



June 17, 2010

The Honorable William Monning
Chair, California Assembly Committee on Health
State Capitol, Room 6005
10th and L Streets
Sacramento, CA 95814

The Honorable Elaine Alquist
Chair, California Senate Committee on Health
State Capitol, Room 5108
10th and L Streets
Sacramento, CA 95814

Via E-mail only

Dear Assembly Member Monning and Senator Alquist:

I am writing in response to a query from staff of the Assembly Health Committee regarding Senate Bill (SB) 961 (2010), which was amended on June 10, 2010.

The California Health Benefits Review Program (CHBRP) submitted *Analysis of Senate Bill 961: Cancer Treatment* on April 17, 2010. The full report is available at: <http://www.chbrp.org/analyses.html>. CHBRP analyzed the language¹ of the March 9, 2010 version of SB 961. The March 9 version would have required health plans and policies regulated by the Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI) that provide

“coverage for orally administered cancer medications used to kill or slow the growth of cancerous cells...not charge a co-payment for these drugs in excess of 200% of the lowest co-payment required by the plan [/policy] for brand name medications in the plans’ [/policies’] formulary.”

Therefore, the bill would have limited flat dollar copays for oral anticancer medications. The impact for each enrollee would have differed among enrollees depending on the exact cost sharing provisions of the enrollee’s plan contract or policy.

SB 961 was amended on June 10, 2010, and the Assembly Health Committee staff asked whether CHBRP’s analysis is still applicable.

The June 10 version of SB 961 would require that DMHC-regulated plans and CDI-regulated policies

- (1) “provide coverage for a prescribed, orally administered, nongeneric cancer medication used to kill or slow the growth of cancerous cells” and “review the percentage cost share for oral nongeneric

¹ On February 13, 2009, the Senate Health Committee asked CHBRP to analyze the February 5, 2010 version of SB 961. At the request of the health committee staff, CHBRP analyzed bill language submitted to CHBRP on February 19, 2010 which was formally taken as amendments on March 9, 2010.

cancer medications and intravenous or injected nongeneric cancer medications and apply the lower of the two as the cost-sharing provision for oral nongeneric cancer medications.”

- (2) “not provide for an increase in enrollee cost sharing for nongeneric cancer medications to any greater extent than the contract provides for an increase in enrollee cost sharing for other nongeneric covered medications.”

The June 10 version of SB 961 also specifies that the mandate will

- (3) “not apply to a health care service plan contract [or policy] that does not provide coverage for prescription drugs”
- (4) “remain in effect only until January 1, 2015, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2015, deletes or extends that date.”

The June 10 version of SB 961 is substantially different from the March 9 version. The differences are too great for CHBRP’s report on SB 961 to remain applicable. However, the amended bill uses language similar to SB 161 (2009), a bill on the same topic also proposed by Senator Wright.

SB 961’s requirements would produce, in the first year after implementation, results similar to the effects of SB 161 (2009) as reported in CHBRP’s, *Analysis of Senate Bill 161: Chemotherapy Treatment*, submitted on April 17, 2009 (available at: <http://www.chbrp.org/analyses.html>). CHBRP’s report on SB 161 (2009) is relevant for a discussion of the June 10 version of SB 961 (2010), with consideration of the following caveats:

- CHBRP’s report on SB 161 (2009) addressed the bill’s impact on cost sharing for both brand name and generic oral anticancer medications, because that bill would have affected cost sharing for all oral anticancer medications. The June 10 version of SB 961 only affects cost sharing for brand name oral anticancer medications. In addition, a new brand name oral anticancer medication was approved in 2009 following the completion of CHBRP’s report on SB 161. Therefore, CHBRP’s report on SB 161 focused on how that bill would impact coverage for 38 oral anticancer medications, where the June 10 version of SB 961 (2010) would affect the coverage of approximately 31 oral anticancer medications.
- CHBRP’s report on SB 161 (2009) used information current at that time. All of CHBRP’s reports rely upon data and literature available at the time. For example, the cost impact of SB 161 is based on the CHBRP Cost Model used in 2009.

Understanding the caveats listed above, much of the report on SB 161 (2009) would be relevant to a discussion of the June 10 version of SB 961 (2010). Key elements of the report that should be considered are:

- Despite a slightly changed list of medications² for which coverage would be affected, the explanations as to the clinical roles of oral anticancer medications in the *Medical Effectiveness* section remain relevant.
- Despite a slightly changed list of medications for which coverage would be affected, the impacts estimated in the *Cost, Utilization and Coverage Impacts* section of the SB 161 (2009) report remain relevant for the year following implementation. The estimates remain relevant for two reasons: (1) because both bills would impact cost sharing for brand name medications, which are more important cost drivers than are generic medications; and (2) because cost sharing for oral anticancer medications is little changed³ since the 2009 report was submitted.
- Despite the exclusion of CalPERS from the mandate, the impacts estimated in the *Cost, Utilization and Coverage Impacts* section of the SB 161 (2009) report remain roughly relevant for the year following implementation. The impact on CalPERS’ employer expenditures was anticipated to be modest (an

² Neither SB 161 (2009) nor SB 961 (2010) would require that plans or policies alter their formularies.

