

FACT SHEET

Medicare and HIV/AIDS

February 2009

Medicare, the federal health insurance program for people age 65 and older and younger adults with permanent disabilities,¹ is an important source of health coverage for an estimated 100,000 people with HIV.^{2,18} It covers approximately one fifth of people with HIV estimated to be receiving care in the United States, but only a relatively small fraction (<.01%) of the overall Medicare population of 45 million.¹ With the implementation of the Medicare Part D prescription drug benefit in 2006, Medicare assumed an even more critical role for people with HIV, as it began to pay for prescription drugs.³

Medicare Beneficiaries with HIV

Most people with HIV on Medicare are under age 65 and qualify because they are disabled and receiving Social Security Disability Insurance (SSDI) payments (93% of beneficiaries²), which entitle them to Medicare after a two-year waiting period. A small share (7%) becomes eligible as seniors.² The number of people with HIV on Medicare has grown over time, reflecting growth in the size of the HIV positive population in the U.S. as a result of a steady number of new infections and an increased lifespan for people with HIV due to antiretrovirals (ARVs) and other treatment advances. Between 1997 and 2003, for example, the number of Medicare beneficiaries with HIV increased by 80% (from 42,520 to 76,500), and rose more rapidly among women than men.² Medicare beneficiaries with HIV are more likely to be male, under age 65 and disabled, Black, and to live in urban areas compared to other Medicare beneficiaries.²

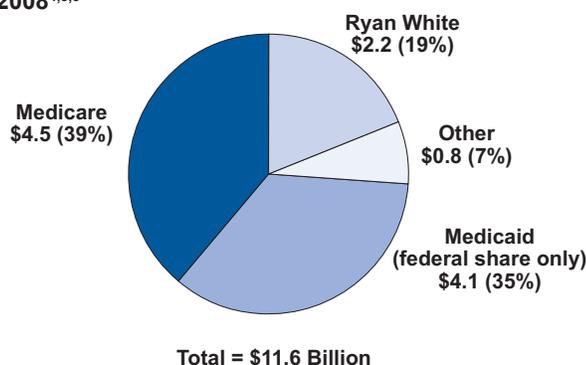
According to the Centers for Medicare and Medicaid Services (CMS) which administers the Medicare and Medicaid programs, Medicare spending on HIV became the single largest source of federal financing for HIV care in 2006, surpassing federal Medicaid spending on the disease for the first time.^{8,9,10,11} This was due to the implementation of Medicare Part D which provided medications to Medicare beneficiaries, including those with HIV, for the first time. Most Medicare beneficiaries with HIV are also covered by Medicaid (so-called “dual eligibles”) and for this group, the implementation of Part D shifted their prescription drug costs from Medicaid to Medicare.

Medicare Eligibility

There are three main pathways to Medicare eligibility (see Figure 2):

- Most people age 65 and older are entitled to Medicare if they are eligible for Social Security payments, which are based on “credits” earned through working.
- People under age 65 may be eligible for Medicare if they are determined to be “permanently disabled” due to a physical or mental impairment that prevents them from working for a year or more or that is expected to result in death, and they have earned enough work credits to receive SSDI payments (the number of credits needed depends on age). This is the main Medicare pathway for people with HIV. After disability is determined, federal law requires a 5-month waiting period before receipt of SSDI benefits followed by a 24-month waiting period for Medicare coverage. The two-year Medicare waiting period has been identified as a barrier to access for people with disabilities, including those with HIV, and legislation has been introduced to eliminate it.¹²
- People with end-stage renal disease (ESRD) or Lou Gehrig’s disease of any age are eligible for Medicare as soon as they begin receiving SSDI payments (with no 24-month waiting period). HIV disease, and some of its treatments, is associated with renal complications, including ESRD,¹³ and some people with HIV qualify for Medicare due to ESRD. Approximately 7% of Medicare beneficiaries with HIV have renal complications.²

Figure 1: Federal Funding for HIV/AIDS Care by Program, FY 2008^{4,5,6}



Medicare Spending on HIV Care

In FY 2008, Medicare spending on HIV totaled \$4.5 billion, representing 39 percent of federal spending on HIV care (Figure 1); it is expected to reach \$4.8 billion in FY 2009.^{4,5,6} HIV spending under Medicare has increased over time, as the number of beneficiaries has grown. Still, Medicare spending on HIV represents less than 1% of total Medicare spending.⁷

Figure 2: Medicare Eligibility Pathways for People with HIV/AIDS¹

| Eligibility Category | Eligibility Criteria |
|--|---|
| Individuals age 65 and older | Sufficient number of work credits to qualify for Social Security payments |
| Individuals under age 65 with permanent disability | Sufficient number of work credits to qualify for SSDI payments due to disability; eligible for Medicare after receiving SSDI payments for 24 months |
| Individuals with End-Stage Renal Disease (ESRD) or Lou Gehrig’s disease of any age | Sufficient number of work credits to qualify for SSDI; eligible for Medicare as soon as they start receiving SSDI payments (no waiting period) |

