

HIV Medicare and Medicaid Working Group

Medicare Beneficiaries with HIV/AIDS: Recommendation to Improve Access to Life-saving Medications and Medical Care

An estimated 100,000 Medicare beneficiaries living with HIV/AIDS rely on Medicare for their medical care including prescription drug coverage. It is estimated that nearly 80,000 of them also are dually eligible for Medicaid. A majority of Medicare beneficiaries with HIV/AIDS qualify for Medicare after being disabled by AIDS-related conditions for more than two years and suffer from advanced disease progression. Their lives depend on reliable, affordable access to medical care and a combination of antiretroviral medications to treat HIV disease along with a host of medications to address co-occurring conditions and treatment side effects.

STRENGTHEN THE MEDICARE PART D BENEFIT

Since the implementation of Medicare Part D in 2006, limited formularies, increased cost sharing and burdensome bureaucratic processes have left some Medicare beneficiaries with HIV/AIDS with inadequate prescription drug coverage threatening their health and well being. In the last session of Congress, the House-passed CHAMP Act included numerous beneficiary improvements which we support. Going forward, the following are top priorities of the HIV/AIDS community.

Allow expenditures made by AIDS Drug Assistance Programs (ADAPs) to count toward the True-Out-of-Pocket (TrOOP) limit. ADAPs are discretionary programs funded through the annual federal and state appropriation processes with 40 states contributing to their ADAP budgets. While ADAPs may wrap around Medicare Part D by helping people with HIV/AIDS cover their Medicare Part D cost sharing, their contributions are barred from counting toward the true out of pocket cost limit known as TrOOP. TrOOP is critical because it triggers the end of the coverage gap and initiates catastrophic coverage. If ADAPs supplement Medicare Part D, beneficiaries remain in the “donut hole” and the ADAP assumes responsibility for their drug costs for the rest of the year. Supplemental coverage from ADAPs is critical to many Medicare beneficiaries with HIV/AIDS who cannot afford the cost sharing required under Part D. In addition, ADAPs can only assist with payment for those drugs on its formulary, leaving many Medicare beneficiaries with significant out of pocket expenses on other necessary prescription drugs. State dollars account for 22% of the overall ADAP budget. The Congressional Budget Office scored a provision to allow ADAP and Indian Health Services (IHS) expenditures to count toward TrOOP at \$100 million over 5 years, the vast majority of cost coming from IHS. Making this relatively inexpensive policy change would improve access to lifesaving medications for Medicare beneficiaries with HIV/AIDS and persons who receive services from the Indian Health Services (IHS).

Codify the current CMS guideline that requires plans to cover “all or substantially all” drugs available in the antiretroviral class and five other drug classes. The Centers for Medicare and Medicaid (CMS) requires drug plans to cover “all or substantially all” drugs for six classes of drugs because of the risks and serious consequences that can occur when people taking these medications experience medication lapses. CMS grants additional protections to the antiretroviral class by prohibiting the use of utilization management techniques for all antiretrovirals. This reflects standard practice across insurers. State Medicaid programs and private insurers nationwide recognize the importance of providing uninterrupted and unrestricted coverage of antiretrovirals by including all drugs in this class on their formularies, and restricting the use of prior authorization and step therapy techniques. The protected class status and prior authorization protections should be written in statute and allow for the addition of new protected classes, as necessary to ensure ongoing access to these critical medications. The Congressional Budget Office has scored codification of the current regulatory policy as costing \$0.

Impose a nominal monthly cap on cost-sharing for people eligible for the low income subsidy (LIS) program. People living with HIV/AIDS generally depend on access to 8 to 14 prescriptions a month to suppress HIV, manage treatment side effects and co-occurring conditions. Co-payments and other cost sharing disproportionately burden people who are the sickest, the most in need of drugs and struggling to live on very low monthly incomes that range from \$600 to \$1,200. Even co-payments as low as \$3 and \$5 require them to spend a significant portion of their incomes on medications forcing them to make difficult choices between food, shelter and lifesaving health care and treatment.

Ensure that all Medicare beneficiaries have the option of selecting a drug plan that provides meaningful drug coverage during the “donut hole” by mandating availability of a national, federally administered “enhanced” plan option. With monthly drug costs that can easily total \$3,000, the “donut hole” poses a serious threat to Medicare beneficiaries with HIV/AIDS who do not qualify for the low-income subsidy program. Most people with HIV/AIDS reach the coverage gap in the second or third month of the plan year. In the first year of Medicare Part D, “enhanced” plans played an important role in making drugs affordable during the “donut-hole” coverage gap. However, the availability of meaningful coverage during the donut hole has dwindled since then and in 2008 there is only one plan in Florida that covers both brand name and generic drugs. In this instance, the private market will not support such a critical patient protection.

