LIFELINE

WHY CANCER PATIENTS DEPEND ON MEDICARE FOR CRITICAL COVERAGE

Cancer Action Network℠

American Cancer Society®

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ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. ACS CAN works to encourage elected officials and candidates to make cancer a top national priority. For more information, visit acscan.org.

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WHY CANCER PATIENTS DEPEND ON MEDICARE FOR CRITICAL COVERAGE

INTRODUCTION

The importance of Medicare to cancer patients and survivors cannot be underestimated. The program provides a lifeline of affordable, quality health care coverage for thousands of cancer patients. In 2012, more than 1.6 million new cases of cancer were diagnosed in the United States. Fully half of those individuals – 880,000 – were over the age of 65.[1] While the number of older Americans will increase during the coming decades, the number of elderly survivors living with cancer will also grow by more than 40% over the next 10 years alone.

This report is intended to provide policy makers and the public with an overview of the relationship between Medicare and cancer – how cancer affects the elderly and the financial impact the disease has on the program and its beneficiaries. The report includes statistics related to cancer incidence and death among the elderly, Medicare expenditures for cancer care, and out-of-pocket costs for Medicare beneficiaries with cancer compared to those who do not have the disease. The information included is timely as policy makers continue to examine the nation's budgetary priorities and fiscal stability for the future.

In the current debate over spending and deficit reduction, policy makers representing all sides of the political spectrum have suggested changes to Medicare in order to contain program spending. Some of these recommendations focus on increasing the out-of-pocket costs imposed on beneficiaries. It is important to note the significant out-of-pocket expenses that beneficiaries with complex and chronic illnesses like cancer already incur in Medicare. The same is true of beneficiaries with other leading chronic conditions such as hypertension, diabetes, and stroke, demonstrating the extent to which these additional direct patient costs are felt by those who are in the poorest health.[2]

1. American Cancer Society. *Cancer Facts & Figures 2013.* http://www.cancer.org/acs/groups/content/@epidemiologysurveilance/documents/document/acspc-036845.pdf
2. Medicare Beneficiaries Out-of-Pocket Spending for Health Care. AARP Public Policy Institute analysis of the Medicare Current Beneficiary Survey (MCBS) 2007 Cost and Use File. Policy Brief. May 2012.

HIGHLIGHTS

Cancer is a disease of the aging. The elderly account for more than half of all new cancer cases in the United States, and they are 10 times more likely than younger people to get cancer, regardless of race or ethnicity.

Lung cancer is the leading cause of death from cancer among the elderly and accounts for about one in six new cancer cases. Prostate, breast, and colorectal cancer are also leading causes of new cases of the disease in those age 65 and older.

Medicare beneficiaries with cancer have higher annual out-of-pocket costs than beneficiaries without cancer. These costs, which vary by the type of cancer, are approximately $1,500 more than for beneficiaries without the disease. For example, patients with breast and prostate cancer have higher cost-sharing expenses than patients with lung and colon cancer.

Medicare payments for cancer treatment, including amounts paid by, or on behalf of, beneficiaries totaled $34.4 billion in 2011. This amount represents almost 10% of Medicare fee-for-service dollars. Most Medicare spending on cancer covers physician services (office visits, lab tests, and Part B drugs), followed by hospital services.

In 2011, four cancers accounted for nearly half of Medicare payments for cancer. Lung and bronchus cancer accounted for 13% of Medicare cancer expenditures; breast and colorectal cancer each contributed 11%; and prostate cancer accounted for another 10%.

Cancer patients utilize hospice services at a higher rate than patients who have other chronic conditions. Lung cancer alone accounts for 9% of all hospice cases. Medicare expenditures by type of cancer are higher in the initial 12 months after a cancer diagnosis, and during the last 12 months of life.

BACKGROUND ON MEDICARE

WHO IS COVERED?

Medicare covers nearly all elderly Americans and millions of disabled individuals. Of the program's approximately 50 million beneficiaries, 41 million are 65 years of age or older and 9 million are disabled.[3]

WHAT IS COVERED?

Medicare provides a comprehensive set of benefits. Part A, the Hospital Insurance program, covers inpatient hospital services, post-hospital skilled nursing facility stays, some home-health visits, and hospice care. Part B, the Supplementary Medical Insurance program, covers physician services and a broad range of outpatient services, including care provided in hospital clinics, emergency rooms, and ambulatory surgical centers; durable medical equipment (DME); clinical laboratory and physical therapy services; and some home-health visits.

In general, outpatient prescription drugs are covered in Medicare Part D. However, some drugs, including certain medications used to treat cancer or the side effects of chemotherapy, are covered in Medicare Part B. Drugs covered under Part B are generally those that are administered to a patient by a health care professional in an office or clinic setting.

Cancer screenings, smoking cessation counseling, and other preventive health services are also covered under Part B, subject to certain guidelines. The table below lists Medicare's coverage requirements for cancer screenings.

A "Welcome to Medicare" preventive visit is covered for beneficiaries during their first year of enrollment, and annual wellness visits are covered thereafter. These visits include a thorough review of the person's health; education and counseling on preventive services, including cancer screenings; and referrals for other needed care. The secretary of Health and Human Services has the discretion to expand Medicare coverage to include additional preventive services in the future.

Breast cancer screening (mammograms)	Covered annually for female beneficiaries over age 40, with a baseline mammogram for those ages 35 to 39
Cervical cancer screening (Pap test and pelvic exam)	Covered once every 24 months, and annually for certain high-risk women
Prostate cancer screening (digital rectal exam and prostate-specific antigen [PSA] test)	Covered annually for male beneficiaries age 50 and older
Colorectal cancer screening (fecal occult blood test, colonoscopy, and sigmoidoscopy)	Fecal occult blood test covered annually; colonoscopy covered every 10 years (more frequently for high-risk patients); or flexible sigmoidoscopy covered every 48 months

3. Congressional Research Service, Medicare Primer 2012.

Hospice care is limited to people with a terminal illness who are expected to live six months or less if the disease runs its normal course and to people who are willing to forego curative treatment. Hospice benefits include pain relief, supportive medical and social services, physical therapy, nursing services, and symptom management for a terminal illness. Medicare will also cover some short-term inpatient stays (for pain and symptom management) and inpatient respite care.

