**PA10-063**

**SB050**

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|---|---|---|
| House | 4083-4103 | 21 |
| Insurance | 463-510, 568-612, 644-645, 1402, 1405 | 97 |
| Senate | 1468-1480, 1497-1498 | 15 |
| | | 133 |

**H – 1085**

# CONNECTICUT
# GENERAL ASSEMBLY
# HOUSE

## PROCEEDINGS
## 2010

**VOL.53**
**PART 13**
**3923 – 4245**

On page 22, Calendar 425, Substitute for Senate Bill Number 50, AN ACT CONCERNING ORAL CHEMOTHERAPY TREATMENTS, favorable report of the Committee on Appropriations.

DEPUTY SPEAKER O'ROURKE:

The Chair recognizes the chairman of the Insurance Committee, Representative Fontana.

REP. FONTANA (87th):

Thank you, Mr. Speaker.

Mr. Speaker, I move for acceptance of the joint committee's favorable report and passage of the bill in concurrence with the Senate.

DEPUTY SPEAKER O'ROURKE:

Motion is on acceptance and passage.

Will you remark?

REP. FONTANA (87th):

Thank you, Mr. Speaker.

Mr. Speaker, this bill requires health insurance policies that currently cover intravenously and orally administered anti-cancer medications to cover orally administered medications on at least as favorable a basis as intravenously administered medications. It also prohibits insurers from reclassifying anti-cancer

medications or increasing a patient's out-of-pocket costs for medications as a way of complying with this requirement.

Mr. Speaker, I have a -- a few remarks I'd like to offer before I offer a technical amendment.

Mr. Speaker, just to explain the background of this bill, every year in the Insurance Committee we hear a proposed bill that really causes all of us on a bipartisan basis to sit up and take note. And this year, Mr. Speaker, this bill was that bill. For those of you who don't know the cancer treatment methodologies have been evolving over time. Formerly, of course, the traditional form of treatment was intravenously administered chemotherapy. It was developed in the 60s and 70s and for a long time was the only way of providing cancer treatment of that type.

Most recently however though, Mr. Speaker, the industry has been developing oral chemotherapy treatments and this is good news for patients because oral chemotherapy treatments avoid a number of problems such as risk of infection, transporting yourself to and from a doctor's office or another facility, as well as concern about child care or

the amount of time away from work that you have to take in order for -- to receive the treatment.

The bad news is that many policies and plans do not cover them on an equivalent basis. Oral chemotherapies cost far more because policies typically place a much larger out-of-pocket cost on oral chemotherapies than they do on equivalent intravenous therapies. If, in fact, there are any equivalent therapies at all, Mr. Speaker, which is part of the problem and I'll get to back to that in a moment.

The bottom line, Mr. Speaker, is that if you need oral chemotherapy treatment to treat your particular form of cancer, it can cost you far more than if intravenous were available to you and this could have a terribly detrimental impact on numerous families. Mr. Speaker, we heard testimony in our hearings from women all over the state talking about the difficulty they and their families were experiencing in dealing with this.

And I'd just like to share two of those stories with the Chamber, if I could, to try to illustrate the difficulty that these women face. One woman, Mr. Speaker, a young woman from West

Hartford, came before us and said I take oral chemotherapy because the port in my chest where I received intravenous chemotherapy became infected and that infection moved to my heart. I had to go to Saint Francis Hospital for open heart surgery and spent 40 days there. As a result I can no longer receive intravenous chemotherapy; I can only receive oral chemotherapy.

And what's worse is, given the manner in which her plan deals with prescription drug benefits, it's much more difficult to pay for that. In fact, instead of paying $20 per co-pay per intravenous treatment, she must pay $700 a month which is practically more than she can afford. In fact, Mr. Speaker, she works part-time while she's receiving chemotherapy treatment to pay for her chemotherapy treatment.

And Mr. Speaker, the most significant communication I received came from a woman who may be watching now for all I know on CT-N who shared with me, through emails, her -- her personal experience and I'd like to share that with the Chamber.

Mr. Speaker, she pays $4,400 a month for her

chemotherapy. She has no choice in the matter. Her physician has prescribed that oral chemotherapy and there is no intravenous equivalent. She must take the oral chemotherapy to treat her cancer or she will die. The problem is, Mr. Speaker, that her policy covers 100 percent of intravenous chemotherapy costs but only $2,000 annually for all prescription drugs under her plan. So even though she's fully insured, she has to spend $52,800 a year out of her own pocket for her oral chemotherapy in order to live.

And the worst part, Mr. Speaker, according to her, she just keeps charging up her monthly prescription drug costs on her credit card because she doesn't have that money.

Mr. Speaker, the bill before us is patterned on laws already in effect in Oregon, Indiana, Hawaii, Vermont, Iowa and the District of Columbia and it is not, repeat not, a new mandate. It is a redefinition or clarification, if you will, of an existing mandate that companies have to comply with to cover chemotherapy treatment.

And with that, Mr. Speaker, I would ask that the Clerk please call an amendment, LCO 3006,

otherwise identified as Senate Amendment Schedule "A." I ask that he call it and I seek permission to summarize.

(Deputy Speaker Godfrey in the Chair.)

DEPUTY SPEAKER GODFREY:

Clerk is in possession of LCO Number 3006, previously designated as Senate Amendment Schedule "A."

Mr. Clerk, please call the amendment.

THE CLERK:

LCO Number 3006, Senate "A," offered by Senator Crisco and Representative Fontana.

DEPUTY SPEAKER GODFREY:

Gentleman has asked leave of the Chamber to summarize.

Is there objection?

Hearing none, please proceed Representative Fontana.

REP. FONTANA (87th):

Thank you, Mr. Speaker.

Mr. Speaker, this amendment makes a clarifying technical change to the underlying bill. It has no

fiscal impact. I move for its adoption.

DEPUTY SPEAKER GODFREY:

The question is on adoption.

Will you remark on Senate Amendment Schedule "A?" Will you remark on Senate Amendment Schedule "A?"

If not, let me try your minds.

All those in favor, signify by saying aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER GODFREY:

Opposed nay.

The ayes have it. The amendment is adopted.

Will you remark on the bill as amended?

The gentleman from West Hartford, Representative Fleischmann.

REP. FLEISCHMANN (18th):

Thank you, Mr. Speaker.

Mr. Speaker, I rise in strong support of the bill that's before us and I wanted to express my personal thanks to the chairs of the Insurance Committee, Representative Fontana and Senator Crisco. If you spend time around a cancer center, you get to know people who have all sorts of

different protocols. A lot of folks assume that, you know, chemotherapy is chemotherapy. There are as many varieties of chemotherapy as there are varieties of cancer.

If an oncologist decides that what is needed is an oral chemotherapeutic agent, than that is what is needed. There is absolutely no reason that I could ever imagine in an equitable world that an insurance policy that covered intravenous chemotherapy would not also cover oral chemotherapy. I have friends who have been put on oral chemotherapy regiments. I've had to help people try and get coverage for these pills that are saving their lives. It doesn't make any sense at all that such fights should happen.

And -- so again I wanted to thank the Insurance Committee and its leadership for promoting this legislation and I hope all my colleagues will join me in supporting it.

DEPUTY SPEAKER GODFREY:

Thank you, sir.

The gentleman from Waterbury, Representative D'Amelio.

REP. D'AMELIO (71st):

Thank you, Mr. Speaker and good evening to you.

Mr. Speaker, I also rise in strong support of the bill before us. You know there's nothing really more to add. Representative Fontana did a great job in bringing this bill out. I just can't believe in today's day and age that we're standing here having to debate these bills.

These pills are -- are necessary for so -- so many people in the State of Connecticut. As Representative Fontana brought out two examples that the women that he talked about testified before our committee they have no choice but to go to the oral chemotherapy. But by the passage of this bill we're going to give a better quality of life to many people in the State of Connecticut.

People are no longer going to have to go to -- to the cancer centers to receive chemotherapy. If they qualify for this drug or if this drug -- the oral chemotherapy is something that they can do, they can do it at home and go to work and enjoy their families. So with that, ladies and gentlemen, I -- I just hope the entire Chamber supports this bill.

Thank you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Thank you, sir.

The gentleman from Stratford, Representative Miller.

REP. MILLER (122nd):

Thank you, Mr. Speaker.

I rise in support of the bill but I have a couple of questions.

DEPUTY SPEAKER GODFREY:

Please proceed, sir.

REP. MILLER (122nd):

There's so much new medicine coming out, new discoveries every -- every week almost and there are a number of drugs that are made intentionally to be taken by mouth. As you've said it's for convenience. They don't have to go to the hospital. They don't have to get hooked up; the whole nine yards.

But now these things are oral medications and they run around $8,000 a month and some insurance companies might consider them experimental, although they're proven drugs today. With these because they're not administered by vein, they're

pills, would they be covered?

Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, if a -- if a oral chemotherapy treatment is classified in any way as experimental, I do not believe it is covered. If it is approved for use, it would be covered and that applies whether it's $80 a month, $800 a month or $8,000 a month.

Through you.

DEPUTY SPEAKER GODFREY:

Representative Miller.

REP. MILLER (122nd):

I think that's it, Mr. Speaker.

Thank you very much, Representative Fontana.

DEPUTY SPEAKER GODFREY:

Thank you, sir.

Gentlewoman from Norwich, Representative Hovey.

REP. HOVEY (112th):

Thank you, Mr. Speaker.

Mr. Speaker, I rise in support of this

legislation. You know when someone is in a fight for their life, they should not be having a fight with their insurance company.

Thank you, sir.

DEPUTY SPEAKER GODFREY:

Thank you, madam.

Gentleman from New Canaan, Representative Hetherington.

REP. HETHERINGTON (125th):

Thank you, Mr. Speaker.

Just a quick question or two to the proponent.

DEPUTY SPEAKER GODFREY:

Please proceed, sir.

REP. HETHERINGTON (125th):

Thank you.

Are there some cancer therapy drugs that can be administered either intravenously or by mouth?

Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, yes there are.

DEPUTY SPEAKER GODFREY:

Representative Hetherington.

REP. HETHERINGTON (125th):

Thank you.

My intuitive reaction is that it ought to be a lot more cost effective to deliver this therapy orally than intravenously because obviously it doesn't require intrusive procedure.

Could you comment on that please?

Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, the gentleman makes a good point and, in fact, that was the subject of some questioning in our public hearing. It truly depends upon the particular cancer that a person suffers from along with the particular oral and intravenous treatments.

It is true and that his belief was our belief. That if you add up the costs of going to a facility, time off from work, the cost of the intravenous treatment itself, the risks of infection and hospitalization as a result of -- of infection, that yes in fact, in many cases, the cost of intravenous treatment does equal or exceed

the costs of oral treatment.

It just depends upon the particular pairing, if you will, in those cases where both exist and we were not able to get sufficient detail or data from the insurance industry to know whether, in fact, that was true in every case. But certainly I agree with the gentleman's premise which is that in many cases, when there are both oral and intravenous alternatives, the oral will be, if it is not already, more cost effective.

Through you.

DEPUTY SPEAKER GODFREY:

Representative Hetherington.

REP. HETHERINGTON (125th):

I thank the gentleman and thank you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Thank you, sir.

Gentleman from Norwich, Representative Coutu.

REP. COUTU (47th):

Thank you, Mr. Speaker.

Mr. Speaker, a few questions to the proponent of the bill, through you.

DEPUTY SPEAKER GODFREY:

Please proceed.

REP. COUTU (47th):

Thank you.

I just have one -- two questions. The first being obviously I suspect the oral medication is something new that's why I -- I would assume the cost is probably a little more and has any other states passed this type of legislation?

DEPUTY SPEAKER GODFREY:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, yes in many cases because the industry seems to be going in the direction of oral as opposed to intravenous chemotherapies, they are initially more expensive although the price comes down and as I indicated earlier there are a number of oral chemotherapy treatments that are actually extremely cost effective, vis-a-vis, intravenous alternatives.

Having said that, to answer the gentleman's second question, yes there are I believe five states and I apologize. It was I believe Oregon, Indiana, Iowa, Hawaii, Vermont and the District of Columbia that already have these laws in place and

there are bills in other states pending.

Through you.

DEPUTY SPEAKER GODFREY:

Representative Coutu.

REP. COUTU (47th):

Thank you, Mr. Speaker.

And secondly, do we have an idea of what the cost would be for a mandate like this per patient?

DEPUTY SPEAKER GODFREY:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, no we do not have an assessment of that cost. Again we did not get sufficient data from the industry to make even a stab at that kind of analysis or assessment. We did receive data from people representing the Susan G. Komen Race for the Cure organization, a foundation, indicating that for many oral chemotherapy treatments the price is cost competitive with intravenous.

But on a patient-by-patient basis it really depends, Mr. Speaker, on the particular cancer, the particular pairing of oral and intravenous, assuming a pairing actually exists, along with the

particular duration of treatment. So I -- I really can't answer that with more specificity.

Through you.

DEPUTY SPEAKER GODFREY:

Representative Coutu.

REP. COUTU (47th):

Thank you, Mr. Speaker.

Mr. Speaker, as somebody who has lost multiple people this year from cancer in my family, I'm passionate on this issue and I understand how it seems each year we have new mandates put on the insurance sector, in my view, with insurance plans and it's hard to really say that you're not against them when you know there is complications from such things as getting the needles in other ways when you can take something like this orally.

But I just want to point to last year there was 10 to 15 other mandates proposed and for somebody who in the past had to pay, me and my wife, up to $500 a month for insurance, we were at a point where if there was another mandate and it cost another $10, we wouldn't have been able to have any insurance.

So I just think in the future we always have

to be conscious that when there's a lot of mandates proposed, yes there's going to be specific examples where people need this important medical service but some companies are on the brink of extinction and when you add a few more mandates and they have to pay another $10, $20, $30, $40 per employee, it ends up they basically layoff employees or they move on to another state so I just think we have to be conscious of that.

With that being said, it's really hard to be against something like this when we know there are people out there who need this but we'll leave it at that.

Thank you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Thank you, sir.

Gentlewoman from Plainville, Representative Boukus.

REP. BOUKUS (22nd):

Thank you, Mr. Speaker.

Mr. Speaker, we've heard a great deal about oral chemotherapy and you may have received the same email that I have that I received on Sunday and it's from a person, a person could be our

neighbor, could be our friend, could be a relative and what she states that she has no other choice that it's a prescription only for oral chemotherapy. She pays -- if she went to Sloan-Kettering it would be $5,000 a month. She pays $4,400 at a local drug store. She also pays $1,536 each month for her own insurance for her two -- her family of two adults and two children. Her total cost for healthcare is $71,232. That's unfathomable for me to understand that healthcare is so expensive.

But it also points out to me there are people in great need and, if we've ever thought about healthcare, we really ought to think about it in terms of this one person. She writes she has no choice but to just put it on her credit card each month. A frightening, frightening situation so I absolutely stand in support of this. As more people become serviced by this type of treatment costs will come down. In the long run not having to go to the hospital, not having to survive the ramifications of the other kinds of chemotherapy, this seems to be a -- a godsend and as a godsend I truly support it.

So thank you.

DEPUTY SPEAKER GODFREY:

Thank you, madam.

Will you remark further on the bill as amended? Will you remark further on the bill as amended?

If not, staff and guests please come to the well of the House. Members take their seats. The machine will be open.

THE CLERK:

The House of Representatives is voting by roll call. Members to the chamber. The House is voting by roll call. Members to the chamber.

DEPUTY SPEAKER GODFREY:

Have all members voted? Have all members voted? If so, the machine will be locked and the Clerk will take a tally and the Clerk will announce the tally.

THE CLERK:

Senate Bill Number 50 as amended by Senate "A" in concurrence with the Senate.

| | |
|---|---|
| Total number voting | 150 |
| Necessary for passage | 76 |
| Those voting Yea | 150 |
| Those voting Nay | 0 |

Those absent and not voting 1

DEPUTY SPEAKER GODFREY:

The bill as amended is passed in concurrence with the Senate.

(Deputy Speaker O'Rourke in the Chair.)

DEPUTY SPEAKER O'ROURKE:

Mr. Clerk, please call Calendar 403.

THE CLERK:

On page 18, Calendar 403, Substitute for Senate Bill Number 215, AN ACT CONCERNING VETERAN TUITION WAIVERS, favorable report of the Committee on Higher Education and Employment Advancement.

DEPUTY SPEAKER O'ROURKE:

Representative Graziani.

REP. GRAZIANI (57th):

Thank you very much, Mr. Speaker.

Mr. Speaker, I move for the acceptance of the joint committee's favorable report and passage of the bill.

DEPUTY SPEAKER O'ROURKE:

Motion is on acceptance of the committee's favorable report and passage of the bill.

**S – 602**

# CONNECTICUT
# GENERAL ASSEMBLY
# SENATE

## PROCEEDINGS
## 2010

**VOL. 53**
**PART 5**
**1267 – 1608**

Senator Fasano.

SENATOR FASANO:

Thank you, Mr. President.

Mr. President, I do not have an amendment, however, I just wanted to make the comment that as I approach it, 60 seems a little bit young to be starting that but just as a comment.

Thank you, Mr. President.

THE CHAIR:

Will you remark further on Senate Bill 190? Will you remark further?

Senator Crisco.

SENATOR CRISCO:

Thank you, Mr. President.

Since this bill qualifies for bill of the year, I ask that it be placed on the consent calendar.

THE CHAIR:

There is a motion on the floor to place the item on Consent.

Seeing no objection, so ordered.

Mr. Clerk.

THE CLERK:

Calendar page 29, Calendar Number 129, File

SB 50

Number 160, Substitute for Senate Bill 50, AN ACT CONCERNING ORAL CHEMOTHERAPY TREATMENTS, favorable report of the Committee on Insurance and Appropriations.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Thank you, Mr. President.

Mr. President, I move for acceptance of the Joint Committee's favorable report and passage of the bill.

THE CHAIR:

Acting on acceptance and approval, sir, would you like to remark further?

SENATOR CRISCO:

Yes, Mr. President.

THE CHAIR:

Please proceed.

SENATOR CRISCO:

The Clerk has -- sorry, sir.

THE CHAIR:

That's okay, please proceed.

SENATOR CRISCO:

Mr. President, the Clerk has LCO Number 3006.

I request that it be called and I be given permission to summarize.

THE CHAIR:

Mr. Clerk.

THE CLERK:

LCO 3006, which will be designated Senate Amendment Schedule "A," is offered by Senator Crisco of the 17th district.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Mr. President, I move for its adoption.

THE CHAIR:

Please proceed, sir.

SENATOR CRISCO:

Mr. President, this amendment is strictly technical and addresses the necessary redrafting of -- of the legislation.

THE CHAIR:

Thank you, sir.

Will you remark further on Senate "A?" Will you remark further on Senate "A?"

If not, I will try your minds. All those in favor, please signify by saying, aye.

