Medicare Patients Face Rising Costs for Ca Drugs

BY ALICIA AULT

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WASHINGTON — A new study shows that Medicare beneficiaries will be paying more out of pocket for cancer therapies in 2009, and also will have more restrictions on access than they had in the past.

The American Cancer Society's Cancer Action Network (ACS CAN) and Avalere Health, a health care consulting company, studied the changing patterns in out-of-pocket payments and presented the results at a meeting sponsored by the two organizations.

Cancer therapies are covered under Part B and Part D of the Medicare program. Beneficiaries are responsible for copayments that vary. The ACS and Avalere analysis was based on claims and formulary data for about 4,500 Medicare prescription drug plans.

The researchers found that the plans have been moving brand-name oral cancer drugs to higher formulary tiers—essentially requiring much higher copayments from patients.

Tier 1 requires no or very low copays. Cost sharing rises with each succeeding tier level, with beneficiaries being asked to make a copayment for tiers 1-3 and a percentage of the drug's cost starting on tier 4. Four-tier formularies are the most common, although some plans use as many as six tiers, said the Avalere and ACS CAN researchers.

In 2009, the drugs Gleevec (imatinib mesylate), Sutent (sunitinib malate), Tarceva (erlotinib), Thalomid (thalidomide), and Tykerb (lapatinib) will all be placed on a top formulary tier, with beneficiaries having to pay 26%-35% of the drugs' cost. These therapies cost anywhere from $2,000 to $5,000 a month, depending on the drug. Sixty-two percent to 74% of plans require prior authorization for these five therapies, and a quarter to a third limit the quantity of the drug, for instance by limiting the number of pills that can be received in a month.

This reflects a growing trend, said the analysts, noting that from 2006 to 2008, a growing number of health plans have moved Gleevec to a formulary tier requiring greater cost sharing. In 2006, only 37% had the drug on tier 4; in 2007, 73% had the drug on tier 4, and by 2008, 74% listed it as a tier 4 therapy, 8% as a tier 5, and 2% as a tier 6. In 2009, 63% of plans will list Gleevec as a tier 4 drug, 13% as a tier 5, and none as a tier 6, according to Avalere and ACS.

Medicare beneficiaries are also paying a greater percentage of each drug's cost in each year since 2006. For Gleevec, Sutent, and Tarceva, beneficiaries paid an average of 27% of the cost in 2006; by 2009, that will rise to 33%.

A generic of the drug tamoxifen, however, is on the lowest formulary tier for most plans. No plans require prior authorization and 2% limit quantities. Patients generally pay nothing or $10 for a tamoxifen prescription.

The analysts also looked at the typical drug mix for breast and colon cancer and calculated how much beneficiaries would pay out of pocket in 2006 and in 2009. For breast cancer, they used an example of a woman with comorbidities, since it provides a more realistic picture of the patient's total cost-sharing burden, said the analysts. For a breast cancer patient with hyperlipidemia, type 2 diabetes, and hypertension, the Part B cost, which includes the premium and physician administration fees (and assumes that the beneficiary does not have supplemental Part B insurance), would decline from $7,196 in 2006 to $4,964 in 2009.

Drugs covered under Part B included Adriamycin (doxorubicin), Cytoxan (cyclophosphamide), Taxotere (docetaxel), Kytril (granisetron), Neulasta (pegfilgrastim), and Aloxi (palonosetron) in 2006. In 2009, Taxotere and Kytril were removed and Taxol (paclitaxel) and Benadryl were added. The Part D cost sharing would rise from a range of $1,747-$2,810 in 2006 to $2,122-$3,239 in 2009. Those therapies include Arimidex (anastrozole), dexamethasone, prochlorperazine, Lipitor (atorvastatin), Glucophage (metformin), hydrochlorothiazide and Ativan (lorazepam). Fosamax (alendronate) was added to the calculations for 2009.

The difference is starker for colon cancer, largely because of the addition of a single therapy. In 2006, the typical regimen—Camptosar (irinotecan), leucovorin, fluorouracil, dolasetron, and dexamethasone—was $8,395 for Part B, and Part D cost sharing (for prochlorperazine) ranged from $29 to $825. With fluorouracil and leucovorin dropped and Erbitux (cetuximab) added to the mix in 2009, Part B costs will hit $14,780. Part D sharing will be relatively unchanged at $21-$654. It also appears that beneficiary Part D out-of-pocket costs vary depending on the state of residence. For instance, breast cancer patients living in California would spend about $3,000 in 2009 if they have coverage with the Humana Standard plan, while patients in Illinois and Florida on the same plan would pay several hundred dollars less.

Premiums, deductibles, and cost sharing for various plans vary greatly, the analysts found. At the five largest drug plans, beneficiaries paid anywhere from nothing to $7 for first-tier drugs. Second-tier therapies cost $22-$40; although one plan charged a 28% coinsurance rate and another 25%. With so much variation, it's difficult to make a blanket statement about the impact of cost sharing for beneficiaries, said Sarah Barber, an ACS CAN researcher. How much beneficiaries will shoulder depends on the type of cancer they have, where they live, the mix of drugs they receive, and what plan they have for Part D, she said. ■

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