American Cancer Society Cancer Action Network℠

2024

Cancer in Medicare:

An American Cancer Society Cancer Action Network Chartbook

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The American Cancer Society Cancer Action Network℠ (ACS CAN) is making cancer a top priority for public officials and candidates at the federal, state and local levels.

ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change, as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society's nonprofit, nonpartisan advocacy affiliate, ACS CAN is more determined than ever to end cancer as we know it, for everyone.

This ACS CAN chartbook provides cancer-specific data related to Medicare, including basic information about the program, a discussion of its components, characteristics of enrollees, coverage of services specifically related to cancer care, program expenditures and enrollees' out-of-pocket costs. This report also includes policy recommendations on how to improve the Medicare program for beneficiaries who have a history of cancer, are in active cancer treatment or who could develop cancer.

Acknowledgements

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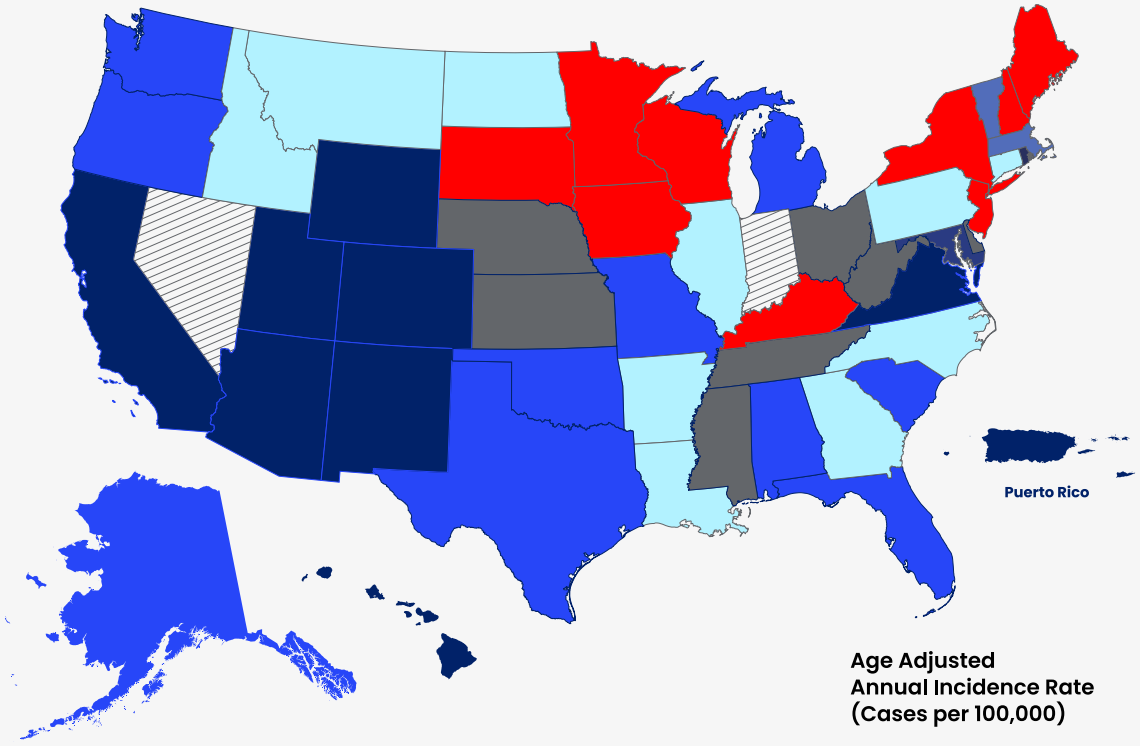
Introduction

The risk of cancer increases with age,[1] and having health insurance coverage is strongly associated with survival following a cancer diagnosis.[2] Cancer is the leading cause of death among Medicare beneficiaries ages 65-74,[3] and 7 out of 10 cancer deaths occur among Medicare beneficiaries.[4] The Medicare program is vitally important to those who qualify including millions of older Americans and those with disabilities who are undergoing active cancer treatment, are cancer survivors or who may develop cancer. In 2024, more than 2 million Americans are projected to be diagnosed with cancer.[5] Over 1 million of those diagnosed are age 65 or older and rely on the Medicare program as their primary source of health care coverage.[6] Cancer incidence rates also vary substantially across the U.S. (see map).

Figure 1: Incidence Rates† for United States by State, All Cancer Sites, 2016-2020 All Races (includes Hispanic), Both Sexes, Ages 65+



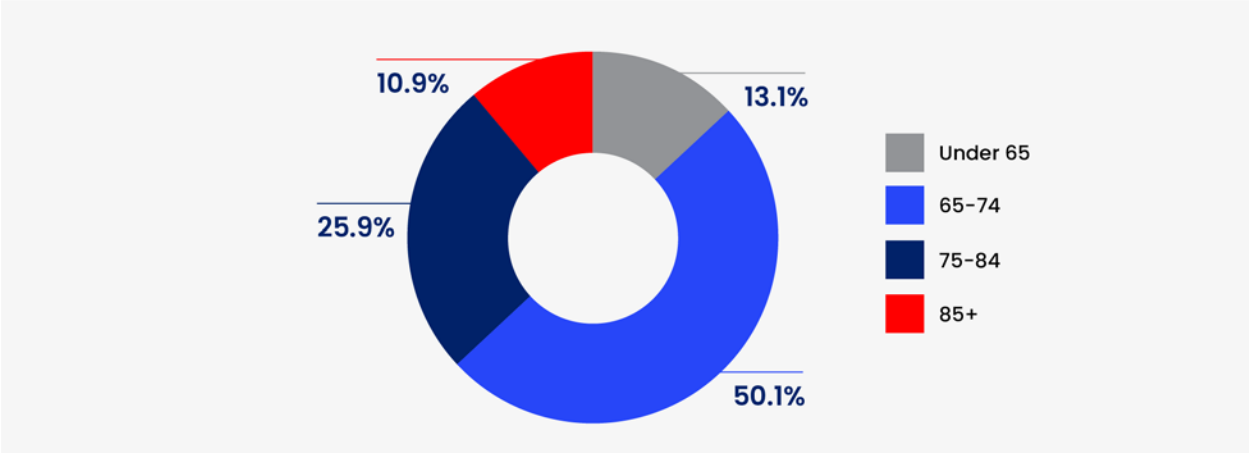
Notes:
Note: Alaska, DC, Hawaii and Puerto Rico are not drawn to scale.
State Cancer Registries may provide more current or more local data.
Data presented on the State Cancer Profiles Web Site may differ from statistics reported by the State Cancer Registries (for more information).
† Incidence rates (cases over 100,000 population per year) are age-adjusted to the 2000 US standard population (19 age groups: <1, 1-4, 5-9, ... 80-84, 85+). Rates are for invasive cancer only (except for bladder which is invasive and in situ) or unless otherwise specified. Rates calculated using SEER*Stat.
Population counts for denominators are based on Census populations as modified by NCI.
The US Population Data File is used for SEER and NPCR incidence rates.
Rates are computed using cancers classified as malignant based on ICD-O-3. For more information see malignant.html
▫ Data not available for this combination of geography, statistic, age and race/ethnicity
Data for the United States does not include data from Puerto Rico

Source: National Cancer Institute. State Cancer Profiles. Interactive Maps. 2023. Available at: Interactive Maps.(cancer.gov).

Medicare Program Basics

Medicare is a federal health program that provides health coverage for 65 million people, 57.1 million of whom qualify based on age (65 years and older) and work history (worked and paid payroll taxes for at least 40 quarters [10 years]) and 7.9 million of whom qualify based on a disability.[7] Almost 9 in 10 beneficiaries are ages 65 and older, and half of beneficiaries are between the ages of 65 and 74. The total number of people enrolled in the Medicare program is expected to increase to approximately 77 million people by 2030, due in part to the baby boom generation aging into the program.[8]

Figure 2: Share of Medicare Population by Age, 2020



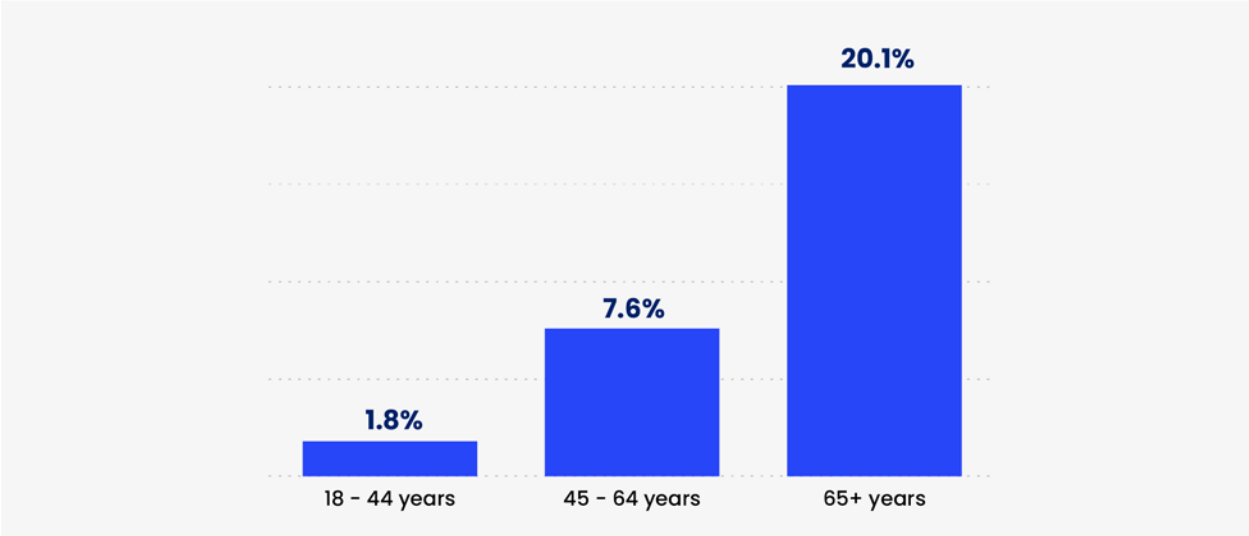
Source: MedPAC 2023 data book.

These demographic changes are particularly important for those interested in cancer policy because the risk of cancer increases with age.[9]

Cancer diagnoses

Most new cancers are diagnosed in individuals who are over the age of 65, and thus rely on Medicare as their primary source of coverage.

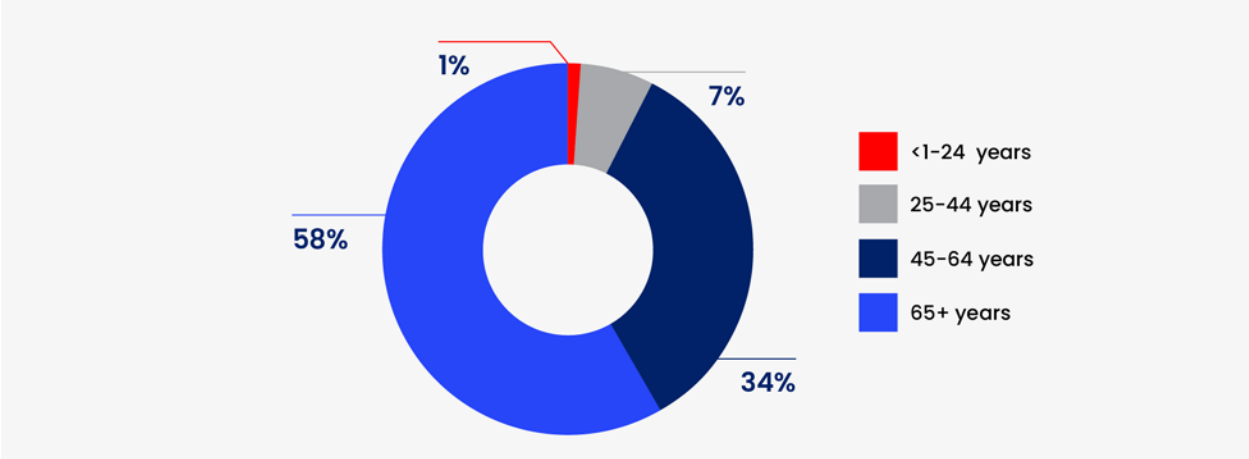
Figure 3: Reported History of Cancer in Adults by Age, 2019



Source: National Center for Health Statistics. Health, United States, 2020-2021: Table CanHst. Hyattsville, MD. 2023. Available from: cdc.gov/nchs/hus/data-finder.htm.

Of the more than 1.7 million new cancer cases expected to be diagnosed in 2023, over 1 million of those cases are expected to be diagnosed in individuals over the age of 65.

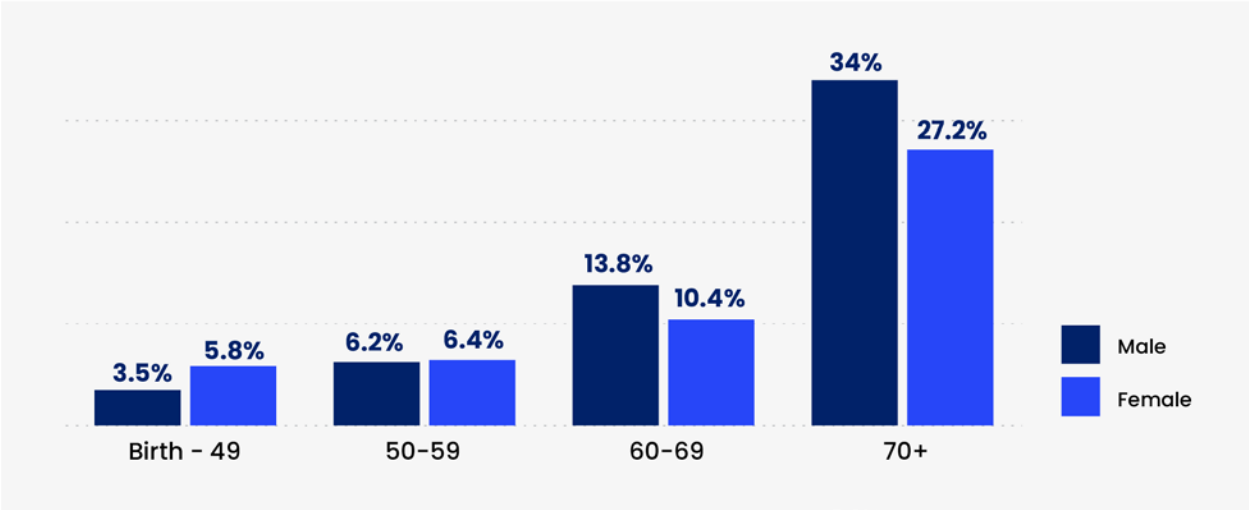
Figure 4: Incidence of New Cancer Cases, 2020



Source: U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on 2022 submission data (1999-2020): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; https://www.cdc.gov/cancer/dataviz, released in November 2023.

Not only does the incidence or risk of cancer increase with age, but the probability of developing an invasive form of cancer does as well. Invasive cancers occur when the cancer has spread beyond the area in which it initially develops and is growing into healthy tissue.[10]

Figure 5: Probability of Developing Invasive Cancer by Age Intervals and Gender, 2017-2019

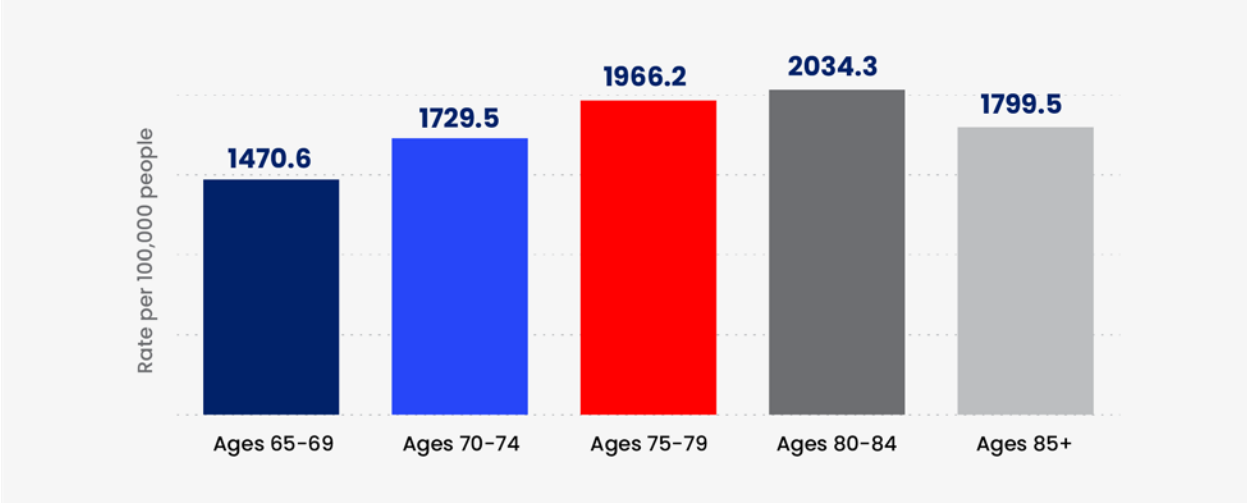


Source: Siegel, RL, Miller, KD, Wagle, NS, Jemal, A. Cancer statistics, 2023. *CA Cancer J Clin*. 2023; 73(1): 17- 48. doi:10.3322/caac.21763.

Distribution of cancers diagnosed among adults 65+

The incidence of cancer increases with age beyond age 65. Individuals between 80 and 84 years of age have the highest incidence of cancer diagnosis.

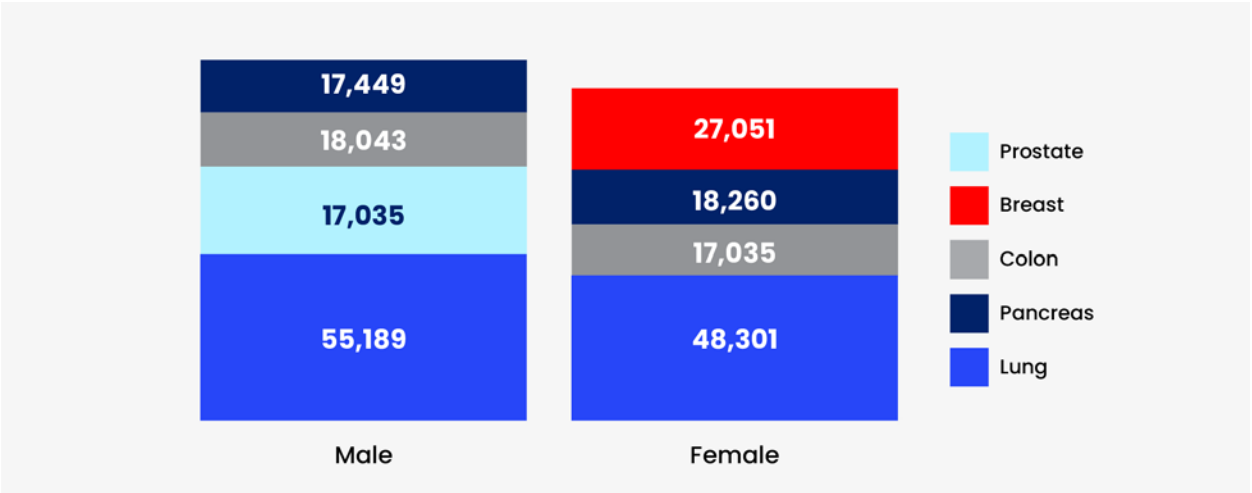
Figure 6: Incidence of Cancer Diagnosis by Age Group, 2020



Source: U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on 2022 submission data (1999-2020): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; https://www.cdc.gov/cancer/dataviz, released in November 2023.

The leading cause of cancer deaths in individuals ages 65 and over varies slightly by gender.

Figure 7: Leading Causes of Cancer Deaths Ages 65+ by Gender, 2020

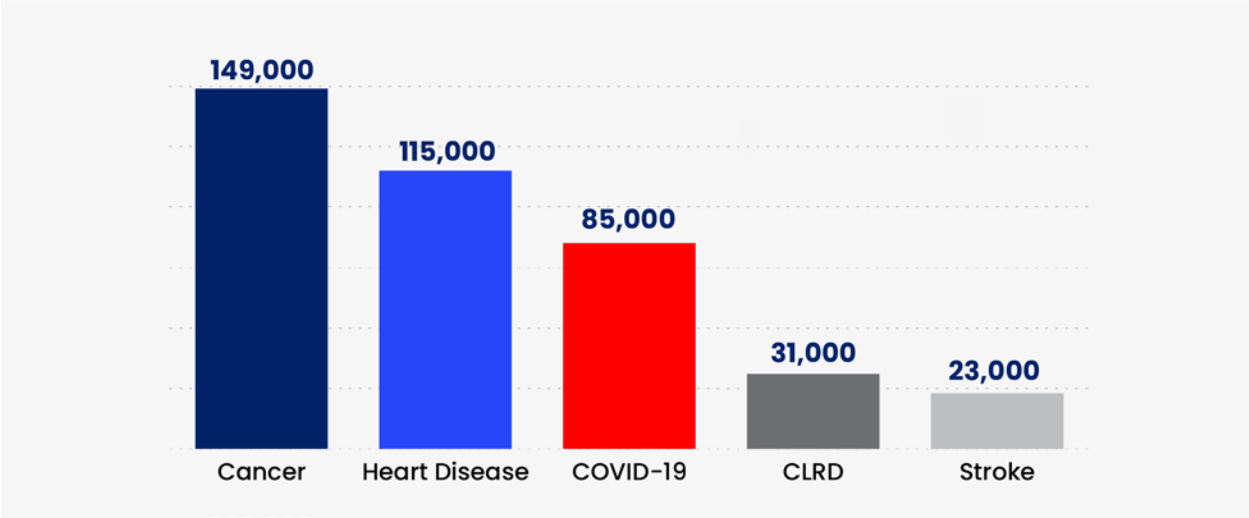


Source: Siegel RL, Miller KD, Sandeep Wagle N, Jemal A. Cancer Statistics, 2023. *Cancer.* Jan. 2023. doi.org.10.3322/caac.21763.

Cancer deaths

Cancer is the leading cause of death in adults ages 65-74.

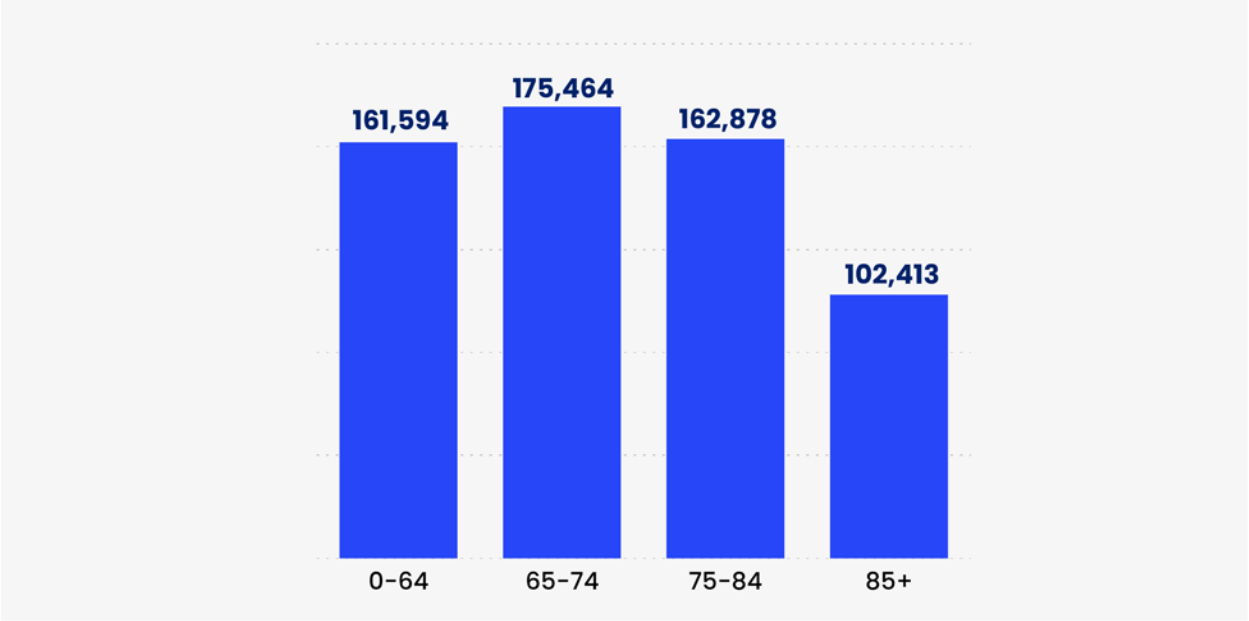
Figure 8: Leading Causes of Death for Individuals 65-74, January to October 2021



Note: CLRD refers to chronic lower respiratory disease.
Source: Shiels MS, Haque AT, Berrington de González A, Freedman ND. Leading Causes of Death in the US During the COVID-19 Pandemic, March 2020 to October 2021. *JAMA Intern Med.* 2022;182(8):883–886. doi:10.1001/jamainternmed.2022.2476.