SENATORS:

Aye.

THE CHAIR:

Opposed, nays.

The ayes have it. The motion is adopted.

Senator Crisco.

SENATOR CRISCO:

Mr. President, thank you.

Mr. President, just a brief summary. This bill demonstrates the technology changes that is occurring in the medical care. Prior to oral chemotherapy, individuals had to sit for hours through an IV treatment for their chemotherapy. We had an individual testify that because of this invasion of the body, this person developed an infection that affected the heart and where heart required surgery.

Since that time the pharmaceuticals have come up with an oral chemotherapy method where an individual, if they can tolerate the medication, instead of going in for IV chemotherapy, could take their medication at home, could work at home, could possibly even go to work with the oral chemotherapy and -- if their system could tolerate the system.

It shows a great change in technology and basically what this bill is asking for is just parity between the IV treatment and the oral chemotherapy treatment. It has been found that some insurance companies, not all, were increasing the deductibles and co-pays for oral chemotherapy which really the -- the technique results in less cost than more cost.

THE CHAIR:

Thank you, sir.

Will you remark on the bill as amended?

Senator Caligiuri.

SENATOR CALIGIURI:

Thank you, Mr. President.

If I may I have a -- a few questions through you to Senator Crisco.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Yes, Mr. President.

SENATOR CALIGIURI:

Thank you, Mr. President.

Just for the sake of the record and -- and Senator Crisco alluded to this but I think it's

very important that we make this as clear as possible and -- and the following is my understanding and I want to see if it comports with Senator Crisco's understanding.

The legislation and the intention of the Insurance Committee when we drafted this legislation was not to create a new benefit or an additional benefit but rather to ensure that health insurers treat orally available chemotherapy the same as they do intravenous-based chemotherapy in cases where patients are prescribed oral chemotherapy for them as being better for them than IV. And that what we're really trying to do, in this language, is to make sure that the two forms of chemotherapy are treated equally and not to add a benefit per se.

Is that a correct understanding, through you, Mr. President, to Senator Crisco?

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Mr. President, through you to Senator Caligiuri, absolutely correct.

THE CHAIR:

Senator Caligiuri.

SENATOR CALIGIURI:

I thank you, Mr. President.

I than Senator Crisco for that response and if I may by way of commenting on the bill as amended, that is my understanding as well which is reason why, despite the fact that I opposed every bill this year in committee that I can recall that I thought amounted to an additional mandate or a new mandate, I supported this bill in committee because I viewed this legislation as being designed to create parity between two types of chemotherapy and not as adding a new level of coverage or an additional level of coverage that is not otherwise being provided for today.

And from that point of view I felt very comfortable supporting the legislation and the Insurance Committee feel support -- comfortable supporting it today because I really believe, from my point of view, that this is about creating parity and equal treatment between these two forms of chemotherapy given the evolving technology and medical advancements that we've made and the fact that some people simply need or react better to the

oral chemotherapy than they do through the IV that -- that I believe this bill is worthy of our support today.

And so with that, Mr. President, I thank Senator Crisco and I thank you for the opportunity to speak on the bill.

THE CHAIR:

Thank you, Senator Caligiuri.

Will you remark further?

Senator Boucher.

SENATOR BOUCHER:

Thank you, Mr. President.

Mr. President, I rise to express my appreciation for the dialogue that just took place that probably answered one of the two questions that I had concerning this bill, as you well know, that many of us are concerned for the number of new mandates being placed on insurance policies that cause some of our insurance carriers to raise rates on our smaller and larger employers here in the state of Connecticut.

The -- the -- I still have the question of why we actually need this bill if, in fact, it's recognized that they do have parity in this motive

of medicine but also to the fact that oftentimes it's much less expensive.

Added to that, I guess my further question would be has there been a significant problem for us to raise this bill and, secondarily, if in fact someone has not -- been denied the oral chemotherapy, were they aware that we really passed ground breaking legislation that provided for an outside appeals process for any insurance denial on health care to go through our state insurance department, where they would actually mediate a decision and oftentimes has overturned a number of complaints and grievances that have come forward.

Through you, Mr. President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Mr. President, through you to Senator Boucher, the intention of the bill, in addition to parity, is to give a better quality of life for those who unfortunately have cancer. The reason that the Insurance Committee addressed the bill is because it was brought to our attention that there was not parity in -- within some insurance companies and

those people, who would prefer oral treatment and who could tolerate it, were not given equal treatment in regards to cost and that is why the Insurance Committee almost unanimously supported this legislation.

THE CHAIR:

Senator Boucher.

SENATOR BOUCHER:

Through you, Mr. President, then am I to understand that if a patient decides they would prefer oral chemotherapy versus intravenous, that they would then proceed in that direction whether it was the decision being rendered by either the doctor or the insurance company?

For some clarification, through you, Mr. President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Mr. President, through you to Senator Boucher, it is not one's choice, it is what is prescribed by their attending physician.

THE CHAIR:

Senator Boucher.

SENATOR BOUCHER:

Thank you, Mr. President.

Thank you for the clarification. It's -- it's unfortunate we need to actually put this in statute because it just seems like common sense and like our good Senator Caligiuri, I likewise will take this rare moment to not oppose this particular legislation and vote in favor of it.

Thank you very much.

THE CHAIR:

Thank you.

Will you remark on Senate Bill 50 as amended by Senate "A?"

Senator Fasano.

SENATOR FASANO:

Thank you, Mr. President.

Mr. President, I rise in support of this bill. Mr. President, a very close friend whose wife was undergoing chemotherapy and she had the chemo with -- with respect to the IV. She developed several complications as a result of that and the only way she could get some help was by virtue of taking the oral chemotherapy pill.

She ended up taking it for a period of six

months. Absent that -- it was a very aggressive, I should say is a very aggressive stomach cancer. Absent that, the prognosis was not good at all. His particular insurance carrier did not pick up the pill but did the chemotherapy but not the -- the actual chemo pill.

As a result, he was out-of-pocket for this expense and it is expensive for a period of the five to six months. We tried to determine if we could work out the difference in costs and that was -- answer was no and then we tried appealing and that's where he is now, sort of after the fact, and she will be going another round of this I think at the end of summer.

But the point of it is, Mr. President, absent this oral pill, I don't know if she would be with us today. This woman is in her mid-50s, was diagnosed about a year ago so it was very aggressive very fast moving.

So, Mr. President, when you have something like that I'm not exactly sure what the impediments are to this bill or if I understand Senator Boucher, and I don't believe it should cost more because it is a substitute, but I think it is an

important issue because the chemotherapy is what saves lives. My wife went through chemotherapy and everything worked out great. But for those who can't have that because of the reaction, then you need this pill and that will solve the problem.

So with that, Mr. President, I support this bill. Thank you.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Mr. President, I appreciate the comments of -- of my colleagues and on behalf of making life better for those who are suffering from cancer I ask this be placed on the consent calendar.

THE CHAIR:

Is there any further discussion on Senate Bill 50 as amended by Senate "A?"

Seeing none, there is a motion on the floor to place this item on the consent calendar.

Without objection, so ordered.

Mr. Clerk.

THE CLERK:

Calendar page 32, File Number 191 -- File Number 261, Substitute for Senate Bill 407, AN ACT

has been ordered in the Senate on the consent calendar. Will all Senators please return to the Chamber.

Mr. President, the items placed Consent Calendar Number 1 begin on calendar page 1, Calendar 435, House Joint Resolution Number 102; calendar page 2, Calendar 436, House Joint Resolution Number 103; Calendar 437, House Joint Resolution Number 104; Calendar 438, House Joint Resolution Number 105; calendar page 3, Calendar Number 53, Substitute for Senate Bill 141; Calendar 61, Senate Bill 131; Calendar Number 69, Senate Bill 62; calendar page 5, Calendar 139, Substitute for Senate Bill 173; Calendar 151, Substitute for Senate Bill 149; calendar page 8, Calendar 221, Senate Bill 156; calendar page 11, Calendar 332, Substitute for Senate Bill 153, calendar page 12, Calendar 339, Senate Bill 443; calendar page 26, Calendar Number 54, Senate Bill 190; calendar page 29, Calendar 129, Substitute for Senate Bill 50 and calendar page 32, Calendar Number 191, Substitute for Senate Bill 407.

Mr. President, that completes those items placed on the first consent calendar.

THE CHAIR:

Thank you, sir.

Please call the consent. The machine will be open.

THE CLERK:

The Senate is now voting by roll call on the consent calendar. Will all Senators please return to the Chamber. The Senate is now voting by roll on the consent calendar. Will all Senators please return to the chamber.

THE CHAIR:

Have all Senators voted? If all Senators have voted, please check your vote. The machine will be locked. The Clerk will call the tally.

THE CLERK:

Motion is on adoption of consent calendar Number 1.

| | |
|---|---|
| Total number voting | 35 |
| Those voting Yea | 35 |
| Those voting Nay | 0 |
| Those absent and not voting | 1 |

THE CHAIR:

Consent calendar passes.

Senator Looney.

# JOINT
# STANDING
# COMMITTEE
# HEARINGS

## INSURANCE AND
## REAL ESTATE
## PART 2
## 340 – 672

**2010**

CHAIRMEN: Senator Crisco
Representative Fontana

VICE CHAIRMEN: Senator Hartley
Representative Megna

MEMBERS PRESENT:
SENATORS: Caligiuri

REPRESENTATIVES: D'Amelio, Abercrombie, Aldarondo, Alberts, Altobello, Bacchiochi, Dargan, Geragosian, Nardello, O'Connor, Schofield, Williams, C. Wright

SENATOR CRISCO: -- hearing on the agenda that's indicated for today. Obviously, thank you all for being here. We appreciate it and not to prolong our -- the time of our hearing I would just pay attention to the emergency exits and the regular exits.

As always, we appreciate the shutting down of cell phones and pagers. And if you have a conversation, please take it out in the hall.

And with that we will begin. Let's begin with Eric George followed by Susan Halpin.

ERIC GEORGE: Senator Crisco, Representative Fontana and members of the Insurance and Real Estate Committee, thank you for allowing me to testify before you today.

My name is Eric George, the associate counsel for CBIA, speaking on Senate Bill 50 and all mandates that come before your committee. You've heard this testimony before but let me

kind of put this in the lens of the small employer, which represents over 95 percent of our membership. With each health benefit mandate that you pass, you're making small employers less likely to be able to afford health insurance.

You're raising the costs, and as I understand it on an anecdotal level, this is one of the more expensive ones you're going to be considering today. I understand the benefit that it's going to be providing for consumers, but understand the access issue that you are impacting. Small employers right now are struggling to afford insurance under its current costs.

With each mandate that you pass, you're making it more expensive. You're making it harder for them to afford it to their employees. It should be the charge of this committee and the entire assembly to help small employers afford insurance and to make it less expensive.

So I would ask that as you proceed, please keep that in mind. I understand you need to weigh and balance everything. But this is a time of fiscal crisis that we really need to understand the cost of doing business is too high, and we want to encourage small employers to do the right thing and provide insurance for their employees. So I'll keep me comments brief and be happy to answer any questions.

SENATOR CRISCO: Thank you, Eric.

Are there any -- any questions -- any questions, Mr. Chairman.

No, but let me just say this, Eric, and you know we go back and forth. You know it's

always about this committee enacting mandates. But never anything about -- and I'm going to be straight with you -- about the money that early diagnosis, you know, saves. And we never hear that maybe after 10 years of record net income, that insurance companies should be making maybe one-tenth less of percent. That's just a personal opinion. So --

ERIC GEORGE: Understood.

SENATOR CRISCO: We've been there before. We respect your position, but we think it's unfair to make that claim that this committee is hurting small business. We're not. We're really helping small business and their employees. And we could go on for the next five hours and not come to agreement.

ERIC GEORGE: I'd be here for five hours if you'd like to continue.

SENATOR CRISCO: Sure. Sure. We'll gladly meet you at five o'clock with no problem.

Any other questions? Thank you very much.

ERIC GEORGE: Thank you.

SENATOR CRISCO: Susan.

SUSAN HALPIN: Good afternoon, Senator Crisco, Representative Fontana, Senator Caligiuri, Representative D'Amelio and members of the committee. Thank you for having us here today.

For the record, I'm Susan Halpin from the Connecticut Association of Health Plans. And I'm here today to testify respectfully for your rejection of Senate Bill 50, AN ACT

CONCERNING ORAL CHEMOTHERAPY TREATMENTS.

For each mandate, there are a number of factors around cost and quality that we hope that you'll take into account when deliberating on this issue.

Drugs of this nature can cost up to $10,000 per month. They're very expensive treatments at this point in time. And they're typically considered under a pharmacy benefit. Currently health plans in Connecticut are held to a copay of $40, a consumer protection that also extends to oral chemotherapy drugs as well as any other pharmaceutical. Requiring that these drugs be treated as medical benefits as opposed to pharmacy benefits could have unintended consequences that we hope you'll consider. It could cost a member more, for instance, if they have a benefit design that includes a high deductible because what you're really doing here is just cost shifting from one segment of the insurance benefit to another.

Furthermore, in some of our conversations, it's come to light that Senate Bill 50 may violate the new federal interim rules under the mental health -- federal Mental Health Parity Act, which becomes effective July 1, 2010. These rules state that a health plan cannot set up a formulary or any other cost-sharing mechanism that treats any medical condition differently than a mental health or substance abuse condition. And that only reasonable factors may be used to make cost differentiations about drug coverage. Health plans cannot make cost differentiations for drugs based on the health conditions that they cover.

We also, in doing a little bit of research -- haven't had a lot of time to research this issue -- but a little bit of research around it, suggests that there could be some serious quality issues that should warrant your consideration, and in the interest of the buzzer, I will just say that we've cited a few of the studies below that talk about compliance and direct supervision from a -- a health care provider and what that could mean for a recipient. So I thank you for your consideration, and I'm happy to answer any questions if I can.

SENATOR CRISCO: Thank you, Susan.

Are there any questions?

Yes, Chairman Fontana.

REP. FONTANA Thank you, Mr. Chairman.

And good afternoon Susan.

SUSAN HALPIN: Good afternoon.

REP. FONTANA Will doubtless hear testimony from the other side shortly, but I'd just like to sort of give you the opportunity to address some of the concerns that I've heard raised. And those center around the idea that, essentially, the statutes currently provide for treatment for cancer or cancerous illnesses, but that perhaps the law hasn't kept up with technology, that when you and I were kids, the only form of cancer treatment that was available was intravenous. Whereas, in fact, over time treatment has evolved to the point now where there are oral treatments as well as intravenous. In some cases, the oral treatment is comparable to the

intravenous but cheaper. And in some cases, there is no intravenous alternative. So, heaven forbid I suppose that you or I would suffer from a cancer of some kind and the only treatment was an oral treatment opposed to intravenous.

To that extent, how would you recommend that we handle this? There's got to be a mechanism, it seems to me, to follow the spirit of the statute, which as I read it, asks or requires a company to cover treatment for cancer, and yet we have this evolving disparity where depending upon whether you want to go into the doctor's office and sit there for two hours and have intravenous treatment, or if, in fact, an oral treatment is indicated, you can't get the oral treatment because you can't afford to get that instead of going to the doctor's office for the shot. How would you respond to that concern?

SUSAN HALPIN: I think first and foremost, I need to say that I need to do additional research on how our individual plans, you know, handle these situations. But having said that, I think that you do need to be careful about, essentially, moving a pharmacy benefit as -- as I understand these drugs are currently handled into a medical benefit because there's -- there's a difference in the way those are treated and how those are funded and, you know, what the mechanisms are. I think it's more complicated than just, you know, some of the typical mandates that you've had under your consideration.

And I would be happy to kind of get back to you more, you know, on how those situations are being handled.

REP. FONTANA Thanks, Chairman.

Yes, Susan, if I could, I think that that would be helpful. But I think that I agree with you. It is much more complicated than some of the other situations we discuss. And there are many potential scenarios that one could construct. One would be a case in which there is an oral alternative, which is more expensive than the intravenous treatment; one in which there is an oral alternative which is cheaper than the intravenous treatment; and then one situation in which there is no intravenous treatment but only and oral treatment.

And so I think we've got different situations. And I think it would bear for the discussion to try work through these because it seems to me there are opportunities here to try to do the right thing for people in a way that doesn't actually cost anyone, either the patient or the insurance company, more money than they currently pay.

SUSAN HALPIN: And I understand what you're saying. And I think also combined within that conversation needs to be -- and I'm not here to suggest that there aren't quality measures -- but need to assure that those -- those quality issues and compliance issues are also, you know, factored into the discussion.

REP. FONTANA Right. So thank you for doing the additional research and then getting back to us, because I would like to have that additional conversation with you about how can we, perhaps, get at some of the problems -- some of the problems at least that are being experienced by people who are needing or wanting oral chemotherapy. So thank you.

SUSAN HALPIN: Thank you.

SENATOR CRISCO: Thank you, Mr. Chairman.

Senator Caligiuri.

SENATOR CALIGIURI: Thank you, Mr. Chairman.

And just very briefly, Sue. I -- I too would be interested. I mean the notion that, you know, treating it as a medical as opposed to a pharmacy benefit and all the problems that that may create. I mean, that's something I think I'd like to know a lot more about because I can't see it firsthand why there would be such a significant difference between the two. But depending on what you eventually get back to us, if we were able to structure this as just an expanded pharmacy benefit, for example, would that solve the problem, from your point of view, setting aside the cost issue?

SUSAN HALPIN: I mean, I think, obviously, I'd have to see and -- and get back to you on that issue. The one thing I will say is that you know, pharmacy is one of the largest drivers obviously. These are very expensive drugs that we're talking about. And I just think that, you know, there really does need to be more conversations, you know, around this issue. Because, you know, simply shifting the costs from one part of the benefit package to another without, you know, a broader discussion around the merits, you know, of that conversation, I don't think addresses the issues.

SENATOR CALIGIURI: I understand and I agree. The only reason I make the point that I make is

because I think cost is clearly an issue. It always is when we're talking about a new mandate. But because you focused your testimony on having it become a medical, as opposed to a pharmacy benefit. If that really becomes a driver of concern, it seems to me we need to -- it seems to me that's something we could draft around if we, otherwise, got our hands around the cost issue. So, you know, if it's going to be that then I think we can might be able to solve it by drafting. But if it's not that, then we need to understand that. That's the only point I'm making.

SUSAN HALPIN: And, of course, if -- you know, if you -- if you look at it that way, you still have a general considerations --

SENATOR CALIGIURI: Right.

SUSAN HALPIN: -- (Inaudible.)

SENATOR CALIGIURI: Thank you.

Thank you, Mr. Chairman.

SENATOR CRISCO: Thank you, Senator.

Are there any other questions?

Yes, Representative Nardello.

REP. NARDELLO: Thank you.

