

Medicare Part D and ADAP

The Medicare prescription drug benefit, also referred to as Medicare Part D, was included as a part of the *Medicare Prescription Drug, Improvement, and Modernization Act (MMA)*, enacted in December 2004. The benefit, which took effect in January 2006, provides prescription drug coverage to Medicare beneficiaries through a model that mirrors private health insurance. State and federal programs that previously supplied medications to those now eligible for Medicare Part D will be impacted by this new benefit. For people living with HIV/AIDS, the most significant programs that are impacted are Medicaid and state AIDS Drug Assistance Programs (ADAP).

MEDICARE AND HIV/AIDS

Medicare is the second largest federal payer for HIV/AIDS health coverage.¹ The majority of the 85,000 people living with HIV/AIDS that Medicare serves are eligible through Social Security Disability Insurance (SSDI). Individuals who have a disability that prevents them from working and have sufficient work credits are eligible for SSDI payments; however, there is a 24-month waiting period to receive Medicare benefits. These beneficiaries also tend to be in more advanced stages of illness – 65 percent with CD4 counts below 200 (the threshold for an AIDS diagnosis). Approximately 82 percent of beneficiaries with HIV/AIDS are under the age of 50.

Medicare pays for health care in four different parts; one is automatic while three are optional. Part A provides coverage for inpatient hospital costs. Part

B, which is optional, and requires payment of a premium, covers out-patient hospital services as well as other medical and physician services. Part C (Medicare Advantage) provides an option for beneficiaries to combine Part A and B through a managed care plan. And finally, Part D provides an outpatient prescription drug benefit for any beneficiary receiving Part A or enrolled in Part B.²

MEDICARE PART D

In order to receive Medicare Part D coverage, Medicare beneficiaries must sign up for a prescription drug plan (PDP) that is either stand-alone or offered through a Medicare Advantage plan. Each year, costs to the beneficiary are adjusted based on the increase in average total drug expenses of Medicare beneficiaries. In addition to a monthly premium, which in 2006 averaged \$32,³ all plans must be equal to, or actuarially equivalent to, the following standard benefit (See Table 1):

TABLE 1: MEDICARE PART D BENEFIT DESIGN

	2006	2007
Deductible: <i>Beneficiary is responsible for the deductible payment</i>	\$250	\$265
Initial Coverage Limit: <i>Beneficiaries pay 25 percent of total drug costs after the deductible up to this point</i>	\$2,250	\$2,400
Out-of-pocket threshold: <i>Beneficiaries are responsible for 100 percent of drug costs after reaching the initial coverage limit until they reach the out-of-pocket threshold—this is known as the “doughnut hole”</i>	\$3,600	\$3,850
Total Drug Spending Threshold (Catastrophic Limit): <i>After reaching the catastrophic limit in total drugs costs, the beneficiary pays 5 percent coinsurance or a co-pay of \$2 for generic drugs and \$5 for brand name drugs</i>	\$5,100	\$5,451

Source: Centers for Medicare and Medicaid Services



TRUE OUT OF POCKET (TROOP) COSTS

Under Medicare Part D, the true out of pocket (TrOOP) costs of beneficiaries are tallied to determine when a beneficiary reaches the catastrophic coverage limit. As indicated in Table 1, beneficiaries' cost sharing amounts are greatly reduced once they have reached the threshold limit of \$3,850 (2007). Payments for drugs, co-payments, and co-insurance made by the beneficiary, friends, family members, State Pharmacy Assistance Programs, charities, and the Medicare low-income subsidy (LIS) count towards TrOOP costs.⁴ Payments for premiums, drugs not on plan formularies, and payments by other types of insurance, group health programs, government-funded health programs (including AIDS Drug Assistance Programs) and several other third-party payers are not counted as TrOOP costs.

LOW-INCOME SUBSIDY

A LIS is available to assist beneficiaries who qualify based on income or who are dually eligible for both Medicaid and Medicare. The vast majority (two-thirds) of benefici-

aries living with HIV/AIDS are dually eligible for Medicaid and Medicare.⁵ Table 2 summarizes the groups who qualify for the LIS and their corresponding required costs.

