Approved: 2-2-10
Date

MINUTES OF THE SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

The meeting was called to order by Chairman Ruth Teichman at 9:30 a.m. on January 28, 2010, in Room 152-S of the Capitol.

All members were present.

Committee staff present:
Ken Wilke, Office of the Revisor of Statutes
Melissa Calderwood, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Beverly Beam, Committee Assistant

Conferees appearing before the Committee:
Senator Susan Wagle, (Attachment 1)
Dr. Mark Fesen, Oncologist, (Attachment 2)
Christopher Masoner, American Cancer Society (3)
Ben Steinmetz, Glaxosmithkline, (Attachment 4)
Peggy Johnson, Kansas Cancer Partnership (Attachment 5)
Christina Osbourn, Susan G. Komen For The Cure (Attachment 6)
Kim Olson, Social Worker, Cotton-O'Neill Cancer Center (Attachment 3)
Michele Krier, (written only) (Attachment 7)

Others attending:
See attached list.

The Chair called the meeting to order.

Hearing on

SB 195 - Providing insurance coverage for orally administered anti-cancer medications.

1/28/10

The Chair called on Melissa Calderwood for a brief overview of **SB 195.** Ms. Calderwood stated that **SB 195** would require all individual and group health insurance policies, contracts and the State Health Employee Health Plan that provide coverage for prescription drugs to provide coverage for prescribed, orally administered anti-cancer medications on a basis no less favorable than intravenously administered or injected cancer medications. She said the Kansas Insurance Department indicates this bill could be implemented within the agency's existing staff and operating expenditures. She said according to the Kansas Health Policy Authority, passage of the bill would have no fiscal effect on the State Employee Health Plan or agency operations.

Senator Susan Wagle testified in support of **SB 195.** She stated that **SB 195** demands payment parity. She said if an insurance plan covers intravenous therapy similar to an office visit, then they must also treat oral therapy in the same manner with the same deductible. She said this bill does not require that a pharmaceutical product be covered under an insurance plan and does not mandate that any particular provider of health care services be covered. She said this bill is clearly not a mandate as set forth in Kansas statutes, it is merely an attempt to provide payer parity within the current policy structure. She concluded by stating that this bill does not tell the plans how to provide parity, that is left up to each individual plan or policy. (Attachment 1)

Dr. Mark Fesen, Oncologist, testified in support of **SB 195.** He stated that while understanding that the goal of the current bill is parity between the reimbursement rate for intravenous and oral chemotherapy, it would be important to seek a mean whereby the reimbursement rate for intravenous chemotherapy is not lowered further. He said it is expected that parity could best be achieved by raising the reimbursement rate for oral chemotherapy to equal that of the intravenous chemotherapy. He said the current bill starts the process to assist many Kansas residents afflicted with cancer. He said by creating parity between the reimbursement of oral and intravenous chemotherapy agents **SB 195** will help many be able to start the treatment they need. (Attachment 2)

Minutes of the Senate Financial Institutions and Insurance Committee at 9:30 a.m. on January 28, 2010, in Room 152-S of the Capitol.

Christopher Masoner, American Cancer Society, testified in support of **SB 195.** Mr. Masoner stated that The American Cancer Society supports **SB 195** and the goal of providing insurance coverage for oral chemotherapy that is no less favorable than the coverage provided for IV chemotherapy. (Attachment 3)

Mr. Masoner introduced Mr. and Mrs. Steve Yarrington who told of the expense involved in obtaining necessary drugs to treat Mr. Yarrington's cancer.

Ben Steinmetz, GlaxoSmithKline testified in support of **SB 195.** Mr. Steinmetz stated that GlaxoSmithKline is a pharmaceutical company that manufactures, markets and is developing intravenous/injected and oral chemotherapy drugs. The company commissioned Milliman to develop and author a whitepaper to quantify the cost of parity in a commercial population. He said Milliman is a leading source of health actuarial expertise to the insurance industry and is a well known name among State Insurance Departments. He said Milliman defined parity as:

For an individual who receives both oral and intravenous/injected chemotherapy drugs, the percent cost sharing for the oral chemotherapy drugs will be no more than the percent cost sharing for their intravenous/injected chemotherapy drugs;

For an individual who receives only oral chemotherapy drugs, the percent cost sharing for the oral chemotherapy drugs will be no more than the average percent cost sharing for the intravenous/injected drugs as administered by their health plan. (Attachment 4)

Peggy Johnson, Kansas Cancer Partnership, testified in support of **SB 195.** Ms. Johnson said the Kansas Cancer Partnership is a group of approximately 200 individuals from institutions, clinics, county health departments, large and small hospitals, organizations and advocacy groups who have worked together to develop a coordinated and comprehensive plan, the Kansas Comprehensive Cancer Control and Prevention Plan. She said the plan addresses the burden of cancer on Kansas citizens, families, communities and the government and provides the framework to reduce cancer incidence, morbidity and mortality in the state through prevention, early detection, screening, treatment and survivorship. She said equal access to oral medications for the treatment of cancer shouldn't be a financial decision. It should be the decision of the patient and their physician based on the best treatment options for their cancer. She stated that the cancer pill of the future is finally beginning to show up and these new therapies need to be made available to patients. (Attachment 5)

Christina Osbourn, Executive Director, Mid-Kansas Affiliate Susan G. Komen for the Cure, testified in support of **SB 195.** She testified that Komen for the Cure is the world's largest grassroots network of breast cancer survivors and activists fighting to save lives, empower people, ensure quality care for all and energize science to find the cures. She said the Komen Kansas Affiliates support **SB 195** because they believe health decisions should be made between a patient and their doctor. She noted that Komen Affiliates support efforts at the state and federal level to require group and individual health insurance 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. (Attachment 6)

Kim Olson, Social Worker, Cotton-O'Neil Cancer Center, testified that oral chemotherapy treatments for cancer are lifesaving and often are cost-effective when compared to surgery or IV chemotherapy treatments. She said insurance coverage for these drugs benefits all, and eliminates the need for patients to undergo more expensive surgeries and IV chemotherapy when lower cost oral chemotherapy agents are safe and effective. (Attachment 3)

Michele Krier, Survivor, submitted written testimony only. (Attachment 7)

Due to time constraints, opponents of **SB 195** did not have an opportunity to testify. The Chair stated that she would not close the hearing until they can testify.

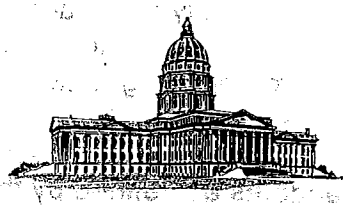
The next meeting is scheduled for February 2, 2010. The meeting was adjourned at 10:30 a.m.

