage in the nation.

HEALTH INSURANCE COVERAGE IN WISCONSIN

Health insurance is an important safeguard for individuals and families. Wisconsin traditionally has been among the leading states in health insurance coverage. In 2011, about 90% of Wisconsin residents had health insurance, according to the U.S. Census Bu-

Figure 1: Wisconsin Uninsured Rate Below U.S. Average
2002-2011



reau. Only nine states had a smaller percentage of their residents uninsured. Moreover, in 11 of the 12 years from 2000 through 2011, Wisconsin ranked among the top 10 states in insurance coverage; in nine years it ranked among the top five.

Wisconsin's uninsured rate has remained consistently below the national average (see Figure 1). During 2002-11, the percentage of uninsured Wisconsinites ranged from 8.0% to 10.4%. During those same years, the national low was 13.9% (2002).

Sources of Insurance

Wisconsin residents obtain their insurance from a variety of sources. In 2011, 32.1% of Wisconsin residents obtained health insurance from government sources (either Medicare, Medicaid, or the military), about the same percentage as the U.S. (32.2%).

However, Wisconsin residents relied to a greater degree on the private market for health insurance than did residents of other states. In 2011, 72.1% had some form of private health coverage. That percentage was 10th highest nationally and significantly above the national average (63.9%).

Most residents get insurance through their place of work. In 2011, nearly 60% of Wisconsinites had some kind of coverage through an employer, compared to 55% nationally. Since 1999, employer-based coverage here has been four to 10 percentage points higher than the U.S. norm.

In 2011, 534 companies were authorized to sell health insurance in Wisconsin. Of these, 73 were domestic. Wisconsin ranked 13th nationally in health insurance premiums written.

With an above-average share of residents covered by their employer, it follows that many Wisconsin employers offer health insurance. In 2011, 97% of large (50 or more employees) employers offered health insurance compared to 96% nationally. However, only 33% of Wisconsin's small employers (fewer than 50 employees) offer health insurance vs. 36% nationally.

Table 1: Health Insurance Companies/Premiums
Companies Authorized in Wis., Premiums, 2002-11

	Co's Authorized to Write in Wis.						Prem's
	Life/ Health	HMO	Frat.	Other	Total	Dom.	$ bill.
2002	505	20	52	16	593	76	$7.79
2003	488	21	52	16	577	74	$8.51
2004	477	24	51	15	567	77	$8.81
2005	478	26	49	14	567	79	$9.37
2006	473	25	48	14	560	77	$10.57
2007	462	24	48	13	547	74	$11.63
2008	457	23	48	14	542	75	$12.29
2009	453	23	48	15	539	75	$13.66
2010	451	23	47	16	537	75	$13.90
2011	452	23	45	14	534	73	$14.24

WISCONSIN'S HEALTH INSURANCE INDUSTRY

Several types of companies are allowed to sell health insurance in Wisconsin. Most are either authorized to sell life, accident, and health insurance or are health maintenance organizations (HMOs). Fraternal benefit societies—nonstock corporations that exist for social, educational, charitable, or religious purposes—are authorized to sell insurance to members. Other companies provide more limited coverage, e.g., vision or dental.

In 2011, health insurance companies in Wisconsin wrote $14.24 billion in premiums, ranking the state 13th nationally in premiums written. Between 2002 and 2011, the amount of premiums written here rose 82.9%. The amount paid by health insurers for medical services rose 88.8% during that same period.

In 2011, 534 companies were authorized to sell health insurance in Wisconsin. Of them, 73 were domestic companies. Of the 534 companies, 452 (85%) were either stock or mutual life/health companies. Another 23 (4%) were HMOs. Since 2002, the number of companies authorized to write health insurance has declined from 593 to 534. However, the number of domestic companies fell by only three over the ten years.

The National Association of Insurance Commissioners (NAIC) provides comparative state information on insurers. According to NAIC, Wisconsin ranks among the top ten states in the number of health insurers authorized to offer coverage.

EMPLOYMENT

The health insurance industry has two major components: health insurers that provide the insurance and brokers/agents who sell it to individuals and firms.

In 2010, Wisconsin health insurers employed 18,172 state residents. Key state industries with similar employment levels include:

- dairy product manufacturing (19,328);
- telecommunications (17,865);
- electrical equipment manufacturing (18,158); and
- publishing (17,609).

Economic Significance

Economists and economic development specialists use a variety of statistics to assess the importance of an industry to a state. One of the most commonly used measures is the location quotient (LQ), which compares an industry's share of employment in a state to its employment share nationally. A location quotient greater than 1.0 means that an industry employs a greater share of the state's workforce than it does nationally.

Wisconsin's health insurance industry's LQ is 2.08; i.e., Wisconsin's health insurance employment share is more than double the nation's. One interpretation of this figure is that the health insurance industry is what economic development officials call a "basic" industry, drawing money into the state from outside. A location quotient of 1.0 indicates the industry has just enough employment to provide a particular good or service for state residents. An LQ less than one implies the state does not produce enough of a good or service and state residents have to buy it from firms outside the state. The health insurance industry's LQ of more than two indicates that, in selling its products nationally, it is bringing outside money into the state's economy.

The health insurance industry's share of employment in Wisconsin is more than double the national share. From an economic development perspective, health insurance is one of Wisconsin's most important industries.

The health insurance industry's LQ is among the highest of any industry in the state. While the health insurance industry is not often thought of as a key Wisconsin industry, its location quotient is larger than manufacturing's, an industry long thought to be Wisconsin's most dominant.

Additional Jobs

The employment figures cited above reflect individuals employed directly by health insurance providers. However, that underestimates the health industry's employment impact in the state. The industry relies on insurance agencies and brokerages to sell and service its products. In addition to agents and brokers, these offices employ support staff.

Brokers/Agents. Federal employment figures provide information on insurance agencies and brokerages but do not separate them

by type of insurance. Several insurance industry ratios can be used to estimate health insurance employment in these areas.

