COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES
INSURANCE
COMMITTEE HEARING

HERSHEY MEDICAL CENTER
MEDIA CENTER
ROOM T2500
HARRISBURG, PENNSYLVANIA

THURSDAY, MARCH 18, 2010
10:00 A.M.

PRESENTATION ON
HOUSE BILL 1865

BEFORE:
HONORABLE ANTHONY M. DeLUCA, MAJORITY CHAIRMAN
HONORABLE BRENDAN F. BOYLE
HONORABLE FRANK BURNS
HONORABLE BRYAN BARBIN
HONORABLE EDDIE DAY PASHINSKI
HONORABLE RICK TAYLOR
HONORABLE BRAD ROAE
HONORABLE SCOTT W. BOYD
HONORABLE ROBERT W. GODSHALL
HONORABLE GLEN R. GRELL
HONORABLE ADAM C. HARRIS

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ART McNULTY
EXECUTIVE DIRECTOR

KELSEY DUGO
REPORTER

# I N D E X

## TESTIFIERS

P R O C E E D I N G S

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CHAIRMAN DeLUCA: I apologize, for starting a little late. I know some members have some appointments this afternoon. I want to thank them all for coming out today on this public hearing. Before we start, I would like from my right to have the members to introduce themselves.

REPRESENTATIVE HARRIS: Representative Adam Harris; I represent the 82nd District, which is Juniata and parts of Mifflin and Snyder.

REPRESENTATIVE ROAE: Representative Brad Roae; Crawford County.

REPRESENTATIVE GODSHALL: Bob Godshall; Montgomery County.

REPRESENTATIVE BOYD: Scott Boyd; 43rd District, which is a portion of Lancaster County.

REPRESENTATIVE BURNS: Representative Frank Burns; the 72nd District, which is Cambria and Somerset Counties.

EXECUTIVE DIRECTOR McNULTY: Art McNulty; executive director of the House Insurance Committee.

CHAIRMAN DeLUCA: I'm Representative Tony DeLuca, the chairman of the Insurance Committee from Allegheny County.

REPRESENTATIVE PASHINSKI: Good morning. Eddie Day Pashinski; Luzerne County, 121 District.

REPRESENTATIVE BOYLE: Representative Brendan Boyle; 170th District, Philadelphia and Montgomery Counties.

REPRESENTATIVE BARBIN: Representative Bryan Barbin; I represent the Johnstown area and Cambria County.

REPRESENTATIVE GRELL: Glen Grell; 87th District, Cumberland County.

CHAIRMAN DeLUCA: Again, I want to thank the great turnout and the members here today and I want to welcome everyone here this morning for the House Insurance Committee public hearing on House Bill 1865. Legislation is sponsored by Representative Frank Burns.

The legislation will help cancer patients by eliminating one of the issues facing them and selecting the treatment regiment that best fits their needs. Specifically, the bill requires equalizing the patient's share of insurance cost, no matter what form the treatment takes, whether it's by intervenous or through pills.

Before we get to our agenda, I do want to thank Penn State Hershey Medical Center for hosting us today. It's a beautiful facility and it certainly does

a great job. It's clear that this facility is the home to plenty of good work and researching and treating cancer. I also want to thank Representative Burns for sponsoring this integrative legislation and I also want to thank PCN, who does a great job in covering these hearings throughout the state to educate our citizens in Pennsylvania about what's going on in our Commonwealth. So I want to thank PCN for being here today.

Representative Burns is attempting to mandate coverage that is attempted with this bill to walk that fine line. Given this, I will ask Representative Burns to give a few introductory words. Representative Burns.

REPRESENTATIVE BURNS: Thank you, Chairman DeLuca. I would like to thank everybody for coming today. This is a very important bill that I hope that we can all learn something today and we can learn the issues that are affecting, not only cancer patients, but also the insurance companies when dealing with this.

So I was hoping that we could get started and I look forward to learning something here today and I hope you all can share our views. And I thank all of you for coming into the hearing today.

CHAIRMAN DeLUCA: Thank you, Representative Burns. The first person to testify is Dr. Christopher

Ehmann. He is the M.D. for hematology and oncology. Doctor, welcome and thank you for coming out here to testify.

MEDICAL DIRECTOR FOR HEMATOLOGY AND ONCOLOGY EHMANN: Thank you for inviting me. Thank you, Representative DeLuca, for affording me the opportunity to make clear my support for passage of House Bill 1865, and allowing me to address the House Insurance Committee this morning. We, at Penn State Hershey Cancer Institute, and we in the Pennsylvania oncology community eagerly await passage of this important legislation which affords the same insurance coverage benefits for chemotherapy administered orally as intravenously.

Chemotherapy is defined as chemicals administered to produce a toxic effect on cancer cells or organisms. For patients, chemotherapy typically means drugs being given to cure a cancer, drugs often associated with nausea and vomiting and hair loss as side-effects. We often administer a "cocktail" of different drugs, which work by different mechanisms, and all have different, not additive toxicities for patients.

The first such combination was developed at the National Cancer Institute in the 1960s. It was called MOPP, M-O-P-P, and cured 80 percent of patients

with Hodgkin lymphoma. Two of the four drugs in this now 43 year-old regimen were given orally because they were either more convenient and less expensive, or the drug did not exist in intravenous form. Please remember, effective combination chemotherapy, developed almost 50 years ago, half the drugs taken orally, at home.

Since then, the concept of chemotherapy has broadened to include antibody therapies, targeting specific molecules on the surface of tumor cells or to target specialized metabolic pathways that cancer cells utilize. The first and most successful drug in this class is imatinib, or Gleevec, which targets the abnormal enzyme produced by a genetic translocation, which is called the Philadelphia Chromosome because it was discovered there in 1961, in patients with chronic myelogenous leukemia or CML. Although called a chronic disease compared to acute leukemias, this disease nevertheless was fatal to 90 percent of patients within five years of diagnosis. Imatinib and its successors have completely changed the future for patients with this disease: They now take a pill a day, and for most, no further therapy is needed. A pill-a-day, no injections needed. However, this pill costs $80-100 each day.

One of my patients was diagnosed with CML while pregnant. We reduced the number of leukemic cells in her by processing her blood during her pregnancy, we waited until she delivered a healthy baby and we started her on imatinib. Unfortunately, three years out from her diagnosis, she still can't afford the drug, despite long efforts of many people and organizations. So instead of taking a pill a day, as prescribed, she takes one pill every other day, in order to stretch out the 15 pills she can afford each month. While this helps control her blood counts, half-dosing has not produced the suppression of the cancerous clone that we typically see in patients treated with this drug. Each time I see her in clinic, I am fearful that her disease will have progressed to an often fatal aggressive phase because of this inadequate treatment.

The decision of what treatment to use for a patient should be based on evidence that a drug is best for the disease and physician judgment that it is best for a particular patient. The decision should not rest on how the drug is administered. We have almost 50 years experience using effective oral chemotherapy. Patients need coverage for oral chemotherapy.

CHAIRMAN DeLUCA: Thank you, Doctor. Any questions for the doctor from my right? Any questions?

Representative Pashinski.

REPRESENTATIVE PASHINSKI: Doctor, thank you very much. What's the difference in the cost between the intravenous and the imatinib?

MEDICAL DIRECTOR FOR HEMATOLOGY AND ONCOLOGY EHMANN: I have the same questions. I was preparing this yesterday, Representative Pashinski. So I actually called and tried to figure that out. The oral agent for this patient would cost in a years time -- hang on a second, let me get my notes.

REPRESENTATIVE PASHINSKI: That's $80-100 a --

MEDICAL DIRECTOR FOR HEMATOLOGY AND ONCOLOGY EHMANN: That's $36,000 a year. And those estimates are variable because cost varies depending on where you get the drug and under what agents.

If we were to just give her a very cheap intravenous drug once a day, the cost associative with that would be about $133,000 a year. So about 3-and-a-half times the cost over a years time of drug. I chose a drug, somewhat, at random that I wouldn't administer that way because it's so inconvenient, but i wanted some comparison. So about 3-and-a-half times the cost to give a drug intravenously. This drug does not come in intravenous form.

REPRESENTATIVE PASHINSKI: Okay. What contributes to that cost? Personnel and --

MEDICAL DIRECTOR FOR HEMATOLOGY AND ONCOLOGY EHMANN: Yes. The drug itself -- in fact, I chose an old drug that's fairly inexpensive, but it mostly would be the cost associated with it. In fusion time, the preparation of the intravenous supplies and time in the clinic.

REPRESENTATIVE PASHINSKI: Now, I wonder if you can answer this next question. Have you done a price comparison of the drug that we're talking about, imatinib? Is it the same price in Canada.

MEDICAL DIRECTOR FOR HEMATOLOGY AND ONCOLOGY EHMANN: I have no idea.

REPRESENTATIVE PASHINSKI: Or in India?

MEDICAL DIRECTOR FOR HEMATOLOGY AND ONCOLOGY EHMANN: I don't know.

REPRESENTATIVE PASHINSKI: Does anybody in the audience know that answer?

FINANCIAL COORDINATOR FLENNER: I have one patient that gets them in Canada and she does pay a little less. I'm a nurse and we'll be talking later, but it's about $6,000 for a regular patient in Pennsylvania to get this drug for one months supply. And I have one patient that I know goes to Canada, but

they don't know the exact.

REPRESENTATIVE PASHINSKI: There are significant differences in the cost of pharmaceuticals in America or Canada or Great Britain, etcetera, Plavix being one example. That, I'm very familiar with. It's about $3.88 cost to Americans and it's about a dollar in Canada. So I was wondering whether this would be something that we could look into? I thank you very much, Doctor. I appreciate it.

MEDICAL DIRECTOR FOR HEMATOLOGY AND ONCOLOGY EHMANN: Thank you.

CHAIRMAN DeLUCA: Representative Barbin.

REPRESENTATIVE BARBIN: Thank you, Mr. Chairman and thank you, Dr. Ehmann. I have a question and it goes back to your original testimony. You said that since the 1960s, oncologists have known that by mixing different pills or intravenous treatments, there are better outcomes. If that's the case, is there any question -- among the other people that are providing treatment to cancer patients, is there any doubt in your mind or in the general research in the field that different, either pills or intravenous drugs, are required for successful results? Because it sounds like this bill is about making a decision as to allowing the doctor to decide which one is in the best interest of

the patient. It also sounds like these drugs are covered in different forms. In some instances, they won't be covered if they are a pill.

The question is, is there any doubt in the research or in the practitioner level that the pills outcomes will vary based upon whether the pill is given or whether the intravenous is given?

MEDICAL DIRECTOR FOR HEMATOLOGY AND ONCOLOGY EHMANN: I'm not sure if I understand your question.

REPRESENTATIVE BARBIN: My question is, is there any doubt -- if you had every oncologist in the room today and they were asked the question, should there be parity between the pill form and the intravenous-type treatment --

MEDICAL DIRECTOR FOR HEMATOLOGY AND ONCOLOGY EHMANN: Financial or insurance parity, absolutely. No question about it.

REPRESENTATIVE BARBIN: That's my question today.

MEDICAL DIRECTOR FOR HEMATOLOGY AND ONCOLOGY EHMANN: A lot of the drugs that we use, for example, imatinib, is not available in intravenous form, so we have no choice. That and in that class of drugs are all oral agents, so there's no option in that setting.

REPRESENTATIVE BARBIN: Is there any

question to any of the drugs, in which you seek parity for, are drugs that are agreed to by the practitioners and researchers as being effective for the types of cancer that you're prescribing them? Is there any question in what you're asking for parity for is an effective drug?

MEDICAL DIRECTOR FOR HEMATOLOGY AND ONCOLOGY EHMANN: No.

REPRESENTATIVE BARBIN: So the only question today is, whether or not if a physician chooses to prescribe a known successful drug for a particular patient, whether that should be covered by insurance?

MEDICAL DIRECTOR FOR HEMATOLOGY AND ONCOLOGY EHMANN: That's my assessment of the issue. Yes, I would agree. I think that virtually every oncologist, and every nurse or every healthcare provider would agree with that.

REPRESENTATIVE BARBIN: Okay. Thank you.

CHAIRMAN DeLUCA: Representative Boyd.

REPRESENTATIVE BOYD: Thank you, Mr. Chairman. Just out of curiosity sake, why do the pharmaceutical companies choose to have some drugs intravenous and some in oral form? Is there a reason behind that?

MEDICAL DIRECTOR FOR HEMATOLOGY AND ONCOLOGY

EHMANN: I think people, in general, would love to have drugs in oral form. It's more convenient for people to take it when they want, rather than having to go through the difficulty of an intravenous, accessing the patient's veins, sticking them and giving the drug. But absorption is the issue and the pharmaceutical kinetics of the drugs is very dependent, whether being given intravenously or by oral. So it's a practical matter for the drug more than anything else.

REPRESENTATIVE BOYD: So is it fair for me to assume that some drugs can be assimilated by the human body orally and then some can't? The ones that can't have to be administrated --

MEDICAL DIRECTOR FOR HEMATOLOGY AND ONCOLOGY EHMANN: Some drugs we actually have intravenous and oral forms for. Prednisone is a classic example. But many drugs is either one or the other, not both.

REPRESENTATIVE BOYD: So the form of the medication has less to do with cost than any of that? It has to do solely with the best way to get it into the body for the most positive affect?

MEDICAL DIRECTOR FOR HEMATOLOGY AND ONCOLOGY EHMANN: Yes, and I would add the surest way to get it in. These people have trouble with some of the pills, not taking them on time and things like that. If

there's an issue about it, then the intravenous root becomes more attractive in some rare occasions.

REPRESENTATIVE BOYD: Now, this is kind of a tough question, and it's probably not a fair one, but I want to get it out and get it on the record. A medication that can be taken in an oral form, could it be administered in an intravenous form also?

MEDICAL DIRECTOR FOR HEMATOLOGY AND ONCOLOGY EHMANN: There are many medications that have both intravenous and oral forms. There are a lot of medications, specifically, chemotherapy drugs, that do not have an intravenous form, that are only oral. The drug I mentioned is among them.

REPRESENTATIVE BOYD: Thank you. Thank you, Mr. Chairman.

CHAIRMAN DeLUCA: Any other questions? To my right. Representative Grell.

