

2007 Costs and Coverage of Antiretrovirals Under Medicare Part D for People With HIV/AIDS Living in North Carolina

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Abstract

Background: Effective January 1, 2006 Medicare Part D became a new source of prescription drug coverage for people with HIV/AIDS in the United States. The implementation of Part D has affected access to antiretrovirals for people with HIV/AIDS. In North Carolina, access can be difficult because of the state's struggling safety net programs and the growing HIV-infected populations among Blacks and in poor rural counties. This analysis examines Medicare Part D antiretroviral coverage in 2007 for beneficiaries with HIV/AIDS in North Carolina, particularly those who did not qualify as dual eligibles or for a full low-income subsidy.

Methods: Data describing program coverage were obtained from the Web site www.medicare.gov and descriptive analyses were performed to assess changes in antiretroviral coverage in Part D prescription drug plans in North Carolina.

Results: Most of the 26 antiretrovirals are covered in some way by 76 North Carolina prescription drug plans. There may be variability in coverage however associated with (a) antiretroviral classification within formularies; (b) drug premiums; (c) whether premiums can be waived; (d) annual deductibles; and (e) whether coverage is provided in the "doughnut hole."

Limitations: The data may not reflect actual patterns of drug use and realized access to the drugs. The findings are limited to antiretroviral coverage in North Carolina's Part D offerings but could be generalized to other states with similar prescription drug plan costs and coverage.

Conclusion: These concerns continue to pose significant challenges to accessing antiretrovirals for Part D beneficiaries with HIV/AIDS in North Carolina. Variability demonstrated within prescription drug plans will continue, and beneficiaries with HIV/AIDS who do not qualify as dual eligibles or for low-income subsidies will need to evaluate these issues when selecting a prescription drug plan in future enrollment periods.

Key Words: HIV, AIDS, Medicare, antiretrovirals, health services accessibility

In many states, the implementation of Medicare Part D in 2006—a new source of prescription drug coverage for eligible beneficiaries—had the potential to improve access to care for people with human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) given the critical role of antiretroviral treatment in their care. Along with state-sponsored AIDS Drug Assistance Programs (ADAPs), Medicaid, and industry-sponsored Patient Assistance Programs, Part D could strengthen the tenuous health care safety net¹ by providing drug coverage for people with HIV/AIDS who are under the age of 65 years and who qualify for Social Security Disability Insurance payments (and thus Medicare) as a consequence of HIV-related disabilities.²

Concerns persist, however, that Medicare Part D jeopardizes access to AIDS care for some patients because Medicaid, as of 2006, no longer provided drug coverage for dual eligibles (persons on both Medicare and Medicaid);³ some states require all of their ADAP clients to enroll in Part D;⁴ and a new kickback statute may make companies sponsoring Patient Assistance Programs criminally liable if they compete with the Part D program.⁵

North Carolina is an example of a state where Medicare Part D could have important consequences for the safety net as Part D becomes a source to cover AIDS-related treatment for the poor with HIV/AIDS. In North Carolina access to antiretrovirals is an ever-increasing problem because of increases in the number of people infected by HIV and the state's struggling ADAP and

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Patient Assistance Programs. HIV-infection growth rates are growing rapidly among Blacks and those living in poor rural counties. As of December 31, 2006 North Carolina reported 15 746 AIDS cases with 67% of those cases among Blacks (well above the national average of 40%) at an annual rate of 36.6 per 100 000.⁶ In the same surveillance report, two rural counties in North Carolina—Wilson and Edgecombe counties—had 3-year average incidence rates from 2004-2006 of greater than 30 per 100 000.⁶ As the number of AIDS cases continues to increase, the role of Part D will grow over time. Indeed, the proportion of those required to use Part D in North Carolina will expand for 3 major reasons: (a) ADAP clients may have no other choice but to enroll in a prescription drug plan (PDP) under Part D;⁴ (b) the roughly 18% who are dual eligibles⁷ are automatically enrolled into prescription drug plans; and (c) the future of company-sponsored Patient Assistance Programs remains uncertain.⁵ This article will describe the 2007 landscape of prescription drug plans covering antiretrovirals in North Carolina with a focus on the coverage and cost implications for HIV-positive beneficiaries, particularly for those who do not qualify as dual eligibles or those who may not qualify for a full low-income subsidy to help with paying the out-of-pocket costs for their antiretrovirals.