In 2010, there were 18,609 residents employed in insurance agencies and brokerages or other insurance-related areas (claims adjusting, etc.). Some of these were health insurance related, while others were related to life, property and casualty, or some other type of insurance.

Various estimates suggest that, within agencies, brokerages, and other miscellaneous industries, there were between 4,900 and 6,300 jobs related to health insurance. That brings the total number of health insurance jobs in the state to between 23,500 and 24,900.

Other Jobs Supported by the Industry. When workers in the health insurance industry spend their wages, they help support jobs in other industries. Economists refer to this as the multiplier effect. When this effect is accounted for, the health insurance industry supports an additional 40,300 to 42,200 jobs throughout the state. Combined with direct industry employment, the health insurance industry supports between 63,800 and 67,100 jobs statewide.

Figure 2: Life/Health Ins. Industry Job Growth High
Cumulative % Change in Employment Since 2001, 2001-10

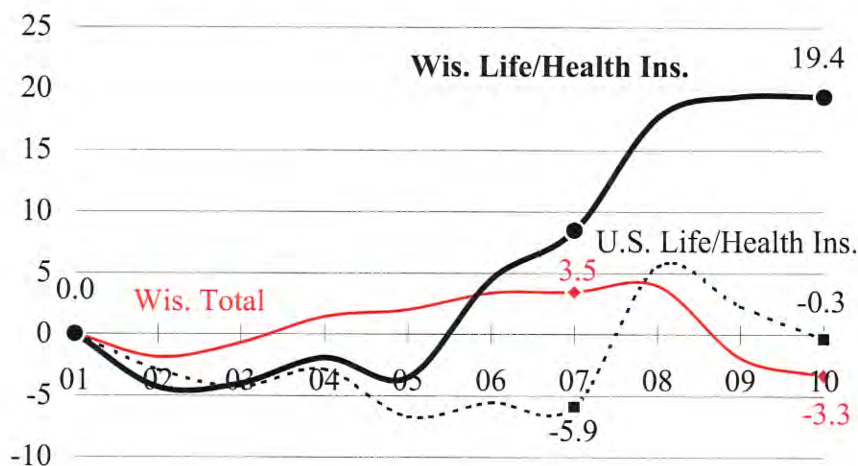
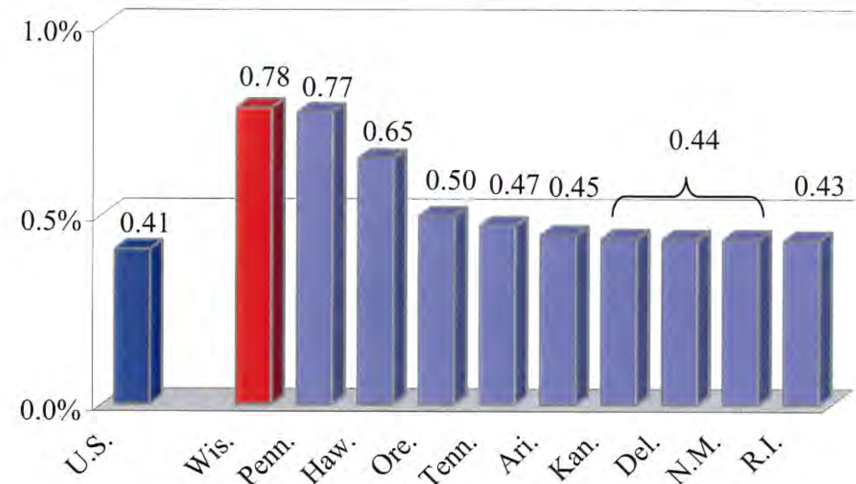


Figure 3: Wis. Health Insurance Industry Among Top Ten
Health Insurance Employment % of Total State Employment, 2010



Employment Growth

Not only is the health insurance industry a significant state employer, its growth over the last ten years has outpaced other industries. Federal figures show 2001-10 job growth of 50% in Wisconsin's health insurance industry. However, those numbers could be skewed by reclassification of firms selling both life and health insurance. These firms are classified based on the predominant insurance line sold.

Figure 2 shows employment growth among life and health insurers combined. From 2001 through 2010, employment growth in these industries combined grew 19.4%. That compares favorably with both overall Wisconsin employment (-3.3%) and life/health insurers nationally (-0.3%).

National Context

Wisconsin's health insurance employment compares favorably with other states. The industry employed 0.78% of all workers statewide; the corresponding national figure was 0.41% (see Figure 3, page 4). Pennsylvania (0.77%) and Hawaii (0.65%) were the only other states to employ more than 0.5% of their workers in this industry.

Wisconsin employed 4.0% of all health insurance workers nationally, which is more than all but six states: California, Florida, New York, Ohio, Pennsylvania, and Texas.

WAGES AND SALARIES

Like the industry as a whole, the health insurance industry provides jobs with above-average wages. In 2010, the average wage in the health insurance industry was $53,691, nearly 40% above the state average ($39,176).

Total Payroll

The payroll for Wisconsin's health insurance industry totalled $1.24 billion in 2010. As a percent of total statewide payroll, health insurance was nearly 1.4%.

Again, because of reclassification issues, it is difficult to track health insurance payroll over time. However, combined life/health industry's payroll has risen more than twice as fast as total statewide payrolls. From 2001 through 2010, life/health payrolls rose 55.0%, compared to 22.4% for total payrolls.

Total Payroll Impact

Just as employment impacts filter through the economy and help support other jobs, payroll also has multiplier effects. The industry's $1.24 billion payroll supports an additional $1.46 billion in wages in other industries. Both directly and indirectly, Wisconsin's health insurance industry supports $2.70 billion in wages statewide.

TAXES PAID

In addition to providing many high-paying jobs, Wisconsin's health insurance industry contributes a significant amount of tax revenue to state and local governments to help provide essential public services.

