Medi - Mess

In 2006, Karen Bates, who qualifies for both Medicare and Medicaid, will get her HIV meds through a new, “modernized” plan--or will she?

June 1, 2005 By Tim Murphy

Karen Bates, 51 and HIV positive, was a paralegal in Columbia, South Carolina, until a stroke felled her in 1998. Unable to work and struggling daily with dizziness and memory problems, Bates is fortunate in one way: She belongs to a well-insured class of 7 million American “dual-eligibles,” people who receive Medicare, due to age or long-term disability, *plus*, Medicaid, due to low income. Medicare gives Bates access to doctors and hospitals—and Medicaid pays for the HIV meds and other drugs she needs to stay alive. But in late 2003, Congress passed the Medicare Modernization Act—only one in a series of moves by the Bush administration to “streamline” health-care coverage. The act’s centerpiece is a new prescription-drug plan, effective January 2006. It requires seniors and chronically disabled folks (like some HIVers) to get their meds not from a central state source, as Medicaid provides, but from a range of private drug-plan options. “It’s dizzying,” Bates says. “My house is inundated with paper. You don’t even know where to start.”

Beyond its complexity, the “modernization” plan (Bates calls the name “doublespeak”) is most controversial for barring the government from negotiating with drug companies for the lowest possible med prices. Big pharma lobbied hard for this provision, raising the question of who benefits from the new system. Indeed, it’s not clear that those plans will cover all the meds HIVers need. “What happens January 1, 2006?” Bates asks, her voice quavering. “All the rules change.” She and 60,000-odd dual-eligible HIVers face a future full of questions.

Dual-eligible PWAs are often “the poorest and the sickest” of HIVers, according to HIV-benefits advocate Lei Chou. He understands Bates’ fears: The program calls for private drug plans to cover at least two options per HIV drug class—but not every med in all four classes. It’s hard enough for PWAs, many with resistant HIV, to find a combo that can control their virus—and that they can live with. Finding one based on a limited med list may be impossible. What if, for example, you need the soon-to-be-approved protease inhibitor (PI) tipranavir because of resistance to other PIs—but your plan covers only Kaletra and Reyataz? “People with AIDS have to be able to move to another drug immediately,” says the AIDS Institute’s Carl Schmid, who unsuccessfully lobbied with other AIDS advocates for the Medicare plan to guarantee coverage of all HIV meds. “We don’t know if the plan they get on [in the new Medicare program] is going to have that drug.” This doesn’t mean Bates *won’t* get all her meds, including Truvada and Viramune as well as Neurontin, Valtrex and

meds for GI problems and allergies—but she will likely have to jump through hoops to do so. As Chou says, “there’s nothing concrete right now.” (But that doesn’t mean there’s nothing you can do—see “Preparing for the Unknown,” right.)

Peter Ashkenaz, a rep for the Centers for Medicare and Medicaid Services (CMS), the federal agency implementing the new Medicare drug program, delivers a mixed message. “All of these [HIV meds] have to be on the formulary” of any drug plan included in the program, he insists. But moments later he adds, “My guess is you’re going to find that one plan offers [a certain drug] and the other does not,” noting that plans will have to “provide strong justification” for withholding key meds. HIVers denied a needed drug will likely be entitled to a fast-track appeals process, he says. CMS has promised that if your doctor deems a drug medically necessary, the plan must provide it.

Your best bet? Choose a drug plan carefully, zooming in on those that offer the widest array of HIV meds you might need now or for your next regimen. CMS says it will automatically enroll all 6.3 million dual-eligibles by fall 2005, so keep an eye on your summer mail. Once you get that notice, you will need to review your automatically selected plan, compare it to other available plans, decide which one you want and switch if necessary. (Dual-eligibles can change plans anytime if needed, but that means more paperwork.) But participating drug plans, which are signing on to the program in dribs and drabs, aren’t required to post their formularies, or drug menus, until mid-October, leaving only 10 weeks for decision making. When the plans are posted, says Ashkenaz, you can compare the drug formularies by calling 800.633.4227 or visiting www.medicare.gov.

Bates is preparing by talking to her doctor now, reviewing which drugs she might need in the future and then trawling for plans that include those meds (this gives “sequencing” a new meaning!). And once the enrollment notice arrives and the formularies become public, she says she’ll consult her pharmacist to help her choose the best plan.

As she weathers what she terms “all this immune-damaging stress,” Bates at least has her dog Missy to comfort her on days when she’s not even feeling up to making her support group. “She was a rescued child,” says Bates of the mutt. “I adopted her when she needed a home.” Bates hopes she can make the new Medicare drug plan rescue her.

PREPARING FOR THE UNKNOWN

Dual-eligible HIVers anxious about Medicare’s new drug plan can…

FIND information on the Medicare act at www.cms.hhs.gov/medicarereform. Or call the Center for Medicaid and Medicare Services toll-free at 877.267.2323 (TTY: 866.226.1819).

CONNECT with help. Lei Chou recommends a sit-down with a case manager at your local AIDS service organization; Karen Bates says turn to your doc and pharmacist.

DIG deeper. For detailed coverage, click on “Advocacy,” then “Medicare” at www.hivma.org.

NOT DUAL-ELIGIBLE? THE MEDICARE MODERNIZATION ACT AFFECTS YOU, TOO:

- About 30,000 HIVers on Medicare alone will now get their meds through the program. This may remove some pressure from overtaxed AIDS Drug Assistance Programs (ADAPs), says the AIDS Institute's Carl Schmid.
- Unlike dual-eligibles, who pay no premium and whose copays will not exceed $3 per prescription, in 2006 regular Medicare drug-plan users will shell out an average $35 monthly premium and a $250 deductible, then pay into a complicated cost-sharing system that could push the annual out-of-pocket beyond $3,600 for HIVers with costly drug regimens.
- For a relatively simple plan explanation, click on "Fact Sheet" at www.kff.org/medicare/7044.cfm.

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