Medicare and the Cost of Cancer Treatment

This article is for both the person facing cancer today, wanting to know what to expect from their Medicare insurance as well as for the person turning 65 and weighing the pros and cons of staying with Original Medicare or moving to Medicare Advantage.

I realize the article is a bit long, but the subject matter is critically important. When first diagnosed with cancer, there is a lot going through your mind. One small part is the question of “What is this going to cost me?” The battle with cancer can be emotionally draining without worrying or wondering about your health insurance and how it works. This information on how Medicare handles the cost of cancer treatment is much more difficult to find and piece together than it should be. I believe the information in this article can be a great relief, benefit and resource for anyone about to embark on a very tough personal battle. The information has been compiled from numerous sources including Medicare.gov and the National Cancer Society.

For those new to Medicare, this information will help you decide if you are more comfortable with Original Medicare or Medicare Advantage. For the person who has cancer or a history of cancer, we hope the information will ease any financial uncertainty of not knowing what part of your treatment may or may not be covered by your current Medicare plan and how much out-of-pocket expense can be expected from you.

According to Medicare, for people 65 and older, cancer results in higher out-of-pocket medical costs than any other illness. Cancer patients utilize Hospice care more than patients with other conditions, and the cost of medical care during the first 12 months of care average higher than medical costs in the last 12 months of life.

When a Medicare beneficiary is first diagnosed with cancer and then informed they will require chemotherapy, the first thing they do is check their Part D Prescription drug coverage. That is typically followed by a panic as they find none of their chemotherapy prescriptions are listed in the Part D Formulary. There is a reason for that. So, don’t panic. Just read on to find out how your plan will deal with the medication.

We know this can be a bit confusing, so we will start with a brief general description of the differences between Original Medicare, Medicare Supplement Plans, Medicare Advantage and Part D prescription drug plans. For a detailed description, please read the linked articles in your Medicare & You handbook.
Medicare at a Glance

Original Medicare consists of three parts;

- Medicare Part A insures you when you are an in-patient at a hospital. Medicare pays for 100% your inpatient expenses for a full 60-days after you pay the deductible. As of 2015, the deductible is $1,260. After 60-days you pick up some of the daily cost in the form of a co-pay. Part A also includes Skilled Nursing Facility coverage. Medicare Part A is usually free.

- Medicare Part B insures you for outpatient coverage. After you pay an annual deductible ($147 for 2015), Medicare pays 80% of your coverage, you pay 20%. This assumes your doctor or hospital accepts Medicare assignment. Only 3% of doctors that accept Medicare do not take Medicare assignment. Medicare Part B has a monthly premium that depends on your income. The minimum monthly premium for 2015 is $104.90 per month. This premium must be paid even if you choose a Medicare Advantage plan instead of Original Medicare.

- Medicare Part D is your prescription drug coverage. It includes an annual deductible of up to $360 for 2016. There is a co-pay for each drug that depends on the Tier it was assigned by the insurance company. Each drug plan has a different Formulary. The Formulary is the list of covered drugs. Your particular prescription drug may or may not be covered, however, all Medicare Part D plans must cover drugs from each category or class. That means that if your drug is not listed in the Formulary, a competing drug or generic should be available.

Medicare Supplements:

Medicare Supplement plans are private insurance plans with benefits that are standardized by the U.S. government Center for Medicare & Medicaid Services (CMS). There are eleven different standardized plans, each designated by a letter; A, B, C, D, F, F-HD, G, K, L, M, N. They are standardized so that the benefits all Medigap Plan F’s are identical, all Medigap Plan G’s are identical etc.

- Medicare Supplement plans pay all or part of the deductibles and co-pays that are intrinsic with Original Medicare. They also extend in-patient hospital coverage to over 365-days. The result is that a person on Original Medicare with a Supplement can have a maximum annual out-of-pocket risk of between zero and $147 for 2015.

Medicare Advantage Plans

Medicare Advantage, also called Medicare Part C, is not a part of Original Medicare. Medicare Advantage plans replace Original Medicare with an insurance plan run by a private insurance company. These for-profit plans are HMO’s, PPO’s etc. that have a local network from which you are to select your coverage. You may or may not be required to get permission from a Primary Care doctor before seeing a specialist. While it is intended to be “actuarially equivalent” to Medicare Parts A and B, it has different coverage, different co-pays, different deductibles and the it is the insurance company that
is the final arbiter determining if the procedure your doctor recommends is medically necessary and therefore covered by your insurance plan. The cost, features and benefits of these plans are not standardized and will change every year.

- Medicare Advantage Plans have a defined annual maximum out-of-pocket (MOOP) expense you are required to pay if you need care. This MOOP is up to $6,700 per year for using doctor’s in-network, $10,000 for out of network care if you have a PPO and unlimited for an HMO. Each Medicare Advantage plan is different. These are not standardized plans like the Medicare Supplements. You may not have a Medicare Supplement plan with a Medicare Advantage plan. Most Medicare Advantage plans come with their own bundled Part D prescription plan.

