

Moving Cancer Drugs from Medicare Part B to Part D Could Harm Cancer Patients



In a May 2018 regulatory notice, the Administration and the Centers for Medicare & Medicaid Services (CMS) indicated it was considering moving coverage of prescription drugs currently covered in the Medicare Part B program to the Part D program.¹

ACS CAN is very concerned about proposed policy changes that would move coverage of cancer and supportive care drugs from Part B to Part D. Proposed policy changes could jeopardize patient access to drugs, create potential safety issues, and increase out-of-pocket costs for patients who already struggle to afford cancer treatment under the current Medicare program.

Under the current Medicare program several categories of drugs “incident to” physician services are covered under Part B. These include: some antigens, injectable osteoporosis drugs, erythropoiesis-stimulating drugs, blood clotting factors, oral end stage renal disease drugs, cancer medications, parenteral and enteral nutrition, nebulizers, immunosuppressives, intravenous immune globulin, and vaccines.² Historically, coverage was provided under Part B because these medications are generally administered by a physician – not self-administered by a patient – and therefore should be reimbursed under the physician component of Medicare.

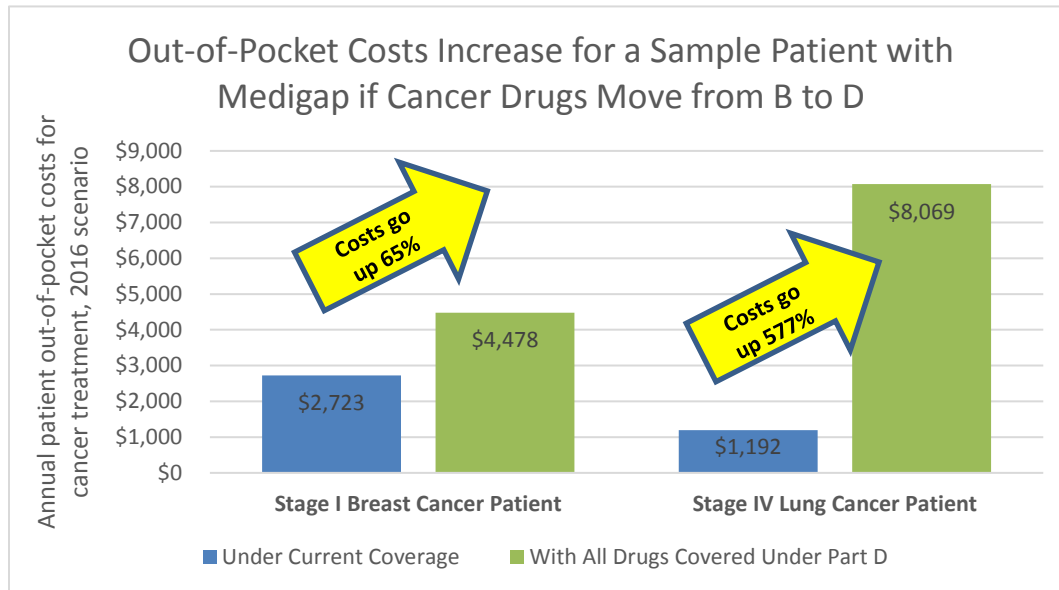
Increased Patient Costs

The average Medicare beneficiary maintains a modest income – half of all Medicare beneficiaries have incomes of less than two times the federal poverty level (\$24,280 for an individual and \$32,920 for a family of two in 2018).³ Moving the coverage of cancer drugs from Medicare Part B to D has several implications for beneficiary costs.

To illustrate how shifting cancer drugs from Part B to Part D could affect beneficiary out-of-pocket spending, ACS CAN created two common patient treatment scenarios for Stage I breast cancer and Stage IV lung cancer. Working with American Cancer Society medical experts, we identified typical drug regimens for these two diagnoses. The scenarios include drugs currently covered under Medicare Part B and Part D. This analysis is limited only to drugs that would be provided to the patient for cancer care, though we recognize that most beneficiaries would be taking additional prescription drugs related to other conditions. Analysts at Avalere simulated the total healthcare costs and patient out-of-pocket costs for these patients’ care if their Part B drugs were to move to coverage under Part D.

