

# Cost-Sharing for Cancer Patients in Medicare: Seven Case Studies

Prepared by:

Avalere Health LLC  
Catherine Harrison  
Khoa Nguyen

Prepared for:

The American Cancer Society

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Medicare beneficiaries with cancer may be treated with a range of pharmaceutical therapies that are covered under Medicare Part B or under the new outpatient prescription drug benefit, Part D. A key concern for such beneficiaries may be the affordability of Medicare's cost-sharing for pharmaceuticals, particularly considering that chemotherapy protocols and supportive care typically include many drugs. Working with the American Cancer Society (ACS), Avalere undertook the following analysis to illustrate total Medicare beneficiary cost-sharing for common cancer treatment regimens and to investigate the sources and extent of variation in Part D cost-sharing for these protocols. The analysis relies on seven cancer treatment protocols designed by ACS, public information about Part B cost-sharing for drugs and physician administration services, and Avalere's proprietary database of Part D plan features, DataFrame™.

## Methods

ACS provided seven cancer treatment protocols for this analysis, as shown in Figure 1 below. The protocols included generic and brand-name drugs, some of which are reimbursed under the Medicare Part B benefit and others of which are covered under Part D.<sup>1</sup>

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<sup>1</sup> Whether a drug is eligible for Part B coverage depends on: 1) whether the drug is statutorily included in the Part B benefit, and 2) whether the drug is usually self-administered or administered incident to a physician's service. Depending on circumstances for individual patients, a given drug can be reimbursed under Part B in some cases and Part D in other cases. In this analysis, all infused chemotherapy and supportive care products were assumed to be paid for under Part B. None of the oral medications in this analysis are statutorily included in the Part B benefit; therefore, all oral medications were treated as eligible for Part D coverage.

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**Figure 1** Treatment Protocols for People with Cancer

Cancer Protocol	Part B Drugs	Part D Drugs	Other (Not covered under B or D)
1 – Breast (With hyperlipidemia, type 2 diabetes, and hypertension)	Adriamycin, Cytoxan, Taxotere, Kytril, Neulasta, Aloxi	Arimidex, Dexamethasone, Prochlorperazine, <i>Lipitor</i> , <i>Metformin</i> , <i>Hydrochlorothiazide</i>	Ativan
2 - Metastatic Colon (FOLFOX) (With asthma)	Oxaliplatin, Folinic acid, Fluorouracil, Dolasetron, Dexamethasone IV	<i>Proventil</i>	
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, <i>Vasotec</i>	
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, <i>Zocor</i> , <i>Lisinopril</i> , <i>Zoloft</i>	Senokot, Colace
7 - Non-Small Cell Lung		Tarceva	

Drugs listed in italics in Figure 1 are therapies for conditions other than cancer. These products were included for some of the regimens so that cost-sharing for cancer patients with certain common co-morbidities—such as hyperlipidemia and asthma—could be illustrated. Protocols 1, 2, 4, and 6 include such drugs whereas protocols 3, 5, and 7 are composed only of cancer treatment agents.

For each of the seven regimens, ACS provided detailed information on dosing and treatment duration, based on consultation with clinical experts. The protocols selected are standard, first-line treatment regimens chosen based on staging of the disease in seven hypothetical cancer patients. We assumed that the treatment protocols began on January 1, 2006, the first day of the Medicare benefit year. The drugs indicated for co-morbid conditions were assumed to be taken by the beneficiary for the entire year, while the chemotherapy regimens varied in duration.

**Part B Cost-Sharing.** Beneficiaries enrolled in Part B in 2006 pay a monthly premium of \$88.60. The benefit design includes a \$124 deductible and beneficiary cost-sharing of 20% of the Medicare Allowable Payment for all additional covered services.<sup>2</sup> Because

<sup>2</sup> Medicare Allowable Payment for drugs equals 106% of Average Sales Price (ASP). In this analysis, ASP was taken from the Centers for Medicare and Medicaid Services (CMS) July 2006 Average Sales Price (ASP) Pricing File, updated 6/26/06.

the Part B drugs in this analysis are administered by a physician, we included beneficiary cost-sharing for the physician administration fees in our total cost-sharing calculation.<sup>3</sup>

**Part D Plan Selection and Cost-Sharing.** Unlike the Part B benefit, Medicare Part D is offered through private health insurers. Part D is available as a stand-alone addition to Medicare parts A and B fee-for-service coverage through Prescription Drug Plans (PDPs). Alternatively, beneficiaries can receive Part D through a Medicare Advantage Prescription Drug plan (MA-PD) that offers integrated parts A, B and D benefits. All insurers offering Part D are required to provide a certain baseline level of drug coverage but are free to design their own plans—including formularies and cost-sharing designs—within that framework. As a result, individual beneficiaries enrolled in different Part D plans might pay different cost-sharing amounts for the same treatment protocol.

