

FEATURE STORY

The Medicare Prognosis

BY TERESA MCUSIC

The 44-year-old health insurance program faces a thorough examination.

There is good news and bad news for cancer patients using Medicare this year: More off-label cancer treatments are now covered, but some drugs may end up costing patients more.

Last fall, the federal government changed its rules to allow Medicare Part B coverage of more cancer drugs prescribed off-label—uses not approved by the Food and Drug Administration. In 2007, there were only two approved compendia—reference guides for prescription drugs—that Medicare used to determine which drugs to cover; as of November 2008, there are four.

Medicare Part B (physician and outpatient services) now covers off-label uses as long as the use is listed in one or more of the compendia, or if peer-reviewed literature supports the use. Medicare will not cover a drug if any of the compendia list the specific use as not medically accepted.

The news was also good for cancer patients receiving treatment coverage through Part D, the Medicare drug benefit. The Medicare Improvements for Patients and Providers Act of 2008, passed last July and effective January 1 of this year, applied the Part B compendia and peer-reviewed literature rules to Part D cancer drugs prescribed off-label.



The new Medicare law means Janet Cooper's Tarceva, prescribed off-label, is now covered under Part D. Photo by Eric Limon.

“That’s a big deal for us,” says Paul Precht, policy director of the Medicare Rights Center. “It was a standard of coverage under Part B, when drugs are administered in the doctor’s office. Now Part D is aligned with Part B.”

Thalomid (thalidomide) is an example of an off-label use that will now be covered under Part D, according to the National Comprehensive Cancer Network, whose compendium was among those added. Currently, the FDA-approved indication for Thalomid states that it must be given in combination with dexamethasone in patients with newly diagnosed multiple myeloma. Based on research data, NCCN also recommends using Thalomid in combination with melphalan and prednisone as primary treatment for non-transplant candidates.

But unpleasant news soon followed when new research released in December 2008 showed that oral cancer-fighting drugs covered under Part D will likely cost beneficiaries more this year. The study, released by Avalere Health and the American Cancer Society Cancer Action Network (ACS CAN), found that many oral cancer drugs have been moved by insurers to more expensive formulary tiers over the past four years, resulting in the potential for more out-of-pocket costs.

More Part D insurers have put brand-name drugs, including Gleevec -(imatinib), Sutent (sunitinib), Tarceva (erlotinib), Thalomid, and Tykerb (lapatinib), on specialty tiers that require cost sharing of 26 to 35 percent for each prescription. For example, 76 percent of the Medicare stand-alone prescription drug plans (PDPs) sampled in the study placed Gleevec on the higher-cost specialty tiers in 2009 compared with just 43 percent of the plans sampled in 2006.

[View Graphic: Whose Fair Share?](#)

This year, the cost-sharing increases mean that those with Part D plans could reach the “doughnut hole,” or gap in coverage, sooner. In 2009, when retail price total of the drug coverage (coinsurance paid by the insured plus what the insurer pays) reaches \$2,700, coverage stops and the insured is required to pay 100 percent of his or her drug coverage until their total out-of-pocket costs reach

\$4,350. After that, catastrophic coverage kicks in and the insured pays up to 5 percent of the cost of the drug for the rest of the year.

[View Graphic: Medicare Part D: Footing the Bill](#)

In addition, researchers found that the Medicare stand-alone PDPs sampled for the study are increasing their use of prior authorization to control access to branded cancer drugs. Gleevec had the largest increase with 76 percent of plans requiring it in 2009, up from 40 percent in 2006. Prior authorization for Tarceva is now required in 68 percent of the plans and for Thalomid in 71 percent of the plans, up from 41 percent and 46 percent of the plans sampled in 2006, respectively.

Cancer survivor Janet Cooper, 72, battled with insurers under Part D to get coverage for Tarceva, a \$100-a-day pill to treat her lung cancer.

Last year, she underwent weeks of appeals to Medicare that she eventually lost because the drug was prescribed as a first-line treatment after surgery that removed the upper left lobe of the cancerous lung. After paying for the first month, Cooper was able to obtain the drug last year at no cost under an income-based program offered by the drug's manufacturer, Genentech. Now, because of the new compendia that apply to Part D, she gets the drug under her Part D insurer.

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—Dick Woodruff

Despite the bureaucratic mess for her drug coverage, the Massachusetts-based artist has nothing but praise for Medicare. “I’m not against Medicare,” she says. “I had a \$36,000 operation and I didn’t pay a penny. I don’t believe there are many programs around like it.”

Indeed, Medicare has been a financial life saver for thousands of cancer patients. The program pays out \$425 billion in health care benefits each year to 44.1 million Americans 65 and older or disabled. And it is a particularly vital link to health care for almost any retiree after a cancer diagnosis.

“The majority of people diagnosed with cancer are older than 60 and therefore depend on Medicare to cover their cancer care needs,” says Susan Silver, director of communications and programs for the National Coalition for Cancer Survivorship.

In addition, as the single largest health insurer in the country, Medicare’s influence extends well beyond individual beneficiaries to the health care industry as a whole: The program covers a third of all hospital stays and controls one in

five dollars paid for health care services, according to the U.S. Department of Health and Human Services.