Medicare Part D Vernacular

Medicare Part D has its own nomenclature. Table 1 presents terms and definitions that will be used throughout this article.⁸

Methods

Data were obtained from the Web site www.medicare.gov in the period May 16-18, 2007. The number of PDPs offered in North Carolina and their general out-of-pocket costs were identified under “Learn More About Health Plans In Your Area” for North Carolina.⁹ The result was a list of the number of stand-alone PDPs and Medicare Advantage-Prescription Drug (MA-PD) plans, their monthly premiums, annual deductibles, and whether or not they cover any classifications of medication in the “doughnut hole.” The doughnut hole refers to the gap in coverage when no prescription drug benefit is available; an enrollee must pay a designated amount of out-of-pocket drug expenses before coverage continues.⁸ Stratifying

these PDPs by type, descriptive statistics were calculated that included median and ranges for monthly premiums and frequencies for annual deductible categories, number of PDPs covering generics in the doughnut hole, and number of PDPs offering \$0 monthly premiums to beneficiaries who qualify for a full low-income subsidy.

Next, 26 antiretrovirals approved by the US Federal Drug Administration were selected under “Formulary Finder” for North Carolina within www.medicare.gov.¹⁰ The result is a list of the PDPs that cover all or a majority of the 26 antiretrovirals. In accessing each PDP, additional information is provided about each antiretroviral’s formulary status classification and whether or not there are any restrictions set by the PDP for each antiretroviral. Two analyses were conducted describing

Table 1.
Medicare Part D Glossary

Coverage gap (or “doughnut hole”)	The coverage gap is the period when beneficiaries pay 100% of their Part D medication expenditures. In 2007, the coverage gap begins when the total spending for drugs reaches \$2400, exclusive of the beneficiary’s monthly premium, and ends when the beneficiary has reached \$3850 in true out-of-pocket costs (TrOOP). Afterwards, beneficiaries pay 5% of their costs as coinsurance or copayments.
Dual eligible	An individual who is eligible for both Medicare and Medicaid coverage. In the past, Medicaid paid for drugs for this population. Dual eligibles will now receive most of their prescriptions from a Part D plan. Their premiums and deductibles will be fully subsidized and their copayments will be zero or nominal (approximately \$3 for brand/\$1 for generics).
Formulary	A list of specific drugs covered by a Part D prescription drug plan (PDP).
Stand-alone prescription drug plan	The most common PDP that Medicare beneficiaries could enroll in if they wish to stay in traditional Medicare and receive drug coverage.
Low-income subsidy (or extra help)	Financial assistance that lowers the premiums and copayments for beneficiaries with income limits defined as a percentage of the federal poverty guidelines (FPG). To qualify for a full low-income subsidy, beneficiaries need to be below 135% FPG, or \$13 784 for an individual and \$17 820 for a couple in 2007. Full subsidy pays for the entire premium and deductible for recipients and nearly all of the cost-sharing below the out-of-pocket threshold.
Medicare Advantage Prescription Drug Plan (MA-PD)	A private managed care plan established under Medicare Part C (formerly known as Medicare + Choice) that also provides standard Part D drug coverage.
Prescription drug plan (PDP)	Also known as “Part D plans,” can be either stand-alone or MA-PD.
True out-of-pocket spending (TrOOP)	The amount a beneficiary must pay on covered drugs to reach catastrophic coverage. An individual’s payment of the deductible, coinsurance, and/or copayments and drug costs in the doughnut hole count towards TrOOP. For 2007 the TrOOP limit is \$3850. Currently, the Part D premium and ADAP subsidies do not count towards TrOOP.

Source: A Medicare drug benefit glossary. MedicareRxMatters Web site. http://www.medicarrxmatters.org/People/Glossary/index.asp#partial_subsidy. Accessed May 27, 2007.

antiretroviral coverage and cost-sharing responsibility within North Carolina PDPs. The first analysis focused on the number of PDPs classified by formulary status and restrictions (prior authorization and quantity limits) set by PDPs for each of the 26 antiretrovirals. Analysis involved producing a summary table that was a total count of the number of PDPs (a) in each tier of the formulary status and (b) that had quantity limits or prior authorization for each of the 26 antiretrovirals. The second analysis looked at antiretroviral coverage classified by formulary status for each North Carolina PDP. The first step of this analysis involved calculating a total count of the number of antiretrovirals covered in each tier for each PDP. The second step involved stratifying the PDPs by type (stand-alone or MA-PD) and by the number of antiretrovirals they covered within each tier. These data were presented in bar graphs to demonstrate clustering patterns of the number of antiretrovirals covered by the PDPs.

