Medicare and Cancer

The National Medicare Congress
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Christy Schmidt
Senior Director, Policy
National Government
Relations Department

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Covered Preventive Services

- **Welcome to Medicare" Visit**
- **Colorectal cancer screening**
- **Screening mammogram**
- **Pap test/pelvic exam/clinical breast exam**
- **Prostate cancer screening**
- **Smoking & Tobacco Use Cessation Counseling**

- **Bone mass measurement**
- **Glaucoma testing**
- **Flu shots**
- **Hepatitis B shots**
- **Pneumococcal shots**
- **Cardiovascular screening**
- **Diabetes screening**

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“Welcome to Medicare” Visit

- Medicare covers a one-time “Welcome to Medicare” exam (IPPE) within the first 6-months of enrolling in Medicare.
- Exam includes a thorough review of the person’s health; education and counseling on preventive services, like cancer screenings; and referrals for other needed care.
- Visit is subject to the usual Medicare Part B deductible and 20% coinsurance.
- Legislative efforts include extending the 6-month timeframe.

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Cancer Screenings

- **Breast Cancer Screening**
  - **-- Medicare covers** mammogram screenings for all women age 40 and older every 12 months; one baseline mammogram between ages 35 and 39; and a clinical breast exam once every 24 months.
  - -- Copayment/coinsurance, but no deductible

- **Cervical Cancer Screening**
  - -- Medicare covers a pap smear and pelvic exam once every 24 months; or every 12 months if the woman is at high risk for cervical or vaginal cancer, or is of childbearing age and had an abnormal pap smear in the past 36 months.
  - -- Copayment/coinsurance for pap test collection & pelvic exam (no cost-sharing for pap lab test), but no deductible

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Cancer Screenings Cont'd

- **Colon & Rectal Cancer Screening**
  - **-- Medicare covers for people aged 50 and older at average risk of colon cancer, an FOBT every 12 months, a flexible sigmoidoscopy once every 4 years, a screening colonscopy once every 10 years, or a barium enema once every 4 years.**
  - **-- For those at high risk, Medicare pays for a screening colonoscopy once every 2 years (no minimum age required) and a barium enema once every 2 years.**
  - **-- No copayment/coinsurance or deductible for FOBT; for all other tests, copayment/coinsurance & deductible apply**
  - **-- *Excepted from the deductible beginning in 2007*.**
- **Prostate Cancer Screening**
  - **-- Medicare covers a DRE (digital rectal exam) and a**

Cancer Patients & Part D

- Part D plans are required to cover “all or substantially all” cancer drugs
- But only required to cover 1 or 2 drugs in each class/category, so specific cancer drug may not be covered
- Majority of cancer drugs continue to be covered under Medicare Part B

  -- **Rule of thumb**: if a drug was covered under Part B, it continues to be covered under Part B (i.e., if the administration of a drug requires that it be infused by a doctor in a doctor’s office or outpatient hospital setting, it will be covered under Part B)

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Purpose

- Analyze Medicare beneficiary cost-sharing for seven illustrative cancer treatment protocols, including patients with co-morbidities

- Explore sources and extent of Part D cost-sharing variation by:
  - Part D plan (formularies, benefit designs)
  - Geographic location
  - Low-income subsidy eligibility

