15.0117.06000

FISCAL NOTE

Requested by Legislative Council
04/02/2015

Amendment to: HB 1072

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2013-2015 Biennium		2015-2017 Biennium		2017-2019 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	$0	$0	$0
Expenditures	$0	$0	$0	$0	$173,000	$268,000
Appropriations	$0	$0	$0	$0	$0	$0

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2013-2015 Biennium	2015-2017 Biennium	2017-2019 Biennium
Counties	$0	$0	$59,000
Cities	$0	$0	$48,000
School Districts	$0	$0	$31,000
Townships	$0	$0	$0

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

Provides coverage for cancer treatment medications that are patient administered. The change would occur July, 2017 for the NDPERS Health Plan.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

BCBS estimates a cost impact to the NDPERS Health Plan of $300,000 per year ($13.20 per active contract per year).

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The cost would result in $26.40 per FTE for the 2017-2019 biennium.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

The cost would result in an additional required health premium of $26.40 per FTE for the 2017-2019 biennium.

Name: Sparb Collins
Agency: NDPERS
Telephone: 701-328-3900
Date Prepared: 02/15/2014

15.0117.05000

FISCAL NOTE

Requested by Legislative Council
02/13/2015

Amendment to: HB 1072

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2013-2015 Biennium		2015-2017 Biennium		2017-2019 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	$0	$0	$0
Expenditures	$0	$0	$0	$0	$173,000	$268,000
Appropriations	$0	$0	$0	$0	$0	$0

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2013-2015 Biennium	2015-2017 Biennium	2017-2019 Biennium
Counties	$0	$0	$59,000
Cities	$0	$0	$48,000
School Districts	$0	$0	$31,000
Townships	$0	$0	$0

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

Provides coverage for cancer treatment medications that are patient administered. The change would occur July, 2017 for the NDPERS Health Plan.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

BCBS estimates a cost impact to the NDPERS Health Plan of $300,000 per year ($13.20 per active contract per year).

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The cost would result in $26.40 per FTE for the 2017-2019 biennium.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

The cost would result in an additional required health premium of $26.40 per FTE for the 2017-2019 biennium.

Name: Sparb Collins
Agency: NDPERS
Telephone: 701-328-3900
Date Prepared: 02/15/2014

15.0117.04000

FISCAL NOTE
Requested by Legislative Council
12/22/2014

Bill/Resolution No.: HB 1072

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2013-2015 Biennium		2015-2017 Biennium		2017-2019 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	$0	$0	$0
Expenditures	$0	$0	$0	$0	$173,000	$268,000
Appropriations	$0	$0	$0	$0	$0	$0

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2013-2015 Biennium	2015-2017 Biennium	2017-2019 Biennium
Counties	$0	$0	$59,000
Cities	$0	$0	$48,000
School Districts	$0	$0	$31,000
Townships	$0	$0	$0

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

Provides coverage for cancer treatment medications that are patient administered. The change would occur July, 2017 for the NDPERS Health Plan.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

BCBS estimates a cost impact to the NDPERS Health Plan of $300,000 per year ($13.20 per active contract per year).

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The cost would result in $26.40 per FTE for the 2017-2019 biennium.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

The cost would result in an additional required health premium of $26.40 per FTE for the 2017-2019 biennium.

Name: Sparb Collins
Agency: NDPERS
Telephone: 701-328-3900
Date Prepared: 12/30/2014

2015 HOUSE HUMAN SERVICES

HB 1072

2015 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1072
1/19/2015
21903

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Explanation or reason for introduction of bill/resolution:

Insurance coverage of cancer treatment medications and provide for application.

Minutes: Testimonies 1-8

Chairman Weisz opened the hearing on HB 1072.

Rep. Maragos: Introduced and supported HB 1072. He handed in Al Wartner's testimony. (See Testimony #1)

Rep. Dockter: From District 7 out of Bismarck testified in support of the bill. The interim committee had a unanimous vote to this bill. I look at this bill as the oral for chemotherapy as not a mandate, but as another option.

Rep. Porter: Did you have this bill in front of you at the employees benefit interim committee?

Rep. Dockter: Yes it did come to our committee. Ken Tupa can give you more information.

Rep. Randy Boehning: From District 27 out of Fargo testified in support of the bill. These drugs have fewer side effects. You save time taking these drugs versus going to the clinic and having your cancer treatments. This is good for all those have cancer. This is not a mandate and doctors can prescribe better medications. I ask you put a Do Pass on this. (Passed out a handout with information in it.) (See Handout #2)

Rep. Porter: You used the word mandate in your sentences as you were explaining this bill. When I see this bill that increases the cost of the state PERS plan I also know it will affect every small business across the state. How is it not a mandate if it is mandating a specific type of coverage and it comes with an increased cost? Why wouldn't we want to know from our experts at Milliman that we have contracted with what those actual affects to the small business community would be? Why would we exempt that process which we have had in place for last 10-15 years that has been our bell weather to make sure we know what we are doing in regards to all of the insurance policies across the state?

Rep. Boehning: If you look in the back of the handout there is information of other states and what their costs have been to the plan on an individual basis. I look at it differently. If the cost of the plan is a dollar or more, the dollar is well worth it if you have one employee that has have cancer treatment. You lose a worker and may have to hire someone to fill in. This is such a small dollar amount. I think the PERS plan went up $179 per month for the state employees alone. With the $300,000 and some fiscal note I don't know where they came up with their estimate of that. I think it is worth it to you to pick that extra dollar up.

Rep. Porter: Are you insuring the major medical side of it? A dollar and there and it comes up to the point that small businesses can't afford to provide any meaningful coverage and it all comes out of the employees pocket anyway.

Rep. Boehning: I think there is a cap on the PERS plan the amount of prescription drugs you can purchase per year. Once you reach that cap you have to pay out of your pocket. I don't think the fiscal note is correct.

17:08
Ken Tupa: Testified on behalf of the American Cancer Society Cancer Action Network in support of the bill. (See Testimony #3) Many states have implemented a bill similar to this have found minimum to no cost in insurance premiums.

Chairman Weisz: Explain no co-pay.

Tupa: In 2014 when this bill was being reviewed by the committee. Pharmacy would be an oral treatment and the medical benefit would be the IV treatment. The estimate for the essential cost of the plan of the loss member cost sharing with both of those components to be approximately $300,000. What we are asking for in this bill is not to zero out all of that. We are asking for the out of pocket costs for the oral treatment be no greater than that being covered for the IV treatment. The committee in December gave this bill a 12 y 0 n in favor of this bill.

Rep. Porter: Why take out that independent look that we rely on from an outside source to lay this out for us?

Tupa: Section 3 on page 2, because it is part of that section and chapter there.

Rep. Porter: You don't have an issue that we have a cost benefit analysis?

Tupa: No. It could be a small cost or even zero. Many states have looked at this and I can provide that information where some states say there is no cost and other states have said it is very small. There has been a question raised whether the ACA addresses this issue. The answer is there are out of pocket maximums with the ACA. It is my understanding it is like a $6600 annually. When you have out of pocket maximums that high it doesn't address the issue we are trying to get at today. The other issue is would this affect grandfathered plans and I think not.

35:00

Chairman Weisz: When you combining the pharmacy and medical, can you have a more expensive drug where the companies are required to pay for that or is there an issue if it is not in the formulary for the drug company? Will that make a difference here?

Tupa: I don't think I can answer that.

36:38
Tracy Evans: I am here to submit written testimony from Leukemia and Lymphoma Society: (See Testimony #4)

Renae Byre: Testified in support of the bill. (See Testimony #5)

42:00
Beth Dolan: My husband, child and I lived in Utah. My family is from Minot and my husband and I wanted to come back to ND. My grandmother died and my husband lost his job and lost 70 pounds. It turns out he has cancer. He had two options. A bone transplant or take an oral medication. We moved back to ND. My husband's medication was $5,000 for one month's supply. I was lucky to have family to pay for the medication. He got better, but eventually his blood levels went up and had to go on another oral medication. We had to wait weeks for the pharmacy to get approval to get that medication in. Please support HB 1072.

Brenda Nagel: I developed a noncurable cancer 8 years ago. I have been in remission for 7 ½ years. My levels are now going up. I can't afford to pay the cost of my medication. Please support this bill.

OPPOSITION

Jack McDonald: Appeared on behalf of America's Health Insurance Plans. We oppose this bill. (See Testimony #6)

1:00
Rep. Mooney: You reference the difference between the intravenous and the oral medications. I saw $9 million versus $850,000. On lines 21 and 22 it references that the amount of the cancer treatment medication can't exceed the intravenous equivalent. So wouldn't that then make that moot?

McDonald: BC/BS who will testify can answer the question better. That is the parity provision of this bill. Insurance companies are required to treat all of the treatments on the same basis no matter what the costs are.

1:02
Megan Houn: Director of Government Relations for BC/BS of ND testified. (See Testimony #7)

1:10

Chairman Weisz: You said you would be supporting writing out of pocket cap into the statute if it allowed you to keep your benefit administration the same. Would expand on that statement?

Houn: You raised a question before about whether this bill would pre-empt formulary. The answer to that is yes. When we looked into our most recent data as we shared on average per day, our members are paying $7 versus the plan paying $125.00. If it would provide less heartburn for the folks here today, we would be willing to say a $250 out of pocket maximum for our members in the state for oral chemotherapy would be just fine.

Rep. Mooney: We have heard from people that have been told by a doctor, this is what we believe you should be doing. Yet we have an insurance company saying no that is not the case. You can do that, but you have to pay out of pocket to the tune of thousands of dollars opposed to $7. What am I missing in this picture?

Houn: I'll let Brent who is our pharmaceutical expert.

Brent Solseng: Pharmacist for BC/BS. Looking at things from a medical policy and utilization management perspective, pharmacists such as myself that have health care plans choose to have appropriateness of the patient determined by providers in order to reduce costs or inappropriateness. We feel by blanket legislation or mandates that would allow patients access to any prescription that there is a risk of departure of clinical evidence.

Chairman Weisz: Are you trying to imply that the drug formulary that you use will also be affected?

Solseng: We are trying to convey the consequential affects that the bill could cause. By mandating that one drug is equal to another. By mandating that one drug is equal to another in terms of price we are concerned about the affect it would have on the utilization management programs that we use along with our formulary.

Rep. Porter: How did the testimonies we heard today fit into the formulary of BC/BS?

Solseng: The utilization management and medical policy that we apply of the drugs I heard mentioned today, there is a pathway access to those drugs at the formulary level for BC/BS North Dakota members. If that access is clinically appropriate, members would enjoy the benefit of that drug at the formulary level. The ACA caps or the other out of pocket maximums for members would apply. Currently pharmacy management does provide access while maintaining some sort of management insuring the members get appropriate medication. Several conditions, cancer particularly require first and second line treatments as a patient progresses.

Rep. Kiefert: Are all the oral treatments available in IV form?

Solseng: There are fewer oral agents and they are newer and not the same as IV treatments. These are new drugs.

One of the drugs that were mentioned earlier today was not under the formulary. Under this bill you would have to (inaudible) under the medical coverage?

Solseng: Gleevec is the first oral oncology drug that came to the market and the first we had medical policy on. It will be the first oral oncology drug to have a generic equivalent. If this bill mandates us to pay for Gleevec when there is a generic to it, there will be additional costs. That is one concern. If this mandate would mean that a member would pay the same for Gleevec than they would for an appropriate IV first line drug, then it will increase costs.

Weisz: Will this do that?

Solseng: If this bill was law tomorrow and there was a generic equivalent to Gleevec, we could not prefer the generic to the more expensive brand.

Rep. Fehr: My question is for Megan. My understanding is that without the bill and the way things are right now, if somebody is needing treatment, this out of pocket cap applies under the ACA regardless of whether it is a grandfathered plan or any plan.

Houn: I believe these are metallic products and that grandfathered plan would have out of pocket caps as well.

Rebecca Ternes: Deputy Insurance Commissioner. Most of the plans in ND are grandfathered plans and PERS is one of them. Whatever that policy or contract says is what applies for the grandfathered plans.

Weisz: If this went into effect would it affect the grandfathered provision of our current PERS plan?

Ternes: Yes. I don't think it would lose its grandfathered status. We have state mandates that have to do with treatments and benefits and deliveries. The federal mandates are different from the state mandates definitions. This is not a federal cost sharing mandate.

Chairman Weisz closed the hearing on HB 1072.

Megan Houn handed out a graph on oral chemotherapy parity. (See Handout #8)

2015 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1072
2/10/2010
23601

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to create and enact a new section to chapter 26.1-36; a new section to chapter 54-52.1 of the North Dakota Century Code, relating to insurance coverage of cancer treatment medications; and to provide for application.

Minutes: Attachment #1

Chairman Weisz: Reconvened the discussion on HB 1072.

Ken Tuba: Heart Association explained the amendment. (See Attachment #1) It inserts a second option. Either the pharmacy match or $100 cap on the prescription pill.

Chairman Weisz: Would you need that language after the last comma on line 22?

Tuba: Regardless of the formulation of benefit category. It is fine to stay there. It would apply to Option A.

Rep. Oversen: Are we providing the option for the companies to cover it under the pharmacy benefit or the medical benefit with a cap?

Tuba: The short answer is yes. The way the bill is drafted in front of you, this amendment give the companies an option.

Rep. Oversen: Does PERS have the freedom to choose between Coverage A or Coverage B?

Tuba: That would be the intent. Option A or option B.

Rep. Hofstad: I move the amendment 04001.

Rep. Seibel: Second.

Rep. Fehr: Could we hear from insurance BC/BS?

Chairman Weisz: It doesn't look like they are here.

VOICE VOTE: MOTION CARRIED

Rep. Mooney: Does this bill allow a generic version as we move forward here?

Chairman Weisz: They could be included.

Rep Mooney: Does this Bill allow that in the event of these oral drugs become available, that they would be included in the bill moving forward here?

Chairman Weisz: They certainly have that ability.

Rep. Seibel: I would recommend a Do Pass of HB 1072 as Amended.

Rep Hofstad: Seconds the Motion.

Rep Fehr: Is it our understanding that if someone has insurance, that with this amendment that they are going to be covered one way or the other.

Chairman Weisz: This Bill wasn't about whether there was coverage or not. This really only affects how much you are going to pay out of pocket.

Roll Call Vote for a Do Pass as Amended. 11 Yes, 1 No, 1 Absent (Rep. Porter).

Rep Oversen Carries the HB 1072

2/10/15

15.0117.04001
Title.05000

Prepared by the Legislative Council staff for
Representative Weisz
February 6, 2015

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1072

Page 1, line 19, replace "the" with ":

a. The"

Page 1, line 23, after "category" insert: "; or

b. The policy copayment, deductible, and coinsurance amounts for a month's supply of a patient-administered cancer treatment medication do not exceed one hundred dollars per filled prescription"

Renumber accordingly

Date: 2-10-15
Roll Call Vote #: 1

2015 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1072

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 15.0117.04001

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Hofstad Seconded By Seibel

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz			Rep. Mooney		
Vice-Chair Hofstad			Rep. Muscha		
Rep. Bert Anderson			Rep. Oversen		
Rep. Dick Anderson					
Rep. Rich S. Becker					
Rep. Damschen					
Rep. Fehr					
Rep. Kiefert					
Rep. Porter					
Rep. Seibel					

Voice vote
Motion Carried

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-15
Roll Call Vote #: 2

2015 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1072

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 15.0177.04001

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Seibel Seconded By Rep. Hofstad

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz		✓	Rep. Mooney	✓	
Vice-Chair Hofstad	✓		Rep. Muscha	✓	
Rep. Bert Anderson	✓		Rep. Oversen	✓	
Rep. Dick Anderson	✓				
Rep. Rich S. Becker	✓				
Rep. Damschen	✓				
Rep. Fehr	✓				
Rep. Kiefert	✓				
Rep. Porter	A				
Rep. Seibel	✓				

Total (Yes) 11 No 1

Absent 1

Floor Assignment Rep. Oversen

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1072: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (11 YEAS, 1 NAYS, 1 ABSENT AND NOT VOTING). HB 1072 was placed on the Sixth order on the calendar.

Page 1, line 19, replace "the" with ":

a. The"

Page 1, line 23, after "category" insert: "; or

b. The policy copayment, deductible, and coinsurance amounts for a month's supply of a patient-administered cancer treatment medication do not exceed one hundred dollars per filled prescription"

Renumber accordingly

2015 SENATE HUMAN SERVICES

HB 1072

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1072
3/11/2015
24637

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Donald Mueller

Explanation or reason for introduction of bill/resolution:

A bill would require that for health insurance and the PERS uniform group insurance plan, the member cost-sharing for cancer medications administered by the patient not exceed member cost-sharing for cancer medications administered by a health care provider.

Minutes:

Attach #1: Testimony by Al Wartner
Attach #2: Testimony by Ken Tupa
Attach #3: National Landscape of Caps on Patient Out-of-pocket and State Oral Chemotherapy Parity Laws
Attach #4: Testimony by Renae Byre
Attach #5: Testimony by Ellen Schafer
Attach #6: Testimony by Diane Schaeffer
Attach #7: Testimony by Corinna Larson
Attach #8: Testimony by Megan Houn
Attach #9: Testimony by Laney Herauf
Attach #10: Caps for Prescription Co-Pay
Attach #11: International Myeloma Foundation Memorandum of Support
Attach #12: Electronic Testimony of Leukemia and Lymphoma Society
Attach #13: Electronic Testimony Nancy Klatt
Attach #14: Electronic Testimony Laena Shakarian
Attach #15: Electronic Testimony Corina Larson
Attach #16: Testimony by Rod St. Aubyn

Representative Andrew Maragos introduced HB 1072 to Senate Human Services Committee. Representative Maragos provided copy of **Al Wartner** written testimony (attach #1)

Senator Dever stated through the process, this bill was submitted to employee benefits by the North Dakota Public Employees Retirement System (NDPERS) and sent to Blue Cross Blue Shield for comment, and they indicated that it was a minimal impact.

Ken Tupa, representing American Cancer Society Cancer Action Network, testified IN FAVOR of HB 1072 (attach #2. Mr. Tupa also provided the document, National Landscape of Caps on Patient Out-of-Pocket & State Oral Chemotherapy Parity Laws" (attach #3) (end 13:30)

Chairman Judy Lee asked Mr. Tupa, on page 2, line 12, they discuss the board. There is no definition of a board. Is that leftover from the original version.

Mr. Tupa believes that means the NDPERS board.

Chairman Judy Lee disagrees with the definition of parity. Parity means that the insurer provides coverage for medical and mental health the same way. It doesn't necessarily mean that every course of treatment for every condition is treated exactly the same because part of it is determined by practice and part by actuarial study. Some time ago the legislative body stated there should be a cost benefit analysis needed, it needs to be used by the NDPERS population as a control group for two years to ensure it works, and we have never thought that there was something so extraordinary that we should violate that way of determining whether or not this is an effective thing to do. Was this in the original bill and amended out?

Mr. Tupa answered that it was in the original bill with respect to the NDPERS provision. In the discussion process in the employee benefits program committee, the committee had discussion whether it should be drafted this way. The sponsor of the bill revised the draft, provided it to the employee benefits committee as you see it, and they took jurisdiction over the bill. They received an updated actuarial analysis, which was the exact same as previously and it was that version that they passed a 12-0 favorable recommendation.

Chairman Judy Lee indicated that we have learned the fiscal note is wrong and will be updated.

Senator Warner asked is it still possible for insurance companies to control costs through formularies. Can insurance companies direct the course of treatment by recommending to pay for one drug before another.

Mr. Tupa answered yes. This is not designed to restrict that. With respect to the parity or the cap, those provisions are here to provied increased access to the medications. Plans can still manage the formularies how they choose.

Senator Axness in regards to Section 54.03.28 which is the NDPERS exemption, do you have any other examples of drugs that have been exempt from the two year NDPERS provision?

Mr. Tupa responded no. It has not occurred. He doesn't remember when the provisions were put into law, and doesn't believe there have been any exempt. But because of this specific instance, with cancer chemotherapy treatment, it is extremely important and it makes sense.

Chairman Judy Lee stated you can acknowledge that they still have access to the treatment, but may have higher deductibles and co-insurance that may be required for an oral rather than an IV medication. They still will get the treatment.

Mr. Tupa indicated yes. If a patient cannot afford thousands of dollars for medication costs, they may still have access but may not be able to afford it.

Chairman Judy Lee cannot recall a bill that says $100 is the most that anyone will pay for anything - do you feel comfortable putting a dollar amount in statute?

Mr. Tupa answered other states have addressed it that way. The medication abandonment significantly increases as out-of-pocket costs increases, so the $100 is data driven.

Chairman Judy Lee understands the challenges of cancer, but she doesn't get to put in statute what gas will cost. This is more complicated than just saying we don't care about cancer. We should not be dictating to physicians how medical practice takes place and how they interact with their patients - the physicians are the ones making the final decisions.

Senator Howard Anderson, Jr. asked Mr. Tupa to explain the chart you handed out (attach #3). There are some states that indicate they do not have parity in their bill but have a cap.

Mr. Tupa the column "parity" is what we refer to as option A of HB 1072. The column "cap" is what we refer to as option B in HB 1072, which is a cap on the out-of-pocket costs for that prescription drug.

Senator Howard Anderson, Jr. continued, when a patient has an insurance plan that says your maximum out of pocket is $2,250, and they go to the clinic or hospital and get their IV medication treatment, what they pay for coinsurance goes against their cap. What happens to the money they pay for out-of-pocket prescription that they get at the pharmacy? Does that go against the out-of-pocket cap as well?

Mr. Tupa deferred to an insurance expert.

V. Chairman Oley Larsen indicated that when Mr. Tupa was discussing that there is no premium increase, the cost of this medication, putting a cap on consumer of $100, where does that money go. There are billions of dollars on these pills. Who picks that up?

Mr. Tupa answered there may be high out of pocket costs. With legislation like this, if out of pocket was $25 or $50, there is a difference in what they would have paid and what they pay now. It is logical to assume that there is a transfer of the dollar amount. The states that have implemented this indicated there is no increase to premiums. There is a study that compares the cost of oral chemotherapy and traditional treatment, and the study indicates the direct costs for IV therapy was $17,000 more than oral chemotherapy. Some of the data suggests there may be a cost, but in some cases you'll see a savings, no cost shift at all.

Chairman Judy Lee understands how there could be additional cost, as some folks may require a port installed. So yes, with the addition procedure, there could be more cost.

Senator Warner explained early description of biologics for cancer medications. Are we creating a preference for very expensive drugs - biologics are customized to the individual.

Mr. Tupa doesn't think the bill is designed to do that. The oral chemotherapy is relatively new and innovative. There are not a lot of generics available. This bill does not affect that. Formulary management is still very much not affected by this bill.

Senator Howard Anderson, Jr. asked Mr. Tupa to explain with parity in the bill, financial, why the parity provision does not take care of it without the cap. The coinsurance and co-payment would be the same between the IV versus oral with the same medication. Now with the cap, there isn't parity because the IV treatment will be more expensive.

Mr. Tupa responded the cap is an "or". It is an option. Compliance with this statute if enacted would provide the option and the flexibility for the insurer to choose either parity or the cap. Looking at the other states, we decided to have the option to do it either way, whichever is best for the payer to implement this.

V. Chairman Oley Larsen with the new Affordable Care Act and the way insurance is laid out now, it is his understanding that with prescriptions, except for the premium, the maximum out-of-pocket is picked by the consumer in their insurance. This is an expensive deal so they will hit their maximum cap. Does it matter that we are going to do this when we already know we are going to hit the maximum.

Mr. Tupa stated his understanding of the maximum out-of-pocket limits is $6,600 for an individual and $13,200 for a family. While there are caps there, it doesn't address the issue of getting to that level first. That may be in the first few months. There will be out of pocket costs for the oral chemotherapy pills. If they cannot meet those limits in the first month or two, they abandon.

Chairman Judy Lee asked for someone to step forward and answer the question by Senator Howard Anderson, Jr. - is your out of pocket might be $6,600, and everything you pay adds up to $6,600. At the pharmacy, does that include up to the $6,600 maximum or is that separate.

Megan Houn, Blue Cross Blue Shield, indicated yes, they are all included under the same cap, even if paid to the pharmacy.

V. Chairman Oley Larsen stated that is totally different than what it was two years ago. If you had medication, that just kept ticking up. Correct?

Ms. Houn indicated that with Affordable Care Act, insurance changed quite a bit.

