SB 21-175: Provider Testimony, Senate Health and Human Services Committee

Transcription: 8:48:44

Dr. Miller Head of Rocky Mountain Oncology Society, Chief Medical Director of Oncology; Associate Chief Medical Director of Clinical Research, SCL Health Cancer Center of Colorado

- Dr. Miller: Good evening, Madam Chair and members of the committee, thank you for your perseverance, I am president of the state oncology society. The Rocky mountain oncology society. I also currently serve as Chief Medical Director of oncology for SCL health. I've been a medical oncologist for over 35 years and have seen an incredible change in cancer care, and the ability to treat and cure patients over time. I believe that all agree that we need to reduce the medical, financial burden on our patients. This bill, as currently constructed, however well intentioned may do so at the cost of worse clinical outcomes with greater toxicity and less access to care. We've seen a 29% decline in deaths from cancer over the last 26 years, advances in cancer treatments have allowed this to occur while providing options that are less toxic and which can lower the overall cost of care by decreasing adverse events and hospitalization. Many of these new medical newer medications can be delivered in the outpatient setting, rather than requiring or resulting in hospitalization with its costs. Some of the most dramatic increases in cancer survival have been seen in malignant melanoma, where the advent of immunotherapy drugs including Pertuzumab and targeted therapies like Venrafamib have made a huge impact. When I did my oncology fellowship in the mid 1980s The same two drug combination for the treatment of acute myeloblastic leukemia was used, that we still use as the main option until the last few years. This treatment requires two to three weeks of hospitalization and was not offered to older adults due to high toxicity including death. We can now prescribe less toxic treatments that can include older adults with drugs like Vanetaclax. One unintended consequence of upper payment limit is that oncologists and other providers might have to default to using older, less expensive alternatives that are less effective, with greater toxicity, hospitalization and costs of managing the toxicity. Dr. Green mentioned lung cancer, advanced lung cancer can now be treated with non chemotherapy, immunotherapy. With the addition of drugs like Nivolumab, survival from advanced lung cancer is increased from between eight and 12 months to now living between three and five years> If it was your loved one, would you want to be deprived that additional two to three years of having them with you? Another potential unintended consequences is that smaller independent oncology practices might not be able to afford to stay in business. Many of these practices are already strained by the impact of COVID. These independent practices tend to be in the rural and underserved portions of the state where they may provide the only local oncology care. I spoke to an oncologist, the other day from New Mexico who was planning on opening an oncology practice in an underserved oncology area of southern Colorado, but is unsure if he can do this, if this legislation is enacted. This would result in patients needing to travel long distances to receive cancer care, or not receiving it at all. There are additional costs to providers, besides the acquisition of the medication. Many of the most effective drugs are administered intravenously. This requires the operation of infusion centers, with specially trained oncology infusion nurses, physician supervision and administration and fluids and co-medications to prevent side effects. Despite

the provisions on page 22 this may not be able to meet those needs. To summarize, the burden of this legislation appears to fall disproportionately on the providers. As described this could result in patients having decreased access to the most promising treatments, having to travel long distances to receive them, if at all, and hurting most, the population that you're intending to help. Thank you for your time.

- Madam Chair: Thank you for your testimony, Dr. Miller. Are there any questions for this witness Yes, Senator Hakas Lewis.
- Senator Hakas Lewis: Thank you Madam Chair. This question is for Dr. Miller, I'd like to know, , what do you do when your patients can afford oncology meds and have 1000s of dollars of coinsurance per month, as their copay, coinsurance?
- Dr. Miller: We have members of our staff, usually social workers and financial counselors who look for all the different mechanisms possible to help those patients with those costs. I definitely agree that we have to do something to help patients whether they're cancer patients or other patients with the cost of their medications. Unfortunately, Senator Hakas Lewis, and you are my senator from Erie, I don't think this bill achieves that without having more serious unintended consequences.
- Madam Chair: Are there more questions for Dr. Miller? We really appreciate your testimony and thank you for hanging in there with us, to testify tonight. Thank you.

Transcription: 5:40:30
Dr. Kelly Greene: Pulmonologist, ICU Co-Director at Littleton Adventist Hospital

- [Begin presentation by Dr. Kelly Greene, Pulmonologist, at audio counter 05:40:30]
- **DR. KELLY GREENE:** Thank you for having me, this evening now, I guess.
- **CHAIRMAN:** It is.
- **DR. KELLY GREENE:** I am a pulmonary critical care doc. I work for a large health care system, although I'm here representing myself and other colleagues. I'm the medical director of an ICU at the hospital I'm at. I also am the medical director on the Pharmacy and Therapeutics Committee at the hospital, and I am a co-owner of our pulmonary clinic.
- So I'm here in opposition of the bill primarily for two reasons, two big reasons, which is the upper limit spending as well as the board. The concerns that I bring have already really been brought up by many other people. So I'll keep I brief, but my major concern is that this bill, although we all in this room understand and appreciate that patients need better access to medicines, I can give you thousands of stories that have already been shared, patients coming and can't get them.
- I am a firm believer this bill is not going to fix it, and the reason I have concerns is that not only am I concerned that it's not going to fix that problem, but also that it's going to limit access to these very important medications. So the concern of the upper-limit pricing is that it doesn't—it assumes that pharmaceutical companies are going to adhere to that. So many large health care systems purchase their medications, and it is very complicated, but they purchase them from out of state. So they will purchase them at a certain price, and then if there is upper-price limiting, that cost will go to the hospital or it will go to a pharmacy, which has already been—[digital interference]—it will go to a physician's office.

- I don't—we don't infuse any medications at our office, so that's not the issue from an outpatient standpoint, but in an ICU, some patients—and it's really only a few, but it is just the way diseases are—they need these very important high-cost medications, and they cost a lot for a reason, right? There's a lot of R&D that goes behind these medications. We can't change that. It's critical. It needs pharma support. We need that R&D, and so some of these medications are critically critical to some of these patients. And just because they're expensive doesn't mean that they should be limited.
- And the concern is if there is—if this bill goes through, there is no doubt in my mind, access to these medications will be changed to our patients. I have severe asthma patients who despite the inhalers that are awesome for many patients, it's not working for them. They need a biologic, and I can promise you that if this bill goes through and the upper-price limiting happens that affects pharmacies, pharmacies will make decisions about what medications they will have access to. So my patients, in addition to not being able to afford their medications, now are going to lose access to some very critical medications.
- So although we all want to fix this, we need to fix this—I will be the first one to support anything that I think can fix this—I am concerned that we're going to make a bigger problem for our patients rather than helping them. That's for the upper-price limit.
- Regarding the board, again, I sit on P&T. I'm the head of it. Boards are awesome, and they can also be very scary to those of us who are on the front lines. So the concern on this five-member board is it is a political board. They are members appointed by a governor, which means it is a political board. The conflict of interest is very concerning because it means that people who should be sitting on that board can't.
- I have a conflict of interest. Pharmacy has a conflict of interest. Pharma has a conflict of interest. All of those people should be on the board because they're the experts, and although it does have the 14-member advisory committee, they're not dictating it. And so that makes me very, very concerned.
- So, for those reasons, I oppose the bill.