Results

Overview of North Carolina Prescription Drug Plans

A total of 51 stand-alone prescription drug plans and 41 MA-PD plans are offered in North Carolina. Fifty of the stand-alone PDPs cover all or a majority of the antiretrovirals; only 26 of the MA-PD plans offer this extent of coverage. (See Table 2.)

In 2006, only one of the stand-alone PDPs—Humana PDP Complete—offered coverage of brand-name drugs for participants caught in the doughnut hole. The plan, however, converted to only covering generics and increased the monthly premium from \$50 to \$85 in 2007 as a way to reduce costs.¹¹ Variability also is demonstrated both within and across insurance companies (data not shown). For example, Humana offers Humana PDP Complete and Humana PDP Standard. Humana PDP Complete has a no annual deductible and generics are covered in the doughnut hole, but it does not offer \$0 monthly drug premiums for beneficiaries who qualify for a full-low-income subsidy. In contrast, Humana PDP Standard has a \$265 annual deductible and does not cover generics in the doughnut hole, but it offers \$0 monthly drug premiums for beneficiaries who qualify for a full-low-income subsidy. Variability is quite significant across insurance companies. For example, Partners Medicare Options Enhanced has a \$0 annual deductible and generics are covered in the doughnut hole, whereas Security Horizons Medicare Complete Choice also has a \$0 annual deductible but does not cover generics in the doughnut hole.

Analysis 1 evaluates the number of PDPs classified by formulary status, prior authorization, and quantity limits for each antiretroviral. A total of 26 antiretrovirals were selected that are considered standard of care to treat HIV-infected

Table 2.

Summary of North Carolina's Prescription Drug Plans Covering All or the Majority of Antiretrovirals

PDP Type	N	Monthly Premium Median (Range)	Doughnut Hole Coverage Generics	\$0 Premium For Low Income Subsidy	Annual Deductible		
					\$0	\$1 to \$264	\$265
Stand Alone	50	\$36.05 (\$17.80 - \$85.90)	30%	42%	62%	6%	32%
Medicare Advantage (MA-PD)	26	\$21.80 (\$0.00 - \$44.90)	19%	0%	81%	8%	12%

Source: Medicare Prescription Drug Plan Finder: Plans in Your Area.

<http://www.medicare.gov/MPDPF/Public/Include/DataSection/Results/ListPlanByState.asp>. Accessed May 16, 2007.

Monthly drug premiums for the 50 stand-alone PDPs range from \$17.80 (Humana PDP Standard) to \$85.90 (Humana PDP Complete). For the MA-PD plans, monthly drug premiums could be \$0, but the drug benefit premium is usually incorporated into the overall health care premium.⁹ Medicare Advantage Prescription Drug plans with monthly drug premiums range from \$5.70 (Security Horizons Medicare Complete Choice) to \$44.90 (Partners Medicare Options Enhanced).⁹ Annual deductibles range from \$0 to \$265. Forty-two percent of the stand-alone plans and none of the MA-PD plans allow for beneficiaries to pay a \$0 monthly drug premium if the participant qualifies for a full low-income subsidy. Thirty percent of the stand-alone and 19% of the MA-PD plans offer coverage of generics in the doughnut hole which means that beneficiaries with these plans only would need to pay copays for Tier 1 drugs.

Out-of-pocket costs have changed since Part D's inception.

patients; 24 are brand-name drugs and 2 are approved generics. (See Table 3.)

As mentioned, 50 stand-alone PDPs and 26 MA-PD plans cover all or the majority of the 26 antiretrovirals; 6 PDPs (3 stand-alone and 3 MA-PDs) do not cover Videx (Didanosine) and 2 MA-PD plans do not cover Reyataz (atazanavir sulfate). Both of these antiretrovirals are used to treat naïve patients, and Reyataz (atazanavir sulfate) is one of the preferred protease inhibitors.¹²

Within each PDP, the antiretroviral formulary's cost-sharing is classified into tiers. Tier 1 represents the lowest cost-sharing responsibility, and Tier 4 represents the highest cost-sharing responsibility. Tier 1 drugs are usually generics with copays anywhere from \$0 to \$10, or 25% of the drug's cost. Tier 2 drugs are delineated as "Preferred Brand" or "Formulary Brand" with copays ranging from \$17 to \$66, or 25% of the