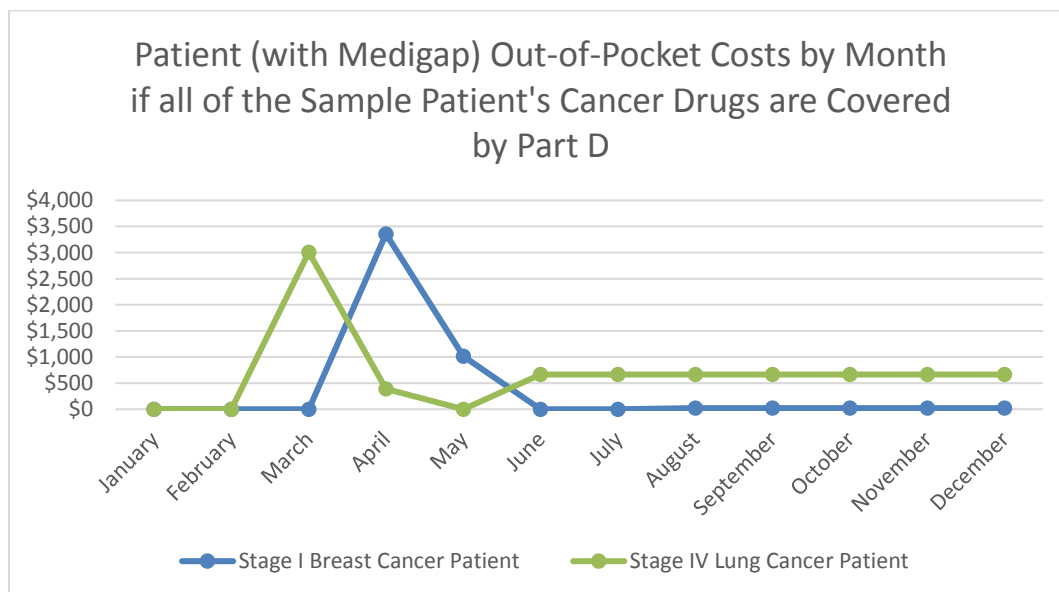
In both cases, the changes in out-of-pocket costs differed based on whether the patient had purchased individual private Medigap coverage. **For the lung and the breast cancer patients who had Medigap coverage, shifting drugs from Part B to Part D caused significant increases in annual out-of-pocket costs for cancer treatment.**⁴ This was primarily because Medigap policies provide coverage for beneficiary cost-sharing related to Part A and B expenses (to varying degrees depending on the plan). Medigap plans do not cover any cost-sharing related to Part D. For purposes of this analysis, we assumed the beneficiary was enrolled in Medigap Plan F - the most popular plan option.⁵

Policy Impact for Beneficiaries with Medigap: Costs increased significantly for the patients in these scenarios with Medigap, particularly for the patient with lung cancer, who receives several months of immunotherapy.



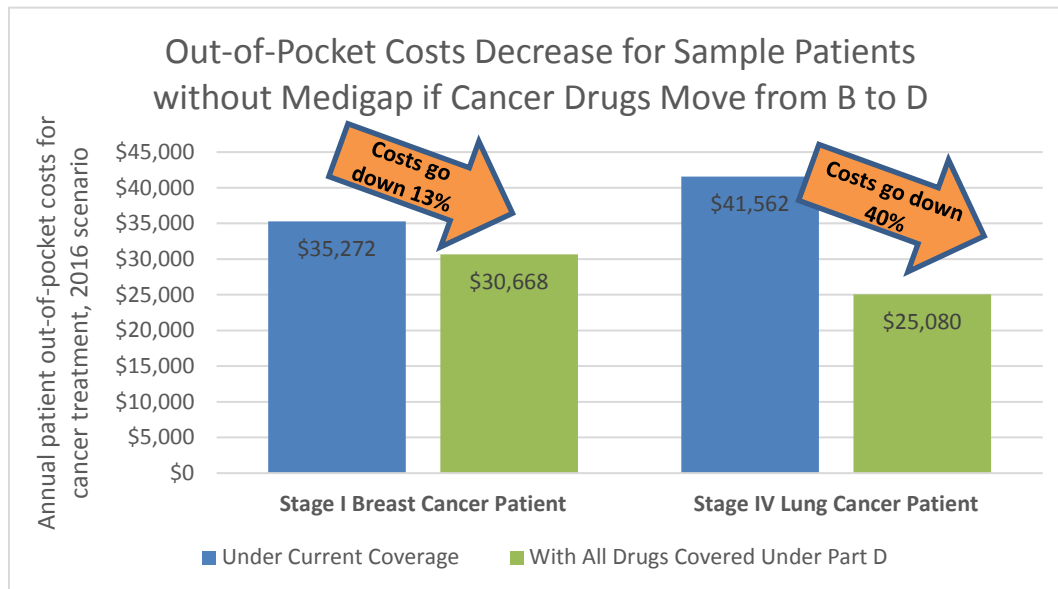
Source: Avalere analysis based on Cost of Cancer Scenarios⁶