REPRESENTATIVE GRELL: Thank you. Thank you, Doctor. Do you or your colleagues ever find yourself recommending an intravenous force of treatment over an oral force of treatment because even though the intravenous might not be what you would really like it to do, that would be covered on more attractive terms than the oral?

MEDICAL DIRECTOR FOR HEMATOLOGY AND ONCOLOGY

EHMANN: I suspect that that probably occurs.

REPRESENTATIVE GRELL: Okay.

CHAIRMAN DeLUCA: Doctor, let me just -- so I understand this. You're saying if they take the oral form, it's $36,000 a year; is that correct?

MEDICAL DIRECTOR FOR HEMATOLOGY AND ONCOLOGY EHMANN: That's a very rough estimate, yes.

CHAIRMAN DeLUCA: And intravenous, it would be --

MEDICAL DIRECTOR FOR HEMATOLOGY AND ONCOLOGY EHMANN: On a different drug, which I might use in this disease. That's how I chose that, yes.

CHAIRMAN DeLUCA: So what would you proceed why the insurance company would not want to have parity in these type of treatments since they're going to save a tremendous -- we're talking about health care costs. We're talking about reducing health care costs and if it's just because it's a mandate, I find that ironic that we will not go over the precept or tell them it's a mandate. And I think that some of these things that we need -- we're talking about reducing costs in health care and we need to look at some of this stuff and forget about whether we're mandating it because if you can make life a better situation for somebody who has cancer and we can save money, then we certainly should

look at it from that standpoint and not from the standpoint of a mandate; would you agree with that?

MEDICAL DIRECTOR FOR HEMATOLOGY AND ONCOLOGY EHMANN: I would with the exception that some of the drugs that we have that are most effective for certain diseases and are proven to be effective, do not exist in an intravenous from. So we have no choice.

CHAIRMAN DeLUCA: We have no choice, but --

MEDICAL DIRECTOR FOR HEMATOLOGY AND ONCOLOGY EHMANN: So I certainly wouldn't want to have the choice of an effective drug versus nothing.

CHAIRMAN DeLUCA: I understand, but you certainly want a choice to -- and I would imagine that we would use the best treatment here, all of your oncology physicians would use the best treatment with patients.

I think there is evidence out there that they're making some breakthroughs on how they can even isolate some of the, especially on cancer, cells that they, instead of given a treatment on a trial basis to see which medication works, I think they are in the stage right now where they can possibly isolate that to see what is the best treatment in the laboratory before they put that patient through all kind of stuff; is that true?

MEDICAL DIRECTOR FOR HEMATOLOGY AND ONCOLOGY EHMANN: Yes, those efforts are certainly on their way. They have a history. They go back numbers of decades and have not shown to be effective in the past. So I have a little hesitation about that idea in general idea, but it's certainly an attractive idea.

CHAIRMAN DeLUCA: No other questions? Doctor, I want to thank you for the testimony, it was very excellent. I want to recognize Representative Taylor that just came in. Thank you very much, Representative Taylor.

REPRESENTATIVE TAYLOR: Thank you, Mr. Chairman.

CHAIRMAN DeLUCA: The next individual to testify is Susan Anderson. She is the Special Assistant to the Governor at the Governor's Office of Health Care Reform. Welcome Susan.

SPECIAL ASSISTANT TO THE GOVERNOR ANDERSON: Thank you.

CHAIRMAN DeLUCA: Whenever you're ready.

SPECIAL ASSISTANT TO THE GOVERNOR ANDERSON: Good morning. It's a pleasure for the Governor's Office of Health Care Reform to appear before you today to provide brief testimony on House Bill 1865. We have been here many times before to discuss critically

important health care issues with you. It is clear to us that your committee remains focused on and committed to dealing with those health issues that affect so many Pennsylvanians.

We all know at this point, the Governor believes that all Pennsylvanians should have access to quality affordable health care. Certainly those Pennsylvanians who are unfortunate enough to be fighting the "fight of their lives" when battling cancer, should not have to choose treatment options based on cost and neither should their physicians' treatment options be constrained because of cost.

As the medical and pharmaceutical communities make great advances in cancer treatments, alternative treatment options are emerging especially in the area of oral chemotherapy; and it appears that we are just at the beginning. Oral chemotherapy, as opposed to intravenous chemotherapy, has distinct medical advantages, as we have heard. But with regard to the cost of health care, oral chemotherapy has other advantages, not the least of which is a reduction in inpatient and outpatient expenses and the costs of administration.

How wonderful for a cancer patient to hear that there is a pill that can cure her cancer or put her

disease into remission. How cruel for her to learn that, although her insurance covers chemotherapy, she can't take the pill because she can't afford the high out of pocket expenses. If she's lucky, there will be comparable IV chemo which will carry a lesser out of pocket expense.

Requiring parity in co-payments, deductibles, co-insurance and maximum out of pocket expenses regardless of the form of administration of chemotherapy makes sense and it's the right thing to do. It provides patients in Pennsylvania with quality and affordable health care.

We know that other states have passed similar legislation and we think Pennsylvania should as well. Our office believes that this bill is the first small step in this area. And we are actually looking forward to expanded legislation that would protect every cancer patient from unaffordable chemotherapy medication, regardless of its administration.

CHAIRMAN DeLUCA: Thank you, Susan. Representative Grell.

REPRESENTATIVE GRELL: Thank you. Thank you for your testimony. I have two questions. First, have you looked at whatever national health care proposal is currently being considered and can you give us any

insight on if that is passed, what affect have would that on this particular issue and would it make this legislation unnecessary or less necessary?

SPECIAL ASSISTANT TO THE GOVERNOR ANDERSON: I don't know the answer to that.

REPRESENTATIVE GRELL: Okay. Second, have you given any analysis on what the impact would be on insurance premiums, either the health insurance premium or the prescription drug premium if insurers were required to equalize the pricing for these drugs?

SPECIAL ASSISTANT TO THE GOVERNOR ANDERSON: I know that a study has been done by the Milliman group and has put some cost back on that. I think it varies from plan to plan. We could be talking about cents to dollars. I think one of the issues or several of the issues that we see in the bill that we're concerned about is the fact that what we're really talking about is parity of cost and parity of cost doesn't have to mean going down, it can mean going up.

And so when we say we want IV and pills to be the same, we know that there were insurers in other states, although most of them went down, some took the product up. So to equalize the payments, they moved them up as opposed to down. So that is one of the issues I think that we have.

I think one of the other issues that we have with the legislation is the fact that we've got insurance companies offering medical plans and then using PBMs or separate contracts for their drug benefit. I don't want to see us pass this legislation and then have the insurance companies say, it's not applicable to us because we're really not offering because the bill says you have to offer both intravenous and oral chemotherapy. That the insurance company would say, well, we cover the intravenous part, but because we have a separate contract for the drug plan for this patient, we don't have to have parity.

REPRESENTATIVE GRELL: If I may follow-up, I did have two questions, but that just -- does the administration have an official position on this legislation at this point? It sounds like you have some concerns about it.

SPECIAL ASSISTANT TO THE GOVERNOR ANDERSON: No, we're fine. We're fine with the legislation as it's written. We would like to see it go beyond where it is to make it more expansive, but, as I said, it's a good first step.

REPRESENTATIVE GRELL: And Mr. Chairman, do we have access to the report that she mentioned on the financial report?

CHAIRMAN DeLUCA: Yes. We'll get you a copy.

REPRESENTATIVE GRELL: Thank you very much.

CHAIRMAN DeLUCA: Representative Boyle.

REPRESENTATIVE BOYLE: And you just talked about the experience of other states in your written testimony. It mentions that there are other states that have passed this legislation. How many other states have passed this legislation?

SPECIAL ASSISTANT TO THE GOVERNOR ANDERSON: I think there were four that have. It's been introduced in some other states as well. I know it's Oregon, New Mexico, Indiana have passed this. Last I read, it was pending in Texas, Washington, New York, Hawaii, Ohio, Oklahoma.

REPRESENTATIVE BOYLE: And then toward the end of answering Representative Grell's questions, you mentioned some of the experiences. That's one of the nice things we have with the system of federalism, even though it tends to be inefficient that we can learn and benefit from the experiences of these other states. But my one concern is a relatively small pool of data from which we're drawing. To the best of your knowledge in those four states, how often was it a case where parity was achieved, but it wasn't bringing cost down, it was a

rising --

SPECIAL ASSISTANT TO THE GOVERNOR ANDERSON: I think there was only one case and it was in Oregon, where one of the insurance companies went and in all the other situations, they came down.

REPRESENTATIVE BOYLE: Thank you.

CHAIRMAN DeLUCA: Representative Pashinski.

REPRESENTATIVE PASHINSKI: Thank you, Susan, for your testimony. Could you, by any chance validate the cost of the medication, 80-100 dollars? Could you break that down in the categories of what piece of the action that PBM gets out of that, what constitutes the cost of this bill at 80-100 dollars? I understand research plays a role into it, production, etcetera, but is it just because it the new poplar drug that can fix the ills that we have or is it really an actual legitimate cost that should be charged?

SPECIAL ASSISTANT TO THE GOVERNOR ANDERSON: You know, I'm not a pharmaceutical expert. I can't give you the breakdown. I would be more than happy to ask folks when I get back to do that, but I don't have that information.

REPRESENTATIVE PASHINSKI: That may have been an unfair question, but I certainly wanted to ask it because I'm always intrigued on cost with some of the

things that we have to use in order to make people well and 80-100 dollars seems like a very exorbitant amount of money for one pill.

SPECIAL ASSISTANT TO THE GOVERNOR ANDERSON: Well, I think we have to remember what we're looking at today. I mean, that issue is an issue that runs throughout the health care system. As we know, the cost of pharmaceuticals throughout the United States, who can afford it and who can't and who has drug coverage and who doesn't. The bill doesn't really talk about that. That's a whole separate issue.

We're really talking about a group of people who need to be helped, but they fairly -- a small group of people, they're lucky enough to have insurance that will cover both their IV chemotherapy probably through their medical plan and also a drug plan that covers the particular drug in question. I mean, we could have -- and then we're saying if that happens, we need to equalize the out of pocket cost for those people. What about the folks who have a medical plan and the drug plan, but the drug isn't object formulary and therefore, they can't get it. Or what about the people who have the medical plan and no drug plan? So this isn't an issue at all and forget about the people who have no health insurance whatsoever.

When I looked at the bill -- when we looked at the bill, we said, wouldn't it be great if we didn't have to talk about IV or pill form, but we could just be talking about chemotherapy, regardless of how it's administered. So if it's going to be covered under the medical plan, it would just say chemotherapy treatment would be covered and then we wouldn't have this issue with regard to what form it's going to take.

REPRESENTATIVE PASHINSKI: I understand and I appreciate that very much. It might have been an unfair question. It's the cost. We use the word affordable constantly, and frankly, health care cost hasn't been affordable for the last 15 or more years. So the evidence, the research is now showing that there is waste and inefficiency and some price gaps here.

I think that the points that you make and then what we are all trying desperately to do is to provide all people in our great country with a reasonable health insurance plan so they know that they can get a reasonable amount of procedures when they are sick. And what a difference between the pill and the intravenous, it's just huge.

Are there any limits that we have to deal with in the reality of it all, where we all would be able to have this? It's basically the haves and the

have-nots. But I really appreciate your testimony and I really appreciate the work that I know that you and Rosemary have done over the years, it's just been terrific. And the Governor has been way out front in trying to get Pennsylvania ahead of that curve. So I appreciate it.

SPECIAL ASSISTANT TO THE GOVERNOR ANDERSON: Thank you.

CHAIRMAN DeLUCA: Representative Boyd.

REPRESENTATIVE BOYD: Thank you, Mr. Chairman. Nice to see you, Susan.

SPECIAL ASSISTANT TO THE GOVERNOR ANDERSON: Nice to see you.

REPRESENTATIVE BOYD: The state currently has a number of state-supported health insurance plans, medical assistance, adult basic, CHIP, how do those plans treat this current situation?

SPECIAL ASSISTANT TO THE GOVERNOR ANDERSON: It depends. One of the things that I wanted to do before I came here today was to check to see if this legislation would have any major financial impact on the state programs. So I did contact DPW, I contacted PBTF and the response came back that it would not be affecting them because of the way that the programs worked. So I have to assume that either -- it's either

covered adequately or they don't believe that their insurers are under the legislation.

REPRESENTATIVE BOYD: I think it's an important question -- I'm kind of looking at Mr. McNulty over here from the staff's standpoint -- under adult basic, if someone has adult basic coverage and needs an orally administered chemo product, is it covered under adult basic? I mean, that's kind of -- and then is it covered under medical assistance and, in fact, is it covered under CHIP? And I think that's a really important point. Are we appropriating the same standard to ourselves that we may be expecting the private sector to adhere to? Do we know?

MR. McNULTY: I don't know off the top of my head. We'll have to check. There is contractors who do sell adult basic. CHIP, I don't know the answer to. That's always been viewed as a very rich benefit. So we'll check on that definitely.

REPRESENTATIVE BOYD: Okay. And then, another question, I think it's important at some point to and I'm not sure if it's appropriate to hit Susan with this, it's almost not fair, but --

SPECIAL ASSISTANT TO THE GOVERNOR ANDERSON: I'll just say I don't know.

REPRESENTATIVE BOYD: Actually, you're one

of the few that have ever just said, I don't know, which is very refreshing to be honest with you. One of the other questions is, if this becomes a law, does it imply to those self-insured plans under ERISA and I'm assuming, like other mandates that we've looked at historically, it wouldn't, which really kind of separates out of the loop.

I believe it's over half of the insured lives in Pennsylvania, which is, again, another one of those problems that we run into when we look at doing mandates. I mean, everything we hear and we see and what we're looking at, it seems to make sense, but when you distill it down, it only hits half of the lives. What impact does it have on the hundreds of thousands of people that are on state supported programs?

So while I commend the maker of the bill for where he's going here, I guess the question becomes, are we only hitting this much of the population and then this much of the population and then what's the net impact on that? So it's just something -- maybe not fair to hit you with that, but to get that on the record again, that these are things that we need to be concerned about as this legislation moves forward.

Thank you, Mr. Chairman.

CHAIRMAN DeLUCA: Go ahead, Susan.

SPECIAL ASSISTANT TO THE GOVERNOR ANDERSON: I think that's why I said, apart from that broad category, even the people that we're talking about who may have medical coverage, if they don't have the drug plan, they're out of this. We're talking about a group of people who clearly -- we can't say that we're not going to do this because it's too small of a group, but we're looking at a very small subset of individuals who have cancer and are getting treatment.