SENATE FINANCIAL INSTITUTIONS & INS. COMMITTEE
GUEST LIST

DATE: 1-28-10

NAME	REPRESENTING
Alex Kotolyantz	KS. Ass. of Professional Ins. Agents
Rob Johnson	Federico Consulting
Dustin Meyer	KHRA
Bill Bay	G-S6
Larrie Ann Brown	Aetna
Chad Austin	KHA
Anne Spiess	American Cancer Society
Tracy Russell	KHCC
CHRISTINA OSBOURN	SUSAN G. KOMEN
Brad Smoot	
Bill Sneed	AHIP
Mallee Carpenter	KAHP
John Beetz	TID
Linda Sheppard	KID
Whitney Damron	City of Topeka

State of Kansas
Senate Chamber



Susan Wagle

First of all, I want to thank Chairman Teichman and the committee for your time and this opportunity to express support for S.B. 195. I'm going to try to be brief and to the point. I authored this bill because the way we treat Cancer is evolving and changing. Cancer treatment technology is advancing and I believe we are close to a cure. As you probably know, we have had to deal with reoccurring cancers in my family on several occasions. My son Paul went through 2 ½ years of chemotherapy for acute lymphocytic leukemia at age 10, he relapsed at age 14 and spent 9 months in a crowded transplant ward in Ft. Worth, Texas getting a stem cell transplant. Paul spent Christmas of 04 in the hospital, while previous patients who had survived the transplant process stopped by to give Paul encouragement and to drop off Christmas presents. Four years later, in Christmas of 08, Paul and I called the hospital to tell them we wanted to visit the transplant kids and bring them presents. We talked to his past health care team who told us there were only 3 kids in the ward. It really wasn't worth our time to make the drive to Texas. This was the same stem cell transplant ward that just 4 years earlier was spending significant dollars adding over 50 additional beds to accommodate new patients. When I asked the Doctors what had happened, they said there had been so many advances in treatment products that they are now curing childhood leukemia during the first round of treatment and stem cell transplants for childhood relapsed leukemia are no longer necessary.

In my case, after being diagnosed with stage 4 Non Hodgkins Lymphoma in 1995, had I not had a targeted cancer breakthrough treatment called Rituxan made available to me on numerous occasions, that only kills cancer cells, I would not be standing here today, before this committee.

I consider many of the new pharmaceutical drugs that are being developed today to treat cancer as miracle drugs. They are target drugs that only kill cancer cells, leaving the patient in a healthier state of being with a stronger immune system. The problem with these drugs is that they are often costly and are covered under a pharmacy benefits package rather than covered as a traditional medical benefit. Insurance benefit designs have evolved over time to where intravenous/injected chemotherapy drugs are typically covered through a medical benefits package where cost sharing is lower, while oral chemotherapy drugs are often covered through pharmacy benefits, where cost sharing is much greater for the patients, and often times, unattainable.

S.B. 195 demands payment parity. If an insurance plan covers I.V. therapy similar to an office visit, then they must also treat oral therapy in the same manner with the same deductible.

FI&I Committee
1-28-10
Attachment 1

SENATOR 30TH DISTRICT
SEDGWICK COUNTY
4 SAGEBRUSH
WICHITA, KANSAS 67230

ROOM 221-E
STATE CAPITOL
TOPEKA, KANSAS 66612
785 296-7386

I have some friends who are going to testify today against this bill. While we have been in agreement on many bills that have crossed our paths in the years we have worked in the State Capitol, in this situation, we are going to agree to disagree. You might hear today that S.B. 195 is a mandate. And, I would like to challenge that premise. According to KSA 40-4248, 2249 and 2249a, an impact study must be conducted prior to the legislature considering mandates as defined by these statues. In addition, any changes must first be effective in the State health care benefit program for a period of at least one year. I am pleased to report to you that the State employees' health benefits plan currently provides parity between oral and IV therapies. In addition, the three specific provisions of these statutes basically cover three situations:

1) Any bill that mandates health insurance coverage for specific services
2) Any bill that mandates health insurance coverage for specific diseases
3) Any bill that mandates health insurance coverage for certain providers or health care services

S.B. 195 does not fall under any of these categories and the data we will present complies with the spirit of those impact requirements. This bill does not mandate health insurance coverage for specific services or specific disease. It creates no requirement that cancer be covered by an insurance policy. It does not require that a pharmaceutical product be covered under an insurance plan. And it certainly does not mandate that any particular provider of health care services be covered. S.B. 195 is clearly not a mandate as set forth in our Kansas statutes. It is merely an attempt to provide payer parity within the current policy structure. The bill doesn't tell the plans how to provide such parity. That is left up to each individual plan or policy.

I ask that you give S.B. 195 serious consideration and pass it favorably on to the floor of the Senate.

Mark R Fesen M.D. F.A.C.P.
2609 Linksland Drive
Hutchinson, Ks. 67502

Orally administered chemotherapy plays an increasingly crucial role in cancer treatment. Many of these agents have provided major advances in wide areas of cancer treatment. Oral chemotherapy agents, either alone or in combination with intravenous agents, are frequently used to treat many common cancers. These include lung cancer, breast cancer, chronic myelogenous leukemia (CML), colon cancer, pancreatic cancer melanoma and others. Barriers exist to the adoption of oral chemotherapy agents. For patients with third party insurance, out of pocket costs can be a substantial hurdle to their receiving treatments.

The out of pocket expenses associated with oral chemotherapy is frequently several hundred dollars per month and usually exceeds the individual's budget. Furthermore these substantial costs can continue indefinitely. These incur immediately and must be paid up front out of pocket before therapy begins. The cost of intravenous chemotherapy is covered by the outpatient portion of the insurance, while oral chemotherapy is covered under the prescription benefit.

Insurance policies where patients are required to pay a percentage of prescription drug costs out of pocket, can be the most challenging. Prescription plans where a patient pays 20-50% of the drug costs are prohibitive for most families. Oral chemotherapy agents frequently cost three to seven thousand dollars EACH month. Treatment is for an indefinite time period for most cancers. Other challenges are when patients are required to pay a substantial amount of the costs of the drug up front, then wait months for reimbursement

Cancer patients are immediately burdened with an overwhelming myriad of other out of pocket expenses including travel, other prescriptions, deductibles and co-pay expenses. These expenses may occur at a time when the breadwinner can no longer work. Patients may be forced to consider other options when resources are depleted.

While understanding that the goal of the current bill is parity between the reimbursement rate for intravenous and oral chemotherapy, it would be important to seek a mean whereby the reimbursement rate for intravenous chemotherapy is not lowered further. It would be expected that parity could best be achieved by raising the reimbursement rate for oral chemotherapy to equal that of the intravenous chemotherapy.

A recently released study, completed by researchers at Tufts Medical Center and at the University of Michigan found that 84% of oncologists considered their patients out of pocket expenses when recommending cancer treatment. Seventy nine percent of oncologists in the study said that they support further government research into the comparative effectiveness of different cancer drugs. Oncologists are also concerned that the professional payments associated with monitoring cancer treatment with oral chemotherapy agents fail to recognize the work that goes into monitoring the use of these complex drugs and are substantially underpaid.

One patient, a farmer suffering with metastatic melanoma, was initially successfully treated on a clinical trial. Later his cancer progressed. Temodar, an oral chemotherapy drug, was given by mouth at an out of pocket cost of three thousand dollars a month. He is reimbursed at a later time for only half of that amount. Even though he and his wife both took out additional jobs,

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Attachment 2

later given costs two to three times that much. When the oral version of Temodar is used, the patient is able to limit his travel into the office and limit days off work.