Thank you, Sue. I just want to clarify something and make sure we're both understanding this. My understanding of the bill is that it doesn't require you to cover it but rather that you cover it in the same way that you do intravenous, if it's intravenous or oral. Is that your

understanding that it's not a mandate for you to cover it? But rather that you're going to cover it in the same manner with the same copayments, deductibles, and it wouldn't be that you're doing both, but you're doing either or?

SUSAN HALPIN: If I could respond with a caveat that I -- I really need to understand better how this works myself. You know, I think when you're dealing with a situation where somebody goes into a facility to receive their treatments that there's, you know, payment structures around that with the specialists at hand and the facility at hand. But when you access drugs through a pharmacy situation or a specialty pharmacy situation, those are different structures. And you have to kind of look at how those two things, I think, go together and what the impact of those changes will be.

And I guess the way we interpret the bill, in answer to your question, is that, in effect, it moves something that's currently a pharmacy benefit into a medical benefit.

REP. NARDELLO: And so I just wanted to state one other thing as I'm looking at the other testimony that you know the National Comprehensive Cancer Network is talking about the fact that evidence-based treatment guidelines suggest that you really do need to determine what is best for the patient in terms of oral or intravenous and that their ability to tolerate the treatment because that's the other consideration here. So, I think that I would like you to take that all into consideration to hopefully find a way that you can be more comfortable with this. But I think there seems to be strong reasons

why you should go in this direction. So --

And I thank you for your testimony today.

SUSAN HALPIN: Thank you, Representative.

SENATOR CRISCO: Thank you, Representative.

Any other questions?

Just one other thing, Susan. If you are gracious enough to get this information, I hope that you would also provide cost information. Not only from, you know, facility, which has certain overhead because intravenous chemotherapies are quite a procedure but also upon the individual. I've been informed that, you know, an individual and the oral chemotherapy does not lose work time, as compared to the other treatment. I think that also has to be taken into consideration. So we greatly appreciate you providing us with the whatever information, and now we're talking about prevention. Thank you very much.

SUSAN HALPIN: Thank you, Senator.

SENATOR CRISCO: Anybody else? No.

Thank you.

Susan, two?

SUSAN GIACALONE: Good afternoon, Senator Crisco and Representative Fontana and the members of the Insurance and Real Estate Committee.

For the record, I'm Susan Giacalone. And I'm here on behalf of the Insurance Association of Connecticut. My comments on Senate Bill 50

are not on the contents of the bill or what the bill does. Basically, it's more on the Senator Caligiuri said a technical drafting issue.

Within the bill, there's two references to include specified disease policies into providing these benefits. As this bill is drafted and its intent applies to pure medical health plans, we respectfully request that those specified diseases be removed. The appearance of division 1 of sub-section D in both sections 1 and 2, specified disease plan. Don't provide this type of benefit, never intended to provide this type of benefit and should not be included, therefore, in this proposal.

Thank you.

SENATOR CRISCO: Thank you.

Any questions?

Mr. Chairman. Any -- any other questions? Nope.

Thank you very much.

SUSAN GIACALONE: Thank you.

SENATOR CRISCO: Anne Morris.

ANNE MORRIS: Good afternoon, Senator Crisco, Representative Fontana and members of the Insurance and Real Estate Committee.

My name is Anne Morris, and I'm the executive director of the Connecticut Affiliate of Susan G. Komen for the Cure. Susan G. Komen for The Cure is the world's largest and most

progressive network of breast cancer survivors and activists. And since 1996, Komen has invested $19 million in Connecticut in breast cancer education, screening treatment, and research. I'm here this afternoon in support of Senate Bill 50, AN ACT CONCERNING ORAL CHEMOTHERAPY TREATMENTS.

Oral chemotherapies are becoming an increasingly available, noninvasive, and more convenient alternative to intravenous chemotherapy. This is good news for cancer patients. It avoids numerous problems, such as risk of infection, transportation to and from cancer treatment facilities, child care concerns, and the amount of time it takes to receive cancer treatment.

The bad news is due to how major medical health plans classify these oral chemotherapies, patients are forced to bear a much larger out-of-pocket cost for the oral therapies than they do for the equivalent IV. And sometimes this is for the repeat of exactly the same drug.

Most health plans cover IV chemotherapy under the medical benefit and the patient's out-of-pocket is usually an office visit copay. That's not the case with oral therapy. Orally administered anti-cancer medications are covered under the health plans pharmacy benefit. These anti-cancer drugs are placed in a specialty or fourth-tier category of the health plans formulary and require an average co-insurance of 28 percent, according to a recent study by the Kaiser Family Foundation.

For an orally administered anti-cancer medication with a $3,000 per month cost, the patient out-of-pocket is $900 per month. That

puts orally administered chemotherapies out of reach of many Connecticut residents. Patients should receive the chemotherapy medication that is recommended by their physician and will be most effective in fighting their cancer.

Lifesaving decisions, such as these, should not be based on whether or not a patient can pay $900 a month out-of-pocket copay. They should be based on what will save, extend, or improve the quality of life of the patient. Passing this legislation will ensure that that happens. Thank you for your consideration. I'd be glad to answer any questions.

SENATOR CRISCO: Thank you, Anne.

Are there any questions?

Yes, Chairman Fontana.

REP. FONTANA: Thank you, Chairman. Good afternoon, Anne. A couple of questions.

ANNE MORRIS: Yes.

REP. FONTANA: Could you comment on the cost of intravenous chemotherapy treatment? In other words, you've talked about what orally administered runs, but can you comment more generally about what it actually costs insurance companies or patients for intravenous?

ANNE MORRIS: Every health plan is different. Every drug is different. Every combination of drug is different. So I can't give you a statistic on a comparison of an intravenous cost versus and oral cost. There have been studies done. There have also been studies

done on the overall impact of oral chemotherapy versus intravenous by Milliman. And they have said that the cost in premium is 50 cents per member per month. I think we're looking at, you know, making the physicians have charge of their patients care and whether that moves it to medical or whether it stays at pharmacy.

I mean the concern of Susan G. Komen for the Cure is that the patients have the access to the best chemotherapy in the most convenient form. I'll be happy to get you that study, though, Steve.

REP. FONTANA: Great. Thank you. And then in terms of situations in which there's only chemotherapy medication in oral form, can you sort of comment on that in greater detail? Do you know why that would be? As if it -- oral is more effective than intravenous for particular types of cancers? Is it because it's cheaper for companies to produce oral instead of intravenous? Is it because something else going on? Could you comment at all on that?

ANNE MORRIS: Some of the newer drugs are coming out in oral-only form. Some of the other drugs are available in both forms.

Obviously from our perspective, it's more convenient to take it orally for the number of reasons I listed in my testimony around transportation, child care, so on and so forth. I don't -- I don't believe that there is a black-and-white answer to your question. I think some of the newer drugs, as I say, that's the direction I think it's moving in. 35 percent of the cost of an intravenous drug treatment in a health care facility is the

medical personnel. So, with the oral, you're actually removing that cost from the -- the cost of care.

REP. FONTANA: Well, I guess -- I guess in the information that you provided if you could provide us any additional information that you can find on why, the why. I understand. I agree with you. I think it may be moving in that direction, but I think anything that you can tell us in terms of why it might be that it's moving in that direction, either on the basis of efficacy, cost, convenience, profits, whatever. I think it would just be helpful I think to know why it might be happening. So, to the extent that you've got that information, we'd welcome that as well.

Thank you, Chairman.

SENATOR CRISCO: You're welcome.

Yes, Representative Nardello.

REP. NARDELLO: Just a quick question. Again in reviewing testimony, it seems to be characterized as a mandate. In your opinion, is this a mandate or an alternative -- a choice of alternatives? Because, again, I keep reading that it's a mandated -- you know, we're suddenly going to have to cover something that we wouldn't cover before. So do you view it as a mandate, or as an alternative choice?

ANNE MORRIS: No, I don't view it as a mandate. Because if someone right now has a health plan that doesn't have -- well, I got to back up a second.

This legislation is written such that the oral

chemotherapy would be moved to the medical part of a health plan. That's not necessarily something that Komen is in favor of. What we are in favor of is giving the patient the opportunity to access oral chemotherapy if it is covered under their plan at the same out-of-pocket cost as they would getting it intravenously. So if you don't have a prescription benefit on your health plan, let's assume that this stays in the prescription side of the health plan and doesn't move over to the medical, if you don't have prescription coverage, this is really not an option for you. So in that light, I would say this is not a mandate. You're not saying that -- that it's mandated that they have access to it. Now if it was moved to medical, that's -- that's a different story.

I think what -- what my experience has been with all of the breast cancer survivors that I come in contact with is they are being forced to go get this intravenously when the same drug is available to them orally because they don't have $900 a month to fork over, when it's apples to apples.

Now, there's also some people I've talked to who there are drugs available only in oral form that they can't access because it's under the prescription and it's under this fourth category. It's not in your regular formulary. It's actually been moved out into a specialty category and copay has been attached to it at a higher copay than, say, going getting an antibiotic or something else in a formulary.

REP. NARDELLO: I appreciate the information that you've provided and the one that you'll provide after this. Thank you.

SENATOR CRISCO: Representative Schofield.

REP. SCHOFIELD:: Thank you, Chairman.

In the previous person's testimony they talked about health plans in Connecticut are prohibited from charging pharmacy copays in excess of $40. I wasn't familiar with that off the top of my head. But, obviously, you're saying that doesn't apply for some reason in these Tier 4 drugs?

ANNE MORRIS: Absolutely not. You'll hear testimony from someone, I think -- believe, right after me who is currently paying, you know, $700 a month. And I talked to many women -- I'm sorry -- I've talked to many women who've paid upwards of $1,000 a month.

REP. SCHOFIELD: Right.

ANNE MORRIS: And it is a prescription. It's under the prescription plan. It's these bio-science's fourth category, that's been created with additional copays, and these drugs are very expensive so are the intravenous ones. I mean nobody is saying that this is not an expensive treatment. It is. I think that, you know, if -- if the difference in how much out of pocket is going to be -- is coming out of the patient for the oral versus the IV.

REP. SCHOFIELD: Are you familiar with how Medicare treats these situations? Because I believe they also cover it under the drug side of the benefit. You get this chemotherapy through a Part D plan, not under Part A or Part B. Correct?

ANNE MORRIS: I do not know that for sure. I do

have access to a study that was done for Vermont that looks how much -- looked at how much the cost to the State would be, obviously, in the 50/50 share on the Medicare part of the -- the coverage. Those copays are usually significantly less, but I can't state fact on that. I'd be glad to look into it for you, if you'd like?

REP. SCHOFIELD: Yes. Thank you.

ANNE MORRIS: Yes.

SENATOR CRISCO: Thank you.

Any other questions? Anything?

Susan, couple of things. Not directly related but -- I'm sorry.

ANNE MORRIS: That's okay. That happens all the time.

SENATOR CRISCO: No, no. We hear from so many Susans (inaudible).

ANNE MORRIS: No. They think I'm from Susan G. Komen for the Cure. So they -- they think my name is Susan.

SENATOR CRISCO: I know, Anne. I'm sorry.

ANNE MORRIS: It's all right, Joe. I know you know.

SENATOR CRISCO: Several things, you know, I wish your group could look into the issue of medical necessity, how that may interplay with this legislation. And number two, indirectly related, I don't know if you've seen the -- the mail piece that the controller has

inserted into state mailings that Nancy Cappello has made available? We're -- we're very proud of that. And --

ANNE MORRIS: And we're very grateful to you for that.

SENATOR CRISCO: Well, everybody has worked together on that. And so we appreciate all your work and sincerely we want to thank you for all the work you do for spouses and families. That's greatly appreciated. Thank you. Thank you.

ANNE MORRIS: Thank you.

SENATOR CRISCO: Kim.

KIMBERLY GREEN: Good afternoon. My name is Kim Green. I reside in the lovely town of West Hartford. And I hope to be able to clear up a couple of the questions that Anne might not have been able to answer on behalf of a breast cancer fighter.

Originally, I wasn't going to testify this week, as you can tell by my voice, I get nervous speaking in large groups. But, ironically, at the same time that Anne asked me to testify, another glitch with my insurance company in my chemotherapy happened. I take two forms of oral chemotherapy daily. That's eleven vitamins-sized pills. And it's quite the routine because some you take with -- with food, some you take without. Some take me -- make me very, very nauseated where I'm not able to work. Others don't affect me as much.

But I take oral chemotherapy because last year the port in my chest that I was receiving IV

chemotherapy through became infected. And it infected my heart. I underwent open heart surgery and spent 40 days in Saint Francis Hospital due to just common cause.

A central line is longer an option so I can only take oral chemotherapy. But I'm grateful and thankful to have these options available to me.

I am so thankful that I have oral chemotherapy to rely on but the problem is it's an absolute financial and logistical nightmare to receive. Every three weeks when it's time to renew my prescriptions, I receive the same reply. The cost of the drug exceeds what the insurance deems reasonable -- but there are no other drugs to take. I've heard this for almost 20 months now. And after many phone calls between my oncologist and the insurance company, it does get rectified, but days are missed of medicine. And when you are a Stage 4 cancer patient, as I am, you can't wait for your medicine.

The cost to my family for oral chemotherapy is quadruple of what it costs when I would go to the hospital and pay my $20 copay to spend the day receiving IV chemotherapy. I even got lunch. My meds now cost over $700 a month. And our insurance premiums are one-third of my family's financial income. My husband will never retire nor will he ever look for another job with the security of knowing that we won't lose our insurance. The idea of a lay-off is unimaginable.

At a time that I should be healing and just enjoying the life that I have left, I work a part-time job to help pay for my meds. How I wish I could go back to the $20 copay and

visits with my IV nurses. There's no stop date for my chemo. I will take this medicine until a cure is found.

I am married and I have a 15-year-old and an 11-year-old. When I think of what they are not receiving because of the money that goes into my medicine right now, I often have tremendous guilt, especially now that college is on the horizon. Money that was worked hard for and out is now gone. My husband keeps telling me that a mother is more important to our children than a college education. And I truly want to believe that. But I think there's a way to do both.

The guilt battles with the true feelings of gratitude and thankfulness that I have for this medicine. These drugs are extending my life so that I will see my children off to college. I will never lose sight of how fortunate that I am. It just seems so logical that avoiding a hospital visit and being able to avoid the anxiety associated with IV chemotherapy is such a step in the right direction for cancer fighters.

By passing this bill and taking away the financial and logistical battles enables us to focus on the fight at hand. And that's the fight for our lives. Thank you for your compassionate consideration.

SENATOR CRISCO: Thank you, Kim.

Just one minute to see if there are any questions.

Representative Nardello.

REP. NARDELLO: Not a question, Kim, but you

started your testimony by saying how difficult it is for you to speak in front of groups. And I have to tell you are one of the most eloquent individuals who has ever come before us. And I thank you for doing that.

KIMBERLY GREEN: Thank you. My privilege, my privilege.

SENATOR CRISCO: Thank you, Representative.

One minute, Kim. I have some other questions.

Chairman Fontana.

REP. FONTANA: Thanks, Mr. Chairman. And I'd like to echo Representative Nardello's comments. You did a great job.

KIMBERLY GREEN: Thank you.

REP. FONTANA: And so as we've often said it's so helpful to have you take some of your valuable time to come here and educate us because so often we don't hear from people who are impacted directly. And your testimony's very powerful.

I don't know that you can provide the information, but I just want to reiterate that I think you and others have been eloquent about the costs to you of the treatments that you need. One of the things that we're missing, though, is the costs that are currently being paid for intravenous care not just by the patient themselves but by the insurance companies on their behalf. And I think that we should, as you indicate, at least get to a point where the companies can say to you we're giving you this amount and whether it's intravenous or oral, it's all the

same to us. And we understand we may not be able to move you on the oral to where we were on the intravenous because it is so much more expensive. But what we can at least do for you, what we do for people on the intravenous. I think that's sort of what you were saying, and I agree with you completely.

KIMBERLY GREEN: Thank you.

REP. FONTANA: So thank you again for your testimony.

KIMBERLY GREEN: Thank you.

SENATOR CRISCO: Not yet, Kim. Kim. Kim, not yet.

Any other questions?

Yes, Representative Altobello.

REP. ALTOBELLO: Thank you.

Good afternoon. Are you aware of how much your oral treatment costs?

KIMBERLY GREEN: My understanding -- my husband has taken this off of -- off of my plate. He fights the fight, him, and I'll fight of rest. They're very comparable to what I was receiving as an IV patient. But my IV -- going to St. Francis Hospital at 7:30 in the morning and coming out at 4 o'clock in the afternoon, costs me $20. This does not. And that's what seems illogical about it. That the drugs were so much -- they might cost the same but because they're in a hospital format, they're not the same. And -- and that's what is so baffling to us.

We really thought that that was going to be

the rainbow out of losing my port was that we'll be able to administer this at home. We won't -- we won't have to have that worry and anxiety of going, taking a day out of work, having child care, and it's been totally flip-flopped. And it -- it just needs to be looked a little bit.

REP. ALTOBELLO: So the short answer is you do not know the cost?

KIMBERLY GREEN: I do not know the cost.

REP. ALTOBELLO: Thank you very much.

Thank you, Mr. Chairman.

SENATOR CRISCO: Thank you, sir.

Any other questions?

One thing, Kim. I just want to clarify my perception is that by taking oral chemotherapy --

KIMBERLY GREEN: Yes.

SENATOR CRISCO: -- you're -- if you're working you're able to continue working, no?

KIMBERLY GREEN: No. Unfortunately, the oral chemotherapy, as I said at the beginning, is 11 pills a day has made me not able to work a full-time job due to the intestinal problems that I now have from it and the additional medicines that I have to take because of it. The medicines that I was receiving IV, Benadryl, they were able to administer a drug beforehand. I was able to have it and it was a day out of my life. This is much more complicated now.

SENATOR CRISCO: Does it vary from patient to patient? Do you know? You may not be able to give us that information, but everybody has a a different reaction. Some people can take Lipitor not to -- and relate some people can but is it possible that some people receive oral chemotherapy could just go to work?

KIMBERLY GREEN: Most -- most of the oral chemotherapy drugs are pretty rough on the intestinal tract from my experience of talking with other cancer survivors.

SENATOR CRISCO: Thank you.

Any other questions? Well, keep up the great work.

KIMBERLY GREEN: Thank you. Thank you for your attention.

SENATOR CRISCO: Stephen.

STEPHEN GRUND: Hello. Senator Crisco, Representative Fontana and members of the Committee. My name is Stephen Grund. I'm a hematologist oncologist and president of the Connecticut Oncology Association. I guess I'm about to lose my testifying before congressional committee virginity.

I'm here to discuss on behalf of myself and the Connecticut Oncology Association, the Raised Bill Number 50. You have -- you have statements from us, and I -- probably a lot of other constituents and a lot of other people in favor of this. And I'm not going to review those.

