

Testimony before the Texas Senate Committee on State Affairs
in support of SB1345
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Pat O'Connell
Red Oak, Texas
972-617-0876
hormonebook@yahoo.com

Chairman Duncan and Members of the Committee;

My name is Pat O'Connell and I'm speaking on behalf of the International Cancer Advocacy Network and my husband, Lloyd Paxson, who died just a few weeks ago of metastatic colon cancer.

Having the option to use an oral chemotherapy drug like Xeloda would have given my husband more months of life and more LIFE in the months he had left. I'm here because I want other families to have better choices than we had.

I'd like you understand just how much difference oral chemo could have made to our lives in those last 15 months.

Lloyd couldn't even *start* chemotherapy until his immune system was strong enough that he could risk sitting in a waiting room full of people who were coughing and sneezing. Any of their ordinary germs could have killed him.

A drug like Xeloda would have let him take his chemo safely at home.

There were times when Lloyd was incredibly weak and barely consumed enough calories to sustain a 50-pound child. But to get chemo, he had to burn precious calories going to and from the clinic, and shivering in the doctor's waiting room, sometimes for an hour before even going into chemo.

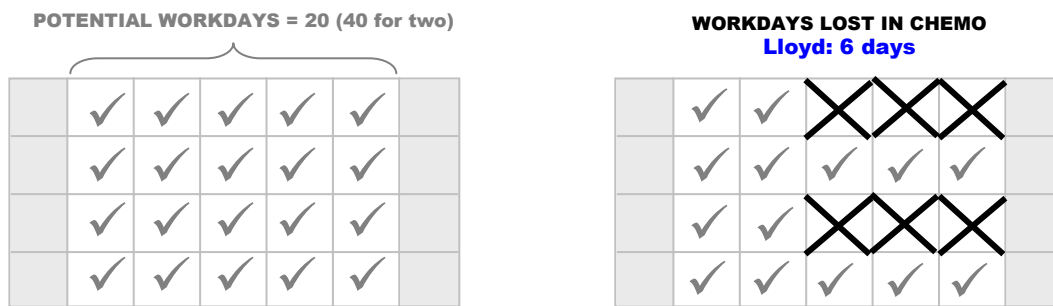
If he were taking chemo at home, he could have rested under a heating blanket and saved his energy for healing and fighting the disease.

Then there are the indignities of going outside the home for treatment. Lloyd still had to sit in that waiting room full of people, even when he wore a bag of green-and-yellow fluids from his liver, even when he had to carry a bucket to throw up in.

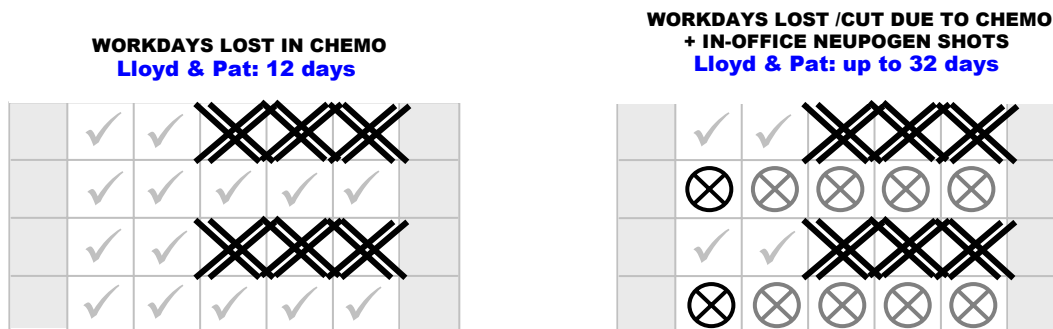
Studies suggest that Xeloda may have reduced his nausea and improved his immune system. And even if it didn't, taking chemo at home would have given him privacy and dignity during his worst days.

But the elephant in the room is: How do cancer patients and their families afford standard chemo when it leaves them so little time to work?

Out of every 4 weeks (20 weekdays), Lloyd lost 6 days for chemo alone; when I had to take him, we lost 12.



We could lose *another* 6 days each month for the Neupogen shots between chemo weeks to boost his white count.¹



Together, we could spend as much as 80% of our weekdays in the chemo clinic. Most people can't keep a job if they can only work 4 days in 4 weeks.