Part D is Medicare's prescription drug program, through which beneficiaries may enroll in a private prescription drug plan that contracts with Medicare. Although a standard benefit is defined in law, plans are permitted to vary the standard design and to include more generous benefits. For cancer patients considering Part D coverage options, a key concern is the adequacy of coverage for cancer-related drugs. Under Centers for Medicare & Medicaid Services (CMS) guidance, the formularies for Part D plans must include all, or substantially all, cancer-related drugs. Accordingly, oral anticancer drugs, including brand-name products, are covered by nearly all plans, although utilization management requirements and high cost-sharing requirements might limit access to some of these drugs.[4]

In Medicare Part C, or Medicare Advantage (MA), beneficiaries may choose to enroll in a private health plan that contracts with Medicare to provide benefits under Parts A and B or Parts A, B, and D. (Most MA plans also offer Part D coverage; such plans are referred to as a Medicare Advantage Prescription Drug or MA-PD plans.) MA plans may also offer additional benefits, but beneficiaries who enroll in these plans may face a restricted choice of providers. In 2012, about one in four Medicare beneficiaries was enrolled in an MA plan.[5]

Medicare has recognized the need to provide certain exceptions for cancer patients, including covering many cancer screening services without cost sharing; covering certain prescription drugs under Part B; requiring Part D plans to cover all, or substantially all, anticancer drugs; and making coverage of anticancer off-label drug uses under Part D consistent with Part B.

HOW MUCH DO BENEFICIARIES PAY?

Medicare beneficiaries pay cost sharing in the form of premiums, deductibles, and coinsurance on covered services. A monthly premium is required for Part B coverage, and those who enroll in a prescription drug plan under Part D pay an additional premium for that coverage as well. No premium is ordinarily required for Part A benefits. A deductible is charged for hospital inpatient stays, for Part B services overall, and in the standard Part D benefit. Subsidies to cover Medicare cost sharing are available to low-income beneficiaries. Cost sharing may differ for MA plan enrollees.

Part B premium. The Part B premium amount is established each year at the level needed for total premium collections to cover 25% of total Part B expenditures. In 2013, the monthly Part B premium is $104.90. Since 2007, higher-income beneficiaries have been required to pay an additional income-related Part B premium. In 2012, about 5% of beneficiaries paid the higher premium. Income thresholds through 2019 are $85,000 for a beneficiary filing an individual income tax return or married and filing a separate return, and $170,000 for a beneficiary filing a joint tax return.

Cost sharing under Parts A and B. Medicare beneficiaries are subject to deductibles and coinsurance for services provided under Parts A and B. A deductible applies to inpatient hospital stays, which is $1,184 in 2013. Daily copayments apply to long hospital stays, beginning after 60 days, and to skilled nursing facility stays after 20 days. An annual deductible ($147 in 2013) applies to all Part B services, except for certain preventive benefits including colorectal cancer screening, mammograms, Pap tests, PSA tests, smoking cessation counseling, and the "Welcome to Medicare" preventive visit and annual wellness visits. Physician visits and most Part B services require a 20% beneficiary coinsurance for each item or service. Medicare does not require any coinsurance on outpatient laboratory tests, which includes Pap tests, PSA tests, and fecal occult blood tests (FOBT) used for colorectal cancer screening. Unlike most private employer health plans, original fee-for-service (FFS) Medicare does not provide a cap on out-of-pocket expenditures by beneficiaries. As a result, even with Medicare coverage, health care can be costly to beneficiaries who are sick and need extensive care.

Part D premiums and cost sharing. Monthly premiums for Part D prescription drug plans (PDPs) vary depending on the plan chosen by the beneficiary. The average monthly premium for a Part D plan in 2013 is approximately $40.18. Plans must offer either the standard benefit or one that is equal in value, and may also offer enhanced benefits. In 2013, the defined standard Part D benefit has a $325 deductible, 25% coinsurance up to an initial coverage limit ($2,970), a $3,985 coverage gap (the donut hole), and catastrophic coverage, which begins once the total covered drug spending for the enrollee reaches $6,955. To reach catastrophic coverage, the enrollee must incur total out-of-pocket costs of $4,750. For

4. Centers for Medicare & Medicaid Services, *Medicare Prescription Drug Benefit Manual*, Chapter 6-Part D Drugs and Formulary Requirements, www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/downloads/Chapter6.pdf

5. Centers for Medicare & Medicaid Services, *Monthly Contract and Enrollment Summary Report*, December 2012.

all covered drug spending after that point, enrollees pay the greater of 5% coinsurance or a copayment ($2.65 generic or $6.60 brand). The Affordable Care Act gradually lowers out-of-pocket costs in the Part D coverage gap. For 2013, enrollees in standard benefit plans, which are those plans that do not provide any additional gap coverage, will pay 47.5% of the total cost of brand-name drugs and 79% of the total cost of generics until they reach the catastrophic coverage limit.

Of particular importance to cancer patients, most PDPs impose higher cost sharing on the use of high-cost specialty drugs by placing them in higher cost-sharing formulary tiers, called specialty tiers. The additional cost sharing required by plans for drugs included in these specialty tiers can add significantly to beneficiary out-of-pocket costs and increase the likelihood of cancer patients reaching the coverage gap. In 2012, median cost sharing for a drug placed on a specialty tier was 30% among PDPs.[6]

Cost sharing in Medicare Advantage. Beneficiaries enrolled in a Medicare Advantage plan face different out-of-pocket costs than those enrolled in original fee-for-service Medicare. Most MA plans do not charge an additional premium above the Part B amount, although some plans do, and some offer rebates to reduce the Part B premium for enrollees. (In general, MA plans are required to offer rebates to beneficiaries in the form of reduced premiums, reduced cost sharing, or increased benefits). An MA plan may impose different copayments, coinsurance, and deductibles for Medicare Part A and Part B services from those charged under original Medicare. However, the overall cost-sharing amount imposed on a beneficiary enrolled in a Medicare Advantage plan cannot exceed what beneficiaries would be expected to pay had they been enrolled in original FFS Medicare. Many MA plans offer reduced cost sharing, including providing for a cap on out-of-pocket costs, and some reduce the beneficiary's Part B premium.

Subsidies for low-income beneficiaries. Subsidies are available to cover Part B and Part D premiums and cost sharing for certain low-income beneficiaries. Beneficiaries who are enrolled in Medicaid (full dual eligibles) and certain others who qualify on the basis of their income can have their Part B premiums paid for by Medicaid. Other beneficiaries can receive assistance through a Medicare Savings Plan. In some states, beneficiaries must meet both an income standard and assets test to qualify for assistance with Part B cost sharing. Eligibility for assistance with Part D is determined separately, based on a single national eligibility standard that includes both an income standard and an assets test. Those who are eligible for Part D assistance can receive a subsidy of up to 100% of the Part D premium.