I would like to just make a few additional

points. You may have remembered in the book by Charles Dickens, "The Tale of Two Cities," I'm going to paraphrase the very first line. These are the best of times. These are the worst of times. That's, I think, an apt description of the state of oncology treatment that we have today. And in order to understand that statement, I just got to give you a very brief history in one and half to two minutes.

Up until to, let's say, 1950, we didn't have very good treatments for cancer. And the treatments we did have really were surgery and radiation. And as I said, not very effective. Between 1950 and 1970, due to buttress by funding from NIH and then the NCI, there was a tremendous explosion in our understanding of cancer. And as a result of that, a few -- a number of chemotherapy drugs were developed. These were all intravenously administered with a few exceptions. And they were not very effective, except in a few rare cancers, for example testicular cancer, which primarily targets young men, and you've all heard of Lance Armstrong. But it, obviously, saved many other young men's lives as well.

And unfortunately, there were tremendous and serious side effects associated with that chemotherapy to the point where patients feared the treatment as much as they did the diagnosis. And unfortunately, that has -- that legacy has carried on even to this very day. I hear patients concerned about the effects that cancer chemotherapy's going to have on them.

REP. FONTANA: Thank you, Doctor. The bell went off. So we're going to go to questions now for you.

STEPHEN GRUND: That was it?

REP. FONTANA: That was it. Three minutes believe it or not.

STEPHEN GRUND: That was three minutes.

REP. FONTANA: Yes. Indeed.

STEPHEN GRUND: Okay. Sorry. Wow.

REP. FONTANA: That's okay. So, Doctor, could you just comment more generally on the movement of the industry away from intravenous treatment toward oral, as well as the costs for intravenous treatment in a hospital setting?

STEPHEN GRUND: Absolutely. Over the last ten years, there's been a development of a number of oral chemotherapy agents for a number of different cancers. And some of them are quite effective. For example in CML, chronic myelogenous leukemia, which uniformly over a period of three to eight years progressed to acute leukemia and was almost uniformly fatal, we now have a pill called Levack which puts all of these patients or merely all of them into remission for many years. And it hasn't been around long enough, but it may be curative. And prior to that, the only treatment was an allogeneic bone marrow transplant.

And there's a number of other medications for lung, breast -- you've heard about breast, kidney cancer and thyroid cancers. And if I could just -- the very -- this week's, I got this on Tuesday, there's an editorial on an article published in the Journal of Clinical Oncology. It was difficult to pick a picture

to conjure up a decade ago by even the most optimistic and seasoned oncologist caring for patients with lung cancer. That a pill taken orally, once a day, could dramatically relieve an interminable cough almost overnight resolved numerous lesions radiographically within days and at times even returned a morbidly sick individual with an enormous tumor burden to a productive work life. All accomplished with fairly acceptable and manageable toxicity.

So that is a comment about the oral treatments.

Now the other question was about the costs and what specifically is -- is the question about costs?

REP. FONTANA: Well, one of the things I think that we're missing is the cost that we currently pay, both as patients and as insurance companies on behalf of patients, to hospitals or other outpatient settings for the intravenous treatment. And I was curious as to whether in your position you had or had access to appropriately redacted information which might allow us to assess more accurately the kind of costs that are paid for intravenous administration of chemotherapy medication?

STEPHEN GRUND: Well, I wasn't -- that's not my field of expertise but I'm sure you could get that information from insurance companies on what the cost of chemotherapy agents are. Some of them -- I mean, for example, I'll give you I do know because I cost this out a number of years ago, that a year's worth of Herceptin, which is intravenous, is about $100,000. And I was speaking to a patient the

other day about Gleevec, which he's 33, and he's quite ill. He's on Gleevec. He feels fine. And he's working full-time and he's having very few side effects. He told me that it's about $50,000 a year for a year's worth of Gleevec.

Now I -- I -- but I -- again, you have to understand as an oncologist, we're all concerned about the costs of these drugs on the healthcare system. We're all well aware that this is having an impact on the healthcare system. But my question and I didn't realize that I was -- didn't have that much time, but my question to you is and this is where I have a tough time understanding. Think about this for a minute, since 1950 until now, think of all the billions of dollars that the NIH and the NCI has spent on improving treatments for cancer care. Right.

And I'm sure every state has allocated over the years a lot of money. And think about all of the cancer centers in the United States and the universities where researchers are working every day for finding better treatments. And then think about all of the drug companies, biotech and pharma, that are expending millions and billions of dollars and research personnel and personnel in improving treatment. So if that's the case and we all think that that's a useful thing to do, why would we then withhold the ability of patients to then get these medications?

REP. FONTANA: Thank you. That's a rhetorical question, but I appreciate it never the less.

Thanks, Mr. Chairman.

SENATOR CRISCO: Are there any other questions?

Any other questions?

Thank you very much. We appreciate it.

Now we have Robin Touhy and Michael Touhy, is that right? Are they here? Do they want to come up together? Or separate? Okay. So the first one is Robin.

ROBIN TOUHY: Good afternoon everyone. I'm Robin Touhy from Prospect, Connecticut. And I'm director of Support Groups for International Myeloma Foundation. In addition to the letter that was submitted to you from Susie Novis, president and cofounder of the International Myeloma Foundation, I just recently attached some documentation from the State of Vermont that does discuss the cost issue so you may want to review that.

I'd also like to add the following: The International Myeloma Foundation believes patients should be able to take advantage of the treatment that is best for them and not have to select the treatment based on insurance coverage.

Hematologist oncologists need the freedom to prescribe therapies based on their potential efficacy. We need an equitable patient-oriented insurance system that acknowledges and covers 21st century test and treatments.

Currently, although oral drugs cost the least to administer, they have the highest out-of-pocket charges for patients. All treatments must be reimbursed at an equitable rate regardless of how they are administered.

We question a system that reimburses the least

for the most cost-effective treatments. We are not promoting oral drugs. We are saying treatment should be based on medical assessment not insurance coverage, that is, based on what patients and physicians working together agree is the optimal treatment for their specific case. Something is very wrong when the largest side effect of a drug is economic, based on inequitable and irrational differences in reimbursement.

This SB 50 that's now being considered in Connecticut would require private insurance companies to cover oral anti-cancer drugs at the same rate they cover intravenous infusions in terms of patient out-of-pocket costs. This is a critical time to stand up for the health issues that affect us directly. Thank you.

REP. FONTANA: Thank you, Robin, very much for your testimony. And thank you for indicating how we can follow up on some of these issues.

Questions for Robin from the members of the committee?

Representative Nardello.

REP. NARDELLO: Actually, I just wanted to thank Robin for being here and for her testimony and to know that she has dedicated a good deal of her time to this issue, and I appreciate that and her being here today.

ROBIN TOUHY: Thank you.

REP. FONTANA: Thank you.

Other questions for Robin from members of the committee?

Seeing none, thank you, Robin.

ROBIN TOUHY: Thank you.

REP. FONTANA: We'll now have Michael Touhy followed by Christine Cappiello.

MICHAEL TOUHY: Good afternoon. I'm Michael Touhy from Prospect, Connecticut.

I was diagnosed with multiple myeloma in 2000 when I was 36 years old. I have been fortunate that my insurance coverage has allowed me and my team of doctors to choose the best medical treatments available. I've been on an oral therapy for the past three and a half years, and I'm thrilled to tell you that I'm in remission and enjoying a good quality of life.

However, I personally know of many patients in situations where they, along with their doctors, are faced not only with fighting cancer but fighting insurance companies to reimburse their oral treatments. Patients and doctors should be basing treatment decisions upon what medically is the best option available to them. Not what they can afford.

Over the last 10 years, I've seen many exciting novel therapies approved to help patients live longer and more productive and active lives. New therapies have made a dramatic difference, advancing the treatment of multiple myeloma, extending lives and improving the quality of many patients. These new therapies are both oral and intravenous, yet many insurance policies require higher out-of-pocket expenditures for the oral drugs. This means many patients that have had to forego getting the drug that's optimal for

their treatment, and they've had to go into debt to meet the copayments required.

In the myeloma support group that I run in Waterbury, I have listened to many stories about a patient's fear and anxiety. They will not be able to afford the copay for the oral drug that their doctor has recommended. One such story is a woman who was newly diagnosed. Her doctor recommended an oral therapy as her best treatment option. She's in remission, but she had to sell her house and is now living with her daughter so she can afford the copay for the oral therapy saving her life.

REP. FONTANA: Michael, please conclude if you would?

MICHAEL TOUHY: Sure. We're now living in a new and exciting time where science and brilliant minds have advanced cancer therapies. But if patients are not able to afford them then how far have we actually come? We need to update our laws so that there is insurance parity for oral and IV drugs. On behalf of all cancer patients, I implore you to support SB 50.

Thank you.

REP. FONTANA: Michael, thank you very much. And of course, let me thank you and Robin for taking time out of your day to come.

MICHAEL TOUHY: Thank you.

REP. FONTANA: That's one of the reasons why we try to place public testimony here in the committee initially to give people an opportunity to take time out of their day to be here.

MICHAEL TOUHY: I appreciate that.

REP. FONTANA: So we thank you.

Questions for Michael?

Representative D'Amelio.

REP. D'AMELIO: Thank you, Mr. Chairman.

Good afternoon, Michael, and thank you for being here and sharing your testimony.

I'm just interested to know that when you were going through this ordeal, did -- did you ever -- did you start with intravenous chemotherapy?

MICHAEL TOUHY: Actually, I -- I -- for 10 years I've been diagnosed with multiple myeloma, and actually, my first treatment was a stem cell transplant, and I got a three-year remission. There's no cure for myeloma so it's basically a battle constantly. After my three-year remission, it was time to decide if the cancer came back what did I have to do to fight the disease. Fortunately, I had an insurance that covered my oral therapies so instead of having to go through another transplant, I picked a drug that was best suited for me at the time, and I've been on that particular drug for five years now. And I'm in full remission so I don't think -- I'm blessed to be lucky.

Mainly here for other patients that we run a support group, and I know people constantly they're scared to death. We have one man in our support group who doesn't want to put his family into debt, and he's not taking the

treatment that's best for him. It's an uphill battle.

REP. D'AMELIO: We've heard from a speaker previous that had no choice but to go with the oral medication because of problems that she occurred. If you -- if you're insurance didn't cover the oral prescription, what were your other choices?

MICHAEL TOUHY: I probably could have done -- fortunately, in the last 10 years, there have been new therapies coming out. And at the time, I could have done another transplant, but I had major issues with transplant. I had allergies to drugs, certain drugs that you need to take when you have the transplant so it was pretty messy. So, I -- I can't honestly answer that right now because they way we decided to go has worked fantastic for me. So I'm -- I'm assuming I would have gone on an IV drug.

REP. D'AMELIO: Well, thank you for being here and good luck to you.

MICHAEL TOUHY: Thank you very much.

SENATOR CRISCO: Any other questions for Michael? No.

Thank you.

MICHAEL TOUHY: Thank you.

SENATOR CRISCO: Keep up the good fight, Michael.

We'll proceed with Christine. Is Christine here?

CHRISTINE CAPPIELLO: Good afternoon, Senator

Crisco, Representative Fontana, Senator Caligiuri, Representative D'Amelio.

For the record, my name is Christina Cappiello. And I am the government relations director for Anthem Blue Cross Blue Shield. And I'm here today to speak in opposition to Senate Bill 50.

You know our position on mandates and that it takes away the choice that can -- that employers need in when they're purchasing health insurance. We're also have in my testimony some concerns about this specific mandate that we -- we wanted to raise your attention that previous speakers have mentioned, Susan Halpin specifically. There is some concern and there has been some studies related to situations with folks that take oral chemotherapy that there may not be -- there are situations where they don't take the entire medication as opposed to when they're in the doctor's office. And so that obviously lessens the effectiveness of it. There is questions about not having direct supervision of being in the doctor's office if a side effect begins to occur. And finally, I think one of the things that we're sort of talking about is also benefit design that needs to be taken into account.

In some situations -- I can only speak for Anthem -- the chemotherapy is covered -- the intravenous chemotherapy is covered under the medical side and there is an office visit copay that goes on it. If somebody has a pharmacy benefit, there can be higher copays on that side. And/or if they don't have a pharmacy benefit at all. Some of them -- we also sell some individual products. There are some group products that don't have pharmacy

benefits. Either they chose to use someone else to administer the pharmacy benefits, or they chose not to have them at all. And they would be in a situation potentially where it wouldn't be covered.

So any questions that you might have?

SENATOR CRISCO: Thank you.

Chairman Fontana.

REP. FONTANA: Thank you, Christine. And again, I'll reiterate my request that if you could provide me with any sort of information on the relative cost of some of the intravenous treatments and procedures that would be helpful.

CHRISTINE CAPPIELLO: Okay.

REP. FONTANA: And then, hopefully, we could have a conversation again about this issue of relative balance for efficacy, if you will. You know, it's hard for me to understand how Anthem or another company could be willing to pay, let's say, $1,000 per week or per month or whatever it is for an intravenous treatment procedure and not be willing to, essentially, provide that 1,000 dollar's worth of value to an alternative but ostensibly no less efficacious and ostensibly even possibly more efficacious means for treating the cancer other than that. So I guess that sort of where I am at.

I understand how the bill is written currently, but I'm really trying to wrap my mind around, perhaps some of the other members of committee as well, are trying to wrap their minds around why from, your perspective, not

you Christine of course, but Anthem, $1,000 isn't $1,000. And if, you know, Doctor A says the best thing for you is an oral with an outpatient visit as opposed to a intravenous with a hospital visit, Anthem is going to give you 1,000 bucks either way --

CHRISTINE CAPPIELLO: Right.

REP. FONTANA: -- we're going to go this route, and I understand you're still going to pay more for the oral than you'd be paying for the the intravenous but --

CHRISTINE CAPPIELLO: Right.

REP. FONTANA: -- you know, Anthem says this is what it -- this is what our benefit is. I'm still having trouble wrapping my mind around why --

CHRISTINE CAPPIELLO: Okay.

REP. FONTANA: -- that's not the case. And hopefully, in our discussion about the cost and whatnot, we can we can sort of come to an understanding about that.

Does that -- that really seems to really cause me a little bit of puzzlement.

CHRISTINE CAPPIELLO: Yes. We certainly can review it. I think some of it is more around the process of how we -- how we administer it on the medical side as opposed to how we administer it on the pharmacy side, but we certainly -- we could certainly talk about it.

It sounds like you're almost, if I'm understanding correctly to your point, here's -- here's $1,000, let's take that as

the number, to do with it what you will, almost if you want to do the hospitalization so --

REP. FONTANA: In essence -- I mean, the way I would reframe it is, you and your doctor have decided that the most efficacious form of treatment for you is indicated through an oral method as opposed to an intravenous method. Either because there is no intravenous method --

CHRISTINE CAPPIELLO: Yes.

REP. FONTANA: -- or for reasons as Ms. Green indicated there might be --

CHRISTINE CAPPIELLO: -- works better for you.

REP. FONTANA: -- a risk of infection, which would then also ostensibly drive up the costs, not just to the patient but to the company. So you have made the determination that this's the best form of treatment for you.

Were we able to put you into an intravenous situation in a hospital setting, we would be essentially providing you this amount of benefit.

CHRISTINE CAPPIELLO: I see. Yes.

REP. FONTANA: Since you're choosing to go the other route, we will provide you that same level of value.

CHRISTINE CAPPIELLO: I see.

REP. FONTANA: So if I framed that properly.

CHRISTINE CAPPIELLO: Okay. No, I understand.

REP. FONTANA: Great. Thank you.

Thank you, Mr. Chairman.

SENATOR CRISCO: You're welcome.

Any other -- Senator Caligiuri.

SENATOR CALIGIURI: Thank you, Mr. Chairman.

Christine, just to -- just to pile on a little bit, I -- you know, when I sit here and think about it and I know a lot of it's going to come down to the data and to the facts. But as I sit here, I wanted to share with you my impression that if it turns out that it's even less expensive in some cases, it just makes no sense.

CHRISTINE CAPPIELLO: Right.

SENATOR CALIGIURI: And it's -- I think it's going to be pretty hard for the industry to -- without some other very good reasons that so far I haven't heard.

CHRISTINE CAPPIELLO: Right. I understand.

SENATOR CALIGIURI: -- to defend a practice where, you know, it could be even less costly.

CHRISTINE CAPPIELLO: Right.

SENATOR CALIGIURI: And that's --

CHRISTINE CAPPIELLO: I understand.

SENATOR CALIGIURI: You know, that's a really big deal. I think just as a basic issue of

fairness.

And then beyond that, one other thought I had is having talked to some of the health actuaries about pricing products, I know that they use Medicare and the reimbursement rates on the Medicare is a basis for pricing a lot of their products, and I'd be curious to know and maybe you can help us to find out how Medicare, you know, treats these types of drugs and what role that plays in pricing for you guys. And maybe that'll be a way for us to answer the question as well.

CHRISTINE CAPPIELLO: Sure.

SENATOR CALIGIURI: Thank you.

Thank you, Mr. Chairman.

SENATOR CRISCO: You're welcome.
Senator D'Amelio, did you have a question?

REP. D'AMELIO: No.

SENATOR CRISCO: No, no.

Any other questions?

Yes, Representative Schofield.

REP. SCHOFIELD: A number of questions. Thank you. I forgot my little button here.

In reading your testimony, it looks like you're sort of trying to make the case that's part of the reason that you're -- that you're company doesn't provide the -- the oral drugs at as favorable a copay is because you think they're not as -- because the compliance with the therapy is not as good? Is that part of

the justification?

CHRISTINE CAPPIELLO: I think I'd have to -- I can't make a general statement because I think different products treat it differently. I don't know for a fact that -- that I can say that all of our products, because we have so many, favorably treat it on the medical side intravenously than on the oral side so kind of start with that.

There is some concern that goes into the benefit design related to some of these studies. We have used and the industry has used the studies as a reason for, perhaps, taking a look at them and -- and not covering them perhaps as favorably as the intravenous because the -- because of the intravenous you have to go. I do -- I do understand that there is -- there were some points that were raised that, you know, if you can't get transportation there, and I honestly don't know if these studies took into consideration those things.

But it's been generally our -- our -- our experience that if somebody goes into a facility to have the chemotherapy, they stay for the whole time as opposed to just apparently some of these drugs, the oral drugs, it's like to 20 or 30 pills a day. So I think we've all experienced -- certainly not on anything like that, stay aware. You know, you're suppose to take four antibiotics in a day and you get to the end of the day and you're like I forgot. I only took three. I was supposed to take four. So I think that's probably some of the compliance that goes along with it. But we can provide the more in depth in the study.

REP. SCHOFIELD: I guess I would echo Representative Fontana's request that we get a little bit more on the medical necessity because I think just as a blanket assumption that the oral is never going to be as effective as the IV. I don't think that case can be made on a diagnosis-by-diagnosis or patient-by-patient kind of basis and maybe it needs to be assessed on each -- in each case.