- Assess Part B cost-sharing and impact of supplemental coverage

Seven Treatment Protocols Analyzed

Cancer Type	Part B Drugs	Part D Drugs	Other*
1 – Breast (With hyperlipidemia, type 2 diabetes, and hypertension)	Adriamycin, Cytoxan, Taxotere, Kytril, Neulasta, Aloxi	Arimidex, Dexamethasone, Prochlorperazine, *Lipitor, Metformin, Hydrochlorothiazide*	Ativan
2 - Metastatic Colon (FOLFOX) (With asthma)	Oxaliplatin, Folinic acid, Fluorouracil, Dolasetron, Dexamethasone IV	*Proventil*	
3 - Metastatic Colon (FOLFIRI)	Irinotecan, Folinic acid, Fluorouracil, Dolasetron, Dexamethasone IV	Prochlorperazine	
4 - High Grade Lymphoma (R-CHOP) (With hypertension)	Cyclophosphamide, Doxorubicin, Oncovin, Prednisone, Rituximab, Dolasetron, Dexamethasone IV, Neulasta	Prochlorperazine, *Vasotec*	
5 - Low Grade Lymphoma (CHOP/Rituxan)	Cytoxan, Adriamycin, Vincristine, Rituxan, Dexamethasone IV, Benadryl, Kytril, Neulasta	Prednisone, Prochlorperazine	Ativan
6 - Metastatic Breast (With hyperlipidemia, hypertension, and depression)	Paclitaxel, Carboplatin, Trastuzumab, Dexamethasone IV, Diphenhydramine, Ranitidine, Aredia	MS Contin, Percocet, *Zocor, Lisinopril, Zoloft*	Senokot, Colace
7 - Non-Small Cell Lung		Tarceva	

Indicates drugs taken for non-cancer related conditions.

*Ativan is a benzodiazepine; Senokot and Colace are over-the-counter products. These two categories of drugs are both statutorily excluded from the Part D program.

Details on Out-of-Pocket Spending Calculations

- **Part B**
  - Includes premium and cost-sharing for physician administration services
- **Part D**
  - Assumes treatment protocols begin January 1, 2006
  - Assumes drugs for co-morbidities are taken for a full year
  - Assumes beneficiaries do not receive outside cost-sharing assistance
- Assumes beneficiary pays retail price for non-covered drugs

Total Beneficiary Out-of-Pocket Cost

Cancer Protocol	Part B Beneficiary Cost*	Part D Beneficiary Cost Range**
1 – Breast (With hyperlipidemia, type 2 diabetes, and hypertension)	**$7,196**	**$1,747 - 2,810**
2 - Metastatic Colon (FOLFOX) (With asthma)	**$10,920**	**$355 - 1,075**
3 - Metastatic Colon (FOLFIRI)	**$8,395**	**$29 - 825**
4 - High Grade Lymphoma (R-CHOP) (With hypertension)	**$9,133**	**$179 - 941**
5 - Low Grade Lymphoma (CHOP/Rituxan)	**$7,602**	**$136 - 931**
6 - Metastatic Breast (With hyperlipidemia, hypertension, and depression)	**$4,691**	**$1,145 - 1,681**
7 - Non-Small Cell Lung	**$0**	**$779 - 4,198**

Source: Avalere Health analysis using DrugNameTM, Avalere's proprietary database of Medicare Part D plan features. Data from April 2006. Part B analysis based on Centers for Medicare & Medicaid Services (CMS) July 2006 Average Sales Price (ASP) Pricing File (updated 6/26/06) and February 24, 2006 Correction to 2006 Medicare Physician Fee Schedule Payment for Drug Administration Current Procedural Technology (CPT) codes.

*Includes Part B premium and physician administration fees. Assumes no supplemental Part B coverage.

**Low and high shown across all plans included in this analysis. Calculation reflects substitution of AB-rated generic drugs in Part D when available. Calculation includes premiums, drugs excluded from Part D (Ativan, Senokot, and Colace) and spending on any off-formulary drugs.

Key Findings

- **Part D Drugs For These Cases Are Covered Almost Universally**
- **Copays Can Be More Expensive Than Coinsurance**
- **Coverage Gap Affects 3 Protocols**
  - **1 – Breast Cancer, with hyperlipidemia, type 2 diabetes, hypertension**
  - **6 – Metastatic Breast Cancer, with hyperlipidemia, hypertension, depression**
  - **7 – Non-Small Cell Lung Cancer**
- **Coverage in the Gap: Benefits, and a Few Caveats**
- **High Premium Plans May Not Provide Better Value**
- **Part D Premiums Add Some Regional Variation in Cost-Sharing**
- **Low Income Subsidy Confers Significant Benefit**
- **Part B and Supplemental Insurance Remain Crucial**

CMS “Substantially All” Coverage Policy for Cancer Drugs Is Critical

- All cancer drugs in these protocols are covered by 100% of plans
- Overall coverage rate for these case studies is 98%
  - Assumes AB-rated generics substituted for Vasotec, MS Contin, Percocet and Zocor
  - Proventil HFA is off formulary for three plans
- Overall coverage rate is 87% without generic substitution