Medicare supplemental coverage. Most beneficiaries do not pay Medicare cost sharing directly. One-third have employer coverage to supplement Medicare; 24% purchase private Medicare supplemental policies, otherwise known as Medigap; and 20% receive coverage through Medicaid. Another 19% are covered by Medicare Advantage plans. Only 12% are covered by fee-for-service Medicare alone.[7] While 60% of beneficiaries have prescription drug coverage through Part D, another 30% get their drug coverage through employer-sponsored retiree health plans, the Veterans Administration, or other public and private sources.[8]

6. Medicare Payment Advisory Commission, *A Data Book: Health Care Spending and the Medicare Program*, Section 10, Prescription Drugs, June 2012, www.medpac.gov/document_TOC.cfm?id=617

7. Kaiser Family Foundation, Medicare at a Glance Fact Sheet, November 2012.

8. Medicare Payment Advisory Commission, *A Data Book: Health Care Spending and the Medicare Program*, Section 10, Prescription Drugs, June 2012, www.medpac.gov/document_TOC_.cfm?id=617

LIST OF CHARTS

NOTES ON THE CHARTS

Medicare claims data analysis. Many of the charts in this report are based on analysis of Medicare expenditures for 2011 prepared by Direct Research, LLC. The analysis was conducted using the Medicare 5% sample limited data set (LDS) standard analytic files (SAF) for 2011. Totals shown for physician payment include payments for physician office visits, independent laboratory, ambulance, Part B drugs, and certain other Part B services. Likewise, payment totals for outpatient hospital services also include payments to dialysis facilities and certain other freestanding outpatient facilities.

Facility claims with a principal diagnosis of cancer and claims for physician care and other services with a line-item diagnosis of cancer were identified as cancer claims. This approach does not capture the additional cost burden from cancer when it is coded on the claim as a secondary diagnosis, but it does include the costs of follow-up services for persons with cancer in remission. Diagnosis codes included in the Clinical Classification System categories of "Other and unspecified benign neoplasm" and "Neoplasms of unspecified nature or uncertain behavior" were not included in the cancer totals. Similarly, the costs of treating the side effects of cancer treatments are generally not captured because diagnoses other than cancer are coded for these claims.

Finally, claims for anti-anemia drugs (i.e., erythropoietin, Aranesp, Procrit), coded as unrelated to end-stage renal disease (ESRD), were analyzed separately. The primary non-ESRD use of these drugs is for treatment of chemotherapy side effects. However, these claims are coded with a diagnosis of anemia, not cancer, and therefore would not be included in the total for cancer care, which reflects claims identified by the presence of a diagnosis code of cancer. By contrast, expenditures for chemotherapy agents or other drugs covered in Medicare Part B are included in the relevant cancer treatment claims totals. That is, Part B drugs billed on physician claims with a line-item diagnosis of cancer are included as Medicare expenditures for physician care, and those billed on hospital outpatient department claims are included as expenditures for hospital outpatient department services.

The Medicare 5% sample database does not include all Medicare expenditures. It is limited to Medicare fee-for-service claims, meaning that expenditures for cancer treatment and screening by private Medicare Advantage plans are not included. About one in four beneficiaries is enrolled in Medicare Advantage for their Medicare benefits. The database also does not include expenditures for outpatient prescription drugs, which are not covered under fee-for-service Medicare. More than 60% of Medicare beneficiaries are enrolled in private stand-alone Medicare Part D prescription drug plans or Medicare Advantage plans with Part D coverage.[9]

Additional analyses. Other charts for this report were prepared by the Surveillance and Health Services Research Program of the American Cancer Society using data from the North American Association of Central Cancer Registries, the National Center for Health Statistics, the National Cancer Institute, and various journal articles.

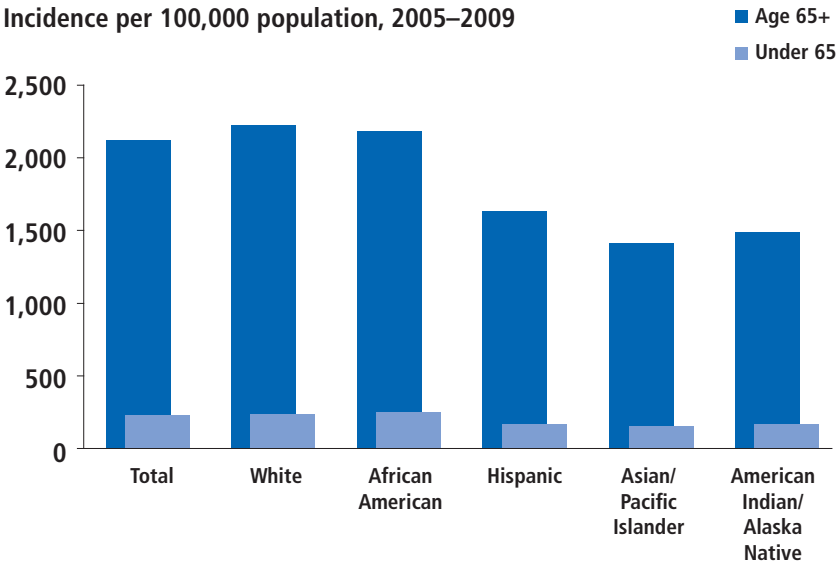
References to breast cancer and lung cancer. Breast cancer refers to female breast cancer only except for Chart 3 in the Out-of-pocket Costs for Medicare Beneficiaries with Cancer section and Chart 2 in the Medicare Expenditures for Cancer Care section, which presents Medicare expenditures for all breast cancer. Unless otherwise stated, lung cancer refers to cancers of the lung and bronchus combined.

9. CMS, *Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Contract Report – Monthly Summary Report*, (Data as of December 2012).

THE IMPACT OF CANCER ON THE ELDERLY

CHART 1

The elderly are 10 times more likely than younger people to get cancer.