REPRESENTATIVE BOYD: Thank you.

CHAIRMAN DeLUCA: Susan, I want to thank you for your testimony. I want to thank you for being supportive of this legislation. As you know, we have been working together. This committee has been working with the Health Care Committee, with you, and Rosemary and we have accomplished, I believe, a lot. Bipartisanly, I want to say that, bipartisanly, and I certainly want to thank you for what you have done, trying to address the public health care issues.

One thing I want to put a plug in, I would hope that you would try to help us move the cancer clinical trial bill that sits over in the Senate. I believe, when we're talking about breakthroughs in treatment for cancer, that we move that piece of legislation. So I would hope --

SPECIAL ASSISTANT TO THE GOVERNOR ANDERSON: I didn't know that it was over there and when I get back, I'll take a look.

CHAIRMAN DeLUCA: It's over there and I bipartisanly supported it and it came out of the House unanimously and I think that's an important piece of legislation to address to try to get the people in the middle-age group into these cancer clinical trials to try to come up with a breakthrough for the future generations. So I would hope that I would be talking to you on that. Maybe we can get you to put a little pressure on them over there. Again, thank you for your testimony.

SPECIAL ASSISTANT TO THE GOVERNOR ANDERSON: Thank you, Representative DeLuca and the Committee.

CHAIRMAN DeLUCA: Next individual to testify is Jane Flenner. She's the RN and a Financial Coordinator. And Nicole Rode, who an RN and an Office Manager for Andrews & Patel Associates.

I have a group back home, Patel, are you familiar with that group back home in western Pennsylvania?

OFFICE MANAGER RODE: No, I'm not, sir.

CHAIRMAN DeLUCA: Okay. Welcome, both of you.

OFFICE MANAGER RODE: Good morning, Mr. Chairman and Members of the House Insurance Committee. We appreciate the opportunity to speak to you today about parity issues that affect patients in need of cancer treatment. My name is Nicole Rode. I am an oncology certified nurse and office manager for the Andrews & Patel oncology practice. With me is Jane Flenner, who is also a registered nurse and the financial counselor.

Andrews & Patel is an eight-member oncology practice with office located in Camp Hill and Harrisburg. Together, our physicians have 151 years of oncology experience. Annually, our practice sees 1,680 new patients, with 11,000 treatment visits, and 16,000 established patient office visits. Out purpose in speaking with you today is to talk about insurance coverage and how it affects patient treatment, quality of life, and very specifically, the difference between coverage for intravenous chemotherapy and oral chemotherapy.

I have worked with the practice for five years as the office manager of our Harrisburg location. Prior to that, I worked in a private oncology practice in Harrisburg for six years as a chemotherapy nurse. In my role as office manager, I am responsible for

staffing, over-seeing daily office functions, and also assisting patients with insurance coverage concerns. In addition, i am responsible for teaching patiens how to use oral chemotherapy, and I help them get coverage for their medications.

Ms. Flenner has worked as a financial counselor in the practice for four years and has been an RN for 44 years, all of which has been in the field of oncology.

In her role as a financial counselor, Jane works directly with patients on coverage issues. It is her responsibility to review the treatment recommendations by our physicians and ascertain what each patient's insurance plan will cover. In today's world, this is a full-time, non-reimbursable position within the practice. Helping patients navigate insurance coverage is definitely part of today's cancer treatment regimen. In fact, Ms. Flenner's work is recognized in the April 15, 2009 article from the New York Times that accompanies our testimony.

For decades, intravenous chemotherapy was a mainstay of cancer treatment. However, in the past six years, some oral medication options have been developed. Oral chemotherapy provides flexibility for the physician and patient, but their health plan coverage presents a

whole new set of problems.

Typically, we find that for most patients, intravenous chemotherapy and oral chemotherapy are covered under completely separate insurance plan sections with different coverage parameters. Like surgery, IV medications are covered within the medical benefit, while oral medications are covered under the pharmaceutical benefit.

From a clinical perspective, IV chemotherapy must be administered within a clinical setting, while oral chemotherapy may be taken by the patient at home. Unfortunately, we are finding that, although oral options are becoming increasingly available, insurance barriers sometimes limit access to their use. When oral chemotherapy is covered under a pharmacy benefit, patients are frequently subjected to co-pays and out-of-pocket expenses that are well above those under the medical benefit.

It is also very important to point out that not all treatment modalities are available for all types of cancer. Some types of cancer have a variety of treatment option, while others have a few or none. There is not always an oral chemotherapy or an IV equivalent available for each cancer situation. This makes it all the more important for the treatment

determination to be made between the physician and the patient, not which plan their chemotherapy is covered. That is why we are here today asking for you to require parity between oral and intravenous chemotherapies. We ae sure that you recognize that anyone facing cancer wants access to what will work best for his or her particular diagnosis.

When available, oral chemotherapy and anti-nausea medications are generally preferred by patients for a variety of reasons. They can be taken at home and do not require the administration of an IV ina doctor's office. This also allows the patient to continue to work without taking time off, which could be with or without pay, to come to the office. Missing work can contribute to a patient's financial burden, and we want to avoid that whenever possible.

Having cancer and receiving treatment can bother be very difficult. If patients do not have to find transportation to our office and do not have to be hooked up to an IV for several hours when they are feeling their sickest, that is a significant benefit to their physical and emotional well-being.

Although our oncologists may prescribe an oral medication as the preferred mode of treatment for some patients, we find that many plans inhibit access to

oral chemo in a way that is not present for intravenous medications.

The best case scenario is this: The physician prescribes an oral oncolytic, the patient and family are taught about the potential and expected side effects of their medication, we dispense the medication from our office, and the patient is able to start his or her treatment that same day. Unfortunately, this is not the usual case. We have been able to provide this kind of service for only six patients in our practice.

The usual scenario is as follows: The physician orders the medication, the patient and family are taught about the medication, we initiate an insurance authorization, which typically can take several days, much paperwork, and numerous telephone calls. This process is frustrating for the patient who does not understand why he or she can't start their life-saving treatment immediately. Once the insurance authorization is obtained, we often discover that the patient must utilize a specialty pharmacy as dictated by their insurance plan. We then need to fax the prescription to the appropriate pharmacy, who then, again, does an insurance investigation.

If the patient cannot afford their co-pay, we then need to assist them in applying to various

co-pay assistance foundations. Many of these medications cost 2,000-10,000 dollars for a 30-day supply. It can take a minimum of two weeks to get approval from these agencies, sometimes longer. It can take another one to two weeks for the patient to receive their medication in the mail form the specialty pharmacy. Most times, this requires someone to sign for the package.

Your committee can greatly assist cancer patients by enacting legislation that would provide parity in the coverage of oral and intravenous cancer medications. No one wants to hear the words "you have cancer." Equally, no one then wants to find out that there is a paperwork process or unaffordable co-pay that will delay or prevent his or her cancer treatment. Cancer is already tough. We need to assure that our patients have access to the care that they need.

Thank you again for the opportunity to speak to you today. We welcome any questions that you may have.

CHAIRMAN DeLUCA: Thank you for your excellent testimony. Representative Boyd.

REPRESENTATIVE BOYD: Thank you, Mr. Chairman. Thank you for your testimony, I appreciate it. I'm going to ask you kind of a tough question. At

the end of your testimony, you went through this process of how you would like to see it work and then the process of how it really works. It's a bit rhetorical, but why do you think the system works the way it does at this point?

OFFICE MANAGER RODE: I honestly don't have an answer to that question, but I could give you what I could assume to be the answer and that would be, I think it's a way that the insurance company is trying to control cost, but I don't know that they're necessarily doing it in the best way and I don't know if they're accomplishing the cost control in this method.

REPRESENTATIVE BOYD: Okay. Good answer, very good answer, because as a consumer, and actually as a small business guy who purchased benefits for my employees and their families, I had insurance companies come in and make proposals to me for my company and for my employees. What do you think was one of the driving forces as to how I would purchase them?

OFFICE MANAGER RODE: I would hope that it would be coverage and then, of course, cost.

REPRESENTATIVE BOYD: They go hand-in-hand. I mean, they do, coverage and cost because, I mean, everybody, and I mean this honestly, I think most employers would love to provide Cadillacs of coverage

for their employees. It's a way to attract good employees, it really is. The issue is, I can't charge Cadillac prices for the products that I sell so there's always this tension in how do I get the best quality product for the best price. What I find insurance companies do, they're negotiating for the most cost effective price, if you will, on a particular medication.

So in the methodology that you described, why is there a disparity between what you would charge for that medication or wherever you would buy it and what the insurance company has negotiated with some other company and that if we could ever get access to the contracts and actually get true transparency -- and I'm looking at my friends from the insurance companies back there -- and find out what those numbers are. I would submit to you that there's great disparity in those numbers.

So the question is, is why. Who's making the money where because it's hidden from the average consumer. So we're really, as a business person providing benefits, I would love if things worked exactly the way you said.

But let me put a little footnote to that. At the best possible price, and that there would be some

sort of a mechanism and some teeth that if we find out that your practice or whoever you're buying your Meds from, are gouging, that there would be some serious consequences to that, so that, ultimately, we're not only getting an efficiency in the system, but we're getting the fairest pricing structures. So how do we accomplish that?

OFFICE MANAGER RODE: I can tell you that our practice -- we may charge a hundred dollars for a particular drug. We're contracted with different insurance companies and they may pay us $75 for that drug. So even though we're charging $100, that's not what we get paid, and a lot of it is based on quantity. So the insurance companies are going with the PBMs because, obviously, they're buying the drug in larger quantities than those of us in a private practice are because they're dispensing thousands more than we are. They're getting a better price because, as you know, when you buy things in quantity, it lowers the cost of it, as with anything in today's world.

So they contract with them and they make you go through this vendor because they may pay them $65 for the drug, they're paying us $75 because their cost is better than ours is the best way I can explain it.

REPRESENTATIVE BOYD: So what you find

happening is, the system, while at this point, is inefficient, that's a kind word. It's focus is to try and get the least cost for that treatment that ultimately gets passed on to the consumer who is buying the insurance product, whether it's a business or whether it's Government. Whether we're the one that's buying. I mean, Governor Rendell had quite an initiative to go after purchasing all Meds by the state and there's a lot of discussion about that whole, why did he want to do that? Because he felt like the state, buying in volume could get the best possible price and then we'll dispense them.

OFFICE MANAGER RODE: We would love to be able to make up the price for medications, but, unfortunately, we pay a certain price for the medication and we need to make sure that we can at least get that price back, if not a little more to pay for our management people who are doing it. And it's just like when you go to a restaurant and buy a steak. They may pay $9 for that steak, but they're not going to charge you $7 for it. They're going to want to get $12 or $15 out of that to cover their cook and wait staff. So I mean, it's a similar situation here, we're just talking about health care.

REPRESENTATIVE BOYD: So as I say that, I

guess, the question still, the proverbial question, which we haven't gotten an answer to is, what's the most efficient way of doing that? And while I agree with you on what we're doing right now isn't efficient, it does have some teeth in terms of trying to reduce the overall cost, although it doesn't seem to be working well at all.

OFFICE MANAGER RODE: And I guess you would have to go to the person who makes up that cost, and that, unfortunately, not the health care providers. We just want to get our patients their treatment.

REPRESENTATIVE BOYD: Understood. Thank you.

CHAIRMAN DeLUCA: Representative Pashinski -- I'm sorry.

FINANCIAL COUNSELOR FLENNER: I just wanted to make a quick comment. When we do this, we really just want the doctor to be able to be the doctor for that patient and treat that patient with the drug that he thinks they need.

If we put you in a chair and give you intravenous, we can make some pretty big bucks. If we order an oral medication, most times we don't make any money at all, in fact, we lose because we're spending my time, they're paying me a full salary and we don't make

any money on it.

One example is, a patient that had lung cancer, he needed Parsiva. It costs $6,000 for a one-month supply. That would have been the best drug for that patient. The physician wouldn't have made any money and the patient would have had pretty good response, probably a two-year survival with good quality of life. But his insurance absolutely refused to pay it. So they put him in a chair and gave him a drug called Olympta, which is intravenous, which is new, which is very expensive, $21,000, twice a month for two years with a lot of side effects and not so good of quality of life. And this was a family member of mine, not even one of our patients. I mean, do the math $6,000 a month for f.

$42,000 a month for two years for an elderly gentleman who would have done better on the oral. These are the kinds of things we see everyday.

I had a young woman recently who had been a nurse in Vietnam, came here and who was a phlebotomist because we don't recognize her credentials. She worked for the hospital, thought she had good medical insurance and she had a prescription plan. She came to us also with lung cancer, a non-smoker and an Asian woman who should respond very, very well to Parsiva. It took us

one full month to get it because when she went to the pharmacy, she had a $700 cap per year and we're giving her one drug, one prescription, for $6,000. So I had to try to get it free for her, which I can't.

There are lots of co-pay insurance companies out there. A lot of these drug companies know these drugs are so expensive and they do donate millions of dollars to the co-pay foundations that Nicole and I tap into and we'll get 7,500 or 10,000 for the year. And after they're through their Medicare donut holes, that pays quite a bit when they're into their five percent. So we get coverage, but it takes two to three weeks while the patient, again, is waiting for their treatments and wondering why they can't get them.

CHAIRMAN DeLUCA: Representative Pashinski.

REPRESENTATIVE PASHINSKI: Thank you very much for your testimony. This is so educational. It always seems as though everything involved, whether it's health care, or energy, or transportation, it's always extremely complicated. Yet, when we bring it back down to human terms, someone is sick, there's ways to treat them, it's available, but you have all of these roadblocks.

I also found it very interesting to find out that, basically, Ms. Flenner, you are involved in trying

to find places that you can help these people. So you are being employed just to do that research and paperwork, which then adds on to the cost. And this comes back to that PBM business, where it's my opinion that PBM, I believe, was just designed to be a pass through. They were there to take the medication, package it, get it to the people and not be able to take a big cut.

From the research I have done, again, seemed to be negotiating prices and as a result that's also been part of the problem. I think the other point that you made, and I would like, again, to make this for the record. The doctor should always have the final say, they are the experts, they should always have the final say.

