

An Advocate's Guide to AIDS Drug Assistance Program (ADAP) & Medicare Part D: Understanding the Decisions Every Program Must Make



Beginning in January 2006, Medicare beneficiaries will have the opportunity to receive prescription drug coverage from Medicare Part D. Because some Medicare beneficiaries are also enrolled in AIDS Drug Assistance Programs (ADAP), implementation of Medicare Part D will have a significant impact on ADAP. It may provide savings to ADAP, but may also add new, albeit reduced, types of expenses to the Program including co-payments or cost shares. Inevitably, it will require ADAP Programs to make important decisions and create new procedures to ensure that its current Medicare beneficiaries continue to receive an ADAP benefit comparable to the benefit provided prior to the implementation of Part D.

This policy brief is designed to help HIV/AIDS Advocates better understand how ADAP and Medicare Part D can work together to assure continued comprehensive drug coverage for persons living with HIV. To date, the Health Resources and Services Administration (HRSA) and Centers for Medicare and Medicaid Services (CMS) have set certain parameters concerning what ADAP can and cannot do to supplement Medicare Part D. These agencies have also given state ADAPs significant flexibility in deciding how they want to interact with Medicare Part D. In the upcoming months, ADAP Programs will be faced with important decisions concerning Medicare Part D. This guide is designed to help you understand what ADAP Programs can and cannot do and what decisions must be made. With this information, advocates can effectively promote the changes necessary to protect the health of Medicare beneficiaries.

This policy brief assumes that the advocate has a working knowledge of Medicare Part D. For more information on Medicare's new prescription drug plans, please visit www.makemedicarework.org. There are several fact sheets, PowerPoint presentations, and benefit guides available on this website to assist advocates in better understanding Medicare Part D. The CMS website, www.medicare.gov, also contains detailed information on the new drug plans.

Setting the Parameters: Current Guidance for ADAP Programs

Here is the current guidance, as set out by HRSA and CMS concerning ADAP and Medicare Part D:

- * **ADAP Programs must require their Medicare beneficiaries to enroll in Medicare Part D.** Fearful of change, many ADAP enrollees may prefer to continue coverage under ADAP and ignore Medicare Part D, even if it means paying a penalty in the future. In addition, some ADAP Programs might also prefer to ignore Medicare Part D. This will not be allowed. As a result, to ensure continued coverage for Medicare consumers, ADAP Programs must determine how their benefits will coordinate with Medicare Part D.
- * **ADAP expenditures will not count toward a Medicare beneficiary's True Out-Of-Pocket expenses (TROOP).** Individuals who do not qualify for "extra help" under Medicare Part D will pay up to \$3600 in out of pocket costs prior to reaching the Medicare Part D catastrophic coverage level. Once they reach the catastrophic coverage level, these individuals will have to pay a 5% co-insurance. Under current Medicare Part D regulations, ADAP Programs can cover expenditures that are part of an individual's out of pocket costs. If they do, the out of pocket costs paid by ADAP do not count for purposes of reaching the individual's catastrophic coverage level. As a practical matter, this means that most Medicare beneficiaries who are enrolled in ADAP will NOT reach the catastrophic coverage level unless they have significant non-ADAP expenditures.
- * **ADAP Programs may not use state money to "wrap around" Medicare Part D coverage and assist individuals in reaching the catastrophic coverage level.** Recent guidance has clarified that state ADAP expenditures may not be counted toward a Medicare beneficiary's TROOP. Some advocates had considered the possibility of shifting some state ADAP expenditures to a State Pharmaceutical Assistance Program (SPAP) in order to assist ADAP enrollees in reaching the catastrophic coverage limit. HRSA has stated that this will not be allowed. However, this does NOT prohibit an SPAP from covering ADAP medications with other monies as part of its "wrap around" coverage.
- * **ADAP Programs may cover an individual's co-payments, co-insurance, premiums, and deductibles.** This is the only way for ADAP to "wrap around" Medicare Part D and ensure sufficient coverage. For dual eligibles, assistance with co-payments may be very important, as the co-payments under Part D may prevent individuals from accessing the new benefit. For those who do not qualify for "extra help", assistance with the co-payments, co-insurance, premiums and deductibles can create a more comprehensive

package of coverage for ADAP enrollees. Strategies for maximizing coverage will be discussed further below.