Many other hurdles limit cancer treatment for Kansas residents are not addressed here. By far, the most immediate and concerning of these are the limitations placed by the Medicare system. The sick elderly cancer patients, who are least able to advocate for themselves, are placed at a substantial disadvantage for their care through Medicare.

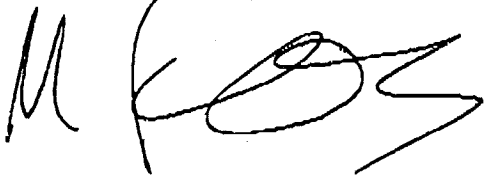
The current bill starts the process to assist many Kansas residents afflicted with cancer. By creating parity between the reimbursement of oral and intravenous chemotherapy agents Senate Bill 195 will help many be able to start the treatment that they need.

Mark R. Fesen MD FACP

Medical Oncologist

Author of *Surviving the Cancer System*

Hutchinson, Kansas



2-2

TO: SENATE INSURANCE AND FINANCIAL INSTITUTIONS COMMITTEE
SENATOR RUTH TEICHMAN, CHAIR

FROM: CHRISTOPHER J. MASONER,
AMERICAN CANCER SOCIETY

JAMES J. HAMILTON, JR. MD, FACS
VOLUNTEER BOARD MEMBER,
AMERICAN CANCER SOCIETY
STATE CHAIR, COMMISSION ON CANCER

KIM OLSON,
COTTON-O'NEIL CANCER CENTER

DATE: JANUARY 28, 2010

RE: SB 195 – INSURANCE PARITY FOR ORAL CHEMOTHERAPY

LEGISLATIVE TESTIMONY ON BEHALF OF THE
AMERICAN CANCER SOCIETY

Senator Teichman, Members of the Committee, thank you for the opportunity to testify today regarding the issue of insurance coverage parity for oral chemotherapy medication.

The American Cancer Society supports SB 195 and the goal of providing insurance coverage for oral chemotherapy that is not less favorable than the coverage provided for IV chemotherapy. For background, I have attached a copy of an article from Medscape Today, dated May 7, 2009, which summarizes the dilemma faced by many cancer patients due to the disparate coverage provided to oral chemotherapy treatment compared to IV chemotherapy and other forms of treatment. The key components of the Society's position are as follows:

- Fifteen to twenty percent of cancer patients will be diagnosed with a type of cancer where oral chemotherapy is the best and sometimes the only form of treatment.
- The emergence of clinically safe and effective, orally administered anticancer medication has significantly increased the treatment options for cancer patients. Many researchers and physicians expect the emergence and utilization of such treatment regimens will increase in coming years.
- In spite of successes there is often a significant cost barrier to patients when using orally administered chemotherapy.

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- Chemotherapy that is administered intravenously is typically covered as a medical benefit which requires the patient to pay an office visit fee after all deductible obligations are met. On the other hand, orally administered chemotherapy is typically covered under a plan's pharmacy benefit where many of these drugs are placed on a 4th tier or specialty tier of a prescription plan's formulary. Drugs placed on these specialty tiers often require a high out-of pocket co-insurance rate for the patient.
- The American Cancer Society Cancer supports SB 195 because it will make out-of pocket costs for cancer patients equitable. In many cases there is no intravenous chemotherapy option. No one should be financially penalized for getting the "wrong kind of cancer" or for which an oral chemotherapy would produce the best patient outcome.

As an example, we provide the experience of Ms. Terry Henderson, a patient of Dr. Hamilton's. Terry has granted us permission to use her name and tell her story. She is working during committee testimony, and will not be able to attend the hearing.

Terry Henderson is a productive, working Kansan who has twice been diagnosed with breast cancer. She kept working through both of her mastectomies in order to keep her health insurance and support herself. She lost her husband to kidney failure several years ago. After her second diagnosis with breast cancer, her oncologist recommended therapy with an oral chemotherapy agent, Arimidex. Arimidex works by blocking the effects of estrogen on cancer cells. This agent was not covered by her insurance, and the cost of the drug was more than she could afford. Terry decided to have surgery to remove her ovaries (and their estrogen production) to decrease her risk that the cancer would come back, as this procedure was covered by her health insurance.

Terry underwent invasive surgery with attendant risks when insurance coverage for the oral chemotherapy agent, Arimidex, would have allowed her to afford the drug and avoid more surgery. Terry has already had both of her breasts removed as treatment of her cancer, and then decided to have her ovaries removed to reduce her risk of recurrence because her insurance would not cover the cost of oral chemotherapy that would have eliminated the need for surgery.

Oral chemotherapy treatments for cancer are lifesaving and often are cost-effective when compared to surgery or IV chemotherapy treatments. Insurance coverage for these drugs benefits all, and eliminates the need for patients to undergo more expensive surgeries and IV chemotherapy, when lower cost oral chemotherapy agents are safe and effective.

On behalf of all cancer patients with health insurance in Kansas, Terry Henderson, Dr. Hamilton, and the American Cancer Society strongly encourage your support for this Bill.

My name is Kim Olson and I am a social worker at the Cotton O-Neil Cancer Center. I have been at the cancer center for 2 and a half years. I spend the majority of my time trying to help patient get their life-saving anti-cancer medications, which they cannot afford. When a patient is prescribed IV chemotherapy, there is usually no problem with cost or insurance coverage because the treatment is covered as a medical benefit. However, when the prescription is for oral chemotherapy medication, the patient faces a tremendous burden and significant costs—in addition to all of the familiar physical side effects of chemotherapy—because their insurance policy covers the treatment as a prescription drug benefit. Because of this distinction, patients often have a $200-2,000 out-of-pocket expense every month. There are programs to help patients with these expenses, but the requirements for obtaining assistance are complex and time-consuming. Meanwhile, the patient is waiting to get the medication they need to save their life. Ironically, for patients that do not have insurance, it is much easier because they will get free medicine and the process is much easier. It is the insured or underinsured where this is a problem.

Following is an example of the kind of story I deal with every day. Unfortunately, Ms. Gibbs is unable to attend today's hearing, but she does ask that you consider her written testimony:

> My name is Tammy Gibbs. On June 28th 2009, I was diagnosed with Stage IV Lung Cancer at the age of 46 with no signs or symptoms. I have 3 children ages 17, 22, & 30. At that time I had an in-home daycare business, which due to my health I had to close. Immediately I was started on a systemic treatment (IV treatment) for the first line of treatment. The IV treatment is covered under my major medical insurance, and I did not have any problems with the coverage or the payments. I went for treatment every 3 weeks for 6-8 hours at the Stormont Vail Cancer Center. After 6 months, my physician changed my treatment to Tarceva which is an oral prescription chemotherapy drug and not available in IV form. The up side of this chemotherapy drug is that I take it once a day, and not having to go every 3 weeks for IV treatment for 6-8 hours. The down side to this chemotherapy drug is my insurance prescription coverage only covers 50% and Tarceva is a very expensive drug. My monthly portion is something my family can't afford.
>
> Myself along with the social worker at Stormont Vail Cancer Center has worked very hard for me to be able to get this drug, and we continue to work hard each month to be able to get my prescription.
>
> Someone that is battling cancer that needs this type of treatment to possibly save their life should not have to battle to get their prescription filled each month. Oral chemotherapy drugs should be covered under Major Medical just the same as chemotherapy IV infusions.

