



# Medicare's New Drug Program Creates Challenges

**Part D is  
Part Drug Coverage,  
Part Difficult,  
Part Distressing**

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A dizzying array of rules, options, and costs await the 41 million Medicare recipients under the new prescription drug program rolling out later next year.

For people with HIV, the program offers both a new opportunity to obtain prescription drug coverage and a maze of pitfalls and barriers that threaten to undermine continuous access to lifesaving medications—the hallmark of high-quality HIV/AIDS care.

Medicare is the nation's healthcare insurance program for retired seniors and disabled workers, which until now has only covered inpatient services (hospitalizations) and, for an additional monthly cost (called a premium), outpatient services. Oddly enough, the basic program has not previously offered prescription drug coverage, creating a serious gap for its millions of beneficiaries. To obtain their medications, many beneficiaries have purchased supplemental private coverage, if they could afford it, or turned to Medicaid (run by their state) if they are extremely low income.

With the 2003 enactment of the Medicare Modernization Act, that landscape is changing. Beginning in October (and through May), Medicare patients will have to choose prescription drug coverage through a complicated new program known officially as "Part D." Helping the estimated 85,000 people with HIV on Medicare navigate the new program and understand their options and obligations will be a monumental task for case managers, benefit counselors, and AIDS service organizations. It's worth noting that only those eligible for Medicare will be affected—essentially people who receive a monthly Social Security Disability Income (SSDI) check and not those who receive only a Social Security Income (SSI) check.

#### **PART DERBY—HISTORY**

The legislation that created Part D drew heavily on recommendations from

influential pharmaceutical and insurance lobbyists and modeled the program to resemble insurance products sold in the private sector. In fact, the federal government is providing generous subsidies to health insurance companies to make prescription drug plans available across the country. Approved plans, to be announced on October 15, can decide what drugs to cover and how to structure their benefits, within the parameters established by the federal Centers for Medicare and Medicaid Services (CMS). Federal officials have stated publicly that plans will be expected to provide most HIV antiretroviral medications, which is welcome news. How plans differ in terms of extra costs and access to other needed medications will not be known until participating plans are publicly announced.

Most Medicare recipients will have until May 15, 2006 to enroll in Part D and must pick a plan offered in their area. They will have the option to change plans only once a year. Enrolling in Part D is optional, but a penalty (higher premiums) will be assessed on those who enroll after May 15, 2006, unless they already have prescription drug coverage "of equal or greater value."

#### **PART DAUNTING—OUT-OF-POCKET COSTS**

An important way to measure the value of Part D for each beneficiary will be to assess both what the program will offer in terms of benefits and what it will cost. Congress devised a peculiar cost structure for beneficiaries. Most people will have to pay a monthly premium estimated at \$37 a month (the cost will rise each year); the first \$250 of their drug costs; 25% of their drug costs between \$250 and \$2,250; 100% of their drug costs between \$2,250 and \$5,100 (this is the so-called "donut hole"); and then 5% of drug costs beyond \$5,100 for a given year. In other words, a beneficiary with high drug costs (like beneficiaries with HIV) will have to pay \$3,600 out-of-pocket (not counting monthly premiums) before





Part D picks up 95% of drug costs. The cost calculator re-sets each year.

What does this all mean for the average person with HIV? The individual cost burden is higher for people with lower incomes and/or high drug costs.

#### LISA

Consider, for example, Lisa's situation. Lisa is a retired nurse's assistant whose annual income from SSDI and investments is \$28,716 (\$2,393 per month). Her drug costs for Trizivir, Kaletra, and a cholesterol lowering medication are around \$15,000 per year (\$1,250 per month). Her annual out-of-pocket costs (including monthly premiums) would be approximately \$4,539 (16% of her gross income). Out-of-pocket costs would rise to \$1,287 in months three and four during the "donut hole" period (more than half her monthly gross income). She would pay \$99.50 in months 6 through 12.