I want to learn a little more about the Tier 4 concept that somebody else was talking about earlier. And you've got a PBM at Anthem, too. Right?

CHRISTINE CAPPIELLO: Well, we actually just sold ours to Express Scripts.

REP. SCHOFIELD: Okay.

CHRISTINE CAPPIELLO: So we don't have one anymore.

REP. SCHOFIELD: You had one?

CHRISTINE CAPPIELLO: We had one. And I don't know I don't know if there is any other --

REP. SCHOFIELD: I don't know if there are any other payers coming up, but I guess one of my concerns always, whenever we do anything in this committee is about picking out a particular diagnosis and not dealing with the larger issue that there are probably many other kinds of diagnoses that also wind up with drugs in a Tier 4 category, which gives them a much higher copay. And so if we single out cancer this year, then what is it next year, and what is --

CHRISTINE CAPPIELLO: Right.

REP. SCHOFIELD: -- the year after that?

CHRISTINE CAPPIELLO: Right.

REP. SCHOFIELD: And is there a bigger issue that we ought to be addressing that if -- if we're saying, well, you get to be diagnosed but then the drugs are unaffordable.

CHRISTINE CAPPIELLO: Right.

REP. SCHOFIELD: You know what good is that.

CHRISTINE CAPPIELLO: What's the point? Right.

REP. SCHOFIELD: And so I want to understand the interplay of the Tier 4 copay with out-of-pocket limits and how whether with the typical out-of-pocket limit in the plan applies on --

CHRISTINE CAPPIELLO: On the medical side?

REP. SCHOFIELD: -- to drugs because there used to be an out-of-pocket maximums on most plans.

CHRISTINE CAPPIELLO: Yes.

REP. SCHOFIELD: But I don't remember if they -- if they also applied to the drug.

CHRISTINE CAPPIELLO: It depends, it depends. I have to go back and check. I do not think we ever had a fourth tier. I don't think when we had our PBM, or there may have been some large self-insureds that had picked the 4 Tiers. But I don't think generally we had any 4 Tier. There are some that have an out-of-pocket maximum on the drugs side but most do not that we sell. So I can only speak for us.

REP. SCHOFIELD: So the health plan out of pocket didn't apply to this?

CHRISTINE CAPPIELLO: Right. On the medical -- right. Right. But I will double-check.

REP. SCHOFIELD: Okay. And I know you do have Medigap --

CHRISTINE CAPPIELLO: Yes.

REP. SCHOFIELD: -- plans.

CHRISTINE CAPPIELLO: We do.

REP. SCHOFIELD: And Medicare is another question for me. I did read, subsequent to me asking the question about Medicare before, I did read in this testimony that -- or in the New York Times article that was appended to someone's testimony that Medicare's copay for these drugs is 25 percent.

CHRISTINE CAPPIELLO: Yes. I don't know.

REP. SCHOFIELD: So this is a problem, not just in the private sector, but also in the public sector where people also are left without that (inaudible). Is that typically is that 25 percent covered under a Part D plan?

CHRISTINE CAPPIELLO: Oh, I don't know.

REP. SCHOFIELD: Or under a (inaudible) plan? Because I suspect that we have the same bifurcation in the public sector.

CHRISTINE CAPPIELLO: Yes. Yes.

REP. SCHOFIELD: -- as in the private sector.

CHRISTINE CAPPIELLO: I don't know. It's a -- It's a good question. I think it's probably under --

REP. SCHOFIELD: Part D.

CHRISTINE CAPPIELLO: -- the part, yes, it's probably under the Part D, but I don't know. These to Part D's are relatively new. Whether this is something that's just -- was a holdover under the supplement policies and it's still there. I don't know. We can find out for you.

REP. SCHOFIELD: I mean, I sort of see this in both the public and private sector as a situation where benefit design is lagging medical innovations.

CHRISTINE CAPPIELLO: Uh-huh, yes.

REP. SCHOFIELD: And, again, it's a bigger issue than just cancer. Although, obviously, cancer is probably the biggest single broad diagnoses that is getting this treatment. But I guess one of the concerns I have in the bill, as written, and I know it's a work in progress, is the notion of simply just reclassifying a drug benefit into a medical plan has a myriad of administrative issues, but maybe there's a way to go at this from looking at an out-of-pocket max or a copay max just within the -- within the pharmacy benefit and not limiting it only to cancer, although that obviously drives up the premiums enormously.

So there's all of those issues all over again of the cost of mandated benefits.

But, one last question is I also read that

Oregon has passed a bill somewhat similar to this, making sure that the IV drugs are not disadvantaged in terms of copay, and I'd like to know how you'd administer that in Oregon if you have a plan?

CHRISTINE CAPPIELLO: We don't do -- the Blue Cross plan of Oregon is not in the Anthem family, but we can certainly reach out.

REP. SCHOFIELD: Or if are there any other insurers, you can answer that later but it would be helpful.

CHRISTINE CAPPIELLO: We can reach out and find out how to find that.

REP. SCHOFIELD: Thank you.

SENATOR CRISCO: Any other questions?

Thank you so much, Christine.

Anybody else to speak on Senate Bill 50?

If not, we'll proceed to Senate Bill 92, Doctor David.

DAVID EMMEL: Good afternoon, Senator Crisco, Representative Fontana and other distinguished members of the Insurance and Real Estate Committee. My name is Doctor David Emmel, and I'm a board certified ophthalmologist practicing in Wethersfield. And I'm here in the capacity of President-elect of the Connecticut Society of Eye Physicians representing 300 Connecticut ophthalmologists in support of SB 92, AN ACT CONCERNING PRESCRIPTION EYE DROPS.

The physicians and surgeons of the Connecticut

CBIA
Connecticut Business & Industry Association

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Eric George
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TESTIMONY
BEFORE THE
INSURANCE AND REAL ESTATE COMMITTEE
LEGISLATIVE OFFICE BUILDING
FEBRUARY 18, 2010

My name is Eric George and I am Associate Counsel for the Connecticut Business & Industry Association (CBIA). CBIA represents approximately 10,000 businesses throughout Connecticut and the vast majority of these are small companies employing less than 50 people.

Both nationally and here in Connecticut, the health care system is in need of repair.

More needs to be done to improve the health of our citizens. Employers find health care costs rising faster than other input costs. Some providers are unable to generate sufficient patient revenue to cover costs. Some patients cannot get timely access to optimal care. And too many individuals remain without health insurance, engage in unhealthy behaviors and live in unhealthy environments.

For the business community, the issues of health care quality, cost and access are critical. After numerous years of double-digit and near-double-digit increases, health insurance has quickly become a product that many people and companies find they can no longer afford. In addition, the cost of health care directly affects businesses' ability to create new jobs. In fact, according to CBIA's latest membership survey, over two-thirds of our members indicated that rising health benefit costs alone are negatively affecting their ability to hire additional workers.

Therefore, CBIA asks this committee to reject **SB 50, AN ACT CONCERNING ORAL CHEMOTHERAPY TREATMENTS.** The business community and other stakeholders are calling for significant reforms to Connecticut's costly and inefficient health care system. As you consider the various proposals to reform the state's health care system, CBIA asks you to refrain from making the already high cost of health care even more unaffordable for the state's companies and residents.

Every health benefit mandate, while providing a benefit to the individuals who utilize those services, increases health insurance premiums for all state-regulated group and individual policies. In fact, the Council for Affordable Health

Insurance (CAHI) has reported that health benefit mandates increase health insurance premiums between less than 20% to more than 50%. According to CAHI, Connecticut's mandates increase group and individual health insurance premiums by as much as 65%.

Connecticut's employers are already struggling to afford health insurance for their employees. The hardest hit among these companies are small employers whose revenues and operating budgets make affording employee health insurance extremely difficult. However, when the legislature adopts new health insurance mandates, it makes affording health insurance particularly difficult for these small employers. This is because state mandated benefits only impact plans that are subject to state regulation. If a company has the financial ability to self-insure, then that company's health plan is governed solely by federal law, including the Employee Retirement Income Security Act (ERISA), and does not have to comply with state health benefit mandates. Companies that are able to self-insure (and therefore not subject to Connecticut's health insurance mandates) are typically larger companies that can afford taking on such risk. Smaller companies usually cannot and are forced to be fully insured and subject to state regulation.

So, Connecticut's health insurance mandates impact smaller employers in the state to a greater degree than larger employers. When the legislature either creates a new mandate or expands an existing mandate, it is making health insurance less affordable for those small companies that can least afford to shoulder these cost increases.

CBIA asks this committee to reject all new or expanded mandate proposals and to enact a moratorium on health insurance mandates. It is crucial that as the state moves forward toward major health care reform, that the General Assembly refrain from taking any actions that would increase the cost of already skyrocketing health insurance premiums.

Again, please reject **SB 50** thank you for the opportunity to offer CBIA's comments on this legislation. I look forward to working with you on this and other issues related to the reforming Connecticut's health care system.

SB 50

*Quality is Our Bottom Line*

**Insurance Committee Public Hearing**
**February 18, 2010**

**Connecticut Association of Health Plans**

**Testimony regarding**

PAGE 1
LINE 4

**SB 50 AAC Oral Chemotherapy Treatments.**

The Connecticut Association of Health Plans respectfully urges the Committee's rejection of SB 50 AAC Oral Chemotherapy Treatments. Each mandate, there are a number of factors around cost and quality that should be taken into account.

Drugs of this nature can cost up to $10,000 per month and are typically considered under a pharmacy benefit. Currently, health plans in Connecticut are prohibited from charging pharmacy co-pays in excess of $40 – a consumer protection that extends to oral chemotherapy drugs as well as any other pharmaceutical. Requiring that these drugs be treated as medical benefits as opposed to pharmacy benefits could have the unintended consequence of actually costing a member more if, for instance, they have a benefit design that includes a high deductible.

Furthermore, it's possible that legislation such as SB 50 may violate the new federal interim final rules under the Wellstone/Domenici Mental Health Parity Act of 2008 which becomes effective July 1, 2010. These rules state that a health plan cannot set up a formulary or any other cost-sharing mechanism that treats any medical condition differently than a mental health/substance abuse condition. Only "reasonable factors" may be used to make cost differentiations about drug coverage; these factors include cost of drug, efficacy, generic v. brand name and mail order v. pharmacy pick-up. *Health plans may not make cost differentiations for drugs based on the health conditions they cover.*

Legislation of this nature also raises serious issues around quality that should be taken into consideration. Oral chemotherapy regiments typically require a patient to take the medication exactly as prescribed by the doctor, with the average regimen consisting of 10 - 20 pills each day. The regimens may be complex and rely upon the consumer to police his or her own medication without the direct supervision of a licensed and trained medical professional. Without direct supervision, side-effects can be missed; patients may not take all of their medicine, which raises the risk their cancer will worsen; or patients may take too many pills, risking toxic reactions. We should be careful not to embrace specific therapy regimens in statute particularly when they are still fairly new in terms of development. Please consider the following research cites as catalogued by AHIP - America's Health Insurance Plans:

- A study published in the Journal of Clinical Oncology found that Gleevec patients, on average, were taking only 75 percent of their prescribed doses. (*Journal of Clinical Oncology, Vol. 24, No. 18S (June 20 Supplement), 2006: 6038)*

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- A study of anastrozole (Arimidex) in breast cancer suggests that adherence declines over time. For women with 3 years of continuous eligibility, mean adherence diminished each year, dropping from between 78% and 86% in year 1 to between 62% and 79% by year 3. The study concluded that many women were "suboptimally adherent" to this oral treatment. (*Partridge AH et al., Journal of Clinical Oncology, 2008; 24:556.562)*

- Safety practices for oral chemotherapy treatments may be inadequate, according to a survey of 42 U.S. cancer centers. The study concluded that few of the safeguards routinely used for infusion chemotherapy have been adopted for oral chemotherapy regiments and there was no consensus among the centers as to what constitutes safe practices. (*Weingart, S. et al.,British Medical Journal (BMJ) 2007; 334:407)*

In addition, patients and their families can receive inadequate information about the safe handling of the chemotherapy drugs, as well as proper storage and disposal techniques.

In light of the above, we respectfully request you take no action on SB 50. Thank you for your consideration.

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Senator Giaccolone / PAGE 2 LINE 6

## *Insurance Association of Connecticut*

### *Insurance and Real Estate Committee*

Thursday, February 18, 2010

SB 50, An Act Concerning Oral Chemotherapy Treatments

The Insurance Association of Connecticut (IAC) is opposed to SB 50's mandate that specified disease policies provide orally-administered anticancer medications. Specified disease policies do not provide benefits in the same manner as a typical pure health policy. Specified disease policies benefits, typically lump sum cash payments, are paid if a designated trigger is met. For example, a person is diagnosed with cancer and the person has a specified disease policy—then the policy's benefits may be paid. The trigger for the benefit being paid is not dependent on a person receiving treatment or the therapy for the diagnosis, but quite simply on the diagnosis.

Mandating that such policies provide coverage for orally-administered anticancer medications is adding a benefit to the policy it does not provide. Specified disease policies do not have a drug reimbursement provision. It would be like mandating an auto policy to provide coverage for a garage that was struck by lightning.

The IAC respectfully requests that subdivision (1) of subsection (d) of Sections 1 and 2 be amended to remove any reference to subdivision (13) of Section 38a-369.

Connecticut Affiliate
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860-728-4955, www.komenct.org

SB50
Anne Morris
✓
PAGE 1
LINE 11

**Testimony of Anne Morris to the Insurance and Real Estate Committee**
**SB 50: An Act Concerning Oral Chemotherapy Treatments**
**Insurance and Real Estate Public Hearing**
**February 18, 2010**
**Legislative Office Building, Hartford**

Good afternoon Senator Crisco, Representative Fontana and members of the Insurance and Real Estate Committee. My name is Anne Morris and I am the Executive Director of the Connecticut Affiliate of Susan G. Komen for the Cure®. Susan G. Komen for the Cure® is the world's largest and most progressive grassroots network of breast cancer survivors and advocates. Since 1996, Komen has invested over $19 million in breast cancer education, screening, treatment and research in Connecticut.

I am here this afternoon in support of SB 50 An Act Concerning Oral Chemotherapy Treatments.

Oral chemotherapies are becoming an increasingly available, non-invasive and more convenient alternative to intravenous chemotherapy. This is good news for cancer patients and avoids numerous problems such as risk of infection from intravenous lines, transportation to and from the cancer treatment facilities, child care concerns and reduces the amount of time it takes to receive treatment. The bad news is that due to how health plans classify these oral chemotherapies, patients are forced to bear a much larger out of pocket cost for oral treatments than they do for the equivalent IV treatment – sometimes for the exact same medication.

Connecticut Affiliate
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Most health plans cover IV chemotherapy under the medical benefit and the patient's out of pocket cost is an office visit co-pay. That is not the case with oral therapy.

Orally administered anti-cancer medications are covered under the health plan's pharmacy benefit. These anti-cancer drugs are placed in a specialty or 4th tier of the health plan's formulary and require an average coinsurance of 28% according to a recent study by the Kaiser Family Foundation. For an orally administered anti-cancer medication with a $3,000 per month cost, the patient out of pocket is $900 per month. This puts orally administered anti-cancer medications out of reach for many Connecticut residents.

In some cases, new chemotherapy medications are only available in oral form causing patients who cannot afford these high out of pocket costs, to take a less effective drug.

Patients should receive the chemotherapy medication that is recommended by their physician and will be most effective in fighting their cancer. Life saving decisions such as these should not be based on whether or not a patient can afford a $900 per month out of pocket co-pay. They should be based on what will save, extend or improve the quality of life of the patient. Passing this legislation will ensure that happens.

Thank you for your consideration.

SB 50
Kim Green
✓
PAGE 3
LINE 10

TESTIMONY OF KIM GREEN
INSURANCE & REAL ESTATE COMMITTEE PUBLIC HEARING
February 18, 2010

Re: Support of Raised Bill 50 - ***AN ACT CONCERNING ORAL CHEMOTHERAPY TREATMENTS***

Good morning, my name is Kim Green and I want to thank you on behalf of my self and other breast cancer fighters for your attention to this very important bill.

Originally I was not going to testify but last week something happened just as Anne's invitation to testify came to me via email. – Another glitch with my insurance company and my chemo.

I take two forms of oral chemotherapy daily – that's eleven vitamin sized pills. It's quite the routine because some have to be taken on an empty stomach, others with food, and don't combine and make sure you take your other medication, etc, etc. I take oral chemotherapy because last year the port in my chest that had been administering my intravenous chemo for the past eleven years, became infected. The infection spread to my heart and permanently damaged it. I underwent open heart surgery and spent 40 days in St. Francis. A central line is no longer an option. I am so thankful that I have oral chemotherapy to rely on; the problem is it is an absolute financial and logistical nightmare to receive. Every three weeks, when it is time to renew my prescriptions I receive the same reply, the cost of the drug exceeds what the insurance deems reasonable. There are no other drugs to take. I have heard this for 20 months now. After many phone calls to my oncologist and to my insurance company the issue gets resolve – but often several days have passed with no medication. The emotional impact is enormous. When you are a stage 4 cancer patient, taking your medicine on time is of utmost importance.

The cost to my family for oral chemotherapy is quadruple of what it was when I would go to the hospital for the day and pay my $20 co pay. My meds cost over $700 a month. Our insurance premium alone is one third of our family income. My husband will never retire nor will he change jobs because of the fear of losing the insurance that is priceless to us. The idea of a layoff is unimaginable. At a time that I should be healing and just enjoying the life that I have left, I am working in a small retail business to help cover medical costs. How I wish I could go back to the IV treatment that cost our family $20 per visit even though it was an all day, painful, stressful day. There is no stop date for my chemo. I will take it until a cure is found.

I am married and have a 15 year old and 11 year old. When I think of what they are not receiving because of the cost of my meds – I often have tremendous guilt, especially now that college is on the horizon. Money that was worked hard for and out away is now gone. My husband keeps telling me that having a mother is more valuable than a college education, I so want to believe that....

The guilt battles with the true feelings of gratitude and thankfulness all of the time. These drugs are extending my life so that I can see my children off to college – I will never lose sight of how fortunate I am.

It just seem so logical that avoiding a hospital visit and being able to avoid the anxiety associated with a day of IV chemo is such a step in the right direction for cancer fighters. By passing this bill and taking away the financial and logistical battles enables us to focus on the fight at hand. The fight for our lives.

Thank you for your compassionate consideration.