While an ADAP Program may cover these expenses, they cannot be counted toward the person's TROOP in order to reach their catastrophic coverage level. For example: Let's say that a person receives no "extra help." ADAP can cover the individual's deductible of \$250. ADAP can also cover the 25% co-insurance on their next \$2000 in drug expenses, which totals another \$500. After these costs, the individual must pay 100% of their drug costs while in the "doughnut hole." During this time, the individual will have to pay their next \$2850 in drug coverage PLUS THE ADDITIONAL \$750 COVERED BY ADAP in order to reach catastrophic coverage. Why does the person have to pay an extra \$750 to leave the "doughnut hole"? Because the \$750 paid by ADAP will not count toward their TROOP expenses needed to reach the catastrophic coverage level.

- ✱ **The basic Medicare Part D benefit WILL NOT provide the same comprehensive and affordable coverage of HIV/AIDS drugs that ADAP Programs do.** All of the Medicare Part D Prescription Drug Plans (PDPs) are required to carry all or substantially all HIV/AIDS drugs. In addition, the PDPs are not allowed to use benefit management tools such as step therapy and prior authorization for these medications. However, the \$3600 cost sharing required to reach catastrophic coverage is simply unaffordable for most ADAP consumers. Therefore, if an ADAP consumer does not qualify for "extra help" and ADAP does not cover their drug expenses, they will, in effect, lose access to life-saving HIV/AIDS medications. This is why it is imperative that ADAP programs DO NOT drop Medicare beneficiaries from their ADAP Programs altogether.
- ✱ **The partial subsidy "extra help" under Medicare Part D WILL NOT provide the same comprehensive and affordable coverage of HIV/AIDS drugs that ADAP Programs do.** Again, while the PDPs will offer the HIV/AIDS medications provided by ADAP Programs, those who qualify for partial subsidy "extra help" will still face significant co-insurance amounts to access these medications. If an ADAP consumer receives a partial subsidy under Medicare Part D, he or she may pay up to 15% in cost sharing until he or she reaches catastrophic coverage. Given the costs of HIV/AIDS medications, this 15% will be cost prohibitive without further assistance from ADAP Programs.
- ✱ **Depending on the comprehensiveness of specific PDPs, full subsidy "extra help" under Medicare Part D may provide the same comprehensive coverage of HIV/AIDS drugs that ADAP Programs now do.** However, for those with the lowest incomes, the co-payments may

cause a financial strain. Under the full subsidy “extra help”, individuals pay a co-payment of \$1/\$3 or \$2/\$5 (name-brand/generic). Unlike Medicaid, pharmacies may deny prescriptions if the consumer does not pay the co-payment. It is up to the individual pharmacy, with some limited requirements. ADAP Programs may pay these co-payments to assure those of all income levels can access their HIV/AIDS medications.

The Interplay of ADAP and Medicare Part D: A Roadmap for New Policy Considerations

Set out below are a list of decisions that each ADAP Program must make concerning Medicare Part D. Advocates should meet with the ADAP decision makers to assure that they are following these steps and informing enrollees of their decisions.

Step 1: Identify how many ADAP enrollees are entitled to receive Medicare Part A and/or enrolled in Medicare Part B and who they are.

First, ADAP Programs must identify those individuals who are enrolled in their Program and entitled to Medicare Part A and/or enrolled in Part B. Obviously, the number and percentage of ADAP enrollees also enrolled in Medicare will vary from state to state. But, there is no doubt that each ADAP Program has a significant number of Medicare beneficiaries enrolled in its Program.

Advocates Tip: Most Programs have not tracked the Medicare status of their enrollees, since this has been irrelevant to drug coverage up until now. However, you should urge your ADAP Program to determine as best as possible how many Medicare beneficiaries are enrolled in the Program. These numbers will assist in analyzing costs and savings to ADAP budgets under Medicare Part D.

Step 2: Create an Education and Outreach Plan to reach each Medicare beneficiary currently enrolled in ADAP.