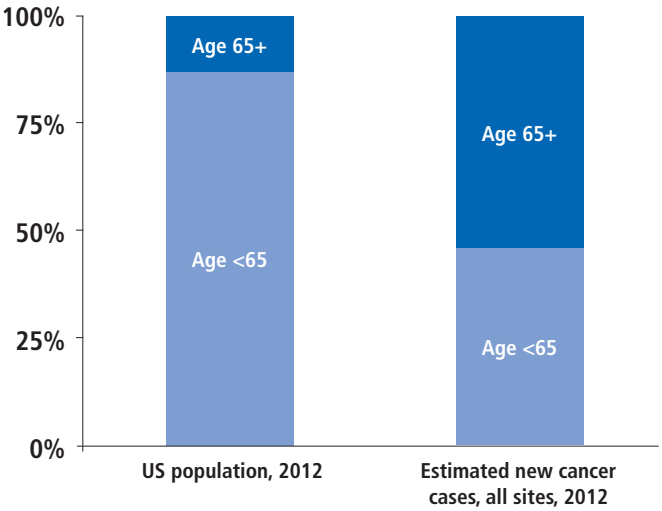
The incidence of cancer among the elderly is 10 times higher than for those under 65, a finding that holds true across racial and ethnic groups.

Notes: Rates are age adjusted to the 2000 US standard population. Data shown are for whites and African Americans and exclude Hispanics.

Source: Surveillance, Epidemiology, and End Results Program (SEER), SEER 17 Registries, Division of Cancer Control and Population Science, National Cancer Institute. Prepared by the Surveillance and Health Services Research Program of the American Cancer Society, 2012.

CHART 2

Medicare beneficiaries over age 65 account for 54% of all new cancer cases.



Those ages 65 and older accounted for more than 880,000 of the estimated 1.6 million new cancer cases in 2012.

Although they account for half of the new cancer cases, the elderly make up only 14% of the national population.

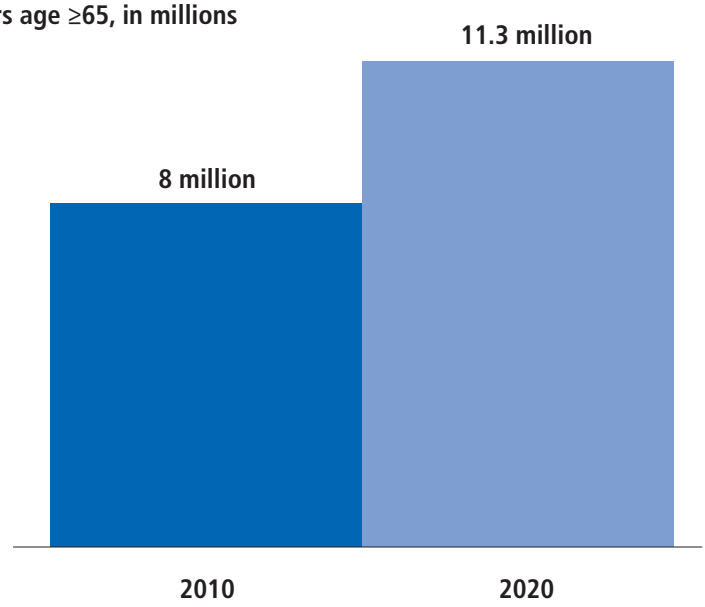
Note: The method for estimating new case counts has changed from previous years.

Source: Estimated cases are based on 1995-2008 incidence rates from 48 states and the District of Columbia, representing about 95% of the US population as reported by the North American Association of Central Cancer Registries. Prepared by the Surveillance and Health Services Research Program of the American Cancer Society, 2012. Population projections from the US Census Bureau.

CHART 3

The number of cancer survivors over age 65 will increase by 42% over the next decade.

Total number of cancer survivors age ≥65, in millions



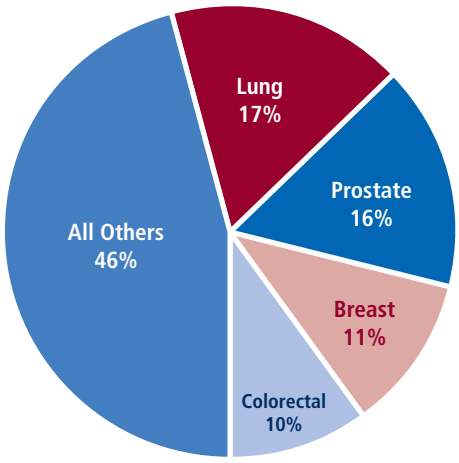
The number of elderly cancer survivors is expected to increase by more than 3 million over the next 10 years.

Source: Mariotto AB, Yabroff KR, Shao Y, Feuer EJ, Brown ML.,"*Projections of the Cost of Cancer Care in the United States: 2010-2020,*" Journal of the National Cancer Institute, January 19, 2011.

CHART 4

Four cancers account for more than half of all new cancer cases among the elderly.

Estimated new cancer cases, age 65+, 2012



Lung cancer accounts for about one in six new cancer cases among the elderly, followed by prostate, breast, and colorectal cancer.

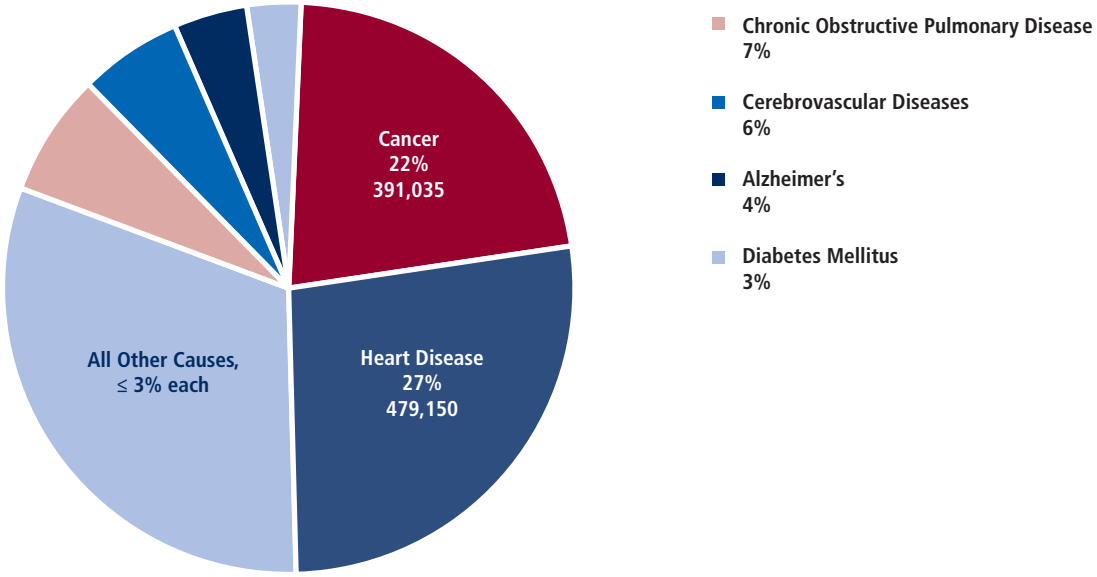
Note: The method for estimating new case counts has changed from previous years.