Is there anything that you could add with all the years of your experience? If there were one or two things that you think -- if you had the power, what would you do to be able to provide these kinds of treatments that are needed, and to do it in the most cost effective way? I say that because the research now is showing that, in the health care system in the United States, between 500 and 800 billion dollars is being wasted, inefficiencies, price gouging, etc. You've been there for a long time. Would you care to offer one or

two things that would make a big difference?

OFFICE MANAGER FLENNER: I think we need to take things back to the community, back to the "mom and pop" operations. The drug companies are out there, we know they have the pattens, they can charge whatever they want for this, and we can't do anything about that.

REPRESENTATIVE PASHINSKI: Why not?

OFFICE MANAGER FLENNER: And most of -- oh, well, you guys can. We can't. We would just love to be able to just have our doctors be the doctors. You talked about my position at the office now. A lot of doctors' offices don't have a me or a Nicole in their office to do this leg work. So they don't even order some to the gold standard treatments for cancer in the United States, like for Multiple Myeloma, and whatever is relevant, it's $10,000.

The drug that Teddy Kennedy took, cost $13,000 for his first treatment with his radiation, which it was a pill. And I had hoped that he would be more public about that, about how much these drugs cost, and what happens to the people that don't have that kind of coverage. But I think if we could just take things back, kind of into the community a little bit -- and, again, they pay me a full salary, but I don't do anything that generates any kind of income because

almost every prescription that I help starting to fight, ends up in a specialty drug pharmacy, being filled and shipped to the patient, not always monitored.

REPRESENTATIVE PASHINSKI: But you are doing a great service to those patients.

OFFICE MANAGER FLENNER: Yes. And I think it's great that our doctors believe it's important enough, just to help the patients.

REPRESENTATIVE PASHINSKI: Yes, they need to be commended, absolutely. I appreciate it very much, thank you.

CHAIRMAN DeLUCA: As I understand what your testimony is, and I understand from the other testifiers, what we're talking about here is quality of life, number one, plus, the fact, by using this oral medication we can save money; is that what I'm hearing?

OFFICE MANAGER FLENNER: I think they could --

CHAIRMAN DeLUCA: So it really doesn't make any sense. If we're trying to drive down health care cost, why should there be an impediment to be enabled to do that? And I think that's what I'm getting from the testifiers that are testifying. It makes no sense when you start looking at the cost.

I understand the cost, it sounds pretty high

for a pill, but also, if you do the other treatment -- and it reminds me of a situation where a fellow had to have a bone marrow transplant and the insurance company wanted him to do it as an inpatient, where it would cost more money. Instead of going to an outpatient in Arkansas, where they did a double bone marrow transplant, and the quality of life would be better. Thank God they did let him go there. It's been ten years now and he is still living to see his children grow up.

I mean some of these things are -- just doesn't make any sense sometimes. I want to thank you for your excellent testimony on this stuff.

I guess the other thing that I would like to say -- and I think Representative Pashinski talked about the cost of some of these pharmaceuticals -- but I image if the -- I know it's high and I know they have the patents, and I would imagine if they're not making the profit margin that they want to make. The research and development would probably not be as great to come up with these type of breakthroughs that could help people, maybe save their lives too. So I want to be fair about it. I think that --

FINANCIAL COORDINATOR FLENNER: One comment, if I could. 42 percent of everything that is in the

pipeline right now for oncology, is going to be oral. So this is just the tip of the ice burg. Right now, I have about 15 drugs we work with, but it's going to get bigger, it's going to be a bigger problem.

OFFICE MANAGER RODE: I would just like to comment on Representative Boyd's earlier question about the medical assistance -- you had a question about the medical assistance and the basic adult, and we do deal with some of those patients at our office. I can tell you from our experience that, most of the time, that is covered under the pharmacy benefit for a co-pay for those patients. Sometimes you have to get the authorization and things like that, but we have found that it is covered.

FINANCIAL COORDINATOR FLENNER: PACE also --

OFFICE MANAGER RODE: PACE is excellent. We love PACE. And just to comment on Medicare. Medicare has it about half right. They cover some oral medications under the medical benefit and I'll are use the lota as an instance because there is an IV equivalent to that. So Medicare's rule is, when there's an oral and an IV equivalent, they will cover it under their medical benefit.

But, as we discussed earlier, there are medications out there that don't have an IV equivalent

and those medications are not covered under Medicare and that has to go through your part D benefit, which is, of course, a whole other ball of wax to get involved in.

So Medicare's almost there. But, of course, we would like to see that go just a little bit further with that, but they have it about half right.

CHAIRMAN DeLUCA: Well, I want to thank you both for your excellent testimony. Thank you very much for taking the time to come out here.

The next individual is Dr. Richard Snyder. He is the Senior Vice President and Chief Medical Officer for Independence Blue Cross. Welcome, Doctor and thank you for coming this morning.

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: Good morning, Chairman DeLuca and distinguished members of the House Insurance Committee. As you indicated my name is Richard Snyder. I am a physician and the Senior Vice President and Chief Medical Officer for Independence Blue Cross.

What I speak of today is, usually or predominantly from my perspective, from looking at it through the Independence Blue Cross lens so that may vary from payer to payer. Independence Blue Cross provides health insurance coverage for over 2.6 million people in Southeastern Pennsylvania and has a

longstanding history of providing individual and group health insurance policies with coverage for chemotherapy as described under the Act. While we understand the good intentions of House Bill 1856 (sic), we believe and have some concern that the unintended impact of the "oncology parity bill" will be to raise the cost of care for our members suffering form cancer and for a variety of reasons that I will describe.

While House Bill 1856 (sic) specifically addresses the member cost sharing features of individual and group health insurance policies, it is important -- as we've been discussing this morning -- to also understand the relationship between medical and pharmacy benefits because they are, in many ways, overlapping regarding to some of those treatments.

Independence provides pharmacy benefits to nearly half of its members through a wholly owned pharmacy benefits management subsidiary named FutureScripts. Members with pharmacy benefits through FutureScripts have access to coverage for oral and some of the related drugs that are used during chemotherapy that are self-injectable. Approximately half of the Independence members have pharmacy benefits through another independent pharmacy benefits management company, or they do not have pharmacy benefits on the

site at all.

The medical benefits defined in our individual and group health insurance policies administered by us provide coverage to members for medically necessary covered services. For certain policies, the benefits are filed with and approved by the Pennsylvania Insurance Department, as you know. The benefit design, however, is selected by the individual or the group customer -- as was discussed earlier -- who's purchasing the coverage from Independence based on their selection criteria, which may include the need for affordability as was discussed. Currently, the member cost sharing features of the individual or group health insurance policy, including the co-payments, deductibles, coinsurance provisions and maximum out-of-pocket limits, vary based on the benefit design selected by our individual or group customer. In addition, those member cost sharing features may vary based on the type of service, the place of service, whether or not the service is being performed by a participating provider, and the subject to general limitations and exclusions of that policy. And to be specific about it, the cost sharing features are often somewhat proportional to the cost of the care or the setting.

Independence provides coverage for chemotherapy subject to medical policy and medical necessity based on the unique clinical circumstances of our members. The medical benefits defined in the individual or group health insurance policy purchased from Independence cover chemotherapy delivered by the provider regardless of the method of delivery. And that's important, regardless of method delivery. So we'll cover the oral or the injectable intravenous chemotherapy in the physician office in the outpatient setting. And I just also want to make clear that the co-payment is frequently the setting co-payment as opposed to the co-payment for the drug in the instance when it's covered under the medical benefit. It's really for the office visit co-pay or the facility co-pay if it's delivered intravenously in an outpatient facility.

However, oral and potentially self-injectable chemotherapeutic -- I'm talking about the drugs used to support people on chemotherapy -- agents can be secured at a pharmacy under the pharmacy benefits, subject, again, to the member cost sharing features of that particular contract, which is separate and distinct from the medical benefit. Pharmacy benefits are distinct including co-payments,

deductibles, coinsurance, depending on the design of that benefit. Some only have co-pay, some have limits, some have coinsurance, they're not all the same, as you know. As noted above, the pharmacy benefit contracts are separate from and cannot coordinate with the medical benefits on member cost sharing features including the co-payments, deductibles, coinsurance provisions and maximum out-of-pocket limits.

Independence does not select or dictate the form of chemotherapy a patient is to receive. That decision is made by the prescribing physician. When a request for prior authorization for chemotherapy is received from the ordering physician, Independence will first determine fi the request is for a covered service under the terms of the individual or group health insurance policy. If the requested service is a covered service, then Independence will determine fi the request is medically necessary. And that typically means, is the service something that is evidence-based and appropriate for the condition, etcetera. Independence will provide coverage under the individual or group health insurance policy for medically necessary covered services subject to the member cost sharing features that we've discussed.

If the ordering physician dispenses a

prescription rather than dispensing the medication in the office for an oral chemotherapeutic agent, then the request will be considered under the pharmacy benefit by the applicable pharmacy benefit management company. In the case of FutureScripts, that would be us. In the case of an employer group customer that has purchased another PBM product, it would be through them. Once again, there is no coordination of member cost sharing between the PBM contract and the medical contract. They're two decreet contracts.

Individual and group health insurance policies have different member cost sharing features by type of service, place of service, and provider of service, for very good reasons. A well intended coordination of equalized member cost sharing features might have the unintended consequencive raising the aggregate member out-of-pocket exposure, somewhat like what was discussed a little bit earlier.

House Bill 1856 (sic), as written, will require significant time and cost to implement the necessary changes to existing claims payment systems and administrative systems within health plans and the processes to administer the proposed benefit structure since this one condition will be managed differently from members with other similar chronic conditions that

are not obviously diagnostic cancer. In some cases the same drug will need to be handled differently when administered to a member with cancer than a member who has another chronic condition for which the drug is being prescribed. Insurance premiums will increase to accommodate these transformational costs because that is, obviously, part of the entire package of health care insurance.

House Bill 1856 (sic) does not define whether "cancer chemotherapy" is inclusive of drugs needed to treat the potential side effects of cancer chemotherapy and some of those were mentioned here earlier. Many of those drugs are also very expensive and administered along with cancer chemotherapy. However, they are used for many unrelated conditions as well. So simply coding the system to adjust the co-payment for the drug for cancer is fairly difficult in a claims payment system and it would require some significant cost and time. If they are intended to be included, this will require additional system and process modifications, further inflating the cost of administering the mandate.

House Bill 1856 (sic) would increase insurance premiums by shifting costs from what were traditionally pharmacy benefit costs into the medical

benefit. Someone alluded earlier that pharmacy benefit management companies, through their large volume of purchase, are able to negotiate substantially lower cost for drugs than a physician office could negotiate. We've had a lot of discussion about that and I think it's on point. I think it's a good discussion and valuable to your insight.

The potential unintended consequence of driving oral medication use from the pharmacy benefit to the medical benefit in the medicare setting, initially for cancer and perhaps later for other conditions, will be to reduce the volume based negotiating power of pharmacy benefit management companies, ultimately leading to increased insurance premiums and increased profits for pharmaceutical manufacturers.

House Bill 1856 (sic), be requiring equal member cost sharing regardless of the method of delivery, will likely increase the cost to the member. Today, the co-payments, deductibles and coinsurance are a reflection of the intensity and cost of services as I mentioned earlier. Inpatient treatment often incorporates the administration of chemotherapy in bundled rates subject to facility based cost sharing, which in the case of a participating facility for us would be minimal to nothing. To require us to add a

co-payment for cancer chemotherapy that's provided in that setting, it would inflate the member's out-of-pocket cost share. Requiring an incremental "equalized" member cost share for the chemotherapy would subject members to co-payments they do not have today. Outpatient facility based intravenous administration of chemotherapy frequently has greater costs and greater member cost sharing than office based intravenous administration or oral administration, that meaning, provision of oral medications by the physicians' office, which we do cover under the medical benefit with no co-pay.

House Bill 1856 (sic), by eliminating higher member cost sharing when care is provided by a non-participating providers could also have an adverse impact or increase use of non-participating providers and would expose members to the higher overall out-of-pocket costs related to the gap between actual charges and the allowable amount that a participating provider has agreed to accept as payment in full.

A classic example would be securing care in New York City where the charges are many times greater than Philadelphia and a participating provider in Philadelphia would agree to accept our allowable as payment in full. If you go to New York City, you would

not only incur the out-of-pocket expenses for the out of network co-pay and that's a different deductible, typically, but, in addition to that, you're responsible for the difference between our allowable and our charges and the physicians will usually charge that difference. So that's a concern as we view it in the way this House Bill is written.

So in summary, there are a number of reasons that I've outlined that I think might have an adverse impact on the total cost of care for the patient and ultimately for the citizens who purchase our products. And with that, I'll close and be open for questions.

CHAIRMAN DeLUCA: Thank you, Doctor. Representative Roae.

REPRESENTATIVE ROAE: Thank you, Mr. Chairman and thank you for your testimony. If I heard you correctly, I think you said that about half of your customers that have medical insurance through you also have prescription drug coverage through a subsidiary for your company.

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: That's correct.

REPRESENTATIVE ROAE: And then under House Bill 1865, the insurance company has coverage for the intravenous application and an oral applications, things

would have to be treated equally, like, the deductibles, co-pays and so on. How do you guys currently do that for customers that have both?

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: There is no coordination of out-of-pocket cost because that's a completely elective separate decision to buy the pharmacy benefits through our PBM. So our systems are separate. We don't bring those dollars together to help create an out-of-pocket maximum for a member.

REPRESENTATIVE ROAE: Just for the sake of argument, for your customers who have both Blue Cross and through the subsidiary that has the drug coverage, if less was getting paid out in cost from the drug coverage, but more was paid out for the medical part, it would kind of be a wash, wouldn't it as far as --

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: Theoretically, and that's typically reflected in the premiums. The premiums get adjusted based on the experience for the product.

REPRESENTATIVE ROAE: So wouldn't it make sense for the customers who have both, medical coverage and the drug coverage through Independence Blue Cross and the subsidiary that does the drug coverage, wouldn't it make sense if the deductibles and co-pays and things

like that, were equal?

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: That would be a question for the insurance department because they approve the product as we send it. So if you're adding something else to the formula, that might change the approval process and the ultimate outcome of the submitted set of benefits to the insurance department.

I mean, what you're asking is to expand the scope of the benefits that we submitted for approval to include or incorporate the pharmacy benefits, which are not typically provided through the medical benefits.

