



CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

June 20, 2012

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

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

Via E-mail only

Dear Assembly Member Monning and Senator Hernández:

I am writing in response to a request from Senate Health Committee staff (on June 4, 2012) regarding Assembly Bill (AB) 1000 (Perea) Cancer Treatment, which was amended on May 16, 2012. Last year, on April 21, 2011, the California Health Benefits Review Program (CHBRP) submitted a report, *Analysis of Assembly Bill 1000: Cancer Treatment*, which analyzed an earlier version of the bill. The full report and an executive summary are available on CHBRP's website at: <http://www.chbrp.org/analyses.html>. Senate Health Committee staff asked whether the current language in AB 1000 would alter the analysis CHBRP conducted last year or the conclusions it reached.

Having reviewed the amended language, CHBRP believes that its 2011 report (based on the February 18, 2011 version of the bill) is still **generally applicable** to the current (May 16, 2012) version of AB 1000.

Although we believe our earlier analysis is generally applicable, a thorough response requires a short discussion of differences in language between the two versions of AB 1000 and why we have determined that the differences would not substantially affect conclusions reported last year.

The current version of AB 1000 differs from the 2011 version analyzed by CHBRP in three key ways:

- The current version does not require plans or policies regulated by the Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI) to provide coverage for oral anticancer medications.
- The current version prohibits DMHC-regulated plans and CDI-regulated policies from applying terms to coverage for either generic or brand-name oral anticancer medications that would result in cost-sharing in excess of cost-sharing for covered injected or intravenous anticancer medications.
- The current version would not require any plan or policy to exceed essential health benefits (EHBs).

These three differences would not substantially alter CHBRP's 2011 analysis or conclusions because:

- Although the prior version of the bill would have required plans and policies to provide coverage for oral anticancer medications, the prior version stated that no plan or policy would be required to cover any additional medication or be prohibited from removing a medication from its formulary. Therefore, CHBRP assumed that the bill would not increase the number of Californians with coverage for oral anticancer medications. The conclusions in the report remain valid because the current version of the bill would not require benefit coverage for enrollees who do not already have it.
- Although the prior version of the bill addressed cost-sharing only for nongeneric (brand name) anticancer medications, this version applies to cost-sharing for generic and brand name anticancer medications. CHBRP would expect cost impacts and the direction of projected cost shifts (from enrollees to plans and policies) to be similar to what was projected for the prior version of the bill because brand name medications are both more costly and more frequently subject to higher levels of cost-sharing than are their generic equivalents. Therefore, brand name medications typically have a much stronger impact on costs and cost-sharing and so adding consideration of generic medications would not be expected to greatly alter the estimates provided in the report.
- Although CHBRP noted in the 2011 report that coverage for EHBs would be required in 2014, so little was known about how EHBs would be defined that CHBRP could make no projection on possible interactions between EHBs and the bill's proposed benefit mandate. Although EHBs are still not clearly defined, the current version of the bill explicitly indicates that coverage exceeding EHBs will not be required, so no interaction(s) would be expected.

While CHBRP considers the April 2011 analysis to be generally applicable to the current (2012) version of AB 1000, it is important to note two caveats that might alter the analysis if CHBRP were to produce an updated report. First, for all of CHBRP's reports, estimates are current for the year of the report because CHBRP must rely upon data and literature available at the time. Thus, the impacts estimated in the 2011 report are based on the CHBRP Cost Model used to project expenditures in 2011. Some changes in the estimates would be expected if CHBRP used 2012 data to complete the analysis. In addition, CHBRP's projected cost impacts and medical effectiveness analysis presented in the 2011 report are based on information that was available last spring. Therefore, the report focused on the 42 oral anticancer medications (ten of which had generic equivalents) that at that time had been approved by the United States Food and Drug Administration to treat 57 types of cancer. Since then, one or more new medications may have been approved and one or more new generic equivalents may have become available. Although CHBRP would not expect more than a limited number of new approvals or newly available generic equivalents in the past year, if CHBRP were to complete a new report some changes in the medical effectiveness analysis and in cost estimates would be expected.

My colleagues and I appreciate the opportunity to respond to your request and we are pleased to respond to any additional questions you or your staff may have. Please feel free to contact me at your convenience.

Sincerely,



Garen Corbett, MS
Director, CHBRP
Division of Health Sciences and Services
University of California, Office of the President

cc: Assembly Member Henry Perea, Author of Assembly Bill 1000
Assembly Member John Pérez, Speaker of the Assembly
Senator Darrell Steinberg, President Pro Tem of the Senate
Assembly Member Dan Logue, Vice Chair, Assembly Committee on Health
Assembly Member Felipe Fuentes, Chair, Assembly Committee on Appropriations
Assembly Member Diane L. Harkey, Vice Chair, Assembly Committee on Appropriations
Senator Tom Harman, Vice Chair, Senate Committee on Health
Senator Christine Kehoe, Chair, Senate Committee on Appropriations
Senator Mimi Walters, Vice Chair, Senate Committee on Appropriations
Celia Mata, Legislative Director, Office of Assembly Member Perea
Teri Boughton, Chief Consultant, Assembly Committee on Health
Melanie Moreno, Staff Director, Senate Committee on Health
Katie Trueworthy, Consultant, Senate Committee on Health
Bob Franzoia, Staff Director, Senate Committee on Appropriations
Brendan McCarthy, Consultant, Senate Committee on Appropriations
Lisa Murawski, Principal Consultant, Assembly Committee on Appropriations
Tim Conaghan, Consultant, Senate Republican Caucus
Kevin Hanley, Consultant, Assembly Republican Caucus
Shawn Martin, Director, Health Services, Legislative Analyst's Office
Leonor Ehling, Director, Senate Office of Research
Gareth Elliot, Deputy Legislative Secretary, Office of Governor Jerry Brown
Michael R. O. Martinez, Deputy Commissioner, Legislative Director, CDI
Brent Barnhardt, Director, California Department of Managed Care (DMHC)
Sherrie Lowenstein, Acting Assistant Director, California DMHC
Charlaine Hamilton, Senior Supervising Counsel/Legislative Coordinator, California DMHC
Mark Yudof, President, University of California, Office of the President (UCOP)
Dan Dooley, Senior Vice President, External Relations, UCOP
Steve Juarez, Associate Vice President and Director, State Governmental Relations, UCOP
Angela Gilliard, Legislative Director, State Governmental Relations, UCOP
John Stobo, Senior Vice President, Health Sciences and Services, UCOP
Lauren LeRoy, President and CEO, Grantmakers In Health and CHBRP, National Advisory
Council Chair In Health and CHBRP, National Advisory Council Chair