Sparb Collins, North Dakota Public Employee Retirement System, indicated you do have a different coinsurance limit for prescription drugs. The coinsurance maximum does not apply to the non-formulary. He believes there are differences.

Chairman Judy Lee indicated that there could be flexible spending accounts also.

Mr. Collins explained these benefits, where there is a maximum of $2,400 for flexible spending accounts, this would qualify under the medical service for the IRS definition.

Roberta Young, nurse, testified IN FAVOR for HB 1072. (no written testimony). She has cared for cancer patients for several years. In terms of cancer care, people always have a choice, so when a physician presents a good regiment, it includes both oral and infusion chemotherapy. When it comes to the oral part and patients recognize the cost, they come back to the physician with concerns. Physicians work to create a plan not just medical, but also personal situation, such as family considerations. She would like to see that when the optimal treatment is provided to the patient, there isn't a barrier to the patient. This is a whole change of landscape in cancer. Cancer is a chronic disease, over life. We are all aging, more and more people are dealing with the chronic cancer, long treatment over a long period of time. We are a land of choice, but we need to look at the expense of it and keep it controlled.

V. Chairman Oley Larsen stated it was discussed that some cancers can only have oral therapy. What are some of the cancers?

Ms. Young indicated most cancers are treated with both IV and oral treatments. Cancers can be treated with surgery, waiting, IV, radiation and oral therapy. It is often a combination of all treatment therapies together. Some of the biggest advances in oral chemotherapy are in leukemia. It is not the only treatment, but sometimes the best treatment.

Chairman Judy Lee regarding the biologics, it is explosive new research to the individual, these are very expensive. Where do you see that fitting in here?

Ms. Young explained some of the biologics are the prescribed treatment. It is sometimes the first line treatment. We will likely see a lot of growth here, but it will be expensive. We have been using biologic testing for some types of cancers and only see this growing. It will be a combination.

Renae Byre, testified IN FAVOR of HB 1072 (attach #4)(45:30-50:40)

Senator Howard Anderson, Jr. the $4,000 that you had to pay, was that included in your maximum out-of-pocket insurance.

Ms. Byre indicated it was not included. She had already reached her maximum, and that was several years ago.

Chairman Judy Lee explained to the audience the "Prescription Connection" through the Insurance Department. It is an excellent program, easy to apply, the drugs that one is taking, they have connections to the manufacturers of the drugs, and they have many fine programs to help.

Ellen Schafer testified IN FAVOR of HB 1072 (Attach #5) (52:22-56:12)

Chairman Judy Lee asked wouldn't that low white count be just as important for the oral chemotherapy as well as the IV treatment.

Ms. Schafer responded yes.

Diane Schaeffer testified IN FAVOR of HB 1072 (attach #6)(about 57:00-59:36)

Chairman Judy Lee explained we heard earlier about biologics, we all know about cancer and all the different things happening, how do we limit this bill just to cancer when there are extraordinary drugs for things like cystic fibrosis. How do we not give them the same break?

Ms. Schaeffer responded that in all fairness, everyone should have this break.

Chairman Judy Lee but then who pays.

Corinna Larson, on behalf of the Missouri Valley Oncology Nursing Society (ONS), testified IN FAVOR of HB 1072 (attach #7)(1:01:30-1:04:28)

Senator Warner stated that Ms. Larson raised an issue that he had not previously considered. Things that aren't exactly chemotherapy but still required, such as anti-nausea, appetite stimulants, are those kind of drugs covered.

Ms. Larson responded they are expensive, such as Zofran, which can cost $80 per month. They aren't necessarily always used with oral, because the side effects of oral drugs can be very different than for IV therapies. Some of the IV therapies are often higher potency and they have higher nausea associated.

Senator Warner so those would not receive protections under this bill.

Ms. Larson they would fall under the pharmaceutical.

Chairman Judy Lee indicated that anti-nausea medications have been around for a long time.

Conrad Davidson, testified IN FAVOR, discussed Revlimed medication. He was diagnosed with multiple myeloma three years ago. Within months, he had lesions on his bones. Mr. Davidson provided personal example and his experience with treatment including medications. (1:09:45)

Senator Howard Anderson, Jr. can you follow-up on whether the $800 you paid applied to your out of pocket for insurance to your maximum?

Mr. Davidson is on a flex plan, so the $800 took up 25% in one month for the flex fund. The fortunate thing was that the second month it was $300, and by December it was $20. His concern is that when he moves into Medicare, he is trying to figure out what part D plan is going to work.

OPPOSITION TO HB 1072

Melissa Houn, Director of Government Relations for Blue Cross Blue Shield, testified in OPPOSITION to HB 1072 (attach #8) (1:11:50-1:20:12)

Senator Dever when we heard this in employee benefits, didn't it go to Blue Cross Blue Shield and they indicated the cost was not significant.

Ms. Houn indicated they had concerns with mandates and parity consideration. Blue Cross Blue Shield did do the analysis for NDPERS, because at the time they were the administrator for the NDPERS program. It would cost $400,000 to $500,000 per year under NDPERS. It protects an expensive set of drugs, so we don't know the impact. If pharmaceutical companies, who have no interaction with consumer, requires Blue Cross Blue Shield to pay, it becomes unquantifiable. Even some of the older oncology drugs are being bought up and becoming more expensive.

Chairman Judy Lee what is happening in part is brand name is buying up generic to make sure they are not competing. This means drugs remain high priced.

Ms. Houn confirmed.

Chairman Judy Lee offered her opinion about complaints to the pharmaceutical manufacturers who have no sympathy for what we do here, including trying to get vaccines at the federal rate for children in North Dakota, but that's another story.

Senator Warner asked how big is the universe of NDPERS - how many clients.

Ms. Houn 29,000 contracts, and 67,000 covered lives.

Senator Warner so this is a significant number to gather data.

Ms. Houn added regarding the NDPERS study, it is statistically significant. That was used as the testing pool because there are people all over the state, so this being the first mandate sets a very dangerous precedent to pull the NDPERS study off. When looking at the NDPERS trial, it is tricky to state for this set of drugs.

Laney Herauf testified in OPPOSITION to HB 1072 (attach #9)1:24:56-1:26:00

Chairman Judy Lee did your organization have any discussion about whether or not the two year NDPERS trial run that has been required for some time should also be required here.

Ms. Herauf does not know but does not think that was not discussed.

Robert Harms, Lobbyist for CVS Health, testified OPPOSED to HB 1072 (attach #10)(1:26:39-1:29:14)

Senator Axness asked if Mr. Harms was aware of any prescription oral chemotherapy medication coming out in the next 2 years that would be exempt to the NDPERS requirement.

Mr. Harms is not aware of any.

Senator Dever your last sentence indicated have "not had rigorous public vetting". This hearing is now one.

Senator Dever stated it does say "or", and it is the insurer who decides which provision it falls under. Is that a problem?

Mr. Harms responded that his understanding, CVS Health is opposed to the bill as written. There has been some discussion about the parity provision. It also sets the table for future mandates in future sessions. It is occurring nationwide.

NEUTRAL to HB 1072
No Neutral testimony.

Closed Public Hearing.

Additional electronic testimony and information was provided by the following:
- **International Myeloma Foundation** Memorandum of support (attach #11)
- **Christina Lee, Leukemia and Lymphoma Society** (attach #12)
- **Nancy Klatt**, Manager of Altru Cancer Center (attach #13)
- **Laena Shakarian**, International Myeloma Foundation (attach #14)
- **Corina Larson**, Missouri Valley Oncology Nursing Society (ONS) (attach #15)
- **Rod St. Aubyn**, representing the Pharmaceutical Care Management Association (attach #16)

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1072
3/11/2015
24688

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Donald Mueller

Explanation or reason for introduction of bill/resolution:

A bill would require that for health insurance and the PERS uniform group insurance plan, the member cost-sharing for cancer medications administered by the patient not exceed member cost-sharing for cancer medications administered by a health care provider.

Minutes:

Attach #1: Testimony by Jack McDonald
Attach #2: The Cost of Cancer Drugs

The Senate Human Services Committee met on March 11, 2015 at 2:28 for committee work on HB 1072.

Chairman Judy Lee invited Rod St. Aubyn to the podium for comment.

Rod St. Aubyn, representing the Pharmaceutical Care Management Association, provided written testimony in the hearing (Recording 24637, attachment #16). Mr. St. Aubyn summarized his written testimony. They are opposed to HB 1072. They believe it will increase costs for pharmacy benefit managers work for health care plans. They believe it will increase the cost for consumers. While the patient may have some reduced costs, it shifts to the insurance company, and premiums will be impacted. He disputes avoiding the health insurance mandate of the law, because that was designed with the study. Once you have the mandate, apply to North Dakota Public Employees Retirement System (NDPERS) plan for the two year period to analyze what the real cost is, and then after the 2 years the legislative body can decide if it is cost effective. This particular bill specifically exempts this bill from that process. If you already have a state process that is designed, and you have mandates, there will be the same strategy. It is a good process. This is in the interest of pharmaceutical vendors - they want to sell brand drugs versus generic drugs. Why just cancer patients? There are a lot of other significant terminal diseases, so what about the other people. It is not a good public policy to single out one particular group.

Senator Howard Anderson, Jr. indicated let's assume that we forget the cap, and compare the figures, it was stated in testimony that IV therapy costs $17,000 more than oral therapy.

Rod St. Aubyn indicated that he could make a statement and say its fact. He provided example of his sister who does oral and IV infusion.

Senator Howard Anderson, Jr. asked for clarification if the cost of drugs applies to the maximum out-of-pocket costs. In testimony, it was stated both ways. For example, in NDPERS, it is separate and $1,000 cap for the drugs. Other testimony indicated they pay $4,000 a month and it doesn't apply to the maximum out-of-pocket.

Mr. St. Aubyn agreed that it is a valid point. It is one of the pitfalls of these state laws. When working at Blue Cross Blue Shield, 50% of business was self-funded, and they abide by Employee Retirement Income Security Act of 1974 (ERISA). 50% would not be impacted by this law because they don't have to abide by state law. There are different types of options with self-funded plans. Even if you pass this, there will be certain element that this doesn't apply to.

Chairman Judy Lee referred to Section 54 is the NDPERS section.

Mr. St. Aubyn the state law under NDPERS has the authority to go under self-funded if they wanted to.

Chairman Judy Lee another concern is the $100 maximum and how we would put dollar amount in statute, and think that is going to be a cost containment thing. Looking at bills expenditures going up so high.

Mr. St. Aubyn stated ultimately what is going to happen, if consumer saves, the insurance company will increase the premiums to offset the cost.

Additional electronic testimony and information was provided by the following:
- **Jack McDonald**, on behalf of America's Health Insurance Plans written testimony (attach #1)
- **Megan Houn** provided an article, "The Cost of Cancer Drugs" (attach #2)

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1072
3/17/2015
25011

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Donald Mueller

Explanation or reason for introduction of bill/resolution:

A bill would require that for health insurance and the PERS uniform group insurance plan, the member cost-sharing for cancer medications administered by the patient not exceed member cost-sharing for cancer medications administered by a health care provider.

Minutes:

Attach #1: Letter from Medica
Attach #2: Document: Increases Health Care Costs for ND Consumers and Employers
Attach #3: America's Health Insurance Plans Memorandum

The Senate Human Services Committee met on March 27, 2015 to discuss HB 1072 in committee work.

Chairman Judy Lee has talked with **Mr. Sparb Collins**, North Dakota Public Employee Retirement System, and he does not see a significant change to the fiscal impact to the bill as it was received from the House. **Chairman Judy Lee** also talked with medical providers and insurance companies and indicated to the committee that they are not on the same page.

Megan Houn, Blue Cross Blue Shield, provided a copy and read **Jay McLaren**, Medica, Senior Director of Public Policy and Government Relations, letter (attach #1).

The following documents were distributed to the committee:
- HB 1072 - Increases Health Care Costs for ND Consumers and Employers (attach #2)
- America's Health Insurance Plans Memorandum (attach #3)

Chairman Judy Lee read from the America's Health Insurance Plans Memorandum.

Chairman Judy Lee stated that from the memorandum, the perspective of the health insurance companies is that there are concerns in other states. Chairman Judy Lee restated her concerns about setting precedent if we eliminate the two-year North Dakota Public Employees Retirement System (NDPERS) review. This mandate has been in place a long time and this is the first time where there is serious consideration of removing the two-year application to NDPERS first. Even if it isn't going to indicate that there is a

significant impact on the NDPERS group, who next year will be asked to be excused from the two-year implementation.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1072
3/30/2015
25620

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Donald Mueller Mary Monson

Explanation or reason for introduction of bill/resolution:

A bill would require that for health insurance and the PERS uniform group insurance plan, the member cost-sharing for cancer medications administered by the patient not exceed member cost-sharing for cancer medications administered by a health care provider.

Minutes:

Attach #1: Letter from Jay McLaren, Medica

Chairman Judy Lee reviewed her notes and asked if they ever received answers on whether payers can still use formularies and how that affects biologics.

Senator Howard Anderson, Jr. said that all the biologics with the definition that was used before are not necessarily the same drugs so he had a hard time making the case that it was the same treatment. Biologics are very seldom all medications.

A letter from **Jay McLaren, Medica**, was distributed (attachment #1).

Senator Howard Anderson, Jr. wanted to know if it is going to be in the PERS program first.

Chairman Judy Lee thinks the PERS is a slippery slope.

Senator Dever had some angst about how this whole process came about. Blue Cross was there during the interim and testified that employee benefits was a small amount of money, about $300k total, $13.20 per active contract per year, $1.10 per month per contract. Their number crunchers put that together. If they applied it, that is what they would charge in premium. As chairman of employee benefits it was at Sen. Dever's suggestion that the requirement that it go through PERS was removed, so there was no significant cost to do that. The requirement for PERS was passed in the 2001 session and he voted against it. He went on to explain his vote and why he changed his vote when it was brought back. If you can't calculate what the benefit is going to cost, it should apply to PERS. The amount was determined by BCBS. We are in a contract for a 2 year period, and if we want to apply it to PERS then it wouldn't apply until the following biennium.

Chairman Judy Lee indicated that, according to Sparb Collins, it would be a two year delay now, not a four year delay.

Senator Dever didn't understand why the dollars aren't in the coming biennium but are listed in the following biennium.

Chairman Judy Lee spoke about her conversation with Sparb Collins and said he indicated it would go into effect this coming summer, be effective this coming biennium, and then report in 2017. She said Sparb was giving conflicting information.

Senator Dever indicated that BCBS was also giving conflicting information.

Senator Howard Anderson, Jr. pointed out that the answer to that question may be important.

Chairman Judy Lee referred to the letter from Medica (attachment #1). A primary concern is that it places artificial caps on cost sharing of oral chemo in a way that would be exceptionally difficult and expensive. They would propose removing the cap which she thinks is fine and putting in statute which bothers her.

Senator Dever said that in the minutes of the Employee Benefits meeting this women's testimony said that BCBS would prefer to put a cap on out of pocket expenses for oral cancer drugs.

Senator Howard Anderson, Jr. conjectured that what they meant at that time was an out-of-pocket cap means the annual cap.

Chairman Judy Lee continued walking thru Medica's recommendations on the bottom of their letter. She cited instances where it would have been great to have had oral meds available and also said it wasn't totally fair to look back at the history of cancer in families that we are part of or that we know of. It is such an evolving treatment. There are oral meds available now, but they weren't always. Some of the treatments were so terribly difficult for patients to deal with.

Senator Dever mentioned that his mother lived with cancer in 2006 and he took her to treatments. If oral or IV are each as effective as the other, he didn't understand why one is more expensive when they are manufactured by the same company? It seems like a simple request.

Chairman Judy Lee thought the problem might be that there is nothing less simple than the price of prescription medications. The pharmaceutical manufacturers know everyone would rather have oral meds. It is a more attractive treatment option. You can stay home and take that medication. The manufacturer knows that it is more desirable for the patient, and, as a result, it is part of the equation.

Senator Warner wasn't part of the initial discussions with the 2 years PERS, but his understanding was that it was more difficult to determine the value of prophylactic treatment so you needed actuarial data for those kinds of determinations. Where we

already have a dollar amount and know the costs, if that is to be believed, then why do we have to delay for 2 or 4 years for a study. The study is relevant for the more complex situations. He is inclined not to use the PERS study.

Chairman Judy Lee told the committee that they needed to figure out the PERS study and the cap.

Senator Axness was willing to act on one of the two. If putting in statute that it does not exceed $100 per filled prescription, without any inflationary adjustment, means they need to adjust it every 2 years, he was not comfortable with it.

Senator Axness moved the Senate Human Services Committee ADOPT AMENDMENT to remove the $100 cap (Subsection 2b, page 2, lines 1-3). **V. Chairman Oley Larsen** seconded the motion.

Discussion
Senator Dever was curious if that was the primary objection of the PBMs? Were they otherwise okay with the bill?

Rod St. Aubyn, representing PCMA, stated that it was multiple concerns. One in terms of that part in their impression would increase the costs for their members which are health insurers. He finds it incredible a cap is put on if it is not going to increase costs. If there are additional costs, it is being shifted to someone - the health insurer. The other issue is that half of their business was self-funded and this law would not apply to them. It is up to the individual group to decide what they want for the benefits.

Chairman Judy Lee asked if it is more than 40% now of lives that are ERISA covered.

Mr. St. Aubyn indicated approximately 50%. That is not all insurers either, although they had significant market share. He clarified the mandate review - he was instrumental in getting that passed a few years ago. The process was that a standing committee would do an initial review whether or not approximate costs for some insurance mandate. From there, if the committee decides to go ahead and is approved by the Employee Benefits Committee, then the law requires that it should apply to PERS for 2 years. It is only for the upcoming biennium. The idea was to figure out the true costs because the PERS plan is such a large plan it would be more representative of the overall market share. At the end of that two year period PERS has to report what has been the actual cost for whatever the health mandate is and to submit a bill for the next legislative session to have it apply for all health insurance other than self-funded. So it is only supposed to be for 2 years and he didn't know where the discussion of 4 years came from.

Senator Dever clarified that it is still 2 years. The discussion is that it is not the next 2 years but the following 2 years because we are already under contract.

Chairman Judy Lee asked for clarification.

Mr. St. Aubyn answered that for a standard renewal contract, how it happened before, any new mandates that are applied are added to the bid contract in addition. So if you have any new mandates that go into effect that is just added on to the total cost of the contract.

Chairman Judy Lee stated that she had specifically asked Sparb Collins if a mandate was passed today and it had the 2 years PERS test, would that not go into effect this summer of 2015 and apply until the summer of 2017. Then if it was approved in the 2017 legislative session it would be moved forward to all the other insurance policies. Sparb answered yes.

Mr. St. Aubyn replied that is exactly how the law is written. The current law is that it would go into effect on July 1, 2015, for PERS and then PERS would track the mandate. They submit a bill, for example, for the 2017 legislative session. They won't have 2 years of data. The 2017 legislative session would consider a bill to have this mandate apply to all health insurance and including continuation for PERS.

Senator Howard Anderson, Jr. asked if there are increased costs to PERS and their carriers that would be passed along to PERS as part of their contract. Would they renegotiate contract?

Mr. St. Aubyn said his understanding would be that, if they pass this bill that would include a mandate, the health insurance, Sanford in this case, would have the authority to increase the bid for the anticipated costs. Their actual costs would be adjusted for the following biennium.

Chairman Judy Lee said that Milliman has been used for years for outside service that does the cost benefit analysis. She reviewed a prior attachment from them about a pharmacy cost sharing limits analysis. (22:00)

Chairman Judy Lee referred to the lady who testified and said she paid $4400. She meets the annual copay in the first or second month and after that it's the insurance company's responsibility if you have a high priced drug.

V. Chairman Oley Larsen asked how many people of the 14,000 that can be on PERS have cancer now and are taking these.

Chairman Judy Lee replied that she didn't know but they keep being told there is no fiscal impact.

Senator Dever, looking at the testimony signed by Megan Houn of BCBS and James McLaren of Medica, pointed out that throughout the testimony it says their primary concern is the artificial caps on the oral chemotherapy. It almost sounds like that is their only objection to the bill.

Chairman Judy Lee wasn't sure it was the only but certainly would be their prime concern.

Senator Dever asked if they could allow Ken Tupa to comment since Rod St. Aubyn was allowed to comment.

Chairman Judy Lee asked Ken Tupa if he would like to comment.

Ken Tupa, American Cancer Society Network, spoke about the $100 cap. They supported this amendment in the House as a means to address questions that they were encountering about the potential blending of the medical and pharmacy benefit. The whole issue is about the IV chemotherapy being a medical benefit having $25 copay and the oral chemotherapy being a pharmacy benefit and having $800 or more co-pay. That also depends on the plan and how it is set up with the tiers and if the drugs are formulary or non-formulary. The non-formulary drugs don't necessarily have out of pocket maximums. That cost can be ongoing for a good period of time. The question of the administrative ability to manage the parity provision with the medical benefit was between medical versus pharmacy. That cap may be selected by a plan as an easier way to administer this.

Chairman Judy Lee asked if this was introduced by him

Mr. Tupa responded, yes.

Chairman Judy Lee asked why this should only apply to cancer patients.

Mr. Tupa said he was not aware of the innovation in other particular areas of medicine.

Chairman Judy Lee cited several other diseases and asked why we leave those people out.

Mr. Tupa replied that the innovation in this space of medicine which is cancer has been significant. That's the evolution of these oral chemotherapies which are particularly effective, and in some cases, about the only effective treatment for certain cancers. Plans have not kept up with the innovation or pace of this disease and the drugs that are available for these patients. It doesn't make sense that oral chemotherapy costs so much more than IV.

Chairman Judy Lee suggested that maybe it is the cost of developing the compound for the oral chemotherapy.

Senator Howard Anderson, Jr. asked whether it would also be true that the cap might not apply to IV non-formulary.

Mr. Tupa indicated it could be but he wasn't certain.

(28:58) Chairman Judy Lee gave examples of people with multiple sclerosis and cystic fibrosis and how the pharmaceutical manufacturer raises the price of drugs dramatically without causing pain to the patient. The problem is the drug prices, not just the insurance plan. They are jacking up the price, giving rebates, then manufacturer gets cost. If you squeeze somewhere, someone else gets the bill. We aren't controlling health care costs, but shifting the costs.
She is troubled that the beneficiaries here are just cancer patients - they are not the only ones who are struggling with high priced medications.

Mr. Tupa said that this bill, HB 1072, does not mandate a new benefit. It only addresses plans with an existing chemotherapy benefit. If your plan covers chemotherapy, why is it $25 on medical side for IV but $1000 or more on the pharmacy side for an oral? It's the same benefit. In this particular space and the innovation is why we were here. Ten years ago we wouldn't have had this conversation.

Chairman Judy Lee pointed out that there weren't oral meds ten years ago at the same level

Senator Dever indicated the fiscal note had the cap in it. If we are going to apply it to PERS, then maybe we should look at the whole thing, including the cap.

Chairman Judy Lee said she was seeing it separately. She told the committee they needed to decide if they wanted to do these together or separately. If they wish it to go to PERS and include the cap, that's one thing. If they want to eliminate the cap and not go to PERS, that's another option. She then called for the vote.

Roll Call Vote to Amend (Remove $100)
5 Yes, 1 No, 0 Absent. Motion passes.

Senator Axness asked if they needed to take out the "or" from page 1, line 24, or if it was just clerical that would be taken care of.
The committee agreed that "or" needed to be taken out and included it in the motion.

Chairman Judy Lee next asked about the 2 years PERS study.
Senator Warner indicated it is currently excluded from PERS.

Senator Howard Anderson, Jr. moved the Senate Human Services Committee DO PASS Engrossed HB 1072 AS AMENDED.
The motion was seconded by **V. Chairman Oley Larsen**. No Discussion.

Roll Call Vote
5 Yes, 1 No, 0 Absent. Motion passes.

Senator Howard Anderson, Jr. will carry HB 1072 to the floor.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1072
3/31/2015
25661

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Donald Mueller

Explanation or reason for introduction of bill/resolution:

A bill would require that for health insurance and the PERS uniform group insurance plan, the member cost-sharing for cancer medications administered by the patient not exceed member cost-sharing for cancer medications administered by a health care provider.

Minutes: No attachments

Chairman Judy Lee brought the committee to order to discuss HB 1072.
There was a misconnect of information from Sparb Collins, so Rod St Aubyn was asked to provide more information.