For this analysis, we sampled Part D plans to evaluate their beneficiary cost-sharing requirements. We selected PDP sponsors with the highest total Part D enrollment nationally across all their plan offerings. We selected particular plans offered by MA-PD sponsors with the highest enrollment in key states: California, Florida, Pennsylvania, and Illinois.<sup>4</sup> The PDPs and MA-PDs selected for this analysis along with the key features of their benefit designs are listed in Figures 2 and 3.

We used Avalere's proprietary database of Part D plan information, DataFrame™, to supply monthly premium and deductible amounts for the selected plans. We also used DataFrame™ to analyze the plans' formulary coverage and cost-sharing for the Part D drugs in the seven treatment protocols.<sup>5</sup> In cases where a Food and Drug Administration (FDA)-approved, AB-rated generic was available for a brand-name Part D drug in the protocols, we ran two sets of cost-sharing numbers—one with the branded drug and one with the equivalent generic.<sup>6</sup> In this way, we were able to evaluate how cost-sharing would change if generics were substituted for the brand-name drugs.

Some Part D plan designs feature a gap in coverage during which beneficiaries pay 100% cost-sharing (the full negotiated price of the drug). In 2006, for all Part D plans, the coverage gap begins when a beneficiary's total drug spending reaches \$2,250 and ends when a beneficiary's out-of-pocket drug spending reaches \$3,600. To determine beneficiary cost-sharing in the gap, we queried the Centers for Medicare and Medicaid Services (CMS) Medicare Prescription Drug Plan Finder at [www.medicare.gov](http://www.medicare.gov), which displays cost-sharing amounts in the coverage gap per drug for each Part D plan.<sup>7</sup>

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<sup>3</sup> Physician administration fees were calculated based on CMS's "February 24, 2006 Correction to 2006 Medicare Physician Fee Schedule Payment for Drug Administration Current Procedural Terminology (CPT) Codes."

<sup>4</sup> These states were selected based on their large total population (according to the 2005 U.S. Census), large elderly population (2001 U.S. Census), and geographic diversity.

<sup>5</sup> Data from April 2006.

<sup>6</sup> The brand-name drugs included in ACS's protocols that have generic AB-rated generic equivalents are Vasotec (enalapril), MS Contin (morphine sulfate ER), Percocet (oxycodone), and Zocor (simvastatin).

<sup>7</sup> Accessed between August 3 and September 30, 2006. Users must enter a zip code to access the information in the Plan Finder tool. For the PDPs in this analysis, we used zip code 92831, which represents a region in Orange County, CA, one of the most populous counties in the state. Plans' negotiated prices may vary slightly by zip code. For the MA-PDs in this analysis, we used selected zip codes from the first or second most populous counties in our selected states: 92831 (Orange County, CA), 33028 (Broward County, FL), 19102 (Philadelphia County, PA), 60076 (Cook County, IL).

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**Figure 2** PDPs Selected for Analysis

PDP Name	Monthly Premium*	Deductible	Coinsurance / Copays	Coverage in the Gap
Humana Standard	\$5.41-13.32	\$250	Coinsurance	None
Humana Enhanced	\$11.25-20.12	\$0	Copay	None
Humana Complete	\$50.91-61.70	\$0	Copay	Generics and brands
PacifiCare Saver	\$19.02-26.99	\$0	Copay	None
PacifiCare Select	\$32.35-41.72	\$0	Copay	None
PacifiCare Comprehensive	\$37.67-41.37	\$0	Copay	Generics only
AARP United	\$23.22-26.68	\$0	Copay	None
United MedAdvance	\$27.84-29.33	\$0	Copay	None

\*Premium range for plans in four zip codes: 92831, 60076, 19102, and 33028

**Figure 3** MA-PDs Selected for Analysis

MA-PD Name	State	Monthly Premium*	Deductible	Coinsurance/ Copays	Coverage in the Gap
Secure Horizons Value Plan (PacifiCare)	CA	\$0.00	\$0.00	Coinsurance	None
HumanaChoicePPO R5826-005	FL	\$22.99	\$0.00	Copay	None
Keystone 65 Direct Rx Option III (Independence Blue Cross)	PA	\$67.25	\$0.00	Copay	Generics
HumanaChoicePPO R5826-037	IL	\$14.24	\$250.00	Copay	None

\*Premiums are for Part D coverage only and correspond to the following zip codes: 92831, 33028, 19102, and 60076.