Wisconsin's health insurance companies had 2010 payroll totalling $1.24 billion. However, through employee spending, those dollars support an additional $1.46 billion in wages in other industries. Directly and indirectly, Wisconsin's health insurance industry supports nearly $2.7 billion in wages statewide.

Corporate Taxes

Insurance companies operating in Wisconsin—including those selling health insurance—pay one of two corporate taxes. Most out-of-state companies (and some domestics) pay a 2% tax on gross premiums written. For example, if an Illinois insurance company writes a $10,000 health insurance policy for a state resident, it must pay a $200 premiums tax to the state.

Most domestic, nonlife insurance companies pay the corporate income tax at 7.9% of taxable income. However, a firm's tax liability cannot exceed what it would owe under the 2% premiums tax.

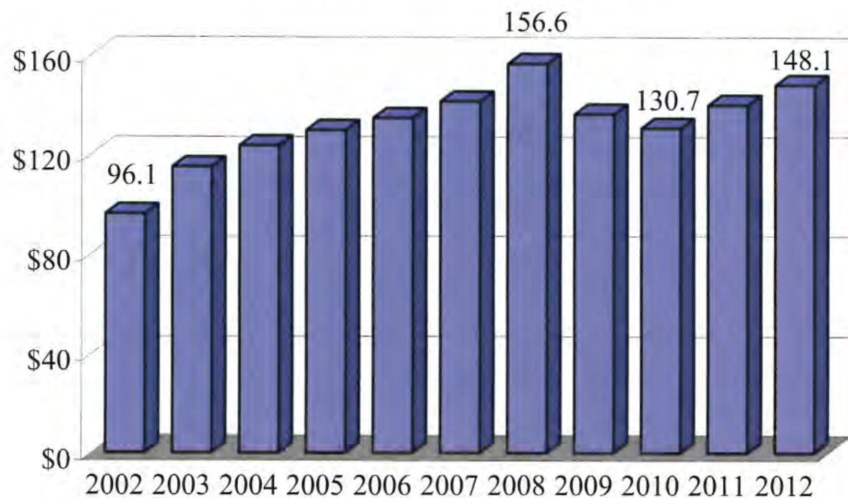
Premium Taxes. Information on premiums taxes collected from all types of insurance companies are provided by the Wisconsin Department of Revenue (DOR). From 2002 through 2011, these taxes rose 54%, from $96.1 million to $148.1 million (see Figure 4 on page six). Premiums taxes peaked at $156.6 million in 2008, before declining for two years during the recession.

The DOR figures do not allow for a breakdown of premiums taxes by industry. However, during 2002-11, health insurance was about 50% of all insurance written, with annual shares ranging from 46% in 2002 to 56% in each of 2009, 2010, and 2011.

Corporate Income Taxes. Corporate income taxes fluctuate widely as profits rise and fall with the economy. Health insurance profits are affected by the number of firms offering health insurance, expansion or contraction of state and federal health programs (Medicare and Medicaid), and law changes (e.g., mandated coverages).

In 2009 (the latest year for which the state Department of Revenue has information), corporate income taxes paid by all insurance carriers and insurance agents totaled $28.0 million. Over the ten years ending in 2009, annual tax payments varied from $18.0 million in 2006 to $69.8 million in 2004. Corporate tax payments were not separately provided for health insurance companies.

Figure 4: Wisconsin Insurance Taxes Rise
Premiums Taxes, $ Millions,
Fiscal Years 2001-02 Through 2011-12



As a percentage of all corporate income taxes paid, the insurance industry's share ranged from 2.3% in 2006 to 10.7% in 2004. In 2009, insurance companies and agencies paid 4.5% of all Wisconsin corporate income taxes.

Not all firms in the insurance industry pay taxes on their business income through the corporate income tax. Some (most likely insurance agencies and brokerages) are organized as partnerships or as subchapter S corporations. In these cases, profits flow through to the owners and taxes on business' profits are paid through the individual income tax.

Individual Income Taxes

Health insurance industry employees pay state income taxes on their wages and other income. Because average industry pay is above average, its employees pay taxes at higher average rates than the general population. Statewide, the typical state taxpayer paid 4.5% of income in state income taxes. The typical insurance industry employee had an average tax rate of about 4.7%.

Industry employees pay taxes on their wages and on other income (interest, capital gains, etc.). In 2011, industry employees paid state income taxes totaling an estimated $74.6 million.

Property Taxes

Like other state residents, insurance industry employees pay state sales and local property taxes. Insurance companies also pay local property taxes on their facilities, as well as sales taxes on taxable purchases. Insufficient data make it impossible to estimate these amounts.

OTHER IMPACTS

In addition to providing good paying jobs and paying significant taxes, insurance companies boost community development in many ways, including charitable giving and purchasing municipal bonds issued by states, public schools, municipalities, counties, and other local governments.

While Wisconsin data are not available, the insurance industry nationally held more than $452 billion in municipal bonds in 2011. The industry held more than 12% of all of these types of securities. During 2002-11, the industry's holding of municipal bonds more than doubled from $202.9 billion to $452.6 billion.

CONCLUSION

Wisconsin's health insurance industry has far-reaching impacts on Wisconsin's economy. The industry directly employs more than 23,000 state residents in high-paying jobs. Industry wages average more than $53,000 per year, almost 40% above the state average.

The industry's economic impact extends beyond its employees. When health insurance industry workers spend their earnings, they help support jobs in the retail, food service, and other industries. When these impacts are added, Wisconsin's health insurance industry supports, either directly or indirectly, about 67,000 jobs in the state.

The industry helps support state public services with the taxes it pays on premiums, corporate and individual income, property, and sales. Industry employees paid an estimated $75 million in individual income taxes in 2010.

