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ENVIRONMENT COMMITTEE
JUDICIARY COMMITTEE

February 18, 2010

Senator Crisco, Representative Fontana, Senator Caligiuri, Representative D'Amelio and Distinguished Members of the Insurance and Real Estate Committee:

Thank you for raising Senate Bill 50, An Act Concerning Oral Chemotherapy Treatments. I attach to my testimony a letter I received from my constituent, Duke Moore, together with a *New York Times* article he sent me and an OLR report I asked for on this topic. For all the reasons outlined in Mr. Moore's letter, passage of this bill will assist individuals and their families who are seeking the best treatment options in their battle against cancer.

Thank you again for raising this important bill.

DUKE MOORE AIA ARCHITECT

FALLS VILLAGE, CT 06031
PHONE (860) 824-5526
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Senator Andrew Roraback
P.O. Box 357
455 Milton Road
Goshen, CT 06756

April 20, 2009

Dear Senator Roraback,

I am writing to you regarding what I believe to be an important healthcare issue. Enclosed is an article from the New York Times describing the use of pills as an alternative to intravenous chemotherapy for cancer treatment. This is becoming more frequent as medicine advances in its fight against cancer and other diseases. Unfortunately, medical insurance has not advanced as rapidly. While insurance companies will pay for the more costly chemotherapy, many of them won't pay for a prescription, which will do the same thing or in some cases, the prescription is the only resource against certain illnesses and diseases. While cheaper than chemotherapy, the prescriptions, as the article points out, are not cheap. Some of them cost thousands of dollars per month.

Oregon and certain other states have begun to correct this failure of the insurance companies to reimburse patients for oral medicines, and now require them to do so. I am interested in learning your opinion on this matter and am wondering if you would sponsor similar legislation in our state.

Thank you for your time in this matter, and I await to hear from you.

Best,



Duke Moore
175 Dublin Road
Falls Village, CT 06031

The New York Times

Late Edition

Today, morning showers, then mostly cloudy and cool, high 49. Tonight, clearing, patchy fog late, low 39. Tomorrow, sunny and milder, high 59. Weather map, Page A18.

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"All the News That's Fit to Print"

Insurance Lags As Cancer Care Comes in a Pill

Expensive Alternative to Intravenous Drugs

By ANDREW POLLACK

Chuck Stauffer's insurance covered the surgery to remove his brain tumor. It covered his brain scans. And it would have paid fully for tens of thousands of dollars of intravenous chemotherapy at a doctor's office or hospital.

But his insurance covered hardly any of the cost of the cancer pills the doctor prescribed for him to take at home. Mr. Stauffer, a 62-year-old Oregon farmer, had to pay \$5,500 for the first 42-day supply of the drug, Temodar, and \$1,700 a month after that.

"Because it was a pill," he said, "I had to pay — not the insurance."

Pills and capsules are the new wave in cancer treatment, expected to account for 25 percent of all cancer medicines in a few years, up from less than 10 percent now.

The oral drugs can free patients from frequent trips to a clinic to be hooked to an intravenous line for hours. Fewer visits might save the health system money as well as time. And the pills are a step toward making cancer a manageable chronic condition, like diabetes.

But for many patients, exchanging an I.V. bag for a pill is a lopsided trade because the economics and practice of cancer medicine have not caught up with the convenience of oral drugs.

Start with the double ledger of drug insurance. Drugs that are infused at a clinic are typically paid for as a medical benefit, like surgery. Pills, though, are usually covered by prescription drug plans, which are typically much less generous; for expensive cancer pills, patients might face huge co-payments or quickly exceed an annual coverage limit. Sometimes, as in Mr. Stauffer's case, a

Continued on Page A17

New In Pill Form

A growing number of cancer treatments are available as pills or capsules. Here is a sampling of the main ones now in use.