Source: Estimated cases are based on 1995-2008 incidence rates from 48 states and the District of Columbia, representing about 95% of the US population as reported by the North American Association of Central Cancer Registries. Prepared by the Surveillance and Health Services Research Program of the American Cancer Society, 2012. Population projections from the US Census Bureau.

CHART 5

Cancer is a leading cause of death among the elderly.

Causes of death, age 65+, 2009
Total deaths = 1,761,937

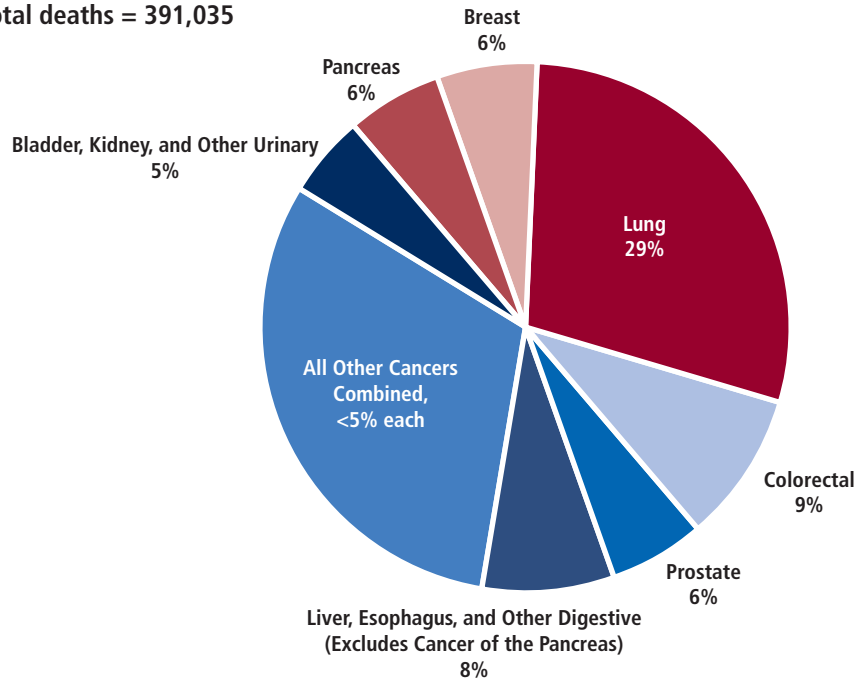


Source: National Center for Health Statistics. Prepared by the Surveillance and Health Services Research Program of the American Cancer Society, 2012.

CHART 6

Lung cancer leads among all cancer deaths for those over age 65.

Cancer deaths age 65+, 2009
Total deaths = 391,035



Colorectal cancer ranks second after lung cancer, causing 9% of cancer deaths in the elderly.

Prostate, breast, and pancreatic cancer are also the cause of many cancer deaths among those ages 65 and older.

Source: National Center for Health Statistics. Prepared by the Surveillance and Health Services Research Program of the American Cancer Society, 2012.

OUT-OF-POCKET COSTS FOR MEDICARE BENEFICIARIES WITH CANCER

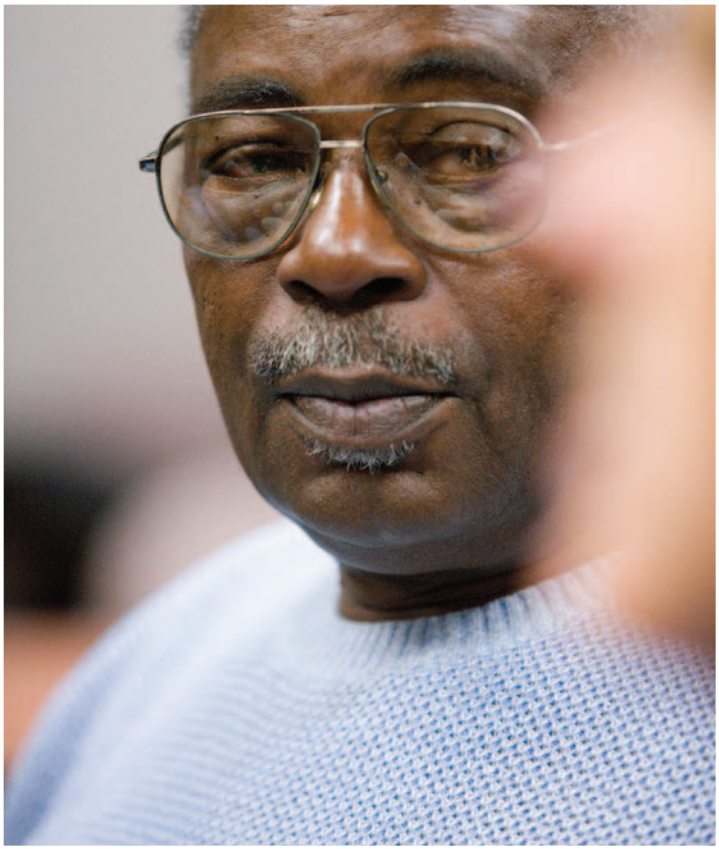
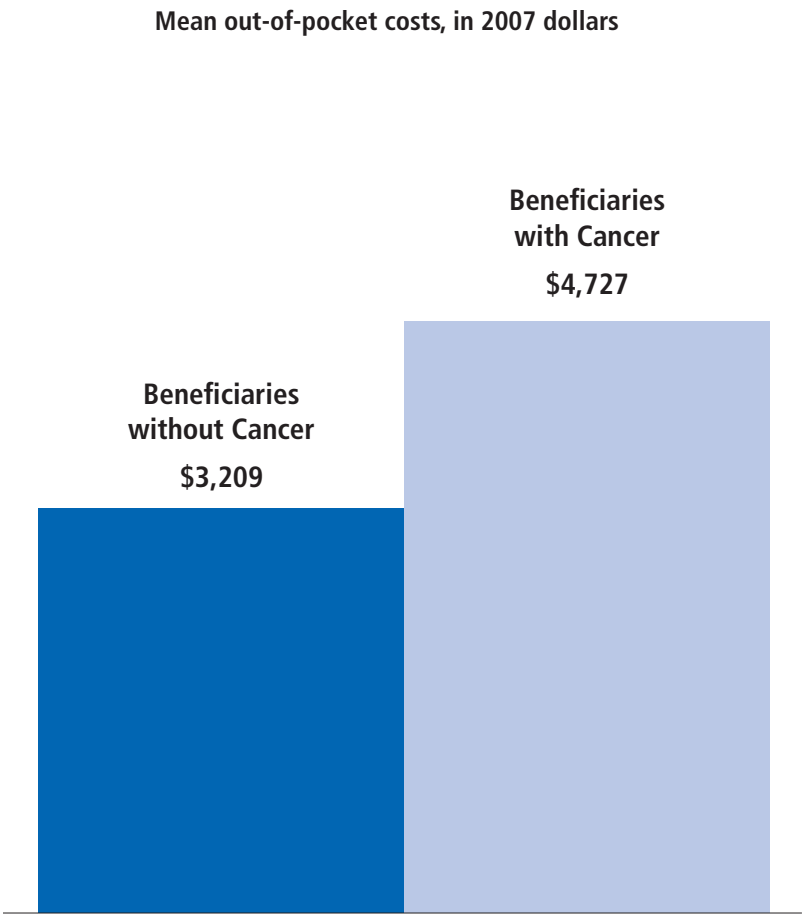