Rod St. Aubyn indicated there is an exemption on the mandate review process. Under this process, you have a bill and it will actually apply on July 1 the mandate review on North Dakota Public Employee Retirement System after the legislative session. It is evaluated for the biennium, but they don't have a full biennium to evaluate; instead, it ends up being about one year worth of data. The North Dakota Public Employee Retirement System will submit a report back to legislature, what the actual cost benefit is applying it to the North Dakota Public Employee Retirement System. In 2015, let's say there is the mandate on the bill. For North Dakota Public Employee Retirement System only, it would go into effect July 1. North Dakota Public Employee Retirement System will evaluate that until the next legislative session and will provide report under North Dakota Public Employee Retirement System, and they will submit a bill to have it apply to all health insurance companies. Can't remember if the North Dakota Public Employee Retirement System is only good for 2 years, and then the bill that applies to all insurance if that also applies to North Dakota Public Employee Retirement System, or North Dakota Public Employee Retirement System just stays in effect the whole time. In that particular case, there is a fiscal impact for 2015-2017 biennium, potentially. The fiscal note reflected $300,000 per year in 2017-2019. If those potentially could be the fiscal impact for 2015-2017 if we did have the review for North Dakota Public Employee Retirement System.

If you have the exemption, which is on the bill now, the law will go into effect August 1, 2015, but the contract for North Dakota Public Employee Retirement System coverage goes into effect July 1, 2015 for two years. So since it goes into effect afterwards, it will

apply to any contracts that are renewed on that date or thereafter. If you have individual policy, it will be in effective when your insurance comes due - for example, September 1st. It would not apply to North Dakota Public Employee Retirement System people until July 1, 2017, because that is the next renewal period. But it will apply to private at any renewal period.

The fiscal not for the $300,000 starting in 2017 was based on Blue Cross Blue Shield fiscal note, because at that time they had not awarded the contract to Sanford. They are trying to get a new fiscal note, so at this point he doesn't know (Sparb Collins). Even if they get a new fiscal note, he doesn't know what Sanford is going to say. The fiscal note reflected is for Blue Cross Blue Shield. As the bill sits right now, it will not apply to North Dakota Public Employee Retirement System until July 1, 2017, but for all other private insurance other than self-funded, it will apply to them on their renewal date of their policy anytime August 1st or after.

Chairman Judy Lee is not trying to fight what the committee did on HB 1072. It didn't compute. She asked Mr. Collins to look at it again, she asked for fiscal review. What it amounts to, because of the timing of the signing of the North Dakota Public Employee Retirement System contract with Sanford, the Blue Cross Blue Shield implemented in whatever the contract they signed in August whatever changes they made preceded that signing. So if Blue Cross Blue Shield had continued the North Dakota Public Employee Retirement System contract, they would have put into their proposal response what the legislature would have mandated.

Mr. St. Aubyn indicated that Blue Cross Blue Shield hadn't included it, so they would have had additional costs to North Dakota Public Employee Retirement System.

Chairman Judy Lee restated now, but she thought she understood that because Blue Cross Blue Shield prepared the fiscal note as if they were going to continue to have the North Dakota Public Employee Retirement System contract, they said there was no impact because they would be putting it in the contract, which would be signed and be effective.

Mr. St. Aubyn responded no, they are not sure that is the case with Sanford, when they submitted theirs, they don't know if that is reflective in their bid right now.

Chairman Judy Lee indicated that Sanford wouldn't have known about SB 1072.

Mr. St. Aubyn indicated that Mr. Collins had met with the bidders about bills that were considered for the interim.

Chairman Judy Lee doesn't want to put anybody in a bad spot. She doesn't want Sanford to have something they are not supposed to prepare for. She wants us to know what is going on, with a concern if we say there is no fiscal impact when in fact there is.

Mr. St. Aubyn indicated as it sits right now, there will be no fiscal impact with either Sanford or Blue Cross Blue Shield. Potentially, there could be a fiscal impact in 2017-2019 when North Dakota Public Employee Retirement System would have to adopt this.

Senator Howard Anderson, Jr. stated everyone said they would reach their out-of-pocket cap anyways. It doesn't change the way the insurance will pay.

Chairman Judy Lee stated you may be right - Mr. Collins doesn't know either.

Senator Howard Anderson, Jr. stated he understands if it was $100, he understands a fiscal impact. If you reach the cap, it doesn't matter.

Mr. St. Aubyn indicated it will be an increase because anything that is a reduction from the member will be an increase for the insurance. So if the member isn't paying something that they were before, than the insurance is picking up the additional amount. If there is some savings for the member, there are increases for the insurer.

Chairman Judy Lee stated because of confusion, she wants to hold the bill. We want no confusion on the floor if there are costs.

Mr. St. Aubyn indicated the bill as it is with the exemption, even with Sanford, there is no increase in 2015-2017, but could be for 2017-2019. North Dakota Public Employee Retirement System will not receive this benefit until July 1, 2017.

Chairman Judy Lee stated they get it later than the private insurance companies do.

Mr. St. Aubyn confirmed correct. If the North Dakota Public Employee Retirement System mandate were to apply, then it would only apply North Dakota Public Employee Retirement System July 1, 2015 through June 30, 2017, and theoretically, possibly expand to general public in July 1, 2017. This would have a fiscal impact in July 1, 2015.

Chairman Judy Lee indicated how it bothered her that information from Mr. Collins was different between Senator Dever and Chairman Judy Lee. The questions may have been answered from a different perspective.

Mr. St. Aubyn indicated that if Mr. Collins will provide a fiscal note, he will request it tomorrow.

Senator Dever doesn't have an issue with waiting for a fiscal note. The additional costs we are talking about - is it because oral drugs are more expensive than the IV drugs, or because people have to pay it for themselves and the cost would be shifted to the insurance company.

Mr. St. Aubyn responded that as the bill is right now, we removed the cap, but you still have the parity issue where the cost share has to be the same with medical versus pharmaceutical. It is theoretically costing the member less, which means the insurer picks up what the member did not - on the oral medication.

Senator Dever restated, so we are saying the cost of the oral and IV may be the same without the bill, the insured is paying the extra cost, and with bill the insurer is paying.

Chairman Judy Lee stated the copay is less on IV because it is a medical procedure, than it is on the oral medication because the coding for that is under a pharmaceutical.

Senator Dever asked that the cost of the medication, either way, is not the factor that is driving the argument.

Chairman Judy Lee answered that nobody has ever said that it was, but she can't say for sure because we haven't asked any pharmaceutical manufacturer. It depends on the drug.

Senator Dever indicated the difference is the delivery system and how it is reimbursed.

Mr. St. Aubyn stated the drug for the oral and the IV is not the same drug.

Senator Howard Anderson, Jr. stated if that's true, than the parity wouldn't apply. This only applies if it is the same drug administered IV or orally. The contention is that even if the drug per patient per month was exactly the same, the cost to administer the IV portion is higher because they have to go into the hospital, they have the nurse, they have to do all these things. So there should be some savings assuming the patient would select the oral medications now because they don't have to pay anymore when previously they had to pay extra for oral than they would have if they had gone in to get an IV. Now if the contention is true, that the oral drug is less expensive, then there would be additional savings to somebody - the patient, the insurance carrier, whatever. He is not sure in a fiscal note that you balance those things out. You just assume that what you have to pay extra is the cost. You don't always consider because you can't prove how many people are going to switch from going into the clinic and getting the IV medicine at a higher cost - how many of those are going to switch over to oral because the cost is now the same.

Chairman Judy Lee thinks the question brought up by Senator Dever is a good question. Nobody has talked about the what the cost of the oral and IV total costs, including the administration of the drug, what the difference is between the two.

Mr. St. Aubyn stated his confusion. He understood that it isn't necessarily the same drug.

Chairman Judy Lee provided an example - if it is penicillin, you can get it IV or tablet. It is the same antibiotic.

Mr. St. Aubyn indicated it is really the plan design in terms of what they have for cost share under the pharmaceutical benefit versus the cost share under the medical care, being clinic or hospital. That is the difference they would be looking at.

Senator Howard Anderson, Jr. stated what we are looking at in the bill is for the patient, we are looking at the same cost whether oral or IV.

Chairman Judy Lee indicated her goal is not to rehash the discussion, but her concern is that whether or not the fiscal note is accurate. If they come back and say it's not going to cost anything, then fine, we've asked three times.

Mr. St. Aubyn stated hopefully you'll hear within one day. That is the explanation, if it is under mandatory review, there is a fiscal impact for this biennium, potentially, applying to North Dakota Public Employee Retirement System. If it is exempt, like the bill passed out of committee, it applies to people on their insurance after August 1st renewal period and does not apply to North Dakota Public Employee Retirement System until July 1, 2017. They will determine if there is a fiscal impact in which biennium.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1072
4/1/2015
25720

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Donald Mueller

Explanation or reason for introduction of bill/resolution:

A bill would require that for health insurance and the PERS uniform group insurance plan, the member cost-sharing for cancer medications administered by the patient not exceed member cost-sharing for cancer medications administered by a health care provider.

Minutes:

Attach #1: Scenario Examples from NDPERS

The Senate Human Services Committee met on April 1, 2015 for HB 1072 committee work.

Chairman Judy Lee provided handout of scenarios from Sparb Collins, North Dakota Public Employee Retirement System. (attach #1)

Rod St. Aubyn explained the scenarios - when the effective date. Appropriation bills go into effect July 1, but other bills go into effect on August 1. We tried to distinguish between the North Dakota Public Employee Retirement System fully insured members - where the health insurance company assumes all risk and underwriting, typical of most insurance when buying on their own. Self-funded would typically be large employer funds - they assume all risk and they assume underwriting, because it is their money. They usually hire a third-party administrator, or insurance company, to manage their plans. The self-funded plans are regulated by the federal government, so any law we pass does not override the federal government. The Blue Cross Blue Shield membership was approximately 50% self-insured, and 50% was self-funded. For comparison purposes, he listed a small subset. The North Dakota Public Employee Retirement System plan goes from July 1 2015 to June 30 2017. Sanford will be managing the North Dakota Public Employee Retirement System plan, so the next renewal period is June 30, 2017. This legislation, if it passes, goes into effect August 1, 2015. That means that health insurance plans will abide by those laws, effective on August 1, 2015 or their next renewal date. We are assuming the North Dakota Public Employee Retirement System members in this group have this contract 07/01/2015 to 06/30/2017. In the attached document, he went through date examples. On page 2, he gives scenarios of what happens.

The first is how the bill has been passed out of committee - with North Dakota Public Employee Retirement System exemption. It begins after August 1, 2015, so North Dakota

Public Employee Retirement System plan are already under contract on July 1, 2015, so technically it won't be effective until July 1, 2017, under the new renewal period. He assumes Sanford could elect to say that they will start July 1, 2015. According to the law, they would not have to comply until July 1, 2017.

For people not on North Dakota Public Employee Retirement System, it would be the next renewal date after the August 1, 2015 date. Mr. St. Aubyn provided scenarios under this.

The second scenario he gave is that if it does have the North Dakota Public Employee Retirement System review. Then, it would go through July 1, 2015 through June 30, 2017. You will not have two years' worth of data because the legislature will be in session before that, so you may have one year of data. The idea of the North Dakota Public Employee Retirement System review process is they would have a bill apply to all insurance companies, starting in 2017 legislative session.

Senator Howard Anderson, Jr. stated he doesn't understand how including the North Dakota Public Employee Retirement System mandate moves the date up by two years. Why is it now effective July 1, 2015?

Mr. St. Aubyn stated it is based on the law, any law that passes for a mandate would go into effect right away with. In the past when we had these changes, then it was a choice of North Dakota Public Employee Retirement System whether they wanted to accept additional costs or not.

Mr. St. Aubyn continued. In that particular case, the legislature in 2017, North Dakota Public Employee Retirement System would offer a bill and have it apply to all insurers, and legislature would determine if they want to make this available to everyone and North Dakota Public Employee Retirement System. North Dakota Public Employee Retirement System would be effective July 1, 2015. For non-North Dakota Public Employee Retirement System, they would wait until after July 1, 2017 or their renewal date after July 1, 2017. Mr. St. Aubyn ran through some of the examples. Mr. St. Aubyn indicated Sparb Collins agreed with the assessment.

Chairman Judy Lee asked if Mr. Collins indicated that there is still no major fiscal impact.

Mr. St. Aubyn indicated that was the other question, whether removing the cap will have a significant impact on the fiscal note. He believes that Mr. Collins indicated that information he has gotten from both Sanford and Blue Cross Blue Shield that it will not have a significant impact on the Blue Cross Blue Shield fiscal note or the Sanford bid.

Senator Axness asked does the North Dakota Public Employee Retirement System have any other benefits for pharmaceutical companies and insurance providers. Explain the benefit besides just the interaction between the two. We don't know the real cost of the pharmaceutical drugs. Does the study bring the actual costs out?

Chairman Judy Lee asked about the PBM (pharmacy benefit manager) regarding the costs of the drugs.

Mr. St. Aubyn indicated what happens on that is the PBM is hired by the health insurer to manage the pharmacy benefit. They get the participating providers. In terms of the cost, they basically they have a fee schedule for those drugs. In terms of the cost here - he clarified regarding Senator Howard Anderson, Jr. comment if these are the same drugs - IV or oral. For the most part in cancer drugs, visiting with pharmacy directors from Blue Cross Blue Shield, in the cancer area, with both oral and IV drugs, they are basically the same. Are the oral chemo the same as the IV drugs? The answer is that the oral drugs are new. Are the prices different - the oral chemo costs thousands where the IV drugs are hundreds. But the IV therapies usually cheaper for the drug but there are administrative fees, ancillary supplies, facility fees, etc. Even with the additional fees, the oral chemo is still more expensive. This is not typically the physician who makes the decision on giving a choice of oral or IV. It is typically more a best-practices protocol. There are a lot of variables. Everything from what stage of the cancer - they may recommend what is for a person because an oral is available. It is not a situation where there is a choice of oral or IV, but what is best practices.

Senator Dever commented early in the process, the reason we said oral was more expensive was because they were older that came off of patent and companies were buying other companies and then raising the price. Now we are talking about newer drugs that are under patent and are more expensive, likely to recover their research and development costs. If they are new, can we say they are new and improved and more effective, better drugs? We aren't talking about what costs more, but what is parity in the way they are reimbursed so that if insurance reimburses for IV but doesn't reimburse for new and more effective oral drugs, then what?

St. Aubyn indicated he is not sure if that's true that these were older drugs that are going there. To his understanding, it is the newer drugs. It is the protocol of the physician to determine that it is a new drug, been studied and released, and recommends the oral for the patient, then that is what they get.

Senator Dever stated the question then becomes will they get reimbursed. Does the doctor always make the decision based on the most effective oral meds available or cost?

Chairman Judy Lee stated they are both going to get reimbursed by the insurance company if it is an appropriate choice. The difference is what the copay is going to be for the patient.

Senator Dever added that from oral, it could be thousands of dollars is what we are being told.

Chairman Judy Lee answered it may be, if the drug is that expensive. Some of the drugs coming off patent were now not going to have as many competitive generics because the name brand companies were buying them up. That's part of the factor in the enormous general increase in the price of drugs. She never would have meant to suggest that oral meds are an older medication for cancer treatment because she knows better than that. She wants to make it clear so no one understands that it was not part of the conversation specifically.

Mr. St. Aubyn indicated that was the other question he had included. What is the typical out-of-pocket maximum for these drugs. The insurance company gets more confusing - there are different types of plans, such as grandfathered plans, non-grandfathered plans, self-funded, etc. For grandfathered plans, it is typically $1,000 per person. For non-grandfathered plans, the medical maximum and pharmacy maximum are combined now. For individual and small group, depending on the plan, the combined maximums range between $3,000 and $5,000. Self-funded can make whatever rules they want, and this bill does not impact that.

Senator Howard Anderson, Jr. thinks what the bottom line is parity - when the consumer looks at the potential treatment for that consumer, the coinsurance and copays are the same for however they receive that drug. If it comes down that a more expensive drug is used on one side, they get washed out. From consumer perspective, they don't want to be surprised by when they get the oral medication, it's $4,000 and when he got an IV, it was significantly lower. They want the same copay and coinsurance on each side.

Chairman Judy Lee asked how does John Doe who has cancer have a lower participation amount compared to Jane Smith who has Multiple Sclerosis, and isn't going to have the same perc and benefit under this bill. She stated she has trouble with that.

Senator Howard Anderson, Jr. responded that he doesn't have a problem if we want to expand this bill to all therapies. But it came as a cancer parity bill. In other cases, if there is oral and IV therapies, he doesn't have a problem with that. In his opinion, it is a place to start.

Senator Warner doesn't quite understand the distinction between a medically induced drug and a pharmacy drug. If a doctor in a cancer treatment center, he must prescribe the intravenous drug and it is administered by the center. He doesn't quite understand the process where it becomes baptized as a medical issue rather than a pharmaceutical issue.

Chairman Judy Lee provided an example where the patient is in the Roger Marris Cancer Center and you have to go to the unit, you have a port, and they are putting an IV in - that's a medical procedure. If it's oral, it's a pill.

Senator Warner stated the procedure is medical, but the drug is still pharmaceutical.

Senator Howard Anderson, Jr. explained the difference. It is the way the payment process has developed over the years. If you go to a hospital or clinic, it's billed on a 1500 form, or a UB92 form as a medical procedure. Historically, that process developed separately from the process for paying for a prescription. When you get a prescription, then you go to the pharmacy, or out-patient pharmacy at the hospital, and when that is filled, it is a different payment system that has been set up. The copays and the coinsurance has been developed differently for that process. Does that make sense in today's world? Maybe it doesn't, but it is the way it is. If you got that same IV medication supplied to you by prescription and you went to the pharmacy and picked it up, then the same payment procedures would apply as if you got pills, and then you would have to take your drugs back to your clinic who would then administer that drug for you and charge all the additional ancillary expenses, the IV bag, the stay overnight, the doctor and nurse, etc.

that was administering it to you - that would be paid separately under the medical model payment plan. There are a few circumstances where we dispense medication to a patient. In most cases, they administer the IV drug at the same time, so they then roll the billing into the same form.

Senator Warner stated that on occasions when he has had surgery, there is a release package - take this and put an antibiotic on the wound for the next two weeks. It's not a prescription, but a vial. Is that billed as medical instead of pharmaceutical?

Senator Howard Anderson, Jr. stated if they sent IV bags or bottles, that was billed under the prescription benefit. If port or IV lines, that would be charged separately. It would be billed under the outpatient pharmacy system.

Senator Warner stated if you sent to Roger Maris Cancer Center and they handed you the pills, that it could be billed under the medical side, but apparently not.

Chairman Judy Lee stated the irony was that they were able to do this yesterday and now we are looking two years from now.

Senator Dever asked for Mr. Tupa to respond.

Chairman Judy Lee indicated that she doesn't see things changing.

Ken Tupa referred to the examples in attachment #1. You see the benefit of the bill that you acted on. The benefits of the bill are applied two years earlier to the general public. That illustrates the benefit of the bill that you have acted. The only other comment, in response to the data, cost benefit data, we already have that information - it has been provided by the Employee Benefits Program and subsequent fiscal notes. That information is already there. We believe and support the bill as it has been acted on.

Chairman Judy Lee stated with the exemption, the North Dakota Public Employee Retirement System would receive it earlier. You are picking one over the other, regardless of what side of the bill you are on.

Mr. Tupa because of the provisions, you have to start somewhere, the sooner you start, the benefits to everyone is sooner.

V. Chairman Oley Larsen asked what is the average out of pocket for cancer.

Mr. Tupa stated he couldn't begin to give that information - he would be guessing. A study to an individual or family - financial bankruptcy is significantly higher, straining on individual or family who have cancer event.

Chairman Judy Lee asked if there were any further comments on HB 1072. She looks forward to discussion on the floor.

15.0117.05001
Title.06000

Adopted by the Human Services Committee

March 30, 2015

3/30/15 JAE

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1072

Page 1, line 1, replace the semicolon with "and"

Page 1, line 19, remove the underscored colon

Page 1, line 20, replace "a. The" with "the"

Page 1, line 24, replace "; or" with an underscored period

Page 2, remove lines 1 through 3

Renumber accordingly

Date: 03/30 2015
Roll Call Vote #: 1

2015 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1072

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: Remove $100 cap 15.0117.05001 Title 06000

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Sen. Axness Seconded By Sen. Larsen

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	✓		Senator Tyler Axness	✓	
Senator Oley Larsen (V-Chair)	✓		Senator John M. Warner	✓	
Senator Howard C. Anderson, Jr.	✓				
Senator Dick Dever		✓			

Total (Yes) 5 No 1

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 03/30 2015
Roll Call Vote #: 2

2015 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB1072

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 15.0117.05001 Title 06000

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Sen. Anderson Seconded By Sen. Larsen

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)		✓	Senator Tyler Axness	✓	
Senator Oley Larsen (V-Chair)	✓		Senator John M. Warner	✓	
Senator Howard C. Anderson, Jr.	✓				
Senator Dick Dever	✓				

Total (Yes) 5 No 1

Absent 0

Floor Assignment Sen. Anderson

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1072, as engrossed: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (5 YEAS, 1 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1072 was placed on the Sixth order on the calendar.

Page 1, line 1, replace the semicolon with "and"

Page 1, line 19, remove the underscored colon

Page 1, line 20, replace "a. The" with "the"

Page 1, line 24, replace "; or" with an underscored period

Page 2, remove lines 1 through 3

Renumber accordingly

2015 TESTIMONY

HB 1072

HB 1072
January 19, 2015

#1

Mr. Chairman and Members of the Committee,

My name is Al Wartner and I am pleased to be able to present my testimony to the Committee today.

I was raised in Harvey, North Dakota. At the conclusion of my working career, my wife and I purchased a retirement home in Jamestown. I assumed my retirement health care costs would be minimal as I was covered by Medicare health insurance and a Medicare Part D prescription drug plan.

In April 2013, I was diagnosed with one of the variations of lymphoma. As you know, different cancers require different treatments. If a patient needs oral chemotherapy, or other oral cancer drug they may be in for a rude awakening. My first surprise began shortly after my diagnosis. I traveled to MD Anderson Cancer Treatment center in Houston and met with the leading specialist in my disease. She prescribed an oral drug for my cancer. My then Part D Prescription Drug carrier required pre-authorization for the drug and refused to provide me the medication. They wanted me to undergo "step-therapy". I was to try several other drugs and if they failed, I could attempt an appeal of their original decision. I could not believe that an insurance company knew more about the medication I needed than the leading specialist.

I was "stuck" with that insurance company until the fall of the year 2013. At the end of each year, there is a time period that you are allowed to enroll in a new Part D plan. I searched diligently for a provider that would include the drug I needed in its formulary (If a drug is not in the providers formulary, you cannot obtain the drug unless they grant an exception). I found a provider whose formulary allowed the drug and did not require pre-authorization or step therapy.

However, I received my second surprise. The cost was extraordinary. I take 3 capsules per day. That is considered one-half of the normal dosage. As you may know, Part D prescription Drug plans are divided into three patient payment phases. In the initial payment phase, *my out of pocket cost* is $2960 for a one month supply, my cost in the next phase is $1740. I then reach the "catastrophic" phase and pay $1127.00 per month. Since my drug is considered a specialty drug, I basically pay 25% of the retail cost. There is no cap on my payments, except that the plan starts over each year. If it becomes necessary to take the full dosage, my out of pocket cost would double to $31,940 per year. Who can afford that?

If this drug could be administered to me intravenously, in a hospital setting, the drug would be covered by my hospitalization Insurance, rather than my prescription drug plan and the cost to me would be significantly less.

I don't think it makes sense that a cancer drug that is given orally, and is covered under a health plan prescription drug benefit, should cost significantly more than the same drug administered intravenously and covered under a health plan medical benefit. However, that is what happens to many cancer patients. Cancer care should be based upon the best treatment available.

/

You, your friends and family members may someday face a decision. Do they forego cancer treatment because the medication is orally administered? The Leukemia and Lymphoma Society reported that patients with out of pocket expenses of greater than $200 per prescription were three times less likely to fill a prescription for their oral anti-cancer drugs, compared with those with out of pocket expenses of $100 or less.

This legislation is not unique. The last I read, thirty-four states and the District of Columbia have adopted the legislation. Cancer care is continually evolving. About 30% of cancer medications are now oral. That percentage will continue to increase. Health insurance plans have not kept pace with their coverage of oral cancer drugs. As in my case, with my original Part D Provider, I had no support when I needed it.

Your cancer patient constituents need to be able to obtain the cancer drug that is most appropriate for their care. Their focus should not be on finding a way to pay for their care.

Thank you for your support of this legislation.