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CONNECTICUT ONCOLOGY ASSOCIATION

STEPHEN GRUND
PAGE 4
LINE 6

February 18, 2010

State of Connecticut
Insurance and Real Estate Committee
Room 2800, Legislative Office Building
Hartford, CT 06106

Re: Testimony in support of Raised Senate Bill 50 An Act Concerning Oral Chemotherapy Treatments

ATTENTION: Senator Crisco, Representative Fontana and members of the Committee

Greetings:

The Connecticut Oncology Association (CtOA) is a non-profit organization dedicated solely to oncology care in the state of Connecticut. The Connecticut Oncology Association is the sole professional organization for Connecticut practicing oncologists and their practices. Its mission is to provide education and facilitate communication on issues affecting oncology and the access to quality cancer care for patients in the state.

CtOA is here today to address Raised Senate Bill No. 50, which is now under consideration by the Insurance and Real Estate Committee. On behalf of our patients and our own dedication to the continued access to quality cancer care in Connecticut, we appreciate your vision in considering this raised bill, and would like to lend our support to your efforts.

During the battle of the last four decades on cancer, we have successfully moved the majority of cancer treatments from the more costly inpatient setting into the outpatient and private community oncology practice office. That success is due in large part to the advances in technology and the emergence of new, innovative agents for treating cancer.

The evolution of oncology treatment has outpaced payer and employer management of healthcare benefits. Historically, intravenous/injected chemotherapy agents are typically covered under medical benefit plans, since due to the complexity of cancer care and the toxicity of the drugs, they are delivered under the care of a physician in the office setting. The medical benefit coverage provides patient responsibility for office visit copayments and may include a cap on out-of-pocket expenditures, making necessary treatment for cancer care affordable and accessible for patients.

However, with the recent emergence of orally-administered anticancer agents, payers have moved insurance of many of these agents to the pharmaceutical benefit, which allows the creation of benefit structures that vary significantly and can create a significant financial burden to the cancer patient. It is important to note that evidence-based treatment guidelines, including those issued by the National Comprehensive Cancer Network (NCCN) recommend a variety of combinations of cancer treatments depending upon the individual cancer and stage, and the ability of the patient to tolerate the treatment. These recommendations are made without regard to the route of administration, expecting the physician to determine the most appropriate option for each patient. Restrictive benefit structures that differ between the medical and pharmaceutical benefit are interfering with the medical decision-making and preferred course of treatment for both physicians and patients.

Raised Senate Bill No. 50 proposes to level those differences in benefit structures, so that cancer patients will not be faced with the choice of no treatment, choice of the least costly alternative, or the preferred treatment for their individual cancer. This raised bill will define coverage expectations so that cancer patients may have access to the most appropriate agent for cancer treatment, and not worry that the treatment they need will not be covered under their insurance's medical benefit, or that the costs of co-payments if the drug is only available in the pharmacy benefit will make that same medication completely out of their reach financially.

This is not a cost of drug issue, it is a coverage issue. The difference in cost between the oral and IV versions of drugs is not significant. However, the patient may be forced to pay thousands of dollars more out of pocket for the same medication, depending upon whether the payer covers it under the medical benefit or the pharmaceutical benefit. In another worst case scenario, the patient may not have access at all to a drug they could have received in the office, because their pharmaceutical benefit does not cover that drug in oral form.

Due to complex state pharmacy regulations, many oncologists do not dispense oral medications in their offices, but they do see patients every day, who are prescribed needed anti-cancer agents, only to find that the patient has to decline the drug because their insurance may not have a pharmaceutical benefit, or their pharmaceutical insurance package places anti-cancer drugs in the highest tiers for co-payments and co-insurance, rendering them unaffordable. Some anti-cancer agents are only available in oral form and thus not accessible under the medical benefit, others are available in both oral and IV form but are only accessible to patients under the medical benefit due to differences in financial burden to those patients for the same drug under a pharmaceutical benefit.

This access problem for our patients will continue to exacerbate, with more than 25% of the drugs in the cancer pipeline being developed in an oral formulation. We must move now to ensure parity between patient access to both IV and oral cancer treatments, regardless of which insurance benefit they hold. To allow payers to create different reimbursement structures that become barriers to care is a gross injustice to the people of Connecticut who are already battling the fight of their lives against cancer.

The CtOA urges the Connecticut legislature to quickly pass Raised Senate Bill No. 50, and stop the barriers to care that are restricting needed access to treatment for cancer patients. No matter what the route of administration is (oral, intravenous or injectable) for the preferred treatment for patients, the out-of-pocket cost to that patient should be equivalent and affordable. We therefore recommend, additionally, that verbiage be added to Raised Senate Bill No. 50 assuring that cancer patients not only receive the prescribed therapies based upon their potential efficacy by the prescribing oncologist, whatever the formulation, but also that they are not unjustly assessed unachievable co-pays and co-insurances as seen by recent revised legislation in the state of Oregon and others, as well as private insurance company trends of drug formulary tier placement resulting in a higher patient cost share than other formulations, even for the same medication.

Sincerely,

Stephen Grund, M.D.
President
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4 bca

50
Michael Tuohy
MICHAEL TUOHY
PAGE 4
LINE 18

April 14, 2010

Insurance and Real Estate Committee
Room 2800, Legislative Office Building
Hartford, CT 06106

Testimony in support of Senate Bill 50, AN ACT CONCERNING ORAL CHEMOTHERAPY TREATMENTS

Senator Crisco, Representative Fontana and members of the Committee:

Good Afternoon,

I'm Michael Tuohy, from Prospect, CT. I was diagnosed with Multiple Myeloma in 2000 when I was 36 years old. I have been fortunate in that my insurance coverage has allowed me and my team of doctors to choose the best medical treatments available. I have been on an oral therapy for the past 3.5 years and am thrilled to tell you I am in remission and enjoying a good quality of life. However, I personally know of many patients in situations where they, along with their doctors, are faced not only with fighting cancer, but fighting insurance companies to reimburse their oral treatments. Patients and doctors should be basing treatment decisions upon what is medically the best option available to them, **not** what they can afford.

Over the last 10 years, I have seen many exciting novel therapies approved to help patients live longer, more productive and active lives.

New therapies have made a dramatic difference - advancing the treatment of multiple myeloma, extending lives and improving the quality of life for many patients. These new therapies are both oral and intravenous, yet many insurance policies require higher out-of-pocket expenditures for the oral drugs. This means many patients have had to forego getting the drug that's optimal for their treatment, or they've had to go into debt to meet the co-payments required.

In the myeloma support group that I run in Waterbury, I have listened to too many stories about a patient's fear and anxiety that they will not be able to afford the copay for the oral drug that their doctor has recommended.

One such story is of a woman who was newly diagnosed. Her doctor recommended an oral therapy as her best treatment option. She is in remission, but had to sell her house and is now living with her daughter so she can afford the co-pay for the oral therapy that is saving her life.

We are living in a new and exciting time where science and brilliant minds have advanced cancer therapies, but if patients are not able to afford them, then how far have we actually come? We need to update our laws so that there is insurance parity for oral and IV drugs. On behalf of all cancer patients, I emplore you to support SB 50.

Thank you.

Michael Tuohy
Cancer Survivor
Prospect, CT

ROBIN TUOHY
PAGE 4
LINE 14

**Robin's Messages for Testimony on SB50**

Good Afternoon

I'm Robin Tuohy from Prospect, CT and I am Director of Support Groups for the International Myeloma Foundation. In addition to the letter that was submitted to you from Susie Novis, President and co-founder of the International Myeloma Foundation, I would like to add the following:

The IMF believes patients should be able to take advantage of the treatment that is best for them and not have to select their treatment based on insurance coverage. Hematologist-oncologists need the freedom to prescribe therapies based on their potential efficacy.

- We need an equitable, patient-oriented insurance system that acknowledges and covers 21st Century tests and treatments
- Currently although oral drugs cost the least to administer they have the highest out-of-pocket charges for patients.
- All treatments must be reimbursed at an equitable rate, regardless of how they are administered
- We question a system that reimburses the least for the most cost-effective treatments
- We are not promoting oral drugs; we are saying treatment should be based on medical assessment not insurance coverage. That is, based on what patients and physicians working together agree is the optimal treatment for their specific case
- Something is very wrong when the largest side effect of a drug is economic based upon inequitable and irrational differences in reimbursement.

Oral drug Parity Legislation CT SB 50 is now being considered in CT that would require private insurance companies to cover oral anti-cancer drugs at the same rate they cover intravenous infusions in terms of patient out of pocket costs. This is a critical time to stand-up for the health issues that affect us directly.

Thank you.

**State of Vermont**
**Department of Banking, Insurance,**
**Securities and Health Care Administration**
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Montpelier, VT 05620-3101
**www.bishca.state.vt.us**

Consumer Assistance Only:
Insurance: 1-800-964-1784
Health Care Admin.: 1-800-631-7788
Securities: 1-877-550-3907

TO: Douglas A. Racine, Chair, Senate Committee on Health and Welfare
Stephen B. Maier, Chair, House Committee on Health Care

FROM: Sean Londergan, Assistant General Counsel, Director of Rates and Forms
Department of Banking, Insurance, Securities and Health Care Administration

DATE: January 15, 2009

SUBJECT: Coverage of Oral Anticancer Medications – 8 V.S.A. § 4100h

Section 48 of Act 61 of 2009, An Act Relating to Health Care Reform directs the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) to study the impact of implementing a requirement for health insurance coverage of orally administered anticancer medication. In conducting the study, the Department was asked to consider: (1) projected impact on health insurance premiums; (2) options for mitigating the impact on premiums of the coverage requirement; (3) administrative complexities associated with the mandate; (4) public policy implications of expanding coverage for treatment-specific medications and procedures; (5) appropriate safeguards for accomplishing the purpose of the coverage requirement; and other factors that the Department deems appropriate. As directed, the Department is reporting its findings and recommendations.

## I. Impact on Premiums

The Department has not received information indicating that mandating coverage for orally administered anticancer medications will significantly impact premiums. The Department's assessment is based on information received from three other states (IN, CA & OR), which have passed similar legislation and the Department's contracted actuary.[1] During last year's session, Senator Mullin provided an impact statement for premiums at .00144% for California. Indiana, which passed oral anticancer medication legislation last year, reported a "negligible" impact on premiums so far, although they did not have any hard data. Oregon does not have any information about whether their state's legislation increased premium rates because their insurance department does not track information about premium rate increases. For Vermont, the Department's actuary

[1] The Department notes that at least eight other states, in addition to Indiana, introduced cancer drug parity laws during the last year. In all eight states (Texas, Montana, Colorado, New Mexico, Oklahoma, Minnesota, Ohio and New York) the legislation remains pending in their respective state legislatures.

has concluded that individuals without prescription drug coverage may experience a 0.5% increase in premiums. Approximately 95.0% of insured Vermonters have prescription drug coverage. The insurers contacted for this report provided no indication of significant rate increases as a result of the legislation. Therefore, the Department does not believe that the State's mandate for orally administered anticancer medication will significantly impact premiums for Vermonters.

## II. Administrative Complexities

There may be administrative complexities associated with the mandate. For instance, a majority of Vermonters have Preferred Provider Organization (PPO) coverage that consists of a medical/surgical portion (administered by the insurer) and a freestanding prescription drug portion subcontracted to a Pharmacy Benefit Manager (PBM). Currently, the injectable chemotherapy drugs are provided under the medical/surgical portion; and the orally administered chemotherapy drugs are provided by the PBM. Each coverage type is administrated differently with different patient payment rules.[2] As a result, there may be an administrative challenge to match the benefits of each coverage type to assure oral drug anticancer medication parity. In addition, for those consumers who have opted out of any freestanding prescription drug coverage, insurers will have to either have to administer the mandated benefits themselves; or negotiate with the PBMs to provide coverage only for orally administered chemotherapy drugs. The insurers contacted by the Department for this report did not identify any administrative complexities associated with the mandate.

## III. Public Policy Implications

The mandate has public policy implications. By requiring coverage of oral anticancer medications, the State is opening itself up to questions about whether other promising drugs for other serious illnesses should also be covered.

## IV. Safeguards

The Department has received anecdotal evidence from both Oregon and Indiana suggesting that insurers will choose to move coverage for all chemotherapy drugs to whichever coverage type (medical or pharmacy) provides the least comprehensive coverage and requires the most consumer cost-sharing. Thus, there is the potential that the enacted legislation will be harmful to some consumers because they may end up with

[2] In commissioning the Louisiana Department of Insurance to study the disparities in the amounts of co-payments between orally and intravenously administered chemotherapy medications, the Louisiana Legislature stated that "while traditional intravenous chemotherapy is typically covered under a health plan's medical benefits and requires only an office visit co-payment, oral chemotherapy medications are typically covered by the plan's drug benefit and require significant co-payments or co-insurance to fill the prescription at a pharmacy." The Louisiana Department of Insurance is to report its findings by February 15, 2010.

less coverage and more cost sharing.[3] In both Oregon and Indiana, the potential harm to the consumer was reportedly due to imprecise statutory language, which is very similar to that of 8 V.S.A. § 4100h.[4] However, the Department has been unable to determine how extensive the problem has been due to lack of data in both states.

Indiana at one point considered proposing that coverage for cancer chemotherapy be treated as a non-pharmacy benefit.[5] Ultimately, however, Indiana policymakers, concluded that they would be unable to ensure that all consumers would benefit in every instance and decided not to require a specific coverage type.[6] Indiana's contention that their mandate would be better for consumers if it were covered as a non-pharmacy benefit may have merit.[7] However, the Department's actuary estimated that for Vermonters who have PPO coverage with freestanding prescription drug coverage, consumer payments under their pharmacy benefit would be lower for orally administered anticancer medications in most instances (80 to 85% of the time) than if coverage was provided under the medical portion. Similar to the experience of Indiana and Oregon, the Department is hesitant to recommend that coverage for all cancer chemotherapy be treated as a non-pharmacy or as a pharmacy benefit, because there is no guarantee that in so doing the consumer will benefit in each instance.

## V. Conclusion

Despite possible administrative complexities associated with the requirement for health insurance coverage for orally administered anticancer medication, the Department does

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[3] Oregon also reported that its legislation did not fix the problem of affordability for oral cancer medications because consumers were still paying high copays and coinsurance for the medications.

[4] Oregon's statute reads as follows: "a health benefit plan that provides coverage for cancer chemotherapy treatment must provide coverage for a prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected cancer medications that are covered as medical benefits." 56 O.R.S. §743.068. Indiana statue reads as follows: "Coverage for orally administered cancer chemotherapy under an individual contract or a group contract must not be subject to dollar limits, copayments, deductibles, or coinsurance provisions that are less favorable to an enrollee than the dollar limits, copayments, deductibles, or coinsurance provisions that apply to coverage for cancer chemotherapy that is administered intravenously or by injection under the individual contract or group contract." I.C. 27-13-7-20.

[5] In an attempt to make the Indiana legislation more precise the following language was recommended "A policy of accident and sickness insurance that provides coverage for cancer chemotherapy, regardless of the method of administration, may not be issued, amended, or delivered or renewed in Indiana unless the policy treats chemotherapy as a non-pharmacy benefit."

[6] Indiana's conclusion on this matter was the same as Oregon's. The Oregon Legislature requested that their Department of Insurance recommend a type of coverage (either a pharmacy or major medical) for the mandated benefits. The Department of Insurance was unable to make a recommendation because the answer was inconclusive depending on the individual or group health plan.

[7] It must be noted that since the passage of Indiana's mandate some consumers have reportedly experienced greater cost sharing as a result of insurers moving oral anticancer medication from a pharmacy benefit to a major medical benefit.

not believe that the Vermont's mandate will significantly impact premiums for Vermonters. A greater concern is anecdotal evidence from states with similar legislation stating that insurers will choose to move coverage for all chemotherapy drugs to whichever coverage type (medical or pharmacy) that provides the least comprehensive coverage and greatest cost sharing. The Department was unable to determine whether there is a legislative solution that eliminates this concern without adversely impacting some consumers.

## VI. Recommendations

1. The Legislature should consider articulating the rationale for mandating coverage of oral anticancer medication and consider establishing criteria to be used for the analysis of additional requests in order to avoid future controversies.

2. The Department should monitor the implementation of the oral anticancer medication mandate for unintended consequences and report to the legislature with a recommended solution if problems arise.

Anthem Blue Cross and Blue Shield
370 Bassett Road
North Haven, Connecticut 06473-4201
Tel 203-239-4911

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Christine Cappiello

Anthem.

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LINE 8

February 18, 2010

**Statement**
**Of**
**Anthem Blue Cross and Blue Shield**
**On**
**SB 50 An Act Concerning Oral Chemotherapy Treatments**

Good afternoon Senator Crisco, Representative Fontana and members of the Insurance Committee, my name is Christine Cappiello and I am the Director of Government Relations for Anthem Blue Cross and Blue Shield in Connecticut. I am on testifying on SB 50 An Act Concerning Oral Chemotherapy Treatments

We are concerned about SB 50 because it seeks to impose a new mandate for all individuals and group policies, potentially including the State of Connecticut State Employees Health Insurance Plan. Mandates remove any choice that employers or individuals might have in purchasing health care. Our goal as a managed care organization is to provide a comprehensive meaningful set of benefits to individuals and employers purchasing our product. How we accomplish this goal changes as the needs and desires of the market changes. Mandating benefits take away the flexibility insurers have in developing products in response to the needs of the marketplace. The cost of mandates may cause the purchasers of health care, specifically employers to stop offering health insurance all together.

I would also like to add that the mandating of oral chemotherapy does several issues that we believe would be valuable for the Committee to know. It raises patient safety concerns because the lack of an in-office treatment removes the physician's direct supervision which provides an opportunity for the physician to see the side effects first hand and address them. Another concern is that they have been studies (A study published in the Journal of Clinical Oncology found that Gleevec patients, on average, were taking only 75 percent of their prescribed doses. (*Journal of Clinical Oncology,Vol. 24, No. 18S (June 20 Supplement), 2006: 6038) and a* study of anastrozole (Arimidex) in breast cancer suggests that adherence declines over time. For women with 3 years of continuous eligibility, mean adherence diminished each year, dropping from between 78% and 86% in year 1 to between 62% and 79% by year 3. The study concluded that many women were "suboptimally adherent" to this oral treatment. (*Partridge AH et al., Journal of Clinical Oncology, 2008; 24:556.562)* that show that some patients do not take all of their medicine as directed. Finally, this proposal does not take into consideration the structure of the health plan - which provides coverage for IV drugs as medical benefits and oral prescriptions as a pharmacy benefit - this may increase the member's out of pocket expense than they currently experience and offers no remedy if the member chooses not to have prescription drug coverage.

Thank you for the opportunity to speak on this bill and welcome any questions you may have.