CHART 1

Medicare beneficiaries with cancer have higher out-of-pocket costs than beneficiaries without cancer.

On average, out-of-pocket costs for beneficiaries with cancer are approximately $1,500 more than for beneficiaries without cancer.



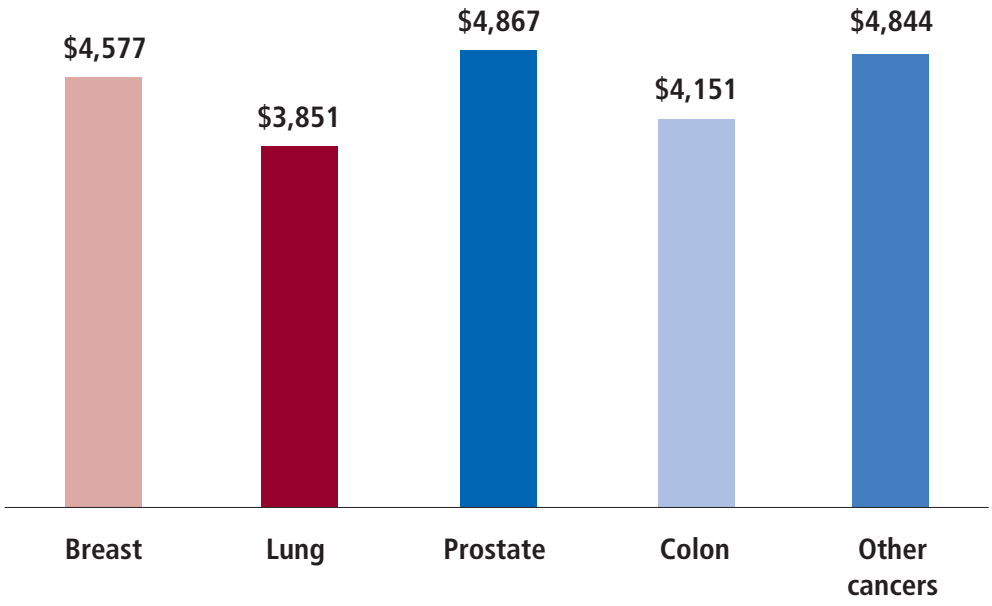
Note: Out-of-pocket costs are measured over a two-year period and include deductibles, copayments, and coinsurance for services that are and are not covered by Medicare. For beneficiaries with cancer, data from the cancer diagnosis and subsequent year are captured. For beneficiaries without cancer, a matched two-year period is considered.

Source: Amy J. Davidoff and others, "*Out-of-Pocket Health Care Expenditure Burden for Medicare Beneficiaries With Cancer*," Cancer, December 7, 2012.

CHART 2

Average Medicare beneficiary out-of-pocket costs vary by type of cancer.

Average out-of-pocket costs are higher for patients with cancers of the breast and prostate than for patients with lung or colon cancer.



Note: Out-of-pocket costs are measured for the cancer diagnosis and subsequent year, and include patient cost-sharing amounts for services that are and are not covered by Medicare. "Other cancers" includes all cancer sites, excluding breast, lung, prostate, and colon.

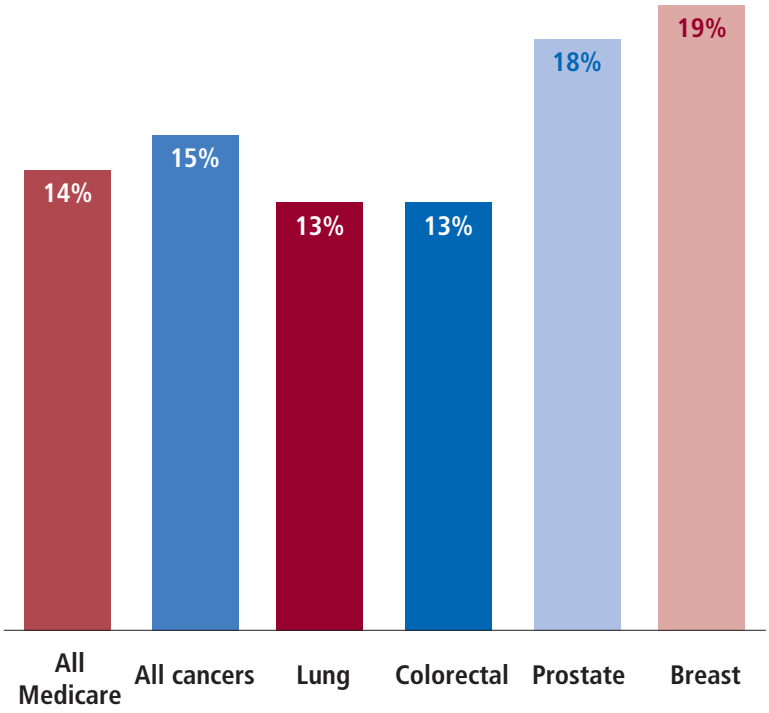
Source: Amy J. Davidoff and others, "Out-of-Pocket Health Care Expenditure Burden for Medicare Beneficiaries With Cancer," Cancer, December 7, 2012.