I ask you to consider a change to these guidelines of prescription coverage for oral chemotherapy drug treatment to be covered under major medical, the same way my IV treatment was covered.

Please consider all the families that are battling cancer and all that they have to go through without having to worry about getting their medication paid for each month. Thank you for your time and consideration.

-Tammy Gibbs- Patient in need of coverage for Tarceva
785-273-1240

From Medscape Medical News

Oral Chemotherapy Poses Financial Burden to Patients

Roxanne Nelson

Authors and Disclosures

Print This

May 7, 2009 — Oral chemotherapeutic agents are becoming increasingly available, giving patients a convenient and noninvasive treatment option. However, although oral drugs might be on the cusp of heralding in a new era in cancer care, both private and public insurance plans in the United States frequently require patients to shoulder a large burden of the cost for these agents. Another issue is patient adherence to oral therapy, which in some cases stems from the inability to pay for the drugs.

For cancer patients in the United States, there is a big difference in how much they have to pay toward the cost of an oral drug and how much they have to pay for an intravenous product that is administered in the physician's office or clinic.

The primary reason for this inequity is that oral chemotherapy is generally covered under a prescription benefit, which tends to require higher copayments. Intravenous infusions, however, are traditionally covered under a medical benefit that tends to be more generous in its coverage.

> **"It was never meant to interfere with life-saving treatment."**

"The original intention of copayments and coinsurance was to limit unnecessary and inappropriate unitization of drugs," said David L. Knowlton, MA, a member of the board of directors of the HealthWell Foundation, a national nonprofit organization that provides financial assistance to underinsured patients with chronic or life-threatening illnesses to cover certain out-of-pocket costs. "It was never meant to interfere with life-saving treatment. But unfortunately, the intent has shifted from utilization to cost."

The HealthWell Foundation was established in 2003, and Mr. Knowlton contends that the situation for patients has worsened since that time. "Five or 10 years ago, if a patient had any copay, it was about $5 or $10," said Mr. Knowlton.

He noted that although some copayments have remained low, particularly for generics, some patients can have out-of-pocket costs of hundreds or even thousands of dollars a month.

The gap in insurance coverage is becoming more problematic, especially when lives are depending on it, Mr. Knowlton explained in an interview. "Medicare patients also face uneven coverage for chemotherapy."

Prior to the advent of Medicare Part D, coverage of oral chemotherapeutics was limited to oral drugs that had injectable counterparts that were covered under Medicare Part B, such as capecitabine (*Xeloda*). Part D coverage is not provided within the traditional Medicare program, and beneficiaries must enroll in 1 of the many Part D plans offered by private companies. Although virtually all oral cancer chemotherapies are included in formularies, out-of-pocket costs can vary by type of cancer, the mix of drugs prescribed, and the Part D benefit design.

"Health plans are finding that the only place to gain leverage is in increasing copays and deductibles" Mr. Knowlton commented. He pointed out that although he is not opposed to copays in theory, what is happening now is shifting cost. "It's not cutting down utilization on unnecessary treatment . . . but simply shifting the cost over to the patient," he said. "And it doesn't make sense to put high copays on a drug that someone really

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3-5

needs, because in the long run, noncompliance may cost the health plan more money than paying for the drug."

Why Are Costs Rising?

Patients face a double-edged sword when it comes to rising out-of-pocket costs; the rising prices of drugs, coupled with a larger out-of-pocket expenditure. Oral chemotherapy agents have been available for decades, but during the past few years, there has been an accelerated expansion in their development. According to a March 2008 National Comprehensive Cancer Network (NCCN) Task Force Report, an estimated one quarter of the 400 antineoplastic agents currently in the pipeline are planned as oral drugs (*J Natl Compr Canc Netw.* 2008;6[Suppl 3]:S1-S14).

The new oral chemotherapy drugs are considerably more expensive than those developed before1996. As an example, the NCCN report notes that the annual cost of lenalidomide (*Revlimid)* for a patient with multiple myeloma is $74,000. Imatinib (*Gleevec*), used to treat chronic myelogenous leukemia, ranges in cost from $29,000 to $57,000, depending on dosage, and accounts for the largest percentage of spending on oral chemotherapeutic agents. Although oral drugs still constitute only a small proportion of total pharmacy-benefit costs, spending on these agents more than doubled between 2002 and 2006, from 0.3% to 0.7%.

Medicare Part D

Individuals 65 years and older comprised more than 750,000 of the 1.4 million new cancer cases in the United States in 2008, and estimates from the National Cancer Institute state that Medicare accounted for 45% of all spending on cancer treatment in 2004. Therefore, Medicare's handling of oral cancer drugs affects a large percentage of cancer patients. In addition, private insurers often take their cues from Medicare.

As it was originally set up, Medicare Part D covered the first $2000, with a 25% copay, followed by a $2850 coverage gap known as the "donut hole," for which the beneficiary must pay out of pocket. When the $2850 has been fully paid, the beneficiary is then responsible for 5% of the remaining costs. This cycle restarts at the beginning of every calendar year. Because of the high cost of many oral cancer drugs, some patients will enter the donut hole after a single prescription.

In 2008, the Kaiser Family Foundation reported that these amounts had risen. The standard Part D benefit has a $275 deductible and 25% coinsurance up to an initial coverage limit of $2510 in total drug costs. The donut hole has now increased to $3216, which enrollees must pay out of pocket.

An analysis released in December 2008 by Avalere Health, a Washington, DC–based advisory-services company, and the American Cancer Society Cancer Action Network (ACS CAN), reported that cancer patients enrolled in Medicare Part D plans will have increased out-of-pocket expenses for oral drugs and face increased restrictions on access to them in 2009. Medicare stand-alone prescription drug plans (PDPs) have been increasingly and consistently shifting name-brand oral cancer drugs to higher formulary tiers over the past 4 years.

The majority of PDPs have now positioned these agents on tier 4, which is often a plan's specialty tier and can charge coinsurance up to 33%. According to the Avalere–ACS CAN report, imatinib, sunitinib (*Sutent)*, and erlotinib (*Tarceva*) all increased their coinsurance amounts, from 27% in 2006 to 33% in 2009. At the same time, copayment for generic tamoxifen remained stable, at just under $5.50.

The Avalere–ACS CAN report also found that in addition to altering tier placement, PDPs are increasing their use of prior authorization to control access to branded cancer drugs. As an example, imatinib had the largest increase in the number of PDPs requiring prior authorization, from 40% in 2006 to 76% in 2009. Erlotinib was a close second, with 62% of PDPs requiring prior authorization in 2009, up from 35% in 2006.