REPRESENTATIVE ROAE: I guess my point is, instead of paying it out of your left pocket, you're paying it out of your right pocket. It seems like the customers -- the patients should be treated equally.

I can see where if it's some other totally unrelated organization that's offering the drug coverage, you have to shift the cost from that other company to your company. I can see the concerns with that. But for half of your customers, where you have both, it just seems like -- things like deductibles and co-pays and things like that, should be on an equal basis.

SENIOR VICE PRESIDENT & CHIEF MEDICAL

OFFICER SNYDER: Except that we offer many different benefit packages on the medical side and many different packages on the pharmacy benefits side. The purchaser is the one who makes that decision, we don't. If we were forced to marry them so that the co-pay -- we would only sell combinations where it's the same. That's probably not what our customers are asking for. Customers want choice.

REPRESENTATIVE ROAE: One other question. Several other people have testified today that oral medications tend to be significantly less expensive than the intravenous application method. Have you guys seen the same thing?

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: That's a complicated question because there are inexpensive intravenous drugs and expensive intravenous drugs, and there are inexpensive and expensive oral drugs. So it really varies depending on the diagnosis and the prescribed medication.

REPRESENTATIVE ROAE: It seems like if there's a way to treat somebody for $36,000 a year or $100,000 a year, it seems like the $36,000 would be the best thing. In the long term, it seems like that would keep premiums down if you're paying out less in your

cost in the care that you're providing. I just hope it's something that gets looked at by all insurance companies and all doctors to give good treatment, but also affordable treatment that can help keep the cost down.

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: I can assure you that my full-time job is to manage this and to provide the services that are prescribed by the physician at the lowest possible cost. The discussion that we had earlier about the relative cost of buying something through PBM or through a specialty pharmacy versus in a physicians' offices all relates to buying power. We're looking for ways to create greater buying power for our customers.

And yes, you're right. If we are given a choice by a physician to pay for and they're equally willing to prescribe the $100,000 or the $36,000 drug and they're equal in outcomes, we're going to go with the least expensive drug, whatever they prefer. They're writing the script.

REPRESENTATIVE ROAE: That concludes my questions and thank you for your answers.

CHAIRMAN DeLUCA: Representative Godshall.

REPRESENTATIVE GODSHALL: Doctor, what percentage of new oral drugs are also IV -- I mean, get

through IV?

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: I think increasingly, I mean, you've heard a couple of answers this morning. I think the one comment was 42 percent of the drugs in the pipeline, which aren't yet available, are oral. But in my view, more of the newer drugs -- and I don't know an exact percentage -- are, in fact, available orally.

REPRESENTATIVE GODSHALL: A lot of new cancer treatments are really oral rather than -- I mean, I, myself, am taking an oral drug, rather than an IV, which I've taken before. But everything that I read, basically, it's the oral stuff that's coming around that are all the new drugs.

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: Yes, there are some concerns about that too. From the physician perspective, you're certain that the drug was inserted in the vein than if you put it in yourself.

They're a number of studies that, both in cancer and other diagnoses, that have serious consequences if you don't take the medication that the adherence rates, people staying on the medication, drops off significantly after the first year. I'm well aware because I chaired and lead some research in the cardiac

arena where, at the end of the first year, in spite of the fact that the drug is life saving, the percentage of patients who remain on the drug is about 40 percent for the major categories of cardiac drugs.

In cancer, the numbers are a little bit higher after a year, but they're in the 70-80 percent range, which means that a significant proportion of people either are not taking them because they can't secure them, can't pay for them, or perhaps don't understand the severity or maybe don't like the side effects of the medication.

REPRESENTATIVE GODSHALL: Thank you. I would just like to say, I know the oral is a lot easier than the IV. It is a lot easier on the person. It is a lot easier than running to the hospital about everyday. And everything that I read, everything is coming through in oral. Thank you.

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: I would agree. One final comment. Even on the PBM's side, we talked about the 80-100 dollar a day drugs, whether the drug is $10,000 or $15,000 a month, the PBM co-pays are very, very low by comparison, on the 30-40 dollar per month range, for most of our PBM products. So that's a very low cost for a very expensive drug.

CHAIRMAN DeLUCA: Representative Barbin.

REPRESENTATIVE BARBIN: Thank you, Mr. Chairman. Thank you, Dr. Snyder, for your testimony. I would commend you for your policy, which is that if a person comes into the doctor's office and receives the oral enclitic in the office, that that would be covered and I understand that that's being covered under the medical portion of the --

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: It is at the moment. Like someone also mentioned specialty pharmacy, if we could package those purchases and secure them at a lower cost with a drop ship program, where they would be sent to the patient's home, that would be a consideration. For the moment, at least, we have a method of doing it, reimbursing the office.

REPRESENTATIVE BARBIN: And I also read the statement that was provided to Chairman DeLuca and Chairman Micozzie. One of the issues that was raised in that statement was that you were afraid with this bill of language that the benefit that was provided -- if you were required to have all oral enclitics provided, if they were prescribed as well as the IV treatments, that it could have unintended consequences for other medical benefit, pharmacy benefit diseases or prevention

treatments.

The problem that I, having heard all of the testimony this morning, is the fact that, to me, as a lament, if you go to see a doctor and the doctor says, you have cancer and he gives you a list of options of things that you can do. You can have surgery; you can radiation; you can have oncological treatment; that's the doctor's decision to somehow separate the benefits as to, it's either in a medical benefit or a pharmacy benefit, seems to defeat the whole purpose of going to see the doctor in the first place.

If other states are providing this type of benefit and they found that they can do it within the regulation of the state, the question is, why shouldn't we? And the testimony we heard this morning was, there are as many cost savings by allowing the patient to have the pill at home as there are reasons to believe that administrative cost would be increased.

So I would ask for this one simple thing. If it's really about how other benefits might be impacted with unintended consequences, then I would ask for your insurance company to take a look at the language that we could include in 1865 to say that, from now on in Pennsylvania, a pill form of an enclitic is not to be covered under the pharmacy benefit, but should

be the covered under all medical policies. If it's covered under all medical policies, then at least your company is already doing that.

The only difference that I can see between what you're doing and what the public is asking us to do is to make sure they can take it at home. Now, if the doctor says that if this person takes this pill at home, he's going to have a better outcome and he's going to save money, we should be doing that.

We should be able to find language that allows you to not worry about this extension of unintended consequences that allows us to lower health care costs by having the drug taken at home for as long a period is safe to make sure that pill is still being taken, that it may be a requirement that the person come in once a month or every two months to make sure that he's still taking that pill so that the outcome that can be expected is what he was looking by prescribing it. But it's a medical benefit and to me the answer is this bill maybe with some addition language that just said this really is a medical benefit.

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: I certainly respect your opinion. The thing that I think I just want to remind us of is, PBM is typically buying billions, potentially, of dollars of

medications and in that buying power, is able to negotiate far better rates than the physician's office, where we might be paying for the drug today. To play that out, I believe the number of $65 or $75 was thrown out. Our PBM maybe able to provide an $80 drug for $65.

If the physician can buy it at $75 because they're a large practice, that $10 dollar delta multiplied by tens of thousands of pills over time is going to drive the cost of health care up. If you move that cost from the PBM to the medical benefit -- I mean, realistically, I understand what you're trying to accomplish, but you're not going to have enough mass in an insurance company to get the same kind of buying power as PBM does because the PBM is agnostic as to what drug you're buying. If their talking to a particular pharmaceutical company, it's about the total spend with that company. I know that because we do that with our PBM. So we'll tell them, look, we're buying $2 million worth of your drugs. We think we want another point off or another two points off if we're adding this oral chemotherapy drug --

REPRESENTATIVE BARBIN: Isn't it fair to say, though, on one hand, you have a medical company over here and on the other hand you have a pharmacy company other here and both of those company's provide

surpluses, the equivalent of profit in a business context? Isn't it fair to say that both of those surpluses go to the same surplus that's the parent company, Independent Blue Cross, don't they go to the same place?

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: I can tell you that all of the profits from the deals that we do with the purchasing power, come back to the insurance company in our case. That is not true when patients buy those services on the market from a different independent Pharmacy Benefits Management company.

REPRESENTATIVE BARBIN: I have one final question, and that is, there is language that is proposed by the American -- by the Community Oncology Alliance would suggest that in addition to the language in 1865 that additional language be included to make sure that if such a merger of benefits would go just into the medical benefit grouping, that there be a limitation to make sure that the intravenous drugs don't go up in price to make up for the fact that there has been a loss in the oral price of the drugs. Do you have an opinion on that provision being provided in this legislation as an amendment?

SENIOR VICE PRESIDENT & CHIEF MEDICAL

OFFICER SNYDER: I would like you to explain maybe a little better because I fully don't understand.

REPRESENTATIVE BARBIN: The language says, and this goes to the origin example that Susan Anderson testified to previously this morning. It says that a patient's out-of-pocket cost related to coverage for an orally administrated -- administered chemotherapy, shall be on a basis no less favorable than coverage provided for intravenously administered injected chemotherapy.

A health insurance insurer cannot achieve compliance with this section, or 1865, by imposing an increase in patient out-of-pocket cost with respect to intravenously administered injected chemotherapy agents covered under the policy on the effective day of the Act.

To me, that means, is that if we were to require 1865 as a requirement, an insurance company -- no insurance company in Pennsylvania would be allowed to raise IV prices to make up for an additional cost that they might have for the oral pill. What would your position be on this provision being included?

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: The way you just described, I don't see it really impacting us. I would be more worried about the cost, today, the purchase of the drug, is a

transaction between the insurance company and the provider's office, the member doesn't really have a co-pay for the drug in that setting.

So if you're asking for equal treatment, then we're going to have to come up presumably some average cost that they are going to have to pay out-of-pocket as a co-pay if they're getting the pill or if they're getting the IV is the way I understand it. And if you equalize that, it seems to me that that's going to harm the patient, especially with more of the drugs being oral.

REPRESENTATIVE BARBIN: What this says is that the if the law passed tomorrow, it would be the policy of the Commonwealth not to allow for an immediate increase in IV cost because of this additional cost that would be related.

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: Let me explain my position. If today, the medication is administered in the physician's office in a pill form, the co-payment would be the visit co-payment, which is nominal. If the drug is prescribed in a facility, it might be the physician's office or it might be an outpatient hospital setting, or another setting. There is a potential, not all benefits have this, but there would be a co-pay and it would be higher

because it's somewhat proportional to the cost of the service that you're securing. And what I believe the bill would require us to do is to come up with a number that's somewhere between zero and the co-pay for the facility setting, whether it's administered orally or intravenously.

REPRESENTATIVE BARBIN: This language would say, it wouldn't matter --

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: I understand that.

REPRESENTATIVE BARBIN: So what it says is, you would not be allowed to raise those out-of-pocket costs because there would be the immediate exception that you would be recovering something that we're trying to produce.

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: Let me try to explain my position. For the sake of numbers, I'm going to make it real easy for me and myself here. If the co-pay in a facility is $200 to get the intravenous drug, and the physician co-pay is $25, what I believe the bill is mandating is that we have to find a number somewhere in between that's cost mutual for the system, but is an average. So you're asking me to increase the co-pay on the oral medications to $112.

REPRESENTATIVE BARBIN: What I was asking you was, if we went ahead with the bill and if we were going to approach it, just to make sure that there aren't any immediate increases to make up for additional cost or your perceived additional cost under having the pills done at home, there would be no increase. It's not an average cost. You could charge what you charged before, you just couldn't charge anymore. And my question was, if that was also included in this law, would you be in favor of that or not favor of that?

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: I'm not sure if I can answer that question because I don't know --

REPRESENTATIVE BARBIN: I would be happy to talk to you after the hearing to straighten it out.

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: Do you understand my perspective when we talk about equalize co-pays or co-payments? I am concerned. I don't want to have to charge the patient what I'm not charging today for an oral medication. We don't want to increase that. We don't want to make it more of a barrier than it is today.

REPRESENTATIVE BARBIN: Thank you, Mr. Chairman.

CHAIRMAN DeLUCA: Representative Pashinski.

REPRESENTATIVE PASHINSKI: Thank you very much. PBM's -- let's go back to that. How many PBMs are there in Pennsylvania?

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: I have no idea.

REPRESENTATIVE PASHINSKI: Do you have your own exclusive PBM?

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: We also use that PBM to sell to other -- on a self-funded basis to other organizations that want to buy services from us, although, predominately, it serves our members.

REPRESENTATIVE PASHINSKI: So is it fair to say that you don't really negotiate with any other PBMs? You select a PBM that you feel is good for your company and they do the bargaining for you?

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: They help us to negotiate rates or the drug purchases that are administered under that pharmacy benefit, yes.

REPRESENTATIVE PASHINSKI: Okay. What is your cost/lost ratio?

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: On the pharmacy benefits side?

REPRESENTATIVE PASHINSKI: Well, you can do

a total or however you want to do it.

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: Well, they're separate, I'm not sure. On the pharmacy benefit side, there really aren't profits. The savings are approved back to the health plan because that's the way we had structured it. We wanted to maximize the benefit for our members.

On the medical side, we have a lot of different products and they all have their own medical cost ratio, but the medical cost ratio for our products runs 89-91 percent -- 92 percent on at least one product.

REPRESENTATIVE PASHINSKI: Very good.

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: That was easy.

REPRESENTATIVE PASHINSKI: Thank you.

CHAIRMAN DeLUCA: Doctor, I want to thank you for your testimony -- Representative Burns.

REPRESENTATIVE BURNS: I just have one quick question. You said in your earlier testimony that the oral treatments would actually have a cost savings to it when it's in the pharmacy -- when they received the pills in the pharmacy; is that what we were told earlier?

SENIOR VICE PRESIDENT & CHIEF MEDICAL

OFFICER SNYDER: Compared to the physician's office or compared to the IV?

REPRESENTATIVE BURNS: Yes.

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: I would think if there are both options that usually the oral administration would be less expensive because you don't have the related costs of the people, the time, the equipment that deliver the medications.

REPRESENTATIVE BURNS: So the insurance companies cover that -- your insurance company covers that as a medical benefit?

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: Yes.

REPRESENTATIVE BURNS: However, not in the pharmacies, you don't cover that?