Randy Boehm's Testimony

HB 1072
January 19, 2015

#2

New Study Shows Cost Savings of Oral Cancer Therapies

COST STUDY BACKGROUND

A study published online in the *Journal of Medical Economics* on January 3, 2013[1] compared overall costs of treatment for intravenous (IV) and oral therapies used in relapsed/refractory Multiple Myeloma.[2]

In the study, researchers calculated total treatment costs for two commonly prescribed regimens for relapsed/refractory multiple myeloma over the course of one year. One regimen was administered intravenously at the doctor's office/infusion center, while the other included two medications which are taken orally in a pill form, often at home. Total treatment costs included:

- **Drug Costs** – the cost of the brand name drugs[3], at rates commonly paid by CMS and private health plans.
- **Direct Medical Costs** –the cost of office visits, drug administration, laboratory tests, and administration of any pre-packaged fluids/electrolytes to keep patients hydrated during treatment.
- **Adverse Event Management** - the cost to manage any major adverse events that commonly occur during treatment, such as anemia, pneumonia, or a significant reduction in infection-fighting white blood cells.

AUTHORS' CONCLUSIONS

TOTAL TREATMENT COSTS were higher for the IV therapy, even though the drug costs were about the same for the IV and oral therapies that were compared.

ANNUAL TREATMENT COSTS for the IV regimen were over $17,000 higher than the costs for the oral regimen, or approximately $47 higher per day.

DIRECT MEDICAL COSTS WERE RESPONSIBLE for the higher cost of care for the IV treatment. Total direct medical costs were some $5,000 higher per patient for the IV regimen, or approximately $35 higher per patient per day.

ENSURING PATIENT ACCESS TO ORAL THERAPIES SAVES MONEY

- This study demonstrates that **oral therapies can save the health care system money**. Oral cancer therapies are also more convenient for the patient and can have fewer debilitating side effects. For these reasons, they are often the treatment of choice. In some cases, there is no other choice - an oral medication may be the only effective treatment option available.
- Unfortunately, **cancer patients can face significantly higher out-of-pocket costs if their treatment is taken orally rather than intravenously**. The problem is out-of-date insurance benefit design. Some health insurance companies have not adapted benefit design to ensure patients have access to innovative oral cancer therapies, even if they are more medically appropriate or, as in this case, can save the health plan money.
- To provide patients access to life-saving therapies and create savings for the overall health care system, legislation should be approved to require **health plans that cover cancer treatments to do so equally for IV and oral therapies.**

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[1] *Durie BGM, Binder G, Pashas CL, Khan ZM, Hussein MA, Borrello I. Total cost comparison in relapsed/refractory multiple myeloma. Journal of Medicol Economics. Epub 2013Jon 3.*

[2] *Relapsed/refractory Multiple Myeloma refers to cancer of the plasma cells in the blood in which there is a reappearance of signs and symptoms of the disease after a period of improvement (relapsed) or that the cancer is unresponsive to standard treatments (refractory)*

[3] *Because one of the drugs in the oral regimen is generic, the cost was considered negligible and not included.*

Providing Affordable Access to Oral Anti-cancer Treatments ... miums for All

STATE	YEAR LAW ENACTED	STATE REGULATOR REVIEW	OUTCOME OF REVIEW
California	January 1, 2015	Analysis conducted by California Health Benefits Review Program.	Analysis found negligible increase in premiums of .00144%.
Colorado	January 1, 2011	Official study not conducted by the Division of Insurance (DOI), but DOI did respond to an inquiry from a Tennessee legislator, regarding premium increases since enactment of parity law.	In response to the TN legislator, CO Comm. of Insur. stated, "Because of the extent of changes to state and federal law, affecting health insurance premiums and cost sharing, we cannot attribute any change due to this specific provision."
Connecticut	January 1, 2011	Official study not conducted by the CT Insur. Dept., but did they respond to inquiry from a TN legislator, regarding premium increases since enactment of parity law.	CT Insur. Dept. found, "while [health] plans raised concerns during the legislative process, once the law was enacted, we have not had concerns raised.
Illinois	January 1, 2012	An official study was not conducted by the Illinois Department of Insurance, but the department did respond to an inquiry from a Tennessee legislator, regarding premium increases since enactment of parity law.	**Q:** "Have any health plans 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?" **A:** "Yes; but that has been a standard defense against any new mandates. To date, such claims have not been supported by actual rate increase

2

Part of #2 HB1072 January 19, 2015

STATE	YEAR LAW ENACTED	STATE REGULATOR REVIEW	OUTCOME OF REVIEW
Indiana	January 1, 2010	Yes. Bill sponsor sent letter to Indiana Insurance Department, asking if premiums had increased, as a result of enactment of oral chemotherapy parity law.	Indiana Dept. of Insurance confirmed 1 year after enactment that "no increase [in premiums] has materialized at this time."
Kansas	April 1, 2010	The Kansas State Employees Health Care Commission conducted a review of impact on premiums.	KS State Employees Health Care Commission found "minimal impact to the health plan finances."
Kentucky	January 1, 2015	Yes. Study conducted by the Kentucky Department of Insurance.	Determined an increase in all premiums between .67-.84 cents per month per member.
Maine	January 1, 2015	Yes. Study conducted by the Maine Department of Insurance.	Determined no increase in premiums.
Massachusetts	May 1, 2013	Mandated Benefit Review of SB 1070 (An Act to Relative to Oral Cancer Therapy) conducted by the Division of Health Care Policy and Finance.	Found that bill would cause no more than a 0.044 percent increase in insurance premiums. Five-year total estimated impact on premiums ranges from 0.008 to 0.044 percent of annual premium."
Missouri	January 1, 2015	Report commissioned by Missouri Joint Committee on Legislative Research- Oversight Division.	Report estimated a 0.23%, or $0.81, per member increase.
Oregon	January 1, 2008	Yes, the Oregon Insurance Division (OID) conducted a review.	OID stated impact on premiums "very MINIMAL." Just 9 out of 79 plans cited a minimal impact on premium rates.

3

Party #2

HB 1072
January 19, 2015

STATE	YEAR LAW ENACTED	STATE REGULATOR REVIEW	OUTCOME OF REVIEW
Texas	September 1, 2011	Yes. Study conducted by the Texas Department of Insurance, PRIOR to introduction of bill, at the request of Governor Rick Perry.	Study found, "The implication of reducing patient out-of-pocket costs for pharmacy benefits is that costs are effectively shifted from the patient to health plans. **The cost of implementing chemotherapy parity is estimated at less than $0.50 per member per month in most cases,** although estimate can increase to $1.30 per member per month in cases where enrollee faces high cost sharing for pharmacy benefits & low cost sharing for medical benefits."
Vermont	April 1, 2010	Yes, an analysis was conducted by the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA).	Final BISHCA analysis concluded, "The Dept. has not received information indicating that mandating coverage for orally administered anticancer medications will significantly impact premiums.
Washington (State)	January 1, 2012	Review conducted by Washington Department of Insurance.	Review found a nominal increase in premiums of 0.2% as result of enactment of oral chemotherapy parity law.
Wisconsin	January 1, 2015	Bill reviewed by Wisconsin Office of the Commissioner of Insurance (OCI).	OCI declared legislation NOT a mandate.

4

Part of #2
HB 1092
January 19, 2015

#3

Testimony in Support of **HB 1072**
House Human Services Committee
January 19, 2015
Ken Tupa, American Cancer Society Cancer Action Network

Chairman Weisz and members of the committee, my name is Ken Tupa and I am before you this morning on behalf of the American Cancer Society Cancer Action Network. Thank you for the opportunity to testify in support of HB 1072.

I am here representing the 5,500 American Cancer Society Cancer Action Network advocates in North Dakota and the 3,840 North Dakotans who will be diagnosed this year. ACS CAN is just one of the many supporters of this legislation. Together we represent thousands of cancer patients, their families, and community members.

HB 1072 would modernize North Dakota's laws to keep up with the latest research and cancer treatment options by requiring health insurance plans in North Dakota that cover cancer treatments to provide coverage for oral chemotherapy on a no less favorable basis than coverage for traditional IV chemotherapy.

We have made significant advances with our investments in cancer research. But, the advances in research mean nothing if the life-saving treatments are not reaching patients.

Historically, chemotherapy drugs have been primarily administered intravenously. Today, thanks to progress in cancer treatments, there are many types of chemotherapy that can be taken as a pill or liquid. And many of these therapies are the only appropriate treatment for certain types of cancer.

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. Today, oral oncology therapies comprise about 10% of the available therapies. It is estimated that 25% of the medications in the oncology development pipeline are oral therapies.

While research and technology continues to change the nature of medical treatment for serious diseases like cancer, many healthcare benefit plans have not adapted to ensure patient access. As a result, cancer patients face significantly higher out-of-pocket costs simply because their chemotherapy is dispensed orally rather than intravenously.

Physicians must be able to make the best choice for their patients, considering the unique aspects of each patient and the progress of the disease. Recent studies and surveys have revealed that oncologists consider patient out-of-pocket expenses when making prescribing decisions. Oral oncology parity laws allow many patients and physicians to choose the right therapy that offers the most hope—without

part of #3 HB 1072
January 19, 2015

worrying about outdated health plan benefit designs that charge patients more simply because the therapy they need is only available in pill form.

HB 1072 fixes that problem and allows patients and their oncologists to decide on a course of treatment based on what is best for the patient not by what is covered by insurance.

As of June 2014, 34 states and the District of Columbia (DC) have passed legislation to limit patient out-of-pocket costs for oral anti-cancer medications and a number of others are expected to take action in 2015.

From the experience of other states, we have seen greater access to oral chemotherapy without impacting the cost of premiums. In the 34 states with oral chemotherapy access legislation there is no evidence that this change has increased health insurance premiums.

Because of the convenience of oral chemotherapy, patient preference has been one of the main drivers in the increase in oral chemotherapy agents. Evidence shows that patients receiving traditional IV chemotherapy and their caregivers often have to miss work for treatment and managing side effects. Oral chemotherapy medications support patients' ability to continue working during and after treatments. These therapies are increasing survivorship but are also improving patients' quality of life and employment.

Updating North Dakota's laws so cancer patients can have better access to the advances in cancer care makes sense. We urge your support of HB 1072. Cancer patients cannot afford to wait any longer for North Dakota to join the other 34 states and the District of Columbia that have already passed legislation to address this issue.

I thank you for your time and I would be happy to answer any questions.

#4

LEUKEMIA & LYMPHOMA SOCIETY
fighting blood cancers

www.LLS.org

January 19, 2015

Testimony of the Leukemia and Lymphoma Society on H.B. 1072

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. Approximately one-quarter of all cancer drugs under development are oral, patient-administered treatments, and there is a growing trend toward development of these therapies. Many patients prefer oral medications, as they often have a lower risk of complications as compared to IV counterparts as well as having fewer side effects. 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.

H.B. 1072 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.

No Statistically Relevant Premium Increases Have Been Seen

To date, 34 other states plus the District of Columbia have passed similar bills and implemented the law. Included below 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 most appropriate treatment for them.

LEUKEMIA & LYMPHOMA SOCIETY
fighting blood cancers

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Studies conducted by the Insurance Departments in California, Colorado, Connecticut, Illinois, Indiana, Kansas, Massachusetts, Oregon, Texas, Vermont and Washington state sought evidence that implementation of oral chemotherapy access laws increased health insurance premiums and found there has been no anecdotal evidence of increases. Only two states (Connecticut and the state of Washington) reported a 0.2% increase in premiums.

The Affordable Care Act Does Not Fix This Challenge Facing Patients

Another common question is how the Affordable Care Act (ACA) affects State parity laws. Although the ACA does place an annual out-of-pocket maximum for in-network expenses of $6,600 per individual, this does nothing to address a patient's struggle with the cost of their anti-cancer treatment each month. By supporting this bill, you will help solve the monthly out-of-pocket financial burden for patients.

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[1]. This suggests that exorbitant co-insurance requirements will likely prevent many patients from ever filling even their first prescription because they cannot afford the cost. This can mean a choice between filling their prescription and paying their mortgage. An annual out-of-pocket maximum simply does not protect against the barriers created by excessive patient co-insurance requirements.

H.B. 1072 provides critical patient protections for those suffering from cancer – on behalf of the estimated 3,400 North Dakotans who will be newly diagnosed with a cancer in 2015, The Leukemia & Lymphoma Society urges your support to remove barriers to access for our patients and their families.

[1] Streeter, et al. "Patient and Plan Characteristics Affecting Abandonment of Oral Oncolytic Prescriptions."American Journal of Managed Care, *SP 38*, May 2011

part of #4 HB1072
January 19, 2015

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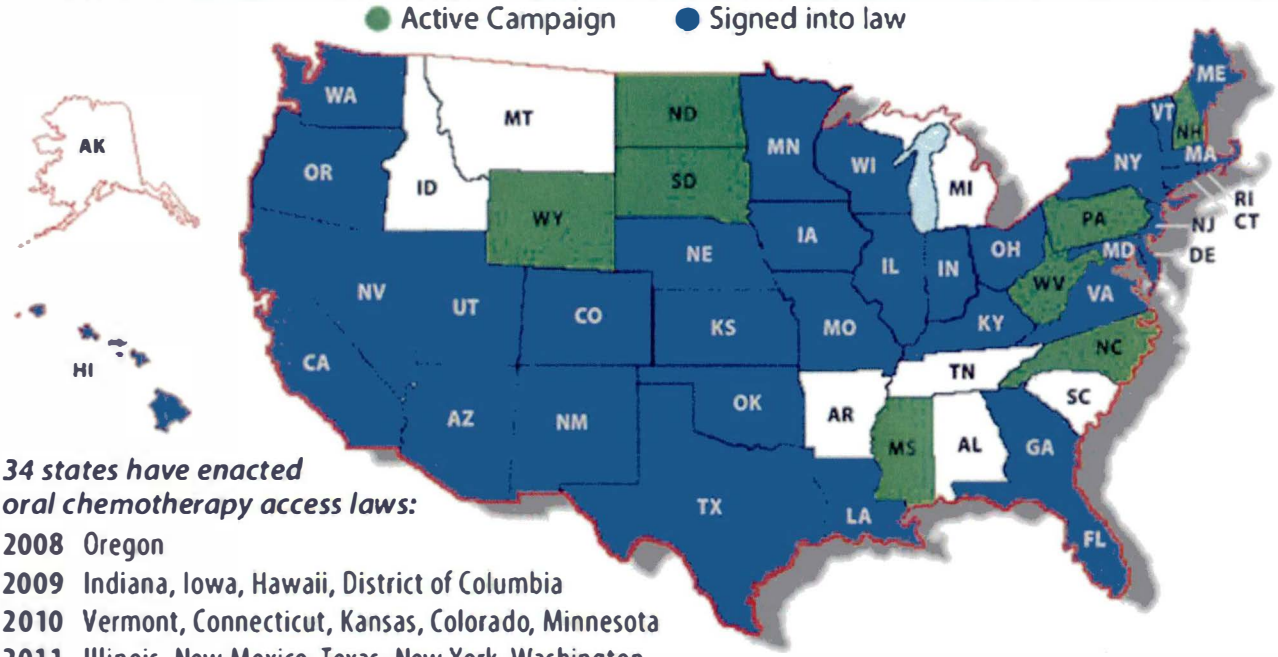
Oral Chemotherapy Access Legislative Landscape – September 2014



34 states have enacted oral chemotherapy access laws:

2008 Oregon
2009 Indiana, Iowa, Hawaii, District of Columbia
2010 Vermont, Connecticut, Kansas, Colorado, Minnesota
2011 Illinois, New Mexico, Texas, New York, Washington
2012 New Jersey, Virginia, Maryland, Nebraska, Delaware, Louisiana
2013 Massachusetts, Oklahoma, Utah, Nevada, Florida, Rhode Island, California
2014 Maine, Missouri, Wisconsin, Kentucky, Georgia, Arizona, Ohio

#5

House Human Services Committee
January 19, 2015
Testimony in Support of HB 1072
Renae Byre
Oral Chemotherapy Cancer Patient
Minot, ND

Chairman Weisz and members of the House Human Services committee;

My name is Renae Byre and I am a resident of district 38. Today I am here to ask you to recommend a **"do pass" for House Bill 1072.**

I wear many hats; one of those hats is cancer patient.

In 2004, at the age of 38, I was first diagnosed with breast cancer. I went through multiple surgeries, IV chemotherapies, radiation and daily medications for several years. Five years later, I was experiencing breathing problems. A biopsy of my lung lining showed my cancer was back. A PET scan also confirmed that I have metastatic breast cancer. This means I will be battling cancer and taking some kind of treatment the rest of my life.

Upon my diagnosis in 2009, my oncologist determined that the best course of medication was an oral chemotherapy called Xeoloda.

I will never forget the day I went to the pharmacy to fill my prescription. Although I was a little concerned about the cost, I thought I had good insurance with NDPERS through Blue Cross/Blue Shield of North Dakota. **I was not prepared to hear my medication would cost me about $4000.00 every three weeks out of pocket**. This was as devastating to me as finding out my cancer had returned. I remember thinking, "well, I guess I'll just die!" Luckily, I have a very resourceful Aunt. She found a program through the drug company that could assist in reducing my cost for treatment.

Xeoloda was very successful at treating my cancer; I only needed to be on the drug for about 4 months. It was possible that I might have needed it for much longer than that. For the last five years I have received an IV of Herceptin every 4 weeks as a maintenance plan for the metastatic breast cancer, in hopes of slowing any mutations.

This past October, we found out the cancer cells mutated once again. This time my oncologist has me taking an IV chemotherapy for treatment. Today, I am half way through treatment and the results have been good. In late February, my new maintenance plan will be a combination of two different IV drugs every three weeks for the rest of my life or until the cancer mutates again. There is no telling what treatments I might need in the future, or what new drugs will be available that can help patients like me. I know that someday, it's a real possibility that I will need oral chemotherapy again.

I want to live long enough see my baby, who was in Kindergarten during my first diagnosis, graduate from high school. I want to see my children grown up, get married, and have children of their own.

No cancer patients, myself included, should have to choose between what the doctor determines as the best course of treatment and which one they can afford. Please support cancer patients by making sure all chemotherapy treatments are covered the same.

Thank you for letting me speak today in support of HB 1072. If you have any questions I would be happy to answer them at this time.

Renae L. Byre
7941 County Road 15 West
Minot, ND 58703
phone: 701-721-0530
E-mail; rebyre@srt.com

#6

January 19, 2015

HOUSE HUMAN SERVICES COMMITTEE
HB 1072

CHAIRMAN WEISZ AND COMMITTEE MEMBERS:

My name is Jack McDonald. I'm appearing on behalf of America's Health Insurance Plans or, as it is commonly known, AHIP. AHIP is the national trade association representing the health insurance industry.

AHIP members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual and small group insurance markets, and public programs such as Medicare and Medicaid.

I am also doing double-duty this morning and am testifying on behalf of Prime Therapeutics.

We respectfully **oppose** this bill for three primary reasons:

1. Oral chemotherapy is significantly more expensive than traditional intravenous treatment.
2. Oral chemotherapy drugs pose concerns for patient safety.
3. The Affordable Care Act renders sections of HB 1072 unnecessary.

Oral chemotherapy is significantly more expensive than traditional intravenous treatment.

Pharmaceutical manufacturers charge as much as $10,000 per month for oral chemotherapy medications. According to 2009 estimates from Kaiser Permanente Colorado, their cost of treating 500 colon-rectal cancer patients with a full range of intravenous treatments and services would be $850,000. The cost of treating the same group with *oral* chemotherapy drugs would be more than $9 million.

The vast majority of oral chemotherapy drugs are branded prescriptions, making them the only drug available with no less expensive generic equivalent. This allows a pharmaceutical manufacturer to charge whatever it deems the market will bear for the drug, as there is no cost control or review for the costs of branded drugs.

In fact, *the Journal of Clinical Oncology* reported that, "With FDA approval occurring faster, and drug AWP [average wholesale pricing] increasing, we can only speculate that the drug companies are not pricing their drugs to recuperate losses associated with research and development, marketing, and operating prices, but rather AWP [cost] depends on what the market itself can bear."

Minimizing the costs of coverage for insureds such as state employees does not reduce the high costs of the drugs. It only shifts them to the purchaser -- in this case, the State of North Dakota – in the form of higher premiums.

Oral chemotherapy drugs pose concerns for patient safety.

Oral treatment shifts the responsibility for direct oversight of chemotherapy treatment away from physicians and nurses and onto patients and their care-givers, making monitoring for toxicity, dosage, frequency and side-effects much more difficult.

There are concerns regarding patient adherence to treatment regimens. A reduction in physician-patient interaction threatens the effectiveness of the patient's treatment plan.

The Affordable Care Act renders sections of HB 1072 unnecessary.

Consumer protections under the ACA establish annual out-of-pocket limits of no more than approximately $6,400 for individuals, $12,500 for families for all essential health benefits.

This out-of-pocket limit applies to oral chemotherapy medications as all prescription drugs are considered an essential health benefit under the ACA.

Because of these ACA requirements, patients will already have out-of-pocket cost sharing that is more predictable and capped, which makes the oral chemotherapy parity provisions in the bill unnecessary.

Thank you for your time and consideration. I'd be happy to answer any questions.

January 19, 2015 #7

Good morning Chairman Weisz and members of the House Human Services Committee. My name is Megan Houn. I am the Director of Government Relations for Blue Cross Blue Shield of North Dakota (BCBSND). I am here today to share our concerns on House Bill 1072, which proposes oral chemotherapy parity.

Blue Cross Blue Shield of North Dakota has been providing North Dakotans with quality, affordable health insurance for 75 years. During that time, we have worked together with health care providers, members, legislators and other stakeholders to provide North Dakotans with the quality and affordable care. BCBSND has maintained a clear focus on and commitment to our members. We have a longstanding history of promoting healthy lifestyles, for example, as The Official Sponsor of Recess, through the Healthy North Dakota worksite wellness initiative, the MediQHome quality program, our sponsorship of the Shoes for Kids program with the Fargo Marathon, and as evidenced in our support of prevention and early detection efforts. We have always and will continue to value the provider patient relationship. It should be noted that 97% of the providers in North Dakota are part of BCBSND's network. Additionally, North Dakota was ahead of the curve in extending coverage to children up to the age of 26 on their parents' policies long before the Affordable Care Act (ACA) required it. And, we continually hear about the richer benefits Blue Cross policyholders experienced prior to the selection of the benchmark plan in North Dakota. It should come as no surprise then that oral chemotherapy is covered by BCBSND and has been since it has been available in the marketplace.

The proposed legislation concerns us because it really isn't about our members. If you look at the facts, oral chemotherapy is a covered benefit despite being relatively new and high cost; the Affordable Care Act already caps out of pocket costs annually; and the North Dakota Insurance Department has received no complaints from consumers on this issue. This is a solution in search of a problem.

HB1072
January 19, 2015

So what and who is this bill about? According to a study published by the Journal of the American Medical Association, laws like the draft legislation before you are "at best an inadequate response to the more fundamental problem of the increasing costs of cancer medication." Rather than being about protecting our members, this bill draft is about the rising cost of pharmaceuticals, a lack of generic drugs, protecting brand name drugs and requiring payers to give pharmaceutical companies a blank check for those brand name drugs. The impact this type of pro-pharma legislation will have on our healthcare system is staggering. (This session alone, there are currently no less than four study proposals before the ND Legislature looking at the health care delivery system. An affordable and sustainable health care system is clearly a concern several of you have, and BCBSND shares that concern with you and is happy to partner to find innovative solutions.)

Pharmacy costs represent the fastest growing element of rising healthcare and health insurance expenses. Pharmaceutical manufacturers charge as much as $10,000 per month for oral chemotherapy medications. Much of those costs are never seen by patients. Currently, BCBSND members pay a very small portion of their pharmacy benefit, including oral and IV chemotherapy medication. In fact, in 2014 BCBSND paid $124.70 per day per member for oral chemotherapy drugs, while the average BCBSND member receiving oral chemo drugs paid $7.08. If I can just restate that, right now without passage of HB 1072, for every day that a member receives oral chemotherapy, the member pays about $7, while BCBSND's share is $125. So, assuming the majority of North Dakotans on oral chemotherapy are our members, they are not seeing the exorbitant out of pocket costs that might occur in other states.