Medicare Advantage is meant to be an actuarial equivalent to Original Medicare (Medicare Part A and Medicare Part B). However, it is not equal to coverage provided by the combination of Medicare Part A and B plus a Medicare Supplement. Because these plans are not standardized and change every year, a person with a Medicare Advantage plan must shop and compare their plan every year during annual Enrollment which is between October 15 and December 07.

**Medicare Part D Pharmaceutical Coverage**

Medicare Part D is for prescription drug coverage. Like Medicare Advantage, Medicare Part D plans are not standardized and change benefits and price every year. Of all the Medicare Plans, Part D is the most complex and most frustrating to deal with.

For 2016, there is a maximum deductible of $360 that must be paid before Medicare Part D benefits can begin. Each plan has its own list of prescription drugs that are covered (called a Formulary) and the level of their coverage (Tier). The rate of coverage or co-pay pertains to the first $3,310 worth of medication (2016). After that initial expense, the Medicare Beneficiary is expected to pay 45% of prescription cost for brand name drugs and 58% of generic drug costs until total annual expenses reach $4,850. Once a Medicare part D beneficiary has reached $4,850 in expenses Catastrophic Coverage begins. In the Catastrophic Coverage portion of Medicare Part D, Medicare pays 95% of prescription costs.

It is important to understand that the maximum annual out-of-pocket expense that is part of a Medicare Advantage plan does not include the Part D portion of coverage. Thus, the Medicare Part D expenses outlined immediately above would be in addition to the $6,700 to $10,000 maximum out-of-pocket coverage discussed earlier in the Medicare Advantage plan section.
How Medicare Looks At Drug Coverage

When Medicare looks at drug coverage they separate it into two categories;

1. Medications administered to you while you are in a hospital or doctor's office
2. Medications for which you are given a prescription and self-administer.

Medications administered while an inpatient in a hospital or at your doctor’s office are typically covered by either Medicare Part A or Medicare Part B. Medications for which you received a prescription and self-administer at home or away from a doctor’s office or hospital setting typically fall under the domain of Medicare Part D prescription drug plans.

Medicare Part A Hospital Inpatient Coverage

When you are an inpatient in a hospital and the hospital is administering drugs to you as part of your treatment, those drugs are covered under Medicare Part A. So, if you are an inpatient in a hospital and they are providing you with any medication as part of your treatment, it is covered 100% by Medicare Part A. If you have a Medicare Advantage plan, chemotherapy drugs will be covered, but not to the same the degree. Most Medicare Advantage plans will cover 80% of the cost of chemotherapy drugs and other cancer related drugs administered in a hospital setting as an inpatient. In this situation, you will need to look at your Medicare Advantage maximum annual out-of-pocket expense as described above to find out what chemotherapy will cost you. It will almost certainly reach
that maximum. Because chemotherapy drugs are very expensive, if your treatment starts at the end of one calendar year and continues into the next, you may end up paying the maximum annual out-of-pocket expense for two consecutive years.

With any Medicare Supplement plan except a High Deductible Plan F, you will not likely have any out-of-pocket cost for Medicare Part A expenses. With a Medicare Supplement Plan F High Deductible you may have to pay the Medicare Part A deductible of $1,260 (2015) and are then covered 100% for all Medicare Part A expenses.

**Medicare Part B Outpatient Services**

Medicare Part B covers chemotherapy drugs and other medications administered to you during an office visit with your physician or outpatient hospital care. This includes infused (administered by IV) or injected (given as a shot). Many chemo drugs and anti-nausea drugs are administered in this manner and covered under Medicare Part B.

If you have Original Medicare with no Medicare Supplement coverage, Medicare will pay 80% of the cost, you will be responsible for the 20% not covered by Medicare.

If you have a Medicare Advantage Plan, your plan will typically cover 80% of the cost and you will be responsible for the remainder of the cost up to your maximum annual out-of-pocket limit. Maximum annual out-of-pocket limits are typically $6,700 for in-network care, $10,000 for out-of-network care with a PPO and unlimited with an HMO. Of course, if your treatment begins near the end of the year and continues into January of the next, you will likely be required to pay the out-of-pocket maximum twice because your covered out-of-pocket financial exposure resets every January 01.
If you have Original Medicare with a Supplement, then your Supplement will likely pay all or virtually all of the 20% not covered by Original Medicare. This depends, of course, on which Medicare Supplement plan you have. The exception would be Medicare Supplement Plan F – High Deductible (Medigap Plan F-HD) which would require you to pay the first $2,180 (2016) of that portion not covered by Original Medicare. After which, 100% of your Medicare expenses are payed for by the Medicare Supplement.

### Chemotherapy By Pill

In most cases, whether a drug is covered by Medicare Part B or Medicare Part D is clear simply by observing how and where the drug is administered. The grey area comes when chemotherapy drugs are given by mouth (oral drugs). In this case some are covered under Medicare Part B and some by Medicare Part D.