**Drugs Not Covered by Part B or Part D.** Some drugs in the protocols are not covered by either Part B or Part D. Part B drug coverage is generally limited to drugs that are not usually self-administered, or certain oral cancer drugs that are specifically covered under statute.<sup>8</sup> Part D covers most other prescription medications, but not benzodiazepines or over-the-counter (OTC) products; they are excluded by law.<sup>9</sup> The three drugs in the protocols that are not covered by Part B or Part D are Ativan (a benzodiazepine), and the OTC medicines Senokot and Colace.

Though Ativan is excluded from Part D, CMS's Medicare Prescription Drug Plan Finder shows an approximate price that a beneficiary would pay for a 30-day supply. We used that amount in calculating total cost-sharing per protocol for this analysis. To estimate how much a beneficiary would pay for OTC Senokot and Colace, we did an internet search for the drugs at the CVS drug store website [www.cvs.com](http://www.cvs.com).<sup>10</sup> The website gave prices for both the brand name and generic version of the products.

**Note Regarding Protocol 7.** Protocol 7 is composed of a single drug, the non-small cell lung (NSCL) cancer agent Tarceva. Whereas we calculated cost-sharing for all the other protocols across all 12 Part D plans selected for this analysis, we dropped one MA-PD plan—Keystone 65 Direct Rx Option III—from our analysis of Protocol 7. We were

<sup>8</sup> U.S. Code 42 (2005) §1395x (s) (2) (Q)

<sup>9</sup> U.S. Code 42 (2005) §1395w-102(e)(2)(A)

<sup>10</sup> Accessed on August 4, 2006.

unable to determine whether this plan included Tarceva on its formulary. While CMS’s Drug Plan Finder indicated Tarceva was off formulary, Keystone’s website listed the drug as covered. Keystone’s website did not provide sufficient cost-sharing information for us to complete our calculations; therefore, we excluded the plan from our analysis of this protocol.

## Results

Figure 4 shows the beneficiary cost-sharing for each cancer protocol, based on the methods described above. The column “Part B Beneficiary Cost” includes cost-sharing for the drug and for physician administration fees. The two columns displaying the Part D beneficiary costs show the range of cost-sharing for the plans in this analysis. The column titled “Part D Beneficiary Cost Range With Generic Substitution” reflects that range with generic equivalents substituted for Vasotec, MS Contin, Percocet, Zocor, Ativan, Senokot and Colace.

**Figure 4** Beneficiary Cost-Sharing Per Protocol, With and Without Part D Generic Substitution

Cancer Protocol	Part B Beneficiary Cost*	Part D Beneficiary Cost Range**	Part D Beneficiary Cost Range, With Generic Substitution**
1 – Breast	\$7,196	\$1,788-2,850	\$1,747-2,810
2 - Metastatic Colon (FOLFOX)	\$10,920	\$355-1,075	\$355-1,075
3 - Metastatic Colon (FOLFIRI)	\$8,395	\$29–825	\$29-825
4 - High Grade Lymphoma (R-CHOP)	\$9,133	\$466-2,065	\$179-941
5 - Low Grade Lymphoma (CHOP/Rituxan)	\$7,602	\$196-991	\$136-931
6 - Metastatic Breast	\$4,691	\$2,757-4,004	\$1,145-1,681
7 – Non-Small Cell Lung	\$0	\$779-4,198	\$779-4,198

\*Includes Part B premium and physician administration fees. \*\*Low and high shown across all plans included in this analysis. Calculation includes premiums, drugs excluded from Part D, and any spending on off-formulary drugs.

