Medicare Part D:
What HIV specialists need to know!

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Goals:
- Understand:
  - Intersection of Medicare & HIV / AIDS
  - Changes to Medicare, particularly the new Rx drug benefit
  - How the new Rx benefit will affect your practice and your patients

- Know resources for ongoing help

Federal spending: HIV/AIDS care and treatment
courtesy of Kaiser Family Foundation

Insurance Coverage of People with HIV/AIDS
courtesy of Kaiser Family Foundation

Medicare Overview
- National standardized health insurance program for 42 million Americans
- Elderly
- Permanent Disabilities
- Administered by the Centers for Medicare & Medicaid Services (CMS) – an agency within HHS

Medicare Benefits
- Part A: Hospital Services (automatic)
  - Inpatient, Hospice
  - Some home health

- Part B: Physician Services (optional)
  - Outpatient
  - Labs, Medical Equipment, Supplies

- Part C: Managed-care plans (optional)
  - Medicare Advantage (formerly Medicare + Choice)
  - Private plans contract with Medicare to provide A & B
Medicare and HIV/AIDS

- Approximately 100,000, mostly disabled
- Sufficient work history to qualify for Social Security Disability Insurance (SSDI)
- Once approved for SSDI, an additional 24 months waiting period for Medicare
- 70-85% are also eligible for Medicaid (a.k.a. "dually eligible")

Medicare Modernization Act (MMA) of 2003

- Adds Rx Drug Benefit to Medicare: Part D on January 1, 2006
- Federally subsidized drug plans administered by private companies
- Interim drug discount cards (2004-2006)
  - Parts A and B are federally standardized
  - Parts C and D are run regionally by private plans

Key Messages for HIV specialists

1. Those who are also on Medicaid will be losing their Medicaid drug coverage and will be auto-assigned randomly into a Part D plan.
2. Most HIV positive Medicare beneficiaries will be eligible for low-income subsidies but many will need to apply for this "extra help."
3. Patients will likely come to you for help to sift through their plan options.

Key Messages for HIV specialists

4. If they enroll in a plan that requires them to switch pharmacies, you may have to re-write your prescriptions.
5. As January approaches, learn where you or your patient can go for more information in your area, as the plans are specific only to your area.
6. Each ADAP is now separately determining how they will interact with the Medicare plans.

Medicaid v. Medicare

- Medicaid
  - Federal and State program with State flexibility
  - Means-tested
  - Takes into account financial resources
  - Poor
  - Disabled or SSI
  - Parents, children, pregnant women, elderly
  - Medically needy
  - Prescription drug benefit
  - 200,000 with HIV/AIDS
  - $4.4 billion (Federal and State) in 2005

- Medicare
  - Federal program
  - No means testing
  - 65 or older OR permanently disabled
  - Under 18 and receiving SSDI for 2 years
  - No prescription drug benefit
  - 100,000 with HIV/AIDS
  - More likely to have an AIDS diagnosis
  - $2.8 billion in 2005

Dual Eligibles

- Qualify for both Medicare and Medicaid
  - ~ 80,000 with HIV/AIDS
- Disabled, poor, and typically quite ill
- Currently rely on Medicaid for HIV meds
- Medicaid benefits vary by state
- ADAP supplements Medicaid medication limitations
Medicare Part D: Basic benefit

- Enrollment period: 11/15/05 to 5/15/06
- Can change plan 1x/year in enrollment period
- Part D optional for non-duals; mandatory for duals
- Choice of at least two plans in region
- Premium: ~ $32/month, but will vary by plan

- Plans have flexibility for varying features:
  - List of drugs on their formularies (outside of ARVs which are mandated) and on which tier
  - Cost-management tools (including cost-sharing)

Medicare Part D and Dual Eligibles

- Starting January 1, the duals will be switched to Medicare for drug coverage
- Impact on beneficiary will be dependent upon:
  - Previous state Medicaid coverage
  - State ADAP coverage
  - Which drug plan beneficiary enrolls in