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: Yes, we do. In other words, if you were to come to us and buy a medical policy and a pharmacy benefits policy, if your physician were to dispense it in the office, you would get covered under the medical benefit with no co-payment. If they ask you to go to the pharmacy because they don't dispense in the office for whatever reason, it would be covered under the pharmacy benefit, subject as a small co-pay relative

to the cost and --

REPRESENTATIVE BURNS: So it's more expensive for you, as a company, to cover it as a medical benefit, but it's covered in the doctors' office; however, it's more expensive for the patient when they go to the pharmacy if it's not dispensed at the doctors' office?

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: Yes. There is a modest co-payment, not any significant portion to the cost of the drug that is administered in the pharmacy because they are separate contracts, they stand alone. So a patient can come to us and buy just pharmacy benefits and the cost of the benefits needs to support the average use by all the people who purchased that product. On the medical side, the same is true.

REPRESENTATIVE BURNS: So when you talked about customer choice out there, you were saying that the price would go up, should this bill be enacted, your cost would have to be passed off to the consumers?

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: To administer the different --

REPRESENTATIVE BURNS: For them to be able to get their medicine at the pharmacy and take it at home.

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: Well, they do that today. That's not a change. That doesn't drive cost. It's when we have to treat a class of drugs differently for one diagnosis than for other diagnoses, that requires coating in the system so -- I mean, today, a very large proportion of the claims go right through the system without human intervention. But it doesn't do so without significant planning and voting and testing and so forth. That's what I'm talking about, those kinds of costs.

REPRESENTATIVE BURNS: So the insurance companies would have less of a medical benefit cost if these were going to the pharmacies instead of being administered in the offices themselves.

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: Yes, that would be true.

REPRESENTATIVE BURNS: So you would be saving money there and then the cost of your pharmacy benefits would then rise for the patients because you have the out of cost. But wouldn't that just -- you, as a company, wouldn't that just wash -- can't you use the profits that you've made from your medical benefits from the savings and sort of cut a break to the people at the pharmacy side? So can't you weigh that out as a company?

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: There are laws about passing money back and forth between companies but --

REPRESENTATIVE BURNS: I'm not saying pass it back and forth, but can't you weigh your profit margins between the two --

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: And we do. At the day, we look at the global cost of care and we work very hard. You can't imagine how hard we work to get our premiums down, and they're not going down, they're going up. We just try to modify the weight of rise.

I'm sure most, if not all, insurance companies are exactly in the same position. To continue to support your customers, you must make a major effort to control medical costs.

In the end, to the degree that we can buy the drugs at a larger volume and at a lesser price in the PBM's site, it lowers the total cost of care for the patient. But if you don't have form pharmacy benefits with us and the law requires all the costs to come back to the medical side, it will unequivocally raise the cost of the premium just because it's all going to be there. Do you understand?

REPRESENTATIVE BURNS: Yes, thank you.

CHAIRMAN DeLUCA: Doctor, I really want to thank you for your testimony, but let me just understand -- I think I got some of it. When you suggest in your testimony, are you suggesting that House Bill 1865 should be expanded of other chronic diseases?

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: No. That would exacerbate the buying power issue that I talked about.

CHAIRMAN DeLUCA: So that would increase --

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: It's got to be all or none, I would think. I mean, the poor patient with a very expensive rare disease is going to want to be treated the same way as someone with cancer. And I would argue that a poor family with a couple of children with asthma are going to want to same kind of treatment. So where do you stop?

CHAIRMAN DeLUCA: Let me ask you about the fact -- I think I heard some of your testimony. I got some of it. Can you address the fact that on House Bill 1865, can you make any suggestions to address the cost issue? Is there amendments that we should be looking at on some way on how to amend the bill to address your cost issue that you raised in your testimony there?

SENIOR VICE PRESIDENT & CHIEF MEDICAL

OFFICER SNYDER: In terms of the cost shifting between pharmacy benefits and -- it gets very mottled. And you were talking earlier about -- actually, I think it was Representative Boyd -- was talking about the different kinds of insurances, the subsidized products, self-funded products, yet the traditional Medicare that's in there, the Medicare advantage products, and it is hard to design something that's going to work for everyone because of the many different organizations that these products are subject to.

We absolutely believe that we want to have cost effective care and the right care, at the right time in the right setting, we will not disagree with you. I am concerned that, as from my testimony, this one bill could drive up cost, even with its good intentions.

CHAIRMAN DeLUCA: And the other thing that I heard in your testimony is about the medical necessity. I think you mentioned medical necessity in part of your testimony there. Who makes those decisions? I mean, do you have -- especially in the oncology situations -- do you have somebody on there that has that expertise that says that they can make that type of decision whether that doctor, who's requesting that treatment, which might be denied? Do you have these oncologists on the

staff to make them decisions, or who makes these decisions because that's been a sticky point and a lot of this stuff of coverage is medically necessity and who decides what's medically -- and actually, when you start deciding, sometimes you take that away from the physician because whoever the group is that's doing that, makes the decisions is denied and then we have to -- and then the individuals have to appeal it. And after three or four appeals, insurance companies relinquish and pay it and permit you to have that procedure and that adds up cost.

So is there somebody who -- I don't know how the boards are made up and -- how does somebody with this type of illness, sickness -- do you have somebody that specializes in -- because I have talked to other physicians, surgeons, and even though there are physicians out there, the oncologist is the one who really has to make that decision. I can't make that decision. So I mean, do you have people on the board that do that, a specialist or something?

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: It's a fairly complicated process. I'm happy to walk through it, but I'll start at a high level and then you can ask if you have additional questions.

For both -- was what described earlier as

pipeline drugs that are not yet available on the market and for new drugs as they come on the market -- we develop medical policies that speak to what conditions they are appropriate, what dosages, etcetera. And those are based on all the public research on the drugs. Those are based on the randomized control trials on the drug, the FDA's indications for the drug and for the dosage of the drug, etcetera, they're based on a review of policies from other federal and state organizations.

We draft those policies and then send them out to independent oncologists in a case of cancer care that are not employed but Independence Blue Cross. We don't pick them necessarily. We may send them to an organization that incoordinates that for us so we don't adversely influence the outcome.

And when we get a final policy that's been embedded through specialists in the same specialty that would ordinarily prescribe that care, then we circulate it to, in this case, in Pennsylvania. It's a Pennsylvania medical society and they have an opportunity to review the medical policy and to an independent physician advisory committee that we have established with multistate physicians on it, to get their opinion.

So it's a vetting process and once the dust

settles and we have a policy that has been reviewed by the appropriate specialties, then we start to apply the criteria within that policy against the requests that are coming in.

As you know, or may not know, Independence Blue Cross covers the routine costs associated with clinical trials, for example. And so we do get -- and we have a lot of institutions in Philadelphia who are involved in randomize clinical trials. We think that's really important. And the reason it's important is, it helps to build the evidence upon which we can rationally make decisions about what care ought to be provided.

There are quite a few physicians who read about something and who want to try it and want to do it outside of the context of a randomized clinical trial, and we don't believe that's appropriate because if something goes wrong, it's not going to be reported as part of a collected body of evidence and it's not going to be -- it's not going to guide us in the future. So that's why we've aggressively moved towards supporting the routine costs associated with clinical trials.

So when I say medical necessity, what I'm really talking about there is not that the person does or doesn't have a bad diagnosis, it's more about because the body of evidence, as viewed by specialists in the

field, suggest that their requested treatment is going to be the right treatment for that patient. Even in that arena, we're not saying, you have to try drug A before you can go to B. That's not what I'm talking about. It's really, we make a decision based on what's requested. We don't tell people to try something different.

CHAIRMAN DeLUCA: And I appreciate that. When we talk about this stuff, we're not talking about Independence Blue Cross, we're talking about your industries, as a whole. We're trying to get all of the information on all of the industries.

On the cost, how about just the traditional coverage where a patient has a major medical -- a pharmaceutical benefit in separate related companies, like IBC situations on cost. We talk about cost right there --

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: You know, for us, the traditional business -- a lot of our indemnity membership, we're a hospital corporation. We manage the hospital cost, the facility cost, and High Mark Blue Shield is the professional side of that equation. So in those instances, they would be the one receiving the request from the physician for outpatient treatment. And I

can't speak for them, but -- well, you could probably ask me to but --

CHAIRMAN DeLUCA: The only thing -- I appreciate your canter in that and the fact is, I guess, when we start talking about -- and I think your company and the rest of the company certainly have an interest in trying to drive down these costs because the fact is, as more and more people become uninsured, people are not going to be able to pay your premiums. And if people don't pay your premiums, you have to layoff people and you can't provide that.

So it affects everybody, the doctors, everybody else because people can't afford the out-of-pocket expenses that are going on in the health care. So we need to drive down the health care. I want to thank you for your excellent testimony.

SENIOR VICE PRESIDENT & CHIEF MEDICAL OFFICER SNYDER: Thank you.

CHAIRMAN DeLUCA: The next individual to testify is Mary Kruczynski, who is the Director of Policy for Community Oncology Alliance.

DIRECTOR OF POLICY KRUCZYNSKI: Well, it's now afternoon and I have to say it's a pleasure to have everyone in front of me. It's not like Washington D.C. where you have to chace your members of congress down

the hall and stop them at the entrances to get a word in with them.

CHAIRMAN DeLUCA: You don't have to do that in the State Government, especially in Pennsylvania.

DIRECTOR OF POLICY KRUCZYNSKI: I can see that. I did prepare written testimony, which, certainly, you all have before you, but I thought it might be easier to speak to slides just to give you a little education on what you're trying to understand.

First a little bit about me and who I represent, Community Oncology, where 80 percent of cancer care is delivered. Most people don't know that. You assume that we go to the Hershey Medical Center, not that it's not a --

CHAIRMAN DeLUCA: And Penn State Hershey Medical Center.

DIRECTOR OF POLICY KRUCZYNSKI: Yes. But 80 percent of care is delivered in the community setting as testified by Jane Flenner and her manager. It's good for you to know. A lot of questions have come up during all these testimonies and I felt like a little kid in the front of the room raising my hand and saying, pick me, pick me because I knew a lot of these answer and it would be nice to have an open --

REPRESENTATIVE BOYLE: Someone saw you

nodding, so we can verify that.

DIRECTOR OF POLICY KRUCZYNSKI: We could really have an open forum here and have a discussion. You would get a lot more answers to your questions. 37 different agents available today -- that was a question that we weren't really sure about. Remember that there are only about eight of them -- eight equivalent infusible agents. So there aren't really many choices when a doctor prescribes an oral enclitic. If they prescribe an oral enclitic, you have to take the oral enclitic. They're mostly single molecules, they're targeted therapies and they're for one thing and that's what it means.

Now, there's a lot of challenges. I've heard a lot of talk about cost and the cost of the drug and how much more would it cost, PBMs, and they bargain for drugs, and they get volume, but everybody's forgetting what's really more important is, A, the patient. This is what it's about, is the patient. And when the physician treats the patient, really, if you could take drugs out of the equation, we would really be very happy because we don't want to be in the drug business. We were forced to be in the drug business when we moved oncology out of the hospital setting.

We spend a lot of time with patients who

have oral therapies prescribed to them as Jane described. It's a very, very long and arduous task to get a drug to a patient and to manage a patient who you are not actually seeing take the medication as the doctor tested to perform in. When you put an IV in somebody's arm, you know if they're going to have a side effect, you know if they got all of their medication, you know what they've been taught what to look for when they go home. When you give somebody a prescription for a pill and you don't see them anymore, you have no idea what happens until they present in your office or in the emergency room in a very bad state.

All of the services that go with oral drugs are not paid. So simply moving a drug from point A to point B, isn't going to solve the bigger problem of taking care of patients under oral medications.

Here's an example of an oral drug and the amount of leg work. This slide was actually provided by Dr. Therese Mulvey and she actually testified with me up on Capitol Hill last month on this very same topic. This is a drug that has a restricted distribution, which means that you can only get it in certain places. You can't go to the Walgreens or to CVS to get it. You have to be in-serviced because it has RENS.

A RENS is a Risk Evaluation Navigation

Strategy. It's put out by the FDA, now the FDAAA and you have to comply with this before you can even give the drug to your patient.

So you're spending at least two to two and a half hours just to get through the paperwork and the inservice, for which you get nothing, by the way. And a nurse that gets 25-35 dollars an hour makes it quite challenging for the office.

You see here, average time to get drug to patient, two to seven days. Average co-pay per month, $1400, that is nothing to sneeze at, I assure you. In fact, I've had the pleasure of going into Anderson and Patel's office about a year ago to take a look at their inpatient pharmacy and to meet some of their patients who were on new orals, who had to get their drugs through a PBM because their insurance company wouldn't allow them to get them there. The horror stories are incredible, drugs being delivered to the wrong house, drugs being sat in a mailbox or on a doorstep in the 90 degree sun, coming on a day that you don't even know that they're coming, not coming at all. There's a lot more to this than simply saying, we have to give the patients the ability to get their drug, regardless of whether it's an oral or an infusible, although that is certainly very important.

37 oral enclitics and one drug for -- I'm not sure how you say it. That's what's on the market today. That's a lot of drugs, they're the diseases. There's going to be, I would venture to say, three years from now, three times that. So we need to get a handle on this issue, we need to get a handle on it now. And that's why we're here today and I applaud you for introducing this legislation.

You asked about parity and how many states had parity. Here's a map of the United States. It changes, literally, day-to-day now. Since the beginning of February, so many states have introduced legislation, as you can see from the lovely lilac color that appears there. There's so much legislation in play from state to state that this, obviously, is an issue of paramount importance, otherwise, you would not see what you see on this map. I happen to be a Pennsylvania resident, so I'm very happy to know that we're addressing this, which is why I decided I think it's important that I come here today. So that if someday I need this drug, and one in two men and one and three women will have cancer in their lifetime. Pretty grim statistics, people. So think about yourselves and your own access.

I thought this was rather interesting. I try and do my homework before I speak to people about

something and looking back in history, this is one of the reasons that I talked to Jerry Levinsky was there was a bill in 1989, where this particular house looked at parity and they were looking at parity, regardless of the setting because some payers were not paying for chemotherapy delivered in certain setting and you thought that was wrong. And it was unanimously voted that that should exist, that there should be parity.

Now, today, we're looking at parity on another claim. We're looking at parity for formulation of medication. I thought that was quite interesting. And somebody asked about well, if we pass these laws state to state, what happens to ERISA, what happens to the Medicare patients? Nothing. That's why Congressman Higgins has put out a bill, actually, he put it out in May of '09. It's in the 11th congress, but it really didn't go anywhere and now we're in the second session. The reason that it didn't go anywhere is because health care reform, as you know, is changing by the minute, literally, by the minute.