Tom Chelius
7404 W Morningside Ct
Franklin, WI 53132
414.529.0809
shagz05@gmail.com

Testimony in Support of Assembly Bill 392: *The Cancer Treatment Fairness Act*

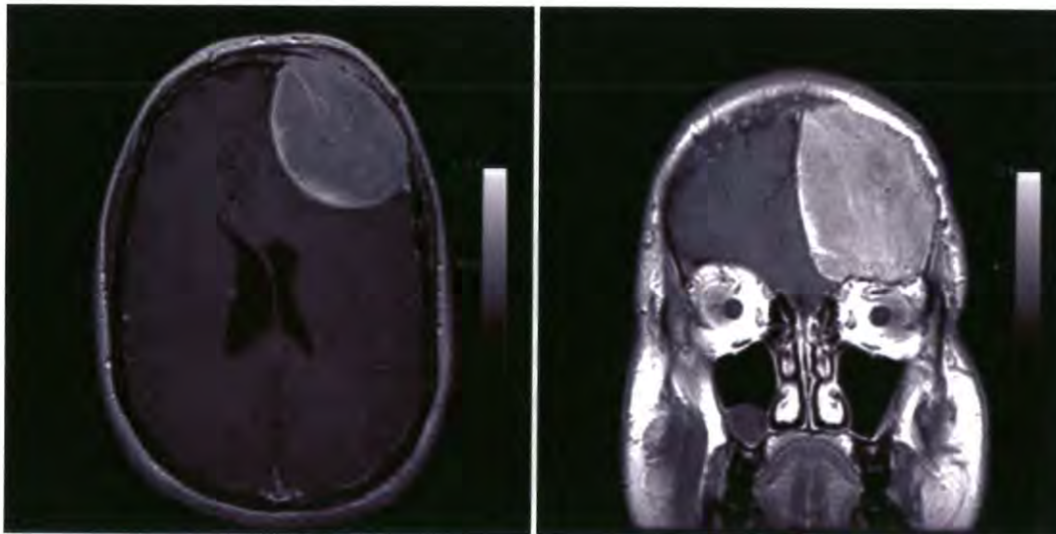
Assembly Committee on Health
State Capitol, Room 225 Northwest
November 13, 2013 Public Hearing

Good morning Chairman Severson and members of the Assembly Committee on Health. Thank you for holding a public hearing today on Assembly Bill 392, the Cancer Treatment Fairness Act. Today's hearing holds so much promise for Wisconsin individuals and families suffering from cancer's many pains and struggles – which are physical, emotional, spiritual, and financial.

I am wholeheartedly in support of this important bill, and I would like to take a couple of minutes to share my story with you, in hopes that others will someday be provided with the lifesaving resources that I have been so fortunate to obtain.

I consider myself lucky, which most people might think is odd. Not long ago, only a third of patients would live 5 years after being diagnosed with multiple myeloma, an incurable cancer of the plasma cells, which are responsible for creating antibodies. I was diagnosed nearly 6 ½ years ago and am happy to say that I am currently in complete remission and am not on any myeloma treatment. This is due to breakthrough innovations, like the new oral anti-cancer medications.

The average multiple myeloma diagnosis is around age 68, but I was diagnosed at 38. I found out I had cancer after having surgery to remove a large mass from my skull. I included two MRI images of the tumor, which you can see includes the large, white area on the pictures below. This tumor ate away part of my skull, my left eye socket and part of a sinus wall. Other scans showed that I had other lesions on my spine and pelvis.



Tom Chelius

7404 W Morningside Ct
Franklin, WI 53132
414.529.0809
shagz05@gmail.com

As a first line of treatment, my oncologist prescribed Revlimid™, a relatively new FDA approved medication at the time, which cost about $7000 per month. **Because of the effectiveness of Revlimid™, however, my oncologist determined that I did not need radiation treatments on the large tumor.**

As a result, I was able to go back to work after a month and a half and was able to lead a *normal life*, socialize with my friends and not have to worry about frequent IV needle sticks. Instead, I just took a pill in the evening. After 4 months, I was in a *partial remission.* This was only open to me because of my insurance coverage provided to me by my employer, the Medical College of Wisconsin. My co-pay was only $20. I am lucky that my employer covers this, but so many others are not so fortunate. Many families are forced to choose between life and financial ruin.

My journey doesn't end there. As a younger patient, my oncologist and I decided that a more aggressive treatment course was needed, with hopes of actually curing me of this cancer. I had a bone marrow transplant with my eldest brother as the donor. While my lab results say that I am in a complete remission, I currently suffer a crippling side effect of the transplant called Graft vs. Host Disease (GvHD). Unfortunately, I have not yet been able to be cured of this disease.

Looking to the future, the treatment of myeloma has changed. Bone marrow transplants are still performed, but there are newer FDA approved drugs available and even more in development. Research shows that these drugs often work better together when treating myeloma. These drug combinations are often at least an oral pill and IV medication. The idea is to have a "1+1 = 3" effect. Researchers are looking at genetic profiles of the cancer which may be helpful in determining which drug is more effective for which "flavor" of myeloma.

I attended a conference on myeloma recently that was held by the International Myeloma Foundation (IMF) and was uplifted by liberal use of the word "cure," and that research is getting close to finding one. The IMF has launched a research program called the Black Swan Initiative. Its purpose is specifically to find a cure to myeloma. It is my belief that this cure will come from combinations of medications. Ultimately, access to the entire range of these anti-cancer

Tom Chelius
7404 W Morningside Ct
Franklin, WI 53132
414.529.0809
shagz05@gmail.com

medications, oral or IV, is vital to the treatment of myeloma. A patient will likely be on a sub-optimal treatment plan without access to oral medication.

The Cancer Treatment Fairness Act (AB 392) is vital in assuring that patients receive the best treatment for their cancer. As a member of the West Bend Area Myeloma Support Group, I have met many others who have been able to continue working during and after treatment because of oral anti-cancer medications. My support group was established and maintained with the help of the International Myeloma Foundation (IMF), the oldest and largest foundation dedicated to improving the lives of myeloma patients while working towards prevention and a cure.