Based upon the experience of Medicare Part D advocates and outreach workers to date, Medicare Part D has been a “hard sell.” We are hearing from everyone out in the field that many are confused and many are stating that they will not sign up for the Program. This is particularly true among those Medicare consumers who are already receiving drug coverage through another program, such as Medicaid or a current SPAP. Given this, it is probably true that many ADAP enrollees will believe that Medicare Part D is unnecessary and fail to enroll.

Obviously, it is important for ADAP Programs to reach out to Medicare Part D beneficiaries and educate them on the new ADAP Program restrictions. ADAP

enrollees must understand that they cannot ignore Medicare Part D and must enroll in order to keep their ADAP benefits. Also, it is in the best interest of each ADAP Program to ensure that its enrollees receive any “extra help” available to them under Medicare Part D. This could provide significant savings to current ADAP budgets and enrollment in “extra help” will probably be a requirement because ADAP must be payer of last resort. Finally, any education and outreach campaign will have to educate ADAP enrollees on which expenses, if any, ADAP will cover for Part D enrollees.

Most outreach efforts are currently being targeted to older persons, rather than Medicare beneficiaries with disabilities under age 65. It is very likely that many ADAP enrollees know little about Medicare Part D in general. It is even more likely that they will have no idea that they must join a Medicare Part D plan to continue to qualify for ADAP. Therefore, materials should provide basic information about Medicare Part D and its “extra help” as well as specific, ADAP-related information.

Outreach strategies may include: mailings, public presentations with HIV/AIDS service providers, media campaigns in local newspapers, and outreach to medical providers and pharmacists.

Advocates Tip: ADAP staff alone cannot effectively reach all the Medicare beneficiaries enrolled in their Program. This education and outreach campaign must be a group effort among ADAP staff, service providers, and advocates. Advocates should help the ADAP Program design an effective campaign that will reach all enrollees.

Step 3: Categorize the ADAP/Medicare enrollees by income and “extra help” status.

Every ADAP Program will need to make certain decisions about how ADAP will coordinate with a consumer’s Medicare Part D benefits. Not surprisingly, ADAP beneficiaries will receive different levels of financial assistance in covering their HIV medications based upon what Medicare Part D consumer “category” they fall into. Those categories include the following:

- The Dual Eligible with an income under 100% of the Federal Poverty Level
- The Dual Eligible with an income over 100% of the Federal Poverty Level
- The Medicare Savings Program (QMB, SLIB, QI-1) Enrollee
- The Full Subsidy “Extra Help” Eligible with Application
- The Partial Subsidy “Extra Help” Eligible with Application
- Not Eligible for Extra Help

Set out below is a chart that describes each consumer category (except “not eligible for extra help”) and what their “extra help” provides:

	Full Subsidy	Partial Subsidy
<p>Dual Eligibles</p> <p>(eligible for both Medicare & Medicaid)</p>	<ul style="list-style-type: none"> • Deemed Eligible (No need to apply for "extra help" and will be automatically enrolled in Prescription Drug Plan (PDP) with opportunity to change monthly) • No Deductible • No Premium • No Doughnut Hole • \$1/\$3 Co-Pay (\$2/\$5 Co-Pay if income is above 100% FPL or \$0 Co-Pay if living in an institution) 	N/A
<p>QMB, SLIB, QI-1, SSI without Medicaid</p> <p>QMB - \$798/month SLIB - \$799-\$957/month QI-1 - \$957-\$1077/month</p>	<ul style="list-style-type: none"> • Deemed Eligible (No need to apply for "extra help" but should still choose a PDP or they will be automatically enrolled) • No Deductible • No Premium • No Doughnut Hole • \$2/\$5 Co-Pay • No cost-sharing above out-of-pocket threshold (after reach threshold, there are no co-pays) 	N/A
<p>Income up to 135% of Federal Poverty Level \$1077/month Assets \$6000 < Individual \$9000 < Couple</p>	<ul style="list-style-type: none"> • Must Apply for "extra help" and enroll in a PDP • No Deductible • No Premium • No Doughnut Hole • \$2/\$5 Co-Pay • No cost-sharing above out-of-pocket threshold 	N/A
<p>Income up to 150% of Federal Poverty Level \$1078-\$1196/month Assets \$10,000 < Individual \$20,000 < Couple</p>	N/A	<ul style="list-style-type: none"> • Must Apply for "extra help" and enroll in a PDP • Sliding Scale Premium • \$50 Deductible • No Doughnut Hole • 15% Co-Insurance • \$2/\$5 co-pay or 5% co-insurance above out of pocket threshold, whichever is higher