If we'll just have a strong arm of a few more people, we'll have a health care reform bill. Somebody in Ohio just caved. But I have to tell you that I spoke with the Congressmen and alleged Counsel and we are talking about reintroducing this bill

because, you're right, what is one good without the other? And he told me very clearly that he certainly doesn't have jurisdiction over the states. They will create their own legislation; however, the movement from all of the states has really short up the ask and given them the momentum to move forward on a national level so that, in fact, we will have true parity in the United States. I'm very hopeful that we will see that in a couple of more sessions of Congress.

Now, Community Oncology Alliance knows that the statistics, they know the problems with orals, they know how many are coming to market, so we tried to get on the front end of this and try to be proactive, rather than reactive. So we decided to pull together a project in research to try and go out into the field to see what the climate is, look at potential solutions, work written various stakeholders. We did talk to insurance companies, with talked to PBMs, we talked to doctors, nurses, patients, foundations, medical directors. So we got a lot of different stakeholder opinions.

What was very interesting is that everybody had a different take on orals. Everybody had a different perspective. Everybody wondered well, what's the big deal if you write a prescript? What's up with that? I said, well, when a physician writes a

prescription, he has to look at the patient first and he has to say, can I trust this patient to be compliant? Will they take their five pill everyday and not mix it with grapefruit juice. Can they afford their drugs? Will they take it routinely? How many other medications are they on? What are the other drug interactions? I have to teach the patient, and does the patient got dementia? Will they even understand when to call the doctor? There's so many implications.

Sometimes, even though an oral might be the best choice for the patient's disease, it's not the best choice for the patient and vice versa. One of the people on our committee is a nurse practitioner out in Arizona. A lot of her patients surround an Indian reservation. She chooses orals, not always because of the optimal treatment, but because they're the only treatment available for that subset of patients. And sometimes the patient is given the choice, and there are not always a lot of choices, as you heard, not too many comparable, infusible, and orals.

A patient likes coming to an office when they have cancer. They want to make sure that they are doing everything that they can for their disease. They like the reassurance of the nurse and the doctor saying, you're doing really well, knowing that their lab values

are the same. They like having their studies done to make sure that the tumor isn't growing, that it's shrinking.

When you take an oral drug, you still need all of those things and currently all of the work that oncology and Community Oncology and all oncology does for cancer patients on oral therapies are not reimbursed. You are seeing offices closing all over the United States and I do have statistics on that if you are interested. So it's an even bigger problem than perhaps you realized.

The administrative burden is incredible. Every practice cannot afford to have some type of individual doing financial counselling, making an application to co-pay assistance funds and foundations because more often than not, the patient cannot afford their oral chemotherapy. Here's an example of a part D coverage for oral enclitics. It was in '09, so only a few months ago. We picked some key drugs, some key oral drugs, they're on everybody's formulary, look at what tier they're on, tier 4. The higher the tier, the bigger your out-of-pocket. I would venture to say that most cancer drugs are on the highest tiers, which correlates to a high out-of-pocket. The IBC plan that Dr. Snyder referred to was just one of a billion and

maybe that particular one, that patient has a minuscule co-pay, but I can assure you that the majority of patients today have a huge co-pay.

They have prior authorization. Patients don't get their own prior authorization, but the providers do. I can't even begin to tell you the aggravation that you go through to get a drug approved for a patient. One of you used the term, "roadblock," good term.

Quantity limits: Patient has to get these drugs usually -- and you really don't want to give a patient a six-month supply of a cancer drug, a little dangerous. It's like taking poison -- but by giving them 30-day limits and having them come back to the office so you can manage them, is a smart thing. When you get a PBM involved and a third party, they ship out the drug, even if you said, you know what, we need to hold back a little bit, your lab values aren't good. Maybe this isn't the right drug for you, maybe we just need to stop. But the PBM's, who have no communication with the prescriber, the one who is medically -- legally liable for that life, call on the phone and say, hi, Mary, it's time for you to renew your medication. And Mary says, well, I just came from the doctor and he said, oh, no, that's not a good thing. Oh, no, you have

to take your medication. The patient is confused. They don't even listen to you when you have a third-party PBM there. And I will tell you the disasters that occur also have been documented because of that.

Primary cost sharing rates: 25-35 percent of an expensive cancer drug is a huge out-of-pocket. If you're a Medicare beneficiary, forget that. Anybody today, because so many people are out of work or have reduced incomes because they had to take lesser jobs, they don't have money for the 25-35 percent. And typically, if they have cancer, they are not just taking a cancer medication. They are taking the antinausea, the antianxiety, and cardiac medicines, the diabetes medicines if it gets out of the hand.

This is today, 2010, 80 percent of PBTs have a specialty tier in 2010. That's the majority. Cancer drugs are always at the top. The GAO put out a study just three weeks ago at the request of our friend, Pete Stark, who said, when part D came out, it seems like our seniors are paying an awful lot of money and all of these drugs are on tiers. I don't think I like this. Look into it. GAO looked into it and in their report, they did, in fact, say that there was a disproportionate share of patients usually with chronic diseases, which cancer has become from all intensive purposes, did pay a

proportionately higher out-of-pocket, but actuarially, everything was honky-dory, but that doesn't help the cancer patient. And coincidently, three years ago, only ten percent of prescription plans had a tier system. Look at it today. It went from 10 to 80 in 3 years.

The data that we garnered from our orals project is so incredibly -- I don't even have the word for it, but everyone was just aghast. The data is so good that we're trying to get it published in a tier review journal. There has not been a study to date, I'm pretty certain that was focussed purely on oral enclitics.

Nine percent of orals reversed. I'm not sure if you know what a reversal is, but if I got Independence Blue Cross as my drug, and the doctor gives me a prescription and I go to CVS and they run it through their claims and adjudication system and IBC says, yes, this is a covered drug on your formulary. The pharmacist fills it, puts my name on it, sits it in the little basket and I come in to get it, they pull it and they say, oh, here, Mary, here's your drug, you have a co-pay of $25 because this is a brand, not a generic, whatever a cancer drug is, that's assuming if they even have it, which they don't.

It usually takes it three days for them to

get it in because they don't want to order it in because it's expensive, so they don't stock it. Then they say, well, you also have a cost share of 35 percent. Well, 35 percent of $1,000, that's a lot of money. So people walk away because they don't have that kind of money. That's a reverse claims because the pharmacy takes that claim and reimburses it or backs it out of the insurance company, so it's gone.

So 9 percent of old claims were reversed, 21 percent of oral enclitics claims were rejected. Now, there's 300 ways why a claim would be rejected, and I'm not exaggerating. It could be a clerical problem; it could be a number, letter wrong or a date of birth wrong; it could be, that's not a primary insurance, that's the secondary insurance; it could be that that's not on the formulary; it could be that you don't have prescription coverage; it could be that the pharmacy made a mistake and thinks that this is a D drug versus a B drug.

Oddly enough, breast cancer was the top diagnosis code for all rejected claims. 25 percent of patients had no apparent follow-up after reversal of their original prescription of an oral oncolytic. What that means is 25 percent of the people who had a reverse claim, apparently, went home and did nothing because

there was no claims history following that where they reapplied. So we have to assume that portion of the 25 percent really did go home and do nothing because they had no choice.

I also want to safely assume that some of them went to the manufacturer, who has some type of assistance program and they went and qualified and got there drug there and then another percentage went to one of the national foundations, NPAF, Lance Armstrong, and they may have helped them. We will never know exactly that number because there are no statistics to support that, but the point remains as that many people are going without oral drugs because there is no parity between a medical plan and a prescription plan and they are surcharged. In essence, they actually are discriminated against because of their disease and, in fact, that an oral is the best choice for them.

I alluded to the meeting that I had with Members of Congress in January. We did a member and staff education day on the hill, and I think it would be great if we could do it for you. We would love to really come in and bring a physician and a nurse and a social worker and a patient to you so that you can have a better understanding of truly what happens on the provider's side with an oral drug. The session was very

well attended and we were told afterwards that is was probably the best briefing they have ever had and no one left. And everyone got their box of lunch and they still stayed. And to show the unity even more, these organizations supported us. When you get all of these national cancers organizations to come together on a topic, then you have to know that it's a serious problem and a growing problem.

Let me see, who was it, it was Representative Barbin, who articulated this language, which was language that was suggested to protect the patient who is on an infusible therapy and the whole point of this language was to simply that, if a patient has an oral therapy and currently are paying $50 and a patient is on an infusible therapy and they currently have $0, if this legislation passed, that the insurer could not then jack up the price for the infusional therapy to $50. I think it's pretty simple.

So I say parity for Pennsylvania. I am here to support you and give you any educational services that you need. Thank you very much.

CHAIRMAN DeLUCA: Great testimony. Representative Boyle.

REPRESENTATIVE BOYLE: I just have one quick question. Can we get a copy of those slides?

DIRECTOR OF POLICY KRUCZYNSKI: Stash has them.

REPRESENTATIVE BOYLE: Okay. If we can provide that to members at some point, that would be great. It's very helpful, especially the map that was related to my questions in terms of what states have already done this in the comparative experience. So that's very helpful, thank you.

CHAIRMAN DeLUCA: Representative Barbin.

REPRESENTATIVE BARBIN: I have one question. In your slide presentation, it occurred to me that if you can give an oral pill at home and the doctor believes that would be the best interest of the patient for whatever reason, so he keeps his job, he keeps his health care, whatever, why isn't there some language either in federal or state legislation that would have required the company that was sending out this $10,000 package of pills, why isn't it required that it go to your oncologist? Why does it go to your home address?

DIRECTOR OF POLICY KRUCZYNSKI: The reason that it does is because there are third-party entities out there that are knocking on the doors of insurance companies everyday and saying, we can save you money if you let us manage your drugs. If you let us control the horizontal and the vertical, we can reduce your bottom

line for drugs because drugs are expensive. And that third party is in essence to the manager. So they want to control the horizontal and vertical.

If I have 30 PBMs sending drugs to my office, could you just imagine the horror -- that's why the CAT Program didn't work that the federal government put out because they wanted us to get all of our drugs from the CAT provider, which no one wanted to be. We would have to keep a separate inventory of those drugs with people's names on them, just as a patient. So we've got all the Medicare drugs in the Medicare cabinet. Okay, so now, we have the Blue Cross drugs in the Blue Cross cabinet. I mean, that would be an absolute nightmare.

Brown bagging is not a good thing. Its' a very, very dangerous thing. In today's counterfeit drugs, which, in fact, there were instances just in the past week or two -- I think somebody just broke into the Lilly facility and stole all of their medications. You never know where your drugs are coming from. They come from Mexico, you've got dangerous substances that can get mixed in with them and this is a serious business. And this is not Asprin, this is poison, this is what this is. So I don't think that we could handle -- I don't think any is even Hershey Medical Center would not

want deliveries everyday from 40 different PBMs.

REPRESENTATIVE BARBIN: So it's just not possible?

DIRECTOR OF POLICY KRUCZYNSKI: It's very impractical, yeah.

REPRESENTATIVE BARBIN: Thank you.

CHAIRMAN DeLUCA: Representative Pashinski.

REPRESENTATIVE PASHINSKI: Thank you very much. Again, very informative. Two things, why can't the drugs be delivered to local pharmacies and then the pharmacies -- the patient could go through the pharmacies?

DIRECTOR OF POLICY KRUCZYNSKI: Are we talking about orals?

REPRESENTATIVE PASHINSKI: Yes.

DIRECTOR OF POLICY KRUCZYNSKI: Well, they are. There are pharmacies that will deliver -- that will fill oral prescriptions, it's just not everyday. They are.

REPRESENTATIVE PASHINSKI: But you highlighted some of the shortcomings of delivering improper delivery methods, leaving them out in the hot sun, people have the ability to steal them, etcetera. So that's a mechanical part, a system failure that could be address.

DIRECTOR OF POLICY KRUCZYNSKI: That's right. When we're looking at folks that are going to take the oral drugs at home, to what degree of TeleMed has been considered?

DIRECTOR OF POLICY KRUCZYNSKI: I don't think that TeleMed -- well, I think TeleMed is considered and is actually used in rural America and there's actually a federal program that supports and funds that. They just did it in Montana and there are even codes where you can get reimbursed. Again, I don't know -- there's a cost to everything and I really don't know what the cost would be.

REPRESENTATIVE PASHINSKI: Well, the reason why I'm saying that is because TeleMed is now being considered very seriously and has been used in the operation and the monitoring of senior citizens. It's a very inexpensive method today, especially if you have a computer. It's a simple camera that connects to the computer and I realize that would be a cost.

But, again, it would be monitoring the patient at home, rather than in a medical setting, where the cops are amplified a hundred times.

DIRECTOR OF POLICY KRUCZYNSKI: Well, not really. If someone is on an oral medication, they are coming into your office to be assessed. It's simply an

office visit and the lab work that they have to get anyway.

REPRESENTATIVE PASHINSKI: But you suggested that they may not take them regularly.

DIRECTOR OF POLICY KRUCZYNSKI: That's correct.

REPRESENTATIVE PASHINSKI: So the TeleMed would be a method by which a prescribed time in front of the camera, the patient would take the medicine as a way to monitor that person.

DIRECTOR OF POLICY KRUCZYNSKI: Well, in a perfect world. If you look at my mother-in-law, who's got dementia, she doesn't even know the time of the day, so what do you do about those people?

REPRESENTATIVE PASHINSKI: Well, then she wouldn't be a candidate for TeleMed.

DIRECTOR OF POLICY KRUCZYNSKI: But then you still have a subset of patients that have to be addressed, so now we're creating --

REPRESENTATIVE PASHINSKI: Well, let me just suggest that the technology out there is allowing for a lot of other uses and methods that wasn't available before. You highlighted the fact that because we don't have doctors in the rural setting, therefore we're using technology and at least monitoring and communicating a

doctor's patient, which is very valuable.

DIRECTOR OF POLICY KRUCZYNSKI: We would very much love to manager our patients and if that's an ability for us to do that, and if we're certainly compensated for our time to do that, remotely versus face to face, I don't see how anyone would disagree.

REPRESENTATIVE PASHINSKI: No, and you should. And that service should be documented and you should be paid for that. Those were just two things that came to my mind as you were presenting your project here. I would like to offer you my card and I would like to continue the conversation at another time, whenever it is convenient for you.