Brand name Generic name Maker Year of approval Approved uses Price	Xeloda capecitabine Roche 1998 Breast, colorectal cancers \$3,600	Temodar temozolomide Schering-Plough 1999 Brain cancer \$2,200 to \$8,800	Gleevec imatinib Novartis 2001 Chronic myeloid leukemia, gastrointestinal stromal tumor \$3,600	Tarceva erlotinib OSI Pharmaceuticals, Genentech 2004 Lung, pancreatic cancers \$3,200 to \$3,700	Nexavar sorafenib Onyx Pharmaceuticals, Bayer 2005 Kidney, liver cancers \$5,600	Revlimid lenalidomide Celgene 2005 Multiple myeloma, myelodysplastic syndrome \$3,000 to \$6,900	Sprycel dasatinib Bristol-Myers Squibb 2006 Chronic myeloid leukemia, acute lymphoblastic leukemia \$6,000	Sutent sunitinib Pfizer 2006 Kidney cancer, gastrointestinal stromal tumor \$4,700	Zolanza vorinostat Merck 2006 Cutaneous T-cell lymphoma \$7,900	Tykerb lapatinib GlaxoSmithKline 2007 Breast cancer \$3,300
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*Wholesale price for a month of treatment, rounded to the nearest \$100, according to the manufacturers. Actual cost can vary.

Source: The companies

THE NEW YORK TIMES

Insurance Lags as Cancer Care Comes in a Pill Instead of an I.V.

Doctors Face Fiscal Squeeze For Treatment

By ANDREW POLLACK

From Page A1

single insurer is involved. Many times, though, a separate company — a so-called pharmacy benefit manager — provides the prescription drug coverage.

The growing use of cancer pills is also thrusting patients and doctors into new roles they have not yet fully mastered. Without a physician's direct supervision, side effects can be missed. Some patients do not take all their medicine, raising the risk their cancer will worsen. Others take too many pills, risking toxic reactions.

For doctors, the new drugs also pose financial challenges. Physicians can profit from infusing drugs in their offices but not from writing prescriptions that are filled at a pharmacy.

With oral cancer drugs, "the technology has outstripped the ability of society to integrate it into the mainstream in a smooth fashion," said Carlton Sedberry, a pharmacy expert at Medical Marketing Economics, a consulting firm.

Oregon, partly in response to Mr. Stauffer's case, has passed a law requiring insurance companies to provide equivalent coverage of oral and intravenous cancer drugs. Some other states are now considering similar measures.

So far the health reform debate in Washington has not delved into specifics like cancer pill coverage.

Infused drugs, of course, can also be frightfully expensive and under some insurance plans — including Medicare — can carry big co-payments. But it is the oral drugs that seem to be causing a disproportionate number of financial problems for cancer patients. The Patient Advocata Foundation, an organization that helps people make insurance co-payments for cancer drugs, says oral medicines accounted for 58 percent of the cases in which it helped Medicare patients last year, even though far more cancer patients were on intravenous drugs.

One oncology practice in central Pennsylvania has a nurse assigned full time to dealing with patients on oral drugs and arranging insurance or charity payments for the pills. "Trying to obtain this drug for the patient — that's my struggle, every single day," said the nurse, Jane Flenner.



Chuck Stauffer's insurance covered hardly any of the cost of the cancer pills the doctor prescribed for him to take at home.

Although drug makers are developing oral versions of some infused cancer medications, most of the new pills and capsules have no intravenous equivalent.

The oral exemplar is Gleevec from Novartis, which since its approval in 2001 has helped turn chronic myeloid leukemia as well as gastrointestinal stromal tumors into manageable diseases for many patients.

Douglas Jensen, 75, of Canby, Ore., has taken Gleevec for 10 years for leukemia. He goes for a blood test once every three months and sees his oncologist every six months, but is healthy enough to go whitewater rafting.

Making it even easier, Mr. Jensen gets his Gleevec free because he participated in an early clinical trial of the drug. Otherwise it would cost more than \$40,000 a year.