About 7 in 10 cancer deaths occur in the Medicare population.

Figure 9: Cancer Deaths by Age, 2020

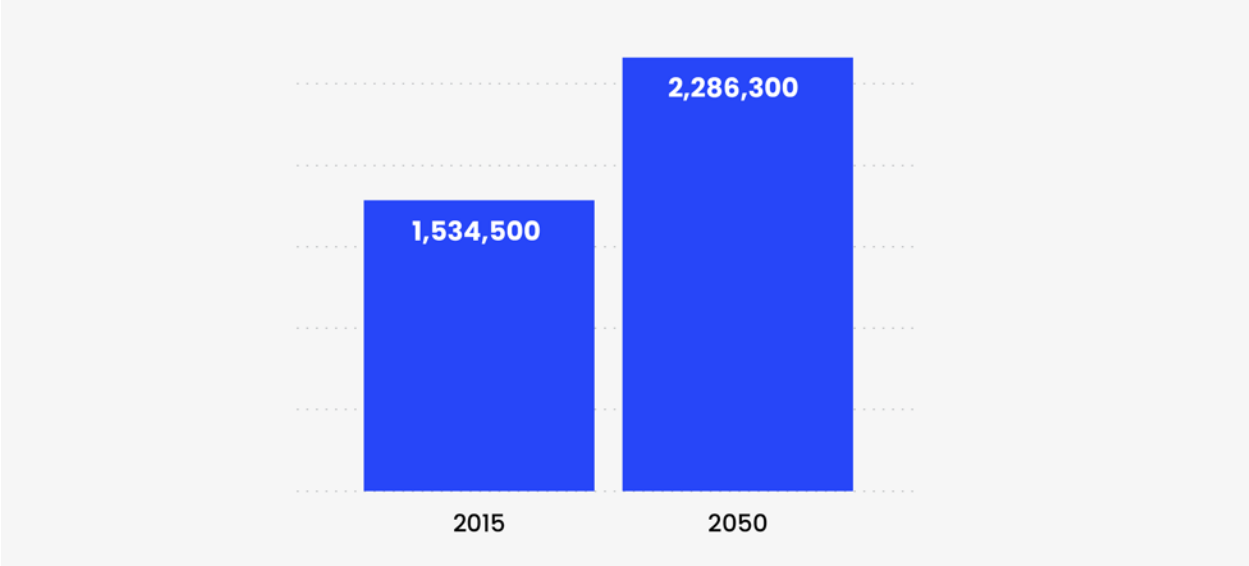


Source: U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on 2022 submission data (1999-2020): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; https://www.cdc.gov/cancer/dataviz, released in June 2023.

Cancer survivors

Due to advances in cancer treatments and earlier diagnoses for some cancers, individuals are surviving cancer and living longer. As a result, the number of individuals with a reported history of cancer is increasing, particularly among individuals over the age of 65. Individuals with a prior history of cancer often have long-term effects from their cancer experiences and tend to utilize more health care services relative to those without a cancer history.

Figure 10: Estimated and Projected Average Annual Cancer Cases



Source: Weir HK, Thompson TD, Stewart SL, White MC. Cancer Incidence Projections in the United States Between 2015 and 2050. Prev Chronic Dis 2021;18:210006. DOI: http://dx.doi.org/10.5888/pcd18.210006.

Components of Medicare

The Medicare program is comprised of several parts:

Medicare Part A covers inpatient hospital stays (including any cancer treatments provided as an inpatient in a hospital), skilled nursing facility stays, home health care and hospice care. Part A also covers costs of surgically implanted breast prosthesis following a mastectomy if the surgery takes place on an inpatient basis.

Medicare Part B covers physician visits, outpatient services, a limited number of preventive services, diagnostic tests, laboratory visits, durable medical equipment, some drugs (such as chemotherapy drugs administered in an outpatient clinic or physician's office and some oral chemotherapy treatments), radiation treatments for cancer, breast prosthesis following a mastectomy if the surgery takes place in an outpatient setting and principal illness navigation services, among other services.

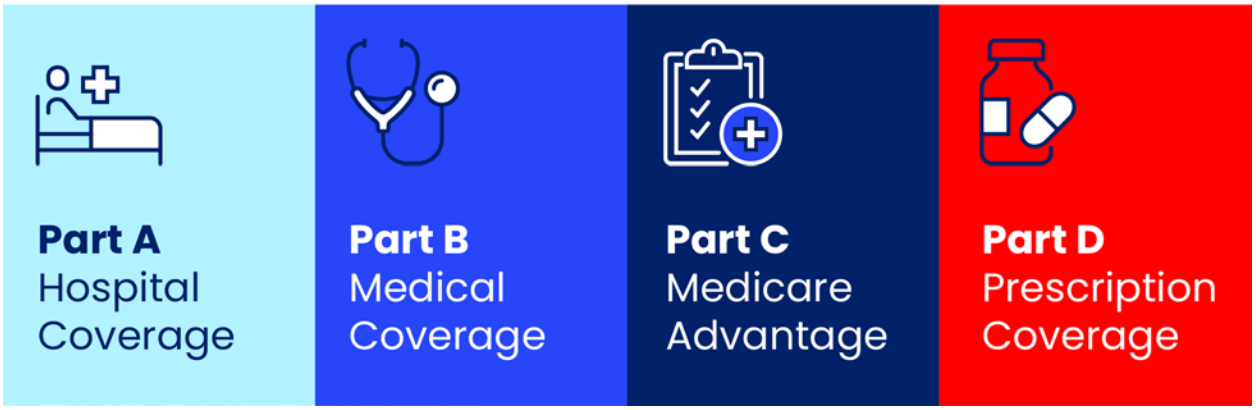
Medicare Part A and B are together considered to be Original Medicare (otherwise known as Original, Traditional or fee-for-service Medicare).

In **Medicare Part C** (also known as Medicare Advantage), beneficiaries enroll in a private health plan where they receive Part A and B benefits, usually Part D benefits and sometimes other benefits not covered under Parts A or B, such as vision and hearing services.

Part D covers outpatient prescription drugs that patients obtain at pharmacies, including some oral chemotherapy drugs, anti-nausea drugs and pain medication. The Part D program is administered through private plans contracted with Medicare.

As discussed in more detail below, beneficiaries face cost sharing for utilizing most Medicare services. As a result, many beneficiaries opt to have supplemental coverage. Beneficiaries who don't have access to supplemental coverage through a current or former employer are often faced with the task of choosing supplemental coverage options – the outcome of which has long-term consequences – when they are first eligible for the program.[11] At the initial enrollment period, beneficiaries can choose to enroll in traditional Medicare (Parts A and B), purchase prescription drug coverage (Part D) and, possibly, supplemental coverage (Medigap), or they choose to enroll in a Medicare Advantage plan. Beneficiaries with lower incomes may qualify for additional assistance that helps pay Medicare premiums and cost sharing.

Parts of Medicare



Part A

What's covered: In general, Medicare Part A pays for medically necessary inpatient hospital services. This includes inpatient hospitalization services related to cancer treatments and/or medically necessary inpatient hospitalization related to side effects related to cancer treatments, some skilled nursing facility stays, home health care for homebound patients[12] and hospice care. Part A also covers the costs of surgically implanted breast prosthesis following a mastectomy only if the surgery was provided on an inpatient basis.

How many people are covered: As of 2022, there were 34.9 million beneficiaries enrolled in Part A.[13]

What beneficiaries pay — premiums: Approximately 99% of Medicare beneficiaries do not pay premiums for Medicare Part A, but rather qualify for the program based on their (or their spouse's) work history and having reached the age of 65. To obtain coverage, beneficiaries must have worked – and paid payroll taxes – for at least 40 quarters (10 years). Some beneficiaries who fail to meet these qualifications may be eligible to purchase Part A coverage.[14] Premiums for those who have to pay for Part A coverage increase each year.[15] While technically individuals can choose to enroll in Medicare Part B (see below) and not also enroll in Part A, most people enroll in Part A when they are first eligible because they face no premiums.[16]

Cost-sharing: Beneficiary cost sharing will vary depending on the service being provided. In 2023, beneficiary cost sharing for various services included:

Inpatient hospitalization:[17] Beneficiaries admitted as inpatients to a hospital will pay a deductible for each benefit period (defined as a spell of illness or an episode of care). In addition to the deductible, beneficiaries may also pay coinsurance (depending on how many days they have spent in the hospital):

Period	Beneficiary Cost-Sharing, 2024[18]
Deductible	$1,632
Daily coinsurance 0-60 days	$0
Daily coinsurance 61-90 days	$408 per day for each benefit period
Daily coinsurance for lifetime reserve days[19]	$816

Home Health: Beneficiaries do not have a copayment for Medicare-covered home health benefits. However, if a beneficiary utilizes durable medical equipment as part of the home health services, their cost-sharing obligation would amount to 20% of the Medicare-approved amount.

Hospice: Beneficiaries generally do not have cost sharing associated with hospice care itself, most of which is delivered in the home. However, beneficiaries in hospice may incur cost sharing for related care. For example, beneficiaries may pay up to $5 per prescription for pain and symptom relief for care at home. If a beneficiary receives inpatient respite care, they will pay 5% of the Medicare-approved amount for that care.

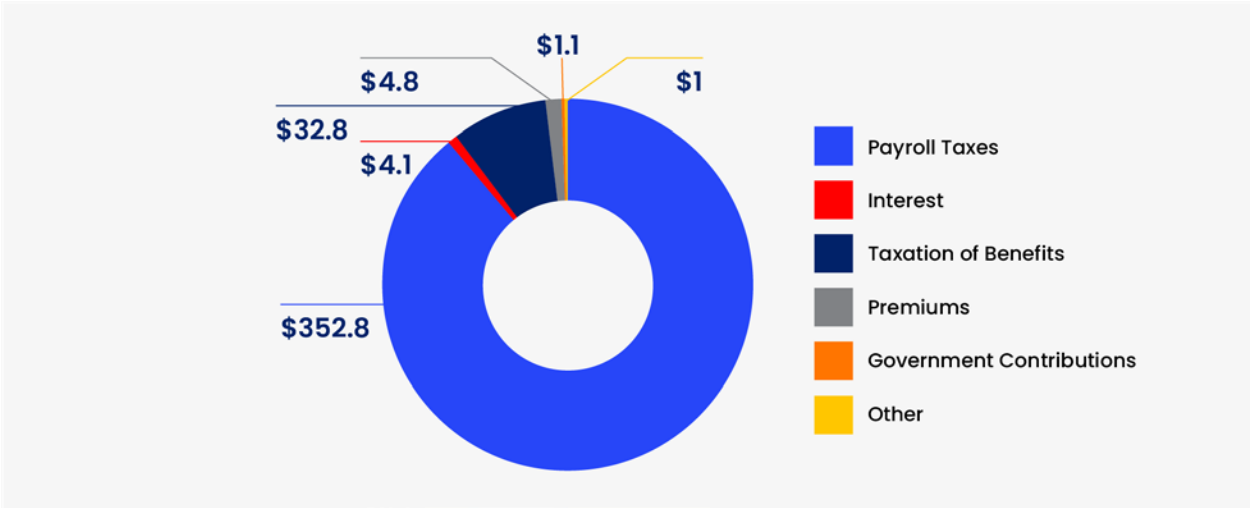
Skilled Nursing Facilities: Medicare will only cover a beneficiary's stay at a skilled nursing facility if the beneficiary was discharged from an inpatient hospital with a minimum stay of three days.[20] The beneficiary's cost sharing for such services would be as follows:

Period	Beneficiary Cost-Sharing, 2024[21]
Deductible	$0
Cost-sharing 1-20 days	$0
Cost-sharing 21-100 days	Up to $204 per day
Cost-sharing 101 days and beyond	Beneficiary pays all charges

Cap on beneficiary out-of-pocket costs: There is no cap on beneficiaries' total out-of-pocket costs.[22]

Source of financing: Medicare Part A is financed through the Hospital Insurance (HI) Trust Fund, which is financed primarily through payroll taxes. Employers and employees each pay 1.45% of a worker's wages, and self-employed individuals pay 2.9% of their net earnings. Starting in January 2023, high-income workers began paying an additional 0.9% tax on their earnings above a certain amount ($200,000 for single tax filers and $250,000 for married couples).

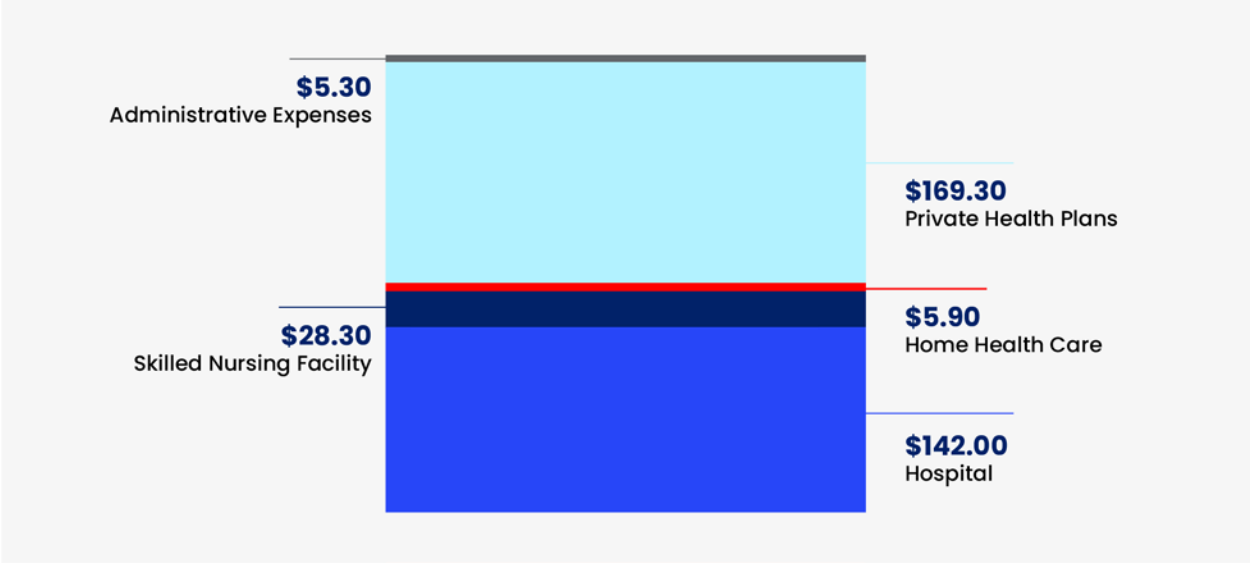
Figure 11: Part A Finances, 2022 (in billions)



Source: The Board of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. 2023 Medicare Trustees Report. 2023. Available from: https://www.cms.gov/oact/tr/2023.

Part A Expenditures: Medicare Part A pays for inpatient hospital services, some skilled nursing facility stays, home health care and hospice care. By far the largest Part A expenditure among Original Medicare is for inpatient hospital services.

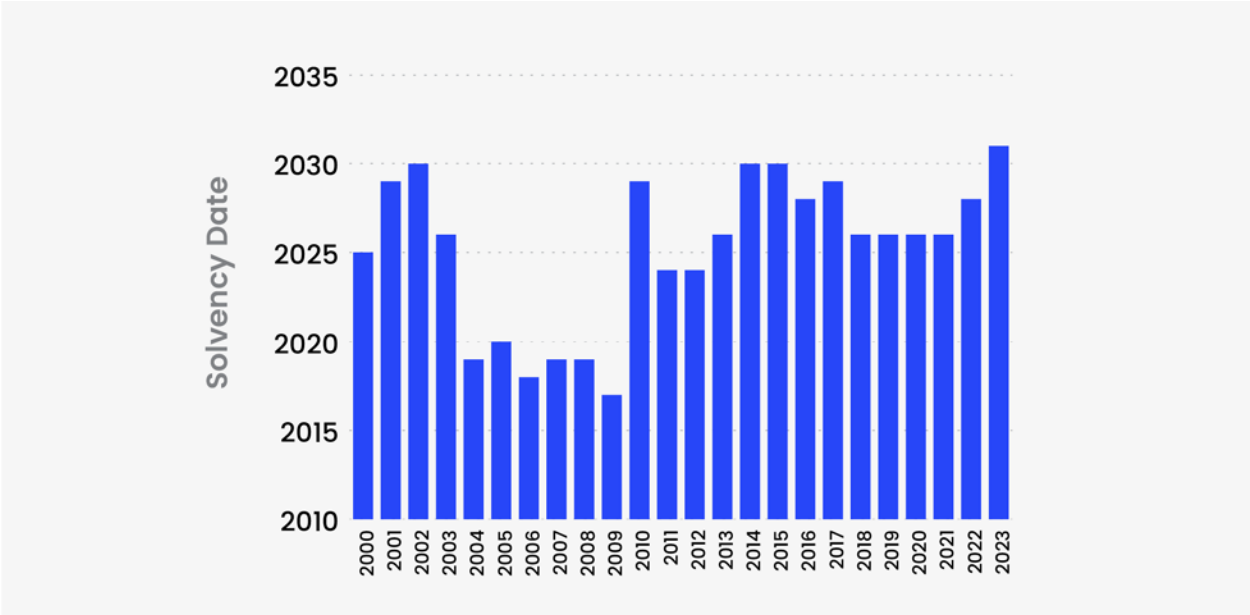
Figure 12: Part A Expenditures, 2022 (in billions)



Note: Private health plans include all categories of costs and are not separately detailed in the 2023 Medicare Trustees Report.
Source: 2023 Medicare Trustees Report.

Solvency: The Medicare Part A program is financed primarily by payroll taxes (89% of program inlays were from payroll taxes in 2023).[23] The Medicare Board of Trustees annually reports on the solvency of the Medicare Part A program. Because Part A program expenditures exceed income, the overall solvency of the program is reduced. When assets are fully depleted, Medicare Part A will have insufficient resources with which to pay benefits, a situation that has never existed in the program's history. In the 2023 Medicare Trustees Report, actuaries projected that the Part A trust fund will be depleted in 2031.

Figure 13: Medicare Trustees' Estimated Year of Part A Insolvency, 2000-2023



Source: Authors' analysis of Medicare Trustees' reports 2000-2023.

Part B

What's covered: In general, Medicare Part B covers physician services (like oncologist services) and outpatient services (such as care provided in hospital emergency room departments, ambulatory surgical centers, durable medical equipment, clinical laboratory services, physical therapy and some home health care). Part B also covers chemotherapy drugs administered in an outpatient clinic or physician's office and some oral chemotherapy treatments. Medicare Part B will also cover FDA-approved drugs and biologics in an anticancer chemotherapeutic regimen for off-label use if the off-label medically accepted indications are supported in one or more compendia or in peer-reviewed medical literature.[24] In addition, Part B covers radiation treatments and breast prosthesis following a mastectomy if the surgery took place in an outpatient setting. Most preventive services (including cancer screenings) are covered under Medicare Part B.

How many people are covered: As of 2022, total enrollment for Original Medicare Part B was 29.7 million.[25]

What beneficiaries pay — premiums: Beneficiaries pay a monthly premium of 25% of projected Part B costs per beneficiary. Part B premiums vary depending on the enrollee's income.[26,27] In 2024, beneficiaries whose annual modified adjusted gross income is less than or equal to $103,000 ($206,000 for couples filing joint returns), will pay the base monthly premium of $174.70. Beneficiaries whose income exceeds that threshold will pay higher monthly premiums.[28]

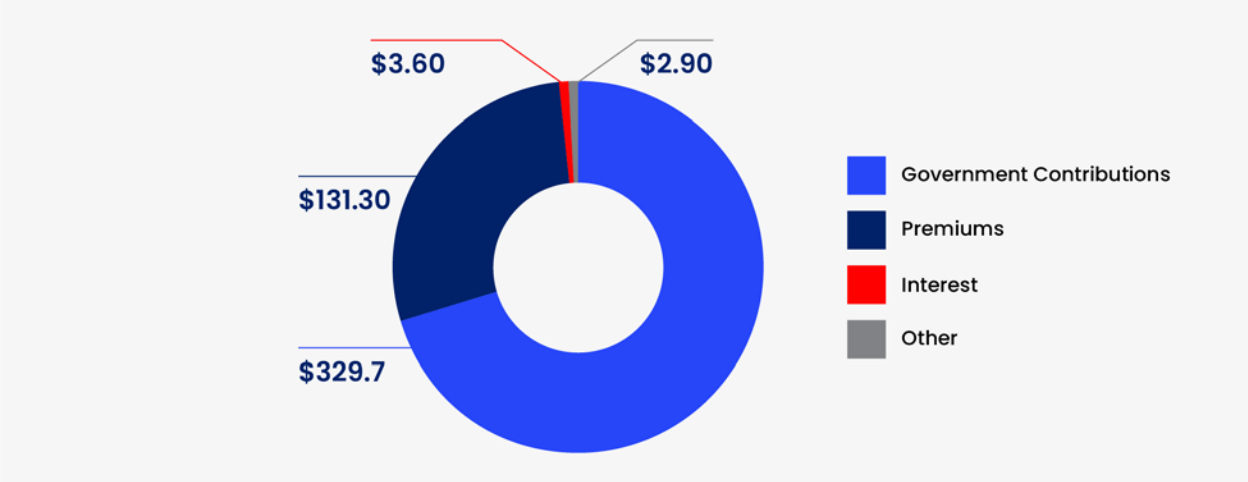
Late-enrollment penalty: Beneficiaries who failed to enroll in Part B when first eligible may face a late enrollment penalty of 10% per year for each year they failed to sign up for Part B.[29] This penalty is permanent for as long as the beneficiary is covered under Medicare.

Cost-sharing: Beneficiaries pay an annual deductible ($240 in 2024),[30] which is modified each year. After the deductible, beneficiaries who lack supplemental coverage generally pay 20% coinsurance for each service (though some services, like certain cancer screenings and other preventive care, are covered at no additional cost to the beneficiary).

Cap on beneficiary out-of-pocket costs: There is no cap on beneficiaries' out-of-pocket costs.[31]

Source of financing: Medicare Part B is financed through the Supplementary Medical Insurance (SMI) Trust Fund, which is funded largely through beneficiary premiums (approximately 25%) and general tax revenue.

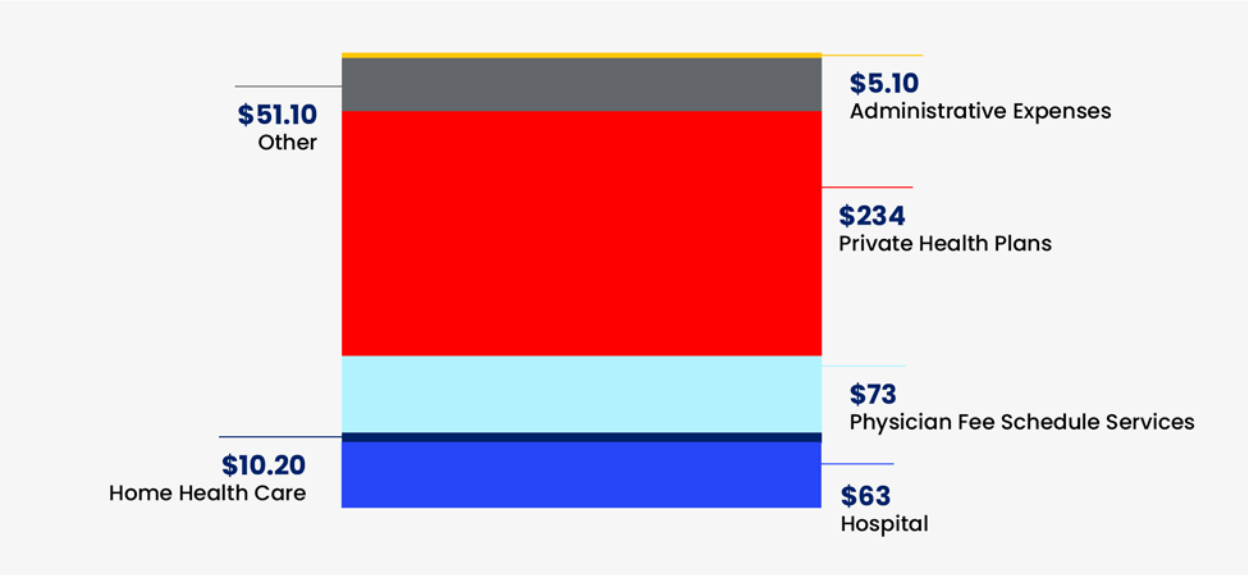
Figure 14: Part B Finances, 2022 (in billions)



Source: 2023 Medicare Trustees Report.

