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As Pills Treat Cancer, Insurance Lags Behind

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

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

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

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

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

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

Start with the double ledger of drug insurance. Drugs that are infused at a clinic are typically paid for as a medical benefit, like surgery. Pills, though, are usually covered by prescription drug plans, which are typically much less generous; for expensive cancer pills, patients might

face huge co-payments or quickly exceed an annual coverage limit. Sometimes, as in Mr. Stauffer's case, a single insurer is involved.

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

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

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

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

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

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

Infused drugs, of course, can also be frightfully expensive and under some insurance plans — including [Medicare](#) — can carry big co-payments. But it is the oral drugs that seem to be causing a disproportionate number of financial problems for cancer patients. The Patient Advocate Foundation, an organization that helps people make insurance co-payments for cancer drugs, says oral medicines accounted for 56 percent of the cases in which it helped Medicare patients last year, even though far more cancer patients were on intravenous drugs.

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

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

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

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

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

While Mr. Jenson has been diligent about taking his five capsules every day at lunchtime, research indicates that many patients on the oral drugs do not consistently take the proper dose. One study, for example, found that Gleevec patients, on average, were taking only 75 percent of their prescribed doses.

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

“When I first started looking into this, I thought, ‘People with cancer have too much to lose, how can they not take their drugs?’ ” said Dr. Ann Partridge, an oncologist at Dana-Farber Cancer Institute in Boston.

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

Gayne Ek of Allen, Tex., said he once skipped all of his Gleevec capsules for six weeks. Then, with the stockpile of capsules he accumulated, he took twice the prescribed dose for six weeks, hoping it would be more effective. It was not.

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

Mary Francis Thomas of Camp Hill, Pa., reached the doughnut hole on her very first prescription of the year. Ms. Thomas, 86, had to pay \$4,300 in January for a month’s supply of Revlimid, to treat a disorder that can lead to leukemia. Having now passed through the doughnut hole, she must pay 5 percent of the cost of the drug for the rest of the year — which still works out to \$377 a month.

Drug companies say they provide free drugs for some patients and give money to charities for co-payment assistance. And Lee Newcomer, senior vice president for oncology at UnitedHealthcare, the big insurer, said many commercial policies capped total annual out-of-pocket expenditures, so patients should not have huge co-payments month after month.

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

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

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