While Mr. Jensen has been diligent about taking his five capsules every day at lunchtime, research indicates that many patients on the oral drugs do not consistently take the proper dose. One study, for example,

found that Gleevec patients, on average, were taking only 75 percent of their prescribed doses.

Some cancer patients skip pills or stop taking them completely — whether because of costs, forgetfulness, side effects, complicated regimens or other factors.

"When I first started looking into this, I thought, 'People with cancer have too much to lose,

Oral medicines are the new wave in cancer treatment.

how can they not take their drugs?" said Dr. Ann Partridge, an oncologist at Dana-Farber Cancer Institute in Boston.

Some other cancer patients, meanwhile, end up taking too many pills.

Gayne Ek of Allen, Tex., said he once skipped all of his Gleevec capsules for six weeks. Then, with the stockpile of capsules he

accumulated, he took twice the prescribed dose for six weeks, hoping it would be more effective. It was not.

For many patients, though, the main challenge is not taking their pills, but paying for them. Under Medicare, most oral cancer drugs are covered by the Part D prescription drug program, which has a 25 percent co-payment. It also has the annual "doughnut hole" — reached when a patient's total drug costs hit \$2,700, after which the patient must shoulder the next \$3,000 or so before coverage resumes.

Mary Francis Thomas of Camp Hill, Pa., reached the doughnut hole on her very first prescription of the year. Ms. Thomas, 88, had to pay \$4,300 in January for a month's supply of Revlimid, to treat a disorder that can lead to leukemia. Having now passed through the doughnut hole, she must pay 5 percent of the cost of the drug for the rest of the year — which still works out to \$377 a month.

Drug companies say they provide free drugs for some patients and give money to charities for

co-payment assistance. And Lee Newcomer, senior vice president for oncology at UnitedHealthcare, the big insurer, said many commercial policies capped total annual out-of-pocket expenditures, so patients should not have huge co-payments month after month.

But nurses and patient advocates say that many patients still have trouble paying for the drugs.

Mr. Stauffer, the Oregon farmer, is no longer one of them, though. After his daughter, Heather Kirk, told his story to Peter Courtney, the president of the state senate, Oregon enacted in late 2007 the nation's first state law requiring insurers to provide equivalent reimbursement for oral and intravenous chemotherapy drugs.

Mr. Stauffer's insurer, Regence Blue Cross Blue Shield, even reimbursed him for the money he had already spent on Temodar. Several other states, including Colorado, Hawaii, Minnesota, Montana, Oklahoma and Washington, are now considering similar legislation.

Even as pills and capsules improve life for some cancer patients, they are sapping the finances of many cancer doctors.

For drugs they administer in their offices, oncologists can make money. They buy those drugs wholesale and then get reimbursed — usually at a higher price — by patients and insurers when they use the drugs. They also are paid for administering the infusion.

But with oral drugs, the doctors just write a prescription the patient fills through a pharmacy. The doctors make no money from the drug, and they have no infusion to bill for.

Some doctors say the pills are actually raising their operating expenses. "The patients are still calling your nurses and talking about side effects, but there's no payment for that," said Dr. Patrick Cobb, a cancer doctor in Montana. He is president of the Community Oncology Alliance, a lobbying group representing oncologists, which has started a project to measure the costs incurred in dealing with oral cancer drugs.

Some large oncology practices are opening their own pharmacies, in part to capture some of the profits from oral drugs. But the doctors say it is mainly for patient convenience, adding that neighborhood drugstores often do not carry cancer drugs because they are costly and used by relatively few customers.

Cancer doctors generally deny that financial considerations spur them to use intravenous drugs over oral drugs when there is a choice, saying they do what is best for the patient. In any case, they say, changes in Medicare reimbursement have greatly reduced the profits oncologists can make on infused drugs.

