

IMPROVE ACCESS TO LIFE-SAVING MEDICATIONS AND MEDICAL CARE FOR MEDICARE BENEFICIARIES WITH HIV/AIDS

An estimated 100,000 Medicare beneficiaries living with HIV/AIDS rely on Medicare for their medical care including prescription drug coverage and it is estimated that nearly 80,000 of them also are dually eligible for Medicaid coverage. Their lives depend on reliable, affordable access to medical care and a combination of antiviral medications to treat HIV disease along with a host of medications to address co-occurring conditions and treatment side effects.

Access to a broad array of prescription drugs—including but not limited to anti-retrovirals—is particularly important for this population because, in order to qualify for Medicare coverage, almost all have been significantly disabled by AIDS related conditions, suffer from advanced disease progression, and often have other severe health conditions.

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.

The following improvements are needed to ensure access to medically necessary prescription drugs for Medicare beneficiaries with HIV/AIDS.

Allow expenditures made by AIDS Drug Assistance Programs (ADAPs) to count toward the True-Out-of-Pocket (TrOOP) limit. While ADAPs may wrap around Medicare Part D by helping people with HIV/AIDS cover their Part D deductibles, co-insurance, and co-payments, these costs are currently barred from counting toward the “total out of pocket” cost limit known as TrOOP. TrOOP is the trigger that ends the coverage gap or “doughnut hole” and leads to catastrophic coverage. Currently, if ADAPs supplement Medicare Part D, the people they help remain in the “doughnut hole” and never reach the catastrophic coverage limit. This means that ADAPs must cover the full cost of the beneficiary’s drug expense for the remainder of the year. ADAPs are the payer of last resort and are funded through annual federal and state appropriations’ processes and have been severely underfunded in the last several years. States must prioritize these limited dollars to respond to the most urgent unmet HIV treatment needs in their states. ADAP dollars that must be used to supplement Medicare are dollars that cannot be allocated to other needy individuals who do not have Medicare coverage. Federal policy should support efforts to maximize Medicare coverage to meet the needs of Medicare beneficiaries with HIV/AIDS. Current policy also means that beneficiaries have access only to the ADAP formulary which in almost all cases is more limited than the Medicare plans. It makes no sense for ADAP Part D contributions to be treated differently than those made by the State Pharmacy Assistance

Programs, which are recognized for TrOOP purposes. We believe that the original intent of Congress was to treat ADAP expenditures in the same way as SPAP expenditures.

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. 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 but one antiretroviral. 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. To ensure reliable and ongoing coverage of the drugs required for successful HIV treatment, the protected class status and prior authorization protections should be written in statute and allow for inclusion of new protected classes, as necessary.

Require drug plans to cover new antiretrovirals within 30 days of approval by the Food and Drug Administration. By virtue of qualifying for Medicare, a majority of Medicare beneficiaries with HIV/AIDS are more treatment experienced than persons with HIV/AIDS who do not qualify for Medicare—and they are more likely to be resistant to available antiretroviral therapies, which means that the available drugs are no longer effective at suppressing HIV. Antiretroviral agents newly approved by the Food and Drug Administration (FDA) may be essential for many Medicare beneficiaries to maintain an effective anti-HIV treatment protocol. They should be added to all drug plans formularies within 30 days of FDA approval to ensure Medicare beneficiaries have access to new HIV therapies that could literally save their lives.

Designate people with HIV/AIDS as a special population granting them access to an open drug formulary. People with HIV/AIDS rely on a range of drugs outside of the antiretroviral class that many of the Medicare Part D drug plans are not adequately covering. In a survey of HIV medical providers, 83% of respondents reported that their patients with AIDS experienced problems getting their prescriptions since joining a Medicare drug plan. Of those who reported problems, 76% reported that patient's drugs were not covered by their drug plan and 75% went without medications. Medical providers reported that Medicare beneficiaries had trouble accessing a range of drugs including medications for HIV-related opportunistic infections, and hypertensive, mental health, cholesterol, pain and hepatitis medications.

Impose a nominal monthly cap on cost-sharing for people eligible for the low income subsidy 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 manage 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 "doughnut hole"

poses a serious threat to Medicare beneficiaries with HIV/AIDS who do not qualify for the low-income subsidy program. In 2006, "enhanced" plans played an important role in making drugs affordable during the "donut-hole" coverage gap. However, in 2007, the "enhanced" plan options offer much less generous coverage and are more expensive than in 2006. Also an "enhanced plan" option is not available in every state. 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.

Automatically provide the low-income subsidy to any Medicare beneficiaries that a state classifies as medically needy, without regard to whether or not they have met their spenddown 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 medically needy 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. This policy results in denying access to many who are truly "medically needy" but happen to have unusually low expenses in a CMS "snapshot" month. Fairness and efficiency support enactment of a federal policy that grants access to the low-income subsidy to any person whom a state Medicaid program has certified as a Medicaid-eligible. With such a policy, those who are truly unable to meet the cost sharing required under Medicare Part D will have access to a low income-subsidy and the life-saving prescription drug coverage they need.

IMPROVE ACCESS TO MEDICARE FOR PEOPLE WITH DISABILITIES



We strongly support **ending the two-year Medicare waiting period for non-elderly people with disabilities.** The waiting period, which 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 Medicare coverage. This retrograde policy can be devastating to people with HIV/AIDS and leads to deteriorated health status that

requires more costly treatment interventions after the waiting period—and shifts significant financial burdens onto individuals and families and Medicaid programs. Many people awaiting Medicare coverage are uninsured and under-insured. Commonly, they are forced to delay doctor visits and forego medically necessary treatment, even though they meet federal disability criteria, while they wait for their Medicare coverage to begin.

The HIV Medicaid and Medicare Working Group (HMMWG)

The HMMWG is a coalition of more than 100 national and community-based AIDS service organizations that represent HIV medical providers, advocates and people living with HIV/AIDS and community organizations that provide critical HIV-related health care and support services.

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