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Insurance and Real Estate Committee
Room 2800, Legislative Office Building
Hartford, CT 06106

April 14, 2010

Testimony in support of Senate Bill 50, AN ACT CONCERNING ORAL CHEMOTHERAPY TREATMENTS

Senator Crisco, Representative Fontana and members of the Committee:

My name is Susan Farrelly and I am a nurse who has worked for many years treating patients with cancer at Black Rock Medical Group (Fairfield, CT). In my job I have seen many patients who have struggled to afford the oral chemotherapy agents they need to treat their cancer. Unfortunately, there are instances where oral agents are the best or only option for a particular patient but the patient is made to pay more out of their own pocket simply because it is not an intravenous or injectable product.

In my experience, obtaining prior authorization for oral chemo drugs has been extremely frustrating. Insurance companies require their own documentation consisting of testing and results, office notes and evaluations. Further, they also require a one-on-one conversation with the Oncologist and their own Medical Authority. This can take at least a week and usually a lot longer. The stress of the newly diagnosed patient increases as each day passes. Approval, if obtained, will frequently lull you into believing that good news has been obtained. The patient now faces "cost factors". In 9 out of 10 cases, the cost is prohibitive. We now have to proceed to a third party pay situation. This process of application leads to another waiting period with increased anxiety to the patient. And there is no guarantee of approval. I believe patients, experiencing the limits of stress when facing the unknown, should at the very least, know that they have access to the drug that is best for them and to also know that it is within their reach.

It is for these reasons that I urge members of the committee to vote in favor of Senate Bill 50 which would provide greater coverage and access for chemotherapy agents regardless or how they are taken by the patient.

Thank you for your consideration.

Respectfully,

Susan Farrelly

Susan Farrelly
87 Killian Ave.
Trumbull, CT 06611

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New England Coalition for Cancer Survivorship
30 Speen Street, Framingham, MA 01701
Phone: (508) 655-3329 e-mail: info@neccs.org www.neccs.org

April 18, 2010

Insurance and Real Estate Committee
Room 2800, Legislative Office Building
Hartford, CT 06106

Testimony in support of Senate Bill 50, AN ACT CONCERNING ORAL CHEMOTHERAPY TREATMENTS

Senator Crisco, Representative Fontana and members of the Committee:

Chemotherapy that is infused at a clinic is paid as a medical benefit while pills are covered under prescription drug plans, allowing insurance companies to transfer costs to the patient.

Needless to say, the financial impact of this can be tremendous. I personally have a co-pay for my oral chemotherapy of $75 every 3 weeks - and I feel fortunate. Based on the type of chemotherapy - others can pay upwards of $1000 or more per month. The challenge of living with cancer is already hard enough without the addition of this financial stress.

But it is not just about finances. Quality of life is also important. Oral chemotherapy is a welcome alternative to the pain of being stuck with a needle, especially for those of us who have bad veins. Already battling fatigue, it removes the additional stress of having long drives into appointments.

In addition, having been a victim of workplace discrimination due to my cancer diagnosis, I also see oral chemotherapies as an option for people not to disclose their cancer diagnosis if they choose not to.

Oral chemotherapies are a blessing. A wonderful alternative for some - the only option for others - but only if people can have access to them to help save their lives.

The passage of this legislation will require insurance companies that provide coverage for IV chemotherapy treatments to also provide the same level of coverage for orally administered anticancer medication-an act that would help so many of your constituents. It is for this reason that we urge you to pass this important legislation for all patients undergoing chemotherapy treatment in the state.

Thank you for your time and attention.

Respectfully yours,

Janice McGrath
President

The Leukemia & Lymphoma Society®
Fighting Blood Cancers

FTR 30

**Memorandum in Support**

**The Leukemia & Lymphoma Society Supports Legislation in Connecticut to Provide Insurance for Oral Chemotherapy Treatments**

The Leukemia & Lymphoma Society (LLS) strongly supports legislation to require health insurance plans in Connecticut, to provide the same coverage for orally administered chemotherapy treatments, as is extended for intravenously dispensed, or injected, chemotherapy. It is part of LLS' mission to ensure that patients with blood cancers have access to the best possible therapies to fight their illness, regardless of a patient's age, ethnicity, income or insurance status.

As a result of ever evolving, cutting-edge research and a commitment to improving treatments and finding cures, researchers are continually identifying new and more effective therapies for cancers. One of the greatest breakthroughs in the blood cancer world has been the development of Gleevec, which is used to treat Chronic Myelogenous Leukemia (CML) and is an oral chemotherapy drug. With Gleevec, CML patients are able to undergo chemotherapy by taking a pill in the comfort of their home, giving them the freedom to carry on with their daily lives; this is true, not just for patients taking Gleevec, but other cancer patients receiving oral chemotherapy treatments.

Oral chemotherapy is an exciting development for cancer patients and its benefits are significant. However, many insurance companies do not provide the same coverage for oral chemotherapies – like Gleevec –, as they do for more traditional IV chemotherapy, making it extremely cost prohibitive for countless patients. Specifically, since this chemotherapy treatment comes in the form of a pill or liquid, insurance companies classify the therapy as a prescription drug treatment. Consequently, the drug is not covered as a traditional "chemo" treatment and the patient is often forced to pay out-of-pocket – usually at a much higher price.

To level the playing field for all cancer patients, insurers in Connecticut should cover the cost of oral treatments as it would standard chemotherapy, ensuring that no matter how administered, cancer patients can relax knowing that they're being given access to the best possible care at a price they can afford.

**For more information, please contact Zina Cary, National Director of State Affairs, The Leukemia & Lymphoma Society at zina.cary@lls.org.**

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**SENATOR ANDREW RORABACK**
DEPUTY MINORITY LEADER PRO TEMPORE
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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
FAX (860) 824-5714

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

Duke Moore
175 Dublin Road
Falls Village, CT 06031

"All the News That's Fit to Print"

# 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.

VOL. CLVIII .... No. 54,646 © 2009 The New York Times NEW YORK, WEDNESDAY, APRIL 15, 2009 $1.50

## 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

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## 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 | Xeloda capecitabine | Temodar temozolomide | Gleevec imatinib | Tarceva erlotinib | Nexavar sorafenib | Revlimid lenalidomide | Sprycel dasatinib | Sutent sunitinib | Zolinza vorinostat | Tykerb lapatinib |
|---|---|---|---|---|---|---|---|---|---|---|
| Maker | Roche | Schering-Plough | Novartis | OSI Pharmaceuticals, Genentech | Onyx Pharmaceuticals, Bayer | Celgene | Bristol-Myers Squibb | Pfizer | Merck | GlaxoSmithKl |
| Year approval | 1998 | 1999 | 2001 | 2004 | 2005 | 2005 | 2006 | 2006 | 2006 | 2007 |
| Cancer uses | Breast, colorectal cancers | Brain cancer | Chronic myeloid leukemia, gastrointestinal stromal tumor | Lung, pancreatic cancers | Kidney, liver cancers | Multiple myeloma, myelodysplastic syndrome | Chronic myeloid leukemia, acute lymphoblastic leukemia | Kidney cancer, gastrointestinal stromal tumor | Cutaneous T-cell lymphoma | Breast cancer |
| Price* | $3,600 | $2,200 to $6,800 | $3,600 | $3,200 to $3,700 | $5,600 | $3,000 to $6,900 | $6,000 | $4,700 | $7,900 | $3,300 |

*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 TI

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

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 drilled 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 Advocate Foundation, an organization that helps people make insurance co-payments for cancer drugs, says oral medicines accounted for 56 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 Fleiher.

DREW LEE FOR THE NEW YORK TIMES

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

*Oral medicines are the new wave in cancer treatment.*

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, 56, 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 Les Newbomer, 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.

# Doctors Face Fiscal Squeeze For Treatment

By ANDREW POLLACK

Even as pills and capsules h prove life for cancer p tients, they are sapping the nances of many cancer doctors.

For drugs they administer their offices, oncologists c make money. They buy tho drugs wholesale and then get r imbursed — usually at a high price — by patients and insure when they use the drugs. Th also are paid for administerin the infusion.

But with oral drugs, the do tors just write a prescription t patient fills through a pharmac The doctors make no money fro the drug, and they have no inf sion to bill for.

Some doctors say the pills a actually raising their operati expenses. "The patients are st calling your nurses and talkin about side effects, but there's n payment for that," said Dr. Pa rick Cribb, a cancer doctor Montana. He is president of th Community Oncology Alliance, lobbying group representing o cologists, which has started project to measure the costs i curred in dealing with oral canc drugs.

Some large oncology practic are opening their own pharm cies, in part to capture some the profits from oral drugs. B the doctors say it is mainly f patient convenience, adding th neighborhood drugstores oft do not carry cancer drugs b cause they are costly and used b relatively few customers.

Cancer doctors generally den that financial considerations ap them to use intravenous drug over oral drugs when there is choice, saying they do what best for the patient. In any cas they say, changes in Medicare r imbursement have greatly r duced the profits oncologists c make on infused drugs.

Oncologists are fighting a d mand by the Medicare overse for New York and Connectic that the doctors first try or drugs to treat the nausea cause by chemotherapy.

Doctors' groups say they a resisting not because of mone but because intravenous antiem sea drugs are often better.

"If you're feeling nauseous said Dawn Holcombe, executiv director of the Connecticut Onco ogy Association, "if someon gave you a pill, would you want t take it?"

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

**Location:**
DISEASES; DRUGS; INSURANCE - HEALTH;

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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# Community Oncology Alliance

*Dedicated to high quality, affordable, and accessible cancer care*

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February 15, 2010

State of Connecticut
Insurance and Real Estate Committee
Room 2800, Legislative Office Building
Hartford, CT 06106

Re: Testimony in support of Senate Bill 50
An Act Concerning Oral Chemotherapy Treatments

ATTENTION: *Senator Crisco, Representative Fontana and members of the Committee*

Gentlemen:

The Community Oncology Alliance (COA) is a non-profit organization dedicated solely to community oncology. COA was founded by community oncology to advocate for patients and providers in the community oncology setting, where over 80 percent of Americans with cancer are treated.

Currently, COA is working with the United States Congress in providing proactive solutions designed to protect the viability of the nation's cancer care delivery system and patients' access to quality, affordable cancer care.

The mission of COA is to protect and foster the community oncology delivery system in the United States through public policy, advocacy, and education. Because over 80% of Americans battling cancer receive treatment in the community setting, ensuring the vitality of the community cancer care delivery system is imperative for patient well-being.

It is noted that the great state of Connecticut is taking under consideration, Raised Bill No. 50; an Act concerning oral chemotherapy treatments. In that COA is committed to adhering to the highest standards of integrity and patient well being, we commend you for tackling this very serious issue as it relates to cancer care.

With more than 25% of the drugs in the cancer pipeline in an oral formulation, it is imperative that a clearly delineated statement of coverage be put into place, allowing cancer patients access to the best form of treatment appropriate for their individual need, as prescribed by their oncologist. Ensuring parity for patient cost sharing for oral and IV cancer treatments will only increase access to and thereby improvement in the care and quality of life for cancer patients. In many instances, this will allow a patient a more expedient re-entry into the workforce, thus removing a burden from the State Medicaid roles, Unemployment Compensation Board, disability insurance, et cetera.

We hereby implore the Connecticut legislature to urgently pass the Bill No. 50 before it, thereby leveling the playing field for cancer patients who must now choose between the least costly alternative versus the treatment of choice. Whether a prescribed therapy be an oral, intravenous or injectable route of administration, the out-of-pocket expense to the patient should not only be equivalent, but achievable. It is, therefore, equally as important to insert

verbiage into Bill No. 50 assuring that cancer patients not only receive the prescribed therapies based upon their potential efficacy by the prescribing oncologist, whatever the formulation, but also that they are not unjustly assessed unachievable co-pays and co-insurances as seen by recent revised legislation in the state of Oregon and others, as well as private insurance company trends of drug formulary tier placement equating to a higher cost share.

We welcome the opportunity to provide further education and insight into this extremely important aspect of cancer care, with COA having just completed a study in conjunction with Avalere Health on barriers to access for oral oncolytics. The results clearly speak to cancer patient access issues—issues which your legislation will help to resolve.

Very truly yours,

Mary Kruczynski
Director of Policy Analysis
Community Oncology Alliance

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*February 18, 2010*

The Honorable Joseph J. Crisco, Co-Chair
The Honorable Steve Fontana, Co-Chair
Insurance and Real Estate Committee
Room 2800, Legislative Office Building
Hartford, CT 06106

Testimony in support of Senate Bill 50
AN ACT CONCERNING ORAL CHEMOTHERAPY TREATMENTS

Senator Crisco, Representative Fontana and Members of the Committee:

On behalf of the International Cancer Advocacy Network (ICAN), we are writing in support of Connecticut Senate Bill 50. We thank the Committee for introducing legislation to address this important patient care issue.

The goal of Senate Bill 50 is to ensure that patients have equal access to orally administered anticancer medications. Currently, differences in patient benefit plans result in greater patient out of pocket costs for oral chemotherapy treatments, thereby providing a major barrier to certain treatment options for cancer patients.

It is important to note that this bill does not require insurance companies to provide chemotherapy coverage, nor does it require any particular product be covered. Senate Bill 50 merely requires that where coverage is already being provided, insurance companies cover intravenous therapy and oral chemotherapy treatments in the same manner with respect to co-payments, deductibles, and/or other patient costs. In short, all chemotherapy should be covered the same regardless of the route of administration.

Most insurers and payers agree that access to chemotherapy is critical for adequate insurance coverage. The problem is that coverage standards have not kept up with advancements in therapy. More and more oral medications have been developed and patients need equal access to these life-saving medications.

No patient and/or their health care provider should be forced to base their decision on the most appropriate chemotherapy treatment on reasons other than the best treatment option for the patient. ICAN is firmly in support of this proposed legislation desperately needed to ensure equal coverage and therefore access to life-saving treatment options.

It is for these reasons that we urge you to pass this vital legislation for cancer patients as soon as possible.

Thank you for your consideration.

Cordially,

Marcia K. Horn

Marcia K. Horn
President and CEO

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**Insurance and Real Estate Committee**
**February 18, 2010**

## Testimony of the American Cancer Society

The American Cancer Society stands in strong support of SB 50 - **AN ACT CONCERNING ORAL CHEMOTHERAPY TREATMENTS.**

Most chemo drugs are injected through an IV (intravenous) line into a person's vein, however thanks to progress in cancer treatments, there are numerous types of chemotherapy that can be taken orally as a liquid, tablet, or capsule. Oral chemo does not need to be injected into the body, and chemotherapy taken by mouth is as strong as the other forms and works just as well.

In fact, while there are some chemo drugs that cannot be taken orally due to difficulties with swallowing or stomach absorption, oral chemotherapy has less severe side effects and is easier on the patient (along with the person who has to give him/her the ride) by allowing non-invasive treatment at home without requiring a patient to go into a hospital or clinic for IV treatment.

According to research, 9 out of 10 cancer patients cited significant improvement in quality of life as the basis for preferring oral chemotherapy. The reasons they cited included: convenience, the pain and difficulty of IV chemotherapy treatment, their desire to have control over where the treatment was given, and travel issues. When doctors cited oral chemotherapy as being as effective as traditional chemotherapy, then oral chemo was the preferred method. [Liu G., Franssen E, Fitch M, Warner E, *Patient Preferences for Oral Versus Intravenous Palliative Chemotheraphy*]

While quality of life would improve for many patients, the cost differential between orally administered chemo and IV injected chemo administered at a hospital, physician's office or clinic is a significant barrier. Most insurance plans classify IV chemotherapy medications as a medical benefit requiring only office co-pays for each treatment and not an additional cost for the IV drug itself.

However oral chemotherapy is currently classified as a prescription drug and placed on a specialty tier of a plan's formulary covered under a pharmacy benefit. The Kaiser Family Foundation reports an average 28% coinsurance rate for these specialty tier drugs according to the *2008 Employer-Sponsored Health Benefits Report*. This means an out of pocket cost to the patient of close to $900 dollars for a $3,000 per month oral anticancer medication.

In most cases, the cost to treat a cancer patient using oral chemotherapies is often actually less than the alternative IV therapy because there are no associated medical costs—visits to hospitals, equipment use, etc.

The American Cancer Society is dedicated to improving the quality of life for all cancer patients by ensuring availability of affordable, quality treatment throughout the continuum of the cancer

experience. We support public policy that ensures access to treatment beginning at diagnosis and continuing throughout the course of disease.

We are asking that oral chemotherapy drugs be a fully covered medical benefit in private health insurance plans, just as oral chemotherapy drugs are presently treated under Medicare. Beyond the obvious cost issue, it is also a quality of life issue.

31 states took some action on this issue in 2009 with bills in California, Iowa, Hawaii, Vermont and Indiana reaching Governor's desks. Similar legislation already signed into law in Oregon and Indiana has resulted in the elimination of high coinsurance rates by state plans.

We urge a favorable report from this committee on SB 50.

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50 Record

*Insurance and Real Estate Committee*
*Room 2800, Legislative Office Building*
*Hartford, CT 06106*

*Testimony in support of Senate Bill 50, AN ACT CONCERNING ORAL CHEMOTHERAPY TREATMENTS*

*Senator Crisco, Representative Fontana and members of the Committee:*

*My name is Dale Danowski and I am a registered nurse who has worked for many years as a nursing leader in an acute care hospital. In my position, I have heard many stories about patients who have struggled to afford the oral chemotherapy agents they need to treat their cancer. Unfortunately, there are instances where oral agents are the best or only option for a particular patient but the patient is made to pay more out of their own pocket simply because it is not an intravenous or injectable product.*

*I have witnessed countless patients who struggle everyday to battle this frightening disease. In addition to facing the physical and emotional challenges, there are often financial burdens which impact patients and their families. The inequity of coverage for oral chemotherapeutic agents is simply not logical.*

*It is for these reasons that I urge members of the committee to vote in favor of Senate Bill 50 which would provide greater coverage and access for chemotherapy agents regardless or how they are taken by the patient.*

*Thank you for your consideration.*

*Respectfully,*

Dale Danowski RN

*Ms. Dale Danowski RN*
*VP Patient Care Services*
*St. Vincent's Medical Center*
*Bridgeport CT 06606*

The premier education and advocacy organization for the oncology team

ACCC

Association of Community Cancer Centers

FTR 50

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February 16, 2010

Insurance and Real Estate Committee
Room 2800, Legislative Office Building
Hartford, CT 06106

**RE: Testimony in support of Senate Bill 50, AN ACT CONCERNING ORAL CHEMOTHERAPY TREATMENTS**

Dear Senator Crisco, Representative Fontana and members of the Committee:

On behalf of the Association of Community Cancer Centers (ACCC), we appreciate this opportunity to support Connecticut Senate Bill 50, a bill addressing the cost of oral anti-cancer chemotherapy. ACCC fully supports this bill, and encourages the Legislature to pass this legislation quickly to help cancer patients in Connecticut.

ACCC is a membership organization whose members include hospitals, physicians, nurses, social workers, and oncology team members who care for millions of patients and families fighting cancer. ACCC's more than 900 member institutions and organizations treat 60 percent of all U.S. cancer patients when combined with our physician membership.