Oncologists are fighting a demand by the Medicare overseer for New York and Connecticut that the doctors first try oral drugs to treat the nausea caused by chemotherapy.

Doctors' groups say they are resisting not because of money but because intravenous anti-nausea drugs are often better.

"If you're feeling nauseous," said Dawn Holcombe, executive director of the Connecticut Oncology Association, "if someone gave you a pill, would you want to take it?"

HEALTH INSURANCE COVERAGE FOR CANCER PILLS
5 of 7 document(s) retrieved

Location:

DISEASES; DRUGS; INSURANCE - HEALTH;

**OLR RESEARCH REPORT**

August 19, 2009

2009-R-0311

HEALTH INSURANCE COVERAGE FOR CANCER PILLS

By: Janet L. Kaminski Leduc, Senior Legislative Attorney

You asked if Connecticut law requires health insurance policies to provide coverage for oral medication to treat cancer and, if not, if a law could be passed to require such coverage. You provided an article from The New York Times that discussed the coverage issue as stemming from the difference in cost between receiving cancer medications intravenously versus orally in pill form (*Insurance Laws as Cancer Care Comes in a Pill*, April 15, 2009).

SUMMARY

Connecticut law does not mandate coverage of oral medication to treat cancer (i. e., cancer pills) and insurance policies filed with the Connecticut Insurance Department do not specifically address oral cancer treatments, according to Dawn McDaniel, a department spokesperson. McDaniel also noted that the department's Consumer Affairs Division is not aware of receiving any complaints on this topic.

The legislature could enact a law that requires coverage of oral cancer treatment. Two states have addressed this issue to date, Oregon and Hawaii. These states require coverage of oral chemotherapy on the same basis as intravenously-administered chemotherapy.

CONNECTICUT

Connecticut does not mandate insurance coverage for oral cancer treatment. But state law includes a requirement for off-label cancer drugs (CGS §§ 38a-492b and 38a-518b). Under this law, if a covered prescription drug is recognized for treatment of a specific type of cancer, an insurance policy cannot exclude coverage of the drug when it is prescribed to treat another type of cancer.

Due to federal law (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans. A self-insured health benefit plan is one that is not backed by an insurance policy. Rather, the plan sponsor funds and administers the plan (i. e., pays claims covered by the benefit plan from its own money, which may include

money collected from plan enrollees as premiums). A plan sponsor may outsource or delegate the administration of its self-insured plan to a third-party administrator (TPA) (often an insurance company), but the TPA does not provide the employer with financial backing or assume financial risk associated with the claims.

For a list of public acts related to cancer passed in Connecticut from 1998 to 2008, see OLR Research Report 2008-R-0349.

OREGON

Oregon enacted a law in 2007 that requires a health benefit plan that covers cancer chemotherapy treatment to cover prescribed, orally administered anticancer medication on a basis that is no less favorable than coverage for intravenously administered or injected cancer medications (Or. Rev. Stat. § 743A.068).

HAWAII

In 2009, Hawaii enacted and the governor signed a law that takes effect on January 1, 2010 (HI S. B. 166, Act No. 168). Under the law, health insurance policies and HMO contracts that cover cancer treatment must cover medically necessary chemotherapy, including orally administered chemotherapy, which must be subject to the same copayment or coinsurance amount that applies to intravenously administered chemotherapy.

The act defines "intravenously administered chemotherapy" as a physician-prescribed cancer treatment that is administered through injection directly into the patient's circulatory system by a physician, physician assistant, nurse practitioner, nurse, or other medical personnel under the supervision of a physician and in a hospital, medical office, or other clinical setting.

It defines "oral chemotherapy" as a U. S. Food and Drug Administration-approved, physician-prescribed cancer treatment that is taken orally in the form of a tablet or capsule and may be administered in a hospital, medical office, or other clinical setting or may be delivered to the patient for self-administration under the direction or supervision of a physician outside of a hospital, medical office, or other clinical setting.

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