The financial burden becomes even steeper on individuals with lower incomes. If Lisa's income were \$15,000 a year (\$1,250 per month) and her drug costs remained the same, she would pay more than she receives in months three and four. The annual cost of the program would be 30% of her gross income.

#### PART DEAL—THE LOW-INCOME SUBSIDY

Some very low-income beneficiaries will receive what is being billed as "extra help" so that out-of-pocket costs are lower. Beneficiaries with incomes below 150% of the federal poverty level (\$14,355 for a single individual and \$19,245 for couples in 2005) and limited assets (such as investments or savings) can qualify for the Low-Income Subsidy (LIS). People who qualify for LIS pay lower premiums, \$1 to \$5 per prescription, or none at all based on their income, and become exempt from the "donut hole."

People who are dually eligible for Medicaid and Medicare will be automatically enrolled in LIS. This includes people who receive Medicaid assistance to maximize

Medicare benefits. All others must complete an LIS application form and meet eligibility criteria to receive the extra help. People who think they may qualify, and who are not dually eligible, will need to elect Part D, apply for LIS, and select a drug plan to receive Part D coverage.

#### PART DIZZYING—TRUE OUT-OF-POCKET COSTS (TRLOOP)

The architects of Part D designed the program to require "cost-sharing" so that beneficiaries bear responsibility for cover-

ing a portion of their drug costs. Cost-sharing is higher for individuals above 150% of poverty and lower—but not entirely eliminated—for the program's poorest members. For most recipients, cost-sharing is steepest in the donut-hole during which 100% of drug costs are borne by the beneficiary.

Programs" can help beneficiaries pay premiums, deductibles, and co-payments (including during the donut hole). All these expenditures count toward TrOOP. Other ways to meet TrOOP include when a family member, private organization (including charitable organizations), or even a Patient Assistance Program pays incurred drug costs.

What does this all mean for the average person with HIV? Beneficiaries need to explore whether their state has an approved assistance program, and if not, whether one

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Beneficiaries receive the most generous coverage after surpassing the donut hole. At this level—called catastrophic coverage—the program pays 95% of a recipient's drug costs for the rest of the year.

The sum of expenditures needed to reach catastrophic coverage is known as TrOOP: True Out-of-Pocket Costs. Federal regulations define approved ways beneficiaries can receive assistance with meeting out-of-pocket costs that continue to count toward TrOOP. Beneficiaries may receive other forms of assistance but such expenditures do not count toward TrOOP.

What counts as TrOOP? Fully state-funded "State Pharmaceutical Assistance

can be created (federal regulations limit what states can do if they don't already have a State Pharmaceutical Assistance Program).

For example, Illinois has established a program to help low-income beneficiaries pay Part D premiums, co-payments, some of the deductible, and some medications during the donut hole. These expenditures help beneficiaries reach the catastrophic level where coverage is most generous. These strategies also help the state maximize scarce healthcare dollars and promote better healthcare.

#### PART DISPIRITING—ADAP

Many unanswered questions remain about the intersection of state AIDS Drug Assistance Programs (ADAP) and Part D. Earlier this year, CMS rejected calls by AIDS advocates to allow ADAP expenditures to count as TrOOP. While it appears ADAPs will be able to provide assistance to





Medicare beneficiaries, ADAPs will have little incentive to do so as such expenditures virtually guarantee that recipients remain in the donut hole (no drug coverage) for the rest of the year.

Allowing ADAP expenditures to count as TrOOP would have helped already cash-strapped programs further stretch their budgets and provide continuity of care for a highly vulnerable population. It would have also provided a powerful incentive for states to invest in their ADAP with state dollars.

As such, some states (especially those with waiting lists) are moving ahead to remove ADAP recipients who qualify for Part D—a dangerous move for the health of these individuals. Because most people assisted by or waiting for ADAP have incomes below 200% of poverty and high drug costs, their out-of-pocket expenditures will make Part D completely unaffordable.

With remarkable shortsightedness, federal officials indicated recently that they will require enrollment in Part D as a condition to receive ADAP (in states that don't exclude them altogether). This will essentially force a monthly premium upon one class of ADAP recipients and pave the way for new, arduous requirements to further diminish services to this vulnerable population.