Medicare Part D: Dual Eligibles

- Duals will be switched to Medicare for drug coverage January 1, 2006
- No transitional period allowed
- Enrollment begins November 15th

Medicare Part D: Dual Eligibles

- CMS will auto-assign all duals early to a plan and notify them in October
- Duals can switch plans at any time
- Federal coverage for early refills and 30-90 day scripts near end of 2005
- Part D plans must have a CMS-approved transition process for new enrollees, with outreach efforts

Case #1: Peter Jones

Now:

- No paid in the highest Medicare
- Income $11,900 per month (~ roughly 200% FPL)
- ARV regimen is indinavir and FTC/3TC (Sustiva/Truvada) at a cost of $1300/mo.

With Medicare Part D:

- $37/month premium
- Month 1: $120 deductible + $205 (20% co-ins.) incurs $1405 balance
- Month 2: 3227 out of pocket (20% of $1600 balance to reach $2500 co-ins. limit)
- $300 (100% co-ins), for balance of $1600
- Month 3: $1750 (100% co-ins.) Peter has now paid $2767 out of pocket towards his drugs.

- Month 4: $1500 (100% co-ins.) for a total of $3,800 in out-of-pocket cost.
- Total drug cost: $2,300 (above $1,100 limit), so the catastrophic coverage has been reached for the year.
- Month 5-12: $50/mo. (20% co-pay)

Peter pays $4,540 for the year.
[Out of premiums, $3,660 out-of-pocket and $550 in co-pays]
Low-income subsidies: "Extra help"
- Annual income < 150% of poverty and limited resources (car and home do not count)
- Two tiers:
  - < 135% FPL (full subsidy)
  - 135-100% FPL (partial subsidy)
- Most Medicare beneficiaries with HIV/AIDS will qualify for some type of low-income subsidy
- All beneficiaries on Medicaid, in a Medicare Savings Program, or on Supplemental Security Income (SSI) automatically qualify for full subsidy!!

Federal Poverty Level
- Indexed each year by the Department of Labor
  - Current federal poverty level for an individual is $9,810 or $13,070 for a couple
  - Higher for Alaska and Hawaii

Low-income Subsidy
- No premiums (unless beneficiary chooses an above-average cost plan)
- No deductibles, co-insurance or donut hole
- Rx co-pay
  - Institutionalized: none
  - < 100 FPL: $1 generic / $3 brand
  - > 100 FPL: $2 generic / $5 brand
- No Rx co-pay once at catastrophic limit

Case # 2: Jane Matthews

- New:
  - On SSDI, Medicare, and Medicaid (dual)
  - SSDI benefit of $790/month (<100 FPL)
  - Antiretroviral regimen is efavirenz and FTC/TDF
  - Drugs cost $1,300 per month
  - With Medicare Part D and subsidy:
    - Jane pays $4 in co-pays per month for two scripts ($2 per generic brand name product)
    - By 4th month, total drug costs of $8,200 (exceeding $5,100 limit)
    - No cost to Jane after that
  - Jana pays $18 for the year
    - (3 months of $6 co-pay)

Beneficiary Payment for Part D
By Eligibility Category and Month
Assumes $5,200/month drug costs. 1 preferred and 1 generic drugs, and premiums of $12/month.

Applying for low-income subsidy
- Duals, those in Medicare Savings Programs, and those receiving SSI don’t have to apply—automatically qualify
- Other low-income beneficiaries may be eligible, but will have to apply for this help!
- The Social Security Administration is sending out applications. So far uptake is weak.
- When in doubt, fill it out!!
How Patients Apply for Help

- Apply at State Medicaid Office
  - Best option
  - They must also screen clients for Medicaid and Medicare Savings Plans
  - To get information regarding individual state Medicaid programs, find your state at: www.cms.hhs.gov/medicaid/default.asp
- Apply on web: www.socialsecurity.gov
- Calling Social Security: (800) 772-1213
- This fall, State Health Insurance Program (SHIP) counselors will offer free personalized counseling