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Copays for Lower Cost Drugs Can Drive Up Beneficiary Costs

Plan	Coinsurance / Copay	Beneficiary Cost*
Protocol 2: Metastatic Colon Cancer (Proventil HFA)		
Humana Standard	Coinsurance	**$290**
Humana Enhanced	Copay	**$464**
AARP Medicare Rx	Copay	**$465**
Humana Choice PPO (IL)	Coinsurance	**$293**

Highlights

- Coinsurance for less expensive drugs keeps beneficiary cost-sharing low
- Some plans' copays exceed the full cost of the drug (beneficiary pays full price)
- Copays are generally preferable for high cost drugs

Source: Avalere Health analysis using DataFrameTM, Avalere's proprietary database of Medicare Part D plan features. Data from April 2006.

*Annual cost for Part D drugs, excluding premiums

Patients Hit the Coverage Gap in Three Protocols

Protocol	Number of Plans	Month of Gap Entry*
1 – Breast (With hyperlipidemia, type 2 diabetes, hypertension)	12 of 12	August or September
6 - Metastatic Breast (With hyperlipidemia, hypertension, and depression)	12 of 12	August or September
7 - Non Small Cell Lung	11 of 11**	February

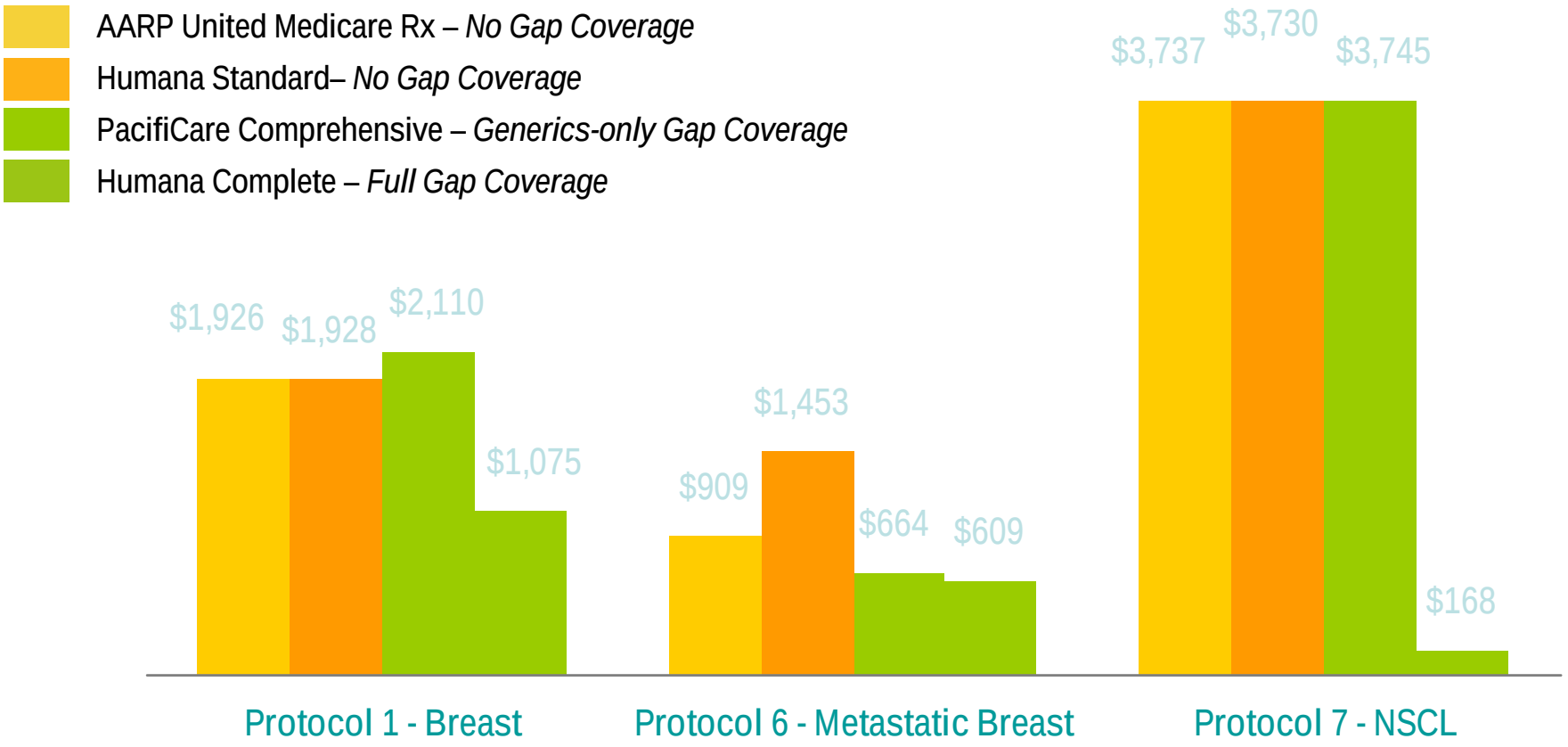
Highlights

- Within these 3 protocols, little difference between plans on when patients reach the gap
- 10 reach catastrophic coverage
- Other patients may incur significant costs that do not count toward Part D

Source: Avalere Health analysis using DataFrameTM, Avalere's proprietary database of Medicare Part D plan features. Data from April 2006.
*Assumes treatment begins on January 1, 2006
**One plan omitted from Tarceva analysis due to conflicting information about formulary coverage.

Coverage in the Gap Can Significantly Lower Beneficiary Cost

Part D Out-of-Pocket Spending for Coverage Gap Protocols*



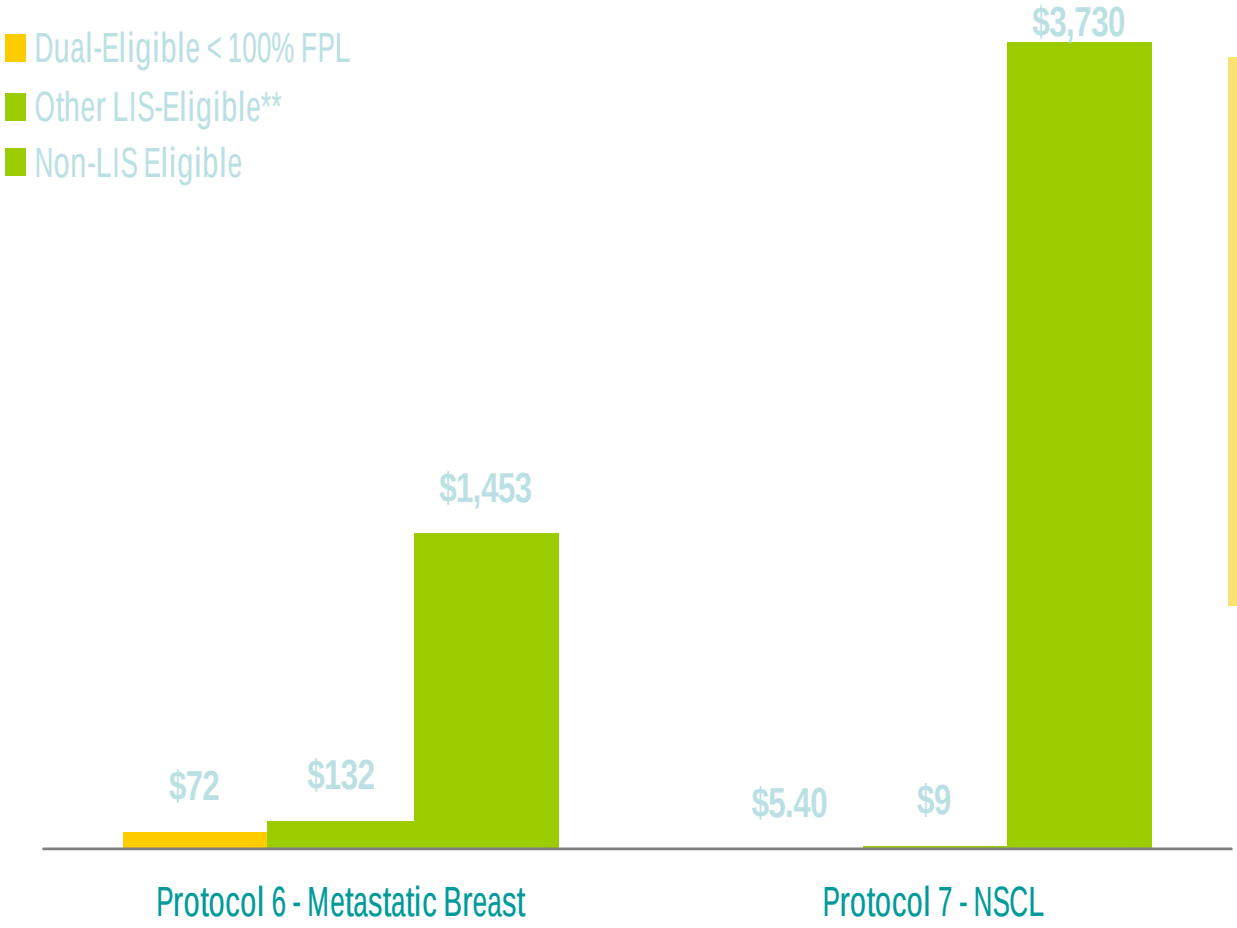
Source: Avalere Health analysis using DataFrameTM, Avalere's proprietary database of Medicare Part D plan features. Data from April 2006.
*Excludes Part D premium and costs for drugs excluded from the Part D program