In addition to ADAP appropriations advocacy, people with HIV/AIDS and their allies need to urge state officials to preserve ADAP benefits for eligible Medicare recipients, explore coverage for Part D premiums and deductibles, and enlist state support in advocacy to make Part D less onerous.

#### PART "DEVIL'S IN THE DETAILS"

It's not hard to imagine disabled and elderly recipients needing help understanding the program, their options, and how to avert a life-threatening gap in drug coverage. Because of the complexity of the program and the many variables for recipients at different income levels, Medicare recipi-

ents are encouraged to consult with a benefits specialist.

Medicare-eligible ADAP recipients and the dual eligible are especially encouraged to carefully plan their enrollment and use of Part D. Dual eligibles will be in a particularly precarious situation at the end of this year when their prescription drug coverage through Medicaid ends by law. They will need to rely solely on Part D for their medication needs.

Thankfully, their out-of-pocket costs will be lower than most Part D recipients and they will have the ability to switch plans at any time—an option not readily available to most recipients. Still, dual eligibles are among the poorest and sickest in the Medicare population and a gap in treatment could prove fatal.

Try the Project Inform Treatment Hotline for more information; call 1-800-822-7422.

#### PART DARWINISM

In the best of cases, Part D will evolve into a more comprehensive and less-Byzantine program that provides affordable benefits to retired and disabled workers. But this will happen only if we remain committed and vocal about its shortcomings, and continue to press government officials for real and immediate remedies. ☒

*David Ernesto Munar is the AIDS Foundation of Chicago's associate director. Thanks to Tom Coburn of Health & Disability Advocates for help in preparing this article.*

#### RESOURCES

**FACT Sheet:** Medicare and HIV/AIDS. Henry J. Kaiser Family Foundation (October 2004): [www.kff.org/hiv/aids/7171.cfm](http://www.kff.org/hiv/aids/7171.cfm).

**FACT Sheet:** Excellent fact sheet from Gay Men's Health Crisis in New York City. Request from Laura Caruso, [laurac@gmhc.org](mailto:laurac@gmhc.org). If you have technical questions about Part D that you would like to have answered by the Centers for Medicare and Medicaid Services, she suggests contacting Andrea Weddle at [aweddle@idsociety.org](mailto:aweddle@idsociety.org). Visit [www.taepusa.org/medicare\\_resources.html](http://www.taepusa.org/medicare_resources.html) for advocacy tools around Medicaid and Medicare.

**Policy and Politics:** Medicare Prescription Drug Coverage. Article from the Bulletin of Experimental Treatments for AIDS (BETA), Summer 2005: [www.sfaf.org/treatment/beta/b57/b57\\_medicare.pdf](http://www.sfaf.org/treatment/beta/b57/b57_medicare.pdf).

**Tip Sheet:** People with Medicare and HIV/AIDS. Centers for Medicare and Medicaid Services, July 2005: <http://www.cms.hhs.gov/medicarereform/AIDS.pdf>.

**Medicare Part D Drug Benefit:** What You Need to Know. American Academy of HIV Medicine: [http://www.aahivm.org/medicare\\_drug\\_benefit\\_d.html](http://www.aahivm.org/medicare_drug_benefit_d.html).

**The New Medicare Prescription Drug Law:** Issues for Dual Eligibles with Disabilities and Serious Conditions. Kaiser Commission on Medicaid and the Uninsured, June 2004: [www.kff.org/medicaid/7119.cfm](http://www.kff.org/medicaid/7119.cfm).

**Do You Speak Medicare Part D?** Definitions of Selected Health Insurance Terminology Under Medicare Part D. Medicare Advocacy Center (July 2005): [www.medicareadvocacy.org/AlertPDFs/07.21.05.PartDSpeak.full.pdf](http://www.medicareadvocacy.org/AlertPDFs/07.21.05.PartDSpeak.full.pdf).