³ For the report on SB 161 (2009) and the report on SB 961 (2010), CHBRP surveyed health plans and insurers about cost sharing provisions for oral anticancer medications.

- increase of \$282,000) in comparison with other impacts anticipated for premiums (an increase of \$18,702,000).
- Despite the addition of language exempting plans and policies that do “not provide coverage for prescription drugs,” the assumption in the *Cost, Utilization and Coverage Impacts* section of the SB 161 (2009) report that all plans and policies will be required to cover oral anticancer medications remains relevant for a discussion of SB 961 (2010). Through coverage of hospital and physician/provider services as part of medical benefit, all plans and policies—even those without an *outpatient pharmacy* benefit—do cover prescription drugs. Therefore, the expectation that the small number of enrollees without an outpatient pharmacy benefit would gain coverage for oral anticancer medications remains relevant. In 2009, CHBRP estimated that 2.2% of enrollees (all in the small group or individual markets) would gain coverage for oral anticancer medications.
 - The language in SB 961 (2010) prohibiting increases was not present in SB 161 (2009). Therefore, the effects of that provision were not analyzed for CHBRP’s report on SB 161 and its impacts are not able to be estimated at this time.
 - The language in SB 961 (2010) establishing a sunset date for the mandate was not present in SB 161 (2009). Therefore, the effects of that provision were not analyzed for CHBRP’s report on SB 161 and its impacts are not able to be estimated at this time. The Patient Protection and Affordable Care Act (PPACA) had not been passed in 2009. Therefore, the effects of that provision were not analyzed for CHBRP’s report on SB 161 and its impacts are not able to be estimated at this time. However, potential implications of PPACA are further discussed in the *Introduction* in CHBRP’s *Analysis of Senate Bill 961: Cancer Treatment*, which is available at <http://www.chbrp.org/analyses.html>.
 - Despite the changes listed above, the potential effect of decreasing the financial burdens (among groups with higher rates of cancers treated with oral anticancer medications) noted in the *Public Health Impacts* section should remain relevant because cost sharing for enrollees is still expected to be, on average, decreased.

My colleagues and I appreciate the opportunity to answer your question, and we are happy to respond to any additional questions you may have. Please feel free to contact me at your convenience.

Thank you.

Sincerely,



Susan Philip, MPP
Director, CHBRP
Division of Health Sciences and Services
University of California, Office of the President

cc: Senator Roderick Wright, Author of Senate Bill 961
Assembly Member John Pérez, Speaker of the Assembly
Senator Darrell Steinberg, President Pro Tem of the Senate
Assembly Member Nathan Fletcher, Vice Chair, Assembly Committee on Health
Assembly Member Felipe Fuentes, Chair, Assembly Committee on Appropriations
Assembly Member Connie Conway, Vice Chair, Assembly Committee on Appropriations
Senator Tony Strickland, Vice Chair, Senate Committee on Health



Senator Christine Kehoe, Chair, Senate Committee on Appropriations
Senator Dave Cox, Vice Chair, Senate Committee on Appropriations
Senator Ron Calderon, Chair, Senate Committee on Banking, Finance, and Insurance
Senator Dave Cogdill, Vice Chair, Senate Committee on Banking, Finance, and Insurance
Stan DiOrio, Legislative Consultant, Office of Senator Wright
Melanie Moreno, Chief Consultant, Assembly Committee on Health
Cassie Rafanan, Consultant, Assembly Committee on Health
Peter Hansel, Staff Director, Senate Committee on Health
Lisa Chan-Sawin, Consultant, Senate Committee on Health
Bob Franzoia, Staff Director, Senate Committee on Appropriations
Mary Ader, Principal Consultant, Assembly Committee on Appropriations
Almis Udrys, Consultant, Assembly Republican Caucus
Tim Conaghan, Consultant, Senate Republican Caucus
Kevin Hanley, Consultant, Assembly Republican Caucus
Shawn Martin, Director, Health Services, Legislative Analyst's Office
Agnes Lee, Director, Senate Office of Research
Jennifer Kent, Deputy Legislative Secretary, Office of Governor Arnold Schwarzenegger
Steve Poizner, Insurance Commissioner, California Department of Insurance
David Link, Deputy Commissioner, California Department of Insurance
Cindy Ehnes, Director, California Department of Managed Health Care (DMHC)
Sherrie Lowenstein, Senior Supervising Counsel/Legislative Coordinator, California DMHC
Mark Yudof, President, University of California, Office of the President (UCOP)
Dan Dooley, Senior Vice President, External Relations, UCOP
Steve Juarez, Associate Vice President and Director, State Governmental Relations, UCOP
Angela Gilliard, Legislative Director, State Governmental Relations, UCOP
John Stobo, Senior Vice President, Health Sciences and Services, UCOP
Lauren LeRoy, President and CEO, Grantmakers In Health and CHBRP,
National Advisory Council Chair