Some cancer drugs are given orally as part of chemotherapy. As a rule of thumb, these drugs are covered under Medicare Part B if they are used instead of the same drug administered by IV or injection. Think of it this way, if your doctor has a choice of giving you an oral medication or administering the same medication via an IV and chooses to give you a pill, the drug will should fall under the domain of Medicare Part B coverage. Some chemotherapy drugs that are currently administered orally used to be administered by IV, but oral is the only form currently available. These drugs are covered under Medicare Part B.
Oral cancer drugs that were never administered via IV are covered under a Part D prescription drug plan. The same rule applies for anti-nausea drugs taken within 48-hours of chemotherapy.

Other drugs that are not chemotherapy and can be taken on your own either orally or via injection would be covered under Medicare Part D. Always check with your Part D drugs plan to see if it on their formulary and under what level of coverage.

The cost of cancer drugs to Medicare beneficiaries varies greatly

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<tbody>
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<td>Breast Cancer (With hyperlipidemia, type 2 diabetes, and hypertension)</td>
<td>$4,964</td>
<td>$2,172 – 3,239</td>
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<tr>
<td>Metastatic Colon Cancer</td>
<td>$14,780</td>
<td>$21 - 654</td>
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*Includes Part B premium and physician administration fees. Assumes no supplemental Part B coverage.
**Includes premiums, drugs excluded from Part D, and spending on any off-formulary drugs. With generic substitution. Range compares premiums and cost sharing for select PDPs and Medicare Advantage Prescription Drug (MA-PD) plans in California.


**Off-Label Drug Treatment for Cancer**

One final point to make that is important for anybody undergoing cancer treatment. Some of the medication your doctor uses to treat you will likely be “off-label”. A drug is considered off-label if it is being used for a purpose not approved by the Food and Drug Administration (FDA). When the FDA approves a drug, its use is approved for specific conditions. Those conditions and official prescribing information are printed in the package insert. Under certain conditions it is perfectly legal and acceptable to prescribe that medication for use that is not approved by the FDA. This is called an off-label prescription.

It’s important to understand that when your doctor prescribes a drug for an off-label use, he or she is not experimenting on you and is not bending or breaking the law. The off-label use is guided by multiple published peer-reviewed studies. When there is more than one peer-reviewed study that indicates safety and efficacy in an off-label use it is called compendia documentation.
The National Comprehensive Cancer Network estimates that 50% of all drugs used in cancer care in the U.S. are off-label.

In most cases, Medicare Part B will pay for off-label drugs for cancer treatment as long the off-label uses are listed in an approved compendium. If Medicare denies coverage, a copy of the compendium or any peer-reviewed articles on the off-label use may be of value in an appeal. Your doctor should help you compile the information for an appeal.

**Which Medicare Plan Offers the Best Coverage?**

Your out-of-pocket cost for cancer treatment will depend on what type of Medicare coverage you have as well as the type of cancer for which you are being treated. Most cancer and anti-nausea drugs will be covered under Medicare Part B or by your Medicare Advantage plan, with your Medicare Part D covering those drugs that have been prescribed to you to self-administer.

In general, people with Medicare Advantage plans should expect to reach their annual maximum out-of-pocket limit relatively quickly. That limit is typically $6,700 for in-network care and $10,000 for out-of-network care. If your Medicare Advantage plan is an HMO, there will be no limit for out-of-network costs because out-of-network doctor visits are not covered except in an emergency.

If you have Original Medicare but do not own a Medicare Supplement, most of the chemotherapy drugs will be covered by Medicare Part B. This means that Medicare will pay for 80% of the cost and you will be responsible for 20% of the cost. Considering that...
chemotherapy drugs are very expensive, there is substantial financial risk for having Original Medicare without also having a Medicare Supplement.

Those who have Original Medicare plus a Medicare Supplement will have very little financial risk for any Medicare Part A or Part B covered reason. Medicare Supplement Plan F will limit your out of pocket risk to zero. However, for reason we spell out in this article, Plan F is seldom a good value. Other plans, like Medicare Supplement Plan G or Medicare Supplement Plan N can limit your out-of-pocket costs to under $200. If you choose a Medicare Supplement Plan F-high deductible because the monthly rates are so low, your out-of-pocket financial risk will be limited to $2,180 (2015) per calendar year.

If your medication falls under the domain of Medicare Part D prescription coverage, there will be a separate deductible and you will be responsible for co-pays for each prescription. The costs associated with Medicare Part D are in addition to any out-of-pocket maximum for your Medicare Advantage plan and any co-pays or deductibles not covered by your Medicare Supplement. There is no limit to your Medicare Part D annual expenses, but once you have reached $4,850 in prescription drug expenses in any one year, Medicare will pay for 95% of your Part D prescription costs.

Lastly, if you choose any plan that has an annual out-of-pocket maximum, you should consider that it’s possible to be diagnosed with any illness near the end of a calendar year. If your treatment spans both the final month of a year and into January, you will probably have to pay your maximum out-of-pocket cost two years in a row. The annual maximum out-of-pocket cost re-sets on January 01 of every year.

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