Some Caveats About Coverage in the Gap

- Other benefit design factors can outweigh the benefit of coverage in the gap
  - Higher copays in the initial coverage period
  - Higher premiums
- Generics-only coverage may still leave beneficiaries taking newer drugs exposed to high costs
- However, gap coverage may help beneficiaries by smoothing out spending from month to month

Part D Low-Income Subsidy Confers Significant Benefit

Part D Cost-Sharing for LIS and Non-LIS Eligibles in Humana Standard Plan*



Highlights

- LIS-eligibles pay no premium, no deductible, and low copays for on-formulary drugs, and have no coverage gap
- Cut-off for LIS eligibility is >150% FPL

Source: Avalere Health analysis using DataFrameTM, Avalere's proprietary database of Medicare Part D plan features. Data from April 2006.
*Excluding Part D premiums and, in Protocol 6, OTC products Senokot and Colace.
**Dual-eligible beneficiaries with incomes >100% FPL and non-duals with incomes below 135% who meet the asset test

Supplemental Coverage Is Crucial in Part B

- Approximately 90% of Medicare beneficiaries have supplemental Part B coverage
- Medicaid and Medigap pay 100% of Part B cost-sharing
  - Medicaid supplemental coverage costs nothing
  - Medigap carries a premium

Average Premium per Year for Medigap Plan F in 2006

State / Zip Code	Average Premium per Year
Pennsylvania / 19102	**$1,770**
Illinois / 60076	**$2,628**
California / 92831	**$2,676**
Florida / 33028	**$2,682**

Highlights

» Cost of Medigap is less than Part B cost-sharing

» Medicare Advantage may provide overall savings

Source: Avalere analysis of Centers for Medicare and Medicaid Services "Medicare Personal Plan Finder" at www.medicare.gov.

Key Takeaways From the Case Studies

- People with cancer can be exposed to wide variation in cost-sharing depending on which Part D plan they choose
- In some cases, conventional wisdom about gap coverage and higher premium plans may be faulty
  - Not all cancer patients will fall into the coverage gap
- Part B coverage policies and supplemental coverage sources are important for people with cancer
- Use of AB-rated generics reduces out-of-pocket spending considerably
- CMS's "substantially all" coverage requirement for cancer drugs is important

Advice

For beneficiaries:

- Coverage is good
- Need to look carefully at plans – consider your treatment drugs – look at out-of-pocket costs and tiers in formulary

Future:

- Monitor Part D only drugs with no generic substitute
- Assess subsidy needs above 150 percent poverty line

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