These results illustrate examples of cost-sharing for cancer protocols that beneficiaries may face in Part B. They also suggest that cost-sharing in Part D can vary considerably by protocol and, within the same protocol, from plan to plan. Our key findings, which focus on the extent and sources of variation in Part D, are discussed in more detail below

## Key Findings

### **Part D plans’ coverage of the drugs in the selected cancer treatment protocols is nearly universal, but cost-sharing varies widely.**

Our analysis suggests that beneficiaries taking any of these seven protocols for cancer and other co-morbid conditions would likely find their drugs on formulary in a variety of Part D plans. Without generic substitution the rate of coverage is 87%. When AB-rated

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generics are substituted, the rate of coverage for all drugs in the analysis rises to 98%.<sup>11</sup> The difference in these figures is due to the fact that the brand-name versions of drugs with AB-rated generics are excluded from several formularies in this analysis. For instance, brand-name Vasotec, MS Contin, and Percocet are each excluded by five plans out of 12, whereas the generic versions of each are covered by all plans in this analysis.

Despite the nearly universal coverage, however, there is dramatic variation in how much beneficiaries would pay in cost-sharing for these protocols from one Part D plan to another, as indicated in Figure 5.

**Figure 5** Range of Part D Beneficiary Cost-Sharing Per Protocol

Cancer Protocol	Part D Beneficiary Cost Range, With Generic Substitution*	% Difference Between Lowest and Highest Cost Part D Plans
1 – Breast	\$1,747-2,810	61%
2 - Metastatic Colon (FOLFOX)	\$355-1,075	203%
3 - Metastatic Colon (FOLFIRI)	\$29-825	2,740%
4 - High Grade Lymphoma (R-CHOP)	\$179-941	426%
5 - Low Grade Lymphoma (CHOP/Rituxan)	\$136-931	546%
6 - Metastatic Breast	\$1,145-1,681	47%
7 – Non-Small Cell Lung	\$779-4,198	439%

\*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, and spending on any off-formulary drugs.

### Part D plans featuring copays can be more costly than coinsurance designs.

For some protocols, significant variation between the cost-sharing associated with different Part D plans was attributable to a difference in benefit design: percentage coinsurance during the initial coverage period (before the beneficiary hits the coverage gap) versus fixed dollar copays. In some cases, the copay amount charged by the plan equaled or exceeded the baseline negotiated price of the drug. This resulted in the beneficiary paying the full negotiated price as cost-sharing.<sup>12</sup> By contrast, plans with a coinsurance design would charge the same beneficiary only a fraction of the negotiated price.

For example, in the case of Protocol 2, the beneficiary is taking only one Part D drug, the brand-name asthma inhaler Proventil HFA. In some plans with a copay design, the cost-sharing for the inhaler over the course of the year was approximately 60% higher than the cost-sharing for the two plans in this analysis with coinsurance in the initial coverage period.

<sup>11</sup> There were four cases of a drug being off formulary out of a possible 179 drug and plan combinations.

<sup>12</sup> Part D plans using a copay design must charge the lower of the copay or the negotiated price of the drug.

**Figure 6** Total Part D Cost-sharing for Protocol 2: Copays vs. Coinsurance

Plan	Coinsurance / Copay	Beneficiary Cost*
Humana Standard	Coinsurance	\$290
Humana Enhanced	Copay	\$464
AARP Medicare Rx	Copay	\$465
Humana Choice PPO (IL)	Coinsurance	\$293

\*Excludes premiums

This finding was true for low cost generic drugs as well as brands; when copays exceeded the negotiated price of the drug, plans with a coinsurance design commonly had lower beneficiary cost-sharing overall. This finding should not be generalized to more costly brand-name drugs, however, for which a Tier 2 or Tier 3 copay of between \$20 and \$60 might be less than the 25% coinsurance a different plan might charge.

**Patients reach the coverage gap in three protocols; month of entry varies by plan and whether generic substitution is employed.**

In this analysis, cancer patients following three of the seven protocols would hit the Part D coverage gap—the break in standard coverage between when a beneficiary’s total drug spending reaches \$2,250 and when his or her out-of-pocket spending hits \$3,600. We calculated that beneficiaries taking protocols 1, 6 and 7 would fall into this coverage gap, as shown in Figure 7.

The month of coverage gap entry varies somewhat by plan for protocols 1 and 6. In Protocol 6, the beneficiary would enter the coverage gap in only nine of the 12 plans. However, it is important to note that the reason that beneficiaries in the other three plans do not hit the coverage gap is that those plans do not cover the brand-name versions of several drugs in the regimens. Therefore, though the beneficiary would incur significant costs in paying for the non-covered drugs out-of-pocket, under Part D rules this spending would not count toward the threshold for entering the gap.