Step 4: Determine if and how the State Pharmaceutical Assistance Program (SPAP) may defray the costs of Medicare Part D for ADAP enrollees.

Under Medicare Part D, State Pharmaceutical Assistance Programs (SPAPs) may provide assistance in paying for prescription drugs for Medicare beneficiaries. SPAPs throughout the country are covering expenses such as premiums, co-insurance, and drug costs during the “doughnut hole’s” 100% cost share. In some states, these expenses are paid for seniors only. Other state SPAPs will include individuals with disabilities. In general, the SPAPs will provide “wrap around” coverage for beneficiaries, covering costs not picked up by Medicare Part D or the “extra help” subsidy. These covered costs WILL COUNT toward TROOP under Medicare Part D.

Prior to deciding what expenses it will cover, ADAP Programs should determine what, if any, expenses will be covered by the SPAP. Clearly, an ADAP Program does not want to cover expenses that could be covered by the SPAP. From a programmatic standpoint, such expenses would be unnecessary and may violate “payer of last resort” rules. From the ADAP consumer perspective, it is more advantageous for the SPAP to cover expenses than for ADAP to do so because of the TROOP rules.

Advocates Tip: State Pharmaceutical Assistance Programs (SPAPs) are designed to help individuals pay the costs associated with Medicare Part D. In many states, these programs are designed for seniors only. However, SPAPs can cover ANY individuals who receive Medicare. Therefore, an important advocacy area may be creating or expanding an SPAP to meet the needs of individuals living with HIV.

Step 5: Decide what, if any, requirements the ADAP Program will institute concerning applying for “extra help.”

Given the varying levels of assistance, it is probably going to be in the best financial interest of an ADAP Program to assure that those who qualify for “extra help” are enrolled in “extra help.” For example, if an ADAP consumer enrolls in full subsidy “extra help,” Medicare Part D will potentially pick up ALL of that individual’s ADAP drug costs, except for co-payments. On the other hand, if that consumer fails to secure the “extra help”, ADAP will continue to pay the vast majority of that individual’s HIV/AIDS medication costs.

While there is a requirement that an ADAP enrollee also enroll in Medicare Part D, there is no requirement that he or she also apply for “extra help” at this time. However, given ADAP’s status as payer of last resort, future HRSA guidance will

probably require individuals who qualify for “extra help” to apply for it. An ADAP Program could institute this requirement in one of two ways: require all Medicare beneficiaries to apply for “extra help” in order to qualify for ADAP, or pre-screen Medicare beneficiaries to identify those who qualify for “extra help” and facilitate their enrollment in “extra help”. Clearly, from a consumer perspective the latter strategy is preferable and given the number of ADAP/Medicare beneficiaries, facilitated enrollment into “extra help” is manageable.

Advocates Tip: ADAP Programs will have a strong interest in getting enrollees to qualify for “extra help” as it will save them a lot of money. While that is understandable, the role of an advocate is to assure that individuals continue to receive comprehensive drug coverage. With proper education and outreach, most, if not all, individuals will enroll in “extra help” on their own. However, this transition is not going to be easy and some people may fail to enroll in “extra help.” You should be sure that your ADAP Program continues to make every effort to facilitate individuals’ enrollment in “extra help” and covers them until they are enrolled. Dis-enrolling beneficiaries simply because they fail to apply for “extra help” without making every effort to help them transition over to Medicare Part D should not occur.

Step 6: Decide what co-payment assistance the ADAP Program will provide to dual eligibles, Medicare Savings Program enrollees, and full subsidy “extra help” enrollees.