Part B expenditures: Medicare Part B covers physician services and outpatient services (including outpatient services that occur in a hospital setting), home health services and other services (including laboratory services).

Figure 15: Part B Expenditures, 2022 (in billions)



Note: The term Private Health Plans includes all categories of costs and is not separately detailed in the 2023 Medicare Trustees Report.
Source: 2023 Medicare Trustees Report.

Solvency: Unlike Part A, which is financed primarily through payroll taxes that finance the HI trust fund, the Part B program is financed primarily through government contributions and premiums. Each year the government authorizes funds to be appropriated and transferred from the general fund of the Treasury. The contributions need to cover expected Part B costs, as well as provide a reserve for Part B contingencies.

Part C

What's covered: Medicare Part C is administered through private managed care plans (also known as Medicare Advantage plans or MA plans) that contract with Medicare to provide the same benefits offered under Medicare Part A and Part B. Under contract requirements, MA plans may also offer additional benefits, known as supplemental benefits, beyond those covered under Original Medicare, such as fitness benefits, enhanced disease management and health education, among others.

How many people are covered: As of August 2023, 32.3 million beneficiaries (48% of eligible beneficiaries) were enrolled in Medicare Advantage plans.[32] Participation in the Medicare Advantage program has increased almost three-fold since 2010.[33] Medicare Advantage plans can offer benefits that are not offered in traditional Medicare, and unlike Original Medicare, MA plans have a cap on beneficiaries' out-of-pocket costs. These additional benefits are one of the common reasons why Medicare beneficiaries choose to enroll in MA plans.[34] But these plans may also require beneficiaries to seek care through their network, which could be a concern for people with cancer who want access to a wide range of providers.

What beneficiaries pay — premiums: Beneficiaries who are enrolled in Medicare Advantage plans pay their Part B premium, as well as a monthly premium to their Medicare Advantage plan. Monthly premiums for Medicare Advantage plans will vary depending on geography, the plan choice and what, if any, supplemental benefits are provided under the plan. In 2023, the average Medicare Advantage monthly premium was $18,[35] though individuals enrolled in Medicare Advantage plans also have to pay their Part B premium. Almost 70% of individuals enrolled in Medicare Advantage plans paid no premiums other than their Part B premium.[36]

Late-enrollment penalty: There is no late enrollment penalty for enrolling in Medicare Advantage plans. However, beneficiaries who are assessed a late enrollment penalty under Part B or D will continue to pay the penalty even if they are enrolled in a Medicare Advantage plan.

Beneficiary cost-sharing: Beneficiary cost sharing will differ depending on the plan chosen. However, Medicare Advantage plans are prohibited from charging beneficiaries more cost sharing than beneficiaries would incur in traditional Medicare. Medicare Advantage plans are permitted to reduce beneficiary cost sharing for services and to offer coverage of benefits not covered under Parts A or B, and a majority of Medicare Advantage plans also cover Part D benefits.

Cap on beneficiary out-of-pocket costs: Unlike Original Medicare, for which there is no cap on beneficiaries' out-of-pocket costs, Medicare Advantage plans are required to cap beneficiaries' out-of-pocket costs for Part A and B services. In 2023, the annual cap on in-network services was $8,300 and $12,450 for in-network and out-of-network services combined.[37]

Types of coverage: Beneficiaries who elect to enroll in Medicare Advantage plans can choose from various types of health plans, including health maintenance organization (HMO) plans, preferred provider organization (PPO) plans, private fee-for-service (PFFS) plans and special needs plans (SNPs). A majority of Medicare Advantage plans control costs by utilizing a network of plan providers (including physicians such as those who specialize in specific types of cancer and facilities, like cancer centers). Depending on the type of plan, beneficiaries may be limited in their choice of provider and may have to file a request with their Medicare Advantage plan to obtain care from an out-of-network provider or face other limitations in coverage. Medicare Advantage plans are rated on 38 unique quality and performance measures, which include breast and colorectal cancer screening measures.

In general, most Medicare Advantage plans also cover the cost of out-patient prescription drugs. Beneficiaries who are enrolled in Medicare Advantage plans without drug coverage can enroll in a Medicare Part D plan.

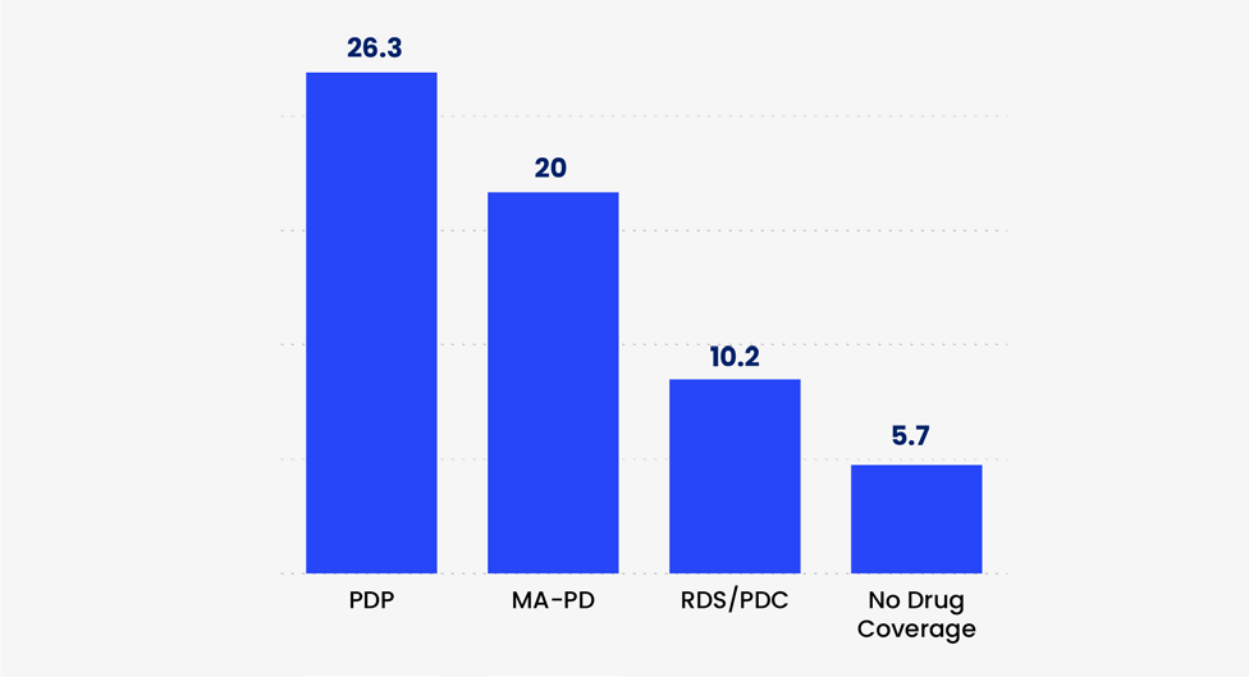
Source of financing: Part C is financed through the HI and SMI trust funds.

Solvency: Because of the way Part C is financed, the overall solvency of the plan is tied to the solvency of the Medicare Part A and B programs. As discussed above, due to the financing mechanism, absent legislative change, the solvency of Part B (and thus, Part B-covered services provided by Part C plans) are not at risk of insolvency. Conversely, as noted above, the solvency of the Part A program fluctuates. If Part A were ever to become insolvent, then Part A-covered services provided by Part C plans could also be at risk.

Part D

What's covered: Medicare Part D covers outpatient prescription drugs. It is administered through private plans that contract with Medicare. As of 2022, approximately 51.4 million beneficiaries were enrolled in Part D plans,[38] an estimate that does not account for beneficiaries who may have another source of drug coverage such as through a retiree benefit.

Figure 16: Medicare Drug Coverage by Type, 2019 (in millions)



Note: The term PDP refers to Prescription Drug Plans. MA-PD refers to Medicare Advantage plans that also offer a Part D benefit. RDS/PDC refers to those who are not enrolled in the Part D program but who have retiree drug coverage through a former employer that receives the retiree drug subsidy (RDS) or those who have private drug coverage (PDC).
Source: Tarazi, W., Welch, WP., Nguyen, N., Bosworth, A., Sheingold, S., De Lew, N., and Sommers, BD. Medicare Beneficiary Enrollment Trends and Demographic Characteristics. (Issue Brief No. HP2022-08). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. March 2022.

Private plans that administer the Part D program (PDPs) are not required to cover every outpatient prescription drug, but they must cover at least two drugs per therapeutic category or class. Since the inception of the Part D program, the Centers for Medicare & Medicaid Services (CMS) has acknowledged that in some cases Medicare beneficiaries may need access to more than two drugs within a therapeutic class, so CMS identified six categories and classes of clinical concern (commonly known as the six protected classes) and requires Part D plans to cover all or substantially all drugs within each of the classes.[39] Antineoplastics, which include many oral chemotherapy drugs, is one of the six protected classes.[40] As with Part B, Medicare Part D will also cover FDA-approved drugs and biologics in an anticancer chemotherapeutic regimen for off-label use if the off-label medically accepted indications are supported in one or more compendia or in peer-reviewed medical literature.[41]

Part D plans are permitted to create their own plan formularies (list of covered drugs) and place drugs into certain formulary tiers with beneficiary cost sharing increasing on higher tiers. All PDPs also have a specialty tier for drugs whose costs exceed a certain amount.[42] Most cancer drugs are placed on the specialty tier due to their cost. CMS sets a maximum allowable cost sharing for drugs on the specialty tier at 25% cost sharing for plans that use a standard deductible and 33% cost sharing for plans that do not use a deductible.[43] PDPs are also permitted to impose utilization management tools (such as prior authorization, step therapy or quantity limits) to control access to prescription drugs.

How many people are covered: As of August 2023, 52 million beneficiaries were enrolled in a prescription drug plan.[44] Of those, 22.5 million beneficiaries were enrolled in a stand-alone prescription drug plan and 29.6 million beneficiaries were enrolled in an MA plan that also provides Part D coverage.[45]

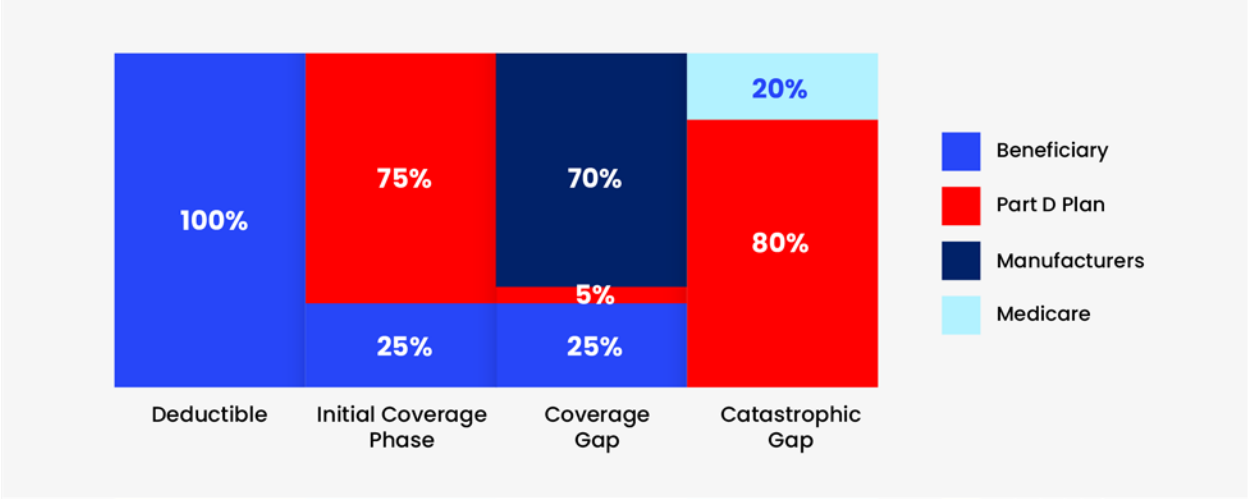
What beneficiaries pay — premiums: Like Part C, premiums for Part D plans vary depending on geography[46] and the type of plan offered. In 2024, the average total Part D monthly premium is estimated to be $55.50.[47] Beneficiaries whose annual modified adjusted gross income is less than or equal to $103,000 ($206,000 for couples filing joint returns) will not face an income-related monthly adjusted amount. Beneficiaries whose income exceeds that threshold will pay higher monthly premiums.[48]

Late enrollment penalty: Beneficiaries who failed to enroll in Part D when first eligible may face a late enrollment penalty of 12% per year for each year they failed to sign up for Part D.[49] This penalty is permanent for as long as the beneficiary is covered under Medicare.

Cost-sharing: Beneficiary cost sharing on outpatient prescription drugs will vary depending on whether the drug is included on the plan's formulary and, if so, the tiering of the prescription drug. In addition, beneficiary cost sharing will also vary depending on the Part D plan's benefit design. Beneficiaries with low incomes may qualify for the Low-Income Subsidy (LIS) program, under which they incur less cost sharing (see below) provided they enroll in a benchmark plan.[50] Beneficiaries who qualify for the LIS program and choose not to enroll in a benchmark plan may be required to pay some portion of their plan's monthly premium.

In 2024, under the standard Part D benefit, the beneficiary will have an annual deductible of no more than $545, after which they enter the initial coverage phase, where the plan pays 75% of the cost of the drugs and the enrollee pays 25%.[51] The initial coverage phase ends once total drug costs exceed a certain point called the initial coverage limit. In 2024, the initial coverage limit is $5,030 in total costs, at which point the beneficiary would have paid $1,666.25 under the standard benefit (that is, the $545 deductible plus $1,121.25 during the initial coverage phase). After the initial coverage phase ends, the beneficiary enters the coverage gap, or donut hole, where they continue to pay 25% cost sharing, but the plan pays 5% and drug manufacturers pay 70% of Part D covered drugs.[52] However, if the enrollee has even higher prescription drug costs (where the enrollee's total out-of-pocket spending, plus any required manufacturer discounts, reaches $8,000), they will pass the catastrophic coverage limit, after which the beneficiary will pay nothing for the cost of their prescription drugs. In this range, their plan will pay 20% of the cost and Medicare will pay 80% of the cost of the drugs.

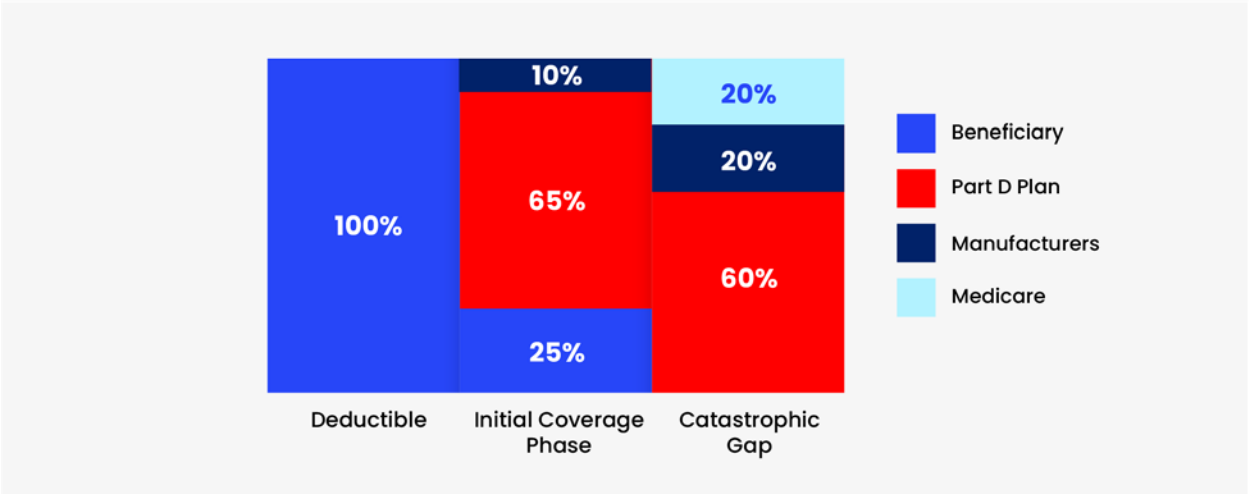
Figure 17: Standard Part B Benefit, 2024



Beginning in 2025, beneficiaries will have the option to enroll in the Medicare Prescription Payment Plan, which will allow them to pay their out-of-pocket prescription drug costs in the form of capped monthly installments.

Cap on beneficiary out-of-pocket costs: The standard Part D benefit design will change in 2025. Beneficiaries will still face an annual deductible, after which they enter the initial coverage period where they still pay 25% of the cost of their drugs, their plan will pay 65% of the cost of the drugs, and manufacturers will pay 10%. However, the coverage gap will be eliminated starting in 2025, and beneficiary out-of-pocket spending for Part D drug costs will be capped at $2,000. So, after the initial coverage phase, the beneficiary will hit the catastrophic cap (set at $2,000 in enrollee out-of-pocket cost for 2025), after which the beneficiary no longer incurs cost sharing. Their plan will pay 60% of the cost of brand drugs, and drug manufacturers and Medicare will each pay 20%. For generic drug costs in the catastrophic phase, the Part D plan pays 60%, but Medicare pays 40% and no manufacturer discount is required.

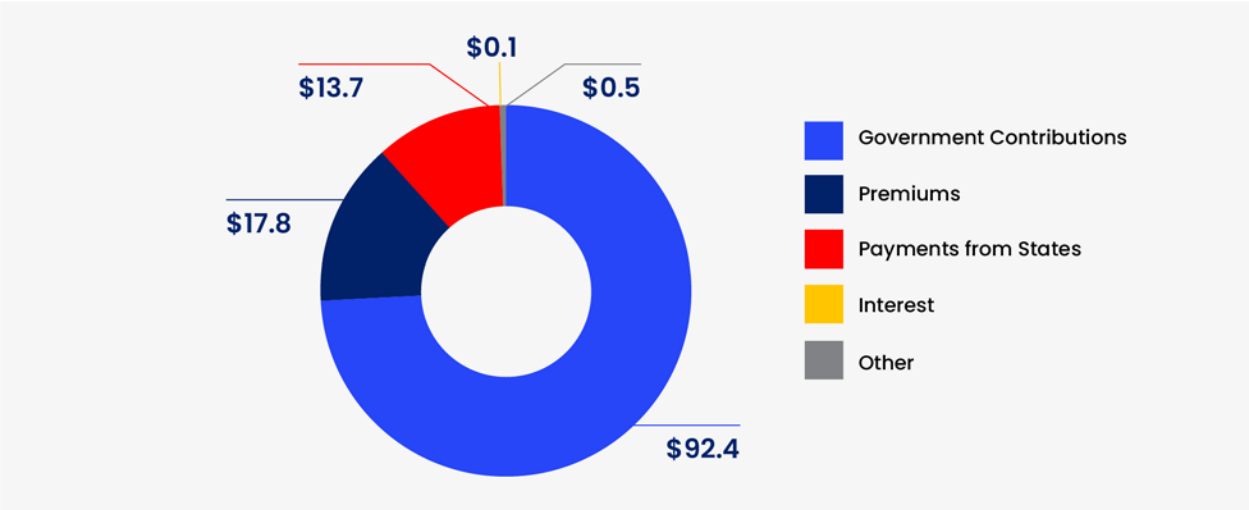
Figure 18: Standard Part D Benefit Design, 2025



In addition, beginning in 2025, beneficiaries will have the option to pay the required cost sharing in capped monthly installments. This was designed to help beneficiaries better afford their drug costs.[53]

Source of financing: Part D is financed through the SMI trust fund, which is funded through beneficiary premiums (approximately 25.5%) and general revenue.

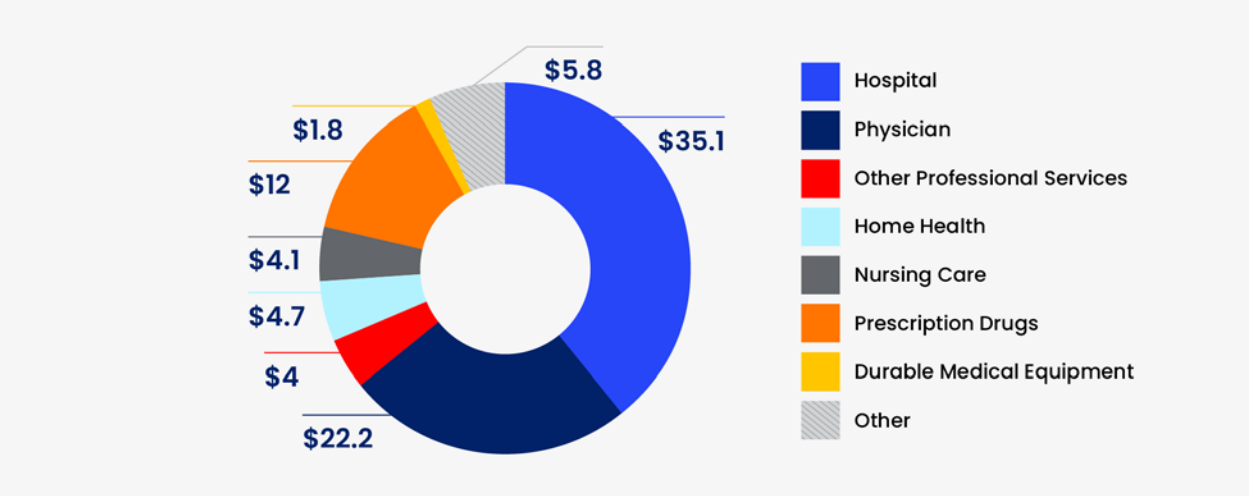
Figure 19: Part D Finances, 2022 (in billions)



Source: 2023 Medicare Trustees Report.

Medicare spending for 2021 was estimated to total over $900.8 billion or 21% of total national health expenditures. The breakdown of spending is as follows:

Figure 20: Medicare Expenditures by Category, 2021 (in billions)



Note: The term "other" includes other professional services, dental services, other non-durable medical products, and other health, residential, and personal care.
Source: Centers for Medicare & Medicaid Services. NHE Tables. Table 19: National Health Expenditures by Type of Expenditure and Program: Calendar Year 2021. Available at https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.

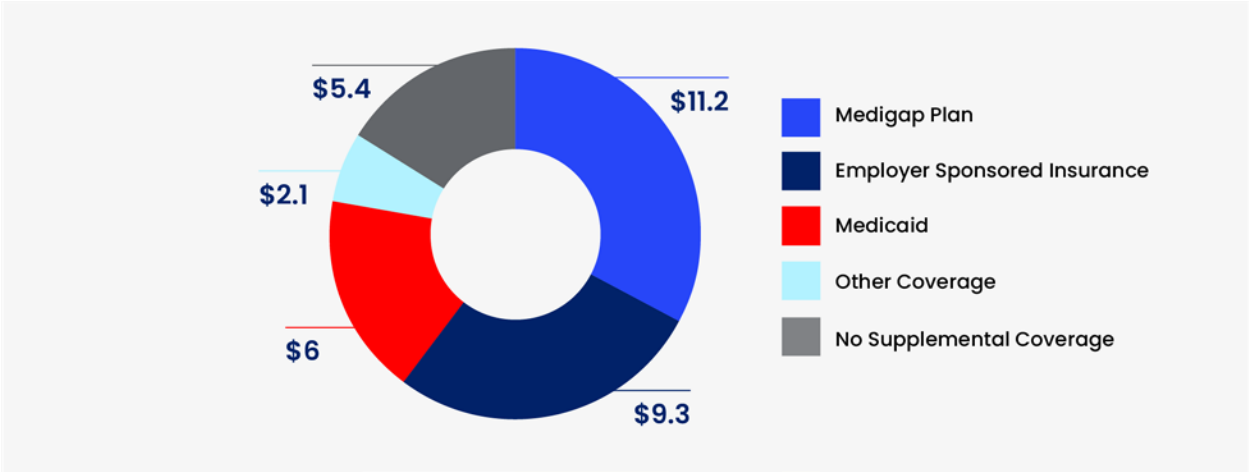
Medicare Supplemental Coverage

Medicare beneficiaries who are enrolled in traditional Medicare (Parts A and B) may choose to purchase a supplemental Medicare policy (often called Medigap) to help pay some of the cost sharing associated with traditional Medicare.[54] Medigap plans are offered by private companies. The plans are standardized,[55] meaning that the benefits offered will be the same across plan carriers. These standardized plans vary in terms of the generosity of the benefit, with some plans providing limited supplemental coverage and others offering more robust coverage. Premiums for these plans will vary depending on geography and the type of plan chosen.

Some beneficiaries may have supplemental coverage in the form of employer-sponsored insurance, either because they receive benefits as a dependent of someone who receives employer-sponsored insurance, or because they have health benefits as part of a retirement package.

Some low-income beneficiaries may qualify for both Medicare and Medicaid, in which case the Medicaid coverage operates as a type of supplemental coverage.