**Figure 7** Protocols With Spending in the Gap and Month of Coverage Gap Entry, Without Generic Substitution

Protocol	Number of Plans	Month of Gap Entry
1 – Breast	12 of 12	August or September
6 - Metastatic Breast	9 of 12	May or September*
7 – Non-Small Cell Lung	11 of 11	February

\*Beneficiary enters the coverage gap in September in two of the nine plans— Secure Horizons and Keystone 65 Direct Rx— which do not cover brand-name MS Contin or Percocet.

Protocol 6 includes three brand-name drugs for which there are FDA-approved, AB-rated generics: MS Contin, Percocet, and Zocor.<sup>13</sup> When we substituted the generics and reran the analysis, we found that all 12 plans covered all the drugs in the protocol, and that a beneficiary’s spending would reach the coverage gap for all 12 plans. In addition, generic substitution delayed the beneficiary’s coverage gap entry by as much as four

<sup>13</sup> Protocol 6 also includes the OTC medicines Senokot and Colace, which are also available in generic forms. It is important to note, however, that spending on these OTC products, which are not included in the Part D benefit, does not count toward the benefit thresholds in Part D. Therefore, substituting these OTC generics for their brand-name counterparts had no effect on whether or when beneficiary entered the coverage gap.

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months; across all plans, the beneficiary would enter the coverage gap in August or September. Generic substitution did not affect the results for protocols 1 or 7, as shown in Figure 8.<sup>14</sup>

**Figure 8** Protocols With Spending in the Gap and Month of Coverage Gap Entry, With Generic Substitution

Protocol	Number of Plans	Month of Gap Entry
1 – Breast	12 of 12	August or September
6 - Metastatic Breast	12 of 12	August or September
7 – Non-Small Cell Lung	11 of 11	February

### Coverage in the gap can significantly lower beneficiary costs, but does not do so in every case.

Three of the 12 Part D plans we examined in this analysis provide some drug coverage in the coverage gap. In 2006, Humana Complete offers coverage for both generics and brands in the gap; PacifiCare Comprehensive and Keystone 65 Direct Rx Option III both cover generics only in the gap.

Our analysis shows that these plans could substantially lower beneficiary costs for the three protocols affected by the coverage gap. For example, for Protocol 6, a beneficiary would have approximately \$1,840 in cost-sharing under the Humana Complete plan, versus \$2,704 for Humana Standard and \$2,248 for Humana Enhanced.

The most striking example of the value of gap coverage is the difference in the beneficiary cost-sharing for Protocol 7, the Tarceva-only regimen, between the plans with no gap coverage (or generics-only coverage) and Humana Complete. Total beneficiary cost-sharing under Humana Complete is \$168 versus approximately \$3,730 for the other plans.<sup>15</sup>

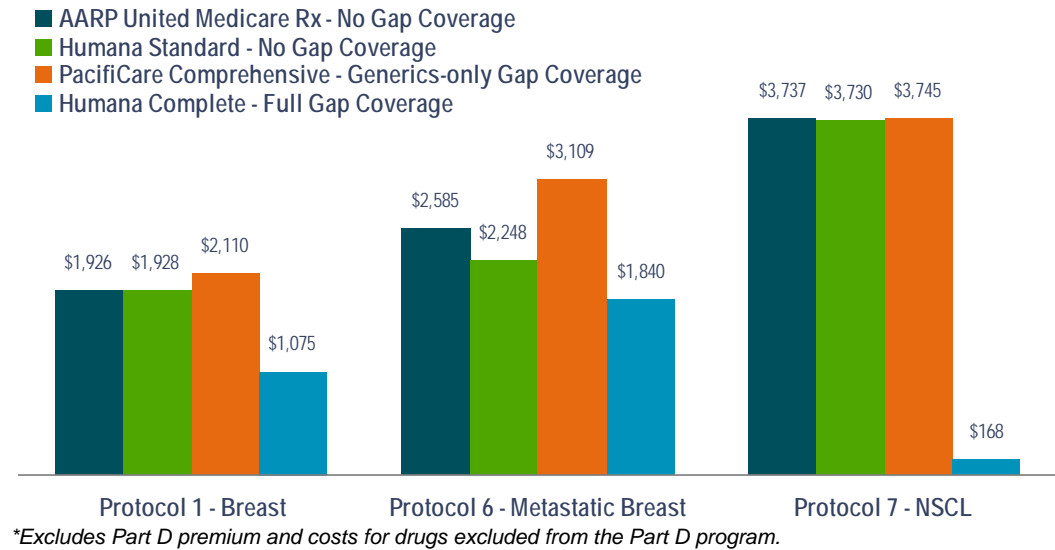
Even with these apparent benefits of coverage in the gap, there are some cases in which other design features of the plans with gap coverage outweigh the benefits for these particular protocols. For instance, there are cases in which a plan with gap coverage charged relatively high copays during the period before the gap, which in turn made overall beneficiary cost-sharing for these plans higher than for other plans without gap coverage. Also, there are some instances where brand-name drugs are off formulary in plans offering gap coverage, which also increased beneficiary cost-sharing overall. Some examples of beneficiary cost-sharing in plans with and without gap coverage are shown in Figure 9.