DIRECTOR OF POLICY KRUCZYNSKI: It would be my pleasure.

CHAIRMAN DeLUCA: Representative Burns.

REPRESENTATIVE BURNS: I wanted to thank you for the testimony. You did a wonderful job. I read through your testimony here and I wanted to, perhaps, maybe elaborate the catastrophic out-of-pocket expense that could be a possible solution. Is there any other states doing that?

DIRECTOR OF POLICY KRUCZYNSKI: Not that I know of. We've been try to think outside of the box to come up with the solution on the federal level, as well

as on a state level, and, in fact, our intention in the coming months is to actually have a payer summit in Washington to sit down with a lot of payers to see what we can come up with for this really disproportionate share of patients that is unlucky enough to have the diagnosis of cancer.

If we can put either a monthly cap, an annual cap, a lifetime cap on the amount that they would have to pay, because again, this is no longer an acute disease for most patients, it's chronic. People have cancer. They don't get diagnosed one day and die the next, they live two year, three years, five years, ten years on medication.

So in thinking outside the box, we thought, perhaps if we could just carve out the oncology benefit, because statistics show that cancer patients disproportionately pay a larger out-of-pocket for their drugs, it's just a fact of life, and somehow, level the playing field for them so that they don't get to these catastrophic levels. It would be important to get people back to their work so that they can pay their own bills. If you can put somebody and this gentleman -- Representative Godshall, you're taking an oral pill and here you are at work. But guess what, you're here. You're at work doing your job and the taxpayers are

happy about that, perfect example.

REPRESENTATIVE BURNS: Thank you.

CHAIRMAN DeLUCA: Thank you, Mary. I just have a couple of questions. You he mentioned in your testimony about on Capitol Hill. Is there any equalization of cost as a vision by House Bill 1865 under the consideration as far as the federal health care --

DIRECTOR OF POLICY KRUCZYNSKI: No.

CHAIRMAN DeLUCA: Let me ask you, in your opinion, why not?

DIRECTOR OF POLICY KRUCZYNSKI: Well, I'll tell you because when we sat down with Members of Congress, who most were totally unaware of issue. That's why it's important for our organization and other members in the room to continue this process of sharing with you of what we do. We don't know what you do on a daily basis and you don't know what we do. And many people cam up to us afterwards and said, wow, why don't we know anything about this?

The only thing that they knew was what Congressman Stark said, was that there was a disproportionate share of dollars being spent by Medicare beneficiary for tier drugs, that they know. Anything more than that has to be addressed. So we're

moving forward and it is our hope through the parity legislation with Congressman Higgins, and also through health reform in general.

We finished another project and it's called components of care and it included to everything that an oncologist does to treat a cancer patient, from soup to nuts, whether it's dietary, social, emotional, the whole nine yards.

We looked at what Medicare reimbursed for all of the services. We were paid 55 percent of what we do, 55 percent. It's only going to get worse as we move down the ladder. I don't think health care reform -- I think health care reform is needed, perhaps not in it's current state. It has been paired down a bit. But the Medicare system is broken and private payers are modelling themselves after the Medicare system.

So what happens in Washington triples down to the state level. So what is wrong there will be wrong here. We have the opportunity in Pennsylvania to take the lead and make a change, make a difference, use it as an example so that I can take it to Washington and say, these states recognized the problem and here is there short-term solution or long-term solution.

We don't know what the costs are going to be. Tennessee has a bill currently in the House and

somebody did a score on it. I guess like CBO does because you really don't know what the costs are going to be. Dr. Snyder talked about administrative cost, if we were to change and move everything under the medical benefit. The same was true in Tennessee. I think they said, the ballpark would be $75,000 and that was for their Medicaid system.

So there would have to be administrative cost if we did make that change. And then they came up with another dollar figure, which was quite nominal as to what the additional out-of-pocket would be if they covered oral drugs the same as they covered -- it has to be just a ballpark because, as I just said, the number of drugs coming into market are huge. So that nut is going to have to get bigger.

CHAIRMAN DeLUCA: Let me ask you, on a national level, are other countries ahead of us as far as the oral oncology medication, survival rates and stuff like that?

DIRECTOR OF POLICY KRUCZYNSKI: No. The United States offers the best cancer care delivery system in the world and, statistically, it is proven that people with cancer in America do better.

If you are in the U.K., for example, there are many drugs that they won't even give you. Like, in

fact, Herceptin was one that just got overturned. If you had breast cancer and you needed Herceptin, you didn't get it because they weren't going to pay for it. So, no, other countries are not --

CHAIRMAN DeLUCA: I guess --

DIRECTOR OF POLICY KRUCZYNSKI: We do pay more for the drugs.

CHAIRMAN DeLUCA: You mentioned the fact that maybe you would like to come back. And maybe if we could set up a joint meeting with the Senate Insurance Committee and our and our committee and if our members would be willing to come back and you could educate us.

I think the whole caucus needs educated on some of these situations because I find that the only time people recognize what's going on is when it affects them personally and when it doesn't affect them personally, they don't pay attention. And like you said one and two --

DIRECTOR OF POLICY KRUCZYNSKI: One and two men, one and three women.

CHAIRMAN DeLUCA: Mary, again, I want to thank you for your testimony.

DIRECTOR OF POLICY KRUCZYNSKI: Thank you so much for allowing me to come here today.

CHAIRMAN DeLUCA: Thank you for taking the

time. And the last person to testify is Sharon Swanger, who's a cancer survivor and it's good to have you here.

CANCER SURVIVOR SWANGER: Thank you very much. I'm not happy to have cancer but I'm happy I'm in the United States and nowhere else.

CHAIRMAN DeLUCA: God bless you, I'll tell you that.

CANCER SURVIVOR SWANGER: Good afternoon, everybody. Thank you for this opportunity to share with you my story and the reasons why I -- as a patient who is currently battling cancer -- so strongly support House Bill 1865 and urge you to vote it out of committee and support its passage on the floor.

My name is Sharon Swanger, and in July of 2008, I was diagnosed with Stage IV metastatic melanoma. At the time of my diagnosis, I was filled with cancer. I had spots in my lungs, brain, as well as, a tumor that was pushing against my windpipe. The prognosis was not good.

My oncologist here at the Penn State Hershey Medical Center suggested a very aggressive biochemical treatment called Interleukin II or as it's known here at the hospital as IL2. But, before I could have that treatment, the tumor on my brain had to be addressed. I underwent Gamma Knife "surgery," which is a form of

focused radiation to shrink the tumor. After the first Gamma Knife treatment, my tumor appeared to have been eliminated, so I was scheduled to begin IL2 treatments shortly thereafter.

A course of IL2 or Interleukin II consists of one week in the hospital, one week off, and then another week back in the hospital. The IL2 has to be administered in the hospital because it's so toxic. I was hooked up to a monitor and observed 24 hours a day. Each week, I was offered 14 grueling treatments. My oncologist warned me that these treatments would make m feel like I had the "worse flu, times 100." And he wasn't kidding. I was never so sick in my life. I had diarrhea, had lots of vomiting, chills with shakes to bad that I got a shot of Demerol after each treatment in an attempt to control the shakes that I had.

As awful as this treatment was, I knew it was my best shot at beating this disease, so I prayed that I would be able to continue. With my body beat up and hurting, I got the call after the second course that I wasn't responding anymore and the treatment was just too toxic to attempt to continue without any results, so I was told that I was done with IL2. I was hysterical. I thought that was the end of the road, but my oncologist told me that he had other patients like

myself that were able to tolerate some IL2 with a moderate response, which, when coupled with an oral chemotherapy drug called Temodar, did quite well. He suggested that I try that next. So for the next year, I took the oral chemotherapy drug from my home. Four pill at bedtime, it was ease. In fact, I commented to my husband that it seemed just too easy.

And, more importantly and amazingly, the treatment regiment worked. I am delighted to tell you that I sit here before you today with no evidence of disease in my body. My last brain scan, taken just this month, was completely clear, and a repeat scan is not needed for another year, so I am very happy about that.

As I enjoy the miracle of this extra time I have been given, I continue to look for the positive experiences that have come out of this illness. After IL2, one of the brightest spots is that, I have been able to take my chemotherapy treatments from the comfort of my own home.

It meant fewer hospital stays and more precious time at home with my loved ones, time that I just couldn't afford to lose. It meant not being hooked up to an IV line for full days at a time, waiting and watching the drip as the world went by outside. It meant protecting my compromised immune system from

contracting infections in the hospital.

And it meant less stress for my loved ones. I was one of the lucky ones to have a loving husband, family and friends. During the IL2 treatments, my husband was at the hospital everyday, and when he couldn't be there, he organized my friends and family so that someone was with me when I got my treatments, so I wouldn't have to go it alone. It was a tremendous strain on our family and friends. If my chemotherapy had also been given in the hospital, it would have made life even more challenging for everyone in my family and support circle.

And I can only begin to imagine what oral chemotherapy means to children with cancer and their families. Being able to be at home, in their own beds, surrounded by the loving and familiar environment of home instead of in a sterile hospital, hooked up to needles and tubes.

State laws and insurance companies need to keep pace with the most current medical cancer treatment options available, such as oral oncology chemo and other types of implantable devices. Especially, for people like me with metastatic melanoma, or those suffering with multiple myeloma, whose treatment options are limited at best.

While not every patient's cancer can be treated with oral chemotherapies, for those who can, they should be able to have that treatment option covered at the same level as IV chemo, period. It makes me said and, frankly, a little mad that some patients either aren't getting it, or are experiencing serious financial and emotional stress because of the steep co-pays that man insurance companies require for it.

Chemotherapy is chemotherapy, no matter the form in which it's given, and should be covered equally. I'm here to be a voice for those patients whose insurance companies are not doing the right thing. I'm here for those patients whose insurance companies are saying, "we'll pay for the drug, but only if you administer it through a needle and tubes." And so, on their behalf, as someone who has walked in their shoes, I urge you to make this right.

Today, by supporting this bill, you have in your power the ability to right a wrong, to provide a measure of fairness, and, ultimately, to make life just a little easier for people like me who are literally engaged in the fight of their life. Thank you for your time and your consideration.

CHAIRMAN DeLUCA: Thank you for coming here today, Sharon.

CANCER SURVIVOR SWANGER: It's my pleasure to be here.

CHAIRMAN DeLUCA: For all the people who are watching out there on PCN, you give a lot of people hope today that, God forbid, have cancer.

CANCER SURVIVOR SWANGER: One thing that I've learned is, it's not a death sentence.

CHAIRMAN DeLUCA: No, and I think when they see this today on PCN, that they'll really have hope that you've given them and I thank you for that.

CANCER SURVIVOR SWANGER: Thank you.

CHAIRMAN DeLUCA: Any questions?

REPRESENTATIVE GRELL: If I could just comment.

CHAIRMAN DeLUCA: Go ahead, Representative Grell.

REPRESENTATIVE GRELL: I just have one question. I'm certainly very glad for your result and I appreciate your testimony here today. Could you just briefly tell us what your coverage situation was? Did you have difficulties with getting the coverage?

CANCER SURVIVOR SWANGER: Again, I think I was one of the lucky ones. I did not -- I worked -- before I retired, because I decided that I needed to retire to battle this beast -- and that was my priority

at the time -- I had worked previously for 27 years for the federal government. I administered the social security office in Lebanon, Pennsylvania and some of you amy be familiar with that.

When I retired, I was lucky to have good health care coverage. And my coverage at the time was Keystone Health Plan Central, it was an HMO. And I had no problems with that. I did have a co-pay with that insurance, but fortunately, I didn't have to jump through some of the hoops and I understand that others do.

REPRESENTATIVE GRELL: Well, I'm glad to hear that also, but apart of what we're trying to accomplish is trying to understand where the snags are and what can be done to eliminate those snags. If you would have had those problems, it would have been helpful to us to understand how you got the coverage that you needed.

CANCER SURVIVOR SWANGER: I was one of the lucky ones.

REPRESENTATIVE GRELL: Well, we're glad for that too. Thank you.

CANCER SURVIVOR SWANGER: Thank you.

CHAIRMAN DeLUCA: Representative Pashinski.

REPRESENTATIVE PASHINSKI: Thank you very

much for your testimony and congratulations on your courageous fight, it was terrific. Earlier on -- I focussed a lot of my questions on PBMs and pharmaceuticals simply because of the fact that in government, we're trying desperately to find ways to lower the cost to try to make sure that we can get health care out to the people of our great states.

I think that a compliment is also appropriate here. If it wasn't for some of the pharmaceutical advancements, our quality of life and the extension of our life would not be evident today. What we're attempting to do is just to try and find ways in which we can solve the problems that are out there that are extremely complicated and it's going to take all of us working together to try to reduce the cost because it is unsustainable. The government can't handle it anymore, regular folks, employers, it doesn't matter where you are. Just as a plea, we're all Americans, we all love this country, it's not a republican or democrat issue, it's an American issue and we have to address it frankly and honestly and I thank all of you for coming out here today and thank you, Mr. Chairman, you've been working pretty hard on this today.

CHAIRMAN DeLUCA: I think, also, I would like to say this and even on the states and federal

level. So many times, we don't have the vision for the future generations because we only look what it's going to cost us today and not what will save in the outer years, but what we will do in the outer years, as far as our kids and our grand kids. I think we need to recognize that.

Again, I want to thank you for coming here today.

CANCER SURVIVOR SWANGER: My pleasure, thank you.

CHAIRMAN DeLUCA: Since that's the last testifier, I want to thank all of the presenters today. As with every piece of legislation in this Committee, there are competing interests with valid perspectives. The information that was presented today will be analyzed and used as a basic for possible amendments as the legislation's process moves forward.

Again, I want to thank Penn State Hershey Medical Center -- Cancer Center. My congratulations for the fine work there on performing out here. At last, but not least, I want to thank all of the members here who have attended this committee meeting. We've got a lot of good information and we'll take that back to our colleagues.

And, as I said before, this is one of the

most active, nonpartisan committees in the House of Pennsylvania. We will attempt to move legislation that will benefit consumers in Pennsylvania and the people that we represent too. Thank you and God bless you.

(The hearing concluded at 12:09 p.m.)

I hereby certify that the proceedings and evidence are contained fully and accurately in the notes taken by me on the within proceedings and that this is a correct transcript of the same.

Kelsey Dugo