"The difference in cost can be dramatic between oral and intravenous drugs," said Lauren Barnes, vice president of product reimbursement and commercialization at Avalere Health. "Part B has a 20% copay, but supplemental insurance can completely cover that. Part D doesn't permit supplemental insurance, and patients are 100% responsible for the donut hole."

“The difference in cost can be dramatic between oral and intravenous drugs.”

Tiered pricing is also common in private/commercial plans outside of Medicare. A 2007 analysis of prescription drug trends from the Kaiser Family Foundation found that 75% of people with employer-sponsored coverage had a cost-sharing arrangement with 3 or 4 tiers. This was over 2.5 times the proportion in 2000 (27%). Copayments for preferred drugs, including those in a formulary or preferred drug list, such as a brand-name drug without a generic substitute, increased by 67%, from an average of $15 in 2000 to $25 in 2007. Although the average copayment for a tier 4 drug was $71, coinsurance for tier 4 drugs averaged 20% to 25%.

Effect on Compliance

Adherence to an oral chemotherapeutic regimen can be a challenging commitment for many patients, with cost being just 1 of myriad factors, said Len Lichtenfeld, MD, MACP, deputy chief medical officer for the national office of the American Cancer Society. "It has been believed that most patients with cancer would take the drugs as prescribed, due to the nature of the illness. But that has not been the case."

Although it was believed that cancer patients would be particularly motivated to comply with therapeutic guidelines, Dr. Lichtenfeld pointed out that adherence can be quite variable. "For example, tamoxifen has been in use since the 1990s, and research shows that patients have not been taking it as directed," he told *Medscape Oncology*. "Some of the oral regimens can get very complicated, even for the most motivated patients and caregivers."

In adult ambulatory care, overall adherence to chronic medication therapy is generally fair to poor, according to the NCCN report. Compliance rates for oral chemotherapy has been shown to vary considerably, ranging from less than 20% to 100%, and can be particularly challenging in certain populations, such as adolescents.

Adherence to parenteral therapy is far more straightforward because it is administered in a controlled environment. Conversely, compliance with oral therapy is a more complex and multifaceted issue. In a 2002 analysis (*J Natl Cancer Inst*. 2002;94:652-661), Eric P. Winer, MD, of the Dana-Farber Cancer Institute in Boston, Massachusetts, and colleagues found that factors associated with nonadherence to oral medication regimens — complex treatment protocols, inadequate supervision, dissatisfaction with care, inadequate social support — required substantial changes in behavior.

The paper was published prior to the implementation of Medicare Part D, and there has been an increase in the number of oral cancer drugs available since that time. In that paper, the authors reported that there was limited information available on the effect of the cost of therapy on adherence.

> **"I don't think we know how much cost plays a role in compliance, but it is an issue that cannot be ignored."**

"I don't think we know how much cost plays a role in compliance, but it is an issue that cannot be ignored," Dr. Winer told *Medscape Oncology*. "This is particularly true with a potentially growing population of uninsured in our present economic environment, a growing population of underinsured, which includes those who fall into the Medicare donut hole, and the increasing cost of many anticancer agents."

This is an issue that is going to have to be dealt with, said Dr. Lichtenfeld. "We are going to have more oral drugs and that is going to influence the economics of cancer care and how we deliver it," he said. "We need to understand what is happening in the real world and how patients will be able to afford these therapies and stay compliant with them."

On the Legislative Front

There is gathering momentum to change the system, according to Ms. Barnes of Avalere Health, but no quick fixes. One option is to move oral chemotherapy from a pharmacy benefit to a medical benefit, which would improve coverage and reduce out-of-pocket expenses. Other options are being discussed, explained Ms. Barnes, and changes might need to originate in the private sector.

Even though commercial payers usually tend to follow Medicare's lead, in this case, it might be the other way around. "Any changes in Medicare have to go through Congress," she said, "so that does present some challenges and can take a long time. We may see overall health reform at some point, but we don't know if this situation is going to be 'fixed' anytime soon."

Commercial insurers might be interested in revisiting this issue because, although it might be more expensive upfront, providing better coverage for these oral therapies could save them more money in the long run, explained Ms. Barnes. "If patients have better compliance, that may prevent complications and hospitalizations," she said. "It's looking more at the long term, but it will reduce the cost to the whole system."

Political action is already occurring at the state level. At the beginning of 2008, Oregon became the first state to require that health insurance carriers that offer coverage for parenteral chemotherapy offer equivalent coverage for orally administered medications. Other states, including Hawaii, Minnesota, Montana, Oklahoma, and Washington, are considering similar legislation. However, a recent proposal that required health insurers to cover the cost of oral chemotherapy as a medical benefit in Colorado was voted down by their House Health and Human Services Committee in a 7 to 4 vote.

Mr. Knowlton pointed out that the main problem is one of access. "We have some of the best healthcare in the world here in the [United States], but not all of us can access it," he said. "We are hoping that we will see healthcare reform that will change that."

"We are happy to be part of a safety net that allows patients access to their medications," he added. "But what

we'd really like to see is a safety net that puts HealthWell out of business."

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Ben Steinmetz, GlaxoSmithKline
Testimony in Support of SB 195
Senate Financial Institutions & Insurance Committee
Thursday, January 28, 2010

Good morning, I'm Ben Steinmetz, VP Policy and Payer Insights for GlaxoSmithKline's specialty areas, which includes oncology.

- My immediately prior position was as head of global product strategy for oncology, in GSK R&D.
- I have been involved in oncology R&D and commercialization for over 20 years.

I want to speak to you today about:

1. A brief overview of cancer (systemic) treatment
2. Contrast chemotherapy with new advancements such as targeted therapy
3. Describe medical versus pharmacy coverage
4. Summarize cost of iv/oral parity as determined by Milliman

Cancer is generally treated by 3 approaches, depending upon stage of disease: surgery, radiation, and systemic therapy such as chemotherapy.

The approach of cytotoxic chemotherapy is generally regarded as to administer cytotoxic "poisons" which, unfortunately, indiscriminately target both normal and tumor cells with the hope that the drug kills more of the rapidly dividing cancer cells than the normal cells.

- Cytotoxic chemotherapy is administered in doses which, in a balance against efficacy, can lead to substantial toxicities (which can include hematologic toxicity→ life-threatening infections, heart failure, neuropathy, mucositis and sometimes death).
- Following administration of cytotoxic chemo it generally takes a patient 1-3 weeks to recover from the toxicities before beginning a new cycle.
- This episodic administration of cytotoxic chemotherapy lends itself to intravenously administered agents, although some of these agents are available for oral administration.

Scientific advances are leading us towards being able to selectively target tumor cells and deliver agents which interfere with cell survival and/or reproduction in a different way than cytotoxics, these are the so called "targeted agents".

- These targeted agents generally require continuous exposure to the medication for which oral administration is well suited, although long "half-life" protein agents such as monoclonal antibodies also provided extended exposure for 1-3 weeks with a single infusion.
- It is important to recognize that these targeted agents are not themselves devoid of toxicity.
- Often, a developer has little choice in the route of administration of a molecule, the route being determined by the nature of molecule or its properties.

