

FEATURE STORY

Maneuvering the Maze of Medicare Part D

BY SAM JAFFE

Although cancer is well-known for attacking people of all ages, the majority of cancer victims are the elderly. Thus Medicare has long been the primary means of insurance for cancer treatment. And as of Jan. 1, 2006, it also became the primary means of paying for prescription drugs. Now many cancer patients are wondering how the changes to the program will affect them.

The answer to that question depends on the individual's specific drugs, income, and previous insurance status. It's all part of Medicare's biggest overhaul since its establishment. Medicare is nothing if not big. Some 43 million Americans get their health care through the program, the majority of whom are over the age of 65. And it will soon get much bigger as the baby boomers start to arrive at retirement age.

Yet the program has also been creaking with its five decades of age. Founded in a time [the mid-1960s] when devastating hospital costs took priority over prescription drug expenses, Medicare didn't cover them. Despite an unsuccessful record to create reform, the government added a prescription drug plan to the system in 2003 called Medicare Part D.

Most Medicare cancer patients who underwent treatment prior to 2006 are probably aware of Medicare Part B—the program that covers any drugs administered to a patient in a doctor's clinic. (Medicare Part A covers inpatient treatment that a patient gets in a hospital.) Since most chemotherapy drugs are taken in a clinical setting, Part B has been the primary payer for most cancer drugs. And that won't change much under the new program.

"Cancer drugs administered in a doctor's office will still be covered under Medicare Part B," says Terry Coleman, a partner at the Washington, D.C. law firm of Ropes & Gray, who helped to lobby for patient advocacy issues in the new program. "If a doctor writes the prescription and you get the drug at a pharmacy, it qualifies for Medicare Part D. But there are only a handful of oral cancer drugs that qualify." Coleman says some of the chemotherapy drugs and anti-emetics (drugs that help with chemotherapy side effects, such as extreme nausea and intestinal distress) have recently come out with oral versions that can be taken at home rather than the doctor's office. But a rule in the program states that if there's an injectable version of an oral drug, it is still covered under Part B.

In order to spread costs across the broadest possible patient base, all Medicare beneficiaries are required to sign up for a Part D plan by May 15, 2006 in order to

avoid a penalty of higher co-pays. Thus millions of seniors have been faced with the unenviable task of finding an insurance plan that fits their needs.

Finding a Plan

Determining the right program is no easy task. There are hundreds of different private insurance companies offering plans, each of which can vary by state. Each plan differentiates itself by offering different co-pay rates, different deductibles and different formularies (specific drugs offered by the plan). However, they all must stick close to the standards set by the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003. Those standards are:

- > A yearly deductible of no more than \$250. In other words, the first \$250 of pharmacy costs must be paid for by the patient.
- > A 25 percent co-payment for the next \$2,000 in drug costs. That means any costs accrued above \$250 and below \$2,250 will be split 75 percent/25 percent between the insurance company and the patient. (Pharmacies are reimbursed by the insurer.)
- > 100 percent of costs for the next \$2,850 in drug costs is covered by the patient. This is the so-called “doughnut hole.” It leaves Medicare patients exposed to high drug costs if they have to pay between \$2,250 and \$5,100 in annual drug costs.
- > If drug costs exceed \$5,100, the co-payment from that point on is 5 percent.

While that might seem complicated enough, remember that those are only standards set by Medicare administrators. Just about every variation in co-payments, deductibles, and doughnut hole amounts is offered by private insurers.

The math alone can get excruciatingly difficult. However, it’s important to remember that in the big picture, all the plans are relatively similar. Whether they charge more for the premium or co-payment, they all must follow the same guidelines for out-of-pocket spending by the patient. Thus the catastrophic costs that used to leave some cancer patients bankrupt and sometimes without necessary treatment should now be a thing of the past for anyone eligible for Medicare.

But the homework in choosing a plan doesn’t stop there. Each insurer is allowed to negotiate its own formulary with drug makers. As a result, a particular insurance plan might not carry a specific drug that you take. Luckily, Congress included an oncology exception to the MMA, which requires that all cancer-related drugs be included in every private insurer’s formulary. Thus all prescription cancer medications that aren’t already covered by Part B, including many anti-emetic and anti-nausea supportive care drugs, will be covered by all Part D plans. It’s the drugs that cancer patients take for other problems, such as hypertension or heart conditions, that might not be covered.

Where to Begin

The first step in determining which drug plan to choose is to make a list of all the drugs you currently take. Then, when you contact insurers about their specific plans, make sure they cover those drugs in their current formulary. A good starting point is the “My Medicare” website (my.medicare.gov), which lists all the insurance plans and contact information by state. Unfortunately, it doesn’t list each plan’s formulary, so a patient must visit the website or call the toll-free phone line of the various insurance companies for more information.