At least our insurance covered the bulk of Lloyd's IV chemo.

But it makes no sense that an insurer would pay \$182,000 a year for IV chemo, but wouldn't equally cover a pill like Xeloda that's just \$5400 a year, 3% of the IV cost.²

¹ (a) For each 15-second Neupogen shot, we lost at least 2.5 workday hours (5 if I drove Lloyd). He could require as many as 5 days of shots on the off-chemo weeks, totaling up to 50 hours consumed every 4 weeks (6.25 work days). (b) Xeloda has less impact on the immune system than comparable IV chemotherapies. Therefore, patients may require fewer shots of drugs like Neupogen. And with a stronger immune system, they may be better able to fight *all* diseases, including their cancer.

² Our insurance covered approximately \$7,000 for each 3-day FOLFOX regimen, every other week, times 26 weeks = \$182,000 for one year. A 50% coinsurance on Xeloda would have cost us an additional \$2700 a year on top of our \$5000 OOP medical max (\$7700/year). An oral chemo drug like Gleevec costs patients about

Instead, Xeloda would have cost us an additional \$2700, plus our \$5000 max, even though it would have saved the insurer over \$174,000 a year. And it could have given us back as many as 20 days of LIFE every month.

Under SB1345, patient costs for chemo would never exceed their medical out-of-pocket maximum, and chemotherapy would cost insurers far less overall. It's really a win-win scenario. And it's all about leveling the playing field.

If IV and oral chemo options were equal, I'd gladly haul a suitcase full of pills to a fulfilling job, to family reunions or weddings, rather than spend 80% of what might be my last days in doctors' offices. I'd fight this horrible disease, hoping I'd beat the odds, but knowing that if I died, I'd lived life with every breath.

The truth is that any of us could wake up one day facing these choices. I did. Last summer I was diagnosed with breast cancer.

I ask you to please vote in favor of this bill.
Thank you.

\$3000 a month, \$36,000 a year with a 50% coinsurance. Yet the insurer's own \$36,000 share is a mere 20% of the amount they routinely pay for in-office IV chemo like Lloyd's.

Financial benefits to patients and insurers of covering oral and IV chemotherapy equally

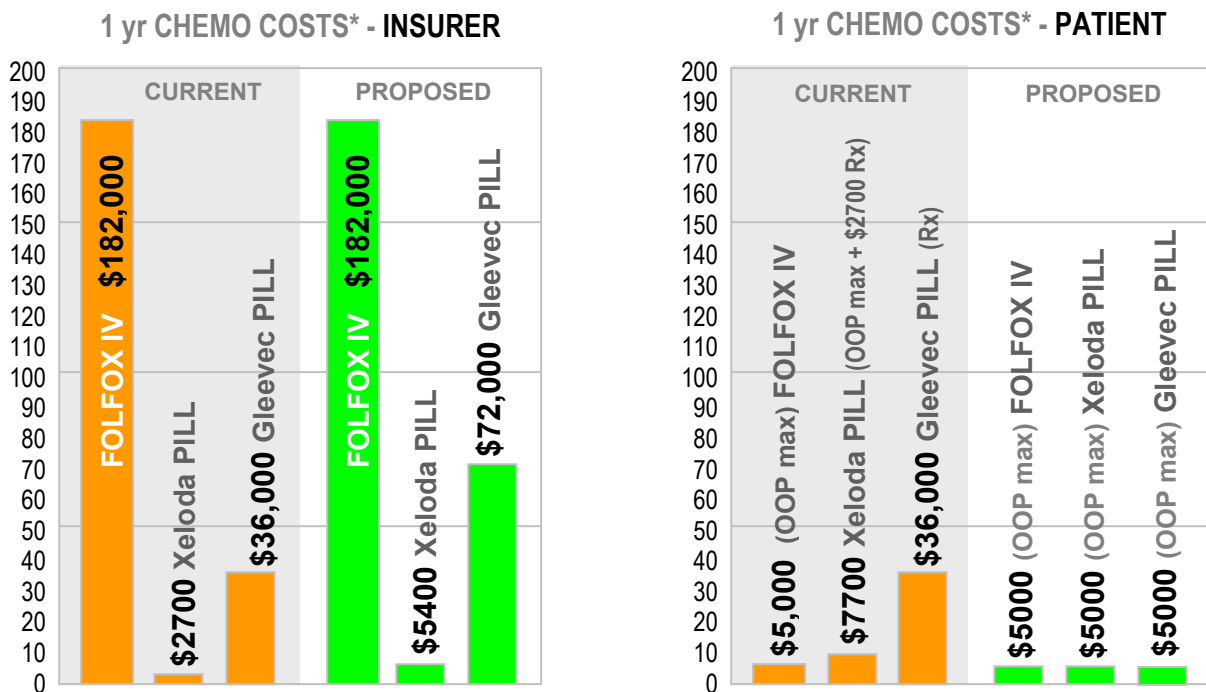
The graphic below shows the difference in costs to the insurer and patient using IV chemotherapy (FOLFOX) versus two chemotherapy pills (Xeloda and Gleevec).