Figure 21: Medicare Supplemental Coverage, 2019 (in millions)



Note: This chart reflects data from 2019 and excludes beneficiaries who are enrolled in Medicare Advantage plans. In 2019 roughly 23.1 million Medicare beneficiaries were enrolled in Medicare Advantage plans.
Source: Tarazi, W., Welch, WP., Nguyen, N., Bosworth, A., Sheingold, S., De Lew, N., and Sommers, BD. Medicare Beneficiary Enrollment Trends and Demographic Characteristics. (Issue Brief No. HP2022-08). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. March 2022.

Beneficiaries may decide over the course of their Medicare enrollment to switch between obtaining coverage through traditional Medicare versus Medicare Advantage. However, there are limitations in doing so. Beneficiaries who initially decline enrollment in a Medigap plan (either because they have enrolled in a Medicare Advantage plan or because they choose to forego supplemental coverage) may be ineligible to purchase a Medigap plan outside their initial enrollment period.

The best time for a beneficiary to enroll in a Medigap plan (as a supplement to traditional Medicare) is during their first eligibility period (generally within six months of turning 65).[56] During this time, a Medigap plan must offer a beneficiary coverage and cannot take into account their individual health history in determining the premiums for the plan. Beneficiaries who want to enroll in a Medigap plan after this period may only do so during the annual enrollment period[57] and will likely be subject to medical underwriting, meaning that the plan can charge higher premiums depending on the health status of the beneficiary.

Medicare Advantage plans are prohibited from taking into account a person's medical history when determining premiums or coverage at any time (including the initial enrollment period and any subsequent year). Thus, beneficiaries who lack supplemental coverage (for example, if they are medically underwritten by a Medigap plan) can enroll in a Medicare Advantage plan. However, Medicare Advantage plans are able to use certain utilization management tools (such as prior authorization or step therapy) before the plan will cover certain drugs or services. In addition, Medicare Advantage plans have requirements that enrollees in the plan use providers that participate in the plan's network.

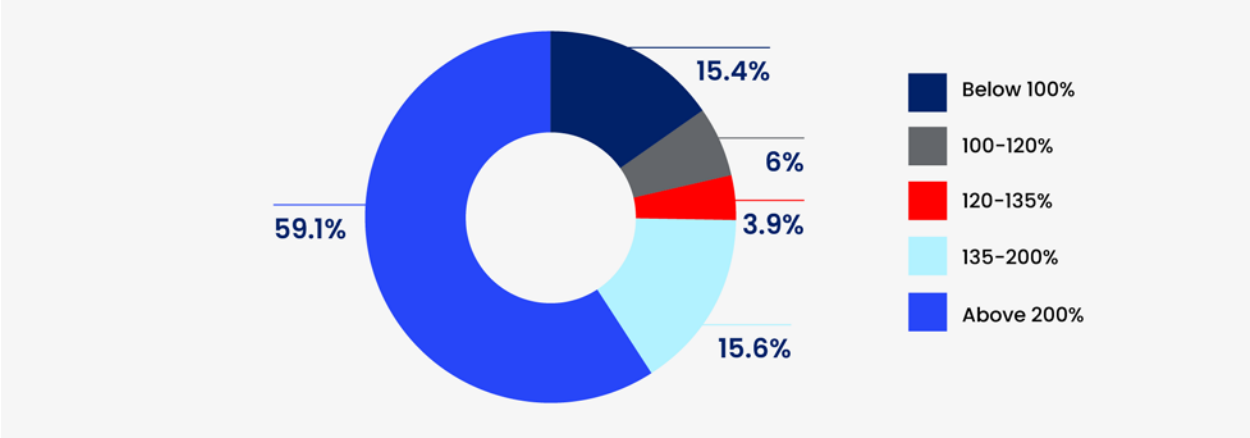
Medicare Beneficiary Characteristics

The Medicare program provides health insurance coverage for tens of millions of Americans across the country. The following highlights some of the characteristics of this diverse population.

Low-Income Medicare Beneficiaries

Almost half (44%) of Medicare beneficiaries have annual incomes below 200% of the federal poverty level.[58] Medicare has several special programs designed to assist individuals who have limited incomes, including joint enrollment in Medicare and Medicaid and a Part D subsidy for low-income beneficiaries.

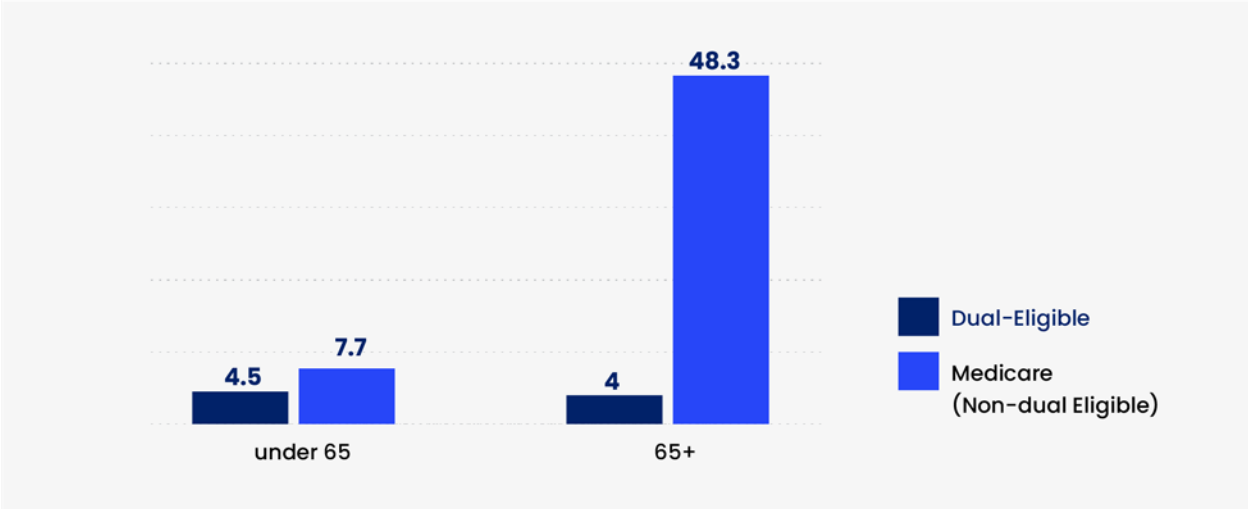
Figure 22: Income Status of Medicare Enrollees (as a percentage of the Federal Poverty Level), 2019



Source: Tarazi, W., Welch, WP., Nguyen, N., Bosworth, A., Sheingold, S., De Lew, N., and Sommers, BD. Medicare Beneficiary Enrollment Trends and Demographic Characteristics. (Issue Brief No. HP2022-08). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. March 2022.

Dual eligibles: The Medicare program provides some beneficiaries with limited incomes additional assistance to help them afford their Medicare coverage. Some beneficiaries whose income is very limited may also be entitled to coverage through the Medicaid program (e.g., dual eligible). Eligibility and benefits of dual eligibles differ depending on an individual's income and asset level.[59] Dual eligible beneficiaries are more likely than non-dual eligibles to be under the age of 65 and have a disability.[60] Medicare pays first for Medicare-covered services provided to dual eligibles and Medicaid is a secondary payer behind Medicare (and other health insurance coverage, if any).

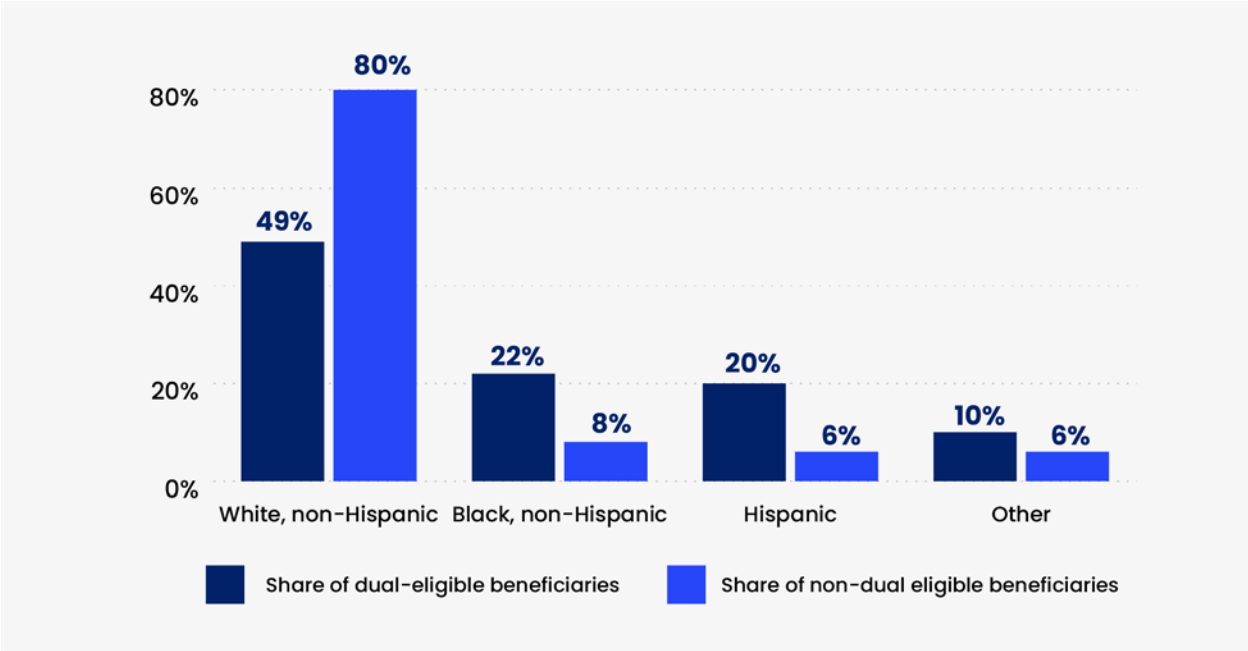
Figure 23: Dual-Eligible Enrollment by Age, 2020 (in millions)



Source: Medicare Payment Advisory Committee. A Data Book: Health Care Spending and the Medicare Program: July 2023. Available at https://www.medpac.gov/wp-content/uploads/2023/07/July2023_MedPAC_DataBook_SEC.pdf.

Dual eligibles are more likely to be ethnically diverse than the overall Medicare population.

Figure 24: Race/Ethnicity of Dual-Eligibles Compared to Non-dual-eligibles, 2020



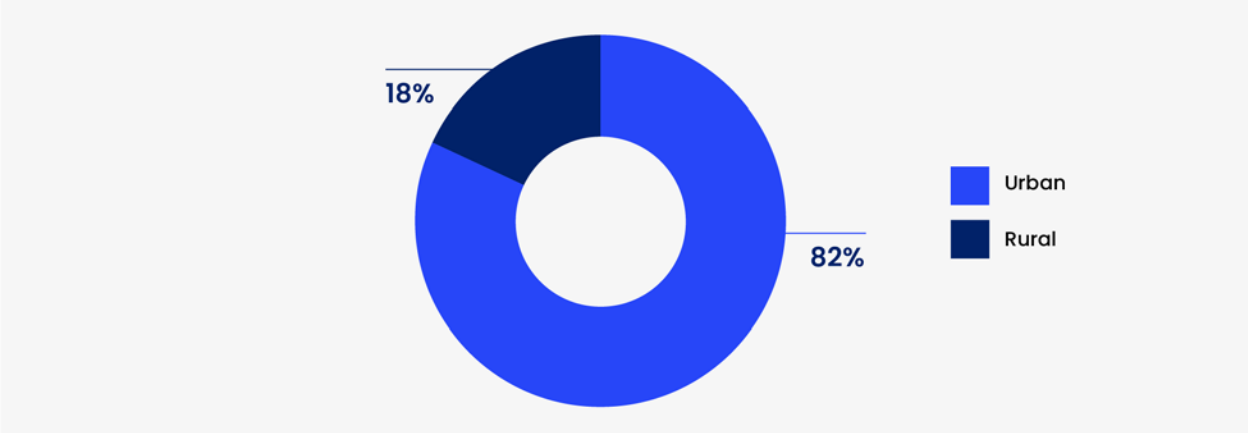
Source: 2023 MedPAC data book.

Part D Low-income Subsidy (LIS): As of 2023, individuals whose annual income was less than $21,870 ($29,580 for married couples) and who had assets of less than $16,600 ($33,240 for married couples) may qualify for additional assistance to help them afford their Part D costs.[61] Some individuals have to apply to receive the LIS, but some individuals automatically qualify.[62] Beneficiaries who qualify for the LIS benefit will pay no monthly premiums, will have no deductible, and will have caps on their out of-pocket costs.[63]

Geographic Distribution of Medicare Beneficiaries

Approximately one-fifth of Medicare beneficiaries reside in rural areas, and that number is increasing. In 2021, individuals ages 65 and older accounted for more than 20% of the rural population for the first time in U.S. Census history.[64] Living in a rural area can create challenges for beneficiaries when accessing health care services, particularly specialty services like cancer care, which tend to be centered in urban areas. Rural residents also tend to have a higher prevalence of unhealthy behaviors and a lower adherence to recommended preventive care (e.g., tobacco cessation) compared to individuals residing in urban areas, placing them at a higher risk of developing cancer.[65]

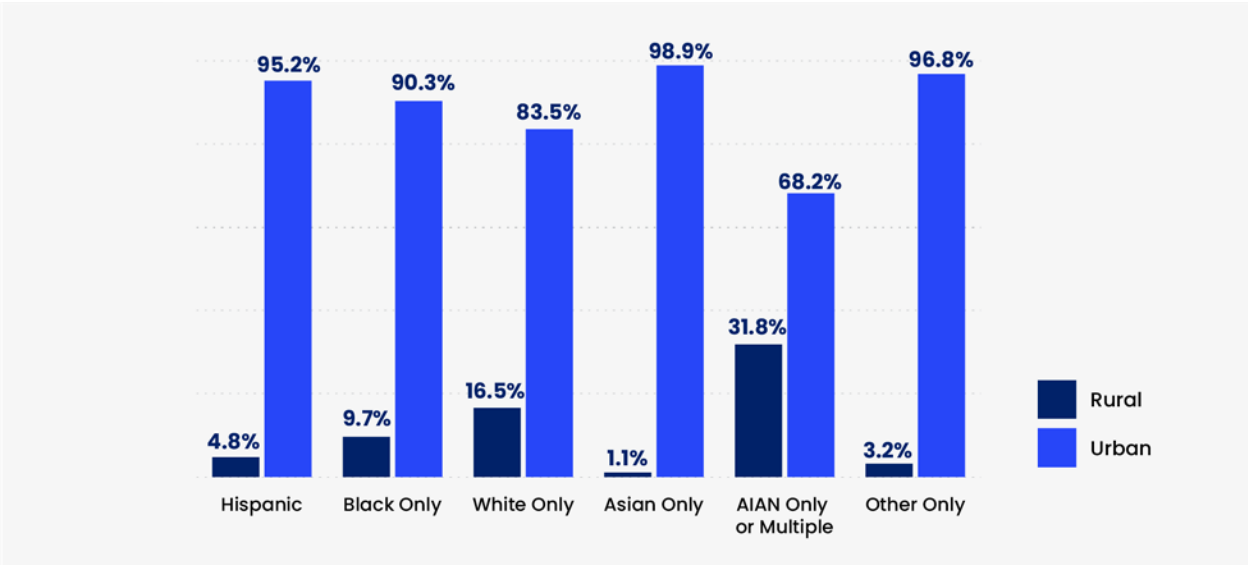
Figure 25: Beneficiaries' Residence: Urban Versus Rural, 2020



Source: Medicare Payment Advisory Commission. A Data Book: Healthcare Spending and the Medicare Program. 2023. Available at: https://www.medpac.gov/wp-content/uploads/2023/07/July2023_MedPAC_DataBook_Sec2_SEC.pdf.

While a majority of Black or African American and Hispanic cancer survivors live in urban areas, almost 10% of Black or African American cancer survivors live in rural areas, which can mean they experience a number of barriers to accessing health care services, as discussed above.

Figure 26: Rural vs. Non-Rural for Cancer Survivors 65+by Race/Ethnicity, 2021



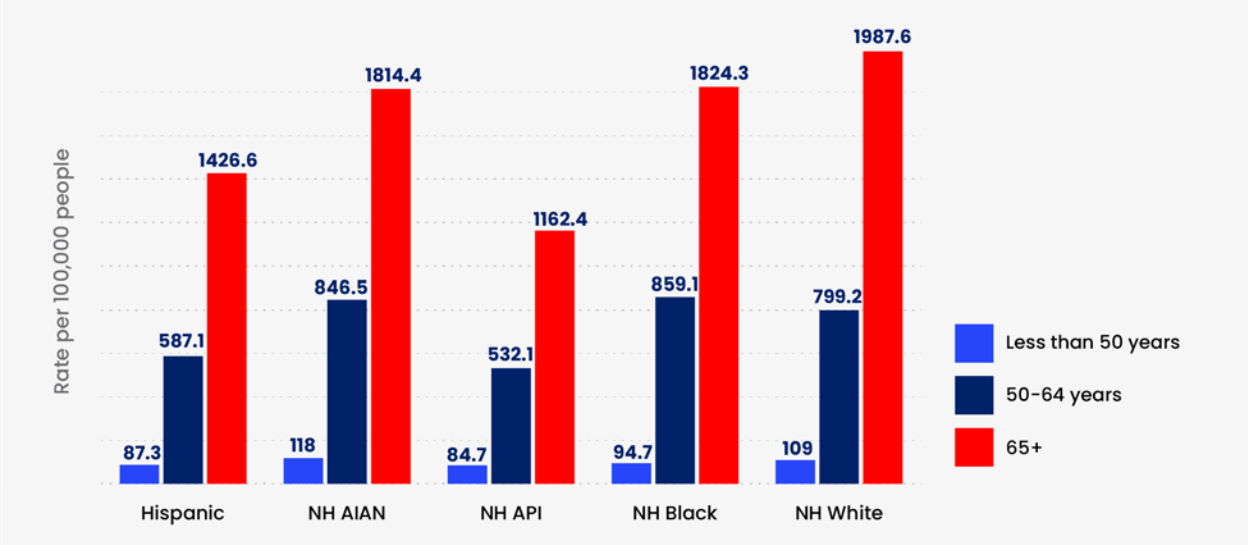
Source: National Health Interview Survey 2021, National Center for Health Statistics, Centers for Disease Control and Prevention. Public-use data file and documentation. (hereinafter National Health Interview Survey, 2021)

Also, approximately one-quarter of cancer survivors who are over the age of 65 live in rural areas and have incomes of less than 200% of the federal poverty level. These individuals are more likely to experience barriers to health care services compared to individuals who live in urban areas.

Health Disparities

Cancer impacts everyone, but it doesn't impact everyone equally. For example, while across the board individuals over the age of 65 are more likely to be diagnosed with cancer relative to younger individuals, when broken out by race and ethnicity, non-Hispanic Whites, non-Hispanic Blacks and American Indian/Alaska Native people are more likely to be diagnosed with cancer before the age of 65 than Hispanic and Asian Pacific Islander persons.

Figure 27: New Cancer Diagnosis by Age and Ethnicity, 2020

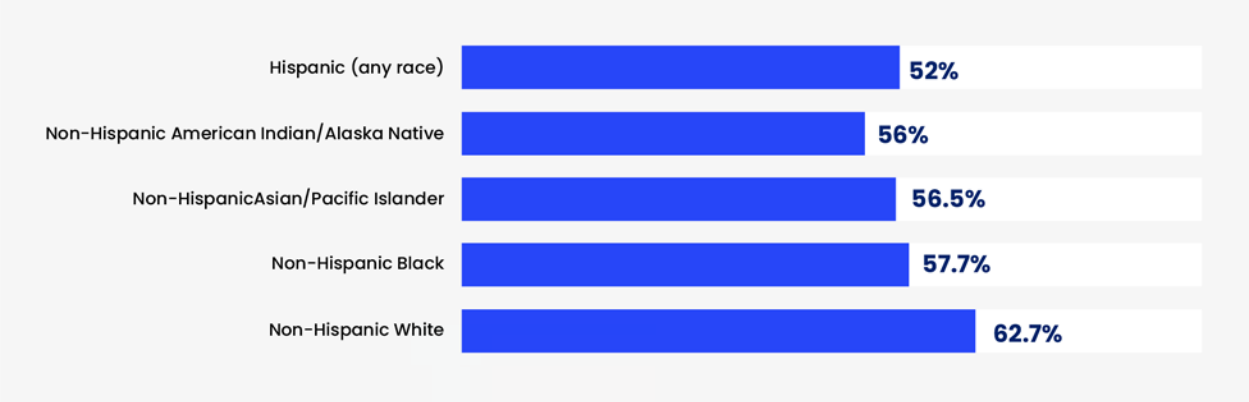


Notes: NH: Non-Hispanic. Rates are age-adjusted to the 2000 US standard population and are adjusted for delays in case reporting. Persons of Hispanic ethnicity may be of any race. Data for American Indians/Alaska Natives are based on Contract Health Service Delivery Area counties. Rates by Hispanic ethnicity exclude the Alaska Native Tumor Registry.
Source: SEER*Explorer: An interactive website for SEER cancer statistics [Internet]. Surveillance Research Program, National Cancer Institute; 2023 Apr 19. [updated: 2023 Jun 8; cited 2023 Jul 13]. Available from: https://seer.cancer.gov/statistics-network/explorer/. Data source(s): SEER Incidence Data, November 2022 Submission (1975-2020), SEER 22 registries.

Survival rates by age and ethnicity

Five-year survival rates for individuals over the age of 65 vary depending on the race and ethnicity of the individual. Non-Hispanic Whites have a higher relative survival rate than any other race or ethnicity.

Figure 28: 5-Year Relative Survival Ratesby Race/Ethnicity and Age 65+, 2013-2019



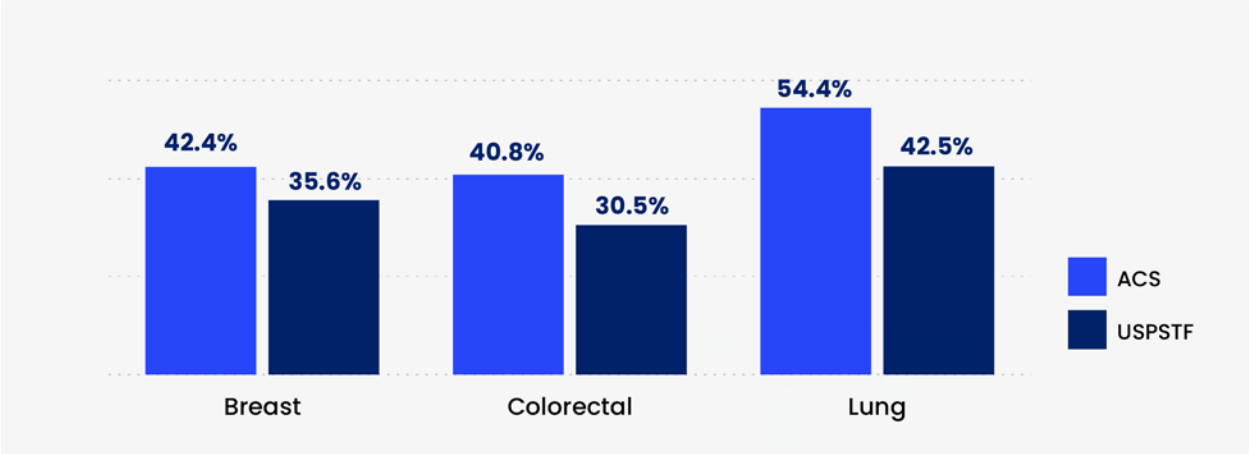
Note: Data include all cancer sites combined for all stages of cancer for both sexes.
Source: SEER*Explorer: An interactive website for SEER cancer statistics [Internet]. Surveillance Research Program, National Cancer Institute; 2023 Apr 19. [updated: 2023 Jun 8; cited 2023 Nov 7]. Available from: https://seer.cancer.gov/statistics-network/explorer/. Data source(s): SEER Incidence Data, November 2022 Submission (1975-2020), SEER 22 registries (excluding Illinois and Massachusetts). Expected Survival Life Tables by Socio-Economic Standards.

Cancer Screening and Prevention in the Medicare Program

A significant number of cancers can be prevented. According to research from the American Cancer Society, approximately 42% of newly diagnosed cancers in the United States (about 840,000 cases in 2024) are potentially avoidable through lifestyle changes.[66] Nineteen percent of all cancers are caused by smoking and 18% are caused by a combination of physical inactivity, excess body weight, poor nutrition and excess alcohol consumption.[67]

There are currently screening recommendations (issued by the U.S. Preventive Services Task Force [USPSTF]) and guidelines (issued by the American Cancer Society) for breast,[68, 69] cervical,[70, 71] colorectal,[72, 73] lung[74, 75] and prostate[76, 77] cancers. Individuals ages 65 and older comprise a large portion of the population that is eligible for specific cancer preventive screenings, though the percentage will change depending on whether the screening guideline used is that of the American Cancer Society or the USPSTF.