Oral chemotherapeutics are becoming a major part in the treatment of cancer as over 25% of current drugs in the pipeline are oral regimens. This means that an increasing number of patients will be receiving their therapies orally, as opposed to through an IV. While this may be good for the patient's overall health, the cost of the oral therapies is often too much to bear for patients. Since most of the oral therapies are covered differently than their IV counterparts, much more of the financial burden falls on the patients. These concerns are often what guide a patient's treatment decision options, as opposed to what might be best for their health.

ACCC feels that SB 50 will begin to address some of these issues, and therefore support its passage. In 2007, the 74th Oregon Legislative Assembly passed a bill pertaining to health insurance coverage of oral chemotherapy. Senate bill 8 states, "a health benefit plan that provides coverage for cancer chemotherapy treatment must provide coverage for a prescribed, orally

administered anticancer medication...no less favorable than intravenously administered or injected cancer medications that are covered as medical benefits." ACCC supported this bill and will continue to support other states that take up similar measures.

Thank you for your consideration.

Sincerely

Matthew Farber, MA
Director, Provider Economics & Public Policy
Association of Community Cancer Centers (ACCC)

AMERICAN LUNG ASSOCIATION.
IN CONNECTICUT

FTR 50

**Testimony of the American Lung Association in Connecticut in Support of Raised Bill No. 50, An Act Concerning Oral Chemotherapy Treatments**

45 Ash St.
East Hartford, CT 06108
Tel: (860) 289-5401
Fax: (860) 289-5405

1-800-LUNG USA
lungne.org

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John J. Votto, DO (New Britain)

February 18, 2010

Insurance and Real Estate Committee
Room 2800, Legislative Office Building
Hartford, CT 06106

Dear Senator Crisco, Representative Fontana and Members of the Committee:

My name is Dr. David Hill; I am a practicing pulmonologist in the State of Connecticut and Chair of the ALA Leadership Board at the American Lung Association in Connecticut. As advocates for promoting lung health and preventing lung diseases - such as lung cancer - the American Lung Association in Connecticut wishes to be recorded in strong support of Raised Bill No. 50, An Act Concerning Oral Chemotherapy Treatments.

Thanks to the continued advances in medicine, oral anticancer medications are available in some cases for treatment. Regrettably, greater patient out-of-pocket costs for oral medication versus IV (intravenous) medication pose a significant barrier to their use.

Typically, IV anticancer medications are covered under an insurance plan's medical benefit - where most patients are only responsible for their copayment for each visit to their health care provider. Their provider administers the treatment and the patient is not required to pay a separate fee for the IV drug. Orally administered anticancer medications are treated as a prescription and covered under a patient's health plan's pharmacy benefit because a patient can take their medication independently.

Currently, several of these oral drugs are placed on a 4th or "specialty" tier of a prescription plan's formulary. According to the Kaiser Family Foundation, the average coinsurance rate for 4th tier drugs is 28 percent. In other words, a $3,000 per month oral anticancer prescription could mean the patient must pay close to $900 out-of-pocket each month. This is a much higher monthly out of pocket cost than for IV medications.

When considering this price disparity, it is important to consider that certain newer chemotherapies are available only in oral formulation.

AMERICAN LUNG ASSOCIATION.
IN CONNECTICUT

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John Victory (Farmington)

John J. Votto, DO (New Britain)

Thus, patients who rely on these drugs are forced to pay more for the treatment recommended by their doctor or possibly take a less effective therapy than initially prescribed due to money restrictions.

The American Lung Association in Connecticut strongly supports physician and patient choice in determining the best course of treatment. We believe that drug formularies must be flexible enough to allow patients to receive the best evidence-based treatment that their physician determines will meet their needs. We understand and support efforts to contain health care costs, but believe that being overly restrictive with the tools available to manage a disease may actually result in more cost for that patient and the insurer in the future. To that end, we strongly support Raised Bill No. 50, An Act Concerning Oral Chemotherapy Treatments. It will assure that patient access to the most effective anticancer therapy is not influenced by reimbursement policy.

It is important to note that this legislation does not direct insurers to cover all oral anticancer medications or any particular oral anticancer medication. However, if an insurer does cover any oral anticancer medication, it has to do so in a similar manner that it covers IV medications. This legislation also forbids insurers from decreasing the level of coverage for covered IV anticancer products in order to achieve parity.

Thank you for your consideration of this bill. We urge the Committee to report out this legislation favorably.

Submitted by:

David Hill, MD

American Lung Association of New England
Medical and Scientific Branch in Connecticut

SB 50
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Are DENSE?

www.areyoudense.org

February 16, 2010

Are You Dense, Inc.
96 Rowley Road
Woodbury, CT 06798

Re: Support of Raised Bill 50 - ***AN ACT CONCERNING ORAL CHEMOTHERAPY TREATMENTS***

Dear Senator Crisco, Representative Fontana and Members of the Insurance and Real Estate Committee:

On behalf of Are You Dense, Inc. a public nonprofit organization dedicated to raising awareness of dense breast tissue for the early detection of breast cancer, I write to you in support of Raised Bill 50.

Another goal of Are You Dense, Inc. is to improve the condition of women diagnosed with breast cancer. As an advanced stage breast cancer survivor, I know first-hand how challenging it is to face this disease even under the best of conditions - a supportive network of family and friends, great physicians and insurance coverage for life saving treatments.

Through my diagnosis and experience, I learned that insurance practices often lag behind current research and science in best screening and treatment options. During my treatment six years ago, oral chemotherapy was not an option offered to me. Oral chemotherapy is quickly emerging as an option for select patients who will comply with the prescribed oral regimens and self-monitoring for potential complications. Oral Chemotherapy also benefits a woman's family and employer as it is more time efficient than intravenous therapies; typically requiring women to travel to the treatment center spending nearly a day away from home or work.

Are You Dense, Inc. supports Connecticut's efforts to require group and individual health coverage and group health plans to provide coverage for oral cancer drugs on terms no less favorable than the coverage provided for intravenously-administered chemotherapy. At the same time, we need to ensure that by adopting this policy, health insurers are not allowed to reduce coverage for intravenous therapies.

Sincerely,

*Nancy M. Cappello*

Nancy M. Cappello, Ph.D.
Founder and President
Are You Dense, Inc.

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IMF

February 15, 2010

The Honorable Joseph Crisco
Connecticut State Senate
Legislative Office Building
Room 2800
Hartford, CT 06106-1591

The Honorable Steve Fontana
Connecticut State Assembly
Legislative Office Building
Room 2802
Hartford, CT 06106-1591

Dear Senator Crisco and Representative Fontana:

On behalf of the International Myeloma Foundation (IMF), the oldest and largest myeloma foundation dedicated to improving the quality of life of myeloma patients while working toward prevention and a cure, I am writing to show our strong support for SB 50, an act concerning oral chemotherapy treatments.

Myeloma is a cancer in the bone marrow affecting production of red cells, white cells, and stem cells. It is also called "multiple myeloma" because multiple areas of bone marrow may be involved. Myeloma is the second most common blood cancer after lymphomas affecting an estimated 750,000 people worldwide and its prevalence appears to be increasing significantly. In 2009, 20,580 Americans were diagnosed with myeloma and 10,580 lost their battle with this disease.

In the last few years 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. The IMF supports your legislation to eliminate these outdated cost inequities between oral and IV chemotherapy treatment that threaten patient care and quality of life.

The IMF stands ready to work with you and your colleagues to advance policies and support programs such as SB 50 that are necessary to the health and well-being of myeloma patients.

Sincerely,

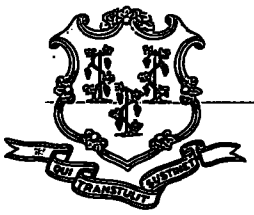
Susie Novis

Susie Novis

12650 Riverside Drive Suite 206, North Hollywood, CA 91607
800-452-CURE (2873)

SENATOR MARTIN M. LOONEY
MAJORITY LEADER

Eleventh District
*New Haven & Hamden*



State of Connecticut
SENATE

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February 18, 2010

Good afternoon Senator Crisco, Representative Fontana and members of the Insurance and Real Estate Committee. Last year I distributed an article from the New York Times regarding the difficulty created by the high cost of biologic prescription drugs. Current therapies for cancer and a number of chronic diseases can include biologics/biopharmaceuticals. These drugs have revolutionized care for some diseases and have offered many patients literally a new lease on life. However, these drugs tend to be extraordinarily expensive. Many of the drugs come in pill form and thus are covered as prescription drugs rather than as medical expenses. Many health plans would cover 100% of an IV infusion but only a percentage of a prescription drug. Thus, if the biologic/biopharmaceutical cost was $5000 per month and the patient had a plan that paid 80% of prescription drug costs, that patient would have to pay $12,000 per year out of pocket, while the out of pocket cost if the procedure was an IV infusion would be $0. This seems an absurd result since oral drugs would seem to save the health system time as well as money. These new drugs are making many diseases manageable but it would appear that the practice of medicine and our healthcare system have not caught up with the power and convenience of these new drugs.

(over)

I appreciate that the Insurance and Real Estate Committee has raised this issue in SB 50, *AN ACT CONCERNING ORAL CHEMOTHERAPY TREATMENTS*; I would encourage that the language in this bill be extended to address other diseases in addition to cancer and that it be made clear that the intent of the bill is to address the highly expensive biologic drugs. Oregon has taken an approach that may not be the best one. That state now requires that insurers provide equivalent reimbursement for oral and intravenous chemotherapy drugs for cancer patients. The problem with this legislation is that cancer is not the only disease which is now treated with biologics/biopharmaceuticals. One approach would be to require that biologics/biopharmaceuticals be covered as medical treatment rather than as prescription drugs.

My suggestion for the language is:

**"A health benefit plan that provides coverage for cancer chemotherapy treatment or biologic drugs for serious, life-threatening or degenerative disease must provide coverage for a prescribed, orally administered biologic medication on a basis no less favorable than intravenously administered or injected medications that are covered as medical benefits."**

Thank you for addressing this important issue.

Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999

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Submitted Testimony on SB 50 before the
Insurance and Real Estate Committee on
SB50
February 18, 2010
1:00 p.m.

We are writing to you today to ask for modification of SB 50.

Aflac sells individual, guaranteed renewable health insurance policies which are designed and sold to provide supplemental benefits in the event of serious illness or hospitalization. These policies, short term disability, and supplemental hospital policies fill a niche not covered by normal health and accident insurance. These insurance products compete in a healthy major market for optional additional coverage and fill gaps in an individual's health coverage as a matter of choice. Unlike comprehensive, major medical or basic health insurance coverage, these individually owned, supplemental policies provide limited benefits and have average annual family premiums of less than $500 per year. Also, the benefits are payable in addition to and regardless of other coverage the insured may have.

Our products are designed to help offset the other costs incurred because of the illness not the actual costs to treat the illness itself. This type of mandated coverage really is more appropriate for major medical than it is for supplemental products.

We have been in contact with the proponents of SB 50 and it is our understanding that this bill is not meant to cover our supplemental policies, and as a result would offer the following changes to the bill (deleting the parts highlighted in red):

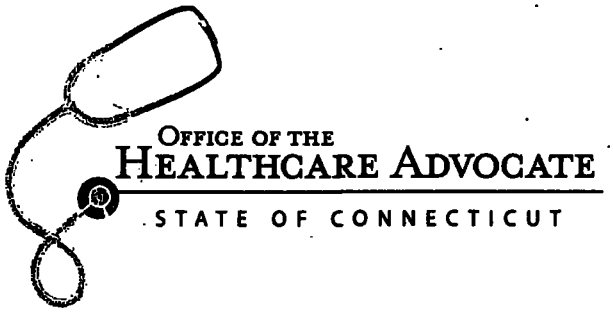
Section 1.(d) (1) Each policy of the type specified in subsection (a) of this section [*and in subdivision (13) of section 38a-469*] that provides outpatient chemotherapy coverage shall provide coverage for orally-administered anticancer medications used to kill or slow the growth of cancerous cells that are prescribed by a prescribing practitioner, as defined in section 20-571.

Section 2.(d) (1) Each policy of the type specified in subsection (a) of this section [*and in subdivision (13) of section 38a-469*] that provides outpatient chemotherapy coverage shall provide coverage for orally-administered anticancer medications used to kill or slow the growth of cancerous cells that are prescribed by a prescribing practitioner, as defined in section 20-571.

We thank the Committee for considering these changes to the proposed bill which again, we understand is not the intent of the proponents.

If you have questions, contact Anita Schepker aschepker@sbcglobal.net or at (860) 604-4749.

SB 50 V FTR




**Testimony of Victoria Veltri**
**General Counsel**

**Before the Insurance and Real Estate Committee**
**In support of SB 50, SB 17 and HB 5004**
**February 18. 2010**

Good afternoon, Representative Fontana, Senator Crisco, Senator Caligiuri, Representative D'Amelio, and members of the Insurance and Real Estate Committee. For the record, I am Vicki Veltri, General Counsel with the Office Healthcare Advocate ("OHA"). OHA is an independent state agency with a three-fold mission: assuring managed care consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health insurance plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems.

I am here today to testify on behalf of OHA, in favor of SB 50, AN ACT CONCERNING ORAL CHEMOTHERAPY TREATMENTS. Consumers who can take their medically necessary chemotherapy by pill, in the convenience of their own home and without the challenges and cost of facility-based chemotherapy ought not be left without coverage. OHA has seen many cases in which this situation has left people without consistent chemotherapy treatment. In the best of circumstances, we assisted consumers to get help from the pharmaceutical company to provide their medication. Most of these consumers had otherwise excellent insurance that might have provided coverage for hospital based chemotherapy at four times the cost.

As good as S.B. 50 is, it could be made even better by including recognition of the many other chronic diseases for which pills have been developed as a substitute for infusion therapy. Cancer is no longer the only disease for which biologics have been developed. Many consumers with these other serious, degenerative or life-threatening illnesses face the same issue as that of cancer sufferers whose treatment might be found in pill form--unequal coverage.

As most policies do not treat oral chemotherapy or oral medication for other serious, degenerative or life-threatening illnesses as medical treatment, we recommend that the committee revise Section 1(d) of the bill to include coverage for these illnesses.

OHA also supports SB 17, AN ACT CONCERNING HEALTH CARE PROVIDER RENTAL NETWORK CONTRACT ARRANGEMENTS, which will correct one of the more insidious problems faced by consumers and providers. With the constant shuffling of the control of rental networks, it is nearly impossible to determine at any one point in time whether a provider is actually participating in a certain network. Our office assisted several providers and their patients in the last few years by sorting through contracts that contradict each other and essentially force providers to remain in rental networks that have changed hands, sometimes more than four or five times, with no control over their reimbursement rates. Often providers will have taken the steps necessary to end their relationships with a rental network, only to find out later that the same network is now owned by a rental network with which the providers have contracts. In other words, these arrangements can wreck havoc in their wakes. These situations hold patients captive because they typically take a long time to resolve, and more often than not, at least in our experience are adjudicated incorrectly. SB 17 will go a long way to resolve these issues by placing obligations on the networks and clarifying that any violation will be deemed an unfair or deceptive insurance practice under the general statutes.

Finally, OHA also supports HB 5004, AN ACT CONCERNING TRANSPARENCY IN HEALTH INSURANCE CLAIMS DATA. This is a common sense bill that gives some bargaining power back into the hands of employers when negotiating insurance coverage for their businesses. While this bill should not be necessary—carriers should provide this information upon the business' request—the bill is narrowly tailored to provide employers with employer-specific confidential utilization and claims data, while not eroding the requirement of carriers to provide compiled utilization and claims data to the Insurance Department for us in the Managed Care Report Card, as required by P.A. 09-46. OHA supports amending the "claims paid definition" in SB 17 to that advanced by the medical providers here today. The amendment clarifies that any cost that is not strictly a claim, as in a claim by an enrolled provider for reimbursement of expenses, must not be counted as a paid claim for purposes of SB 17 and, by extension, P.A. 09-46.

Thank you for providing me the opportunity to deliver OHA's testimony today.

**JOINT**
**STANDING**
**COMMITTEE**
**HEARINGS**

**INSURANCE AND**
**REAL ESTATE**
**PART 5**
**1330 – 1660**

**2010**

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PAGE 9
LINE 10
LINE 12

Dina Berlyn
30 Morris Street
Hamden, CT 06517 (203) 776-3869

March 4, 2010

Good morning, Sen. Crisco, Rep. Fontana and members of the Insurance and Real Estate Committee. My name is Dina Berlyn. Some of you might recognize me at the LOB as State Senate Majority Leader Martin Looney's Counsel and Executive Aide, which I am, but I am not here in that role. I am a patient with multiple sclerosis. I am here to testify on two healthcare policy issues of deep personal interest to me: coverage of routine patient care costs in clinical trials and the burden of proof in appeals from benefit denials. Both SB 260, AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR ROUTINE PATIENT CARE COSTS FOR CLINICAL TRIAL PATIENTS and SB 258, AN ACT CONCERNING APPEALS OF HEALTH INSURANCE BENEFITS DENIALS would make our healthcare coverage more rational and compassionate for patients.

SB50

I have researched, written, and been published on coverage of routine patient care in clinical trials, and I want to share with you my discoveries about this matter -- particularly the irrational nature of the for-cancer-only provision in our statutes.

In 2001, the Connecticut General Assembly passed PA 01-171 AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR CANCER CLINICAL TRIALS, HEARING AIDS FOR CHILDREN AGE TWELVE AND YOUNGER, PAP SMEAR TESTS, COLORECTAL CANCER SCREENING AND MAMMOGRAMS, PSYCHOTROPIC DRUG AVAILABILITY AND MEDICAID COVERAGE FOR MAMMOGRAMS[1]. The bill started with a more conventional title: AN ACT CONCERNING HEALTH INSURANCE COVERAGE DURING CLINICAL TRIALS. This legislation had laudable goals – to require insurers to sustain their responsibility to patients who participate in clinical trials by covering standard of care treatment

[1] In 2007 PA 07-67 made some changes regarding required coverage for out of network costs in cancer clinical trials

SB50

I realize that the oral chemotherapy issue was heard last week and I had not intended to testify but I would like to make a couple of comments. The argument made by the insurers that this is a quality control issue is specious because these biologic drugs are currently in use. The only question is the manner of reimbursement. I would like to encourage the committee to expand the scope of the oral chemotherapy bill to include conditions other than cancer. There are a number of medical conditions (e.g. Multiple Sclerosis, Rheumatoid Arthritis, Crohn's Disease, etc.) which can now be treated with biologics that can be administered P.O. (by mouth) rather than I.V. (intravenous). It does not make a lot of sense that the P.O. drugs often carry an unaffordable co-pay.

I am most appreciative of your efforts on these issues of extraordinary importance.