Additionally, the Affordable Care Act sets annual out of pocket limits of $6,400 per individual and $12,500 for families for all services included in the Essential Health Benefits (EHB), which includes oral chemotherapy and prescriptions in addition to the other services covered like doctor visits, hospital stays, etc. Oral and IV chemotherapy parity is redundant in the era of ACA. All BCBSND plans are ACA-

compliant and include these protections for our members, or contain grandfathered cost-sharing limits. Due to the "Actuarial Value" classifications that ACA mandates, when cost sharing is reduced on one benefit, it must be increased somewhere else in the product to keep the product compliant.

BCBSND believes in the important role that doctors and healthcare professionals play in patient care. We believe in physicians having the freedom to choose with their patients the best course of treatment. In contrast, we do not believe that pharmaceutical companies choosing is always what is best for our members. Requiring that insurers alter benefit structures impedes our ability to control for clinical quality measures and prevent patient complications. Covering oral chemotherapy drugs under the pharmacy benefit allows our pharmacists to perform drug utilization reviews, and alert patients and physicians of any adverse effects to the use of these powerful and expensive drugs. These safety protocols are imperative for patients who take multiple drugs for multiple morbidities, as is the case with many cancer patients. Decisions on treatment appropriateness should be based on clinical evidence and not by mandates restricting utilization management. To state it more simply, we believe that the physician and the patient will choose what is best for the patient. We don't believe that the pharmaceutical companies choosing is what is best for our members.

As a member owned, not for profit insurance company, you can be assured that Blue Cross Blue Shield of North Dakota is not putting profits ahead of our members' best interests. We do not believe in restricting care to increase profits. As a nonprofit we are motivated by serving our members, not increasing profits.

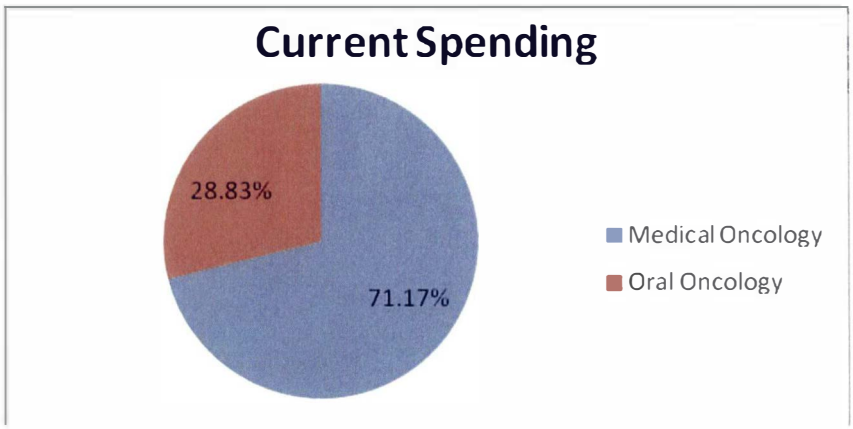
Legislative efforts that provide incentives to seeking more expensive oral medications will only serve to drive up costs for insurance companies, benefitting pharmaceutical companies and leading to potential premium increases for all members if cost-sharing options are limited by legislation. Essentially, HB 1072 will likely raise the cost of healthcare in our state rather than easing the burden on

North Dakotans, whether they have received a cancer diagnosis or not. BCBSND is supportive of oral chemotherapy as proven by our coverage of it since its inception. We already provide low out of pocket coverage. But we have serious concerns about the impacts that would arise from the passage of HB 1072. If the legislation allowed us to keep our benefit administration the same, we would be supportive of writing out of pocket caps into statute. Without this flexibility, HB 1072 as it is now written would ultimately lead to increased costs for health insurance companies, and likely higher premiums for hard working North Dakotans.

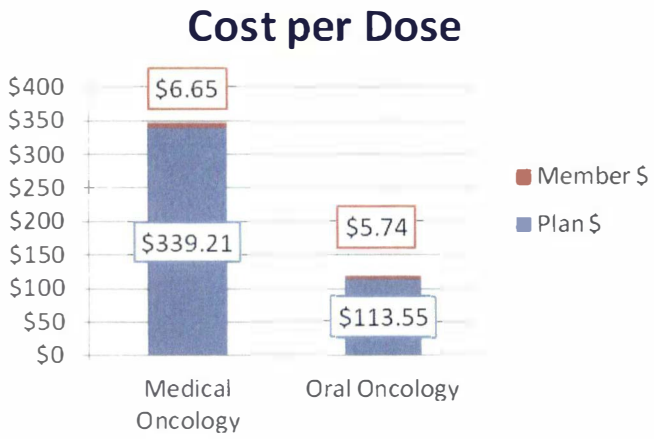
Megan Hoen HB 1072 January 19, 2015 #8

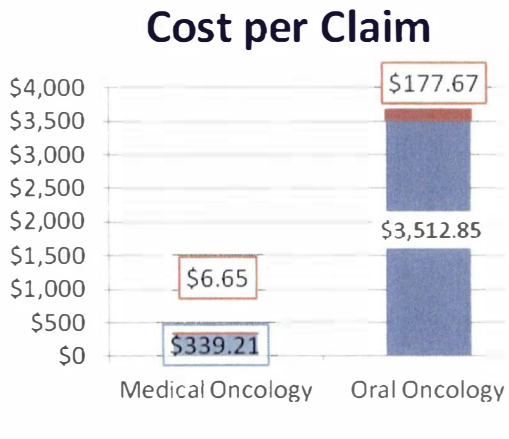
Oral Chemotherapy Parity: A Solution in Search of a Problem

BCBSND performed a comparison of pharmacy and medical claims for oral oncology and injectible (IV) oncology, between July 1, 2013 and June 30, 2014. The majority of oncology treatment occurred in a medical setting and was billed through members' medical benefits.

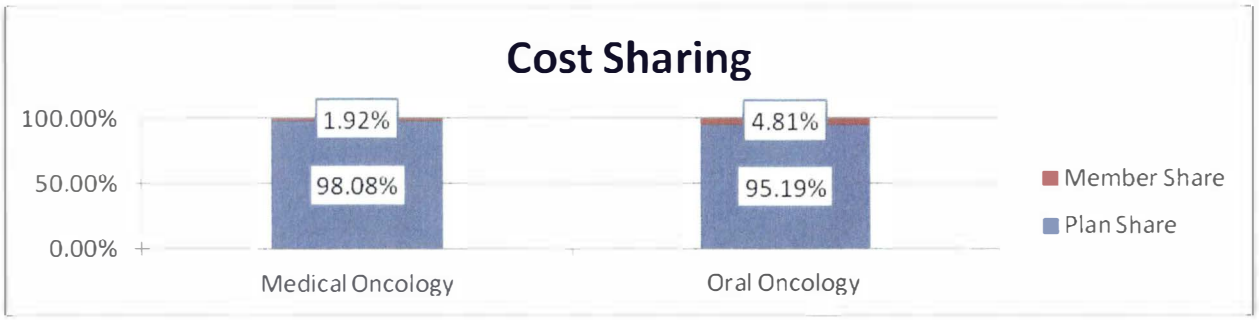


A medical claim consists of a single dose of chemotherapy. Treatment regimens specify various lengths of time between doses. Oral oncology pills are dispensed in various days supply based on the chemotherapy regimen. **Cost per Claim** and **Cost per Dose** contain significant differences due to the nature of provider billing.





The cost sharing applied in each oral oncology and medical (IV) oncology is minimal relative to total spending. Average oral oncology products cost members $5.74 per day. Medical oncology cost members $6.65 per dose.



#1

2/10/15

15.0117.04001
Title.

Prepared by the Legislative Council staff for
Representative Weisz
February 6, 2015

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1072

Page 1, line 19, replace "the" with ";

a. The"

Page 1, line 23, after "category" insert: "; or

b. The policy copayment, deductible, and coinsurance amounts for a month's supply of a patient-administered cancer treatment medication do not exceed one hundred dollars per filled prescription"

Renumber accordingly

1

Attach #1
HB 1072
03/11/15
J# 24637

Mr. Chairman and Members of the Committee,

My name is Al Wartner and I am pleased to be able to present my testimony to the Committee today.

I was raised in Harvey, North Dakota. At the conclusion of my working career, my wife and I purchased a retirement home in Jamestown. I assumed my retirement health care costs would be minimal as I was covered by Medicare health insurance and a Medicare Part D prescription drug plan.

In April 2013, I was diagnosed with one of the variations of lymphoma. As you know, different cancers require different treatments. If a patient needs oral chemotherapy, or other oral cancer drug they may be in for a rude awakening. My first surprise began shortly after my diagnosis. I traveled to MD Anderson Cancer Treatment center in Houston and met with the leading specialist in my disease. She prescribed an oral drug for my cancer. My then Part D Prescription Drug carrier required pre-authorization for the drug and refused to provide me the medication. They wanted me to undergo "step-therapy". I was to try several other drugs and if they failed, I could attempt an appeal of their original decision. I could not believe that an insurance company knew more about the medication I needed than the leading specialist.

I was "stuck" with that insurance company until the fall of the year 2013. At the end of each year, there is a time period that you are allowed to enroll in a new Part D plan. I searched diligently for a provider that would include the drug I needed in its formulary (If a drug is not in the providers formulary, you cannot obtain the drug unless they grant an exception). I found a provider whose formulary allowed the drug and did not require pre-authorization or step therapy.

However, I received my second surprise. The cost was extraordinary. I take 3 capsules per day. That is considered one-half of the normal dosage. As you may know, Part D prescription Drug plans are divided into three patient payment phases. In the initial payment phase, *my out of pocket cost* is $2960 for a one month supply, my cost in the next phase is $1740. I then reach the "catastrophic" phase and pay $1127.00 per month. Since my drug is considered a specialty drug, I basically pay 25% of the retail cost. There is no cap on my payments, except that the plan starts over each year. If it becomes necessary to take the full dosage, my out of pocket cost would double to $31,940 per year. Who can afford that?

If this drug could be administered to me intravenously, in a hospital setting, the drug would be covered by my hospitalization Insurance, rather than my prescription drug plan and the cost to me would be significantly less.

I don't think it makes sense that a cancer drug that is given orally, and is covered under a health plan prescription drug benefit, should cost significantly more than the same drug administered intravenously and covered under a health plan medical benefit. However, that is what happens to many cancer patients. Cancer care should be based upon the best treatment available.

1.2

You, your friends and family members may someday face a decision. Do they forego cancer treatment because the medication is orally administered? The Leukemia and Lymphoma Society reported that patients with out of pocket expenses of greater than $200 per prescription were three times less likely to fill a prescription for their oral anti-cancer drugs, compared with those with out of pocket expenses of $100 or less.

This legislation is not unique. The last I read, thirty-four states and the District of Columbia have adopted the legislation. Cancer care is continually evolving. About 30% of cancer medications are now oral. That percentage will continue to increase. Health insurance plans have not kept pace with their coverage of oral cancer drugs. As in my case, with my original Part D Provider, I had no support when I needed it.

Your cancer patient constituents need to be able to obtain the cancer drug that is most appropriate for their care. Their focus should not be on finding a way to pay for their care.

Thank you for your support of this legislation.

Attach #2
HB1072
03/11/15
J# 24637

Testimony in Support of Engrossed HB 1072
Senate Human Services Committee
March 11, 2015
Ken Tupa, American Cancer Society Cancer Action Network

Chairwoman Lee and members of the Senate Human Services Committee, my name is Ken Tupa and I am before you this morning on behalf of the American Cancer Society Cancer Action Network. Thank you for the opportunity to testify in support of Engrossed HB 1072.

I am here representing the 5,500 American Cancer Society Cancer Action Network advocates in North Dakota and the 3,840 North Dakotans who will be diagnosed with cancer this year. ACS CAN is just one of the many supporters of this legislation. Together we represent thousands of cancer patients, their families, and community members.

HB 1072 would modernize North Dakota's laws to keep up with the latest research and cancer treatment options by requiring in North Dakota that insurance plans cover cancer treatments to provide coverage for self administered, oral chemotherapy on a no less favorable basis than coverage for traditional IV chemotherapy.

We have made significant advances with our investments in cancer research. But, the advances in research mean nothing if the life-saving treatments are not reaching patients.

Historically, chemotherapy drugs have been primarily administered intravenously. Today, thanks to progress in cancer treatments, there are many types of chemotherapy that can be taken as a pill or liquid. And many of these therapies are the only appropriate treatment for certain types of cancer.

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. Today, oral oncology therapies comprise about 10% of the available therapies. It is estimated that 25% of the medications in the oncology development pipeline are oral therapies.

While research and technology continues to change the nature of medical treatment for serious diseases like cancer, many healthcare benefit plans have not adapted to ensure patient access. As a result, cancer patients face significantly higher out-of-pocket costs simply because their chemotherapy is dispensed orally rather than intravenously.

Physicians must be able to make the best choice for their patients, considering the unique aspects of each patient and the progress of the disease. Recent studies and surveys have revealed that oncologists consider patient out-of-pocket expenses when making prescribing decisions. Oral oncology parity laws allow many patients and physicians to choose the right therapy that offers the most hope—without

worrying about outdated health plan benefit designs that charge patients more simply because the therapy they need is only available in pill form.

HB 1072 fixes that problem and allows patients and their oncologists to decide on a course of treatment based on what is best for the patient.

As of this week, 35 states and the District of Columbia (DC) have passed legislation to limit patient out-of-pocket costs for oral anti-cancer medications and a number of others are expected to take action in 2015.

From the experience of other states, we have seen greater access to oral chemotherapy without impacting the cost of premiums. In the states with oral chemotherapy access legislation there is no evidence that this change has increased health insurance premiums for all beneficiaries.

Because of the convenience of oral chemotherapy, patient preference has been one of the main drivers in the increase in oral chemotherapy agents. Evidence shows that patients receiving traditional IV chemotherapy and their caregivers often have to miss work for treatment and managing side effects. Oral chemotherapy medications support patients' ability to continue working during and after treatments. These therapies are increasing survivorship but are also improving patients' quality of life and employment.

Updating North Dakota's laws so cancer patients can have better access to the advances in cancer care makes sense. We urge your support of HB 1072. Cancer patients cannot afford to wait any longer for North Dakota to join the other 35 states and the District of Columbia that have already passed legislation to address this issue.

I thank you for your time and I would be happy to answer any questions.

Attach #3

National Landscape of Caps on Patient Out-of-Pocket & State Oral Chemotherapy Parity Laws

STATE	ENACTMENT DATE	PARITY	CAP	MARKET PLACE PLANS EXCLUDED
Arizona	January 1, 2015	YES	NO	NO
California	**Effective Date:** January 1, 2015 **Sunsets:** January 1, 2019	NO	YES, $200.00 in 1st year. On 1/1/16, & on 1/1 each year after, allows for annual increase no more than Consumer Price Index (CPI).	NO
Colorado	January 1, 2011	YES	NO	NO
Connecticut	January 1, 2011	YES	NO	NO
District of Columbia	December 17, 2009	YES	NO	NO
Delaware	January 1, 2013	YES	NO	NO
Florida	July 1, 2014	NO	YES, $50.	NO
Georgia	July 1, 2015	NO	YES, $200.	NO
Hawaii	January 1, 2010	YES	NO	NO
Illinois	January 1, 2012	YES	NO	NO
Indiana	January 1, 2010	YES	NO	NO
Iowa	January 1, 2009	YES	NO	NO
Kansas	April 1, 2010	YES	NO	NO
Kentucky	January 1, 2015	NO	YES, $100.	NO
Louisiana	January 1, 2013	NO	YES, $100.	YES
Maine	January 1, 2015	YES	NO	NO
Maryland	October 1, 2012	YES	NO	NO
Massachusetts	May 1, 2013	YES	NO	NO

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STATE	ENACTMENT DATE	PARITY	CAP	MARKET PLACE PLANS EXCLUDED
Minnesota	May 14, 2010	YES	NO	NO
Missouri	January 1, 2015	NO	YES, $75. Allows for annual increase based on Consumer Price Index (CPI).	NO
Nebraska	Effective Date: October 1, 2012 Sunset Date: January 1, 2015* *Bill exist to end sunset.	YES	NO	NO
New Jersey	July 16, 2012	YES	NO	NO
New Mexico	June 17, 2011	YES	NO	NO
Nevada	January 1, 2015	NO	YES, $100.	NO
New York	January 1, 2012	YES	NO	NO
Ohio	January 1, 2015	NO	YES, $100.	NO
Oklahoma	November 1, 2013	YES	YES, $100.	NO
Oregon	January 1, 2008	YES	NO	NO
Rhode Island	January 1, 2014	YES	NO	NO
Texas	September 1, 2011	YES	NO	YES
Utah	October 1, 2013	NO	YES, $300.	NO

STATE	ENACTMENT DATE	PARITY	CAP	MARKET PLACE PLANS EXCLUDED
Vermont	April 1, 2010	YES	NO	NO
Virginia	July 1, 2012	YES	NO	NO
Washington	January 1, 2012	YES	NO	NO
Wisconsin	January 1, 2015	NO	YES, $100.	NO

Attach #4
HB1072
03/11/15
J#24637

Senate Human Services Committee
March 11, 2015
Testimony in Support of HB 1072

Chairman Lee and members of the Senate Human Services committee;

My name is Renae Byre and I am a resident of district 38. Today I am here to ask you to recommend a **"do pass" for House Bill 1072.**

I wear many hats; one of those hats is cancer patient.

At the age of 38, I was first diagnosed with breast cancer. I went through multiple surgeries, IV chemotherapies, radiation and daily medications for several years. Five years later, I was experiencing breathing problems. A biopsy of my lung lining showed my cancer was back. A PET scan also confirmed that I have metastatic breast cancer. This means I will be battling cancer and taking some kind of treatment the rest of my life.

Upon my diagnosis in 2009, my oncologist determined that the best course of medication was an oral chemotherapy called Xeoloda.

I will never forget the day I went to the pharmacy to fill my prescription. Although I was a little concerned about the cost, I thought I had good insurance. **I was not prepared to hear my medication would cost me about $4000.00 out of pocket**. This was as devastating to me as finding out my cancer had returned. I remember thinking, "well, I guess I'll just die!" Luckily, I have a very resourceful Aunt. She found a program through the drug company that could assist in reducing my cost for treatment.

Xeoloda was very successful at treating my cancer; I only needed to be on the drug for about 4 months. It was possible that I might have needed it for much longer than that. For the

4.2

last five years I have received an IV of Herceptin every 4 weeks as a maintenance plan for the metastatic breast cancer, in hopes of slowing any mutations.

This past October, we found out the cancer cells mutated once again. This time my oncologist has me taking an IV chemotherapy for treatment. Today, I am half way through treatment and the results have been good. In late February, my new maintenance plan will be a combination of two different IV drugs every three weeks for the rest of my life or until the cancer mutates again. There is no telling what treatments I might need in the future, or what new drugs will be available that can help patients like me. I know that someday, it's a real possibility that I will need oral chemotherapy again.

I want to live long enough see my baby, who was in Kindergarten during my first diagnosis, graduate from high school. I want to see my children grown up, get married, and have children of their own.

No cancer patients, myself included, should have to choose between what the doctor determines as the best course of treatment and which one they can afford. Please support cancer patients by making sure all chemotherapy treatments are covered the same.

Thank you for letting me speak today in support of HB 1072. If you have any questions I would be happy to answer them at this time.

Renae L. Byre
7941 County Road 15 West
Minot, ND 58703
phone: 701-721-0530
E-mail; rebyre@srt.com

Attach#5
HB1072
03/11/15
J# 24637

Senate Human Services Committee
Wednesday, March 11, 2015
Support for HB 1072

Good morning, Chairman Lee and members of the Senate Human Services Committee.

My name is Ellen Schafer and I have been an oncology nurse for 30 years in Bismarck. I retired a few years ago from oncology, but I continue working with home healthcare and hospice. In my time as an oncology nurse, I have seen patients suffer the effects of intravenous chemotherapy treatment. The fatigue and nausea can be so severe, patients sometimes miss work. Prior to new advances in anti-nausea medication, I saw patients who would get sick before treatment just knowing how sick they were going to get FROM the treatments.

In a rural state like North Dakota, many patients travel several hours from their home for treatment. Patients then spend several hours sitting in a chair hooked up to an IV to receive their chemotherapy. There are many complications that come with intravenous treatment. Sometimes after traveling several hours, patients are sent home without treatment because their white blood cell count is not high enough to give them chemotherapy. These patients have to come back another day for treatment. Patients with ports for receiving intravenous chemotherapy are at a constant risk for infection. All the time they spent traveling and recovering from treatment affects employers and can affect patient's incomes. The costs of traveling and missing work can be significant for patients.

Cancer treatment not only affects the patients, but caregivers too. Caregivers also have to take time away from work to take patients to and from treatment. Caregivers experience emotional stress and fatigue from seeing their loved ones fighting for their lives.

Patients taking oral chemotherapy have the benefit of taking their chemotherapy from home under the supervision of a doctor. They require fewer trips to treatment facilities, and that means more time to spend with family. Less travel time, also means more time to work and be productive. But the cost of oral chemotherapy can prevent patients who need these treatments from taking them to save their lives.

5.2

You have the power to give patients affordable access to oral anti-cancer drugs so that they can have the latest treatments available in the fight against cancer, without high out-of-pocket costs. Not everyone has extra money for huge prescription bills and many will decide not to continue treatment if they believe they are forcing their family into poverty. Patients already experience a juggling act that comes with the high cost of cancer treatment. They should not have to worry about paying for the treatment that may save their life as part of that juggling act.

When we consider the minimal cost of this bill to premiums, we should take into consideration the cost of a productive life.

Please vote yes on HB 1072. Thank you for your time today. I would be happy to answer any questions you have.

Ellen Schafer
815 Munich Drive
Bismarck, ND 58504
Ph. 701-224-1793
deschafer@msn.com

Attach#6
HB 1072
03/11/15
J# 24637

Senate Human Services Committee
March 11, 2015
Support for HB 1072

Good morning, Chairman Lee and members of the Senate Human Services Committee. My name is Diane Schaeffer, I am a cancer survivor and I am asking you to vote yes on HB 1072.

Last year I retired after working as an oncology nurse for 25 years. In my time as an oncology nurse, I treated thousands of patients with intravenous chemotherapy. But it was my own diagnosis of breast cancer 5 years ago that gives me the courage to stand before you today to speak on behalf of cancer patients, past, present, and future.

I was diagnosed with an aggressive form of breast cancer known as HER-2 positive. This type of breast cancer is not hormone based. After 3 ½ months of chemotherapy, I had to follow up with one year of treatment with Herceptin. Herceptin is a biologic response modifier that I was given by IV once every 3 weeks for a year to keep cancer cells from reproducing uncontrollably in my body. This treatment is fairly new and was very expensive. Had I been diagnosed 10 years earlier, I may not be here today.

As a cancer survivor, I am excited that there are new and much needed cancer treatments developing each year. This means some cancers that had little hope, now have options for patients who will survive to live productive and meaningful lives. This legislation is important to me as a cancer survivor. If I or another member of my family ever needs oral chemotherapy, I want to know that the treatment will not be financially devastating, regardless of whether it's intravenous or a pill.

Cancer patients in several other states are lucky to know that they have fair coverage for both intravenous and oral chemotherapy. I love living in North Dakota, we have a great state. As a citizen and cancer survivor, I ask you to make life better for cancer patients in North Dakota.

We all have hope that one day there will be a cure for cancer, but in the meantime you can make sure patients are getting the best treatments possible. You can make sure cancer patients can afford their treatment. Please vote yes on HB 1072 and make this bill an issue of chemo fairness.

Thank you for allowing me to speak to this issue.

Diane Schaeffer
713 East Avenue F.
Bismarck, ND 58501
Ph. 701-255-4731
dianeschaeffer194973@q.com

Attach#7
HB1072
03/11/15
J#24637

Senate Human Services Committee
March 11, 2015
In support of HB 1072

Chairman Lee and members of the Senate Human Services Committee, my name is Corinna Larson and I'm here on behalf of the Missouri Valley Oncology Nursing Society (ONS) in support of HB 1072. This pertains to financial coverage of oral anti-cancer medications as a standard of care for cancer patients.

Traditionally, anti-cancer medications are primarily administered intravenously (IV) and covered under a health plan's medical benefit with minimal co-pay or no cost to the patient. As research on anti-cancer medications advances more oral anti-cancer medications are becoming available. These medications are generally covered by the health plan's pharmacy benefit rather than the medical benefit, which results in significant out-of-pocket costs.

