

Perspective

Medicare Part D and Antiretroviral Therapy: Issues for HIV Clinicians

As of January 1, 2006, Medicare Plan D will add a drug benefit to Medicare, potentially affecting antiretroviral therapy for some 60,000 to 80,000 beneficiaries with HIV infection or AIDS. Health care providers should know the basic details of Plan D and how it may affect coverage for Medicare beneficiaries with or without a previous drug benefit under Medicaid. Steps may need to be taken to ensure that there are no lapses in antiretroviral therapy during the transition period from one pharmacy plan to another. This article summarizes a presentation on Medicare Plan D and antiretroviral therapy for patients with HIV or AIDS, given by Laura W. Cheever, MD, at the 8th Annual Clinical Conference for Ryan White CARE Act clinicians in New Orleans in June 2005, and developed by Dr Cheever and Mary R. Vienna, RN.

With the Medicare Modernization Act, the Centers for Medicare and Medicaid Services (CMS) is adding a drug program to Medicare in the form of Medicare Part D. This drug plan begins on January 1, 2006. Currently, there are approximately 60,000 to 80,000 Medicare beneficiaries with HIV infection or AIDS, most of whom qualify for Medicare benefits by receiving Social Security Disability Insurance (SSDI) for 2 years or more; under current Medicare plans, there is no prescription drug benefit. Of these patients, 70% to 85% are “dually eligible” beneficiaries in that they also qualify for Medicaid, which does offer prescription drug coverage. Under Medicare Part D, most Medicare beneficiaries must elect the drug benefit and select a drug benefit plan. If this is not done when Part D first comes into force, patients will have to pay penalties for later enrollment. Dually eligible individuals will be automati-

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cally enrolled in Part D, because prescription drug coverage will switch from Medicaid to Medicare on January 1, 2006. Plan formulations must include all antiretrovirals (they must also include all antidepressant, antipsychotic, anticonvulsant, anti-neoplastic, and immunosuppressive agents). Patients affected by Medicare Part D are likely to turn to their physicians for help in understanding the changes in their pharmacy plans.

Medicare Part D Basics

The basic plans in Part D are shown in Table 1. In general, as poverty level increases, beneficiaries have reduced premiums, reduced deductibles, and reduced coinsurance (amount to be paid by patient). This is because Medicare Part D has low-income subsidies, known as “Extra Help,” for beneficiaries with limited income assets.

Many patients may have income more than 150% of the federal poverty level (FPL) and exceed the asset limit. These beneficiaries will pay the following: a monthly premium that will amount to approximately \$32.20 per month in 2006; a \$250 deductible; 25% coinsurance (the patient pays 25%) up to \$2250 in drug costs for the year; 100% coinsurance (the patient pays all costs) up to a total of \$3600 in true out-of-pocket expenses and \$5100 in total drug

costs for the year; and approximately 5% coinsurance thereafter (at the catastrophic coverage level). Although the plan thus leaves such patients with relatively high out-of-pocket expenses, most Medicare beneficiaries with HIV or AIDS qualify for some type of low-income subsidy. These subsidies count toward out-of-pocket costs and toward reaching the catastrophic coverage level.

Dually eligible beneficiaries, beneficiaries on Supplemental Security Income, and those in a Medicare savings program—Qualified Medicare Beneficiary (QMB), Specified Low-income Medicare Beneficiary (SLMB), and Qualified Individual (QI) programs—are automatically eligible for a subsidy. Other beneficiaries not included in the above groups but who meet income and asset criteria need to apply to Social Security or Medicaid to qualify for a subsidy.

Illustrative Cases

The following case studies provide some indication of how patients at different income levels will be affected by Plan D. The same antiretroviral regimen is specified in each of the cases only to keep the overall drug cost constant for all the cases discussed.

Case 1

JM is on SSDI and receives both Medicare and Medicaid benefits. (She is dually eligible; see Table 1.) Her SSDI benefit amounts to \$780 per month, which puts her at less than 100% of the FPL. Her antiretroviral regimen includes 1 nonnucleoside reverse transcriptase inhibitor (NNRTI) and 2 nucleoside reverse transcriptase inhibitors (NRTIs), which cost \$1300 per month. Since her income is less than 100% of the FPL and the \$3 brand-name co-pay thus applies, JM

pays \$6 in co-pays per month for 2 prescriptions for 3 months. By the fourth month, JM's total drug costs of \$5200 (4 x \$1,300) exceed the \$5100 catastrophic coverage level, and thus she incurs no out-of-pocket costs thereafter. For the year, JM pays a total of \$18 in drug costs (3 months of \$6 co-pays).

Case 2

TS receives SSDI and Medicare benefits and a small private disability insurance benefit; his income of \$1100 per month puts him at 138% of the FPL (see Table 1). TS is receiving 1 NNRTI and 2 nRTIs at a cost of \$1300 per month. TS pays a premium of \$8.00

per month, reflecting a 75% subsidy of the \$32-per-month premium. For month 1, he pays a \$50 deductible, plus \$187.50 reflecting a 15% coinsurance of the \$1250 balance for the monthly drug cost. For months 2 and 3, TS pays \$195 per month in coinsurance (15% coinsurance on \$1300 drug cost). For month 4, he pays \$180 in coinsurance, reflecting 15% of the \$1200 balance before reaching the catastrophic coverage level of \$5100. For months 5 through 12, TS pays \$10 per month, reflecting the \$5 brand name co-pay for 2 prescriptions per month. Thus for the year, TS pays \$983.50, consisting of \$96 in premiums, \$807.50 in deductibles and coinsurance, and \$80 in co-pays.