As you know, if an insurance plan covers chemotherapy, AB 392 would require the plan to equally cover both oral and intravenous treatments. As my example shows, individuals without the coverage I had could be left with the decision between thousands of dollars of unaffordable oral anti-cancer medications, or simply choosing not to be treated as effectively – Possibly denying a patient of potential life-saving options.

On behalf of the IMF, MCW, myeloma patients and all cancer patients living in Wisconsin, I strongly urge you to please vote in favor of AB 392 to ensure access to all anti-cancer medications for all cancer patients. Thank you for your time and consideration. I am available if you have any questions.

TO: Chairman Severson and Members of the Committee on Health
FROM: Michael Kelly, MD, Oncology, Children's Hospital of Wisconsin
DATE: November 13, 2013
RE: AB 392: Oral Chemotherapy

Thank you for holding a hearing on Assembly Bill 392 which is intended to ensure patient access to oral chemotherapy. My name is Dr. Michael Kelly and I am the Medical Director of the Pediatric Cancer Program Children's Hospital of Wisconsin. I also serve as the Director of the Developmental Therapeutics Program, which specializes in the identification of new cancer therapies and the testing of these new therapies in children with cancer. Our Cancer Program is a member of multiple phase 1 consortia including the Children's Oncology Group (COG), which is the most experienced organization in the world in clinical development of new therapeutics for children and adolescents with cancer. In addition, our cancer program was named among the nation's best in *U.S. News & World Report's* 2013-14 Best Children's Hospitals report.

Children's Hospital of Wisconsin is a nationally recognized, free-standing academic pediatric organization dedicated to the health and well being of children. Children's serves children from every county in the state. We have inpatient hospitals in Milwaukee and the Fox Valley. We care for every part of a child's health, from critical care at one of our hospitals to routine checkups in our primary care clinics. Children's also provides specialty care, urgent care, emergency care, school health nurses, foster care and adoption services, family resource centers, child health advocacy, health education, pediatric medical research and the statewide poison hotline.

Children's Hospital of Wisconsin is in support of Assembly Bill 392. We know that the current law is a barrier to many of our pediatric cancer patients because the current co-pays are so high that some families cannot afford them. This bill would go a long way to provide access to those who need it most.

We currently care for approximately 200 children and young adults newly diagnosed with cancer every year. Most receive chemotherapy and over 50% oral chemotherapy as a component of the treatment for their cancer. While intravenous chemotherapy will continue to be an important treatment option for cancer patients, more than 50% percent of the chemotherapy drugs in the oncology pipeline are oral medications. Continuing affordable access to current and future oral oncolytics will be important to improve the survival of children with cancer.

Oral therapies offer a number of benefits in that they:

- Target and destroy cancer cells directly,
- Improve the patient's quality of life,
- Provide a more convenient and less invasive method of therapy, and
- Offer an alternative for patients who have failed to respond to other treatments.

Children's Hospital of Wisconsin strongly supports this bill as it gives our patients access to the treatments they require.

Chairman Severson and committee members, I thank you for your time. Please feel free to contact me with questions.

America's Health Insurance Plans

601 Pennsylvania Avenue, NW
South Building
Suite Five Hundred
Washington, DC 20004

202.778.3200
www.ahip.org

November 13, 2013

Representative Erik Severson
Chair, Committee on Health
Room 221 North
State Capitol
P.O. Box 8953
Madison, WI 53708

Re: A.B. 392 - OPPOSE

Dear Representative Severson,

I write today on behalf of America's Health Insurance Plans (AHIP) to respectfully oppose A.B. 392, legislation that would limit enrollee and insured cost sharing requirements for oral chemotherapy prescriptions under a health insurance policy that offers oral chemotherapy coverage. AHIP is the national trade association representing the health insurance industry. AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. Our members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

Health insurance plans have taken important steps over the last decade to address the critical issues of increasing access to innovative, quality health care products and cost control mechanisms that would better allow individuals and small businesses to obtain coverage in the private market. A.B. 392 threatens these efforts to provide consumers with meaningful health care choices and affordable coverage options.

We respectfully oppose this piece of legislation that will negatively impact consumers and offer the following comments:

Oral chemotherapy is significantly more expensive than traditional intravenous treatment. Oral chemotherapy medications cost as much as $10,000 per month. Co-pays and other forms of cost sharing are substantially higher for oral chemotherapy to account for the high cost of these medications. Unlike traditional intravenous treatment, which is considered an established medical benefit, oral chemotherapy, which is still in the developmental stages, is reimbursed as a specialty pharmaceutical. Specialty pharmaceuticals, targeted to small populations of the public,

are among the most expensive pharmaceuticals on the market, contributing to explosive growth in costs that is making health care more expensive for everyone.

Unintended costs increases for all.
Cost sharing is a crucial part of controlling health care costs. Establishing an arbitrary cost sharing limit for those who are using these expensive medications means more of the cost for oral chemotherapy medication will be borne by the other enrollees in the form of higher premiums. An affordable, sustainable health care system for individuals and businesses must reduce the cost of coverage while covering more people – not increase costs for everyone through new, unproven coverage mandates. Additionally, the proposed cost sharing limits are unnecessary, since changes coming from the federal Affordable Care Act (ACA) set out of pocket limits for consumers, which apply for all prescription and medical out-of-pocket costs combined. The ACA total out-of-pocket maximum limit will cap the out-of-pocket cost sharing of covered services that a cancer patient may experience.

Lowering cost sharing for oral chemotherapy affects the actuarial value.
Non-grandfathered individual and small group plans must meet minimum standards for actuarial value under the ACA. The comprehensive essential health benefit benchmark plan package and restrictions on benefit limits make it difficult to meet the actuarial value requirements for these new plans. Limiting cost sharing for oral chemotherapy will exacerbate the problem, making it necessary to adjust benefits. In order to keep the actuarial value in balance, there will need to be an adjustment made to some other type of cost sharing in the benefit design.