Unfortunately, there can be a notable disparity in the patient out-of-pocket cost (coverage) as a function of whether a treatment is administered in a physician's office (e.g. by infusion) and covered as a medical benefit with typically an office visit co-pay, or taken as oral medication at home and covered as a

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pharmacy benefit, where there can, in some circumstances, be co-insurance costs of 25%-33%, frequently without the extent of caps that many plans have for medical costs.

A bill calling for parity in patient out-of-pocket costs regardless of route of administration was passed in Oregon and several other states, although there remained the question as to what was the "cost of parity."

GlaxoSmithKline, a pharmaceutical company that manufactures, markets, and is developing intravenous/injected and oral chemotherapy drugs, commissioned Milliman to develop and author a whitepaper to quantify the cost of parity in a commercial population.

GlaxoSmithKline provided oncology disease state and treatment expertise, background information on iv/oral chemotherapy treatment paradigms, information on the current status of oral/iv parity legislation, and the general editing of these sections.

Milliman is a leading source of health actuarial expertise to insurance industry, Milliman is a well known name among State Insurance Departments and State Health Departments, they produce and certify 1000's of rate filings each year.

Milliman defined parity as:

- For an individual who receives both oral and intravenous/injected chemotherapy drugs, the percent cost sharing for the oral chemotherapy drugs will be no more than the percent cost sharing for their intravenous/injected chemotherapy drugs.
- For an individual who receives only oral chemotherapy drugs, the percent cost sharing for the oral chemotherapy drugs will be no more than the average percent cost sharing for the intravenous/injected drugs as administered by their benefit plan.

Milliman utilized the Medstat database containing all paid claims generated by over 20 million commercially insured lives. Approximately 1.5% of these lives had medical claims for cancer in a one year period, and approximately 25% of these were under active treatment with systemic agents. Milliman's analysis concluded that for most benefit plans, parity will cost under $0.50 Per Member Per Month (PMPM), which compares to a typical commercial plan cost of over $300 PMPM for all benefits.

- However, there are literally thousands of benefit design variations, and plan design features can affect parity costs. Milliman found that parity for some plan designs with very high cost sharing for oral specialty drugs and low cost sharing for medical benefits could cost about $1.00 PMPM, or, in unusual circumstances, more.
- Parity for other plan designs that have low overall cost sharing could cost as little as $0.05 to $0.10 PMPM.
- These figures did not include plan administrative costs
- Importantly, Milliman estimates also include elasticity in demand, that being the expectation that as costs become lower for oral anti-cancer agents, there will be increased usage.

Thank you for this opportunity to speak.

Ben Steinmetz
January 28, 2010

Kansas State Senate
Financial Institutions and Insurance

Testimony of
Peggy L Johnson
Public Policy Chair
Kansas Cancer Partnership

Thursday, January 28, 2010
Testimony for SB 195

Madame Chair and other members of this committee, my name is Peggy Johnson, I am Executive Director/COO for the Wichita Medical Research and Education Foundation located in Wichita. I am here today representing the Kansas Cancer Partnership for whom I serve as the Public Policy Chair. The Kansas Cancer Partnership supports the passage of Senate Bill 195.

The Kansas Cancer Partnership is a group of approximately 200 individuals from institutions, clinics, county health departments, large and small hospitals, organizations and advocacy groups who have worked together to develop a coordinated and comprehensive plan, the Kansas Comprehensive Cancer Control and Prevention Plan. The plan addresses the burden of cancer on Kansas citizens, families, communities and the government and provides the framework to reduce cancer incidence, morbidity and mortality in the state through prevention, early detection, screening, treatment and survivorship. The Plan was completed and published in March 2005. Each of you should have received a copy of the plan. I have copies of the plan with me today if you didn't receive yours or can't locate it.

According to the Kansas Cancer Registry for 2006 more than 13,000 Kansans were diagnosed with invasive cancer. One very important part of the Kansas Comp Cancer Plan was access to quality cancer care in Kansas. This sounds reasonable; unless you live in the northwest, the southwest, the northcentral or the southeastern regions of Kansas. I am sure each of you, but especially those of you from rural districts understand the uphill struggle rural Kansans have in finding health care in their home communities. If you compound that difficulty with a diagnosis of cancer the burden can become exhausting.

Access is a multi-layered subject. Access is the ability to determine with your oncologist the best possible treatment option for your cancer diagnosis. But it is also access to the treatment option of your choice and not limited by your health care coverage. Making access to oral chemotherapy drugs equal to the access to intravenously injected drugs by your healthcare insurer is very important. It becomes not just an issue of access but a financial one. It can be a two layered problem.

If you are a farmer living in Morton County and you are diagnosed with brain cancer, what are your options? Today one of the best treatments for your type of cancer is an oral chemotherapy drug. It has few side effects and you take it at home. There are no daily or weekly long drives to a treatment center, no four hour treatment regiments, and none of the other side effects associated with intravenous chemotherapy. But more than likely this oral drug will not be covered by your health insurance. Or if it is your portion of the cost will be staggering.

I believe most of us don't really understand what our health insurance will cover until there is a crisis. I ask you, all of you, do you know what will be covered by your health care policy if you are diagnosed with cancer tomorrow?

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I took the test. I have good insurance, not great, but good. I am the Executive Director and I make those decisions about our insurance. Monday, I took out my policy and I tried to figure out how I would be covered for cancer. I read the whole thing.
Here is what I found. Under Covered services, part b. Chemotherapy (chemical treatment) for malignant conditions. (1) Your Doctor's services for administering chemotherapy. (2) The chemotherapy drugs that are injected or given intravenously or taken by mouth and under the direct supervision of Your Doctor. Prescription Drugs for chemotherapy are covered under the health benefits section of this coverage only if You are ***not enrolled*** in prescription drug coverage.

I called my carrier and asked some questions. They couldn't tell me if most chemotherapy drugs were included in my prescription rider, they also told me the list is constantly changing. I then asked, 'What if my drug isn't on the list?' The polite young man hesitated and then answered 'we won't pay for it.' I asked 'any of it?' To which he answered 'no.'

Now when I made the decisions about our health care coverage for this year, I guess I decided not to have cancer this year, and none of my employees can have cancer. We need the prescription drug coverage because I have two diabetics working for me and they need the prescription coverage. We can't have cancer.

Equal access to oral medications for the treatment of cancer shouldn't be a financial decision. It should be the decision of the patient and their physician based on the best treatment options for their cancer.

If you talk to any cancer researcher their dream is to develop a pill to deliver all future cancer drugs. They have less toxicity, easier to administer and less follow up, and less patient morbidity. The cancer pill of the future is finally beginning to show up. We need to be able to make these new therapies available to patients.

Medical debt is the number one cause of bankruptcy in Kansas. We can't allow more of our hard working citizens to face decisions about their cancer treatment based on their ability to travel for treatment or the financial burden it will place on their family.