Figure 29: Percent Population Ages 65+ Eligible for Screening

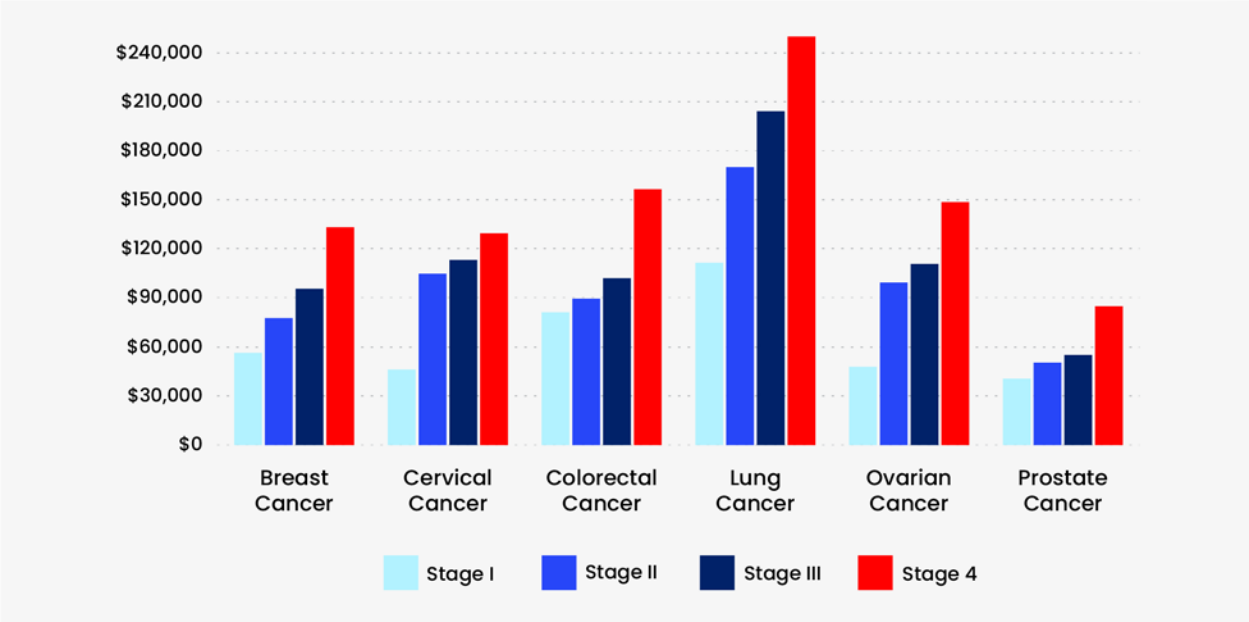


Note: The American Cancer Society (ACS) lung cancer screening guidelines were updated in 2023. Data reflect screening eligibility based on previous ACS lung cancer screening guidelines. While ACS has screening guidelines and the U.S. Preventive Services Task Force (USPSTF) has screening recommendations related to cervical cancer screening, both entities recommend ending screening for individuals at age 65. Both ACS and USPSTF guidelines recommend that prostate cancer screening for age-eligible men of average risk should be discussed with their provider to make an informed decision.
Source: Estimates of breast and colorectal cancer screening eligibility are from the 2021 National Health Interview Survey. Estimates of lung cancer screening eligibility are from the 2022 Behavioral Risk Factor Surveillance System.
*Eligibility was determined by the American Cancer Society and U.S. Preventive Services Task Force recommendations.

Importance of Cancer Screenings

Identifying and treating cancer at an early stage – before it has an opportunity to grow and spread, and thus might be easier to treat – can meaningfully improve clinical outcomes. Diagnosing and treating cancer early can also reduce overall health care expenditures. The chart below shows that across a variety of cancer sites being diagnosed at an earlier stage results in lower health care costs compared to being diagnosed at a later stage. The data presented in the following chart are not limited to the Medicare population, but rather include data across private payers (including commercial, Medicaid, Medicare Advantage). In addition, the mean age ranged from 53.5 to 68.6 years.

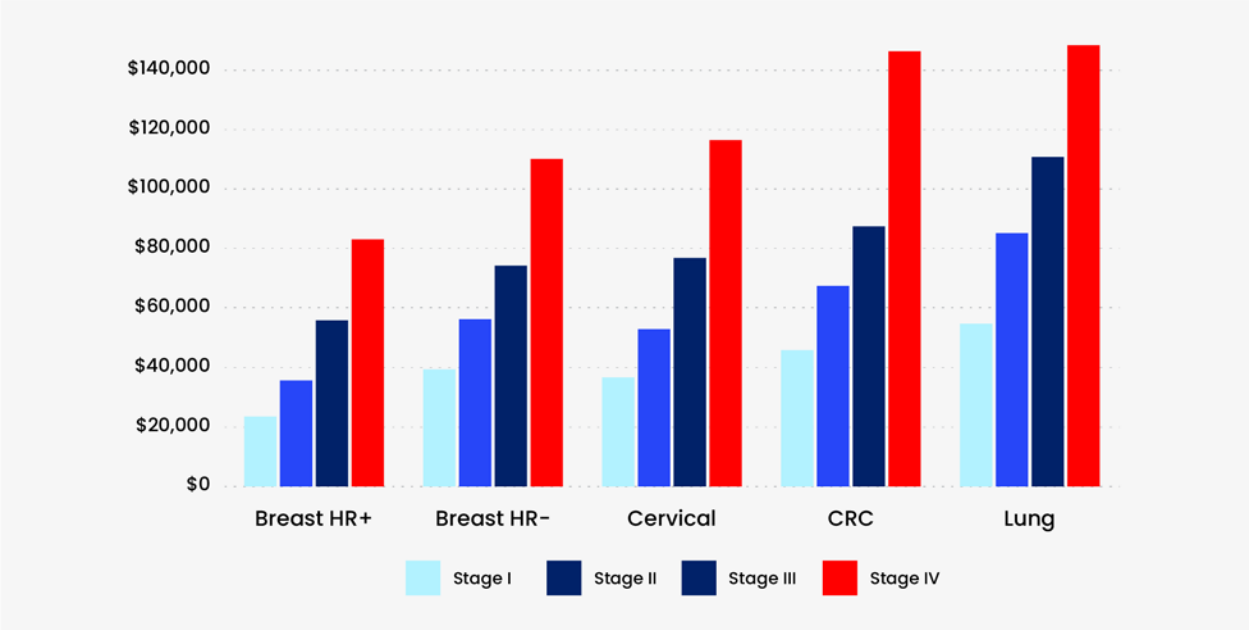
Figure 30: Mean Standard Costs By Stage Within First 6 Months of Treatment for Select Cancers, 2016-2020



NOTE: Data were conducted from Optum's de-identified Integrated Claims-Clinical dataset with Enriched Oncology from January 1, 2008-July 31, 2020.
Source: McGarvey, N., Gitlin, M., Fadli, E. *et al.* Increased healthcare costs by later stage cancer diagnosis. *BMC Health Serv Res* 22, 1155 (2022). https://doi.org/10.1186/s12913-022-08457-6 .

In the Medicare population, average total annual costs of care are up to seven times higher for Medicare beneficiaries who are diagnosed in later stages rather than earlier stages.[78] Looking at just the mean total cancer-related health care costs for just five cancer types – breast cancer HR+, breast cancer HR-, cervical, colorectal and lung – shows a significant difference in cost between those who are diagnosed early versus those who are diagnosed at a later stage.

Figure 31: Total Average Cancer-related Health Care Costs in the First Year of Treatment, 2016-2020



Note: Total average cancer-related health care costs are shown for initial year of treatment. The term CRC refers to colorectal cancer. The term lung refers to cancers of the lung and bronchus.
Source: Sheila R. Reddy, Michael S. Broder, Eunice Chang, Caleb Paydar, Karen C. Chung & Anuraag R. Kansal (2022) Cost of cancer management by stage at diagnosis among Medicare beneficiaries, Current Medical Research and Opinion, 38:8, 1285-1294, DOI: 10.1080/03007995.2022.2047536.

Medicare Coverage of Cancer Screenings

In addition to modifiable risk factors, the early detection of cancer – and in some cases, precancer – can lead to more successful treatment and increase the likelihood of survival for cancers of the breast, colorectum, cervix, lung and prostate. Medicare coverage of cancer screenings, which are considered preventive and not medical services, is limited to cancers for which either (1) Congress created explicit statutory authority for coverage, or (2) if the U.S. Preventive Services Task Force (USPSTF) recommended an A or B rating, and the HHS Secretary determines the service is reasonable and necessary for the prevention of illness or disability and is appropriate for Medicare beneficiaries.

Currently, Medicare only provides coverage of the following cancer screenings (see chart) without cost sharing for individuals who are at average risk of cancer.[79] All of the cancer screenings coverage was provided by statute, with the exception of lung cancer screening. Lung cancer screening was authorized because the USPSTF issued a recommendation for screening.

Figure 32: Medicare Coverage of Cancer Screenings as of January 1, 2024

	Medicare Coverage		
	What Is Covered	**Coverage Parameters**	**Source of Coverage**
Breast cancer screening	Mammograms	Covered annually for female beneficiaries over age 40, with a baseline mammogram for those ages 35 to 39. [80]	Omnibus Budget Reconciliation Act of 1990
Cervical cancer screening	Pap Test and pelvic exam	Covered once every 24 months, and annually for certain high-risk women.[81] HPV testing is covered once every 5 years for asymptomatic women[82] between age 30 and 65 in conjunction with a Pap test.[83]	Omnibus Budget Reconciliation Act of 1989
Prostate cancer screening	Digital rectal exam and prostate-specific antigen (PSA) test	Covered annually for male beneficiaries ages 50 and older.[84]	The Balanced Budget Act of 1997
Colorectal cancer screening	Fecal occult blood test, colonoscopy, multi-target stool DNA test, screening barium enemas and sigmoidoscopy	Beginning at age 45: • Fecal occult blood test covered annually[85] • Colonoscopy covered every 10 years (more frequently for high-risk patients)[86] • Muti-target stool DNA tests every 3 years[87] • Screening barium enemas every 4 years[88,89] • Flexible sigmoidoscopy covered once every 48 months[90] Medicare also covers follow-on screening colonoscopies after a Medicare covered non-invasive stool-based colorectal cancer screening test yields a positive result.[91]	The Balanced Budget Act of 1997
Lung cancer screening	Low-dose computed tomography	Covered annually for beneficiaries who are between ages 50 and 77, asymptomatic, currently smoke (or quit within the past 15 years), and tobacco smoking history of at least 20 “pack years” (average of one pack per day for 20 years).[92]	Administrative authority added through the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)[93]

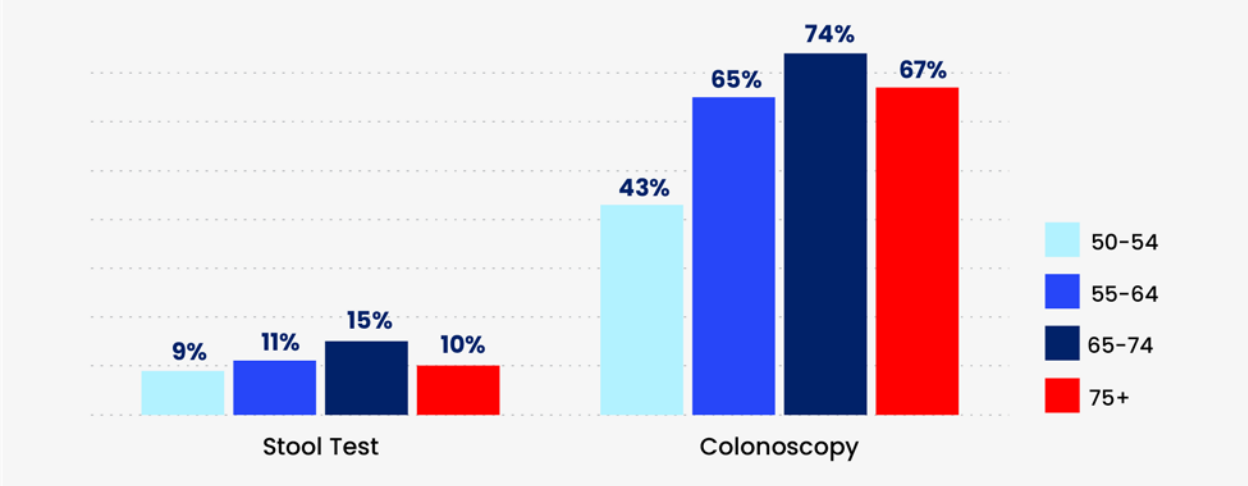
While Medicare covers these specific cancer screenings as a preventive benefit, beneficiary adherence to recommended screening regimens varies depending on the type of screening test, whether the beneficiary possesses supplemental coverage, and sociodemographic characteristics, such as race and income, which may impact an individual's access to resources and preventive care.

The following provides information on Medicare-covered cancer screening rates using data from 2021, unless otherwise noted, and reflects disruptions during the COVID-19 pandemic.

Colorectal Cancer Screening

Colorectal cancer screening rates – measured by whether an individual is current with any of the recommended screening modalities within the recommended time frames – vary by age, with most individuals opting to receive a colonoscopy rather than a stool-based test.

Figure 33: Percentage Screened for Colorectal Cancer by Test, 2021



Source: American Cancer Society. *Colorectal Cancer Facts & Figures 2023-2025*. Atlanta: American Cancer Society; 2023.

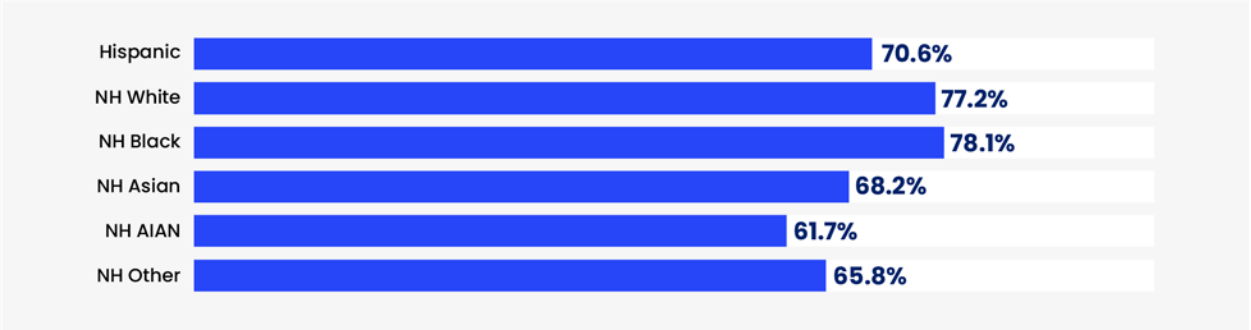
Colorectal screening rates also vary depending on whether the individual possesses supplemental Medicare coverage.

Figure 34: Percentage of Medicare Enrollees Up to Date with Colorectal Cancer Screening, 2018

Note: The term Medicare Only includes Medicare Advantage coverage. The term Medicare + Private Supplemental includes Medigap coverage.
Source: Islami, F, Guerra, CE, Minihan, A, Yabroff, KR, Fedewa, SA, Sloan, K, Wiedt, TL, Thomson, B, Siegel, RL, Nargis, N, Winn, RA, Lacasse, L, Makaroff, L, Daniels, EC, Patel, AV, Cance, WG, Jemal, A. American Cancer Society's report on the status of cancer disparities in the United States, 2021. *CA Cancer J Clin*. 2022. https://doi.org/10.3322/caac.21703.

Colorectal cancer screening rates are generally higher for White and Black individuals compared to individuals of Asian and American Indian/Alaska Native descent.

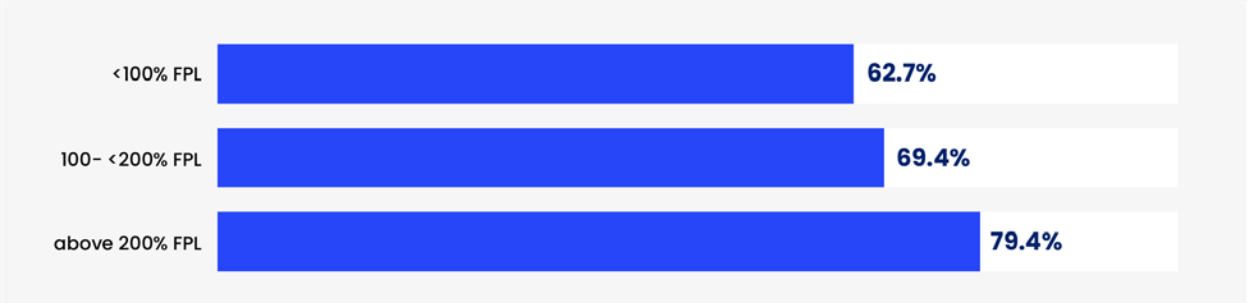
Figure 35: Colorectal Cancer Screening Estimates in Ages 65+ by Race/Ethnicity, 2021



Note: NH refers to non-Hispanic. AIAN refers to American Indian/Alaskan Native.
Source: National Health Interview Survey, 2021.

Colorectal cancer screening rates are higher for individuals whose income is above 200% of the federal poverty level compared to those whose income is at or below the federal poverty level.

Figure 36: Colorectal Cancer Screening Estimates in Ages 65+ by Federal Poverty Level (FPL), 2021



Source: National Health Interview Survey, 2021.

Colorectal cancer screening rates for Medicare Advantage plans have held steady over the past three years (2021-2023), with 72.33% of Medicare Advantage enrollees being up to date with their colorectal cancer screenings in 2023.[94]

Lung Cancer Screening

In 2022, Medicare added coverage for lung cancer screenings.[95] Unfortunately, only a small minority of those enrollees who are eligible for lung cancer screening have undergone screening.

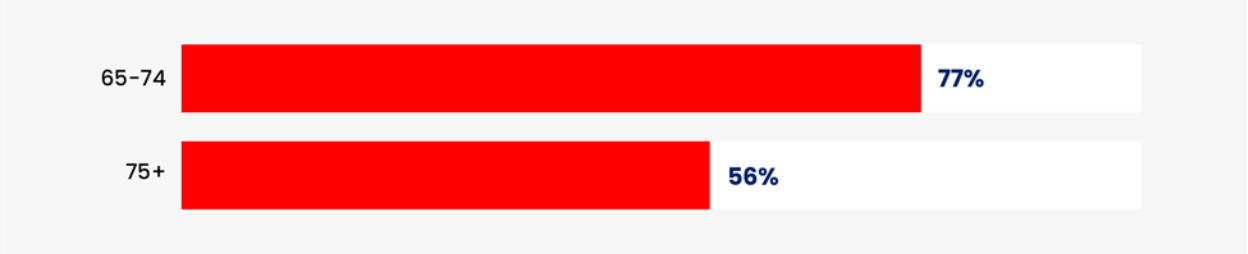
Figure 37: Lung Cancer Screening Rates of Eligible Enrollees Ages 55-75 by Insurance Type, 2017

Source: Hughes DR, Chen J, Wallace AE, et al. Comparison of Lung Cancer Screening Eligibility and Use between Commercial, Medicare, and Medicare Advantage Enrollees. *J Am Coll Radiol*. 2023;20(4):402-410. doi:10.1016/j.jacr.2022.12.022.

Breast Cancer Screening

Mammography screening rates in the Medicare population are relatively high, with more than two-thirds of beneficiaries ages 65-74 up to date with their mammography screenings.

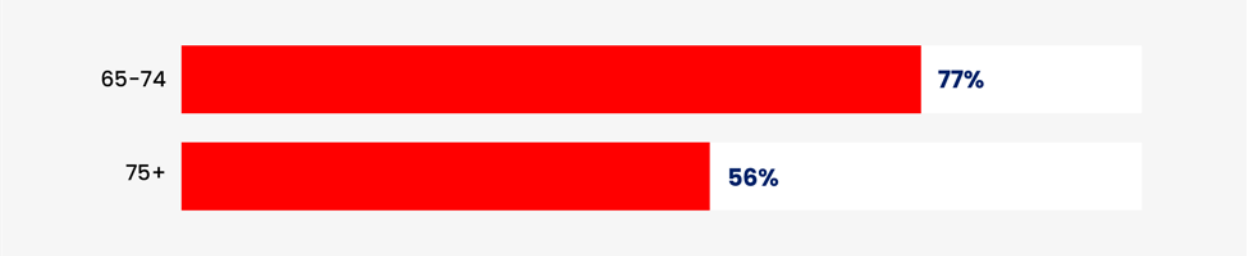
Figure 38: Women Up to Date with Mammograpy Screening, 2021



Note: The American Cancer Society considers up to date as having had a mammogram in the past two years for ages 55 and up.
Source: American Cancer Society. *Cancer Prevention & Early Detection Facts & Figures 2023-2024.* Atlanta: American Cancer Society; 2023.

Mammography screening rates vary depending on whether the Medicare beneficiary possesses supplemental coverage.

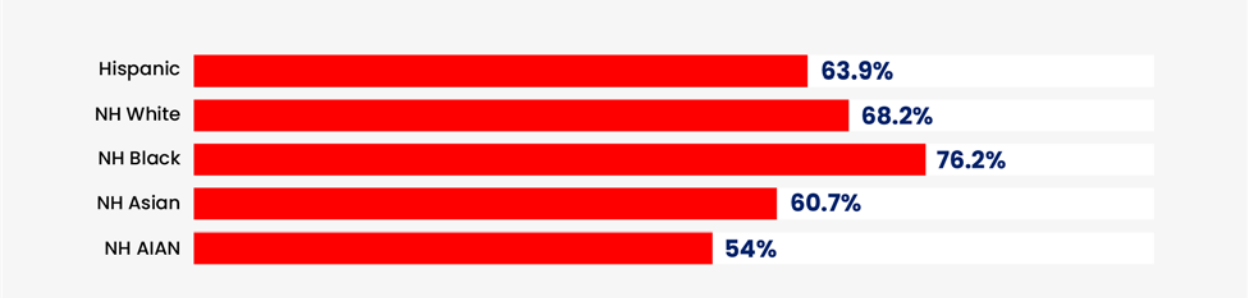
Figure 39: Breast Cancer Screening Rates by Type of Medicare Coverage, 2019



Note: The term Medicare Only includes Medicare Advantage coverage. The term Medicare + Private Supplemental includes Medigap coverage.
Source: Islami, F, Guerra, CE, Minihan, A, Yabroff, KR, Fedewa, SA, Sloan, K, Wiedt, TL, Thomson, B, Siegel, RL, Nargis, N, Winn, RA, Lacasse, L, Makaroff, L, Daniels, EC, Patel, AV, Cance, WG, Jemal, A. American Cancer Society's report on the status of cancer disparities in the United States, 2021. *CA Cancer J Clin*. 2022. https://doi.org/10.3322/caac.21703.

Breast cancer screening rates are generally similar across race and ethnicity, though women of Asian and American Indian/Alaska Native descent have a lower prevalence. However, Black women have the lowest survival for every stage at diagnosis and breast cancer subtype compared to women of other racial/ethnic groups.[96]

Figure 40: Breast Cancer Screening Estimates in Ages 65+ by Race/Ethnicity, 2021



NOTE: NH refers to non-Hispanic. AIAN refers to American Indian/Alaskan Native.
Source: National Health Interview Survey, 2021.

For the Medicare age-eligible population, women of lower incomes are less likely to be up to date on their mammography screenings.

Figure 41: Breast Cancer Screening Estimates in Ages 65+ by Federal Poverty Level (FPL), 2021

Source: National Health Interview Survey, 2021.