For these reasons, AHIP opposes A.B. 392. If you have any questions, please do not hesitate to contact me (gtrujillo@ahip.org, 202-778-1149).

Sincerely,

Geralyn Trujillo, MPP
Regional Director

Carrie Bilicki, MSN, RN, ACNS-BC, OCN President of the Southeastern Wisconsin Oncology Nursing Society (SWONS)

The Oncology Nursing Society (ONS) is one of the largest professional nursing organizations with over 35,000 registered nurses including multidisciplinary groups dedicated to excellence in patient care, education, research, and administration in oncology nursing. Founded in 1975, the mission is to promote excellence in oncology nursing and ensure quality cancer care. This organization is committed to evidenced based oncology nursing, and advocates for issues affecting oncology patients and oncology nursing on local, state, national, and international levels. At the local level, SWONS supports the national strategic strategies.

The incorporation of genetics into the cancer care model is successfully shifting the focus from treatment to risk reduction and prevention, including novel targeted therapies and oral chemotherapy. Together, ONS and the cancer community seek to reduce the risks, incidence, and burden of cancer by encouraging healthy lifestyles, promoting early detection, and improving the management of cancer symptoms and side effects throughout the disease trajectory.

Role of oncology nurses/ navigators

Cancer Nurse Navigator: Oncology specialty trained nurse with knowledgeable of the cancer system. Skilled communicator providing holistic care, timely access to appropriate health care and resources; including removing barriers to care, improving patient outcomes, and overall quality of healthcare delivery (Pedersen & Hack, 2010).

The extensive scope of the patients living with a cancer diagnosis creates challenges for providing comprehensive, holistic care to cancer patients. Medical care primarily aims to cure patients of the physical disease, yet the prevalence of clinically significant psychological distress and uncertainty in illness in cancer patients is well documented in the literature. Cancer care is complex, and often fragmented

General financial and emotional toll on cancer patients

An important support role of the oncology nurse is to facilitate and enhance the patient and families' ability to cope with the broad implications of diagnosis and treatment (Pasacreta et al., 2008).

Chronic myelogenous leukemia (CML) is cancer that starts inside bone marrow, the soft tissue inside bones that helps form blood cells. CML is one of many types of leukemia. There are currently 5 first line treatments for this cancer that are oral. Gleevac is the most prescribed costing on average 7,500/month. For the commercially insured patient, their cost is dependant on a number of factors. Some have high deductibles; some have cost-shares, or copays. Each patients experience is unique to their insurance. **In obtaining prior authorizations or co-pay assistance for patients, it can take nurses up to 4 hours in a day to navigate and advocate on behalf of the insurance to ensure the right treatment is received.**

When patients are diagnosed, they assume that oral chemotherapy is covered the same way as infused chemo. Their assumption is the doctor is ordering what is best, how could it not be covered the same way, regardless of how administered. Hours are spent on behalf of patients writing letters, calling and sitting on hold, filing paperwork, appeals, and triaging patient anxiety how they will afford the medication.

Within our nations movement to Accountable Care Organizations (ACOs), the National Quality Forum Care Coordination Standards (NQF) specifically cites as their goals: reduction of duplication of tests, removal of barriers to care, decreased medical errors resulting from missing information, and ensuring compliance with **evidence-based care** (NQF, 2010). Nurses are critical to ensuring patients have a plan of care based on efficacy, toxicity, cost, and empowering patients to make the best decisions in their care.

"Since starting in oncology in 2000, I have seen a remarkable change in the world of medicine. There have been amazing advancements in the world of oncology treatment and we certainly have much more to offer patients. As of late 2012, >30-40% of chemotherapy drugs approved or in the process of development, however are oral. From a patient perspective this has eased the burden of numerous outpatient visits, possibly improved quality of life allowing for less interference in their lives, and allowed them opportunities for more self-care. Conversely, as a provider, it has produced a major dilemma in offering patients treatment options. Due to oral chemotherapy currently falling under patient's prescription benefit, many of the same rules and regulations apply regarding obtaining these drugs. Unfortunately as a result, patients pay the same copays and percentage of cost of these drugs as they do for many drugs given by other specialties that tend to be largely less expensive.

Currently, oral chemotherapy drugs run on average well over $5000 every month. Paying what may seem a small percentage of this number for average

prescriptions runs a big cost for patients that are prescribed oral chemotherapy. Although there have been many improvements in care since more oral drugs have become available, insurance coverage has fell behind and is not in tune to the current trend in oncology treatment. Our patients are suffering as a result. I have seen delays in obtaining drugs for patients from days to months while they often try to obtain additional prescription coverage that may assist them in affording these drugs. For some patients, there is "adequate coverage", however it is the sheer out of pocket cost and percentage in relation to the cost of these drugs that is largely out of line with what should be reasonably expected for patients to be able to pay. For others, there may be no outpatient prescription benefits and they have limited resources to obtain the medicine. We consider ourselves lucky when a pharmaceutical company offers assistance, however with changing healthcare, I do not believe it is reasonable to believe this will be there to save us in the future.

I truly believe that more than ever, laws and regulation regarding this need to change. As medicine is an ever changing field and new drugs are introduced, just as important as asking the question of whether or not they are effective and safe, is whether or not the patient will have proper access to the drug and be able to reasonable afford them as well."

Kelly Flugaur, FNP-BC, AOCNP Oncology Nurse Practitioner – Franklin, WI.

