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Chairperson Rogers, Vice Chairs Whitsett and VanderWall and members of the committee

I am Dr Jerome Seid, and I am a practicing hematologist and oncologist in Macomb County, MI. I am past president of the Michigan Society of Hematology and Oncology. Thank you for the opportunity to once again come before you and provide testimony today in strong support of House Bill 4071 which provides for insurance coverage parity for oral anticancer medications. I want to personally thank my own Representative Steckloff for re-introduction of this important bill and championing this cause. I use the terms "once again" and "re-introduction" intentionally because in truth, this legislation has been introduced in this state legislature in some form and in both houses every legislative session since Dr. and Senator Roger Kahn first thought to do in 2011, before many if not all of members of today's committee were elected to serve. MSHO has been representing more than 2000 health care professionals in private practice, academic and hospital-based clinics for nearly 40 years. Our mission is and has always been to promote exemplary care for patients, your constituents with cancer and/or blood disorders through advocacy, education, and research. I raise these points because despite the nearly 12 years since this policy issue was first raised in the Michigan legislature you are now in a position, arguably enviable, to consider, debate and decide the merits of House Bill 4071 in an environment where success is achievable, and thousands of patients and families can finally receive the access they deserve.

Let me briefly review key background which provides the basis for the current legislation. Traditional cancer chemotherapy has generally been infused intravenously and is covered under the medical benefit of most insurance plans. Oral chemotherapy is not just a treatment which provides a convenient alternative for cancer patients (I am using the term cancer patients, but this includes patients with various blood disorders as well). In some cancers (and that number is increasing), oral chemotherapy may in fact be the best, first line treatment without an intravenous equivalent, and for physicians who practice the highest guideline concordant medicine, an ethical and scientific imperative as well. In daily hematology/oncology practice, oral chemotherapy agents are an increasing proportion of treatment recommendations, currently estimated to comprise about 25% - and the list is growing thanks to technological advancements.

Yet, in the current health insurance coverage climate, such oral therapies are covered under the outpatient prescription benefit. This can put an oral treatment out of reach for many desperate patients. Higher cost-sharing requirements imposed by insurers applied unevenly across the multitude of plans, even those offered by a single insurer, may result in patients having to skip treatment to save money for other essential costs such as housing, and food, delay treatment until they can pay, accept an intravenous alternative with its own consequences or forego treatment altogether. The increased risk of treatment non-adherence/non-compliance because of prohibitive costs threatens to produce worse outcomes for patients, higher rates of hospital usage, and conversely higher costs to insurers – contrary to some of the arguments you may hear in opposition to this bill. Not to be overlooked, it is a well-published fact that medical and medication costs are key factors in personal bankruptcy filings for US families.

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What has not been shown in any of the 43 states and Washington, D.C. which currently have laws providing for oral chemotherapy coverage parity, is an increase in costs to health plans. Just 4 years ago, the Journal of the American Medical Association published a study which demonstrated that most patients experienced a reduction in out-of-pocket expenses in 16 states that passed similar legislation between 2008 and 2012, without increasing health plan costs. And the non-partisan State of Michigan Senate Fiscal Agency conducted an analysis of a previous identical iteration of this same legislation and projected that it will have little to no impact on state or local government insurance costs and will not impact Medicaid expenditures. This is so because oral chemotherapy is a small portion of the oral pharmaceutical spectrum which contributes far more to overall insurance costs.

Imagine if you will for a moment the loss to an employer of a productive employee who is a patient or caregiver, etc. due to the need to miss work frequently to be at a doctor's office for an IV chemotherapy infusion for themselves or a family member for whom they provide care, merely because the personal out of pocket cost of oral treatment is prohibitive. You might begin to appreciate the actual advantage presented by such a law as the one before you, to that patient employee and business too.

When I last testified before you about this same bill, we were still in the thick of the COVID pandemic which added another dimension to the importance of oral chemotherapy use - to mitigate COVID exposure risk. Fortunately, COVID is now better controlled. However, the potential for COVID to mutate to flare up or for new health crises to emerge is real, and the benefit from reduced in-office exposure offered by oral chemotherapy use remains an important consideration. And in case you perceive my endorsement of oral parity legislation as a way to make things easier or more convenient for medical practices – many small and medium sized businesses – let me remind you of the countless and often non-reimbursable staff hours spent trying to procure oral medication in the current practice landscape. Truth be told, it is far easier and financially beneficial for physicians to use infused cancer drugs, that is to maintain the status quo.

To be clear, this important piece of legislation is not intended to address the pricing of drugs on the market – there are other avenues to do so. But it will reduce the cost-sharing burden on a select group of patients who are fortunate enough to now have quality treatment alternatives that also permit retention of productive independence without having to sacrifice efficacy. It is clearly good for patients, does not appear injurious to employers, and contrary to the stated but unsubstantiated positions of others, insurers either.

This bill - heartfelt, and personally relevant to both Representative Steckloff and to myself and the thousands of Michigan citizens and patients for whom we care is not a mandate. It is not about convenience for patients or doctors. It is and has always been since its inception in 2011, about doing the right thing, by protecting access to needed care for the residents of Michigan.

Once again, Chairperson Rogers I strongly urge this committee to act favorably and swiftly upon this HB4071.

Thank You,
Jerome Seid, M.D., F.A.C.P.