<sup>14</sup> Protocol 7 does not include any drugs for which there are FDA-approved generics. In Protocol 1, the brand-name drugs Arimidex and Lipitor also are not approved in generic form. All other Part D drugs in Protocol 1 were already generic (metformin, hydrochlorothiazide, prochlorperazine and dexamethasone).

<sup>15</sup> We note that, for the 2007 benefit year, Humana Complete plans to offer gap coverage for generics only.

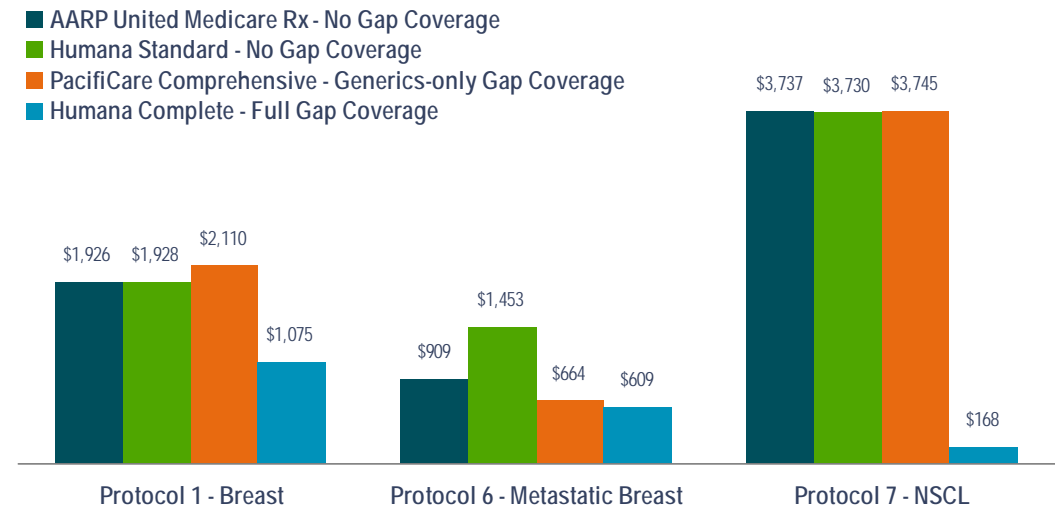
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**Figure 9** Beneficiary Cost-Sharing in Selected Plans With and Without Gap Coverage\*



Here again, substituting generics has an effect on the results for Protocol 6; because the generics were on formulary, beneficiary spending on them counts toward the threshold for entering and moving through the gap. Also, the generics-only gap coverage offered by PacifiCare Comprehensive is more meaningful when more generic drugs were included in the protocols. Figure 10 illustrates the effect of the generic substitution for Protocol 6 on the value of coverage in the gap. The results for protocols 1 and 7, for which generic substitution was not possible, are unchanged.

**Figure 10** Beneficiary Cost-Sharing With Generic Substitution in Selected Plans With and Without Gap Coverage



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### Higher premium plans may not provide better value.

The plans in this analysis have a wide range of monthly premiums, as shown in Figures 2 and 3. While premiums are not typically included in the definition of beneficiary cost-sharing, they are an additional source of cost to beneficiaries beyond copays or coinsurance for drugs. In Part D, beneficiaries have many plans to choose from, with widely varying premiums. Higher premium plans may be marketed as offering lower cost-sharing on drugs or providing coverage in the gap. For these protocols we analyzed whether, when premiums are added to drug cost-sharing, beneficiaries save money overall in these higher premium plans.