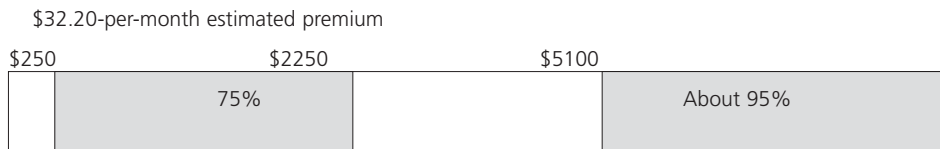
Case 3

CJ is a 65-year-old man who aged into Medicare coverage. His income is \$1600 per month, or 200% of the FPL (see Table 1). He is on the same regimen and has the same drug costs as in cases 1 and 2. CJ pays a premium of \$32.20 per month. For month 1, he pays a \$250 deductible plus \$262 reflecting the 25% coinsurance on the balance of \$1050 in drug costs. For month 2, he pays the following: (1) a \$237 coinsurance, reflecting 25% of the balance needed to reach the \$2250 limit on the 25% coinsurance; and (2) \$350, reflecting 100% coinsurance on the balance of the drug costs for the month. For month 3, he pays all of the \$1300 in drug costs out of pocket. For month 4, he pays \$1201, reflecting 100% of the drug cost until he reaches the total of \$3600 in out-of-pocket costs and the \$5100 total drug cost limit. For months 5 through 12, he pays \$65 per month, representing the 5% co-pay. CJ thus pays a total of \$4506.40 for the year, consisting of \$386.40 in premiums, \$3600 in out-of-pocket expenses, and \$520 in co-pays.

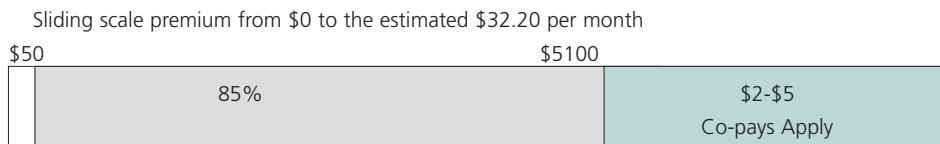
Table 1. Main Drug Benefit and Low-income Provisions Under Medicare Plan D

All numbers are for 2006 □ Beneficiary Pays ■ Plan Pays ■ Co-pays Apply

Main drug benefit for beneficiaries with income more than 150% of the federal poverty level or less than 150% of the federal poverty level but more than the asset limit



Beneficiaries with income less than 150% of the federal poverty level who also meet the asset test (\$11,500 per individual or \$23,000 per couple)



Beneficiaries with income less than 135% of the federal poverty level who also meet the asset test (\$7500 per individual or \$12,000 per couple), SSI recipients, Medicare Savings Programs Groups, and full-benefit dually eligible individuals with income above 100% of the federal poverty level*



Dually eligible individuals with income at or below 100% of the federal poverty level*



*Cost sharing is \$0 if the beneficiary is on Medicaid and institutionalized. SSI indicates Supplemental Security Income. Adapted from the Centers for Medicare and Medicaid Services.

Help With Costs

AIDS Drug Assistance Programs (ADAPs) can assist with drug costs, although they must do so in accordance with policies of individual state programs. An ADAP can pay premiums, deductibles, coinsurance (at the 15%, 25%, and 100% levels), and co-pays. However, ADAP contributions do not count toward the \$3600 in true out-of-pocket expenditures needed to reach the catastrophic coverage levels.

Provider Actions

Health care practitioners are likely to play a crucial role in ensuring that patients' antiretroviral treatment remains intact during the transition to Medicare Part D. As of June 2005, dually eligible patients should have received letters from Medicare informing them that they automatically

will be enrolled in Medicare Part D. Low-income Medicare beneficiaries may have received letters from Social Security about applying for low-income subsidies. Practitioners can encourage their Medicare patients to apply for the subsidies and inform dually eligible beneficiaries to keep their letters for their records. As of October 2005, a publication entitled “Medicare and You” containing information on Plan D should have been sent to all beneficiaries, and dually eligible beneficiaries should have received letters notifying them of the specific plan in which they have automatically been enrolled. Providers can encourage Medicare beneficiaries to enroll in Plan D at the first opportunity and inform dually eligible patients

that they can enroll in a plan different from the one to which they have been assigned. Patients can also be referred to www.medicare.gov or 1-800-MEDICARE for additional information. As of January 1, 2006, dually eligible beneficiaries will receive drugs through the Medicare plan. To help with the transition, CMS informed Medicaid that federal matching funds will be provided for early Medicaid refills and 30- to 90-day prescriptions for dually eligible beneficiaries near the end of 2005. Providers should consider the option of prescribing extra antiretroviral medication to their affected patients to help them get through the transition from one pharmacy plan to the other. During this transition, it is also advisable for

providers to routinely ask affected patients about the status of their access to their medications.

Presentation materials developed by Laura W. Cheever, MD, and Mary R. Vienna, RN, and presented by Dr Cheever in June 2005. First draft prepared from transcripts by Matthew Stenger. Reviewed and edited by Dr Cheever in November 2005.

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