ADAP Programs are allowed to provide co-payment assistance. For individuals in the full subsidy “extra help” categories, their only expenses under Medicare Part D are co-payments, which end after the individual accumulates \$3600 in drug expenses. Individuals who are dual eligibles with incomes under 100% of the Federal Poverty Level have co-payments of \$1 for generic and \$3 for name brand drugs. All others have co-payments of \$2 for generic and \$5 for name brand drugs. Because many HIV/AIDS drugs do not come in generic form, many individuals will accumulate significant co-payments. ADAP Programs can choose to cover these co-payments to assure continued and uninterrupted access to these medications. In addition, ADAP Programs could cover the co-payments associated with non-ADAP formulary drugs.

The cost associated with these co-payments will depend on the number of ADAP enrollees that fall into this category, their prescription drug usage, and what co-payments (ADAP formulary only or all formulary) are covered. Costs will also be dependent upon how many pharmacies waive the co-payments (in some

circumstances, pharmacies may choose to waive co-payments but are not required to do so). A quick analysis of the number and types of medications taken by consumers with incomes under 150% of federal poverty level or even the average ADAP consumer will provide a rough estimate of the cost involved in covering co-payments. It is likely that the costs to be covered by Medicare Part D will more than make up for the cost of covering co-payments.

Advocates Tip: For many individuals, co-payments will represent a new expense for drug coverage. For those with very low incomes who have many prescriptions, co-payments could be a financial hardship. Unlike Medicaid, the choice to waive co-payments is at the discretion of pharmacies. And, this discretion is limited. Waiver must not be a routine practice or advertised. Advocates should encourage their ADAP Program to cover co-payments. They should also reassure ADAP Programs that they will identify pharmacies that do waive co-payments and encourage individuals to utilize those pharmacies, cutting costs for the ADAP budget.

Step 7: Decide what assistance the ADAP Program will provide to partial subsidy “extra help” enrollees, including co-payment assistance, premium assistance, payment of deductibles, and payment of co-insurance.

Individuals enrolled in partial subsidy “extra help” will have more costs associated with their drug coverage. These individuals will pay monthly premiums, a \$50 deductible, 15% co-insurance, and then \$2/\$5 co-payments once their drug expenditures reach \$3600. These costs constitute a SIGNIFICANT increase in the out-of-pocket HIV/AIDS drug costs of individuals who do not receive cost sharing assistance from ADAP Programs.

Again, ADAP Programs should do an analysis of the cost of covering these expenses for individuals receiving a partial subsidy. Costs could include: a sliding scale premium (an ADAP could set an amount that it would contribute to the premium), the \$50 deductible, \$532.50 in co-insurance, and the co-payments after the co-insurance ends. These costs would only be covered for a small number of individuals because of the small income window (135%-149% FPL) required to qualify for this partial subsidy.

Advocates Tip: Those who qualify for partial “extra help” will have SIGNIFICANTLY HIGHER HIV/AIDS medication expenses than they did under ADAP alone in 2005. Therefore, advocates must make sure that their ADAP Program covers the added expenses of those receiving partial extra help. These individuals do not receive the same level of assistance as the other “extra help” categories and should be treated differently by ADAP Programs!

Step 8: Decide what assistance the ADAP Program will provide to those individuals who qualify for no “extra help.”

Of all consumer categories, individuals who qualify for no “extra help” are the group who will need the most assistance from ADAP Programs when Medicare Part D begins. Without the assistance of the ADAP Program, these individuals will face extremely high drug bills in the first or second month of the year. Faced with the doughnut hole and no ADAP assistance, most of these individuals would not be able to afford their HIV/AIDS medications. Therefore, if an ADAP Program chose to dis-enroll all Medicare beneficiaries from its coverage, it would in effect, deny these no “extra help” individuals access to life-sustaining medications altogether.

ADAP Programs do need to make important decisions about which expenses they will cover and how they will cover them for those who do not qualify for “extra help.” Again, ADAP is allowed to pay their premiums, deductibles, co-insurance, and co-payments. The costs associated with covering this will depend on what is covered, how it is covered, and how many individuals in the Program fall into this category. In some states, the number of individuals in this consumer category will be small or none. In other states with the highest income limits, this number may be significant.