The Kansas Cancer Partnership strongly encourages you the fill in this loop hole and take access to treatment and financial concerns out of what is an already stressful situation for your constituents. Please support Senate Bill 195.

On behalf of the 200 members of the Kansas Cancer Partnership I thank you for this important opportunity to talk with you today.

Respectfully yours,
Peggy L Johnson
Public Policy Chair
The Kansas Cancer Partnership

SUSAN G. KOMEN FOR THE CURE® **Kansas Affiliates**

Kansas Senate Committee on Financial Institutions and Insurance

"SENATE BILL No. 195"

Testimony of
Christina L. Osbourn
Executive Director
Mid-Kansas Affiliate Susan G. Komen for the Cure®

Thursday, January 28, 2010

Ms. Chairwoman and Members of the Committee:

Thank you for the opportunity to testify today about Senate Bill No. 195, which would require that insurance companies cover orally-administered anticancer medications on terms no less favorable than intravenously-administered or injected cancer medications. My name is Christina Osbourn, and I am Executive Director of the Mid-Kansas Affiliate of Susan G. Komen for the Cure®. I testify today on behalf of both the Mid-Kansas and Greater Kansas City Affiliates, which together represent the entire state.

Cancer is a national and state epidemic. In 2009 alone, almost 1.5 million people in the U.S. were diagnosed with cancer and 560,000 died. In Kansas, more than 13,000 new cancers were detected and more than 5,000 people died. Some 2,200 women in Kansas are diagnosed with breast cancer each year, and 370 lose their battle with the disease.

Komen for the Cure is the world's largest grassroots network of breast cancer survivors and activists fighting to save lives, empower people, ensure quality care for all and energize science to find the cures. Thanks to events like the Susan G. Komen Race for the Cure® Series, Komen has invested almost $1.5 billion to fulfill our promise, becoming the largest source of nonprofit funds dedicated to the fight against breast cancer in the world, and Komen will invest another $2 billion over the next decade into cutting-edge research and community programs.

In Kansas, the Komen Greater Kansas City and Komen Mid-Kansas Affiliates have granted over $6.1 million into Kansas communities to cover local breast health education and breast cancer screening and treatment programs. This includes over $2 million in grant funds to the State of Kansas' Early Detection Works program — which provides potentially life-saving breast and cervical cancer screening and diagnostics to the state's low-income and uninsured and underinsured women — equaling over 26,000 mammograms for uninsured and underinsured women in Kansas.

SENATE BILL No. 195

The Komen Kansas Affiliates support Senate Bill No. 195. We believe health decisions should be made between a patient and her doctor. These decisions will depend on many factors such as age, type of cancer and the characteristics of the cancer; deciding on a particular treatment option is as much a personal matter as it is a medical one. Treatment decisions should not have to be based on financial factors; the decision should always be based on what is best for the patient. In addition, persons with

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1148 S Hillside, Suite 11 Wichita, KS 67211
316-683-8510 | www.komenmidks.org and www.komenkansascity.org

cancer should be protected from high out-of-pocket medical costs that could lead to financial hardship and even bankruptcy. Medical debt is the number one cause of bankruptcy in the state of Kansas.

Chemotherapy is the use of anti-cancer drugs to kill or disable cancer cells. It is a treatment option for many types of cancer, but it is used differently depending on how advanced the cancer is. Chemotherapy drugs can be taken orally by pill or capsule, or injected intravenously. Typically, a combination of two or three chemotherapy drugs is used. Intravenous drugs must be given in a hospital or physician's office.

The emergence of safe, clinically effective oral chemotherapy has significantly increased the treatment options for cancer patients. According to the National Comprehensive Cancer Network, some 400 anticancer medications are currently under development and about 25 percent of them are intended as oral anticancer medications, which will be used to treat 52 different types of cancer. The most frequently prescribed oral medications are used to treat breast, ovarian, endometrial, and uterine cancers. In discussions with local researchers, we also have learned that oral chemotherapy drugs are expected to be the main source of anti-cancer drug in the future. While oral chemotherapy is available and will become an even more prevalent treatment option in the near future, there are many barriers that impede the use of this treatment option.

There can be a significant difference in the amount cancer patients pay out of pocket for an oral drug and how much they pay for an intravenous product. Intravenous therapies are traditionally covered under a medical benefit, under which most patients are only responsible for an office copayment for each visit and are not required to pay a separate fee for the intravenous drug. By contrast, oral chemotherapy is generally covered under a prescription drug benefit, which tends to have higher copayments or no coverage at all.

Oral chemotherapy drugs can be extremely expensive. And because of oral chemotherapy's higher levels of cost sharing, patients may be exposed to very high out-of-pocket costs. While some copayments have remained low, particularly for generic drugs, some cancer patients face out-of-pocket costs of hundreds or even thousands of dollars a month.

We strongly believe that a health plan that provides coverage for cancer chemotherapy treatment should not require a higher co-payment, deductible, or coinsurance amount for a prescribed, orally administered anticancer medication than what is required for an intravenously administered or injected cancer medication, regardless of formulation or benefit category determination by the health plan. We support efforts by the state to require health insurance 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 must ensure that in adopting this policy, health insurers are not allowed to reduce benefits for intravenous therapies.

Other states are leading the way. Already, Oregon, Indiana, Iowa and Vermont passed oral chemotherapy parity legislation, and legislation is pending in a number of other states.

Access to Quality Cancer Care and Quality of Life for Cancer Patients

Eighty-eight of the 105 counties in the state of Kansas are considered Rural or Frontier. Individuals in Rural and Frontiers areas experience significant barriers to accessing healthcare, let alone quality healthcare. The American Academy of Family Physicians, states, "At least two in five residents in Alabama, Alaska, Florida, Kansas, Mississippi, Missouri, Oregon, South Carolina and Utah have inadequate access to basic health care".

Provider surveys conducted by the Mid-Kansas Affiliate provide a fair overview of programs and services available throughout our service area. The size of the Affiliate's service area made this a difficult task as many of the communities and counties had few, if any, services available for breast cancer screening and treatment. Many communities rely on small county health departments, local clinics, civic

organizations and churches as their only resource for breast health awareness activities. Through the provider surveys and previous grant applications, the Affiliate recognized there are services available, but the distance between services and number of services available creates a significant barrier to Kansans trying to gain access to quality healthcare. The Mid-Kansas Affiliate created an "asset map" (Figure 1) to show where healthcare services were available and we saw a large gap in services, specifically treatment services, in several of our rural regions.