Sound intimidating? Now imagine doing all that if you’re 80 years old and have never used a computer. That describes the mother of John Cox, MD, an oncologist at the Methodist Dallas Medical Center in Texas. Cox is no initiate in this area—he chairs the American Society of Clinical Oncology’s clinical practice panel, which advocated for a prescription drug program for Medicare. So when his mother was having trouble understanding how to enroll, he offered to help. Two visits and several hours at the computer left him no closer to finding the right insurance plan for his mother. “Confusing isn’t the word,” Cox says. “We narrowed it down to six or seven possible providers, but each has various promulgations and it’s maddening trying to get the exact information from different sources.” Cox next plans to turn to the pharmacist in his clinic for advice. “But not everyone has a co-worker in that field. The next few months will be a very confusing time for everyone.”

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—Nova Speece

There are other sources of help, though. One is the Patient Advocate Foundation, a non-profit organization based in Virginia. The PAF has counselors who can assist seniors in determining the right program for them, and will actually enroll them over the phone. (The PAF has no financial connection to any insurance companies.)

One person who took advantage of the PAF’s help is Nova Speece, a 66-year-old retiree from Harmony, North Carolina, who spent as much as \$300 a month in pharmacy costs—nearly half her income. Diagnosed with colon cancer in August of 2005, she underwent chemotherapy and surgery last year. A recent biopsy showed another cyst on her colon, which may or may not be cancerous. The prospect of more medical bills caused her to jump at the chance to find out more about Medicare Part D when she received a postcard from her local Social Security office. A visit to that office resulted only in a promise of more information to be mailed to her. She never received the mailing.

So, on the advice of her doctor, Speece called the PAF and was enrolled immediately in a program. Because she earns less than \$9,576 a year and is single, she qualifies for a low-income Part D plan, with no deductible and a

co-payment of only \$3 per prescription. Her future drug costs will be measured in the tens of dollars rather than in the thousands. “This is so exciting for me. I never would have imagined that one day the government would pay for these drugs. I’m so thankful for it.” Speece says she’ll spend the money she saves in prescription drug costs to pay off the almost \$5,000 she owes for surgery and doctors’ office visits from her bout with cancer.

Cancer Drug Questions

Speece, like many cancer patients, got most of her cancer medications through Medicare Part B. But that doesn’t mean Part D won’t be a big part of some cancer patients’ lives. Some of the most promising new cancer drugs only come in pill form. “One group that will really be helped by Part D will be anyone who is prescribed Gleevec,” says Coleman. Gleevec (imatinib), which costs \$2,200 a month, treats chronic myelogenous leukemia and gastrointestinal stromal tumors and was first approved by the Food and Drug Administration in 2001.



Nova Speece sought help from the Patient Advocate Foundation to find the right plan for her. Photo by Bruce Matlock.

A newly approved drug for myelodysplastic syndromes called Revlimid (lenalidomide) will cost \$4,500 a month and may soon be approved for treating myeloma. Revlimid is a derivative of Thalomid (thalidomide), a little understood chemical that somehow modulates the immune system to better fight myeloma. Though thalidomide has not officially been approved for myeloma, many oncologists are prescribing it for off-label usage. Medicare will pay for off-label use (up to 60 percent of cancer drugs are prescribed off-label) as long as that use is listed in one of three official usage reference books.

One of Cox’s biggest concerns, however, is the impact Medicare Part D will have on patient assistance programs of the pharmaceutical firms. Those programs offer free or reduced-price drugs to lower-income or uninsured patients, all at the cost of the drug companies. Cox estimates that as much as 40 percent of his patients utilize such programs. Now that all senior citizens are technically insurable, federal statute forbids drug companies from providing free pills to them. “The emphasis needs to shift from patient assistance programs to offering co-payment assistance to people in need,” says Nancy Davenport-Ennis, the founder and president of the Patient Advocate Foundation. “A few thousand dollars in co-payment costs might seem like a pittance for some of these drugs, but it might not be affordable to someone living on a small fixed income.”

CURE contacted five large drug companies with questions about the future of patient assistance programs. The only company that responded was Genentech, the biotechnology powerhouse that produces such anti-cancer blockbusters as Avastin (bevacizumab), which costs \$4,400 a month for an uninsured patient, Tarceva (erlotinib), and Herceptin (trastuzumab). Krysta Pellegrino, manager of product communications for the company, doesn’t expect to see much change in how the company runs its program. “Most of our drugs are covered by Part B already, so Part D won’t have a big impact on how we assist patients.”

But as science advances, targeted oral drugs like Gleevec and Avastin will become more the norm than the exception, which means Medicare Part D will become more important to cancer patients in the coming years. “We’re on the verge of a revolution in oral biological drugs that will target individual genes or proteins,” says Coleman. “It’s going to change how cancer is treated.” And, he points out, Medicare Part D will now pay for most such drugs.