"Fortunately our insurance is covering all but the co-pay on Jerry's Gleevec. If only IV treatment was a covered expense, than that is what we would need to do as there is no way we can afford 8,000 / month for his prescription. That would mean going back to long days at chemo centers, more side effects, dependence on others to help with driving, etc. I'm grateful that he is responding to the oral chemo with minimal side effects and has shown progressive improvement in his CML." Greenfield, Wisconsin

"My friend Z is being treated for metastatic renal cancer in a Milwaukee hospital. He was insured thru his union, but did not have oral chemo coverage, something he had no knowledge of until he needed it of course. He has liver metastasis so he can actually feel his tumors grow. When he has to apply to drug companies for free drugs it takes several weeks. It's so frustrating and painful for him to sit around and wait. It's tough enough to deal with the diagnosis and then the loss of his career, but this extra factor really stresses everyone involved." Washington County

"Patient could not afford co-payment of 70/m changed treatment to IV infusion" Madison, Wisconsin

On behalf of oncology nurses and patients I urge you to support the cancer treatment fairness act. Patents are being denied access to newer oral chemotherapy drugs or are required to bear heavy out-of-pocket costs, sometimes thousands of dollars a month, for oral chemotherapy with annual price tags of more than $75,000. Wisconsin's reimbursement system needs to

offer equal benefit that covers IV and oral chemotherapy as a medical benefit. Currently oral chemotherapy as a part of a patient's drug plan is not in alignment with Accountable Care/evidence based care. This inequity is likely to affect increasing numbers of cancer patients, because approximately 25 percent of 400 chemotherapy drugs in the development are oral. Let us not forget patients receiving chemotherapy are often on a number of medications, with co-pays attached. May we end the emotional turmoil of cost, and focus on a cure.

Respectfully Submitted,

Carrie Bilicki MSN, RN, ACNS-BC, OCN

Carrie.bilicki@gmail.com

President Southeastern Wisconsin Oncology Nursing Society

Wisconsin Association of Health Plans

The Voice of Wisconsin's Community-Based Health Plans

November 12, 2013

TO: Members, Assembly Committee on Health

RE: Opposition to Assembly Bill 392: Oral Chemotherapy Statutory Cost-Sharing Restrictions

In the face of skyrocketing costs for prescription drugs and other health care services, the health insurance market has responded by creating a variety of health benefit designs to meet the needs and budgets of purchasers. Health plans balance the high cost of prescription drugs with reasonable cost sharing to ensure enrollee access to care while avoiding excessive premium increases that will price health insurance out of the market for other purchasers.

Members of the Wisconsin Association of Health Plans offer coverage of oral chemotherapy drugs as an alternative to intravenous (IV) chemotherapy. IV chemotherapy is covered as a medical benefit and is typically administered in a physician's office or cancer center. Oral chemotherapy drugs, however, are most frequently covered as a pharmacy benefit. Patients receiving either treatment may be required to pay copayments, deductibles and coinsurance.

In 2014, new federal regulations will limit total cost sharing on health care coverage, reducing any variation in cost sharing between oral chemotherapy drugs and IV chemotherapy.

Assembly Bill 392 presents several problems for Wisconsin employers and employees:

- The cost of certain prescription drugs, including oral chemotherapy drugs, is very high. AB 392 would only shift the cost of oral chemotherapy drugs from some payers to other payers, but it would not reduce the drugs' high cost.
- Arbitrarily limiting cost sharing for oral chemotherapy drugs will increase cost sharing on other benefits to maintain the actuarial value of benefit plans dictated by federal regulations.
- Small businesses are already under extreme cost pressure in providing health insurance coverage to their employees. AB 392's government-imposed restriction on the market will add to that cost pressure and could force employers to decide to stop offering coverage. The result will be reduced access to needed drugs.
- Like all other state health insurance mandates, **AB 392 would apply only to the commercially insured population, affecting less than 30 percent of those with health coverage**. This places an unfair burden on small businesses, most of which commercially insure their employees.

If AB 392 passes, it will result in higher premiums and cost sharing for others to offset the high cost of oral chemotherapy drugs.

The Wisconsin Association of Health Plans encourages legislators to OPPOSE AB 392.

For more information, contact Nancy Wenzel, Chief Executive Officer, Wisconsin Association of Health Plans, at 608-255-8599.

Member Health Plans: Dean Health Plan • Group Health Cooperative of Eau Claire • Group Health Cooperative of South Central Wisconsin • Gundersen Health Plan • Health Tradition Health Plan • MercyCare Health Plans • Network Health • Physicians Plus Insurance Corporation • Security Health Plan. • Unity Health Plans Insurance Corporation

Wisconsin Assembly Committee on Health
AB 392: Cancer Treatment Fairness Act

November 13, 2013 Testimony of Paul Westrick
Leukemia & Lymphoma Society of Wisconsin – Board Chair
WI Coalition for Cancer Treatment Access - Member

Representative Severson and committee members - thanks for the opportunity to speak with you this afternoon. My name is Paul Westrick and I am a resident of Middleton, Wisconsin. I'm representing a few perspectives on this legislation – as Chairperson of the Leukemia & Lymphoma Society Wisconsin Chapter Board; a member of the Wisconsin Coalition for Cancer Treatment Access; a recently retired health system executive; and a 16 year blood cancer survivor.

I understand the concerns that have been raised over the past few months regarding health care costs and the perceptions regarding the potential impact of this legislation. Medical costs in general, and cancer care costs specifically, are significant. The proposed Cancer Treatment Fairness Act neither resolves this problem, nor contributes to it. There is a factual track record established on this policy since 2008, as 27 other states plus the District of Columbia have passed similar bills and implemented their laws. Surveys conducted in many of those states and a 2010 Milliman Report indicate either no impact on rates and in a few cases, up to a fraction of a percent increase in per member per month premiums.

It is fair to question if these oral chemotherapy drugs are so expensive, how can improving patient access NOT increase health plan costs? My personal experience is anecdotal, but might illustrate this paradox. The efficacy of the new targeted therapies is producing cures and better results with fewer side effects. Oral agents are replacing or augmenting more expensive treatments. The cancer care setting has evolved over the past 20 years from the hospital to outpatient cancer centers and now to the home!

In my case – I've survived long enough to experience two very different treatment regimes. I have multiple myeloma, an incurable blood-related cancer with a median survival rate of 5 years when I was diagnosed 16 years ago. Due to these recent advances, that rate has now improved and researchers have begun to speak of possible cures.