If you were to walk in the shoes of a patient receiving IV anti-cancer treatment you would see a patient receiving a surgical procedure to have permanent IV access placed. This puts the patient at higher risk for surgical complications and/or infection. This also is an additional expense for both the insurance company and the patient. The patient is then required to receive monthly maintenance on the IV access line that must be completed by a nurse. The patient would travel to the nearest cancer treatment facility which can be more than 100 miles in one direction. This patient might face exposure to other illnesses (influenza, common colds, bacteria, etc.) or hospital acquired infection when they are going into treatment centers while in an immunocompromised state. They receive pre-medications that make them drowsy prior to the anti-cancer medication administration. Depending on the medication the patient receives they can spend anywhere from 30 minutes to 8 hours at the cancer treatment center. The patient generally needs a family member o friend present with them to drive them to and from treatment which requires the patient to be dependent upon someone else's schedule. Travel expenses are incurred for each treatment. This cycle is then repeated every one to three weeks depending on the regimen the patient is receiving. For many patients this is a regimen that they will undergo for the remainder of their lives.

In contrast, a patient receiving an oral anti-cancer medication simply has to receive the medication from the pharmacy and take as prescribed. This convenience saves the patient and the caregiver a significant amount of time and money, thus improving the quality of life.

Oral anti-cancer agents are not appropriate for every patient. The best treatment option is selected by the physician and the patient and will provide the patient the most effective care with the least amount of hardship. For many patients, financial burden is a determining factor in treatment. As described above, oral anti-cancer treatments are currently covered by a pharmacy

7.2

benefit which results in extremely high out-of-pocket costs for the patient. High out-of-pocket expenses decrease the patient's ability to fill the prescription, forcing the patient to choose the treatment that is most affordable rather than most effective for their individual situation. This may mean that the patient will decline treatment leading to an early death rather than a cure. HB 1072 would empower the patient to make affordable healthcare choices without compromising their health or quality of life.

Please support HB 1072.

Thank you for your time today, and I would be happy to answer any questions.

Corinna Larson

Attach #8
HB 1072
03/11/15
JH 24637

HB 1072

Senate Human Services Committee

Good morning Madam Chair and members of the Senate Human Services Committee. My name is Megan Houn. I am the Director of Government Relations for Blue Cross Blue Shield of North Dakota (BCBSND). I am here today to share some general concerns with House Bill 1072.

Blue Cross Blue Shield of North Dakota has been providing North Dakotans with quality, affordable health insurance for 75 years. During that time, we have worked together with health care providers, members, legislators and other stakeholders to provide North Dakotans with the quality and affordable care. We have always and will continue to value the provider patient relationship. It should be noted that 99.6% of the providers in North Dakota are part of BCBSND's network. Additionally, North Dakota was ahead of the curve in extending coverage to children up to the age of 26 on their parents' policies long before the Affordable Care Act (ACA) required it. And, we continually hear about the richer benefits Blue Cross policyholders experienced prior to the selection of the benchmark plan in North Dakota. It should come as no surprise then that oral chemotherapy is covered by BCBSND and has been since it has been available in the marketplace.

The proposed legislation concerns us because it really isn't about our members. If you look at the facts, oral chemotherapy is a covered benefit despite being relatively new and high cost; the Affordable Care Act already caps out of pocket costs annually; and the North Dakota Insurance Department has received no complaints from consumers on this issue.

An affordable and sustainable health care system is clearly a concern of all of us. In an effort to address this issue, BCBSND has implemented a number of innovative cost containment initiatives over the last few years, including Healthy Blue, Worksite Wellness, and the MediQHome quality program.

8.2

Pharmacy costs represent the fastest growing element of rising healthcare and health insurance expenses. Pharmaceutical manufacturers charge as much as $10,000 per month for oral chemotherapy medications. See attached, *Then and Now: The cost of prescription drugs.* Much of those costs are never seen by patients. Currently, BCBSND members pay a very small portion of their pharmacy benefit, including oral and IV chemotherapy medication. In fact, in 2014 BCBSND paid $124.70 per day per member for oral chemotherapy drugs, while the average BCBSND member receiving oral chemo drugs paid $7.08. If I can just restate that, right now without passage of HB 1072, for every day that a member receives oral chemotherapy, the member pays about $7, while BCBSND's share is $125. So, assuming the majority of North Dakotans on oral chemotherapy are our members, they are not seeing the exorbitant out of pocket costs that might occur in other states.

Additionally, the Affordable Care Act sets annual out of pocket limits of $6,400 per individual and $12,500 for families for all services included in the Essential Health Benefits (EHB), which includes oral chemotherapy and prescriptions in addition to the other services covered like doctor visits, hospital stays, etc. All BCBSND plans are ACA-compliant and include these protections for our members, or contain grandfathered cost-sharing limits. Due to the "Actuarial Value" classifications that ACA mandates, when cost sharing is reduced on one benefit, it must be increased somewhere else in the product to keep the product compliant.

BCBSND believes in the important role that doctors and healthcare professionals play in patient care. We believe in physicians having the freedom to choose with their patients the best course of treatment. In contrast, we do not believe there is a place for pharmaceutical companies in that relationship. Requiring that insurers alter benefit structures impedes our ability to control for clinical quality measures and prevent patient complications. Covering oral chemotherapy drugs under the pharmacy benefit allows our pharmacists to perform drug utilization reviews, and alert patients and physicians of any adverse effects to the use of these powerful and expensive drugs. These safety protocols are imperative for patients who take multiple drugs for multiple morbidities, as is the case with many cancer patients. Decisions on treatment

appropriateness should be based on clinical evidence and not by mandates restricting utilization management.

As a member owned, not for profit insurance company, you can be assured that Blue Cross Blue Shield of North Dakota is not putting profits ahead of our members' best interests. We do not believe in restricting care to increase profits. As a nonprofit we are motivated by serving our members, not increasing profits.

Legislative efforts that provide incentives to seeking more expensive oral medications will only serve to drive up costs for insurance companies, benefitting pharmaceutical companies and leading to potential premium increases for all members if cost-sharing options are limited by legislation. Essentially, HB 1072 will likely raise the cost of healthcare in our state rather than easing the burden on North Dakotans, whether they have received a cancer diagnosis or not. BCBSND is supportive of oral chemotherapy as proven by our coverage of it since its inception. We already provide low out of pocket coverage. But we have serious concerns about the impacts that would arise from the passage of HB 1072. In addition to increased health care costs, HB 1072 gives preferential "status" to oncology drugs, which sets a dangerous precedent. Nothing prevents other special interest groups from lining up in subsequent legislative sessions to demand the same treatment for their pharmaceuticals. Protecting an expensive class of drugs will only lead to more expensive drugs. HB 1072 as it is now written would ultimately lead to increased costs for health insurance companies, and likely higher premiums for hard working North Dakotans.

Finally, we are greatly concerned with Section 3 of this bill, which states that this mandate will not be subject to section 54-03-28, which would require that the public employee's retirement system would study the effect of the cancer treatment medication coverage requirements for a two year trial. Frankly, this is a head scratcher to us. Why would the legislature not want to follow the process which it established which allows it to conduct a cost/benefit analysis on the NDPERS health plan prior to full implementation of a law? This has proven to be a highly beneficial requirement and the removal of this section runs contrary to the desire to hold health care costs down for North Dakota taxpayers.

8.4

Thank you for your time. I am happy to take your questions.

AHIP

8.5

Then and Now: The cost of prescription drugs

Despite the introduction of new, and in many cases more innovative medical treatments, prescription drugs that have been around for years continue to get more and more expensive. And what about claims of innovation when the price of one drug can rise by an astounding 9,145 percent in only six months? 9,145 percent, really? This is just one example that we have highlighted below that shows while the drugs may have stayed the same -- their price tags skyrocketed.

Doxycycline in 2013
$20 per bottle

9,145%
increase

Doxycycline in 2014
$1,849 per bottle

H.P. Acthar Gel in 2007
$700 per vial

4,471%
increase

H.P. Acthar Gel in 2014
$32,000 per vial

U-500 in 2007
$220 per bottle

445%
increase

U-500 in 2014
$1,200 per bottle

EpiPen in 2007
$56.64 per pen

222%
increase

EpiPen in 2014
$184.35 per pen

Benicar in 2007
$2.25 per pill

164%
increase

Benicar in 2014
$5.95 per pill

Gleevac in 2007
$118 per pill

158%
increase

Gleevac in 2014
$306 per pill

Copaxone in 2008
$2,358.60
per 30 syringes

157%
increase

Copaxone in 2014
$6,072.40
per 30 syringes

Sources:
New York Times, "Doctors Denounce Cancer Drug Prices of $100,000 a Year". April 25, 2013
New York Times, "Prices Soaring for Specialty Drugs, Researchers Find". April 15, 2014
Bloomberg, "Drug Prices Soar for Top-Selling Brands". May 1, 2014
New York Times, "The Price of Prevention: Vaccine Costs Are Soaring". July 2, 2014
ProPublica, "The Obscure Drug with a Growing Medicare Tab". Aug. 4, 2014
Forbes, "Could High Drug Prices Be Bad for Innovation?" Oct. 23, 2014

8.6

The New York Times http://nyti.ms/1xr4fS2

The Opinion Pages | OP-ED CONTRIBUTOR

Why Drugs Cost So Much

By PETER B. BACH JAN. 14, 2015

ELI LILLY charges more than $13,000 a month for Cyramza, the newest drug to treat stomach cancer. The latest medicine for lung cancer, Novartis's Zykadia, costs almost $14,000 a month. Amgen's Blincyto, for leukemia, will cost $64,000 a month.

Why? Drug manufacturers blame high prices on the complexity of biology, government regulations and shareholder expectations for high profit margins. In other words, they say, they are hamstrung. But there's a simpler explanation.

Companies are taking advantage of a mix of laws that force insurers to include essentially all expensive drugs in their policies, and a philosophy that demands that every new health care product be available to everyone, no matter how little it helps or how much it costs. Anything else and we're talking death panels.

Examples of companies exploiting these fault lines abound. An article in The New England Journal of Medicine last fall focused on how companies buy up the rights to old, inexpensive generic drugs, lock out competitors and raise prices. For instance, albendazole, a drug for certain kinds of parasitic infection, was approved back in 1996. As recently as 2010, its average wholesale cost was $5.92 per day. By 2013, it had risen to $119.58.

Novartis, the company that makes the leukemia drug Gleevec, keeps raising the drug's price, even though the drug has already delivered billions in profit to the company. In 2001 Novartis charged $4,540, in 2014 dollars, for a month of treatment; now it charges $8,488. In its pricing, Novartis is just keeping up with other companies as they charge more and more for their drugs. They know we can't say no.

But what if we didn't require insurance companies to cover all drugs? We can see the answer in Europe. Many European countries say no to a handful of drugs

8.1

each year, usually those that are both pretty ineffective and highly costly. Because they can say no, yes is not a guarantee. So companies have to offer their drugs at prices that make them attractive to these health care systems. A recent survey of cancer drug policies revealed you don't have to say no very often to get discounts for saying yes. Of the 29 major cancer drugs included in the study that are available in the United States, an estimated 97 percent and 86 percent are also available in Germany and France, respectively.

As a consequence of the stand taken by those countries, prices in Europe for prescription drugs are 50 percent below what we pay, according to a McKinsey study from 2008. Gleevec costs $4,500 per month in Germany today, and $3,300 per month in France, less than what Americans paid in 2001.

Saying no, or even the threat, works to lower prices in the United States, too. But it's rare. In 2012, my hospital said we wouldn't give the colon cancer drug Zaltrap to our patients because it cost twice as much as another drug (Genentech's Avastin) that was just as good. When we refused to use it, the company realized that other cancer hospitals and doctors might follow, and halved its price nationwide.

More recently, Express Scripts, a company that manages pharmacy benefits, showed that approval was no guarantee. It was therefore able to play two makers of treatments for hepatitis C off against each other. Express Scripts said yes to AbbVie's Viekira Pak (for the most common subtype, genotype 1 disease), and said no to Gilead's Sovaldi and Harvoni. Another pharmacy benefit program, CVS Caremark, played it the other way, closing out AbbVie and choosing Gilead.

Either way, the lesson is that Express Scripts, once it showed it could say no, got AbbVie to discount its product. It isn't saying how much, but Steve Miller, a senior executive, said it had "significantly narrowed the gap between prices charged in the United States and Western Europe." Sounds like the kind of progress we need.

You might worry about patients being harmed through these moves. But we rejected Zaltrap knowing it was no better than the alternative. Express Scripts and CVS Caremark played the two drug manufacturers off against each other because both manufacture effective treatments.

The industry might argue that drug spending is only 10 percent of all health care spending, but that 10 percent equals around $300 billion per year. More important, the costs of high-priced drugs are being passed on to patients. Lilly's drug Cyramza will cost the average Medicare patient $2,600 per month without supplemental

8.8

insurance. That's more than most Medicare-age people earn each month, before taxes. Actually, high prices get passed on to us all, either through individual costs or insurance.

That leaves us with two options. We can free insurers and government programs from the requirement to include all expensive drugs in their plans as we explain to the public that some drugs are not effective enough to justify their price. If we do this, we can be confident that manufacturers will lower their prices to ensure their ability to sell their products. Or we can piggyback on the gumption of bolder countries, and demand that policy makers set drug prices in the United States equal to those of Western Europe. Either approach would be vastly superior to the situation we have today.

Peter B. Bach is a physician and director of the Center for Health Policy and Outcomes at Memorial Sloan Kettering Cancer Center.

A version of this op-ed appears in print on January 15, 2015, on page A29 of the New York edition with the headline: Why Drugs Cost So Much

Attach #9

GNDC
Greater North Dakota Chamber

HB1072
03/11/15
J# 24637

Testimony of Laney Herauf
Greater North Dakota Chamber of Commerce
HB 1072
March 11, 2015

Madam Chair and members of the committee, my name is Laney Herauf. I am the Government and Regulatory Affairs Specialist at the Greater North Dakota Chamber, the champions for business in North Dakota. GNDC is working on behalf of our more than 1,100 members, to build the strongest business environment in North Dakota. GNDC also represents the National Association of Manufacturers and works closely with the U.S. Chamber of Commerce. As a group we oppose HB 1072.

This bill seeks to create unnecessary parity between oral and intravenous or injected chemotherapy. This is unnecessary as, while they are treating the same condition, they are two different forms of medication. Oral chemotherapy is already covered by North Dakota health insurances. Blue Cross Blue Shield covers oral chemotherapy at a cost of $125 to them and $7 to the member.

This bill essentially imposes another mandate on our insurance companies by forcing parity. The only way to ensure parity is to completely zero out and have insurance pay the entirety of both chemotherapies. This will increase the cost of healthcare to all. Further, the ND Department of Insurance has not had any complaints on the issue.

HB 1072 is not about cancer patients. It's about a policy that would affect our health insurance industry. This is an issue that is between drug companies and insurance companies, with the end result being higher healthcare costs to the consumer. I respectfully request a DO NOT PASS recommendation on HB 1072.

Champions for Business

PO Box 2639
Bismarck, ND 58502

P: 701-222-0929
F: 701-222-1611

www.ndchamber.com

Attach #10
HB1072

HB 1072 (OPPOSE)
Senate Human Services Committee

March 11, 2015
J#24637

Caps for Prescription Co-pay

Legislation to limit patient cost sharing for drugs will INCREASE premiums.

HB 1072 was amended to include a co-pay cap for a specific subset of medications. This "co-pay cap" strategy is being used across the country and is a fundamental shift in the cost structure for pharmaceuticals and deserves a full, thorough vetting before it becomes law.

What the bills do:
Artificially caps patient cost sharing (co-pays, coinsurance, and deductibles) for prescription drugs.

The Impact – Premiums Will Increase:
Setting artificially low patient cost sharing caps shifts the cost from the patient to the rest of the insured population. ***The patient pays less up front, but EVERYONE pays more.*** All plans, both public and private, will see an increase in premiums if cost sharing caps are implemented.

Limiting patient cost sharing removes one of the tools that employers and plan sponsors have to control health insurance costs. The consumer is a key part of controlling national healthcare costs. Cost share caps is antithetical to employing the consumer to help control costs. Establishing a coinsurance is an incentive for drug manufacturers to compete for a lower price.

HB 1072 will increase costs to state plans; capping co-pays doesn't reduce drug prices, it increases costs to state plans and other payers. HB 1072 will drive patients to more expensive brand name drugs and away from generics by removing the patient's incentive to be cost-conscious consumers.

Why you should oppose co-pay caps:
These bills don't address the underlying issue – the price of high cost prescription drugs. Patient cost sharing is an incentive for drug manufacturers to price their products competitively. Establishing these limits remove the incentive and allows drug manufacturers to price at an elevated rate.

Drug prices and utilization will continue to increase and the gap between the price and patient cost sharing will continue to widen. This will create even higher premiums in future years.

Finally, the ACA established maximum out of pocket expenses. This is not an unregulated corner of the market. Patient protections already exist.

Process Concerns:
The North Dakota Legislature should provide open and competitive markets forces to serve the health-product consumer of North Dakota. It should not foster a policy that guarantees larger profits for drug companies. A major policy shift, such as caps for prescription co-pay, should be pursued in an open, transparent process, rather than as an amendment that did not have a rigorous public vetting before a Legislative Committee.

Attach #11
HB1072
03/11/15
J#24637

International Myeloma Foundation

International
Myeloma
Foundation

Memorandum in Support

The International Myeloma Foundation Supports Equal Access to All Cancer Killing Treatments: Increasing Access to Oral Chemotherapies in North Dakota

The International Myeloma Foundation (IMF), the oldest and largest foundation dedicated to improving the quality of life of multiple myeloma patients while working toward prevention and a cure, strongly urges you to support HB 1072 to eliminate the cost disparity between oral and intravenous anticancer medications, ensuring access to all anticancer medications for all cancer patients.

Affordable access to FDA-approved oral anticancer medications will save countless lives and in the case of myeloma, oral treatments do NOT have intravenous substitutes, forcing patients to absorb thousands of dollars per month out-of-pocket or forgo treatment altogether. Passing legislation in North Dakota that requires health insurers to establish equal out-of-pocket requirements for oral and intravenous anticancer medications, will level the playing field for all cancer patients and ensure they no longer have to worry about accessing and affording care when faced with a cancer diagnosis.

The second most common blood cancer worldwide, multiple myeloma (or myeloma) is a cancer of plasma cells in the bone marrow. It is called "multiple" as the cancer can occur at multiple sites in multiple bones. In 2015 it is estimated that over 26,000 Americans will be diagnosed with myeloma and almost half will lose this battle with this disease. Once a disease of the elderly, it is now being found, in increasing numbers, in people under 65. Fortunately, we have seen dramatic and important advances in treatments for multiple myeloma. However, the needless disparity in coverage between oral drugs and intravenous chemotherapy is a critical issue for many of our patients.

The IMF believes patients and their doctors should be able to take advantage of the treatment that is best for the patient, and not have to select their treatment based on insurance coverage. We extend our sincere gratitude to Senator Dick Dever, for his leadership on this issue and for sponsoring HB 1072. This bill will ensure that all cancer patients in North Dakota have equal access to all anticancer treatments, regardless of how it is administered.

We strongly urge you to support legislation to ensure equality of access and for ALL cancer patients in North Dakota. 35 states plus the District of Columbia have passed oral chemotherapy access bills and we urge North Dakota to join their ranks.

For more information, please contact Laena Shakarian at lshakarian@myeloma.org

12650 Riverside Drive Suite 206, North Hollywood, CA 91607
800-452-CURE (2873)
818-487-7455 telephone 818-487-7454 fax
www.myeloma.org

HB1072
Attach #12
03/11/15
J# 24637

Leukemia & Lymphoma Society -Christina Lee

From: Lee, Christina (National Office) [mailto:Christina.Lee@lls.org]
Sent: Thursday, February 26, 2015 1:51 PM
To: Lee, Judy E.
Subject: Please support HB 1072

Good afternoon Sen. Lee,

Please find attached The Leukemia & Lymphoma Society (LLS) testimonial support for HB 1072, submitted in committee. This issue of self-administered anti-cancer medication parity is important to LLS blood cancer patients and imperative it passes. Patients rely heavily on effective and accessible treatment since there is no cure or prevention for many blood cancers. Often times, there are no intravenous or generic alternatives to these life-saving medications.

Allowing equal coverage will ensure that patients are not discriminated against purely based on how the drug is administered. Please consider supporting this issue and joining the 34 other states and D.C. that have created fair access to oral chemo meds. Wyoming just passed a bill this week and it awaits a governor's signature to become the 35th state. Let's be the 36th in North Dakota!

Please let me know if you have any other questions or would like further information on this important access issue. We look forward to your support of HB 1072.

Sincerely,
Christina

:: **Christina Lee | Director, Government Affairs, Midwest**
:: The Leukemia & Lymphoma Society | Office of Public Policy
:: Cell (914) 420-0135 | www.lls.org | christina.lee@lls.org

LEUKEMIA & LYMPHOMA SOCIETY®
fighting blood cancers

www.LLS.org

Testimony of the Leukemia and Lymphoma Society on H.B. 1072

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. Approximately one-quarter of all cancer drugs under development are oral, patient-administered treatments, and there is a growing trend toward development of these therapies. Many patients prefer oral medications, as they often have a lower risk of complications as compared to IV counterparts as well as having fewer side effects. 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.

H.B. 1072 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.

No Statistically Relevant Premium Increases Have Been Seen

To date, 34 other states plus the District of Columbia have passed similar bills and implemented the law. Included below 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 most appropriate treatment for them.

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Studies conducted by the Insurance Departments in California, Colorado, Connecticut, Illinois, Indiana, Kansas, Massachusetts, Oregon, Texas, Vermont and Washington state sought evidence that implementation of oral chemotherapy access laws increased health insurance premiums and found there has been no anecdotal evidence of increases. Only two states (Connecticut and the state of Washington) reported a 0.2% increase in premiums.

The Affordable Care Act Does Not Fix This Challenge Facing Patients

Another common question is how the Affordable Care Act (ACA) affects State parity laws. Although the ACA does place an annual out-of-pocket maximum for in-network expenses of $6,600 per individual, this does nothing to address a patient's struggle with the cost of their anti-cancer treatment each month. By supporting this bill, you will help solve the monthly out-of-pocket financial burden for patients.

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[1]. This suggests that exorbitant co-insurance requirements will likely prevent many patients from ever filling even their first prescription because they cannot afford the cost. This can mean a choice between filling their prescription and paying their mortgage. An annual out-of-pocket maximum simply does not protect against the barriers created by excessive patient co-insurance requirements.

H.B. 1072 provides critical patient protections for those suffering from cancer – on behalf of the estimated 3,400 North Dakotans who will be newly diagnosed with a cancer in 2015, The Leukemia & Lymphoma Society urges your support to remove barriers to access for our patients and their families.

[1] Streeter, et al. "Patient and Plan Characteristics Affecting Abandonment of Oral Oncolytic Prescriptions." American Journal of Managed Care, *SP 38*, May 2011

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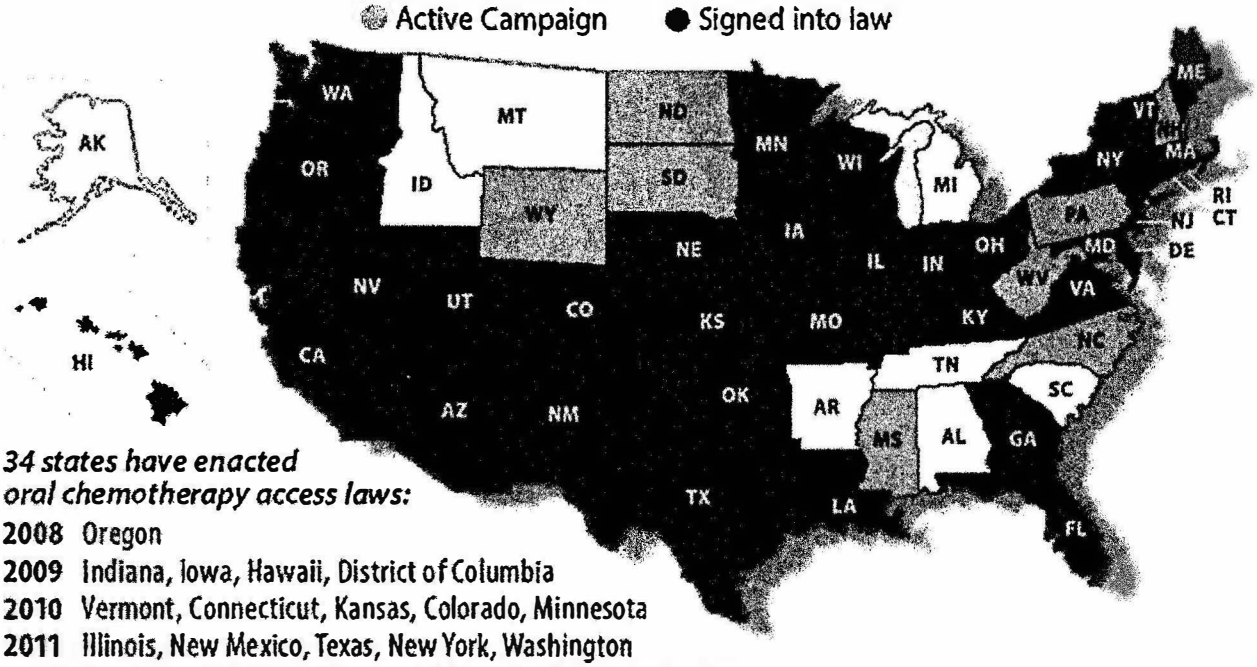
Oral Chemotherapy Access Legislative Landscape – September 2014



34 states have enacted oral chemotherapy access laws:

2008 Oregon
2009 Indiana, Iowa, Hawaii, District of Columbia
2010 Vermont, Connecticut, Kansas, Colorado, Minnesota
2011 Illinois, New Mexico, Texas, New York, Washington
2012 New Jersey, Virginia, Maryland, Nebraska, Delaware, Louisiana
2013 Massachusetts, Oklahoma, Utah, Nevada, Florida, Rhode Island, California
2014 Maine, Missouri, Wisconsin, Kentucky, Georgia, Arizona, Ohio

Attach #13
HB1072
03/11/2015
J# 24637

March 5, 2015

Klatt, Nancy

To: Chairman Judy Lee and members of the Senate Human Services Committee

I am a Registered Nurse, the Manager of Altru Cancer Center for the past 16 years, and have worked with people diagnosed with cancer for nearly 40 years, so have seen many changes in the Oncology treatment world.