In both cases the patients would pay over \$3,000 in out-of-pocket costs in one month. The fact that such significant costs would be imposed over a limited period of time presents an additional burden on beneficiaries – especially since this money might be required to be paid up-front for treatment, and because it only represents the patient’s costs for cancer care. These costs do not include expenses for other conditions, or for other essentials like housing, food, or transportation.



Source: Avalere analysis based on Cost of Cancer Scenarios⁶

Policy Impact for Beneficiaries without Medigap: For the breast and lung cancer patients without Medigap or supplemental coverage, costs would decrease if cancer drugs were shifted from Part B to D.⁷



Source: Avalere analysis based on Cost of Cancer Scenarios⁶

Before implementing any changes to Medicare coverage of cancer drugs, policymakers should give serious consideration to the consequences to beneficiaries in both scenarios. Moving drugs from Part B to Part D coverage will have varying degrees of impact, depending on the beneficiary's source of supplemental coverage, if any. Only about 16 percent of Medicare beneficiaries have no supplemental coverage of any kind.⁸ Of beneficiaries enrolled in traditional Medicare, approximately 27 to 30 percent have some type of Medigap plan.⁹ And as the data above suggests, these beneficiaries will be most likely to experience higher out-of-pocket costs if their prescription drugs were moved from coverage under Part B to Part D. Further, a large number¹⁰ of Part B beneficiaries are not enrolled in a Part D plan. For the cancer patients in this group – the proposal raises questions about how they would obtain coverage of their medication.

Concerns About Safety and Quality of Care

The proposal to move drugs from Part B to Part D also raises some potential safety issues. Beneficiaries enrolled in Part D plans generally get these medications at the local pharmacy or receive the drug through a mail order program. Yet this approach may not be appropriate for many cancer drugs.

As previously stated, the reason many cancer drugs are currently covered under Part B is that delivery of the drug is 'incident to' physician services. This means that physician services are needed before or during drug administration. For example, some patients receiving chemotherapy must have their blood tested or a physical exam to determine if their blood cell counts are at appropriate levels to receive the treatment. Additionally, some supportive care drugs, like anti-nausea medication, must be taken at certain specific times in relation to chemotherapy administration to work most effectively. And sometimes patients receiving chemotherapy have unexpected side effects (like extreme nausea, fatigue or dizziness) during or immediately after treatment that require medical attention. Lastly, the drugs

used to treat cancer often require special handling – for example controlled temperatures or administration within a specified time-period. These are all reasons that cancer drugs are currently administered in-office and reimbursed through Part B.

If cancer drugs were moved to Part D, it is unclear how the Medicare program would ensure care coordination, patient safety, and the proper handling of these medications – particularly if beneficiaries were to bear the responsibility for maintaining the proper temperature of the drugs until the drugs could be delivered to the physician’s office. Such a policy would constitute an unnecessary burden, particularly if beneficiaries have to make additional trips to the pharmacy and their physician’s office prior to infusion. Cancer patients often struggle with transportation issues which would be exacerbated under such a policy change.

Other Considerations

Impact on Part D Program: Moving cancer drugs to Part D could also create unintended costs, including potentially increasing the average Part D beneficiary premium.¹¹ Moreover, Part D plan sponsors have significant leeway in terms of benefit design and determining what drugs are covered under the plan’s formulary (as opposed to Medicare Part B, which does not restrict access to covered drugs). This would be especially concerning if the administration also removed Part D requirements to cover substantially drugs in the “six protected classes,” which includes cancer drugs.¹² The administration has indicated it is considering such a change. The two policy changes combined could result in some cancer patients not having coverage through any part of Medicare for a drug they need. Lastly, even if Part D plan sponsors had to provide coverage of all oncology drugs, we are concerned that these drugs would be placed on the Part D specialty tier, which would result in many patients paying 25 to 33 percent coinsurance.¹³ As discussed in detail above, these out-of-pocket costs can be significant, particularly on a population the majority of which have incomes of no more than twice the federal poverty level.