CHART 3

Medicare beneficiaries pay 15% of Medicare fee-for-service expenditures for cancer care.

As a share of Medicare fee-for-service expenditures, beneficiary out-of-pocket costs are higher for cancer of the prostate and breast than for lung and colorectal cancer.

Beneficiary out-of-pocket costs as a percent of expenditures, 2011



Note: Includes beneficiary out-of-pocket spending (i.e., deductibles and coinsurance), as well as amounts paid directly by Medicare. Medicare fee-for-service expenditures exclude spending by Part D prescription drug plans and Part C Medicare Advantage plans.

Source: Medicare five percent sample LDS SAF files, 2011. Analysis by Direct Research, LLC.

MEDICARE EXPENDITURES FOR CANCER CARE

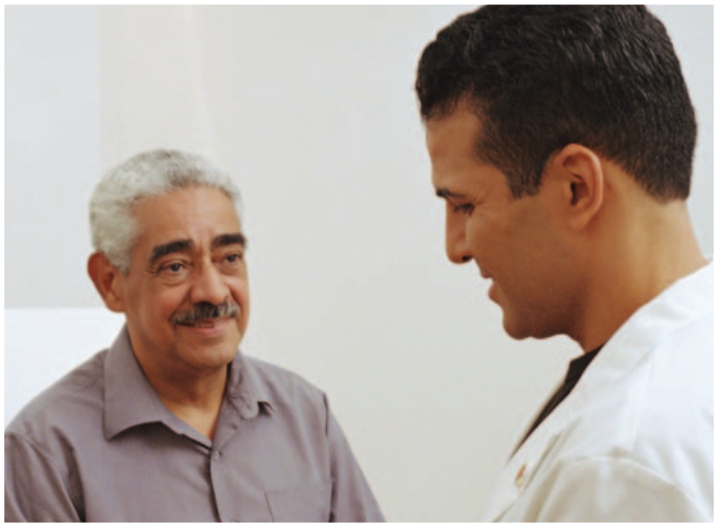
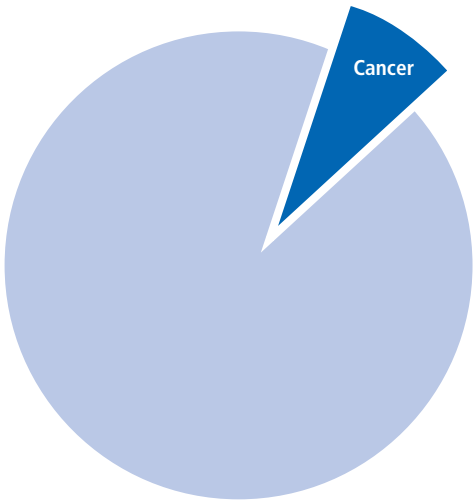


CHART 1

One in 12 Medicare fee-for-service dollars is spent on cancer care.

2011 Medicare fee-for-service payments
Total = $405.1 billion



Medicare fee-for-service payments for cancer care totaled $34.4 billion in 2011.

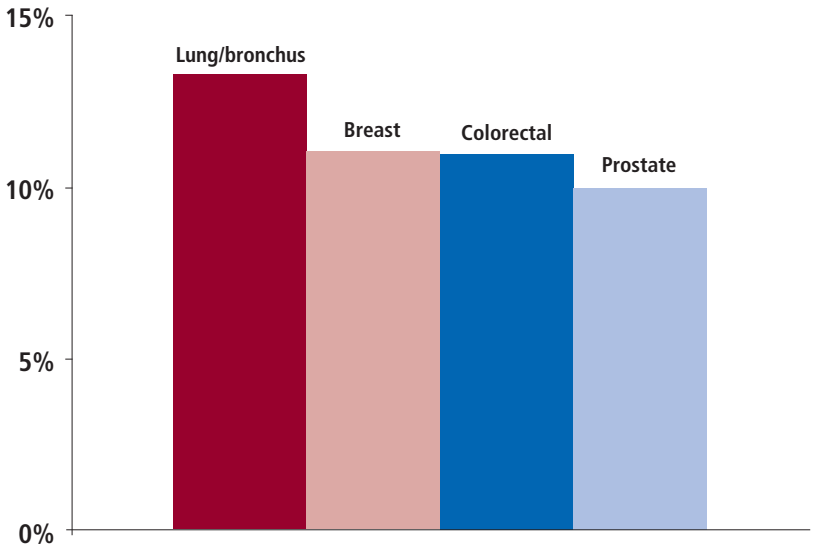
Note: Includes beneficiary cost sharing, as well as amounts paid directly by Medicare. Medicare fee-for-service expenditures exclude spending by Part D prescription drug plans and Part C Medicare Advantage plans.

Source: Medicare five percent sample LDS SAF files, 2011. Analysis by Direct Research, LLC.

CHART 2

Four cancers account for nearly half of Medicare cancer expenditures.

Percent of Medicare fee-for-service cancer payments, 2011
Total = $34 billion



Lung and bronchus cancer accounted for about 13% of Medicare cancer expenditures in 2011; breast and colorectal cancer each contributed 11%; and prostate cancer accounted for another 10%.

