Veltri, Victoria

From: BETSY GLASSMAN <wordpix@optonline.net>
Sent: Thursday, November 17, 2016 1:28 PM
To: LtGovernor Wyman; Barnes, Ben; Veltri, Victoria
Subject: health care costs/ideas from St. 4 cancer patient

Dear Lt. Gov. Wyman, Commissioner Barnes, and Ms. Veltri:

I am a member of the Litchfield DTC and Litchfield County Dem Comm. However, I am writing as an individual to comment to the state's health care cabinet. I understand the comments were due two days ago, but I did not get the word until recently, so please consider my comments as IMO, they are very important.

I am a Stage 4 cancer survivor. My health insurance is Medicare and Medicaid as I am unemployed and forced into retirement early by cancer/treatments. I had private insurance before the ACA was implemented. During that time:

1) My Blue Cross (private) insurance admin. said it would end my coverage with 10 days' notice at the time I was diagnosed; 2) I was able to keep the insurance until my contract date ended and the ACA was implemented, thanks to a congressman who stepped in; 3) during the two most intense months of my illness, tests, diagnosis, and getting major surgery, I paid $20K out of pocket while on private insurance, and payout of $10k/month was not sustainable for my income (zero due to cancer, surgery and recovery time).

With the arrival of the ACA, the state of CT placed me on Medicaid. I soon started chemo featuring a "cocktail" of decades-old drugs. However, I continued to get statements from my private insurer showing my "provider charge" for chemo + admin. was $40K per round of chemo, and I needed 12 rounds. I sent the following to the state's Med Audit in early May 2014: medaudit.dss@po.state.ct.us:

> Dear Med Audit:
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> I am currently on Husky D insurance as an unemployed cancer patient. I recently received a list of claims from my previous insurance company that includes two bills for my first two chemotherapy treatments from Yale New Haven Hosp. One bill was for $37,000 and another for $43,000---each apparently for one infusion of chemo. I get two infusions/month. These bills do not include the oncologist's bills and appear to be for the chemo drugs + administration on chemo days only.
>
> I am wondering why this chemo is so expensive since I have done some research into chemo costs and discovered that the average cost of my specific FOLFOX chemo is $3369/cycle, based on the NIH link below, Table 3.
>
> http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3324994/
>
> One FOLFOX cycle, according to the table, costs 2420 euros for medical administration of the infusion + drugs, which comes to $3369 US.
>
> I am not suggesting that YNHH is doing anything wrong in its billing because I suspect it is typical throughout the country. I just wonder why a $3369 infusion is billed at $40,000. I am very grateful that my costs are covered by Medicaid but also very concerned that the public must incur such a high cost,

greater than 10 times more than the real price. At $40,000 each, my 12 infusions that are scheduled will cost about $1/2 MILLION. If this is an average cost that federal/state agencies are typically paying out for 6 mos. of chemo for one cancer patient needing Medicare/Medicaid or ACA subsidies, as a nation we will soon go even more broke than we already are. I think that you and the US Dept. of Health and Human Services should be made aware as I believe an investigation into billing practices vs. actual costs is warranted; however, having gone to the HHS website, I am directed to you at the state website.

Thank you for investigating these costs and/or passing this information on to HHS.

The response from DSS was that I should look at the "allowed charge" and not the provider charge. The "allowed" charge was about half of the "provider", so still way above the real price stated at the NIH site (about $22K vs. $3369).

One round of my chemo consisted of an IV drip in the doctor's office, taking about 2 hr. I then took the drip home in a porta-pack for another 1-1/2 days, and the infusion line was taken out at the doc's (5 min) on Day 2. For this, Medicaid was billed $22K approx. each time ---for an IV drip of old drugs---or was it? I looked into the cost to Medicaid but I have been told by experts I need to get the state's contract to see what the state pays. Perhaps you will let me know.

My questions: Why are these fantasy numbers allowed in billing? Why are the costs so incredibly inflated? Why are the true costs hidden and the fantasy prices up front? What is the state really paying for a FOLFOX chemo round? Why are there "provider" and "allowed" charges, and yet the state may be paying neither b/c it has a different payment regime to providers? Why is billing opaque?

From what I have learned, medical billing and pricing is a scandal, if not a crime.

I am now almost 3 years past diagnosis, at which time the survival rate is 21% for my type of cancer. I attribute my survival not only to medical intervention but also to my own health regimen. I currently have "no evidence of disease" thanks to an organic, plant-based diet and as much exercise as I can do. Here are my recommendations for the state:

- Purchase drugs competitively. The monopoly of American pharma should end immediately and if the feds won't do it, the state should. Besides, some of these drug companies have ostensibly moved "headquarters" overseas for tax "inversions," and the inverted companies should not be getting the benefits of the American Pharma Monopoly since they are not "American" anymore. See a list of inversions here: https://www.bloomberg.com/quicktake/tax-inversion

- Stop the fantasy number billing and two tiers of billing (provider and allowed). Base pricing on real costs, period.

- Get tough on chemicals allowed in the state for home and agricultural use. Ban the worst (teratogenic glyphosate, for example). Currently there are 16,000 pesticides manufactured and distributed nationwide, of which 11,000 or 65% are either not tested or undertested ((NRDC, figures supported by EPA). The EPA and Dept. of Agriculture are doing little, no doubt due to the revolving door and huge profits from chemicals, so the state needs to get control. These chemicals enter our water supplies and persist up the food chain, and between the chemically contaminated food and water, our entire nation is being poisoned. If the federal gov. will not deal, the state needs to if we want to reduce health costs.

- Promote organic agriculture, community and school gardens. Give municipal and state lands for the gardens and tax breaks to organic farmers and "organic only" nurseries, hardware and feed stores. All of this will put people to work.

- Promote an organic plant-based diet low in salt, sugar, bad fats, meat and dairy, and high in leafy greens and other vegetables.

One last thing: older workers typically are not offered full time jobs if they need to re-enter the job force after recovering from a long illness and treatments. However, they may be offered part-time jobs, giving them a slight increase in income (typical is $20/hr. or less for <20 hr./wk, minus round trip costs, minus tax and other payments to state and federal = slight income increase). Such part-time jobs result in workers being ineligible for Medicaid or ACA subsidies they may have had before the new job, and a small income increase typically does not cover the resulting large increase in health care costs. This situation perpetuates poverty and a downward cycle for older workers who re-enter the workforce with part-time jobs after a serious illness.

Again, preventing the illnesses in the first place is key (see bullet points).

Please let me know if I can be of service in solving any of the problems outlined here, and thanks for listening.

Sincerely,

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