Impact on the Medicare Advantage (MA) Program: Currently, thirty percent of Medicare beneficiaries are enrolled in a managed care plan¹⁴ and 88 percent of Medicare Advantage plans provide prescription drug coverage.¹⁵ If prescription drugs were moved from coverage under Part B (where MA enrollees enjoy some protection) to coverage under the Part D program (where no such protection exists in the MA program), even MA enrollees would see their out-of-pocket costs increase, similar to the expected increases borne by beneficiaries in traditional Medicare, as discussed in detail above.

ACS CAN Policy Position

ACS CAN has strong concerns with proposals under consideration to move cancer and supportive care drugs from coverage under Medicare Part B to Part D including implications for patient safety and access to quality care, and beneficiary costs.

References

- ¹ See RIN 0991-ZA49; HHS Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs; Request for Information, May 16, 2018, <https://www.gpo.gov/fdsys/pkg/FR-2018-05-16/pdf/2018-10435.pdf>
- ² Centers for Medicare & Medicaid Services, *Prescription Drugs (Outpatient)*, <https://www.medicare.gov/coverage/prescription-drugs-outpatient.html>.
- ³ Jacobson G, Griffin S, Neuman T, and Smith K, *Income and Assets of Medicare Beneficiaries, 2016-2035*, Kaiser Family Foundation, April 21, 2017, <https://www.kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2016-2035/>.
- ⁴ Analysis only includes costs for cancer treatment. Amounts are based on the 2016 Medicare benefit, 2016 Medigap Policy F, and a specific, popular 2016 Medicare Part D plan.
- ⁵ As of 1/1/20, new enrollment in Plan F will be suspended but currently the plan has the highest enrollment.
- ⁶ Avalere analysis of 2016 direct cancer healthcare expenditures, based on patient costs scenarios from ACS CAN publication, *The Costs of Cancer: Addressing Patient Costs*, www.acscan.org/costsofcancer. Costs do not include premium payments. Assumed formulary tier placement: medical-benefit generics with costs under \$100/cycle on tier 2 (generic drugs tier), medical-benefit generics with costs of \$100-\$1,000/cycle on tier 3 (preferred brand tier), and all brand medical-benefit drugs, each over \$3,000/ cycle, on tier 5 (specialty).
- ⁷ This analysis only includes costs for cancer treatment. Scenarios only include direct healthcare expenditure, and do not capture the indirect costs of cancer, such as transportation, housing and childcare costs.
- ⁸ Medicare Payment Advisory Commission, *Data Book: Health Care Spending and the Medicare Program*, June 2017, http://medpac.gov/docs/default-source/data-book/jun17_databooksec2_sec.pdf?sfvrsn=0.
- ⁹ AHIP Center for Policy and Research, *Trends in Medigap Enrollment and Coverage Options*, 2014, https://www.ahip.org/wp-content/uploads/2016/04/MedigapEnrollmentReport_Linked.pdf.
- ¹⁰ Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy*, March 2017, http://www.medpac.gov/docs/default-source/reports/mar17_medpac_ch14.pdf.
- ¹¹ Leavitt, Michael O., Report to Congress, *Transitioning Medicare Part B Covered Drugs to Part D*, 2005, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Downloads/RtC_PtbtoPtD_2005_4.pdf.
- ¹² For more information on ACS CAN's concerns about proposed changes to Part D's six protected classes, see <https://www.acscan.org/policy-resources/medicare%E2%80%99s-six-protected-classes-explained>
- ¹³ *Id.*
- ¹⁴ Medicare Payment Advisory Commission, *Data Book: Health Care Spending and the Medicare Program*, June 2017, http://medpac.gov/docs/default-source/data-book/jun17_databooksec2_sec.pdf?sfvrsn=0, at page 25.
- ¹⁵ Kaiser Family Foundation, *Medicare Advantage*, October 10, 2017, <https://www.kff.org/medicare/fact-sheet/medicare-advantage/>.

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