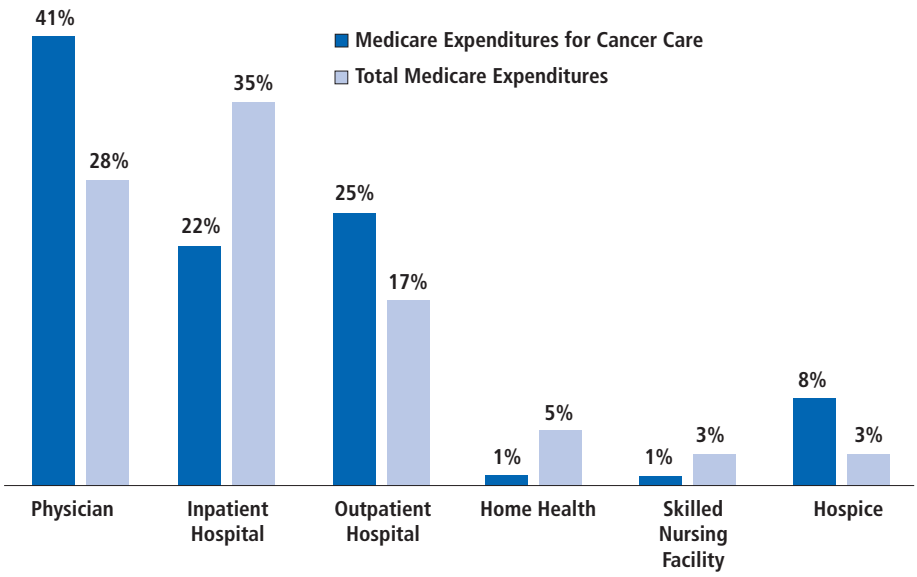
Note: Includes beneficiary cost sharing, as well as amounts paid directly by Medicare. Medicare fee-for-service expenditures exclude spending by Part D prescription drug plans and Part C Medicare Advantage plans.

Source: Medicare five percent sample LDS SAF files, 2011. Analysis by Direct Research, LLC.

CHART 3

Physician services accounted for most Medicare fee-for-service payments for cancer care in 2011.

Distribution of Medicare fee-for-service expenditures, 2011



The mix of services comprising cancer care spending differs from Medicare expenditures overall, with less spending on inpatient hospital care and more on physician, outpatient hospital, and hospice care.

Note: Physician services include payments for office visits, Part B drugs billed by physicians, independent laboratory services, ambulance services, and other services in the Medicare physician claims file. Outpatient hospital services include other freestanding outpatient facilities. Medicare fee-for-service expenditures exclude spending by Part D prescription drug plans and Part C Medicare Advantage plans.

Source: Medicare five percent sample LDS SAF files, 2011. Analysis by Direct Research, LLC.

CHART 4

Cancer drugs account for a large share of Medicare Part B drug expenditures.

Drug	Indication	Allowed charges (in millions)	Percent of 2010 spending	Rank by % of spending
Rituximab	Lymphoma, leukemia, rheumatoid arthritis	$849	7.4%	2
Bevacizumab	Cancer, age-related macular degeneration	$766	6.6%	3
Pegfilgrastim	Cancer	$553	4.8%	5
Darbepoetin alfa	Anemia	$374	3.2%	6
Epoetin alfa	Anemia	$327	2.8%	7
Pemetrexed	Lung cancer	$276	2.4%	8
Docetaxel	Cancer	$269	2.3%	9

Approximately one-third or $3.4 billion of Medicare expenditures for Part B-covered drugs are for seven drugs that either treat cancer or the side effects associated with treating cancer.

Total expenditures for all Part B drugs totaled $11.5 billion in 2010.

Notes: Data reflect Part B-covered drugs administered in physicians' offices or furnished by suppliers and not those furnished in hospital outpatient departments or dialysis facilities.

Source: Medicare Payment Advisory Commission, A Data Book: Healthcare Spending and the Medicare Program, June 2012.

CHART 5

Approximately 30% of Medicare hospice utilization is for cancer patients.

Data for 2009		
Disease category	**Percent of patients using hospice services**	**Percent of patients with length of stay greater than 180 days**
Cancer (except lung cancer)	22%	10%
Lung cancer	9%	8%
Circulatory, except heart failure	10%	19%
Heart failure	7%	21%
Debility, not otherwise specified	10%	25%
Alzheimer's and similar diseases	6%	35%
Other diagnoses	36%	25%
All	100%	20%

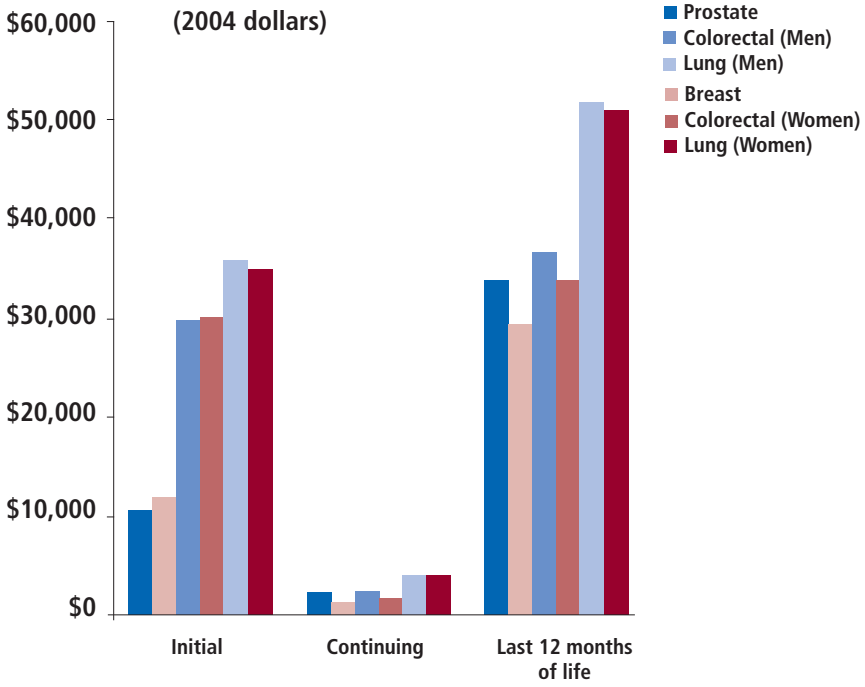
Cancer patients use hospice services at a higher rate when compared to patients who suffer from other chronic conditions.

Lung cancer alone accounts for 9% of all hospice utilization.

Source: Medicare Payment Advisory Commission, A Data Book: Healthcare Spending and the Medicare Program, June 2012.

CHART 6

Costs of cancer care to Medicare are highest in the initial phase of care and the last year of life.



Costs in the last year of life range from $34,000 for prostate cancer in men and colorectal cancer in women to more than $50,000 for lung cancer for both men and women.

Notes: Initial period is the first 12 months following diagnosis; continuing treatment phase is the months between the initial period and the last 12 months of life. Costs of continuing phase are annualized. Costs in the last year of life include cancer patients dying of other causes.

Source: Yabroff, R. and others, "*Cost of Care for Elderly Cancer Patients in the United States*," Journal of the National Cancer Institute, May 7, 2008.

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