My first treatment 10 years ago was an autologous stem cell transplant. This included four months of oral chemotherapy; two weeks in hospital for the transplant and about two months off work. I estimate that the total cost to my insurer was well over $300,000.

I relapsed in 2012, but my second course of treatment was very different. Over a 12 month period, I had six infusions and took a pill 21 days each month. The monthly charge to my health plan for the infusion procedure alone was $8,400 – and that drug was "free" as I was participating in a clinical trial. The price of the oral chemotherapy was $8,600 per month.

Yet the total cost was about one-half that of my first treatment, and I enjoyed minimal lost time away from work, family and friends. Of equal importance, I had a more complete response than the transplant and remain in remission today.

I was fortunate to have insurance coverage with a monthly copayment for the oral chemotherapy of only $150. However, my total medical and pharmaceutical out-of-pocket copays, coinsurance and deductibles for the year were over $5000.

Based on new targeted therapies in the approval pipeline, when I relapse again, I will most likely be able to skip the infusions and take one or two pills each day for a period of time.

AB 392 – the Cancer Treatment Fairness Act - seeks to modernize outdated health insurance benefit structures; to catch up with the current and emerging state of cancer treatment progress.

Today, and every day of the year, 87 Wisconsinites are meeting with an oncologist who delivers the news that "you have cancer". This legislation is an important step in reducing financial barriers to the best, and often most cost-effective care for a subset of vulnerable people battling cancer.

On behalf of the present and future cancer patients of Wisconsin and the members of our coalition, I ask that you vote to approve AB 392. Thanks again for your time and thoughtful consideration of this important issue.

Wisconsin Chapter

200 South Executive Dr. Suite 203 Brookfield, WI 53005 | *tel.* 262.790.4701 | *fax.* 262.790.4706

Testimony by Jennifer Grandkoski
Wisconsin State Assembly Bill 392
Cancer Treatment Fairness Act
November 13, 2013

On April 11, 2000 my life was forever changed. This was the date that I heard the words "You have leukemia". I went from being an active, independent 24 year -old that was six weeks shy of graduating from the University of Wisconsin –Whitewater to being a cancer patient who suddenly had to move back home. My worries quickly shifted from things like securing tickets to the next Dave Matthews Band concert and what outfit to wear to work to figuring out how to care for my central line and how to pay for the life-saving treatment that I needed. My cancer journey began suddenly but truly has lasted for 13 years due to the financial burden left behind by my treatment costs.

After weeks in the hospital, I was released into the care of my parents. I can very clearly remember traveling to the pharmacy the first time we needed to have my prescriptions filled. With a stack of prescriptions in hand, we pulled up to the pharmacy drive-up window. We knew that because I had so many prescriptions that the cost would not be low, but were not prepared for what we were about to hear. The retail cost for one of my prescriptions, an oral chemotherapy drug, was roughly $2,800 for a ten day supply. First, we were told that I needed to get special approval from my insurance company because of the high cost of the drug. Secondly, we were blown away by the news of how much the drug would cost us out of pocket that day. My insurance had plan for prescription drugs. All of my other medications had co-pays that were in the $10 to $35 range for a thirty day supply. This particular drug was not covered in the traditional plan and would need to be paid at the 80/20 level. This meant that my insurance company would pay 80% and we would need to pay 20% out of pocket. The cost ended up being roughly $560 for a ten day supply.

My mom was in shock. I can remember her begging the pharmacy to find another way to run the prescription through. I can still see her expression change from shock to anger to sadness. She cried in the drive through as she expressed her worry that I may not be able to take my dose on time. My mom was faced with the reality that her daughter's life depended on whether or not she could pay for this drug. This is a choice no one should ever have to make. This would merely be the first time she would face this challenge. Over the next 18-20 months, our family would face this challenge repeatedly as this drug- the drug that saved my life- was needed on a rotating basis many times.

I had been very fortunate that my hospitalization and all of the chemotherapy treatments I received while being both in-patient and outpatient were covered under my medical benefit as long as they were given to me in a clinical setting. These treatments were both oral and intravenous. All of these services were covered under the medical benefit of my plan. I paid a very affordable co-pay each time and was able to make payment arrangements on the compounded total. This was interest free and although it took a while to pay back, I knew I would not pay exuberant interest fees. The big change came when it was time for me to receive the oral chemotherapy through a standard pharmacy and take it in the home setting.

Unfortunately, the oral chemotherapy that I needed was covered under my pharmacy benefit. You can not make payment plans with the pharmacy. They do not give you the option of taking the drug home with you unless you have the means to pay. If I went to the clinic to take the drug, then I did not pay the higher co-insurance. We would often try to convince medical providers to allow me to come to the clinic to take the drug in order to keep the cost down. I did not have a choice between taking oral or

intravenous chemotherapy. The type of cancer that I had required a regiment of both types of chemo. I would not be here today without these life-saving drugs. How did we pay for my lifesaving treatment? My parents exhausted every inch of their financial resources including the money that had been set aside for my younger brother, who was a senior in high school at the time of my diagnosis. I can remember draining my savings account and cashing in savings bonds that my brother and I had been saving for many years. Our last resort was credit cards. I ended up putting prescriptions on my credit card. It took me over 12 years to pay off this card at 18% interest. The long lasting impact had financially devastated me.

My cancer journey came with a high price tag- both emotionally and fiscally. My parents and I needed to make countless sacrifices that also had an impact on my younger brother's secondary education. I moved home and lost my independence. No one should have to worry about how to pay for treatment while they are fighting for their life. I urge you to pass the Cancer Treatment Fairness Act. I do not want any other family to have to make the financial sacrifices that we did. A patient should not have choose between saving their life and living day to day.

Testimony submitted by:

Jennifer Grandkoski
N85 W18284 Lawrence Ave
Menomonee Falls, WI 53051
Grandkoski@gmail.com
(262) 613-1785