MEDICARE PART D AND PEOPLE LIVING WITH HIV/AIDS

People living with HIV/AIDS are not designated as a special group under Part D. In recognizing the unique drug needs of people living with HIV/AIDS, the Centers for Medicare and Medicaid Services (CMS) designated all HIV antiretrovirals (ARVs) as protected. Newly approved ARVs must be reviewed by each plan's Pharmacy and Therapeutics (P&T) committee. For drugs in protected classes, the P&T committees must reach a decision within 90 days of approval, as opposed to 180 days for non-protected drugs. Aside from ARVs, however, PDPs are not required to cover all drugs needed by beneficiaries with HIV/AIDS, such as medications to treat side-effects or opportunistic infections.

TABLE 2: MEDICARE PRESCRIPTION DRUG BENEFIT SUBSIDIES FOR LOW-INCOME BENEFICIARIES 2007

Low-Income Subsidy Level	Monthly Premium	Annual Deductible	Co-payments
Full-benefit dual eligibles <100 percent of poverty	\$0	\$0	\$1.00/generic \$3.10/brand-name; no co-pays after total drug spending reaches \$5,451.25
Full-benefit dual eligibles	\$0	\$0	\$2.15/generic \$5.35/brand-name; no co-pays after total drug spending reaches \$5,451.25
Institutionalized full-benefit dual eligibles	\$0	\$0	No co-pays
Individuals with income <135 percent of poverty and resources <\$7,500/individual; \$12,000/couple	\$0	\$0	\$2.15/generic \$5.35/brand-name; no co-pays after total drug spending reaches \$5,451.25
Individuals with income 135 percent-150 percent of poverty	Sliding scale up to \$32.20*	\$50	15 percent of total costs up to \$5,451.25; \$2.15/generic \$5.35/brand-name thereafter

Note: Resources include \$1,500/individual and \$3,000/couple for funeral and burial expenses. *\$32.30 is the national monthly part D base beneficiary premium for 2006. Source: Kaiser Family Foundation summary of Medicare prescription drug benefit low-income subsidies in 2006.



AIDS DRUG ASSISTANCE PROGRAMS (ADAP)

ADAPs, funded primarily by Title II of the Ryan White CARE Act and state contributions, represent the nation's prescription drug safety net for people living with HIV/AIDS, providing life-saving medications to low-income uninsured and underinsured individuals in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam. ADAP is the payer of last resort, meaning it provides prescription drug coverage when no coverage exists or fills in the gaps from private insurance, Medicaid, and Medicare. The primary goal of state ADAPs is to provide access to medications for eligible clients. State ADAPs may also pay to purchase or continue private health insurance.

With over 134,000 enrollees and more than 96,000 clients served in June 2005, ADAPs serve approximately 25 percent of all people with HIV/AIDS in care. Nearly two-thirds (62 percent) of ADAP clients are racial/ethnic minorities and 79 percent are male. Eighty percent of clients have incomes at or below 200 percent of the Federal Poverty Level (FPL), and almost three-fourths (73 percent) are uninsured. Eighteen percent of ADAP clients report having private insurance coverage; 13 percent have Medicare, 10 percent have Medicaid, and 3 percent have both Medicare and Medicaid. In FY2005, the national ADAP budget was \$1.3 billion, nearly all of which supported direct client services.⁶

ADAP programs vary in more ways, including their formularies, infrastructure, and eligibility. As funding is discretionary, many ADAPs face budget shortfalls for several reasons:⁷

- Growth in clients
- Growth in drug expenditures
- Growth in number of prescriptions filled
- Small increases in federal funding that have not kept pace with demand

Budget shortfalls have resulted in ADAPs implementing cost containment measures. The most common cost containment measures include:

- Waiting lists
- Capped enrollment
- Reduced formularies
- Cost-sharing requirements for clients
- Lower eligibility requirements
- Expenditure limits
- Stricter medical eligibility criteria

COORDINATION BETWEEN ADAP AND MEDICARE

It is essential that people with HIV/AIDS receive ARV medications; unfortunately, cost barriers can result in prescriptions not being filled. The Health Resources and Services Administration (HRSA), the agency that oversees the CARE Act, requires ADAPs to ensure that all Medicare Part D eligible clients are enrolled in a PDP. Under Medicare Part D, individuals with incomes above 150 percent of the FPL who do not qualify for the LIS are required to make significant payments to receive their drugs. Therefore, most ADAPs choose to provide wrap-around coverage for people with HIV/AIDS enrolled in Medicare Part D in several ways:

- Picking up costs for beneficiaries when they reach the “doughnut hole” (see Table 1)
- Paying co-pays
- Paying monthly premiums
- Paying deductibles

To facilitate these payments, ADAPs are permitted to coordinate with PDPs. Coordinating with plans, however, is difficult for ADAPs, as some states have up to 40 different plans available. Most third-party payments made on behalf of beneficiaries (including ADAP payments) *do not* count towards TrOOP. Therefore, for beneficiaries for whom ADAP is picking up all costs, getting out of the “doughnut hole” to reach the catastrophic limit is not possible. Coordination with plans



involves working with clients, PDPs, and pharmacies to ensure that clients receive all the appropriate HIV/AIDS-related medication and are assessed correct co-pays; expenditures are flagged to not count towards TrOOP; and wrap-around expenditures are calculated correctly. ADAPs have also worked with their state Medicaid offices to identify dually-eligible clients.

Enrolling people with HIV/AIDS into Medicare Part D will have a financial impact on ADAPs. Roughly 10 percent of ADAP clients are believed eligible to enroll in Medicare Part D.⁸ Initial cost estimates show that ADAPs will save \$53.4 million in 2006 and \$67.6 million in 2007 from Medicare Part D.⁹ These cost savings may enable ADAPs to serve additional clients and/or increase coverage. However, ADAPs will still contribute for many people living with HIV/AIDS enrolled in Part D, as many assist with the cost-sharing obligations. The full effects of ADAP cost-savings or increased costs as a result of Medicare Part D are not yet known, and will continue to fluctuate as Medicare Part D plans change.

FUTURE OUTLOOK

Several impending policy developments may have implications for Medicare Part D and ADAPs. Funding for ADAPs has not kept up with increasing demand. As this trend persists, ADAPs may be unable to continue providing wrap-around coverage for Medicare Part D eligible clients. Proposed levels of funding in both the House and the Senate for FY2007 appear to fall short of meeting demand.

Senator Jeff Bingaman (D-NM) introduced S 3650, "Helping Fill the Medicare Rx Gap Act of 2006." This legislation would allow payments made on behalf of Medicare beneficiaries by ADAPs, Indian Health Service, federally qualified health centers, and pharmaceutical patient assistance programs to count

towards TrOOP costs. This would ease the financial burden on ADAPs providing wrap-around coverage for Medicare eligible clients, as clients would be able to reach the catastrophic coverage limit.

Challenges continue for ADAPs to coordinate benefits with PDPs and pharmacies. ADAPs will continue to work towards ensuring that clients receive as seamless a benefit as possible. Another challenge for ADAPs is that the participating PDPs may change between calendar years. This is difficult if ADAPs have enrolled clients in a specific PDP and worked to coordinate benefits with the PDP. It is unknown at the present time how many of the current PDPs will continue their participation in calendar year 2007 or if the plan parameters will be similar to 2006.

¹ Kaiser Family Foundation. *Trends in U.S. Government Funding for HIV/AIDS: Fiscal Years 1981 to 2004*. March 2004.

² Kaiser Family Foundation. Medicare and HIV/AIDS Factsheet. September 2005.

³ Centers for Medicare and Medicaid Services. *Medicare Premiums and Deductibles for 2006 Factsheet*. Retrieved June 21, 2006 from <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1557>

⁴ Centers for Medicare and Medicaid Services. Understanding True Out-of-Pocket (TrOOP) Costs. May 2006. Retrieved August 2006 from <http://www.cms.hhs.gov/partnerships/downloads/troop.pdf>.

⁵ Bozette, S., et al. "The Care of HIV Infected adults in the United States." *NEJM*, Vol 339, No 26. December 1998.

⁶ Kaiser Family Foundation and National Alliance of State and Territorial AIDS Directors. National ADAP Monitoring Project Annual Report (2006).

⁷ Ibid.

⁸ Number of eligible clients is based upon estimates from the National ADAP Working Group indicating that 10% of ADAP clients are eligible for Medicare.

⁹ The National ADAP Working Group. *Annual Ryan White Care Act- Title II ADAP Needs Projection for FY2007*. Retrieved June 21, 2006 from <http://tiicann.org/complete%20FY07%20projection.pdf>.