Table 3.
Approved Antiretrovirals Covered by North Carolina's
Prescription Drug Plans

Protease inhibitors	Nucleoside reverse transcriptase inhibitors
Agenerase (amprenavir, APV)	Combivir (lamivudine and zidovudine)
Aptivus (tipranavir, TPV)	Emtriva (emtricitabine, FTC)
Crixivan (indinavir, IDV)	Epivir (lamivudine, 3TC)
Invirase (saquinavir mesylate, SQV)	*Retrovir (zidovudine, AZT)
Kaletra (lopinavir and ritonavir, LPV/RTV)	Trizivir (abacavir, zidovudine, and lamivudine)
Lexiva (Fosamprenavir Calcium, FOS-APV)	*Videx (didanosine, DDI)
Norvir (ritonavir, RTV)	Zerit (stavudine, d4T)
Reyataz (atazanavir sulfate, ATV)	Ziagen (abacavir sulfate, ABC)
Viracept (nelfinavir mesylate, NFV)	Epzicom (abacavir and lamivudine)
Nonnucleoside reverse transcriptase inhibitors	Truvada (tenovir disoproxil fumarate and emtricitabine)
Rescriptor (delavirdine, DLV)	Retrovir IV (zidovudine IV)
Sustiva (efavirenz, EFV)	Fusion inhibitors
Viramune (nevirapine, NVP)	Fuzeon (enfuvirtide, T-20)
Viread (tenovir disoproxil fumarate, TDF)	Single tablet regimen
	Atripla (efavirenz, emtricitabine and tenovir disoproxil fumarate)

Source: United States Department of Health and Human Services Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents. Washington, DC: Department of Health and Human Services; 2006.

Note: Brand name of antiretrovirals followed by their generic names in ().

* Indicates antiretrovirals that have generic versions approved by the Federal Drug Administration.

drug's cost. Tier 3 drugs are delineated as "Non-Preferred Brand" or "Brand" with copays anywhere from \$40 to \$60, or as high as 75% of the drug's cost. Tier 4 drugs also are called "Specialty" with copays anywhere from 25% to 33% of the drug's cost.¹³ Each PDP also indicated whether or not any restrictions were imposed on the antiretrovirals in the form of quantity limits or prior authorization, factors that may further affect access to specific drugs.

In Table 4 the data are organized to demonstrate the variability in which antiretrovirals are classified into the formulary status of the 76 North Carolina PDPs, beginning with the 2 generic antiretrovirals—Retrovir (zidovudine) and Videx (didanosine)—that have been classified into Tier 1 by the highest number of PDPs.

Retrovir (zidovudine) is classified in Tier 1 for all 76 PDPs, but Videx (didanosine) is not covered by 6 PDPs; it is classified as Tier 3 for 5 of the PDPs. The majority of the PDPs cover the Brand antiretrovirals at Tier 2. The cost-sharing for Atripla, Aptivus, Retrovir IV, and Fuzeon will be the highest since they are classified more often in Tier 3 and Specialty; Fuzeon is

classified as Specialty in 64 of the PDPs. Only 4 of the antiretrovirals—Aptivus, Emtriva, Reyataz, and Fuzeon—are subject to quantity limits. Some PDPs use quantity limits to restrict how much of a drug they will dispense at one time. Plans commonly limit dispensing to a one month supply or 90 to 100 days for so-called "maintenance drugs" for persons with chronic conditions such as HIV/AIDS.¹⁴ Only Fuzeon is subject to prior authorization which is a process whereby plans require clinical justification before dispensing a drug.¹⁴

Analysis 2 evaluated antiretroviral coverage classified by formulary status for North Carolina PDPs. Figure 1 illustrates antiretroviral coverage within the 76 PDPs' formulary status by presenting a summary of PDPs (stratified by type) by the number of antiretrovirals they cover in Tier 1 through Tier 4.