I am writing in regard to HB 1072 regarding oral chemotherapy parity. Oral chemotherapy medications are increasing in number at a very high level, and this is expected to continue at a rapid pace. Many new medications are in various stages of research and development. Oral chemotherapy medications are convenient for patients as they require fewer trips to a cancer treatment facility, however there are many issues with this form of cancer treatment. One major issue is the cost to patients. While Intravenous medications are generally covered by health insurance, oral medications are generally not. The oral medications generally are under the patient's pharmacy benefit often resulting in much greater out of pocket costs ranging into several thousand dollars per month. Patients must often pay a percentage of the drug cost of coinsurance rather than a flat rate per prescription like they do for other medications or flat copayment covering the cost of Intravenous medications & administration charges. Also some health plan benefit plans do not have an annual out of pocket limit where Intravenous medications will often have an annual cap for out of pocket cost.

I have had cancer patients chose to travel long distances to the Cancer Center to receive intravenous chemotherapy medication rather than take the oral chemotherapy due to the high out of pocket cost. One of our staff members spends a large amount of her time assisting patients with oral chemotherapy prescriptions. She works with their insurance and pharmacy plan, directly with pharmacies and also with pharmaceutical companies accessing their Foundation plans if available for assistance with the cost of these medications. The fact that these medications are not covered the same as IV chemotherapy medications is a big concern.

As oral chemotherapy options continue to increase for cancer treatment, this issue for people dealing with cancer will only become more serious and impact greater numbers of North Dakota residents. House Bill 1072 will make the oral and chemotherapy costs to patients more similar. I ask for your support for this important legislation.

Sincerely,

Nancy Klatt, RN, MS
Manager, Altru Cancer Center
Grand Forks, ND

13.2

HB 1072
03/11/2015

From: NANCY KLATT [mailto:NKLATT@altru.org]
Sent: Monday, March 09, 2015 11:03 AM
To: Lee, Judy E.
Subject: CAN oral chemo letter

I am sending some information I hope you will review prior to considering bill HB1072 regarding parity for oral chemotherapy.
Thank you in advance for consideration of the information

Nancy Klatt, RN, MS
Manager, Altru Cancer Center
Altru Health System, PO Box 6002
Grand Forks, ND 58206-6002
701-780-1060 phone
701-780-1729 fax
nklatt@altru.org

HB1072
03/11/2015
Attach #14
J#24637

From: Laena Shakarian [mailto:lshakarian@myeloma.org]
Sent: Tuesday, March 10, 2015 5:14 PM
To: Laena Shakarian
Subject: IMF Written Testimony

Best regards,

Laena Shakarian
Advocacy Associate
International Myeloma Foundation
Improving Lives - Finding the Cure
12650 Riverside Drive, Suite 206
North Hollywood, CA 91607
Tel: 818. 487-7455, Ext. 228
Fax: 818. 487-7454
E-mail: lshakarian@myeloma.org

International Myeloma Foundation

International Myeloma Foundation

International
Myeloma
Foundation

14.2

February 19, 2015

Testimony of Laena Shakarian
Advocacy Associate, The International Myeloma Foundation (IMF)
North Dakota Senate Health and Human Services Committee
HB 1072 2015

Increasing Affordable Access to Oral Anticancer Treatments:
Saving Lives & Improving Quality of Life for Cancer Patients

I offer the following testimony on behalf of The International Myeloma Foundation (IMF), in **support of HB 1072**, and thank you Chair Lee, Vice Chair Larsen, all members of the Senate Health and Human Services Committee, and our Senate bill cosponsor, Senator Dick Dever, for the opportunity to share the IMF's perspective on this important issue.

The IMF is the oldest and largest foundation in the world, dedicated to improving the quality of life of myeloma patients. The IMF is working collaboratively with a patient-centered coalition representing cancer patients, health care professionals, and cancer care centers in North Dakota. Together we are focused on ensuring affordable access to anticancer regimens including oral anticancer treatments.

The IMF strongly supports HB 1072, which will require insurers in North Dakota to cover oral anticancer treatments at a rate equal to intravenous, or IV, treatments. Currently, patients taking oral anticancer treatments typically have much higher out-of-pocket expenses than those receiving them intravenously; however, HB 1072 will even out the costs of those medications and provide access to treatment for thousands of cancer patients across the state. To date, 35 states and the District of Columbia have enacted laws to increase affordable access of oral anticancer treatments.

The IMF is working to ensure cancer patients have appropriate access to a broad range of approved and medically accepted anticancer regimens including oral, intravenous, and injected drugs. We believe that every cancer patient should have access to the treatments recommended by their physician and that no patient should have to struggle with cost discrimination based on the type of therapy provided or the mechanism of delivery.

Research efforts to find more effective treatments are robust and ongoing. Treatments are currently available for a range of cancers such as breast, multiple myeloma (MM), and chronic myeloid leukemia (CML), helping to greatly extend life and dramatically increase a patient's quality of life. While we have seen dramatic and important advances in treatments for these cancers (and others) that enable patients to live long, full lives, remissions are not always permanent and additional treatment options are essential.

To demonstrate how complicated cancer treatments can be, I'd like to briefly outline a standard course of treatment for patients fighting multiple myeloma. Multiple myeloma (or myeloma) is a cancer of plasma cells in the bone marrow. It is called "multiple" because the cancer can occur at multiple sites in multiple bones. At any one time, there are over 100,000 myeloma patients undergoing treatment for this disease in the United States. There is no cure for myeloma; however, it is highly treatable given the latest advancements in research and drug development.

Treatments for myeloma include five targeted anticancer therapies – two injectable treatments and three orally administered drugs – as well as stem cell transplants. Many myeloma patients use what is known as "combination therapy"—treating the cancer with at least two of these drugs simultaneously. Myeloma is a recurring disease, so patients typically cycle through all of these treatment options as they attempt to control their cancer. For this reason, it is critical that myeloma patients have equal access to ALL treatments, orally administered and intravenously or subcutaneously (injected) administered drugs. This level of complicated therapies is not limited to myeloma, and is the experience of patients battling a range of other cancers.

12650 Riverside Drive Suite 206, North Hollywood, CA 91607
800-452-CURE (2873)
818-487-7455 telephone 818-487-7454 fax
myeloma.org

14.3

International Myeloma Foundation

February 19, 2015

1. This bill is not a mandate.
HB 1072 does not force health plans in North Dakota to cover a service currently not required by state insurance law. In fact, the bill would only affect those plans that currently list cancer treatment medication as a benefit. **It is also critical to note that in May of 2013, the Centers for Medicare and Medicaid Services (CMS), the branch of the U.S. Department of Health & Human Services (HHS) charged with implementing the Affordable Care Act (ACA) issued the following guidance, which specifically addresses the question of whether or not oral chemotherapy parity laws are considered new health mandates on states:**

Q40:
If a state enacts a new requirement that issuers who provide coverage of intravenous (IV) chemotherapy must cover oral chemotherapy at parity, does the state have to defray the cost?

A40:
No. We do not consider such payment parity bills to create a requirement to cover a new benefit.

2. This legislation will not result in increased health insurance premiums.
The first oral anticancer treatment access bill was enacted in 2008. Since then, every analysis conducted post-implementation in the early states found that there has been no to very minimal impact on health insurance premiums related to passage of the legislation. Pre-implementation studies in Vermont and Texas concluded that the legislation was important enough to require legislative action and would not substantially increase health insurance premiums. The state of Indiana, one of the first states to pass the law in 2009, reported that *"There were initial concerns raised by some carriers regarding a potential increase... however no increase has materialized..."* (Source: Indiana Department of Insurance letter to Sen. Becker and *Rep. Welch).*

3. This bill is not about choice and convenience to the patient, but what is medically necessary and in the best interest of the patient.
Nearly all of the oral anticancer drugs currently in use **do not** have an IV or generic equivalent and are specifically indicated as the first and most effective treatment for a range of cancers, making affordability to the patient even more urgent. Treating cancer is an expensive prospect, regardless of the therapy and one that nearly 4,500 North Dakota residents will have to face this year and more than 1,400 of those patients will die from the disease. **It is also important to note that these are not experimental treatments and that ALL of the oral anticancer treatments currently** available to cancer patients have successfully completed all four of the necessary phases of the National Institute of Health's (NIH) clinical trials process and met strict patient safety and efficacy standards established by the U.S. Food and Drug Administration (FDA).

IN CLOSING
As a result of ongoing research and a strong commitment to improving treatments that enhance and extend life, researchers are continually identifying new and more effective therapies for cancers. With nearly 30% of the new therapies in the research pipeline coming in a form administered to the patient by mouth, oral anticancer treatments are truly the wave of the future.

To level the playing field for all cancer patients, insurers in North Dakota should cover the cost of oral anticancer treatments as they do I anticancer treatments, ensuring that no matter how treatment is administered, cancer patients have access to the best possible care at a pric they can afford.

Thank you all for your time and consideration today and the IMF looks forward to working with you as you move forward on this issue.

12650 Riverside Drive Suite 206, North Hollywood, CA 91607
800-452-CURE (2873)
818-487-7455 telephone 818-487-7454 fax
myeloma.org

HB1072
03/11/2015
Attach#15
J#24637

Larson

From: Corina L. Larson [mailto:clarson@bismarckcancercenter.com]
Sent: Monday, March 09, 2015 11:52 AM
To: Lee, Judy E.
Subject: HB 1072

Dear Senator Lee,

My name is Corina Larson and I am the Secretary/Treasurer of the Missouri Valley Oncology Nursing Society (ONS). With the upcoming hearing on HB 1072, I felt that it is important to send you a copy of the request of consideration that was provided to the House of Representatives. I just wanted to give you the opportunity to read through the rationale for changing the oral anti-cancer medication payment prior to the hearing. Please feel free to contact me with any questions or clarifications that you may have. I appreciate your time and consideration for this bill.

Sincerely,

Corina Larson

2/12/2015

Re: HB 1072

Dear Representatives,

We are writing you on behalf of the Missouri Valley Oncology Nursing Society (ONS) in regards to HB 1072. This pertains to financial coverage of oral anti-cancer medications as a standard of care for cancer patients.

Traditionally, anti-cancer medications are primarily administered intravenously (IV) and covered under a health plan's medical benefit with minimal co-pay or no cost to the patient. As research on anti-cancer medications advances more oral anti-cancer medications are becoming available. These medications are generally covered by the health plan's pharmacy benefit rather than the medical benefit, which results in significant out-of-pocket costs.

If you were to walk in the shoes of a patient receiving IV anti-cancer treatment you would see a patient receiving a surgical procedure to have permanent IV access placed. This puts the patient at higher risk for surgical complications and/or infection. This is also an additional expense for both the insurance company and the patient. The patient is then required to receive monthly maintenance on the IV access line that must be completed by a nurse. The patient would travel to the nearest cancer treatment facility which can be more than 100 miles in one direction. This patient might face exposure to other illnesses (influenza, common colds, bacteria, etc.) or hospital acquired infections when they are going into treatment centers while in an immunocompromised state. They receive pre-medications that make them drowsy prior to the anti-cancer medication administration. Depending on the medication the patient receives they can spend anywhere from 30 minutes to 8 hours at the cancer treatment center. The patient generally needs a family member or friend present with them to drive them to and from treatment which requires the patient to be dependent upon someone else's schedule. Travel expenses are incurred for each treatment. This cycle is then repeated every one to three weeks depending on the regimen the patient is receiving. For many patients this is a regimen that they will undergo for the remainder of their lives.

In contrast, a patient receiving an oral anti-cancer medication simply has to receive the medication from the pharmacy and take as prescribed. This convenience saves the patient and the caregiver a significant amount of time and money, thus improving the quality of their life.

Oral anti-cancer agents are not appropriate for every patient. The best treatment option is selected by the physician and the patient and will provide the patient the most effective care with the least amount of hardship. For many patients, financial burden is a determining factor in treatment. As described above, oral anti-cancer treatments are currently covered by a pharmacy benefit which results in extremely high out-of-pocket costs for the patient. High out-of-pocket expenses decrease the

patient's ability to fill the prescription, forcing the patient to choose the treatment that is most affordable rather than most effective for their individual situation. This may mean that the patient will decline treatment leading to an early death rather than a cure.

HB 1072 would empower the patient to make affordable healthcare choices without compromising their health or quality of life.

HB 1072
03/11/2015
Attach #16
J# 24637

HB 1072 Testimony
Senate Human Services Committee
March 11, 2015

Madam Chair and Committee Members, I am Rod St. Aubyn representing the Pharmaceutical Care Management Association (PCMA). PCMA is the trade association for Pharmacy Benefit Managers (PBM's). The PCMA is opposed to HB 1072 because it will definitely increase health care costs for PBM's health insurance clients and their customers. At a time that health insurance premiums continue to escalate and employers and families struggle to maintain insurance, it does not make sense to have the state establish a public policy that increases these costs even more. As amended in the House, this bill caps the monthly copayment, deductible, and coinsurance for one specific medical condition. Why is that good public policy?

I can honestly sympathize with the people who unfortunately have cancer and have been asked to testify for the proponents. I lost my mother a few years ago from cancer, my sister is battling terminal breast cancer, and my best friend is currently being treated for an incurable multiple myloma. I am sure we all are affected by this dreaded disease through oneself, family or friends at one time or the other. But these experiences should not cloud our vision to the reality of this bill.

The proponents allege that the consumer will benefit from this proposed bill. However, in reality it only shifts the costs to health insurers who will be forced to increase premiums even more than regular medical inflation and utilization increases. There is no net decrease in costs with this bill. Will drug manufacturers reduce the prices that they charge for their cancer drugs as a result of greater utilization of brand name drugs rather than generics?

There are often many drugs in a particular class or category of medicines and signaling the cost of specific drugs through patient cost-sharing is an essential tool in keeping medicines affordable. Brand name drug companies have been pushing this legislation in other states to undermine the use of copays that encourage the use of lower cost generic medications. These generic drugs are therapeutically equivalent to the brand name drug. So who is the beneficiary of this change in policy? The brand name drug manufacturer! By capping patient out-of-pocket expenses, doctors and patients may choose more expensive brand drugs over lower cost alternatives, continuing to feed the cycle of price increases.

One of the most disturbing aspects of this bill is listed in Section 3. Section 3 specifically exempts this bill from the state law requiring that this mandate does not have to comply with the required "cost/benefit analysis" by applying it to NDPERS for a two year period to ascertain

the actual cost/benefit that very well may be different than the estimated actuarial estimate. Keep in mind that the original fiscal note and the actuarial analysis were based on the original bill before it was amended. If the proponents are confident that the costs will be minimal, exactly why do they want to exempt this bill to the mandate review law? If the legislature permits this exemption, I guarantee that you will see future mandate proponents trying the same strategy in the future.

The proponents will tell you that the actual experience in other states have been minimal costs. What they don't tell you is that none of the other state's laws are exactly like this bill as amended.

While the proponents argue that this is being done for the benefit of the cancer patient. However, who primarily benefits? Pharmaceutical manufacturers that market patent-protected cancer drugs and will soon lose these patent-protections stand to gain millions of dollars by discouraging the use of generic drugs.

I think is important to look at the facts. This bill has been pushed through many other states. Has the impetus been pushed by the cancer patients that the proponents argue are the real beneficiaries? Or has this been pushed by lobbyists of brand name pharmaceutical companies. I encourage you to look at the Secretary of State's website and see how many pharmaceutical manufacturer lobbyists are registered in our state.

Madam Chair and committee members, HB 1072 is very poor public policy. Ask yourself why we are selecting one disease for this type of special treatment for cost sharing. If this bill is successful, do you honestly think that this will be the last type of bill like this that you will see in the future? I urge you to remove the exemption from the established mandate review process and then give HB 1072 a Do Not Pass recommendation.

I would be willing to try to answer any questions that you may have.

HB1072
03/11/2015
JT#24688
Attach#1

Wednesday, March 11, 2015

SENATE HUMAN SERVICES COMMITTEE
HB 1072

CHAIRMAN LEE AND COMMITTEE MEMBERS:

My name is Jack McDonald. I'm appearing on behalf of America's Health Insurance Plans or, as it is commonly known, AHIP. AHIP is the national trade association representing the health insurance industry.

AHIP members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual and small group insurance markets, and public programs such as Medicare and Medicaid.

I am also doing double-duty this morning and am testifying on behalf of Prime Therapeutics.

We respectfully **oppose** this bill for three primary reasons:

1. Oral chemotherapy is significantly more expensive than traditional intravenous treatment.
2. Oral chemotherapy drugs pose concerns for patient safety.
3. The Affordable Care Act renders sections of HB 1072 unnecessary.

Oral chemotherapy is significantly more expensive than traditional intravenous treatment.

Pharmaceutical manufacturers charge as much as $10,000 per month for oral chemotherapy medications. According to 2009 estimates from Kaiser Permanente Colorado, their cost of treating 500 colon-rectal cancer patients with a full range of intravenous treatments and services would be $850,000. The cost of treating the same group with *oral* chemotherapy drugs would be more than $9 million.

The vast majority of oral chemotherapy drugs are branded prescriptions, making them the only drug available with no less expensive generic equivalent. This allows a pharmaceutical manufacturer to charge whatever it deems the market will bear for the drug, as there is no cost control or review for the costs of branded drugs.

In fact, *the Journal of Clinical Oncology* reported that, "With FDA approval occurring faster, and drug AWP [average wholesale pricing] increasing, we can only speculate that the drug companies are not pricing their drugs to recuperate losses associated with

1.2

research and development, marketing, and operating prices, but rather AWP [cost] depends on what the market itself can bear."

Minimizing the costs of coverage for insureds such as state employees does not reduce the high costs of the drugs. It only shifts them to the purchaser -- in this case, the State of North Dakota – in the form of higher premiums.

Oral chemotherapy drugs pose concerns for patient safety.

Oral treatment shifts the responsibility for direct oversight of chemotherapy treatment away from physicians and nurses and onto patients and their care-givers, making monitoring for toxicity, dosage, frequency and side-effects much more difficult.

There are concerns regarding patient adherence to treatment regimens. A reduction in physician-patient interaction threatens the effectiveness of the patient's treatment plan.

The Affordable Care Act renders sections of HB 1072 unnecessary.

Consumer protections under the ACA establish annual out-of-pocket limits of no more than approximately $6,400 for individuals, $12,500 for families for all essential health benefits.

This out-of-pocket limit applies to oral chemotherapy medications as all prescription drugs are considered an essential health benefit under the ACA. Because of the ACA, this bill is unnecessary.

AMEND

We urge a DO NOT PASS on the bill. However, if you cannot do that, then at the very least you should amend this bill to follow the procedure put in place several sessions ago to cover drug bills such as this and allow it to be tested for two years with PERS.

To do this, please amend the bill by deleting lines 16-20 on page two.

Thank you for your time and consideration. I'd be happy to answer any questions.

HB1072 Attach #2
03/11/15 Ht #24688

THE COST OF CANCER DRUGS

Lesley Stahl discovers the shock and anxiety of a cancer diagnosis can be followed by a second jolt: the astronomical price of cancer drugs

The following is a script of "The Cost of Cancer Drugs" which aired on Oct. 5, 2014. Lesley Stahl is the correspondent. Richard Bonin, producer.

Cancer is so pervasive that it touches virtually every family in this country. More than one out of three Americans will be diagnosed with some form of it in their lifetime. And as anyone who's been through it knows, the shock and anxiety of the diagnosis is followed by a second jolt: the high price of cancer drugs.

They are so astronomical that a growing number of patients can't afford their co-pay, the percentage of their drug bill they have to pay out-of-pocket. This has led to a revolt against the drug companies led by some of the most prominent cancer doctors in the country.

Dr. Leonard Saltz: We're in a situation where a cancer diagnosis is one of the leading causes of personal bankruptcy.

Dr. Leonard Saltz is chief of gastrointestinal oncology at Memorial Sloan Kettering, one of the nation's premier cancer centers, and he's a leading expert on colon cancer.

Lesley Stahl: So, are you saying in effect, that we have to start treating the cost of these drugs almost like a side effect from cancer?

2.2

Dr. Leonard Saltz: I think that's a fair way of looking at it. We're starting to see the term "financial toxicity" being used in the literature. Individual patients are going into bankruptcy trying to deal with these prices.

"I DO WORRY THAT PEOPLE'S FEAR AND ANXIETY'S ARE BEING TAKEN ADVANTAGE OF."

Lesley Stahl: The general price for a new drug is what?

Dr. Leonard Saltz: They're priced at well over $100,000 a year.

Lesley Stahl: Wow.

Dr. Leonard Saltz: And remember that many of these drugs, most of them, don't replace everything else. They get added to it. And if you figure one drug costs $120,000 and the next drug's not going to cost less, you're at a quarter-million dollars in drug costs just to get started.

Lesley Stahl: I mean, you're dealing with people who are desperate.

Dr. Leonard Saltz: I do worry that people's fear and anxiety are being taken advantage of. And yes, it costs money to develop these drugs, but I do think the price is too high.

The drug companies say it costs over a billion dollars to bring a new drug to market, so the prices reflect the cost of innovation.

The companies do provide financial assistance to some patients, but most people aren't eligible. So many in the middle class struggle to meet the cost of their co-payments. Sometimes they take half-doses of the drug to save money. Or delay getting their prescriptions refilled.

Dr. Saltz's battle against the cost of cancer drugs started in 2012 when the FDA approved Zaltrap for treating advanced colon cancer. Saltz compared the clinical trial results of Zaltrap to those of another drug already on the market, Avastin. He says both target the same patient population, work essentially in the same way. And, when given as part of chemotherapy, deliver the identical result: extending median survival by 1.4 months, or 42 days.

Dr. Leonard Saltz: They looked to be about the same. To me, it looked like a Coke and Pepsi sort of thing.

Then Saltz, as head of the hospital's pharmacy committee, discovered how much it would cost: roughly $11,000 per month, more than twice that of Avastin.

60 MINUTES OVERTIME

THE "EYE POPPING" COST OF CANCER DRUGS

Lesley Stahl: So $5,000 versus $11,000. That's quite a jump. Did it have fewer side effects? Was it less toxic? Did it have...

Dr. Leonard Saltz: No...

Lesley Stahl: ...Something that would have explained this double price?

Dr. Leonard Saltz: If anything, it looked like there might be a little more toxicity in the Zaltrap study.

He contacted Dr. Peter Bach, Sloan Kettering's in-house expert on cancer drug prices.

Lesley Stahl: So Zaltrap. One day your phone rings and it's Dr. Saltz. Do you remember what he said?

2.3

Dr. Peter Bach: He said, "Peter, I think we're not going to include a new cancer drug because it costs too much."

Lesley Stahl: Had you ever heard a line like that before?

Dr. Peter Bach: No. My response was, "I'll be right down."

