

## Medicare Matters

### Overview

Medicare is a United States federally funded health insurance program that provides medical care and related services to 41 million eligible individuals, including 35 million elderly beneficiaries and six million disabled persons (not elderly).<sup>i</sup> The latter category includes people living with HIV.

There are three components of the Medicare program. Part A covers inpatient hospital services, skilled nursing care, home health, and hospice care. Part B covers outpatient physician services, laboratory services, medical equipment, and preventive screenings (e.g., mammograms and other cancer screens). Part C is the provision of all Part A and Part B covered services through managed care plans. These plans are called "Medicare Advantage" plans.

Medicare is not a comprehensive insurance program that provides benefits at no cost to the beneficiary. In order for services to be covered, the program requires co-payments and deductibles. For example, beneficiaries must pay \$876 toward their own hospital care through a deductible before Medicare pays for comprehensive coverage.

One important service that currently is not covered by Medicare is prescription drugs, except those drugs that either are administered during a hospital stay or cannot be self-administered. This situation however will be corrected beginning in January 2006, with implementation of the new prescription drug benefit. In December 2003, the Medicare Modernization Act (MMA; P.L. 108-173) was signed into law. The MMA amends "title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the medicare program."<sup>ii</sup> Under MMA a new component, known as the "Part D" benefit, will be administered by private prescription drug insurance plans. Consumers will have a choice of which plan to enroll in, as the plans will have different formularies and provide varying levels of coverage for **each** prescription medication. Beneficiaries will need to meet premium (monthly fee), deductible, and cost-sharing requirements. Some beneficiaries will be eligible for a low-income subsidy that waves or limits the premium and deductible. Regulations for the Part D

benefit are still being written by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS).

In the meantime, Medicare beneficiaries may choose to participate in the Medicare-approved drug discount card program. This program is meant to offer some immediate financial relief to Medicare beneficiaries who do not currently have access to prescription drug coverage through Medicaid or any other insurance (except a Medicare Advantage or Medigap policy). The discounts vary from plan to plan, as do the enrollment fees that people will have to pay to enjoy the benefits. The discount cards expire on December 31, 2005; Medicare's new prescription drug benefit starts on January 1, 2006.<sup>iii</sup>

Currently, Medicare beneficiaries often rely on supplemental Medigap insurance plans, private insurance, or Medicaid to create a comprehensive benefit package that can support services not covered by Medicare, including prescription drugs. Supplemental Medigap plans can be expensive and they may not meet the care and treatment needs of HIV+ people—such plans, for example, may provide limited or no prescription drug coverage. Medicare beneficiaries who are also eligible for Medicaid (called "dual eligibles") generally get their prescription drug coverage through Medicaid.<sup>iv</sup>

### Medicare and AIDS

While the number of people dying from AIDS defining conditions has declined as a result of successful drug therapies, the increasing numbers of people living with HIV highlights the need for comprehensive medical care services.<sup>v</sup>

Life-sustaining anti-retroviral therapies for HIV+ people cost an average of \$10,000 to \$12,000 dollars per person each year. Additional physician visits, lab tests, and prophylactic drugs (drugs to prevent or treat opportunistic infections) can bring the costs to as much as \$20,000 per year.<sup>vi</sup> These treatments are critical for many people who often cannot access them without prescription drug coverage.

Medicare is the second largest source of federal spending for HIV care and treatment; the first is Medicaid. Approximately one out of every five HIV+ people in the United States who is receiving regular medical care depends on the Medicare program for at least part of their health insurance. The Medicare program spent almost \$2.4 billion for HIV care in fiscal year (FY) 2003.<sup>vii</sup> These dollars amounted to 23.2% of federal government spending on people with HIV in FY 2003.<sup>viii</sup>

While Medicare provides important health insurance coverage for people living with HIV, there is a long waiting period before disabled individuals under age 65 can begin to receive Medicare. Individuals living with HIV are eligible for Medicare if they are disabled and have worked long enough to qualify for Social Security Disability Insurance (SSDI). People under 65 qualify for SSDI after the Social Security Administration (SSA) determines that they are disabled. For individuals living with HIV, a disability determination usually comes after an AIDS diagnosis. According to the SSA, you are eligible for a disabled classification “if you cannot do work that you did before and [SSA] decide[s] that you cannot adjust to other work because of your medical condition(s). Your disability must also last or be expected to last for at least one year or to result in death.”<sup>ix</sup> Federal law requires that individuals wait five months after a disability determination is made before receiving SSDI benefits and an additional two years after first receipt of SSDI benefits before receiving Medicare. Ultimately, these requirements result in nearly a two-and-a-half year wait before a disabled individual under age 65 is eligible for Medicare. Most people HIV+ people on Medicare are disabled and receive SSDI.