But despite the role of the four-decades-old program in stabilizing the health and finances of retirees, health care and policy experts agree that Medicare has been careening toward financial difficulty almost since it began. This year, as a new president and Congress roll up their sleeves to tackle fiscal policy, what to do about Medicare—expected to be unable to meet its obligations to beneficiaries in about 10 years—is likely to be a hot topic.

Impending Shortfall

Under current law, Medicare is financed by three main sources: payroll taxes, general revenues, and premiums paid by beneficiaries. Medicare Part A (inpatient hospital and post-acute care) is financed by a payroll tax paid by employers and employees. Part B (physician and outpatient services) and Part D (the Medicare drug benefit) are both financed by a combination of general revenues from the federal budget and beneficiary premiums. In addition, state contributions also help to fund Part D.

Part C of Medicare, also known as Medicare Advantage, covers payments to HMOs and other private plans (which are offered in lieu of Medicare) by drawing from Part A and B funding. With what are sometimes broader benefits and cheaper participant costs, Medicare Advantage plans have been gaining in popularity among senior citizens, despite some coverage issues and misleading sales tactics investigated last year by Congress.

Before the legislation establishing Medicare was signed into law in 1965, one in eight senior citizens 65 and older had health insurance. Today, virtually all Americans 65 and older have hospital, doctor, and prescription drug coverage through Medicare or group insurance from their former employer.

But it has been clear for some time that the program faces two major threats: the rising cost of health care and the impending retirement of the huge population bubble known as the Baby Boomers. With those factors in mind, the trustees of the Medicare program reported last year that the Medicare trust fund for hospital insurance, a reserve fund covering that aspect of the program, will be exhausted by 2019. But Medicare experts and some politicians seem unfazed by the report.

“I think the financial crisis is in the same situation as it has been for 10 years,” says Marilyn Moon, a former Medicare trustee, now vice president and director of health programs at the American Institute for Research, a bipartisan Washington think tank.

Adding 41 million Baby Boomers to the program starting in 2010 will increase costs, Moon says, “but we won’t see a dramatic tsunami coming. The continued rise in health care costs is driven more by the rise in health care overall rather than demographics.”

Concerns and Solutions

“With this new president and administration there are possibilities that didn’t exist before, irrespective of the economic situation,” says Dick Woodruff, senior director of federal government relations for ACS CAN.

Comprehensive care, including a written plan of treatment and ongoing care, and the elimination of co-pays for tobacco cessation services and breast cancer and colon cancer screening tests, are some examples of those initiatives that ACS CAN would like to see implemented, says Woodruff.

Meanwhile, the importance to cancer patients and survivors of a sound Medicare program, even with just the current benefits, can’t be underestimated. The guaranteed benefits of Medicare are now more vital than ever to cancer survivors, who frequently face exclusion from the health insurance market because of their pre-existing conditions.

Advocates say there are a number of ways to shore up Medicare’s financial difficulties. Many estimate that Baby Boomers will continue working (and receiving employer-based health benefits) and in doing so do not fully utilize or delay joining the Medicare program, Moon says.

In addition, Congress has the ability to change the law and use general tax revenues to fund hospital coverage, as it already does for Medicare’s doctors’ fees and drug costs, says Medicare Rights Center’s Precht. Congress could also increase payroll taxes to cover the costs of Part A, he says.

Savings might also come from current overpayments to the private Medicare Advantage plans, as documented by the Medicare Payment Advisory Commission, or MedPAC. The Congressional Budget Office estimates that eliminating this overpayment would save \$158 billion over the next 10 years, Precht says. Politicians also have proposed raising the eligibility age from 65 to 67, as was done on a graduated basis for Social Security.

Political Positions

The answers to Medicare’s problems will depend largely on the political will of President Barack Obama and the Democratic-led Congress.

“The question of Medicare’s solvency is not just a technical question, it’s a political question,” Precht says. “Do we as a society want to pay for health care for the elderly and people with disabilities?”

Policy briefings issued by the presidential candidates’ campaigns last year revealed a distinct difference between how the Republicans and Democrats want to tackle the financial problems of Medicare. “The Republican strategy is much more emphasis on private plans and caps on growth of Medicare,” Moon says.

Sen. John McCain (R-Arizona), a survivor of melanoma, has gone on record to say that Medicare costs should be reined in by focusing on paying providers to manage chronic diseases, rather than “reward” health care providers who provide increasingly complex services.

Some Republicans in Congress also want to limit the population allowed into

Medicare, Precht says. “They’re moving towards a situation where Medicare is less universal and more of a benefit for poor people,” he says.

President Obama supports eliminating the overpayment of the private plans under Medicare, Precht says. Also, Obama said earlier this year that overhauling Social Security and Medicare would be “a central part” of his administration’s attempts to contain federal spending.

Among those reforms may be proposals Obama made during the campaign that he would require providers that participate in Medicare or his proposed public insurance plan to use proven disease management programs for the management of chronic diseases in order to improve care and to contain costs. Providers reimbursed by Medicare also would be rewarded for achieving performance thresholds on outcome measures under Obama’s plan.

If the ultimate goal is to improve access to quality health care for all Americans—a position endorsed by ACS CAN and the American Cancer Society—then shoring up Medicare might be an avenue to achieve that goal, Precht says.

“Medicare could be an option for that,” he says. “It can survive financially if it has more support politically.”