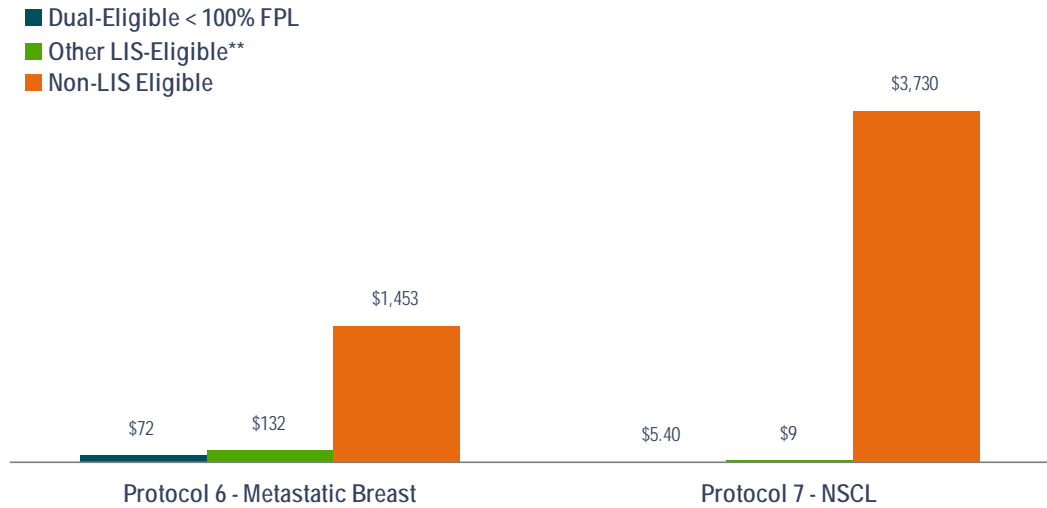
In general, our results on this subject are mixed. In some cases, beneficiaries in higher premium plans have lower out-of-pocket costs overall. However, there is a clear pattern among several of the protocols with relatively few Part D drugs (especially protocols 2, 3, 4, and 5); in those cases, beneficiary costs are higher overall in the high premium plans when premiums are included.

This analysis raises questions regarding whether the premiums charged by the plans offering generics-only coverage in the gap are always worth the higher premiums they carry. Whereas the coverage of both brands and generics offered by Humana Complete saves beneficiaries money over the cheapest Humana plan (Humana Standard) in three out of 7 protocols, PacifiCare Comprehensive is only the cheapest of the PacifiCare offerings once—for Protocol 6, when generic substitution was performed.

### Part D low-income subsidy confers significant benefit.

One point about which there is no ambiguity in our results is that the Part D low-income subsidy (LIS) affords tremendous cost-savings to beneficiaries who qualify. Individuals qualify for this extra assistance if they have incomes at or below 150% of the federal poverty level (FPL) and meet an asset test. In 2006, the lowest-income individuals in that group pay cost-sharing of \$1 for generic drugs and \$3 for brand-name drugs; those with slightly higher incomes or assets pay \$2 for generics and \$5 for brands. In all cases, these beneficiaries pay no premiums or deductibles and do not face a coverage gap. Figure 11 shows some examples of the value of the LIS for protocols 6 and 7.

**Figure 11** Part D Cost-Sharing for LIS and Non-LIS Eligibles in Humana Standard Plan, With Generic Substitution\*



\*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.**

While much of our analysis centered on the Part D side of these protocols, the high cost-sharing totals for Part B displayed in Figure 4 suggest that most drug spending by cancer patients may still be under the Part B benefit. One important difference between Part B and Part D is that beneficiaries are permitted to buy supplemental coverage to help alleviate Part B cost-sharing, whereas such supplemental help is not available for Part D. In fact, about 90% of Part B beneficiaries have supplemental coverage through either Medigap or Medicaid, both of which cover 100% of Part B cost-sharing.<sup>16</sup> Those who qualify for Medicaid receive this benefit at no additional charge; higher-income beneficiaries who purchase Medigap may be faced with relatively high premiums for that coverage. As Figure 12 shows, however, the total amounts spent in a year on Medigap premiums for the most popular Medigap plan (Plan F) in the four zip codes included in this analysis are still thousands of dollars less than what beneficiaries would otherwise have to pay in Part B cost-sharing.