The orange bars represent current costs where oral chemo is covered separately as a prescription drug and the patient must pay up to half the cost, with no annual cap on out-of-pocket expenses.

Green bars indicate the amounts insurers and patients would pay for oral chemo drugs if they were covered as medical expenses, just like IV chemotherapy.

In the scenario proposed by SB1345, **patient chemo costs never exceed their medical out-of-pocket maximums**, regardless of whether they choose oral or IV chemotherapy.

And while insurers pay a larger portion of the *prescription costs* for the chemo pills, **insurers are still paying far less overall for oral chemo than they would for IV chemo.**



*Estimates based on our bills for IV chemo and prescription costs for Xeloda and Gleevec reported online.

References

“A clear plus for Xeloda in the X-ACT study was its favorable toxicity profile with significantly lower incidents of neutropenia [low white count] and stomatitis [mouth inflammation], and lower rates of nausea, vomiting, alopecia [hair loss] and diarrhea.” Peck, Peggy. “Gentler Oral Chemotherapy Shows Efficacy in Advanced Colon Cancer.” *MedPage Today*. June 29, 2005.

“Treating cancer patients with oral medicine versus intravenous chemotherapy results in two-thirds reduction in hospital time and a greater than 50 percent reduction in costly medication side effects.” Twelves, Chris. “Oral Chemotherapy Saves Resources and Time.” *Reuters Medical News*. June 12, 2001.

“Toxicity was substantially less with pills. The risk of hospitalization was 20% with the IV drug; 11% with the pill. Nausea, hair loss and diarrhea were lessened by the pill too.” “It’s very attractive from a biologic and a financial perspective, because the costs of administering chemotherapy intravenously are quite high when you figure in all the personnel required to inject and monitor the IV every time a patient has to come in for a treatment. It is a lot easier and cheaper if the patient can take a pill instead.” Falco, Miriam. “Chemotherapy Pill Causes Fewer Side Effects.” *CNN.com/health*. April 13, 2001.

“Oral treatment will reduce the number of in-patient and out-patient hospital visits with their associated medical and nursing administrative costs, avoid the expense of disposables (e.g. infusion equipment, pumps) and decrease the pharmacy workload.” O’Neill, V.J, and Twelves, C.J. “Oral Cancer Treatment: Developments in Chemotherapy and Beyond.” *British Journal of Cancer*. (2002) 87, 933–937

“Cost-effectiveness: On average, with Xeloda, a patient only needs 8 hospital visits compared to 30 if treated with standard chemotherapy.” “Xeloda Should Replace Burdensome Intravenous Chemotherapy.” *Medical News Today*. May 18, 2005.

“Patients find oral chemotherapy convenient and easy to take; that the treatment has fewer side effects than they expected; that it enables them to live fuller and more normal lives.” *BBC News*. May 27, 2003.

“A clear majority (>80%) of patients prefer oral chemotherapy, but only provided this is not at the expense of efficacy (Liu et al, 1997; Borner et al, 2002). The preference for oral chemotherapy stems largely from the greater convenience of treatment at home (cited by 57% of patients) and avoidance of venepunctures (55%).” O’Neill, V.J, and Twelves, C.J. “Oral Cancer Treatment: Developments in Chemotherapy and Beyond.” *British Journal of Cancer*. (2002) 87, 933–937