Any cost calculation should include the savings received by “wrapping around” Medicare Part D, which is based on the \$1500 in costs covered by Medicare Part D. \$1500 represents the amount Medicare Part D will pay prior to the individual reaching the 100% cost share “doughnut hole”. However, ADAP Programs generally will NOT save exactly \$1500 in drug costs. Because most ADAP Programs pay significantly less for medications than Medicare Part D will pay to the PDPs, \$1500 in Medicare Part D drug costs will not equal \$1500 in ADAP drug costs. For example, \$1500 in Medicare Part D expenditures may cover drug expenses that would only cost an ADAP \$1000 to cover. In that case, the ADAP Program is only saving \$1000 in real cost from its budget, rather than \$1500 in costs.

Because of this, ADAP Programs could see significant variations in cost savings under Part D depending on what the \$1500 in Medicare Part D coverage pays for. For example, if the \$1500 Medicare Part D cost share pays for a drug that costs the ADAP Program \$1000, the savings to ADAP is \$1000. However, if Medicare Part D pays \$1500 for a drug that costs the ADAP Program only \$400, the cost savings is only \$400. If Medicare Part D pays \$1500 for non-ADAP formulary drugs, ADAP saves NOTHING on that individual. Consequently, Medicare Part D savings to ADAP for “no extra help” Medicare beneficiaries will be significantly influenced by WHAT drugs are paid for by Medicare Part D and what drugs “remain” to be paid for by the ADAP Program. ADAP Programs may

consider some sort of mechanism for advising enrollees on what drugs to access through Part D and what drugs to access through ADAP. This would help the ADAP Program ensure that its enrollees are accessing drugs within their PDP at prices closer to ADAP prices, thereby maximizing their cost savings.

Because of the high drug costs of ADAP enrollees, most will reach the doughnut hole early in the year, in February or March. Therefore, outside of the potential costs covered by Medicare Part D, the ADAP Program will basically cover all HIV/AIDS medication costs for Medicare beneficiaries with no "extra help" just as it did prior to Medicare Part D. Unless the individual incurs significant countable out of pocket expenses, beyond amounts that ADAP pays, (through an SPAP or patient assistance program or actual out of pocket expenses) most individuals will never make it to catastrophic coverage, where an ADAP program could realize significant savings on individuals.

Advocates Tip: ADAP enrollees with incomes over 149% of the federal poverty level (\$1196 in 2005) will have the least amount of coverage under Medicare Part D. For most, access to HIV/AIDS medications will be impossible without assistance from ADAP. Therefore, advocates have to make sure that ADAP continues to cover these expenses and does not drop Medicare Part D beneficiaries from the Program. Advocates should push to have ADAP cover as much as is necessary to provide these individuals with the same drug coverage as they had prior to implementation of Medicare Part D.

Step 9: Decide how ADAP will coordinate with Medicare Part D in covering individuals with no "extra help."

ADAPs may require enrollees to utilize their Medicare Part D prescription drug card to access ADAP benefits. In order to do this, the ADAP Program would have to work with the Medicare Part D TROOP coordinator to assure that Medicare Part D is billed for its portion and the ADAP program is billed for the remainder. This is the easiest way to assure coordinated cost-sharing between ADAP and Medicare Part D.

HOWEVER, this coordination option may become problematic once an individual reaches the 100% cost-share in the doughnut hole. At that time, the ADAP Program would begin paying the PDP's price for the medications, rather than the significantly reduced, negotiated price ADAP Programs currently pay. Therefore, ADAP Programs must explore whether the TROOP coordinator can assure that ADAP is not billed under the PDP schedule when an individual reaches the "doughnut hole" which would result in the ADAP Program paying significantly MORE for these Medicare beneficiaries.

Step 10: Decide what level of premium assistance will be provided to Medicare enrollees.

Under Medicare Part D, the PDPs will offer varying levels of coverage for different premiums. PDPs may offer enhanced plans for higher premium amounts and basic plans for lesser amounts. For example, a PDP may charge a higher premium for a plan that utilizes little or no benefit management tools (such as tiered co-payments), requires a lower deductible, or offers a more comprehensive coverage plan.