What is evident when looking at the 4 graphs is that all 50 stand-alone PDPs and 26 MA-PD plans cover one or more antiretrovirals in Tier 1 or Tier 2. For the Tier 1 graph, most of the PDPs cover 1-2 drugs (generics); only one MA-PD plan covers 24 of the antiretrovirals at Tier 1. In the Tier 2 graph, most of the PDPs cover between 19 and 23 of the antiretrovirals; one MA-PD plan covers 24 antiretrovirals at Tier 2. The Tier 3 and Tier 4 graphs show that very few of the antiretrovirals

covered are categorized in these Tiers by the PDPs. Twenty stand-alone PDPs and 9 MA-PD plans cover no antiretrovirals in Tier 3 and the same is true for Tier 4 antiretroviral coverage among 9 stand-alone PDPs and 4 MA-PD plans. Although 2 of the stand-alone PDPs cover 17 antiretrovirals in Tier 3, and 5 stand-alone PDP and 5 MA-PD plans cover 15 of the antiretrovirals at Tier 4, the largest clustering of PDPs illustrated have only between 1 and 3 antiretrovirals in both Tier 3 and Tier 4.

Discussion

Similar to another study of prescription drug plans conducted in 2006,¹³ the 2007 landscape of Medicare Part D PDPs covering antiretrovirals in North Carolina continues to demonstrate several barriers for beneficiaries with HIV/AIDS living in the state and particularly for those who are not dual eligibles or who may not qualify for a full low-income subsidy. The barriers relate to changes and variability within and across Part D prescription drug plans that affect affordability, access, and

Table 4.
Number of Prescription Drug Plans Classified by Formulary Status, Prior Authorization, and Quantity Limits for Each Antiretroviral

Name of Antiretroviral	Formulary Status				Quantity Limits	Prior Authorization
	Tier 1	Tier 2	Tier 3	Specialty		
Retrovir (Zidovudine)	76	0	0	0	0	0
Videx (Didanosine) ^a	65	0	5	0	0	0
Crixivan	1	73	2	1	0	0
Epivir	1	73	2	0	0	0
Viramune	1	73	2	0	0	0
Zerit	1	70	5	0	0	0
Rescriptor	1	70	5	0	0	0
Emtriva	1	68	7	0	9	0
Sustiva	1	68	7	0	0	0
Ziagen	1	68	7	0	0	0
Viread	1	63	2	10	0	0
Lexiva	1	59	3	13	0	0
Agenerase	1	57	5	13	0	0
Combivir	1	57	5	13	0	0
Epzicom	1	57	5	13	0	0
Invirase	0	57	4	15	0	0
Norvir	1	57	5	13	0	0
Trizivir	1	57	5	13	0	0
Viracept	1	57	3	15	0	0
Reyataza	1	57	3	13	9	0
Kaletra	1	55	5	15	0	0
Truvada	1	51	11	13	0	0
Aptivus	1	41	13	21	6	0
Retrovir IV	1	40	32	3	0	0
Atripla	1	33	14	28	0	0
Fuzeon	0	5	7	64	17	10

Source: Formulary finder for prescription drug plans. <http://formularyfinder.medicare.gov/formularyfinder/>. Accessed May 16, 2007.

Note: Most antiretrovirals are covered by 76 PDPs; n = 76 when totaling number in each column under "formulary status."

^a Videx (didanosine) is not covered by 6 PDPs (n = 70), and Reyataz is not covered by 2 PDPs (n = 74).

utilization. Because of these barriers, state-sponsored ADAPs and industry-sponsored Patient Assistance Programs must continue to assist HIV-positive individuals for whom Part D is unaffordable. According to James Coburn, JD, a senior policy analyst with Health & Disability Advocates, the good news is that ADAP in North Carolina has recognized this problem and is allowing enrollees who were required to sign up for Part D to obtain their HIV-related medications from ADAP while in the doughnut hole.¹⁵ These costs covered by ADAP, however, do