Lesley Stahl: You ran down.

Dr. Peter Bach: I think I took the elevator. But yes, exactly.

Bach determined that since patients would have to take Zaltrap for several months, the price tag for 42 days of extra life would run to nearly $60,000. What they then decided to do was unprecedented: reject a drug just because of its price.

Dr. Peter Bach: We did it for one reason. Because we need to take into account the financial consequences of the decisions that we make for our patients. Patients in Medicare would pay more than $2,000 a month themselves, out-of-pocket, for Zaltrap. And that that was the same as the typical income every month for a patient in Medicare.

Lesley Stahl: The co-pay.

Dr. Peter Bach: Right. 20 percent. Taking money from their children's inheritance, from the money they've saved. We couldn't in good conscience say, "We're going to prescribe this more expensive drug."

"IT WAS A SHOCKING EVENT. BECAUSE IT WAS IRREFUTABLE EVIDENCE THAT THE PRICE WAS A FICTION."

And then they trumpeted their decision in the New York Times. Blasting what they called "runaway cancer drug prices," it was a shot across the bow of the pharmaceutical industry and Congress for passing laws that Bach says allow the drug companies to charge whatever they want for cancer medications.

Dr. Peter Bach: Medicare has to pay exactly what the drug company charges. Whatever that number is.

Lesley Stahl: Wait a minute, this is a law?

Dr. Peter Bach: Yes.

Lesley Stahl: And there's no negotiating whatsoever with Medicare?

Dr. Peter Bach: No.

Another reason drug prices are so expensive is that according to an independent study, the single biggest source of income for private practice oncologists is the commission they make from cancer drugs. They're the ones who buy them wholesale from the pharmaceutical companies, and sell them retail to their patients. The mark-up for Medicare patients is guaranteed by law: the average in the case of Zaltrap was six percent.

Dr. Leonard Saltz: What that does is create a very substantial incentive to use a more expensive drug, because if you're getting six percent of $10, that's nothing. If you're getting six percent of $10,000 that starts to add up. So now you have a real conflict of interest.

But it all starts with the drug companies setting the price.

Dr. Peter Bach: We have a pricing system for drugs which is completely dictated by the people who are making the drugs.

Lesley Stahl: How do you think they're deciding the price?

Dr. Peter Bach: It's corporate chutzpah.

Lesley Stahl: We'll just raise the price, period.

2.4

Dr. Peter Bach: Just a question of how brave they are and how little they want to end up in the New York Times or on 60 Minutes.

That's because media exposure, he says, works. Right after their editorial was published, the drug's manufacturer, Sanofi, cut the price of Zaltrap by more than half.

Dr. Peter Bach: It was a shocking event. Because it was irrefutable evidence that the price was a fiction. All of those arguments that we've heard for decades, "We have to charge the price we charge. We have to recoup our money. We're good for society. Trust us. We'll set the right price." One op-ed in the New York Times from one hospital and they said, "Oh, okay, we'll charge a different price." It was like we were in a Turkish bazaar.

Lesley Stahl: What do you mean?

Dr. Peter Bach: They said, "This carpet is $500" and you say, "I'll give you $100." And the guy says, "Okay." They set it up to make it highly profitable for doctors to go for Zaltrap instead of Avastin. It was crazy!

But he says it got even crazier when Sanofi explained the way they were changing the price.

Dr. Peter Bach: They lowered it in a way that doctors could get the drug for less. But patients were still paying as if it was high-priced.

Lesley Stahl: Oh, come on.

Dr. Peter Bach: They said to the doctor, "Buy Zaltrap from us for $11,000 and we'll send you a check for $6,000." Then you give it to your patient and you get to bill the patient's insurance company as if it cost $11,000. So it made it extremely profitable for the doctors. They could basically double their money if they use Zaltrap.

"HIGH CANCER DRUG PRICES ARE HARMING PATIENTS BECAUSE EITHER YOU COME UP WITH THE MONEY, OR YOU DIE."

All this is accepted industry practice. After about six months, once Medicare and private insurers became aware of the doctor's discount, the price was cut in half for everyone.

John Castellani: The drug companies have to put a price on a medicine that reflects the cost of developing them, which is very expensive and takes a long period of time, and the value that it can provide.

John Castellani is president and CEO of PhRMA, the drug industry's trade and lobbying group in Washington.

Lesley Stahl: If you are taking a drug that's no better than another drug already on the market and charging twice as much, and everybody thought the original drug was too much...

John Castellani: We don't set the prices on what the patient pays. What a patient pays is determined by his or her insurance.

Lesley Stahl: Are you saying that the pharmaceutical company's not to blame for how much the patient is paying? You're saying it's the insurance company?

John Castellani: I'm saying the insurance model makes the medicine seem artificially expensive for the patient.

He's talking about the high co-pay for cancer drugs. If you're on Medicare, you pay 20 percent.

Lesley Stahl: Twenty percent of $11,000 a month is a heck of a lot more than 20 percent of $5,000 a month.

John Castellani: But why should it be 20 percent instead of five percent?

Lesley Stahl: Why should it be $11,000 a month?

John Castellani: Because the cost of developing these therapies is so expensive.

2.5

Lesley Stahl: Then why did Sanofi cut it in half when they got some bad publicity?

John Castellani: I can't respond to a specific company.

Sanofi declined our request for an interview, but said in this email that they lowered the price of Zaltrap after listening "to early feedback from the oncology community and ... To ensure affordable choices for patients..."

Dr. Hagop Kantarjian: High cancer drug prices are harming patients because either you come up with the money, or you die.

Hagop Kantarjian chairs the department of leukemia at MD Anderson in Houston. Inspired by the doctors at Sloan Kettering, he enlisted 119 of the world's leading leukemia specialists to co-sign this article about the high price of drugs that don't just add a few weeks of life, but actually add years, like Gleevec.

It treats CML, one of the most common types of blood cancer that used to be a death sentence, but with Gleevec most patients survive for 10 years or more.

60 MINUTES: SEGMENT EXTRAS

NAT'L ONCOLOGISTS GROUP TACKLES SPIRALING DRUG COSTS

Dr. Hagop Kantarjian: This is probably the best drug we ever developed in cancer.
Lesley Stahl: In all cancers?

Dr. Hagop Kantarjian: So far. And that shows the dilemma, because here you have a drug that makes people live their normal life. But in order to live normally, they are enslaved by the cost of the drug. They have to pay every year.

Lesley Stahl: You have to stay on it. You have to keep taking it.

Dr. Hagop Kantarjian: You have to stay on it indefinitely.

Gleevec is the top selling drug for industry giant Novartis, bringing in more than $4 billion a year in sales. $35 billion since the drug came to market. There are now several other drugs like it. So, you'd think with the competition, the price of Gleevec would have come down.

Dr. Hagop Kantarjian: And yet, the price of the drug tripled from $28,000 a year in 2001 to $92,000 a year in 2012.

"THEY ARE MAKING PRICES UNREASONABLE, UNSUSTAINABLE AND, IN MY OPINION, IMMORAL."

Lesley Stahl: Are you saying that the drug companies are raising the prices on their older drugs.

Dr. Hagop Kantarjian: That's correct.

Lesley Stahl: Not just the new ones. So you have a new drug that might come out at a $100,000, but they are also saying the old drugs have to come up to that price, too?

Dr. Hagop Kantarjian: Exactly. They are making prices unreasonable, unsustainable and, in my opinion, immoral.

When we asked Novartis why they tripled the price of Gleevec, they told us, "Gleevec has been a life-changing medicine ... When setting the prices of our medicines we consider ... the benefits they bring to patients ... The price of existing treatments and the investments needed to continue to innovate..."

[Dr. Hagop Kantarjian: This is quite an expensive medication.]

2.16

Dr. Kantarjian says one thing that has to change is the law that prevents Medicare from negotiating for lower prices.

Dr. Hagop Kantarjian: This is unique to the United States. If you look anywhere in the world, there are negotiations. Either by the government or by different regulatory bodies to regulate the price of the drug. And this is why the prices are 50 percent to 80 percent lower anywhere in the world compared to the United States.

Lesley Stahl: Fifty percent to 80 percent?

Dr. Hagop Kantarjian: Fifty percent to 80 percent.

Lesley Stahl: The same drug?

Dr. Hagop Kantarjian: Same drug. American patients end up paying two to three times more for the same drug compared to Canadians or Europeans or Australians and others.

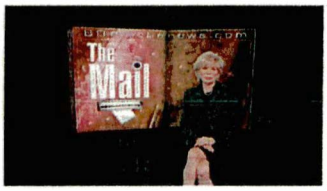
Lesley Stahl: Now, Novartis, which makes Gleevec, says that the price is fair because this is a miracle drug. It really works.

Dr. Hagop Kantarjian: The only drug that works is a drug that a patient can afford.

The challenge, Dr. Saltz at Sloan Kettering says, is knowing where to draw the line between how long a drug extends life and how much it costs.

Lesley Stahl: Where is that line?

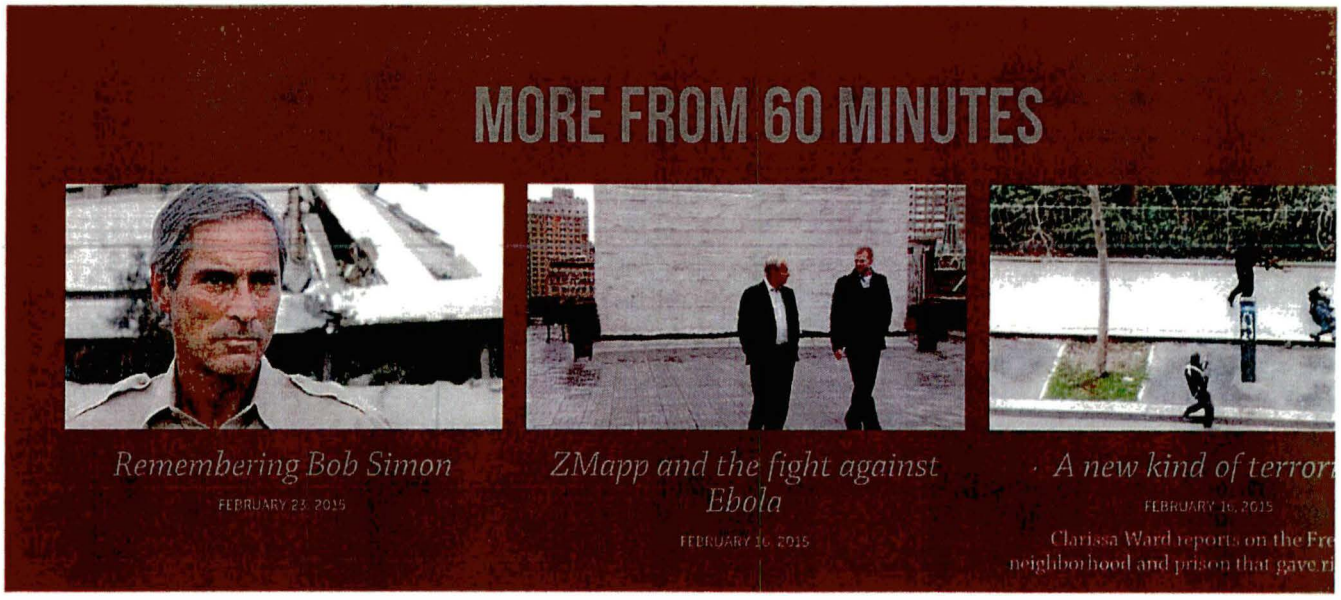
Dr. Leonard Saltz: I don't know where that line is, but we as a society have been unwilling to discuss this topic and, as a result, the only people that are setting the line are the people that are selling the drugs.



HEALTH & SCIENCE

LETTERS ON "THE COST OF CANCER DRUGS"

Lesley Stahl
One of America's most recognized and experienced broadcast journalists, Lesley Stahl has been a 60 Minutes correspondent since 1991.



Attach #1
HB1072
03/17/2015
JH 25011

March 17, 2015

Senator Judy Lee
Chair, Senate Human Services Committee

Dear Senator Lee and Committee Members:

Blue Cross Blue Shield of North Dakota and Medica appreciate the opportunity to provide the committee written feedback on H.B. 1072. Our organizations support the appropriate coverage of oral chemotherapy drugs, and include it under our pharmacy benefits – either as a regular drug or as a specialty formulary benefit. Health plans cover a broad spectrum of treatments for patients to help them fight cancer, including chemotherapy using specialty drugs both by infusion/injection as well as orally.

Our primary concern with H.B. 1072, however, is that it places artificial caps on cost-sharing for oral chemotherapy in a way that would be exceptionally difficult and expensive for our organizations to administer. The cost-sharing mechanism outlined in the bill would require extensive manual work for our organizations. It does not reflect how our benefits are designed, our current practice for tracking member cost-sharing, or how some of these medications are prescribed.

We urge the committee to make the following changes to section one of the bill. This solution lowers cost-sharing for oral chemotherapy treatments while allowing our pharmacy benefit designs to evolve as these medications evolve over time:

- Remove 2a, which caps cost-sharing for oral chemotherapy;
- Remove subdivision 3; and
- Insert a new subdivision 3 to read: "An insurer is in compliance with this section if it does not include orally administered anticancer medication in the fourth tier of its pharmacy benefit."

Thank you for your consideration and please do not hesitate to contact us if you have any questions.

Sincerely,

Jay McLaren

Megan Houn
BCBS of ND
Director, Government Relations

Jay McLaren
Medica
Sr. Director, Public Policy &
Government Relations

HB1072
Attach #2
03/19/15
J#25011

H.B. 1072: Increases Health Care Costs for ND Consumers and Employers

H.B. 1072 Increases health care costs for ALL North Dakota residents

- H.B. 1072 would allow the state to dictate the terms of drug coverage by controlling the price at which patients may obtain certain prescription drugs. This cap, at $100 per month for a single cancer drug would increase insurance costs for **ALL** North Dakota residents who will have to shoulder the additional cost burden in their premiums.
- There are often many drugs in a particular class or category of medicines, and signaling the cost of specific drugs through patient cost-sharing is an essential tool to keeping medicines affordable.
- Brand drug companies are pushing this legislation to undermine the use of copays that encourage the use of lower cost generic medications. Without copayments, consumers would have no incentive to select lower-cost alternative drugs.
- This new mandate would help brand drug companies, but would hurt employers, consumers, and taxpayers by forcing them to pay more in health premiums and overall health care costs.

H.B. 1072 Will Continue the Endless Cycle of Escalating Prescription Drug Prices

- A significant and costly by-product of imposing price controls on consumers' out-of-pocket spending will be an increase in already unreasonable drug prices set by drug manufacturers.
- The skyrocketing cost of specialty drugs are representative of the unchecked, upward growth of drug prices that will result from legislation such as H.B. 1072.
- By capping patient out-of-pocket expenses, doctors and patients may choose more expensive brand drugs over lower cost alternatives, continuing to feed the cycle of price increases.
- This will effectively increase profits for brand manufacturers, encourage the manufacturers to continue to constantly escalate prices for these drugs, and, in turn, increase the cost of prescription drugs and health coverage in general for anyone who has health insurance.

H.B. 1072 Undermines the Ability of Employers to Contain Prescription Drug Costs

- PBMs help their employer and health plan clients promote lower cost generic drugs and clinically effective, lower-cost alternative medicines through formulary management and utilization tools, such as prior authorization and step therapy.
- H.B. 1072's imposition of price controls on out-of-pocket spending will essentially eliminate the ability of payers to effectively use these tools and minimize prescription drug costs for North Dakota employers and consumers.
- While employers, state government plans, and other payers are looking for cutting-edge ways to minimize health care costs, this legislation will only increase costs for patients and payers alike while benefiting brand drug companies.

HB1072
Attach#3
03/17/15
J#25011

From: Gassaway, Leanne [lgassaway@ahip.org]
Sent: Friday, March 13, 2015 12:59 AM Central Standard Time
To:
Cc: Pratt, Mark; Goff, Cindy
Subject: AHIP Update: Prescription Drug Costs - State Activity / Highlights from AHIP Policy Conference and Exchanges Forum

America's Health Insurance Plans

Memorandum

TO: State Government Relations Committee

Small Group Medical Committee

Individual Medical Committee

Medigap and Supplemental Insurance Committee

FROM: Mark Pratt, Senior Vice President, State Affairs

Cindy Goff, Vice President, Product Policy

DATE: March 12, 2015

RE: **Prescription Drug Costs - State Activity / Highlights from AHIP Policy Conference and Exchanges Forum**

We are writing with updates on: (1) examples of how we are engaging with the media on prescription drug costs; and (2) activity today at our AHIP Policy Conference and Exchanges Forum.

Prescription Drug Costs - State Activity

As part of the strategic plan on prescription drugs, we are focusing on preserving and protecting the industry's tools at the state level by engaging with the media as well as key allies to provide balanced information in this important policy debate. Two recent examples include:

- A *Bloomberg* article shines a spotlight on drugmakers using front groups as conduits to push legislation that would cap copayments and coinsurance in states. The article notes: "By limiting copayments, drugmakers effectively insulate Americans with health insurance from the full cost of their products, relieving public pressure for lower prices. Without the flexibility to charge higher copayments for expensive medicines, insurers say the prices trickle down to all consumers in the form of higher monthly premiums. 'Proposals that place a cap on prescription drug coverage without addressing the price side, what's charged for the drug, will only drive costs higher for patients, and for state governments, and for employers,' Karen Ignagni, president of America's Health Insurance Plans, the industry's Washington lobbying group, said in a phone interview. 'It's a shell game that's being played on consumers.'"

- In Oklahoma, where there is legislative activity that would cap copayment and coinsurance costs for prescription drugs, including expensive specialty pharmaceuticals, Oklahoma State Senator Clark Jolley wrote an op-ed column entitled "The wrong medicine for Oklahoma's health care." Senator Jolley's column raises concerns about coverage mandates that lead to higher costs and fewer choices for consumers. Senator Jolley cautions: "Issuing health care mandates only empowers pharmaceutical companies to expect a blank check, perpetuating the rising costs of health care and providing no free-market solution for consumers and business owners."

Kentucky Governor Addresses AHIP Policy Conference

The second day of our AHIP National Health Policy Conference began with a session featuring Kentucky Governor Steve Beshear (D) who highlighted his state's success in implementing both a state-based Exchange and the ACA Medicaid eligibility expansion.

Governor Beshear explained that his Administration worked closely with stakeholders, including health plans, providers and the business community, in making decisions about implementation of Kentucky's Health Insurance Exchange. He noted that approximately 500,000 Kentuckians enrolled in coverage through the Exchange last year, resulting in a significant drop - from 20.4 percent to 9.8 percent - in the state's uninsured rate. The Governor emphasized that this expansion of coverage already is leading to improvements in the health of Kentucky's workforce.

With respect to Medicaid, Governor Beshear said he decided to implement the eligibility expansion simply because "our people desperately needed health care." He cited data from a study, conducted by Deloitte and the University of Louisville's Urban Studies Institute after the first year of implementation, which found that the Medicaid expansion will have a positive economic impact of $30 billion on the state's economy over the next eight years, while having a $819 million positive impact on the state's

budget over the same timeframe. Other findings from the study indicate a 60 percent reduction in costs associated with uncompensated care and improved access to care for patients with high blood pressure, high cholesterol, diabetes, and depression. The Governor noted that the state added 375,000 newly eligible Kentuckians to Medicaid coverage during the first year of the expansion and that an additional 17,000 who were previously eligible also enrolled.

Looking forward, the Governor indicated that he is focused on advancing payment and delivery system reforms with support from federally funded innovation grants. He also cautioned that an adverse ruling from the Supreme Court in the *King v. Burwell* case would cause "significant damage" and would affect Kentucky, even though it has a state Exchange.

CCIIO Director Addresses AHIP Exchanges Forum

Kevin Counihan, Marketplace CEO and Director of the Center for Consumer Information and Insurance Oversight (CCIIO), delivered remarks this afternoon at the opening session of our AHIP Health Insurance Exchanges Forum.

Counihan thanked AHIP members for participating in the ACA Exchanges and said that he is extremely grateful for the relationship CCIIO has formed with insurers that are offering coverage through the Exchanges. He said he is pleased with the outcome of the 2015 Open Enrollment Period and noted that the front-end of the healthcare.gov website is working significantly better than last year. He pointed out that, as part of its focus on improving customer service and promoting simplicity, CCIIO reduced the number of screens needed to complete enrollment from 76 to 16, and that customers were able to complete the enrollment process in 30 minutes. Looking ahead, Counihan emphasized that he is committed to making improvements to the back-end functionality of the website and the ACA's financial management systems, while continuing to maintain a strong focus on meeting the needs of consumers.

Counihan highlighted the importance of the ACA's premium stabilization programs, emphasizing that the Administration is fully committed to the risk corridors program and the other components of the "3Rs." He strongly encouraged member plans to ensure that they meet the April 30 deadline for data submissions that will be used to determine payments under these programs. Counihan also reviewed data and findings from the recently released HHS report on the number of consumers who obtained coverage and qualified for premium tax credits in the 2015 Open Enrollment Period.

Attach #1
HB 1072
03/30/2015
J# 25620

March 17, 2015

Senator Judy Lee
Chair, Senate Human Services Committee

Dear Senator Lee and Committee Members:

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- Insert a new subdivision 3 to read: "An insurer is in compliance with this section if it does not include orally administered anticancer medication in the fourth tier of its pharmacy benefit."

Thank you for your consideration and please do not hesitate to contact us if you have any questions.

Sincerely,

Jay McLaren

Megan Houn
BCBS of ND
Director, Government Relations

Jay McLaren
Medica
Sr. Director, Public Policy &
Government Relations

The following illustrations will explain how different scenarios will apply to NDPERS members, members in fully insured plans, and members in self-funded plans with HB 1072.

HB 1072
01/01/15
Attach #1
JH 25720

P = NDPERS member

F = Fully Insured member (Individual policy holder, small group employer plan, a few larger group plans)

S = Self-Funded person (Typically a member in a large employer plan)

Based on past experience, Blue Cross Blue Shield's membership was about ½ fully insured members and about ½ self-funded members. This is not exact, but will be used to illustrate the examples.

For comparison purposes, I will say that our total membership includes the following members along with their plan renewal dates in brackets:

P (7/1/15 -6/30/17)

P (7/1/15 -6/30/17)

F (7/1/15)

F (9/1/15)

F (1/1/16)

F (4/1/16)

S (10/1/15)

S (1/1/16)

S (1/1/16)

S (2/1/16)

Now I will illustrate when HB 1072 would apply for these members under the following scenarios:

HB 1072 as approved by the committee **with the PERS Mandate Review Exemption**
(Application begins on the renewal date on or after 8/1/15, when the bill becomes effective)

P (7/1/15 -6/30/17 RD) Effective date for HB 1072 – 7/1/17

P (7/1/15 -6/30/17 RD) Effective date for HB 1072 – 7/1/17

F (7/1/15 RD) Effective date for HB 1072 – 7/1/16

F (9/1/15 RD) Effective date for HB 1072 – 9/1/15

F (1/1/16 RD) Effective date for HB 1072 – 1/1/16

F (4/1/16 RD) Effective date for HB 1072 – 4/1/16

S (10/1/15 RD) Effective date for HB 1072 – Not subject to state law

S (1/1/16 RD) Effective date for HB 1072 - Not subject to state law

S (1/1/16 RD) Effective date for HB 1072 - Not subject to state law

S (2/1/16 RD) Effective date for HB 1072 - Not subject to state law

HB 1072 with the PERS Mandate Review
(Application will begin for NDPERS on 7/1/15 and go through 6/30/17, while the cost benefit analysis is compiled. Application for other fully insured plans begins on 8/1/17 or the following renewal date assuming the 2017 Legislature approves a bill for expansion of the mandate.)

P (7/1/15 -6/30/17 RD) Effective date for HB 1072 – 7/1/15

P (7/1/15 -6/30/17 RD) Effective date for HB 1072 – 7/1/15

F (7/1/15 RD) Effective date for HB 1072 – 7/1/18

F (9/1/15 RD) Effective date for HB 1072 – 9/1/17

F (1/1/16 RD) Effective date for HB 1072 – 1/1/18

F (4/1/16 RD) Effective date for HB 1072 – 4/1/18

S (10/1/15 RD) Effective date for HB 1072 – Not subject to state law

S (1/1/16 RD) Effective date for HB 1072 - Not subject to state law

S (1/1/16 RD) Effective date for HB 1072 - Not subject to state law

S (2/1/16 RD) Effective date for HB 1072 - Not subject to state law