Breast cancer screening rates among beneficiaries with Medicare Advantage plans have slightly decreased over the past three years. In 2021, 74.73% of Medicare Advantage enrollees were compliant with breast cancer screenings. This figure dropped to 70.42% in 2023.[97]

Cervical Cancer Screening

While Medicare covers cervical cancer screening (see above) and is not bound by American Cancer Society guidelines or USPSTF recommendations, nevertheless American Cancer Society guidelines and USPSTF recommendations impact physician practice, which explains why less than half of women between the ages of 65 and 74 and less than one-quarter of women over 75 report having had a Pap test within the past three years.[98]

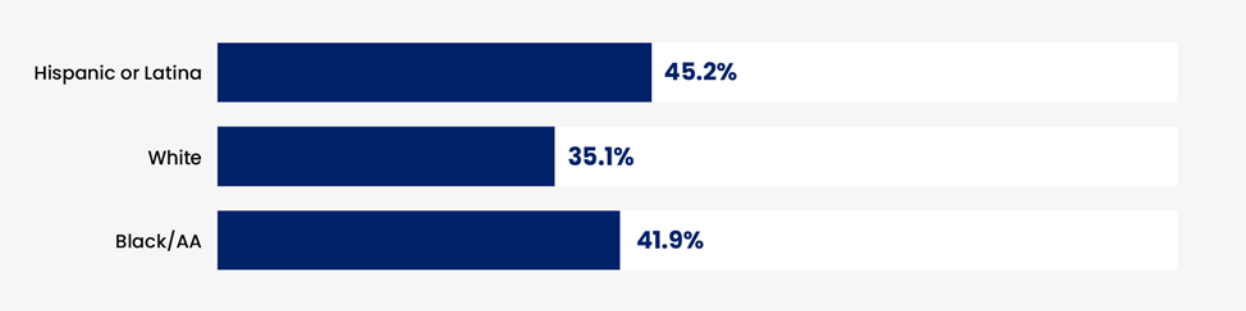
Women 65 years of age who have Medicare and some form of supplemental coverage are more likely to be current with their cervical cancer screening relative to women who only have Medicare coverage.

Figure 42: Percentage of Women Age 65 Who Are Up to Date With Cervical Cancer Screening by Insurance Type, 2018

Note: Data only reflect women who are 65 years of age. The term Medicare Only includes those with Medicare Advantage coverage, and the term Medicare + Private Supplemental includes those with Medigap coverage.
Source: Islami, F, Guerra, CE, Minihan, A, Yabroff, KR, Fedewa, SA, Sloan, K, Wiedt, TL, Thomson, B, Siegel, RL, Nargis, N, Winn, RA, Lacasse, L, Makaroff, L, Daniels, EC, Patel, AV, Cance, WG, Jemal, A. American Cancer Society's report on the status of cancer disparities in the United States, 2021. *CA Cancer J Clin*. 2022. https://doi.org/10.3322/caac.21703.

Cervical cancer screening rates are generally consistent across race and ethnicity, though prevalence among White women is lower than for Black or African American women or Hispanic and Latina women.

Figure 43: Percentage of Woman Age 65+ Screened for Cervical Cancer Using Pap Test by Race/Ethnicity, 2018

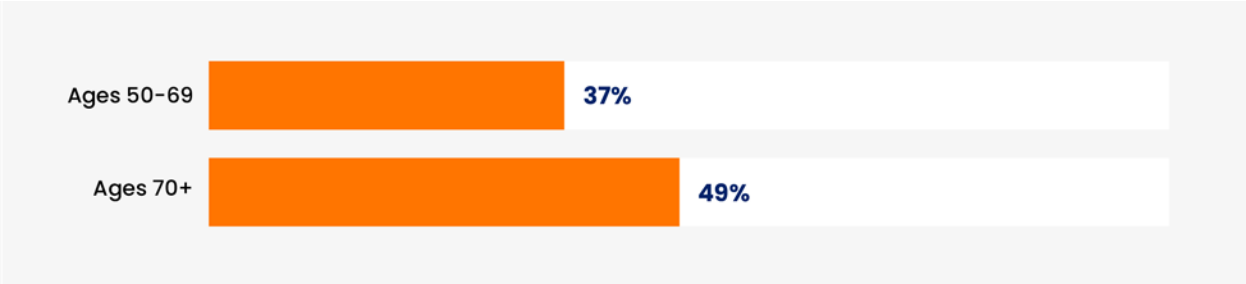


Note: Data only reflect women who have undergone Pap testing and does not include those who received an HPV test with the Pap test in the past 5 years..
Source: National Center for Health Statistics. Health, United States, 2019: Table 34. Hyattsville, MD. 2019.
Available from: https://www.cdc.gov/nchs/hus/data-finder.htm.

Prostate Cancer Screening

Men over the age of 70 are more likely to undergo prostate cancer screening.

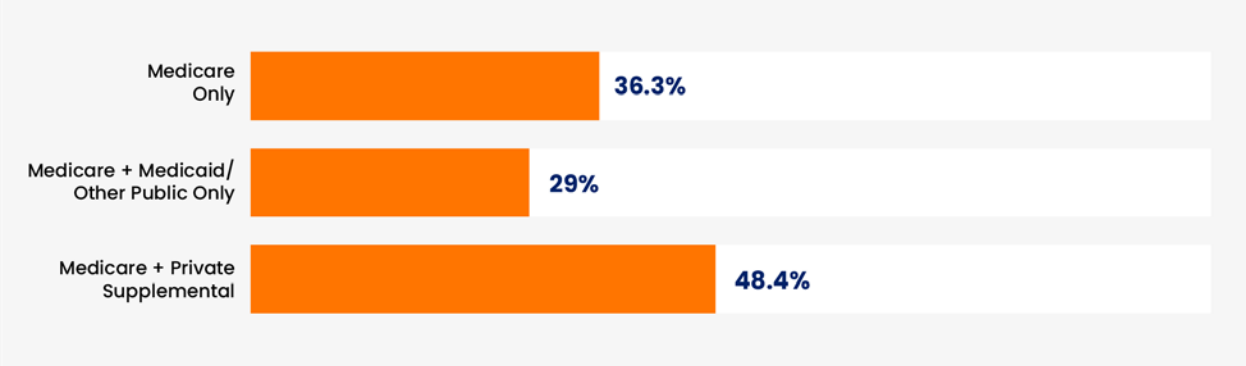
Figure 44: Percentage of Men Who Had Prostate-Specific Antigen (PSA) Test Within Past Year by Age, 2021



Source: National Health Interview Survey, 2021.

Among men ages 65+, those who have Medicare and supplemental coverage are more likely to undergo prostate cancer screening tests.

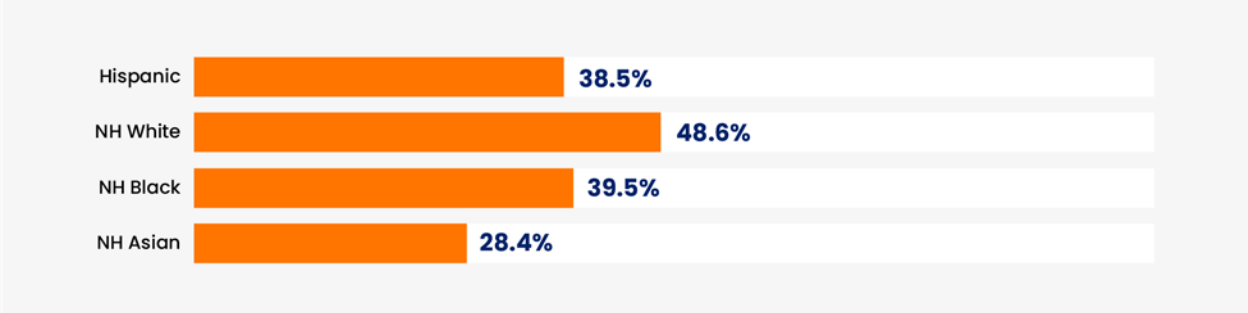
Figure 45: Percentage of Men 65+ who Had Prostate-Specific Antigen (PSA) Test Within Past Year by Insurance Type, 2018



Note: The term Medicare Only includes Medicare Advantage coverage. The term Medicare + Private Supplemental includes Medigap coverage.
Source: Islami, F, Guerra, CE, Minihan, A, Yabroff, KR, Fedewa, SA, Sloan, K, Wiedt, TL, Thomson, B, Siegel, RL, Nargis, N, Winn, RA, Lacasse, L, Makaroff, L, Daniels, EC, Patel, AV, Cance, WG, Jemal, A. American Cancer Society's report on the status of cancer disparities in the United States, 2021. *CA Cancer J Clin*. 2022. https://doi.org/10.3322/caac.21703.

In looking at men over the age of 50, White men are more likely to have prostate cancer screenings compared to all other race/ethnic groups. However, Black men have a significantly higher incidence rate than White men and are twice as likely to die from prostate cancer compared to White men.[99]

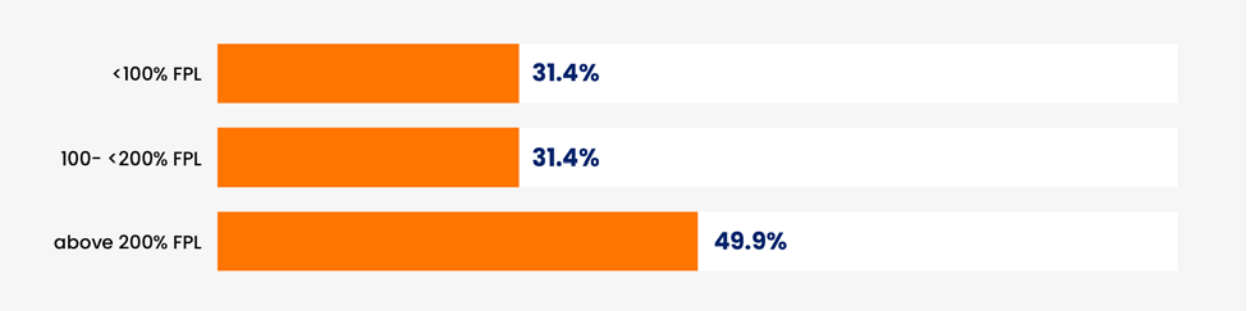
Figure 46: Prostate Cancer Screening Estimates in Ages 65+ by Race/Ethnicity, 2021



Note: NH refers to non-Hispanic.
Source: National Health Interview Survey, 2021.

Men with higher incomes (i.e., incomes at more than twice the federal poverty level) are more likely to be screened for prostate cancer compared to individuals with lower incomes.

Figure 47: Prostate Cancer Screening Estimates in Ages 65+ by Federal Poverty Level (FPL), 2021



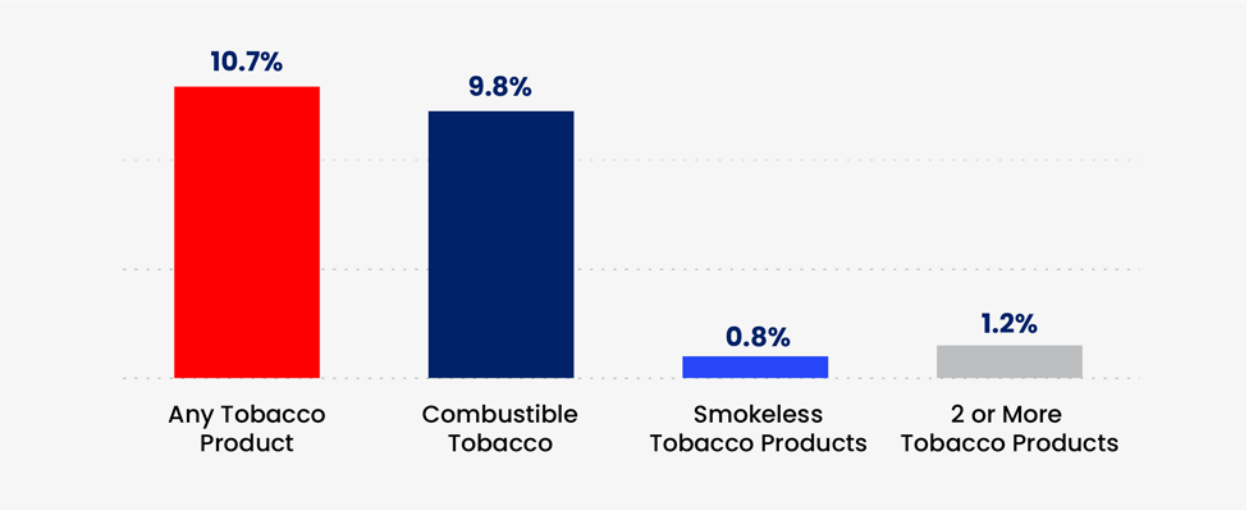
Source: National Health Interview Survey, 2021.

Medicare Coverage of Tobacco Cessation

Medicare Part B covers up to eight visits of smoking and tobacco cessation counseling visits in a 12-month period.[100] Beneficiaries do not incur any cost sharing related to these visits. Medicare Part D does not cover over-the-counter medication. However, Part D plans are permitted to cover prescription-only smoking cessation products,[101] though coverage of these products will vary depending on the plan.

Coverage of tobacco cessation products is important because of the prevalence of tobacco use among individuals over the age of 65 who have Medicare. Approximately 10% of people with Medicare over the age of 65 reported currently use of a tobacco product.

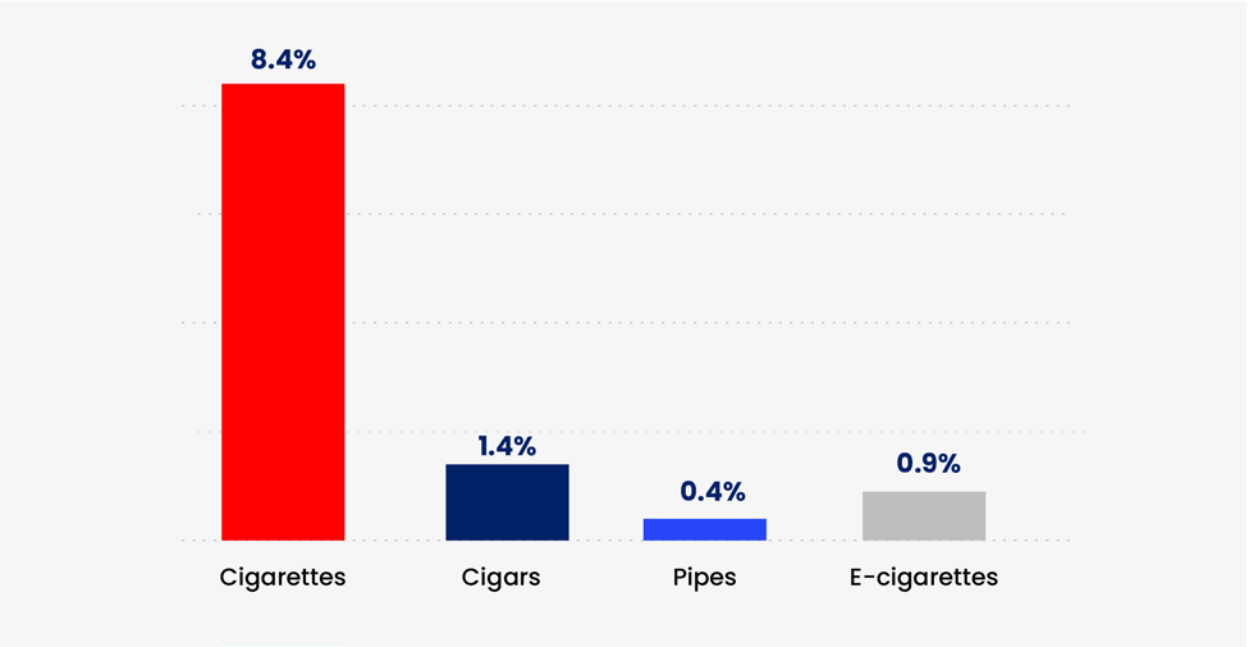
Figure 48: Tobacco Product Use Among Adults Ages 65+, 2021



Source: Cornelius ME, Loretan CG, Jamal A, et al. Tobacco Product Use Among Adults – United States, 2021. *MMWR Mortal Wkly Rep* 2023; 72.

Combustible products, in particular cigarettes, are the most used tobacco product.

Figure 49: Combustible Tobacco Use Among Adults Ages 65+, 2021

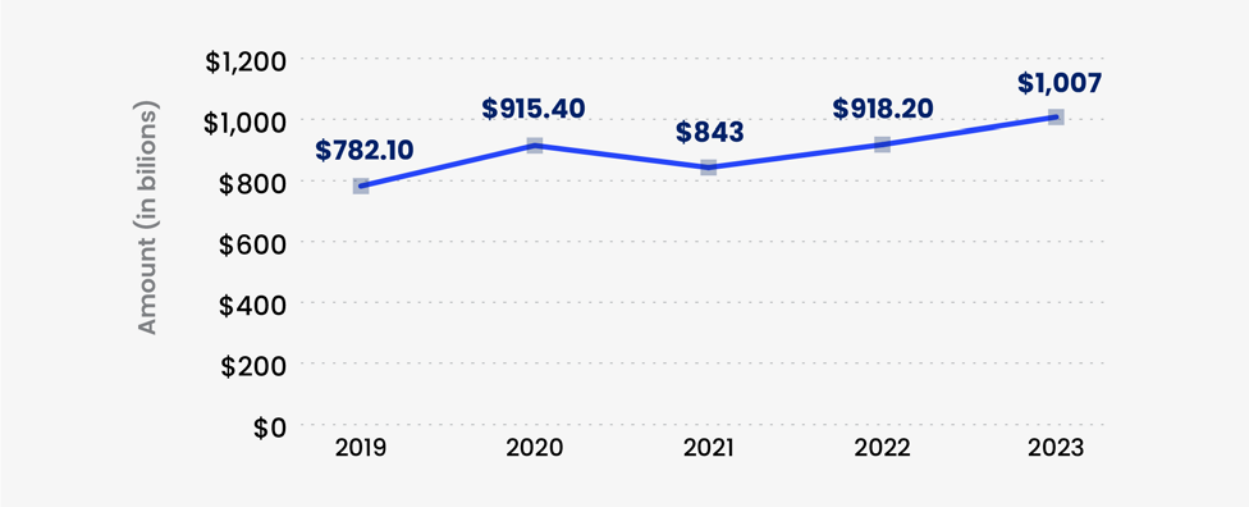


Source: Cornelius ME, Loretan CG, Jamal A, et al. Tobacco Product Use Among Adults – United States, 2021. MMWR Mortal Wkly Rep 2023; 72.

Medicare Expenditures for Cancer Care

Cancer can be very expensive to treat. Given that the incidence of cancer increases with age, the costs associated with cancer treatment have a fiscal impact on the Medicare program.

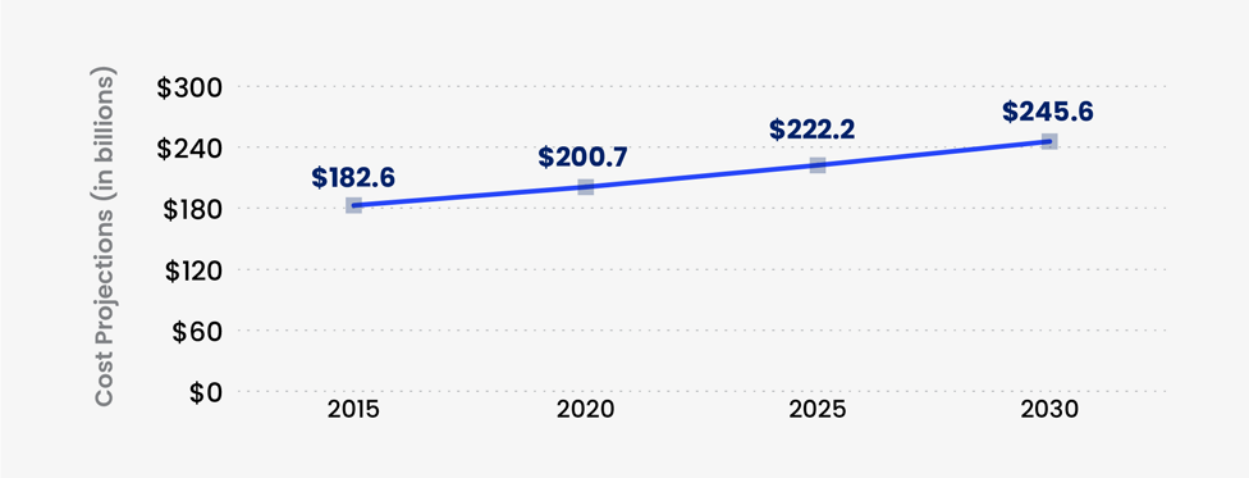
Figure 50: Medicare Expenditure Growth, 2019-2023



Source: 2023 Medicare Trustees Report.

The national cost for all types of cancer is projected to increase over time. Projections shown below reflect only the aging and growing US population and do not incorporate related increases in Medicare expenditures on cancer care.[102]

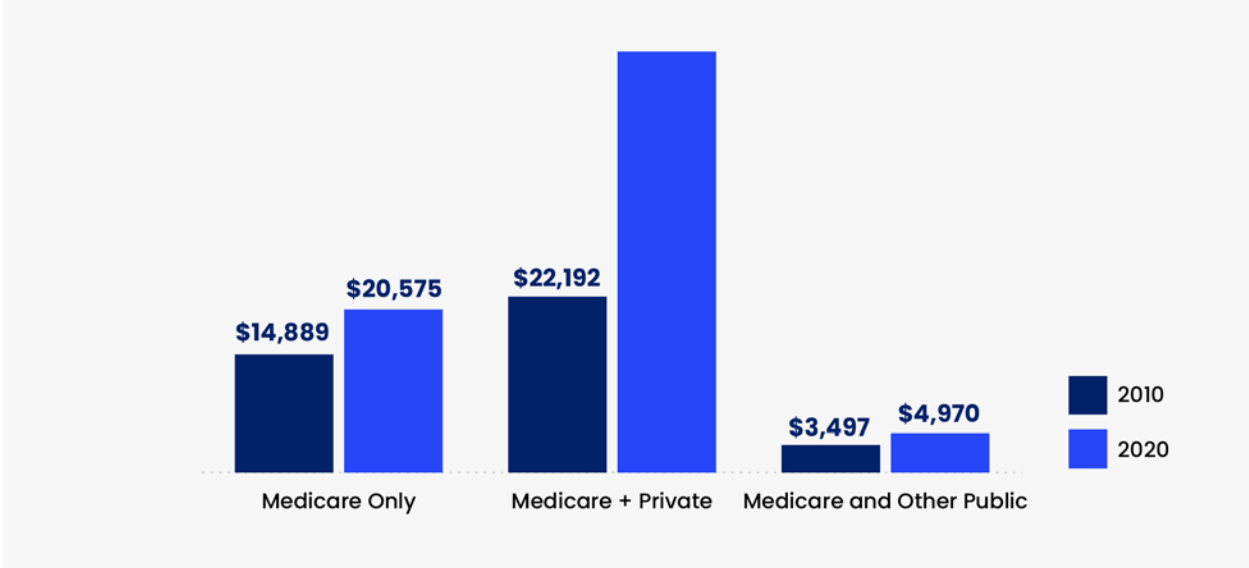
Figure 51: National Cost Projections for All Cancer Sites, 2015-2030



NOTE: All cancer sites of care include bladder, brain, breast, cervical, colorectal, esophagus, Hodgkin, kidney, leukemia (AML, CLL and CML), liver, lung (non-small cell and small cell), melanoma, myeloma, non-Hodgkin, oral, ovary, pancreas, prostate, stomach, thyroid and uterus.
National cost projections include Medical Services (Medicare Part A and B) and Oral Prescription Drugs (Part D).
Source: Mariotto AB, Enewold L, Zhao J, Zeruto CA, Yabroff KR. Medical Care Costs Associated with Cancer Survivorship in the United States. *Cancer Epidemiol Biomarkers Prev.* 2020;29(7):1304-1312. doi:10.1158/1055-9965.EPI-19-1534.

Over one-third (33%) of cancer costs are attributed to the Medicare population.[103] Total expenditures for individuals ages 65 and older with cancer increased over the period from 2010 to 2020. This was particularly true for individuals with both Medicare and private supplemental coverage, with private coverage bearing more responsibility for Medicare cost sharing.

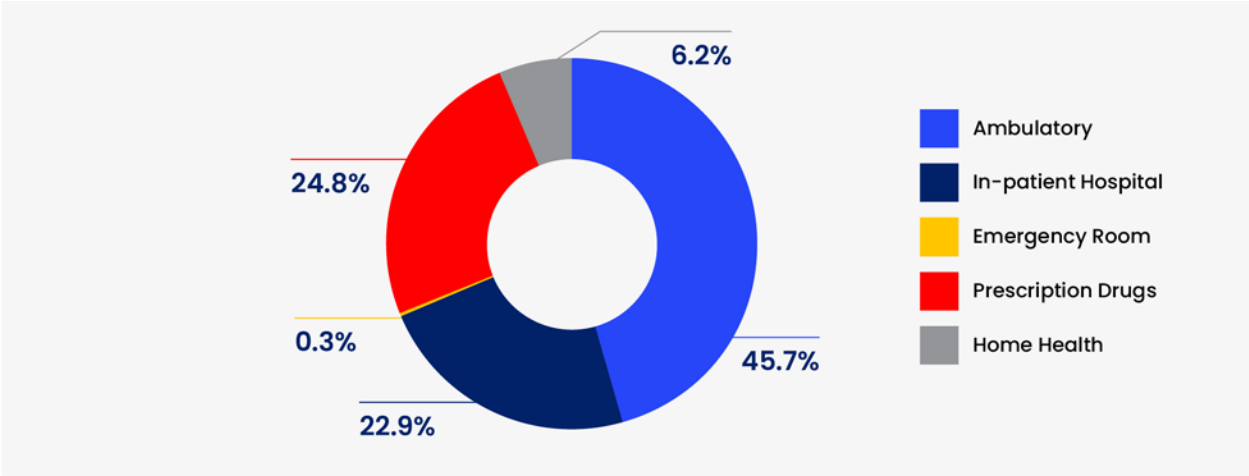
Figure 52: Total Expenditures for Ages 65+ with Cancer by Insurance Type (in millions), 2010-2020



Note: Beneficiaries enrolled in Medicare Advantage plans would be included in the Medicare and Other Public category. The 2020 data comprise the first summary statistics that reflect the coronavirus disease (COVID-19).
Source: Agency for Healthcare Research and Quality. Total expenditures ($) in millions by condition and insurance coverage, 2020. Medical Expenditure Panel Survey. Available from: MEPS-HC Data Tools – Medical Expenditure Panel Survey (MEPS) Household Component (HC) (ahrq.gov).