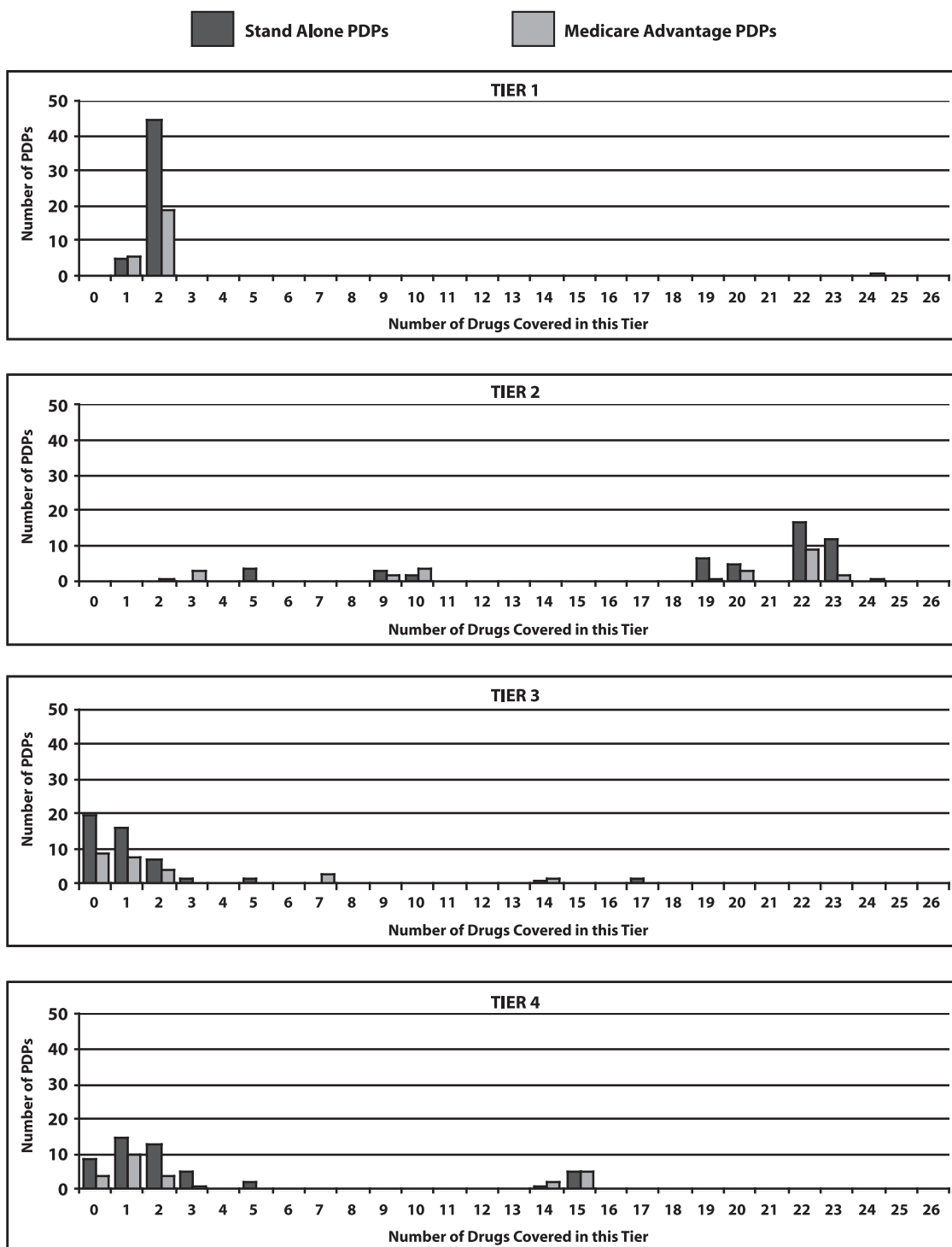
not count toward true out-of-pocket expenses—the amount a beneficiary must pay on covered drugs to reach catastrophic coverage—although recent Congressional hearings have been held that may change this current rule.¹⁶ Another disadvantage with using North Carolina ADAP is that the program requires prior authorization of Fuzeon,¹⁷ which in comparison is required by only 10 of the 76 PDPs covering antiretrovirals. Moreover, we do not know for how long ADAPs and Patient Assistance Programs will be able to bridge the safety net gap at the state

and national levels.

The descriptive analyses presented in this paper focus on antiretroviral coverage and costs in Medicare Part D after 2007 enrollment. On a positive note, the majority of the 26

FDA-approved antiretrovirals are covered by 76 North Carolina PDPs in Tiers 1 and 2, and most of these PDPs do not require quantity limits and prior authorization for these antiretrovirals. Challenges remain, however, relating to the

Figure 1.
Number of Prescription Drug Plans (PDPs) by Number of Antiretrovirals Covered in Each Tier^{9,10}