Medicare Benefits

Medicare provides broad coverage of basic health care services, and is organized into four parts:¹

- Part A (Hospital Insurance): pays for inpatient hospital services, skilled nursing facilities, home health services, and hospice care.
- Part B (Medical Insurance): pays for physician, outpatient, preventive services, and home health visits.
- Part C (Medicare Advantage): private plans (primarily HMOs) contract with Medicare to provide Part A, Part B, and, in most cases, the Part D drug benefit, to enrollees.
- Part D (Prescription Drug Benefit): voluntary outpatient prescription drug benefit implemented in 2006, and delivered through private plans that contract with Medicare; additional premium and cost-sharing assistance for beneficiaries with low-incomes and modest assets.

While Medicare provides basic coverage, it has relatively high cost-sharing requirements, no cap on out-of-pocket spending for seniors covered under Parts A and B, and does not cover all services that may be important to people with HIV, such as long term care and dental care. Most beneficiaries, therefore, have some form of supplemental coverage.¹ For beneficiaries with HIV, the main source of supplemental coverage is Medicaid; other important sources are the Ryan White Program and private insurance.

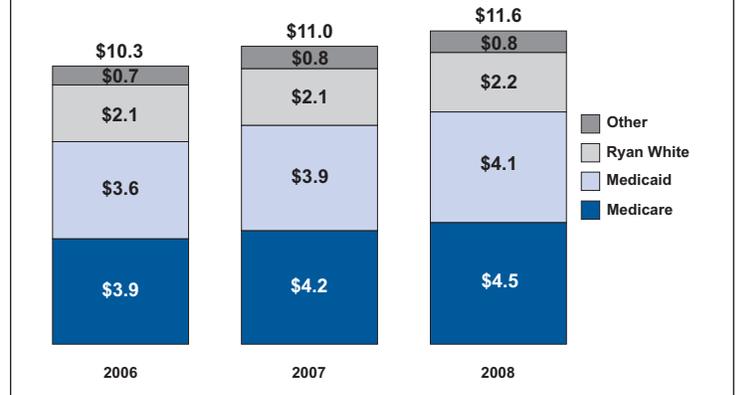
Part D's Role for People with HIV

Part D marked an important change for Medicare beneficiaries with HIV by offering subsidized prescription drug coverage under the program, with a catastrophic benefit.³ Part D plans cover all approved ARVs, consistent with CMS guidelines designating ARVs as one of six protected drug classes.⁹ Plans, however, do not have to offer other, non-ARV, drugs. CMS announced an interim final rule to protect ARVs and the other classes through 2010, but the rule has not yet gone into effect.¹⁴

Part D includes a "coverage gap" or "doughnut hole", during which no coverage is available until beneficiary expenses – called their "true out-of-pocket costs" (TrOOP) – reach a catastrophic level. Low-income beneficiaries receive subsidies during the gap and therefore face minimal drug costs in the gap. These subsidies serve to protect many people with HIV since they are much more likely to be low-income compared to the general Medicare population.¹⁵ In addition, even without subsidies, people with HIV tend to reach the catastrophic level relatively quickly, given the high cost of ARVs.⁹

For those on Part D without low-income subsidies or who still need help paying for medications, the AIDS Drug Assistance Program (ADAP) of Ryan White plays an important role. State ADAPs facilitate beneficiary enrollment in Part D, pay for their Part D premiums and co-payments, and most cover medication expenses during doughnut hole.¹⁶ One issue that has arisen, however, is that ADAP payments during the doughnut hole do not count toward TrOOP, effectively shifting catastrophic drug costs from Medicare to ADAP. Some have raised concerns that ADAPs are treated differently than other programs, such as State Pharmacy Assistance Programs (SPAPs) whose payments do count towards TrOOP in the gap, and that this puts an added strain on limited ADAP resources. Legislation has been introduced to allow ADAP payments to count toward TrOOP.¹⁷

Figure 3: Federal Spending on HIV Care Through Medicare, Medicaid, and Ryan White, FY 2006–2008 (in billions)^{4,5,6}



Future Outlook and Challenges

Medicare will continue to play an important role for people with HIV, particularly now that it helps pay for prescription drugs. Part D's subsidies for low-income beneficiaries and catastrophic coverage are especially critical for people with HIV. Looking forward, ongoing policy challenges concerning Medicare's role for people with HIV include: the 24-month waiting period before SSDI recipients can obtain Medicare benefits; the absence of a cap on out-of-pocket spending; and gaps in existing coverage, such as Part D's coverage gap and current policy which does not count ADAP payments during the gap toward TrOOP. Ongoing efforts to monitor Part D are needed to assess whether plans maintain coverage of ARVs, add newly approved ARVs to formularies, and to what extent they offer non-ARV medications that may be needed by people with HIV. Given the importance of Medicare for people with HIV, this population has much at stake in the larger national discussion around the future of the Medicare program.

References

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