In review: 4 tiers of coverage

- > 150% FPL = basic benefit
- 135 – 150% = partial subsidy
- 100 – 135% = full subsidy
  - co-pays: $2/$5
- < 100% FPL = full subsidy
  - co-pays: $1/$3

ADAP and Medicare

- About 8-10% of ADAP clients also have Medicare (ADAP Monitoring Report)
- AIDS Drug Assistance Programs (in accordance with state program policies) can pay:
  - Premiums
  - Deductibles
  - Coinsurance
  - Co-pays
  - Coverage in the linked rule (please will have to assess capability)
- ADAP contributions do not count towards the $3,600 threshold known as True Out Of Pocket Costs or TCOOP
  * (In some states, these limits are not available)

ADAP and Medicare

- Grantees must require eligible patients to enroll
- Most ADAPs only cover HIV-related meds; Medicare coverage more comprehensive
- Penalty for delayed enrollment

Formulary Issues

- Prescription Drug Plans (PDPs) have some flexibility in establishing formularies
- Must include at least two drugs in each therapeutic class
- Appeals process
- In order to protect against discrimination, CMS will ensure that there is access to all drugs in these categories
  1. Antiretrovirals
  2. Anticonvulsants
  3. Antipsychotics
  4. Antineoplastics
  5. Immuneosuppressants

Challenges

- Costs
  - Unlike Medicaid, no access to medication for failure to pay co-pay
  - Pharmacy can waive co-pay but not required to do so
  - Randomly, no "indemnities"
  - 90 and 30 day script have co-pay costs for those on subsidy (looking for a limited policy from states on this issue)
  - Prevents ADAP from contributing towards TCOOP
- Patient
  - Complicated plan choices; Poor understanding of new program
  - Subsidy covers premium only for average-cost plans in the area
- Providers
  - Poor understanding of new program
  - Concern that patients will be without medications
  - Asking patients to:
    - Applying for subsidy programs;Getting in Medicare Part D
    - Choosing a plan that works for them
    - Appeals process (case by case) for patients who are enrolled
### Solutions

- **Patients**
  - Fill out low-income subsidy application (non-duals)
  - Pay attention to assigned plan (Fall 2005) and switch if unhappy
  - Keep all mailings received from the federal government (CMS, SSA, state Medicaid offices, Medicare, etc.)

- **Providers**
  - Encourage patients about upcoming changes and to fill out low-income applications
  - Assist patients in plan selection
  - Give early refill, 90 day scripts in December

### Timeline

- **May-June**
  - CMS mails notices to people with Medicare who automatically qualify for low-income subsidies
- **July-August**
  - SSA mails applications to potential eligibles who don't automatically qualify
  - Plan information becomes available to public
- **October**
  - CMS notifies duals of their auto-assigned plan and will enroll them in it if they do not choose one on their own by December 31
- **November 15**
  - Open enrollment period for all Medicare patients
- **January 1, 2006**
  - All dual eligibles switch to Medicare for drug coverage
- **April 2006**
  - CMS notifies other people who qualify for the low-income subsidy of the plan that Medicare will enroll them in if they do not join a plan on their own by May 15th

### Provider Role

- Encourage patients to look out for subsidy applications in mail
- Encourage patients to talk to state Medicaid offices and others about "extra help"
- Tell duals to hold onto letters for their records
- Inform duals they can choose a different plan at any time

- Refer patients to
  - State Health Insurance Plan counselors
  - T-ADAP (www.statehiv/aids.org)
  - Other knowledgeable service providers

### Who to go to for answers:

- CMS Regional Offices
- State Medicaid Agency
  - www.cms.hhs.gov/states/default.asp
- Social Security Administration
  - www.socialsecurity.gov
- State Health Insurance Program
- State ADAP
- AAHIVM
  - ahas@ahivm.org
  - (202) 659-0688

### Discussion