The Prescription Drug Benefit and Cancer Patients

by Christian G. Downs

Over the next few months, one of the hottest debates in Washington, D.C., will involve a prescription drug benefit for Medicare patients. Cancer patients and providers should pay special attention to this issue because of its impact on access to treatment.

From an economic standpoint, the costs are daunting. In recent testimony before Congress, Dan Crippen from the Congressional Budget Office (CBO) calculated some of the costs. He told the Senate Finance Committee on March 22 that if Medicare beneficiaries spend a record $1.5 trillion on prescription drugs over the next 10 years as predicted, and the government assumes only half of that cost, then it is still taking on a liability of $728 billion.

GOP leaders and the Bush administration want to spend just $153 billion over the next 10 years on a drug benefit that would cover only 10 percent of Medicare recipients' drug costs. If the plan were narrowed to cover only that part of the Medicare population without drug insurance, coverage would rise to 40 percent.

Crippen noted in his testimony that because of its limited funding the current GOP plan would have to be targeted to certain groups of people, such as the indigent or those suffering from catastrophic illness. If spread out over all beneficiaries, the proposed plan would offer a severely restricted benefit.

Crippen went on to explain the costs of even a basic plan. If a Medicare beneficiary currently has a monthly drug cost of $250, this plan would cover only $125, leaving the patient with a monthly bill of $125. Not a princely sum, but for those on a fixed income this out-of-pocket cost is still a substantial obligation.

The question in Congress then becomes, "How do we make this plan affordable and adequate?" One obvious method of controlling expenses in a Medicare prescription drug benefit is to impose a cap on benefits paid per enrollee each year.

Here is where cancer patients and providers come into the equation. As you know, most cancer patients receive intensive therapy over a relatively short period of time. Given the expense of modern cancer treatment, many cancer patients would surpass any cap very quickly. What happens then? Would cancer patients have to "spend down" all their assets," similarly to those needing nursing home benefits?

ACCC and several other cancer organizations have been clear in their stance on the Medicare prescription drug issue. They support a prescription drug benefit that maintains access to the latest treatments and does *not* compromise the current benefit available "incident to" a physician service currently covered under the hospital outpatient payment system.

ACCC encourages its members to stay engaged in the prescription drug development process. Updates are given frequently online at *www.accc-cancer.org* or in *Oncology Issues*.

CLASS ACTION AGAINST HHS

Two Medicare beneficiaries are suing the government over the use of local coverage determinations, or LCDs, which in the past were known as local medical review policies. The class action lawsuit was filed March 16 in the U.S. District Court for the District of Arizona (Erringer v. Thompson, D. Ariz., No. CIV 01-112-TUC-BPV). The suit alleges that the use of LCDs denies Medicare beneficiaries the right to due process because denial notices fail to state that the reason a denial took place was because of an LCD.

One of the more salient allegations is that the Department of Health and Human Services (HHS) has failed to adopt regulations establishing standards for how local Medicare contractors make LCDs. The suit also claims that the development of LCDs is neither local nor a coverage decision. Many of these policies, according to the suit, are made in collaboration with other carriers around the country and have a way of restricting, rather than clarifying, coverage decisions.

Cancer providers have had varying success with LCDs. Those states that have been most successful have developed a strong and organized state society that reflects the state's standard of practice, have active representation on the Carrier Advisory Committee (CAC), and are familiar with the Medicare Medical Director. When discussing a LCD, the state society should provide the medical director with solid, peer-reviewed medical literature to help make the determination.

Of course, even a strong state society can still have a hard time with a state Medicare Medical Director. If difficulties arise, we advise involving national organizations such as the American Society of Clinical Oncology, the Oncology Nursing Society, and ACCC.

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