Medicare beneficiaries with HIV are more likely to rely on Medicaid to supplement Medicare than the general Medicare population. Approximately 12-13% of people receiving care for HIV are dually eligible for Medicare and Medicaid.<sup>x</sup> Dual eligibles often have low incomes, significant health care needs, and chronic illnesses. The numbers of HIV+ people who are dually eligible is growing as people live longer with HIV and are therefore more likely to qualify for Medicare.

### Future Implications for Medicare Beneficiaries

The future success of Medicare’s ability to meet the needs of people living with HIV will depend largely on the implementation of the new prescription drug benefit beginning on January 1, 2006. While it is promising news that HIV+ Medicare beneficiaries will soon have access to such a benefit, there are still a number of details that need to be clarified before it becomes evident how suitable the new benefit will be for the beneficiaries living with HIV. The following are among AIDS Action’s concerns about the Part D prescription drug benefit:

- It is unclear how comprehensive formularies of the Part D benefit plan will be. For the treatment of HIV to be successful, patients need access to all FDA approved anti-retroviral medications, as well as medications used to treat and prevent opportunistic infections.
- Dual eligibles will only be able to access the Medicare drug benefit even though in many states the Medicaid program has a more comprehensive formulary. As a result, these beneficiaries may be left with a less comprehensive prescription drug benefit than they currently receive under Medicaid. The inability of the Medicaid program to supplement Medicare Part D coverage could leave some dual eligibles worse off than if they were able to maintain Medicaid coverage for their prescription drugs.
- Premiums will be waived for dual eligibles who enroll in a prescription drug plan, as long as the premium of their chosen plan is equal to or less than the premium for an average cost plan in their area for basic coverage. This population, often the sickest and poorest of Medicare beneficiaries, could be left without access to the full range of prescription drug plans in their area.
- Cost-sharing requirements, though they will be minimal for dual eligibles, may still be prohibitive. Medicaid law stipulates that individuals cannot be denied care or services for failure to pay cost-sharing; however, they can be held responsible for their payment. Medicare does not have such a stipulation; therefore, some beneficiaries may be unable to access their medications.

<sup>i</sup> The Henry J. Kaiser Family Foundation. (2004). *Medicare At a Glance*.

<sup>ii</sup> Public Law No: 108-173. *Medicare Prescription Drug, Improvement, and Modernization Act of 2003*.

<sup>iii</sup> AIDS Action. (2004). “Health Organizations Host Congressional Briefing on New Medicare Prescription Drug Cards.” *The Weekly Update*, 3(1).

<sup>iv</sup> This benefit will change in 2006, with the implementation of the Medicare Part D benefit. Dual eligible beneficiaries will only be able to use the Medicare drug benefit.

<sup>v</sup> For more information on HIV/AIDS statistics, see the CDC’s *HIV/AIDS Surveillance Report, Volume 14*.

<sup>vi</sup> Kates, Jennifer. (2004) *Financing HIV/AIDS Care: A Quilt with Many Holes*. The Henry J. Kaiser Family Foundation.

<sup>vii</sup> Ibid.

<sup>viii</sup> Johnson, Judith A. and Coleman, S. (2003) *AIDS Funding for Federal Government Programs: FY1981-FY2004*. Congressional Research Service.

<sup>ix</sup> Social Security Administration. *What We Mean By Disability* (Web page). <http://www.ssa.gov/dibplan/dqualify4.htm> [Retrieved: June 7, 2004].

<sup>x</sup> Kates, J. *Financing HIV/AIDS Care*.