**Figure 12** 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

Source: Avalere analysis of CMS’s “Medicare Personal Plan Finder” at [www.medicare.gov](http://www.medicare.gov).

<sup>16</sup> Testimony of Glenn M. Hackbarth, Chairman, Medicare Payment Advisory Commission, before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, 1 May 2003, [http://www.medpac.gov/publications/congressional\\_testimony/050103\\_medigap.pdf](http://www.medpac.gov/publications/congressional_testimony/050103_medigap.pdf) (accessed 4 February 2006).

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While some Medicare Advantage (MA) plans are included in the Part D component of this analysis, we did not evaluate these plans to determine whether their integrated benefit designs for Medicare parts A, B, and D included reduced Part B cost-sharing. Just as Medigap and Medicaid supplemental coverage can reduce overall beneficiary cost-sharing for Part B, MA plans may also, albeit under a managed care structure.

Overall, an important implication for cancer patients and their advocates is that ensuring the continued success of all sources of supplemental coverage for Part B cost-sharing may be at least as important as the strength and generosity of the Part D benefit offerings.

## Conclusions

Cost-sharing for Medicare beneficiaries with cancer can vary widely based on many factors. Under Part B, beneficiaries may be faced with thousands of dollars worth of cost-sharing, though most may be able to reduce or eliminate it through supplemental coverage sources. Part B coverage policies and access to supplemental coverage are likely to remain of paramount importance for people with cancer.

Under Part D, beneficiary cost-sharing varies dramatically from plan to plan—by hundreds and even thousands of dollars. Many of the key sources of that variation lie in individual plans' benefit designs, including whether their cost-sharing takes the form of coinsurance or copays, whether they fill or partially fill the coverage gap, and the amount of their monthly premium.

On a positive note, this analysis supports other work showing that beneficiaries' access to cancer drugs in Part D is relatively favorable overall; many cancer drugs are covered by almost all plans.<sup>17</sup> This is consistent with CMS's requirement that plans include "all or substantially all" antineoplastic drugs on their formularies in 2006.<sup>18</sup> While this policy has been renewed for the upcoming 2007 benefit year, its future is uncertain. Any changes in this policy after 2007 could significantly affect Part D plans' rate of cancer drug coverage.

Overall, beneficiaries face a difficult choice in selecting a Part D plan, particularly considering that they may not know before enrolling that they will need treatment for cancer. This case study analysis shows that some seemingly reasonable assumptions that beneficiaries with cancer might make about the type of plan they need might prove untrue. Not all cancer patients will have drug spending that reaches the Part D coverage gap threshold, and selecting a plan with gap coverage will not always translate into lower cost-sharing overall.

Similarly, higher premium plans might seem like the right fit for beneficiaries with serious illnesses such as cancer, but this analysis illustrates that higher premiums do not

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<sup>17</sup> Bowman, J. et al., "Access to Cancer Drugs in Medicare Part D: Formulary Placement and Beneficiary Cost Sharing in 2006," *Health Affairs* (25):5, September/October 2006, pp. 1240-47.

<sup>18</sup> CMS, "Medicare Modernization Act Final Guidelines—Formularies: Guidelines for Reviewing Prescription Drug Plan Formularies and Procedures," <http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/FormularyGuidance.pdf>.

## Cost-Sharing for Cancer Patients in Medicare: Seven Case Studies

necessarily mean lower cost-sharing. A worthwhile future research project might be to repeat this type of analysis with a larger number of Part D plans and possibly additional cancer treatment protocols to assess the generalizability of these case study illustrations.

In the meantime, Part D plans have begun marketing their 2007 benefit year offerings and open enrollment will begin on November 15, 2006. Initial information about plan choices for 2007 indicates that beneficiaries will have more plans to choose from than in the first year of the benefit. In addition, more plans are offering coverage in the gap, particularly of generics. Premiums are also shifting in 2007; some beneficiaries will see their premiums decline while others will face an increase. All in all, individual beneficiaries will continue to face a complex decision in choosing a Part D plan. Future endeavors to illuminate trends in the Part D market and inform beneficiaries on how to make decisions may prove valuable.



**Avalere Health LLC**  
1350 Connecticut Ave. NW  
Suite 900  
Washington, DC 20036

[www.avalerehealth.net](http://www.avalerehealth.net)