Unlike the premium assistance offered by the Medicare Part D "extra help" programs, there are no limits to the amount of premium assistance an ADAP Program can provide. "Extra help" can only offer premium assistance for a basic plan (full subsidy) or sliding scale plan (partial subsidy). An ADAP Program could provide full premium assistance for ANY plan.

Why would an ADAP Program do this? By offering full premium assistance for an enhanced plan, an ADAP Program could steer its enrollees into a Plan that covers more costs that ADAP would otherwise pay. For example, a PDP could offer a plan with no deductible, a 10% cost share for the first \$2250 in drug costs, and 100% cost sharing for only \$1500 of drug expenses. Such a plan would entail less cost sharing than the traditional basic plan set out by Medicare because it has no deductible, less cost sharing in the initial phase, and less of a "doughnut hole." ADAP Programs may want to cover the higher premium for this plan to allow ADAP enrollees to get more cost sharing from Medicare Part D and subsequently lower the expenditures for ADAP.

Advocates Tip: ADAP decisions about premium assistance are very important. ADAP Programs are allowed to provide any level of premium assistance. Therefore, ADAP Programs can pay the premium for the best and most comprehensive Prescription Drug Plan. Advocates should analyze the different plans offered in the state and determine which plans offer the most comprehensive coverage with the least cost sharing. Advocates should then encourage the state to pay the premium for these plans no matter what the cost because the Program will realize great savings from steering individuals into the best Plans.

Implementing Steps 1-10: "Best Practices" for a Model Program

Given all the decisions that need to be made, what would a model ADAP Program now look like? While this will vary depending on the environment in each of your states, we can still come up with some general "best practices." These "best practices" are based on two overall goals: continuous,

comprehensive coverage for Medicare beneficiaries with maximum cost savings to the ADAP budget. Such “best practices” might include:

- An accurate count of Medicare Part D eligibles and analysis of their Medicare subsidy eligibility;
- An effective and culturally appropriate education and outreach campaign;
- A requirement that those who are eligible for “extra help” apply for “extra help”;
- A reasonable plan for facilitating enrollment into “extra help,” which would include only dis-enrolling a person from ADAP after all reasonable attempts to get them to apply for “extra help” have failed;
- If applicable, proper coordination with the SPAP;
- Comprehensive co-payment assistance for all prescriptions for those entitled to full subsidy “extra help”;
- Comprehensive co-payment, premium, and co-insurance assistance for those entitled to partial subsidy “extra help”;
- Comprehensive co-payment, premium, and co-insurance assistance for those entitled to no “extra help”;
- Premium assistance that encourages enrollment in plans with most comprehensive coverage and with least amount of out-of-pocket expense that would need to be covered by ADAP;
- Simple, reasonable rules for assuring Medicare Part D covers medications that allow ADAP to realize maximum savings;
- Coordination with Medicare Part D that assures ADAP does not pay PDP prices for ADAP formulary drugs.

Conclusion

For many Medicare consumers, Medicare Part D will significantly change the way in which they access prescription drugs. This significant change has caused widespread confusion and uncertainty. For individuals living with HIV, changes to prescription drug coverage are particularly stressful because these medications are life-sustaining. As advocates, you must assure that the ADAP Program makes decisions about how Medicare beneficiaries will now access prescription drug coverage as soon as possible.

Advocates must engage their ADAP Programs now. Using this step by step guide, you can discuss with the ADAP Program the best and most realistic way for ADAP to operate in a Medicare Part D world. The overall goal should be to assure that individuals receive the same comprehensive drug coverage in 2006 that individuals received prior to Medicare Part D. This can be achieved through a combination of Medicare Part D and ADAP, with Medicare Part D providing a

savings to ADAP Programs. After the smooth transition to Medicare Part D is complete, advocates can begin discussing how to improve the ADAP Program with these new savings.

This policy brief was created by Health & Disability Advocates for the Make Medicare Work Coalition. Any questions, please contact John Coburn at 312-218-0941 or jcoburn@hdadvocates.org.