persistent and changing variability within these PDPs. The analysis demonstrated significant variability in antiretroviral classification in the formulary; only one MA-PD plan covered 24 antiretrovirals in Tier 1 whereas the majority of PDPs covered most antiretrovirals at Tier 2, and nearly 25% of the PDPs covered most antiretrovirals in Tiers 3 and 4. Furthermore, the one MA-PD plan covering 24 antiretrovirals in Tier 1—AETNA Medicare Open Plan—was not available to the 3 urban and rural counties in North Carolina with the highest cumulative AIDS cases (urban Mecklenburg and Wake counties and rural Pitt County) (data not shown). It is unclear how insurance companies make decisions about antiretroviral placement within the formulary status of PDPs since there is no correlation between antiretroviral placement and drug manufacturer (data not shown). Indeed, classifying most of the antiretrovirals at Tier 2 or greater makes the cost-sharing responsibility unaffordable for people with HIV/AIDS with incomes more than 150% of federal poverty guidelines. A second concern relates to the variability of other out-of-pocket costs when comparing PDPs. The analysis demonstrated that even within an insurance company there is variability pertaining to monthly drug premiums, annual deductibles, generic coverage in the doughnut hole, and availability of \$0 monthly premiums for beneficiaries qualifying for a low-income subsidy.

The implications of these out-of-pocket costs can be demonstrated in a case example of a North Carolina beneficiary with HIV/AIDS whose income is \$1700/month (200% federal poverty guideline) and who is enrolled in AARP MedicareRX (one of the top PDPs nationally in 2006¹⁸). This person would not be eligible for Extra Help, the low-income subsidy. The out-of-pocket costs would include a \$30 monthly premium that cannot be waived, no annual deductible, no coverage within the doughnut hole, and a cost-sharing responsibility per drug of roughly 25% to 33% (based on Tier 4 estimates). Without knowing this PDP's specific summary plan description, the beneficiary's annual cost-sharing responsibility, assuming the simplest antiretroviral regimen, Atripla (\$1150.88 for a 30-day supply¹⁹), would be \$360 in total monthly PDP premiums which cannot go towards true out-of-pocket expenses, and \$4258.03 in coinsurance. Table 5 roughly estimates this beneficiary's monthly out-of-pocket costs for Atripla in 2007.

Thus, this person would be spending 23% of his or her income to pay for out-of-pocket Part D drug costs (including premiums). Seventy percent of those out-of-pocket costs would be spent during the doughnut hole. In reality, the annual costs would be much

higher if this person was taking a combination of antiretrovirals and other medications to manage his or her disease, given that the 5% copays after the doughnut hole could be significantly higher.

The case example indirectly addresses the relationship between affordability, access, and utilization. As mentioned, people with HIV/AIDS may take a number of HIV and non-HIV-related medications to manage their HIV and comorbid conditions. It is not unusual for people with HIV/AIDS to change their medication regimens one or more times even within a year. A person with HIV/AIDS, however, cannot change to another PDP mid-year. Thus, he or she may discover the new medication is either not offered, offered at a higher tier, or offered with restrictions in his or her current PDP. This situation not only could make a change in regimen financially unaffordable, but also the patient could decide to stop taking an antiretroviral or stretch out the prescription of an antiretroviral to save money, leading to serious consequences of medication noncompliance and HIV resistance.

With so many issues to consider, how does a North Carolina beneficiary with HIV/AIDS choose a PDP from among the 76 with antiretroviral coverage? This paper may be useful in helping consumers and their advocates recognize the numerous factors—plan availability, antiretroviral tier classification, monthly premium costs, annual deductibles, and generic coverage (for HIV or non-HIV medications) offered in the doughnut hole—that need to be taken into consideration before selecting a PDP. The process of selecting a PDP could be very daunting for beneficiaries with HIV/AIDS who, compared to the majority of elderly Medicare beneficiaries, are more likely to be poorer and less well-educated. Indeed, HIV clinicians must continue to assist patients in understanding these issues and facilitate better access to affordable antiretrovirals within the struggling safety net for years to come. **NCMJ**

Table 5.
Estimated Beneficiary Out-of Pocket Costs for Atripla, by Month, 2007

Month	25% Coinsurance (until \$2400)	100% Pay (doughnut hole until \$3850 TrOOP* limit)	5% Coinsurance (catastrophic limit)	Monthly Payment (excluding premium)
January	\$287.72	\$0.00	\$0.00	\$287.72
February	\$287.72	\$0.00	\$0.00	\$287.72
March	\$24.56	\$1052.64	\$0.00	\$1077.20
April	\$0.00	\$1150.88	\$0.00	\$1150.88
May	\$0.00	\$1046.48	\$5.22	\$1051.70
June- December	\$0.00	\$0.00	\$57.54	\$57.54
Total annual coinsurance				\$4258.03
Total (coinsurance + \$360 premiums)				\$4618.03

* TrOOP - true out-of-pocket expenses

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