Beneficiaries who are diagnosed with cancer will likely use a variety of different Medicare services. The following chart shows the percentage of expenditures by service used by beneficiaries with cancer:

Figure 53: Treatment Expenditures for Ages 65+ with Cancer, 2019

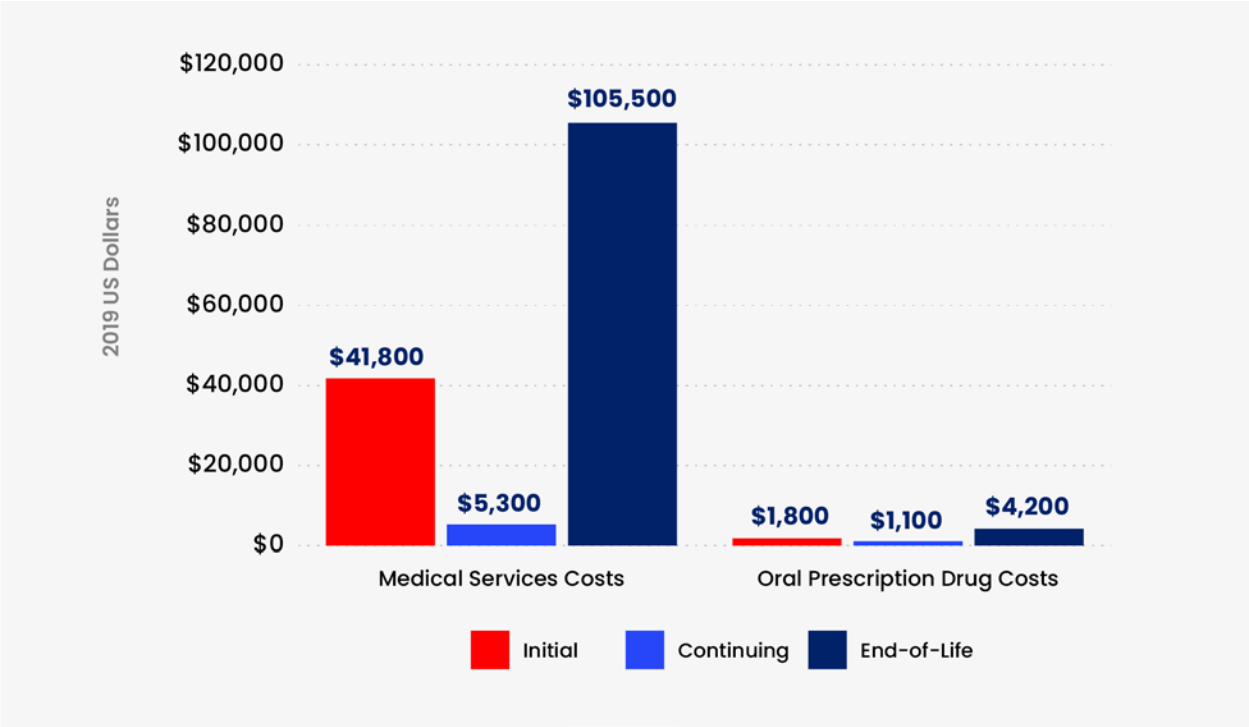


Note: The term Ambulatory includes office-based provider visits and hospital outpatient visits. The term Emergency Room excludes expenses for emergency room services included in an inpatient hospital bill. The term Prescribed Drugs includes all prescribed medicines initially purchased or refilled during the year.
Source: Muhuri, PK. Expenditures for commonly treated conditions among older adults: Estimates from the Medical Expenditure Panel Survey, 2019. 9 Statistical Brief #545. Rockville, MD: Agency for Healthcare Research and Quality; October 2022. https://meps.ahrq.gov/data_files/publications/st545/stat545.pdf.

Research also suggests that individuals ages 65 and older who had a principal diagnosis of cancer had a population rate of hospitalizations that was 15 times higher than the rate among those ages 18-44.[104]

Health care spending for cancer care is generally higher after cancer diagnosis and in the last year of life.

Figure 54: Cancer-attributable Annualized Average Costs



Note: The Initial phase is defined as the first 12 months after each diagnosis. The End-of-Life phase is defined as the 12 months before death among survivors who died. The Continuing phase is the months in between the initial and the end-of-life phases.
Source: Mariotto AB, Enewold L, Zhao J, Zeruto CA, Yabroff KR. Medical Care Costs Associated with Cancer Survivorship in the United States. *Cancer Epidemiol Biomarkers Prev*. 2020;29(7):1304-1312. doi:10.1158/1055-9965.EPI-19-1534.

Improvements in Medicare Still Needed

The Medicare program is vitally important to ensuring that older Americans and those with certain disabilities have access to medically necessary health care services like cancer care. In fact, prior to the enactment of the Medicare program, only about half of Americans ages 65 and older had some type of coverage for hospital care, which didn't necessarily cover surgical procedures.[105] Since the program was enacted in 1965, it has undergone a number of major improvements, including adding the availability of coverage through Medicare Advantage plans (Part C) and coverage of outpatient prescription drugs (Part D). Unfortunately, despite these improvements, Medicare beneficiaries continue to experience barriers to accessing medically necessary care, particularly when diagnosed with cancer.

Transportation barriers and rural cancer disparities

Access to transportation can be challenging for beneficiaries. Roughly 9% of Medicare beneficiaries ages 65-74 report having trouble getting places, while 23% of beneficiaries over the age of 85 report problems.[106] Beneficiaries with lower incomes are more likely to report having trouble getting places.[107] According to a 2022 ACS CAN Survivor Views survey of people with cancer and survivors who have Medicare, 31% reported the distance to care and services in their area presented an access barrier.[108]

Approximately 20% of Medicare beneficiaries reside in rural areas, which can create challenges to accessing care.[109] Individuals living in rural areas have high rates of cancer-related mortality[110] and are more likely to be diagnosed with cancer at later stages.[111] Cancer disparities in rural areas are particularly visible for cancers that can be identified through screening and early detection: lung, cervical, colorectal and prostate.[112] Rural residents also have lower rates of cancer screenings, including for services such as lung cancer screenings for which specialized equipment is needed.[113]

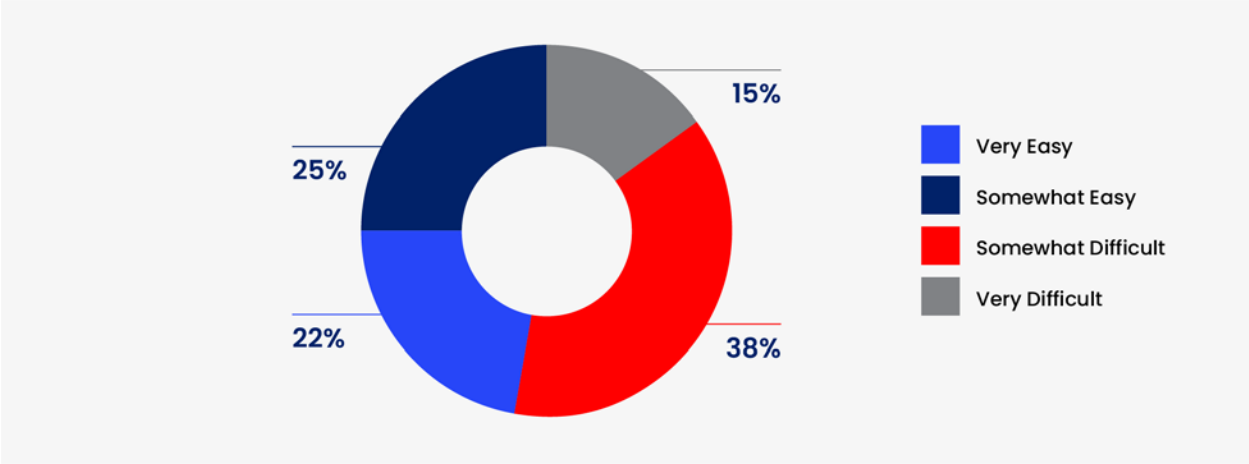
While transportation issues and rural disparities may be endemic, there are policy solutions that can be employed to reduce these burdens on Medicare beneficiaries. One way would be to leverage innovative technologies that are designed to increase access to care, particularly in rural areas. For example, multi-cancer early detection tests are innovative new screening modalities designed to detect many different types of cancer from a blood sample. Once approved by the Food and Drug Administration and when clinical benefit is shown, these technologies will help reduce transportation barriers because beneficiaries will be able to access these tests from a local provider without having to travel long distances to a specialized facility. Accessing these tests from a local provider will also reduce transportation barriers because beneficiaries will be able to utilize these tests in conjunction with other health care services, thus obviating the need for an additional appointment thus obviating the need for an additional appointment in what would be the first step in a cancer screening process. Having access to MCED tests — in addition to currently approved screening modalities -- will help improve cancer screening rates

Medicare Beneficiary Out-Of-Pocket Costs

While the Medicare program provides vital coverage of health care services, beneficiaries (particularly those who are enrolled in Parts A and B without supplemental coverage) can face significant out-of-pocket costs. This can be particularly challenging because as individuals enter retirement age their income generally decreases.[114]

In a 2021 ACS CAN Survivor Views survey of people with cancer and survivors who had Medicare, a majority (53%) reported a degree of difficulty in affording their cancer care:

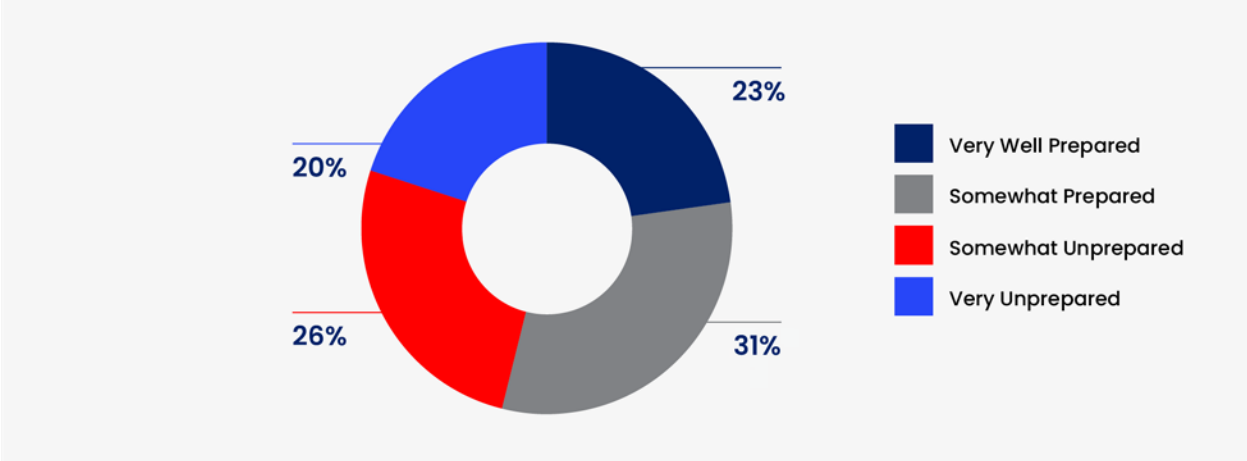
Figure 55: Survivor Views Respondents Who Have Medicare Reporting Difficulty Paying for Care, 2021



Source: American Cancer Society Cancer Action Network. Survivor Views: Affordability, Prescription Drugs, and Pain. Fielded October 22-November 19, 2021.

The cost of cancer care can also be unexpected for people with cancer on Medicare, with slightly less than half (46%) of Survivor Views respondents indicating they were either somewhat or very unprepared for the costs they incurred related to their cancer treatments.

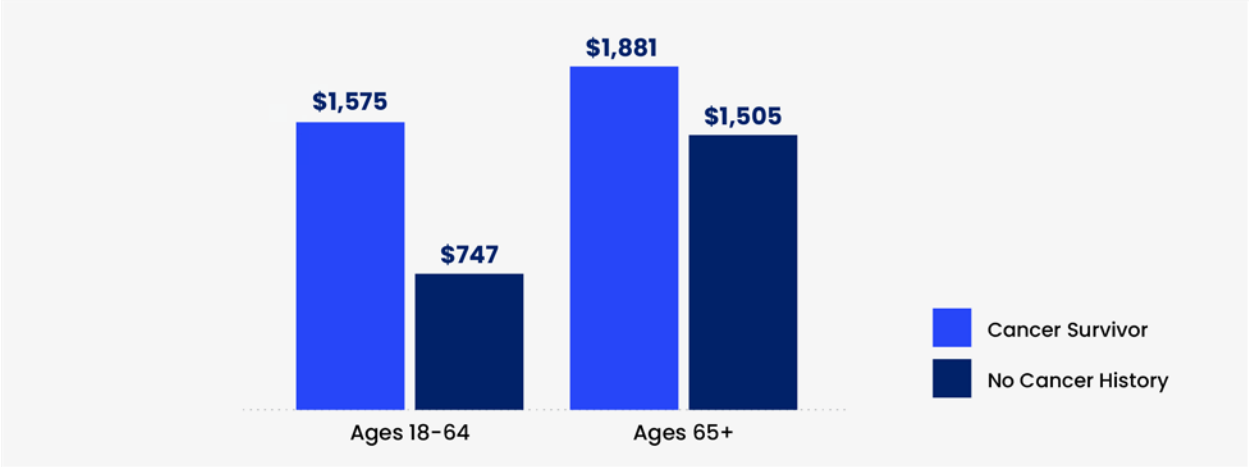
Figure 56: Survivor Views Respondents Who Have Medicare Reporting Financial Preparedness for Coss of Care, 2021



Source: American Cancer Society Cancer Action Network. Survivor Views: Affordability, Prescription Drugs, and Pain. Fielded October 22-November 19, 2021.

In general, cancer survivors have higher out-of-pocket costs for their health care expenses compared to those without a cancer history.

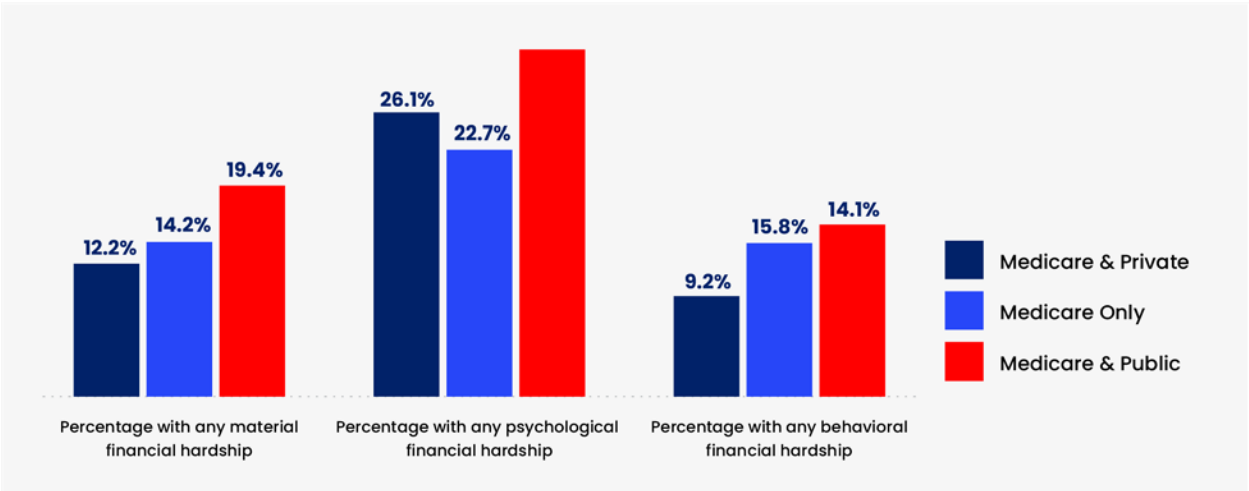
Figure 57: Average Annual Health Care Out-of-pocket Exenditures, 2018-2019



Source: Agency for Healthcare Research and Quality: Medical Expenditure Panel Survey, 2018-2019. Public-use data file and documentation. Retrieved from: https://meps.ahrq.gov/data_stats/download_data_files_detail.jsp?cboPufNumber=HC-216. July 2022.

High out-of-pocket costs can lead to medical financial hardship, which can negatively impact an individual. Medicare beneficiaries without any supplemental Medicare coverage were more likely to report medical financial hardship – financial (19.4%), psychological (41.9) and behavioral (15.8%) – compared to those with some form of supplemental coverage. An additional benefit of screening is that out-of-pocket costs are lower when cancer is detected at an earlier stage.

Figure 58: Any Reported Medical Financial Hardship in Ages 65+ by Insurance Type, 2015-2017



Note: Data are for the general population and are not limited to individuals with a history of cancer. Data were stratified into three domains: (1) material conditions that arise from higher out-of-pocket expenses and lower income (e.g., medical debt); (2) psychological responses; and (3) coping behaviors (e.g., delaying or foregoing care because of cost).
Source: Yabroff KR, Zhao J, Han X, Zheng Z. Prevalence and Correlates of Medical Financial Hardship in the USA. J Gen Intern Med. 2019 Aug;34(8):1494-1502.

As new technologies become available to treat cancer and prolong cancer survivorship, these innovative treatments must be made affordable for beneficiaries. As noted above, many beneficiaries currently struggle with high out-of-pocket costs (particularly those who lack supplemental coverage). The Medicare program must ensure that access to new and innovative technologies are available to all beneficiaries – not just those who have the financial means to access them.

Policy Recommendations

The American Cancer Society Cancer Action Network (ACS CAN) is committed to ensuring that all people with cancer have access to the appropriate care across the cancer continuum from prevention and screening to diagnosis and treatment and into survivorship. Ensuring access to equitable, medically necessary and affordable care is a multi-faceted approach that requires multi-faceted solutions.

To that end, ACS CAN supports the following policies to improve the specific parts of the Medicare program:

Improvements to Part A:

- **Impose a cap on beneficiary cost sharing for Part A services:** Currently, there is no cap on Part A cost sharing, potentially leaving Medicare beneficiaries (particularly those who lack supplemental coverage) with significant out-of-pocket costs. **Congress should enact legislation to cap beneficiaries' Part A out-of-pocket costs.**
- **Ensure long-term solvency of Part A:** Because of the way the Part A program is financed, the long-term solvency of the program is at risk. While the Part A trust fund has never become insolvent to the point where it is no longer able to pay benefits, **Congress should act to ensure long-term solvency of the program.**

Improvements to Part B:

- **Impose a cap on beneficiary cost sharing for Part B services:** Like Part A, there is currently no cap on Part B cost sharing, potentially leaving Medicare beneficiaries who lack supplemental coverage with significant out-of-pocket costs. **Congress should enact legislation to cap beneficiaries' Part B out-of-pocket costs.**
- **Improve Medicare coverage of preventive screening services:**
  - Ensure Medicare coverage of multi-cancer early detection tests: Researchers are developing innovative tests that are capable of detecting many different types of cancer using a simple blood test. This includes many cancers for which there has been no recommended screening. This is particularly important because currently only one in seven cancers are diagnosed through traditional screening measures.[115] **Congress should enact the Medicare Multi-Cancer Early Detection Act, to ensure that Medicare can cover these innovative new tests once they are approved by the Food and Drug Administration and clinical benefit is shown.**
  - Eliminate cost sharing for preventive services: While most cancer screenings are covered without cost sharing,116 Medicare often imposes cost sharing for follow-up testing. For example, while Medicare covers mammography screening as a preventive service benefit, beneficiaries would be assessed 20% cost sharing for imaging and/or a biopsy following a screening mammogram. The American Cancer Society defines cancer screening to include all recommended screening and follow-up testing for an asymptomatic individual, regardless of risk.[117] **Congress should waive all cost sharing for follow-up testing.**
- **Ensure access to biomarker testing:** Biomarker testing is often used to determine the most appropriate treatment for an individual with cancer, such as targeted therapies that are only indicated for cancers with a given biomarker. Biomarker-informed care can lead to improved survivorship and better quality of life for patients. **The Centers for Medicare & Medicaid Services (CMS) should ensure broad coverage of comprehensive biomarker testing consistent with clinical practice guidelines and other evidence.**

Improvements to Part C:

- **Ensure adequacy of provider networks:** While Medicare Advantage plans are required to cover all Part A and B services, they are permitted to utilize plan provider networks to control plan costs. While Medicare Advantage plans are required to adhere to certain network adequacy standards, there is a concern that depending on the adequacy of a plan's network (particularly networks in rural areas) beneficiaries may have to travel long distances to access preventive services or to see a specialist, and the plan may not have a specific subspecialist (including providers and facilities) available in network. **CMS should revisit its network adequacy requirements to ensure that beneficiaries have access to medically necessary providers within the plan's network.**

Improvements to Part D:

- **Maintain the six protected classes:** Part D requires plans to cover all or substantially all categories and classes of drugs within the six categories of clinical concern (also known as the six protected classes). The six classes are immunosuppressants, antidepressants, antipsychotics, anticonvulsants, antiretrovirals and antineoplastics. This policy is needed because drugs within these categories are not necessarily therapeutically equivalent within the same class. For example, the class of antineoplastics contains a subcategory of tyrosine kinase inhibitors, which have been developed to treat cancer, but each drug within this category may target a different mutation that is relevant to a small subcategory of patients with a given disease. **CMS should maintain the current six protected classes policy to ensure that vulnerable beneficiaries have access to medically appropriate therapies.**
- **Improve the ability for beneficiaries to spread cost-sharing requirements over the course of the plan year:** As part of the Inflation Reduction Act, Congress imposed a cap on beneficiaries' Part D cost sharing and instituted a new policy (the Medicare Prescription Payment Plan) that allows beneficiaries the option to pay their Part D cost sharing over the course of the plan year. While the Medicare Prescription Payment Plan will help beneficiaries better afford the cost sharing for their prescription drugs, there is a concern that CMS' initial plan of implementation would not allow beneficiaries to enroll at the point of sale. Allowing beneficiaries to enroll at the point of sale will facilitate enrollment in the program, because otherwise they will face significant administrative hurdles that will hinder enrollment. **CMS should revise the Medicare Prescription Payment Plan requirements to allow beneficiaries to enroll at the point of sale.**

In addition to the Part-specific recommendations, ACS CAN advocates for the following overarching improvements to the Medicare program:

- **Improve affordability:** Medicare beneficiaries can face significant out-of-pocket costs for their cancer care. While these out-of-pocket costs can be mitigated with supplemental coverage, availability of such coverage and premiums associated with that coverage will vary considerably and still impose financial strain on beneficiaries. **Congress should enact caps on beneficiaries' out-of-pocket costs.**
- **Limit the use of utilization management tools:** Medicare Advantage and Part D plans are permitted to impose utilization management tools (such as prior authorization, step therapy, quantity limits, etc.) on covered services, including prescription drugs. In some cases, the use of utilization management tools can be an important safety precaution (for example, imposing a prior authorization requirement to ensure there is a cancer diagnosis before approving coverage of a chemotherapy drug). However, in recent years, there has been a significant increase in the use of utilization management tools, which can be burdensome on providers and delay care for patients. There is also a trend among some issuers to use artificial intelligence and other automated processes to deny medical claims.[118] **CMS should review Medicare Advantage plans' and Part D plans' use of utilization management tools and restrict their use to those tools that are clinically appropriate.**

- **Improve the appeals process:** When Medicare Advantage plans and Part D plans impose utilization management tools or use narrow plan networks, beneficiaries who have unique needs often have to file an appeal in order to get coverage for their product or service. Unfortunately, the Medicare appeals processes are confusing and can be cumbersome and time-consuming.[119] **CMS should improve the Medicare appeals process (as recommended in The Medicare Appeals Process: Reforms Needed to Ensure Beneficiary Access).**

- **Improve access to patient navigation services:** Patient navigation is an evidence-based intervention that eliminates health disparities across the cancer care continuum. Patient navigation services have been shown to help increase cancer screening rates among historically marginalized racial and ethnic populations by providing access to disease prevention education, conducting community outreach and facilitating public education campaigns.[120, 121, 122, 123] One study showed that women with access to patient navigation services were significantly more likely to be up to date on their mammography screening compared to women who did not receive these services, with the largest impact among African American Medicare beneficiaries living in urban areas who were previously not up to date on their breast cancer screenings.[124] However, patient navigation is still absent or limited in many cancer programs and hospital settings due to a lack of long-term funding to pay for these services. **CMS should expand upon the provisions in the FY2024 physician fee schedule, which provides Medicare reimbursement for principal illness navigation services for high-risk illnesses like cancer, to also include patient navigation services beginning with screening services.**

References

1 American Cancer Society. Cancer Fact & Figures 2024. Atlanta: American Cancer Society; 2024 [hereinafter Cancer Facts & Figures 2024].