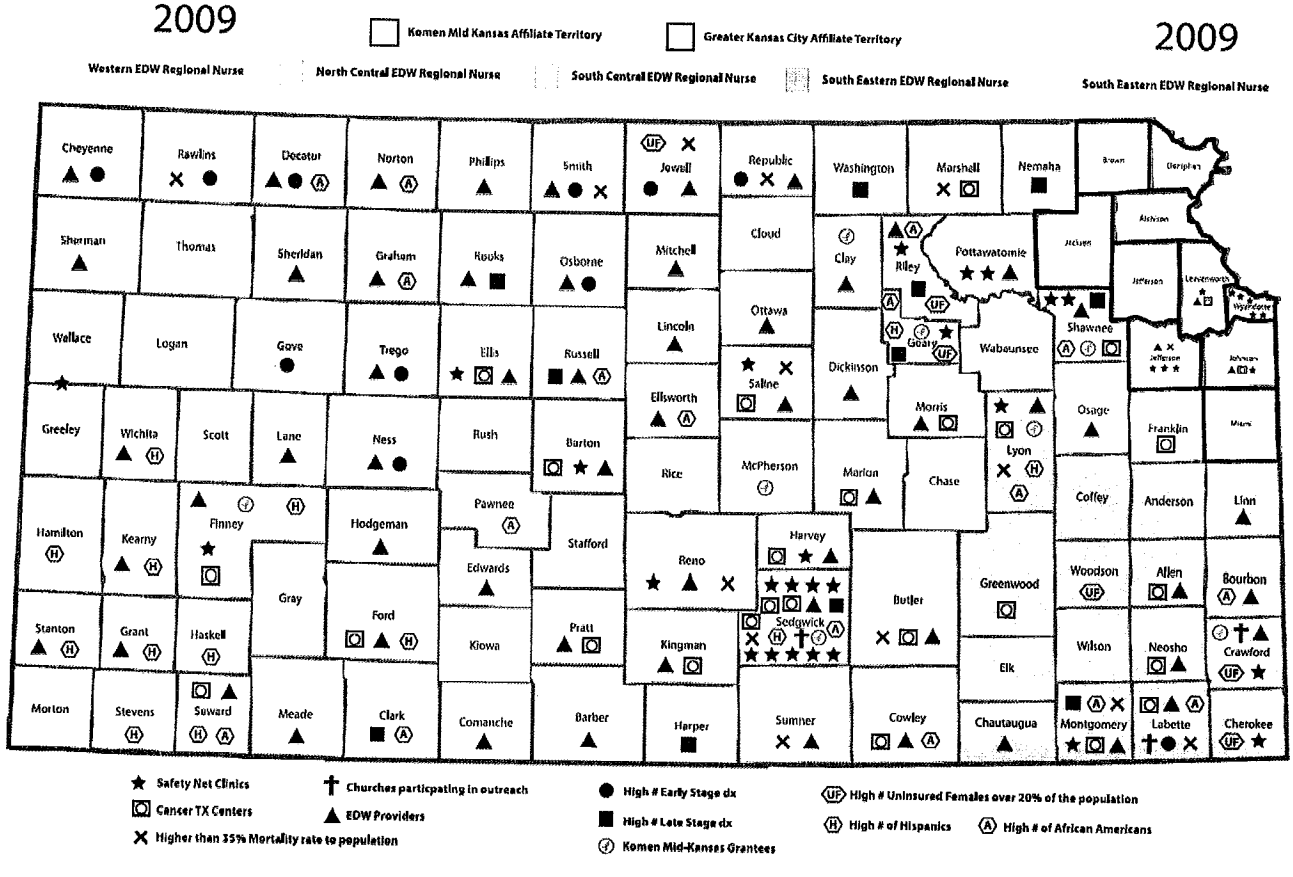
Oral chemotherapy provides several benefits to cancer patients resulting in an overall increase in quality of life; it may allow administration of the medication on a daily basis, may be more convenient for patients (takes away the need to drive long distances and/or schedule time away from work/family) and may reduce the risk of infection or other infiltration complications.

Conclusion

The Komen Greater Kansas City and Komen Mid-Kansas Affiliates of Susan G. Komen for the Cure support Senate Bill No. 195. We support efforts at the state and federal level to require group and individual health insurance 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 must ensure that in adopting this policy, health insurers are not allowed to reduce coverage for intravenous therapies.

For more information, contact Christina Osbourn (Mid-Kansas) at 316-683-8510 or cosbourn@komenmidks.org OR Lori Maris (Greater Kansas City) at 816-842-0410 *or lmaris@komenkansascity.org.*

Figure 1: Map of the Mid-Kansas Affiliate Service Area



Testimony before the Kansas Senate Committee on Financial Institutions and Insurance in Support of Senate Bill No. 195

Michele Krier
Ashland, Kansas
620-635-2241

Ms. Chairwoman and Members of the Committee:

Good morning. My name is Michele Krier, and I live in Ashland, Kansas. Thank you for taking the time today to read my testimony in support of Senate Bill No. 195. Unfortunately, due to my current health condition and work schedule I was unable to make the five hour drive to Topeka to testify before you in person, so I thank you again for taking the time to read my story.

At the age of 47, I was doing a self-breast exam when I found a lump. After a mammogram and MRI, three spots of cancer were found, including the 2.5 cm lump I felt. On November 2, 2009, at the age of 48, I was diagnosed with breast cancer (Happy Birthday, Michele). I had a bi-lateral mastectomy and am currently undergoing intravenous chemotherapy treatments. I drive approximately 80 miles (1.5 hours) to Pratt, KS for all of my cancer-related appointments and treatments. I drive the three hours (round-trip) to get chemotherapy every two weeks and am having to the drive every couple of weeks for additional appointments, as well, including a CT scan in upcoming months.

Without talking with my doctor, I am unsure if oral chemotherapy would have been the appropriate treatment option for me, but I strongly believe that this should be an equal option for all cancer patients, especially those living in rural communities like myself.

If I were able to take oral chemotherapy (vs intravenous chemotherapy) there are several burdens that could be lifted. Due to having to drive three hours to get treatment, I am unable to finish my workday. I actually feel pretty decent the day I receive treatment, so if I were able to take treatment locally, possibly even in the form of a pill, I wouldn't have to take so much time off work. Driving 80 miles just about weekly is financially burdensome, as well. While I am not extremely strapped for cash, I am having to pay for very expensive medications such as Neulasta ($5,300), which is absolutely necessary. I HAVE to pay for this, so I'd rather not have to be wasting money on gasoline. (Neulasta is a prescription medication used to prevent infections in people undergoing certain kinds of chemotherapy. Many types of chemotherapy increase the risk of dangerous infections, and Neulasta can help prevent such infections). I believe the biggest burden is when I have to burden others. When going to receive my Taxol (chemotherapy) treatments I am not going to be able to drive myself. Therefore, I am going to have to ask others to take a full day to drive me to treatment, stay with me, and drive me home from treatment. Almost everyone I know works, so not only am I having to take off work, but they are as well. I am very blessed that I have such a great support system, but I don't know what others would do if they didn't have the same community I do.

The reason I wanted to share my story was for you to hear directly from someone battling breast cancer and undergoing intravenous chemotherapy to help you understand that there is a true access to care barrier in so many Kansas communities, including my own. The idea of all of the time, money, and anxiety I could save from being able to take a pill [oral chemotherapy] is extremely appealing; however, I do not think it is fair to us cancer patients that insurance companies do not treat it equally as intravenous chemotherapy. I feel very strongly that insurance companies should be required to have chemotherapy options on a level playing field so that patients in situations like myself aren't forced to make treatment and quality of life decisions based on our health plan or the cost of the alternative choice.

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