Plans that limit gap coverage to generics are not adequate for people with HIV/AIDS since nearly all HIV drugs are available in brand name only. All Medicare beneficiaries regardless of where they live should have access to a meaningful “enhanced” plan benefit that allows them to minimize disruptions in drug coverage.

Ensure that patients have access to life saving, cutting edge medications for serious illnesses by changing the statutory definition of a “medically accepted indication” for Part D by allowing evidence from peer-reviewed literature to justify off-label use (just like Medicare Part B, Medicaid and much of the private insurance market). Persons with debilitating and life-threatening illnesses, including cancer, HIV/AIDS, and mental illness cannot always get coverage for safe and effective medications because their drug treatments do not meet the restrictive definition of a “medically accepted indication” under Part D. Let doctors practice evidence-based medicine and allow patients coverage for what are often the only medications with demonstrated efficacy for conditions, which if untreated, can result in hospitalizations, permanent disability or death.

Automatically provide the low-income subsidy (LIS) to any Medicare beneficiaries that a state classifies as medically needy, without regard to whether or not they have met their “spend down” in a specific month of the year. Many Medicare beneficiaries with AIDS are eligible for Medicaid through their state Medicaid “medically needy” or “spend down” program. These programs allow people to qualify for Medicaid coverage because their medical expenses are so high that when deducted from their income they meet the Medicaid income eligibility criteria. Under current policy, CMS only automatically enrolls people into the low-income subsidy program who have met the Medicaid spend down requirement during specific “snapshot” months of the calendar year, e.g., from October to December. Individuals who qualified through spend down programs earlier in the year will not automatically be enrolled in the LIS the following year and are at serious risk of losing access to necessary prescription drugs. Without the LIS, they must meet the significant cost sharing requirements of the standard Medicare benefit, including monthly premiums, high copayments and a coverage gap. If their state ADAP is able to help, they never get out of the coverage gap (because ADAP dollars do not count toward TrOOP) and they will only have access to drugs on their state ADAP formulary. In the interest of fairness, efficiency and continuity of care, all persons certified as Medicaid-eligible by states should be deemed eligible for the low-income subsidy program. This will help ensure that those who are truly unable to meet the cost sharing required under Medicare Part D have the help they need to maintain access to life-saving prescription drugs.

IMPROVE MEDICARE COVERAGE FOR PEOPLE WITH DISABILITIES

Require parity for mental health/addiction coinsurance with cost sharing for other Part B medical services by reducing the current 50 percent coinsurance rate for most mental health services to 20 percent. The disparity in Part B coinsurance dates back to the inception of Medicare in 1965 and reflects an outdated benefit design. It represents a serious barrier to care for some of the nation’s most vulnerable populations: older adults and people with disabilities, groups that have a greater need for mental health services than other populations. In a 2006 review of prevalence data, researchers at the George Washington University found that 26 percent of Medicare beneficiaries have mental disorders, compared to 21 percent of the general population. In addition, 59 percent of Medicare beneficiaries with disabilities have a mental disorder, and 37 percent of them have severe disorders. People with HIV/AIDS often suffer from depression, due to treatment side effects or underlying mental health conditions. Many studies have shown that those suffering from untreated depression are much less likely to successfully adhere to a complex HIV treatment regimen, thereby significantly decreasing successful health outcomes.

End the two-year Medicare waiting period for non-elderly people with disabilities. The waiting period requires persons determined by the Social Security Administration to have a serious, permanent disability to wait 29 months from the date of this determination until they can receive health care coverage through Medicare. Many people awaiting Medicare coverage are uninsured and underinsured and forced to delay doctor visits and forego medically necessary treatment while they wait for their Medicare coverage to begin. This retrograde policy shifts significant financial burdens to individuals and families and Medicaid programs, It can be devastating to people with HIV/AIDS. The delay in coverage often results in them becoming sicker and requiring more costly treatment interventions once they finally qualify for Medicare coverage.

The HIV Medicaid and Medicare Working Group (HMMWG) HMMWG is a coalition of nearly 100 national and community-based AIDS service organizations that represent HIV medical providers, advocates and people living with HIV/AIDS and provide critical HIV-related health care and support services. For more information, contact the HMMWG co-chairs Laura Hanen with the National Alliance of State and Territorial AIDS Directors at 202.434.8091 or Robert Greenwald with the Treatment Access Expansion Project at 617.390.2584.