2 Zhao, J., Han, X., Nogueira, L., Fedewa, S.A., Jemal, A., Halpern, M.T. and Yabroff, K.R. (2022), Health insurance status and cancer stage at diagnosis and survival in the United States. CA A Cancer J Clin. https://doi.org/10.3322/caac.21732.

3 Shiels MS, Haque AT, Berrington de González A, Freedman ND. Leading Causes of Death in the US During the COVID-19 Pandemic, March 2020 to October 2021. JAMA Intern Med. 2022;182(8):883–886. doi:10.1001/jamainternmed.2022.2476.

4 U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on 2022 submission data (1999-2020): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; https://www.cdc.gov/cancer/dataviz, released in June 2023.

5 Cancer Facts & Figures 2024.

6 Throughout this report, we assume individuals ages 65 and older qualify for Medicare coverage. Thus, the terms Medicare beneficiary, Medicare enrollee and individuals 65+ are used interchangeably unless otherwise noted.

7 The Board of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. 2023 Medicare Trustees Report. 2023. Available from: https://www.cms.gov/oact/tr/2023 (hereinafter 2023 Medicare Trustees Report).

8 Medicare Payment Advisory Commission. A Data Book: Health Care Spending and the Medicare Program. July 2023. Available from: https://www.medpac.gov/wp-content/uploads/2023/07/July2023_MedPAC_DataBook_SEC.pdf (hereinafter MedPAC 2023 data book).

9 Cancer Facts & Figures 2024.

10 National Cancer Institute. NCI Dictionaries. Available at: https://www.cancer.gov/publications/dictionaries/cancer-terms/def/invasive-cancer.

11 More information is discussed in the Medicare Supplemental Coverage section below.

12 While Medicare Part B covers home health care, Medicare Part A covers and pays for home health care for beneficiaries in certain circumstances after a hospital or skilled nursing facility stay.

13 2023 Medicare Trustees Report. This figure includes enrollment in Original Medicare only. Enrollment information in the Medicare Advantage program is contained in the Medicare Part C section below.

14 Individuals who paid less than 30 quarters in Medicare taxes will pay a Part A premium of $504 a month in 2024. Individuals who paid between 30-39 quarters of Medicare taxes will pay a monthly premium of $278 in 2024. Centers for Medicare & Medicaid Services. Fact Sheet. 2024 Medicare Parts A & B premiums and Deductibles. Oct. 12, 2023. Available from: https://www.cms.gov/newsroom/fact-sheets/2024-medicare-parts-b-premiums-and-deductibles [hereinafter 2024 Medicare Parts A and B fact sheet].

15 Most beneficiaries do not pay a premium for Part A and therefore are not assessed a late enrollment penalty if they fail to enroll in Part A when first eligible. However, beneficiaries who are assessed a Part A premium and who fail to sign up for Part A coverage when they are first eligible to do so, may incur a 10 percent penalty on their monthly premium. This penalty is temporary and is assessed for twice the number of years the beneficiary failed to enroll. Most beneficiaries who work beyond the age of 65 and who receive health insurance coverage from an employer who covers more than 20 full-time employees will not be assessed a late enrollment penalty.

16 In fact, the Centers for Medicare & Medicaid Services (CMS) advises most individuals to enroll in Part A when they turn 65, even if they have health insurance from an employer. See CMS Fact Sheet: Deciding Whether to Enroll in Medicare Part A and Part B When You Turn 65. CMS Prod. No. 11962. Available from https://www.cms.gov/Outreach-and-Education/Find-Your-Provider-Type/Employers-and-Unions/FS3-Enroll-in-Part-A-and-B.pdf.

17 Medicare has different cost obligations for mental health inpatient stays. For more information, see https://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-glance.html#collapse-4808.

18 2024 Medicare Parts A and B fact sheet.

19 Beneficiaries only have 60 "lifetime reserve days" over the course of their lifetime. Beneficiaries who exhaust their lifetime reserve days (following 90 days of inpatient care) are responsible for the full cost of the remainder of their hospital stay. https://www.medicare.gov/basics/costs/medicare-costs#collapse-4808. Beneficiaries who receive mental health services on an inpatient basis face different cost-sharing.

20 Medicare will only pay for skilled nursing facility (SNF) extended-care services immediately following a medically necessary three-consecutive-day inpatient hospital stay (3-Day rule). 42 U.S.C. § 409.30(a).

21 2024 Medicare Parts A and B factsheet.

22 Because of the lack of a cap in out-of-pocket costs, many beneficiaries opt to purchase supplemental coverage to help cover their cost sharing. Supplemental or Medigap coverage charges an additional monthly premium. For more information, see the Medicare Supplemental Coverage section of this report.

23 2023 Medicare Trustees Report.

24 Centers for Medicare & Medicaid Services. Internet-Only Manual, Pub 100-02, Chapter 15, 50.4.5 Off Label Use of Anti-Cancer Drugs and Biologicals.

25 2023 Medicare Trustees Report. This figure includes enrollment in Original Medicare only. Enrollment information in the Medicare Advantage program is contained in the Medicare Part C section below.

26 Medicare uses the beneficiary's reported income to the Internal Revenue Service (IRS) on their tax return from two years prior for purposes of determining a beneficiary's income.

27 Beginning in 2023, Medicare beneficiaries who were 36 months post-kidney transplant (and thus no longer eligible for Medicare) can choose to pay a monthly premium to continue Part B coverage of immunosuppressive drugs. More information on premium amounts for immunosuppressive coverage only can be found at https://www.cms.gov/newsroom/fact-sheets/2024-medicare-parts-b-premiums-and-deductibles.

28 Specific information regarding income related premiums for Part B is available at https://www.cms.gov/newsroom/fact-sheets/2024-medicare-parts-b-premiums-and-deductibles.

29 Most beneficiaries who work beyond the age of 65 and who receive health insurance coverage from an employer will not be assessed a late enrollment penalty. 42 C.F.R. § 407.20(c).

30 2024 Medicare Parts A and B fact sheet.

31 Because of the lack of a cap in out-of-pocket costs, many beneficiaries opt to purchase supplemental coverage to help cover their cost sharing. Supplemental coverage charges an additional monthly premium. For more information, see the Medicare Supplemental Coverage section of this report.

32 Centers for Medicare & Medicaid Services. Medicare Enrollment Dashboard. 2023. Available at: Medicare Enrollment Dashboard - Centers for Medicare & Medicaid Services Data (cms.gov).

33 Id.

34 Faith Leonard et al., Traditional Medicare or Medicare Advantage: How Older Americans Choose and Why (Commonwealth Fund, Oct. 2022). https://doi.org/10.26099/2rfq-z770.

35 Centers for Medicare & Medicaid Services. Press Release. Biden-Harris Administration Announces Lower Premiums for Medicare Advantage and Prescription Drug Plans in 2023. 2022. Available at: https://www.cms.gov/newsroom/press-releases/biden-harris-administration-announces-lower-premiums-medicare-advantage-and-prescription-drug-plans.

36 Kaiser Family Foundation. Medicare Advantage 2023 Spotlight: First Look. 2022. Available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-2023-spotlight-first-look/#:~:text=CMS%20announced%20that%20the%20average,to%20be%20%2418%20a%20month.

37 Kaiser Family Foundation. Medicare Advantage in 2023: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings. 2023. Available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/

38 2023 Medicare Trustees Report Table IV.B.7.

39 Centers for Medicare & Medicaid Services. Medicare Prescription Drug Benefit Manual, Ch. 6 – Part D Drugs and Formulary Requirements, sect. 30.2.5 (Rev. 18, 01-15-16), available at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Part-D-Benefits-Manual-Chapter-6.pdf.

40 The six protected classes include anticonvulsants, antidepressants, antineoplastics, antipsychotics, antiretrovirals, and immunosuppressants.

41 Centers for Medicare & Medicaid Services. Internet-Only Manual, Pub 100-02, Chapter 15, 50.4.5 Off Label Use of Anti-Cancer Drugs and Biologicals.

42 For 2024, the threshold amount for a specialty tier drug is $950 for a 30-day supply. Centers for Medicare & Medicaid Services. Final Contract Year (CY) 2024 Bidding Instructions. Apr. 4, 2023. Available at https://www.cms.gov/files/document/final-cy-2024-part-d-bidding-instructions.pdf.

43 Id.

44 Centers for Medicare & Medicaid Services. Monthly Contract Summary Report July 2023. 2023. Available at: https://www.cms.gov/files/zip/monthly-contract-summary-report-july-2023.zip.

45 Centers for Medicare & Medicaid Services. Medicare Enrollment Dashboard. 2023. Available at: Medicare Enrollment Dashboard - Centers for Medicare & Medicaid Services Data (cms.gov).

46 Geography matters in the Medicare Advantage context because CMS' payment to the MA plan is determined in part based on the local Medicare Advantage benchmark (a local target based on the average fee-for-service spending per beneficiary). For more information, see Medicare Payment Advisory Commission. Payment Basics: Medicare Advantage Program Payment System. October 2022. Available at https://www.medpac.gov/wp-content/uploads/2021/11/MedPAC_Payment_Basics_22_MA_FINAL_SEC.pdf.

47 Centers for Medicare & Medicaid Services. Fact Sheet. CMS Releases 2024 Projected Medicare Part D Premium and Bid Information. 2023. Available at: https://www.cms.gov/newsroom/fact-sheets/cms-releases-2024-projected-medicare-part-d-premium-and-bid-information CMS calculates the average total Part D premium, which is the sum of the average basic premium and the average supplemental premium for plans with enhanced coverage. According to CMS, this figure is the most accurate projection of what Part D enrollees are likely to pay on average.

48 Specific information regarding income-related premiums for Part D is available at https://www.cms.gov/newsroom/fact-sheets/2024-medicare-parts-b-premiums-and-deductibles.

49 Most beneficiaries who work beyond the age of 65 and receive health insurance coverage from an employer who covers more than 20 full-time employees will not be assessed a late enrollment penalty. Individuals who qualify for Extra Help (see section on low-income Medicare beneficiaries) are not assessed a late enrollment penalty.

50 The Part D benchmark premium is the average monthly premium for Part D plans in a given region weighted by enrollment in each plan.

51 Centers for Medicare & Medicaid Services. Announcement of Calendar Year (CY) 2024 Medicare advantage (MA) Capitation Rates and Part C and Part D Payment Policies. Mar. 31, 2023. Available at Announcement of Calendar Year (CY) 2024 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (cms.gov).

52 Drug manufacturer discounts only apply for branded prescription drugs. For generic drugs, the plans pay 75% of the cost in the coverage gap.

53 As of December 31, 2023, CMS has not finalized its guidance implementing the capped monthly installment option.

54 More information is available at https://www.medicare.gov/publications/02110-medigap-guide-health-insurance.pdf.

55 A chart depicting the Medigap plan benefits can be found at https://www.medicare.gov/health-drug-plans/medigap/basics/compare-plan-benefits. Medigap standardization varies in Massachusetts, Minnesota, and Wisconsin. More information is available at https://www.medicare.gov/health-drug-plans/medigap/basics.

56 More information about eligibility for enrollment in Medicare and Medigap plans is available at https://www.medicare.gov/health-drug-plans/medigap/ready-to-buy.

57 Medicare's annual enrollment period runs from October 15 through December 7 each year.

58 In 2023, the federal poverty level for an individual living in the 48 contiguous states and the District of Columbia was $14,580 (200% of the federal poverty level is $29,160). Health and Human Services. Annual Update of the HHS Poverty Guidelines. 88 Fed. Reg. 3424 (Jan. 19, 2023).

59 More information is available at https://www.medpac.gov/wp-content/uploads/2023/02/Feb23_MedPAC_MACPAC_DualsDataBook-WEB-508-SEC.pdf [Table 1].

60 2023 MedPAC data book.

61 Medicare. Help with Drug Costs. What's Extra Help? 2023. Available at: https://www.medicare.gov/basics/costs/help/drug-costs.

62 Individuals who are full benefit duals, those that participate in a Medicare Savings Program, and those who receive Supplemental Security Income (SSI) from Social Security automatically are enrolled in the LIS benefit.

63 More information on LIS beneficiary cost sharing is available at https://www.medicare.gov/basics/costs/help/drug-costs.

64 Davius JC, Rupasingha A, Cromartie J. Rural America at a Glance: 2022 Edition. U.S. Department of Agriculture Economic Research Service. Available from: https://www.ers.usda.gov/webdocs/publications/105155/eib-246.pdf?v=4569.3.

65 National Institutes of Health. National Cancer Institute GIs Portal for Cancer Research. Cancer Map Stories. Rural-Urban Disparities in Cancer. 2023. Available at: https://gis.cancer.gov/mapstory/rural-urban/index.html.

66 Cancer Facts & Figures 2023. Note: This figure is for the entire population, not just the Medicare population.

67 Id.

68 Breast Cancer: Screening. U.S. Preventive Services Task Force, Jan. 11, 2016. Available at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening.

69 Oeffinger KC, Fontham ETH, Etzioni R, et al. Breast Cancer Screening for Women at Average Risk: 2015 Guideline Update From the American Cancer Society. *JAMA.* 2015;314(15):1599–1614. doi:10.1001/jama.2015.12783.

70 Cervical Cancer: Screening. U.S. Preventive Services Task Force, Aug. 21, 2018. Available at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening.

71 Fontham ETH, Wolf AMD, Church TR, Etzioni R, et al. Cervical Cancer Screening for Individuals at Average Risk: 2020 Guideline Update From the American Cancer Society. CA Cancer J Clin. 2020; 321-346. doi:10.3322/caac.21628.

72 Colorectal Cancer: Screening. U.S. Preventive Services Task Force, May 18, 2021. Available at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening.

73 Wolf AMD, Fontham ETH, Church TR, Flowers CR, et al. Colorectal Cancer Screening for Average-Risk Adults: 2018 Guideline Update From the American Cancer Society. CA Cancer J Clin. 2023; 250-281. Doi:10.3322/caac.21457.

74 Lung Cancer: Screening. U.S. Preventive Services Task Force, Mar. 9, 2021. Available at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/lung-cancer-screening.

75 Wolf, AMD, Oeffinger, KC, Shih, TY-C, et al. Screening for lung cancer: 2023 guideline update from the American Cancer Society. CA Cancer J Clin. 2023; 1-32. doi:10.3322/caac.21811.

76 Prostate Cancer: Screening. U.S. Preventive Services Task Force, May 8, 2018. Available at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prostate-cancer-screening.

77 Wolf AMD, Wender RC, Etzioni RB, Thompson IM, et al. American Cancer Society Guideline for the Early Detection of Prostate Cancer: Update 2010. CA Cancer J Clin. 2010; 70-98. doi: 10.3322/caac.200066.

78 Reddy SR, Broder MS, Chang E, Paydar C, Chung KC, Kansal AR. Cost of cancer management by stage at diagnosis among Medicare beneficiaries. Curr Med Res Opin. 2022 Aug;38(8):1285-1294. doi: 10.1080/03007995.2022.2047536. Epub 2022 Apr 20. PMID: 35285354.

79 Medicare has different coverage rules for individuals who are at high risk.

80 42 C.F.R. § 410.34(d).

81 Centers for Medicare & Medicaid Services. CMS Medicare National Coverage Determination Manual. § 210.2. 2023. Available at: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/ncd103c1_part4.pdf.

82 Throughout this document, the term woman or women refers to individuals assigned female at birth.

83 Centers for Medicare & Medicaid Services. CMS Medicare National Coverage Determination Manual §210.2.1. 2023. Available at: Medicare National Coverage Determinations Manual (cms.gov).

84 42 C.F.R. § 410.39(c).

85 42 C.F.R. § 410.37(c).

86 42 C.F.R. § 410.37(g).

87 Centers for Medicare and Medicaid Services. CMS Medicare National Coverage Analysis. 2014. Screening for Colorectal Cancer – Stool DNA Testing (CAG-00440N). Medicare coverage of the Multi-target Stool DNA test is limited to individuals between the ages of 45 and 85 years who are asymptomatic and at average risk of developing colorectal cancer. Centers for Medicare and Medicaid Services. CMS Medicare National Coverage Determination Manual §210.3(B)(2). 2023. Available at: Medicare National Coverage Determinations Manual (cms.gov).

88 42 C.F.R. § 410.37(i).

89 While Medicare provides coverage of screening barium enemas, Medicare enrollees incur 20% co-insurance post deductible.

90 42 C.F.R. § 410.37(e).

91 42 C.F.R. § 410.37(k).

92 Centers for Medicare & Medicaid Services. CMS Medicare National Coverage Determinations Manual. §210.14(B). 2023. Available at: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/ncd103c1_part4.pdf.

93 MIPPA provided the Department of Health and Human Services the authority to expand Medicare coverage for new preventive services using the National Coverage Determination process if the following conditions are met: (1) if the preventive service is reasonable and necessary for the prevention or early detection of an illness or disability; if the preventive services is recommended with a grade of A or B from the U.S. Preventive Services Task Force; and (3) if the preventive service is appropriate for individuals entitled to benefits under Part A or enrolled in Part B. 42 U.S.C. § 1395x(ddd).

94 Centers for Medicare & Medicaid Services. 2023 Medicare Advantage and Part D Star Ratings. Oct. 6, 2023. Available from: https://www.cms.gov/newsroom/fact-sheets/2023-medicare-advantage-and-part-d-star-ratings.

95 Centers for Medicare & Medicaid Services. Screening for Lung Cancer with Low Dose Computed Tomography (LDCT) (CAG-00439R). Feb. 10, 2022. Available at https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=N&ncaid=304.

96 American Cancer Society, Breast Cancer Facts & Figures 2022-2024. Atlanta: American Cancer Society, Inc. 2022.

97 Centers for Medicare & Medicaid Services. 2023 Medicare Advantage and Part D Star Ratings. Oct. 6, 2023. Available from: https://www.cms.gov/newsroom/fact-sheets/2023-medicare-advantage-and-part-d-star-ratings.

98 National Center for Health Statistics. Health, United States, 2020-2021: Table 34. Hyattsville, MD. 2023. Available from: https://www.cdc.gov/nchs/hus/data-finder.htm.

99 American Cancer Society. Cancer Facts & Figures for African American/Black People 2022-2024. Atlanta: American Cancer Society; 2022.

100 Centers for Medicare & Medicaid Services. CMS Medicare National Coverage Determination Manual §210.4. 2023. Available at: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=308&ncdver=1&bc=AAAAEAAAAQAA&.

101 Centers for Medicare & Medicaid Services. Medicare Prescription Drug Benefit Manual. Chapter 6 – Part D Drugs and Formulary Requirements. § 20.1.

102 National Cancer Institute. Cancer Trends Progress Report. Financial Burden of Cancer Care. Aug. 2023. Available from: https://progressreport.cancer.gov/after/economic_burden.

103 Ruiz ES, Seiger K, Mostaghimi A, Schmults C. National cancer expenditure analysis in the United States Medicare population, 2013. *J Clin Oncol*. 2019;37(15 suppl):6647. doi:10.1200/JCO.2019.37.15_SUPPL.6647.

104 Roemer M (AHRQ). Cancer-Related Hospitalizations for Adults, 2017. HCUP Statistical Brief #270. January 2021. Agency for Healthcare Research and Quality, Rockville, MD. https://hcup-us.ahrq.gov/reports/statbriefs/sb270-Cancer-Hospitalizations-Adults-2017.jsp.

105 Social Security Administration. History of SSA During the Johnson Administration 1963-1968. Available at https://www.ssa.gov/history/ssa/lbjmedicare1.html.

106 NORC at the University of Chicago. MCBS Interactives – Transportation. Available at https://mcbs-interactives.norc.org/financial-well-being/transportation/.

107 Id.

108 American Cancer Society Cancer Action Network. Survivor Views: Cancer & Medical Debt. Fielded February 9-February 24, 2022.

109 Jiang C, Yabroff KR, Deng L, Wang Q, Perimbeti S, Shapiro CL, Han X. Self-reported Transportation Barriers to Health Care Among US Cancer Survivors. JAMA Oncol. 2022 May 1;8(5):775-778. doi: 10.1001/jamaoncol.2022.0143. PMID: 35323841; PMCID: PMC8949758.

110 Henley SJ, Anderson RN, Thomas CC, Massetti GM, Peaker B, Richardson LC. Invasive Cancer Incidence, 2004-2013, and Deaths, 2006-2015, in Nonmetropolitan and Metropolitan Counties - United States. MMWR Surveill Summ. 2017 Jul 7;66(14):1-13. doi: 10.15585/mmwr.ss6614a1. PMID: 28683054; PMCID: PMC5879727.

111 Levit LA, Byatt L, Lyss AP, Paskett ED, Levit K, Kirkwood K. Closing the Rural Cancer Care Gap: Three Institutional Approaches. JCO Oncol. 2020. June 23;16(7): 422-430. doi:10.1200/OP.20.00174.

112 Henley SJ, Jemal A: Rural cancer control: Bridging the chasm in geographic health inequity. Cancer Epidemiol Biomarkers Prev 27:1248-1251, 2018.

113 National Institutes of Health. National Cancer Institute GIs Portal for Cancer Research. Cancer Map Stories. Rural-Urban Disparities in Cancer. 2023. Available at: https://gis.cancer.gov/mapstory/rural-urban/index.html.

114 Tax Foundation. Average Income Tends to Rise with Age. 2019. Available at: https://taxfoundation.org/average-income-age/.

115 NORC at the University of Chicago. Only 14% of Cancers Are Detected Through a Preventive Screening Test. Dec. 14, 2022. Available from: https://www.norc.org/content/dam/norc-org/pdfs/State-Specific%20PCDSs%20chart%201213.pdf.

116 For example, while Medicare provides coverage of screening barium enemas, Medicare enrollees incur 20% coinsurance post deductible. See Medicare coverage of cancer screening chart.

117 American Cancer Society Position Statement on the Elimination of Patient Cost-Sharing Associated with Cancer Screening and Follow-up Testing | American Cancer Society.

118 Patrick Rucker, Maya Miller and David Armstrong. "How Signa Saves Millions by Having Its Doctors Reject Claims Without Reading Them." Propublica. Mar. 25, 2023. Available from: https://www.propublica.org/article/cigna-pxdx-medical-health-insurance-rejection-claims.

119 See American Cancer Society Cancer Action Network. The Medicare Appeals Process: Reforms Needed to Ensure Beneficiary Access. Nov. 17, 2020. Available from: https://www.fightcancer.org/policy-resources/medicare-appeals-process-reforms-needed-ensure-beneficiary-access.

120 Natale-Pereira, A., Enard, K., Nevarez, L., Jones, L. (2011) "The Role of Patient Navigators in Eliminating Health Disparities", Cancer, p. 3543-3552, https://acsjournals.onlinelibrary.wiley.com/doi/epdf/10.1002/cncr.26264.

121 Nelson HD, Cantor A, Wagner J, et al. Effectiveness of patient navigation to increase cancer screening in populations adversely affected by health disparities: a meta-analysis. J Gen Intern Med. 2020;35(10):3026-3035. doi:10.1007/s11606-020-06020-9.

122 Guide to Community Preventive Services. Cancer Screening: Patient Navigation Services to Increase Cervical Cancer Screening and Advance Health Equity. https://www.thecommunityguide.org/findings/cancer-screening-patient-navigation-services-to-increase-cervical-cancer-screening.html. Page last updated: January 24, 2023.

123 Marshall, J.K., Mbah, O.M., Ford, J.G. et al. (2016) "Effect of Patient Navigation on Breast Cancer Screening Among African American Medicare Beneficiaries: A Randomized Controlled Trial". Journal of General Internal Medicine, 31, p. 68–76. https://doi.org/10.1007/s11606-015-3484-2.

124 Le Blanc JM, Heller DR, Friedrich A, Lannin DR, Park TS. Association of Medicaid Expansion Under the Affordable Care Act With Breast Cancer Stage at Diagnosis. JAMA Surg. 2020;155(8):752–758. doi:10.1001/jamasurg.2020.1495.