Advocating for Chronic Conditions Entitlements and Social Services

Celebrating over 18 years of service to the chronic illness communities

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Thank you for inviting me

- Always appreciate the opportunity to talk with new groups.
- People with rare chronic conditions need to be more aware of how access to the healthcare system works.
- Being connected to the community is the one of the best steps you can take to ensure access to care.

What do I want you to walk away with today...

- Understand some basics of Medicare
  - Part A
  - Part B
  - Part D
  - Supplements / Medigaps
  - Advantage Plans
- Understand some of the things to look out for when dealing with Medicare options.
- Remind you to look at the therapies and drugs you use and know how Medicare covers them.
- Remind you that the best resources are the people who understand your condition – don’t hesitate to call them when you have any questions!
The PSI A.C.C.E.S.S. Team

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PSI A.C.C.E.S.S.

- ACCESS recently became part of a non-profit organization, Patient Services, Inc., which allows us to continue our mission of the last 20 years.
- We are dedicated to helping people with rare chronic conditions access health care by navigating the often complex maze of health insurance and access to federal entitlement programs.
- Knowledge is the key to fighting the fear associated with chronic conditions – Rachel Warner, Founder ACCESS Program

PSI A.C.C.E.S.S. Helps in Many Ways

Helping Individuals by:
- Attorney representation throughout the Social Security Disability and Supplemental Security income claim processes
- Helping navigate through the disability process to achieve health care through Medicare / Medicaid
- Providing information about your rights and protections under the current insurance rules
- Exploring alternative sources of insurance that may be available
PSI A.C.C.E.S.S. Helps in Many Ways

Helping the Communities we serve by:
- Community outreach and education
- Providing speakers to regional and national groups

18 Times to Call PSI ACCESS

1. I quit my job
2. I lost my job
3. I got a new job
4. I’m looking for work
5. I’m no longer able to work
6. I reduced my hours at work
7. I’m about to lose my health insurance
8. I’m about to use up my health insurance
9. I just lost my health insurance
10. I can’t get health insurance
11. I just got married
12. I just had / adopted a child
13. My child has lots of medical bills that I can’t pay
14. My child just turned 18
15. My child is about to lose for college
16. My spouse stopped working
17. I’m getting a divorce
18. I’m moving

Our Communities
- Alpha1-antitrypsin deficiency
- chronic inflammatory demyelinating polyneuropathy
- Hemophilia and related bleeding disorders
- primary immune deficiency
- pulmonary arterial hypertension
- certain other auto-immune and neuromuscular disorders
Why Does Medicare Work The Way It Does?

- Isn’t there a way to make it make more sense?
- Why we need to look at the system as pieces of the pie.

A little history

- Prior to the 1930s health insurance was very rare. Health care choices were very few.
- First modern insurance created in 1929 when a group of teachers contracted with Baylor hospital in Texas for room, board and medical services in exchange for a monthly fee.
- Medicare was created in 1965 when it was not unusual to have separate hospital and doctor plans. Hospital coverage was automatic and doctor coverage was optional. Note: at that time private programs paid 75% of all health care costs. Medicare covered only those entitled to Social Security Payments.
- In 1972 Medicare was expanded to cover disabled individuals entitled to Social Security Payments (after 2 years)
- Today most private health plans incorporate both doctor and hospital coverage but Medicare holds over the old structure.
How do I get Medicare?

- Persons 65 or older
- Persons entitled to Social Security Disability benefits for 24 months*

*Persons diagnosed with ALS are entitled to Medicare the month in which they are entitled to their first Social Security Disability benefit check. Persons with end-stage renal disease are entitled to Medicare to treat their condition.

Medicare Part A

“Hospital Insurance” Program:
- Covers inpatient hospital services, skilled nursing facility and hospice care.
- Accounts for approximately 40% of all Medicare benefit spending (2008)
- Free for most recipients

Medicare Part B

“Supplementary Medical Insurance” Program:
- Covers physician services, outpatient services, lab tests, certain drug therapies (Dacogen / Vidaza)
- Primarily an 80/20 program
- Premiums range from $96.40 to $308.30 depending on income
- Deductible is $135
- Accounts for 27% of Medicare benefit spending (2008)
Notes on Part B

• You are responsible for 20% share of costs with NO Maximum out of pocket amount.
  – This includes those drug therapies covered by Part B
• Be sure you know if physician “accepts assignment”
  If not, your costs of physician services may be higher.
• Be sure to understand how your specific needs are covered – There are special rules for certain items such as blood transfusions or oxygen needs.

Help with Part B Costs

• Medigap / Medicare Supplements
• Advantage Plans ?
• Medicaid Programs
  – Dual Eligibles (SSI)
  – SLMB
  – QMB
  – Waiver programs
  – Spenddowns / Medically Needy

Medicare Part D

• Medicare Part D became available to all Medicare beneficiaries in January 2006
• When Medicare began, most healthcare did not rely on prescription drugs
• Prescription drugs as routine healthcare is relatively recent.
• By the time Part D became available most Medicare beneficiaries had need for drug coverage.
Medicare Part D

“Optional” Prescription Drug Coverage

- Provided by private plans with certain Federally mandated benefits.
- Covers mostly oral medications, but does cover limited injectibles and some inhaled therapies
- Relatively new benefit - Began in January 2006.
- Requires a separate premium. If you chose to wait to enroll until after the initial enrollment period, your premiums will be higher.
- These new plans are offered through private companies that contract with Medicare. In most areas, there are several plans to choose from with different costs and covered medications.

Quick Rules about Part D

• You must sign up for a Part D plan when you first become eligible or you will be financially penalized if you need to enroll later.
  - Unless you can show that you have been covered by an employer prescription plan that is at least as good as the Medicare Plan AKA Credible coverage
  - (I have never met an employer plan that was not at least as good as Medicare’s standard plan)

Standard Medicare Part D Plan

• Average Premium in 2009 - $364 / year or $30.33 / month
  - $295 deductible
  - 25% of drug costs until total drug costs = $2,700
  - 100% of drug costs until total drug costs = $6154
  - “Donut Hole” + $3,454.00
  - 5% of drug costs thereafter + $4,714.25
  - $4,714.25
Good News / Bad News

You have a choice of plans... but the plans vary widely!

Most use a 4 tier system
- Tier 1 - Generics
- Tier 2 - Preferred brand
- Tier 3 - Non preferred brand
- Tier 4 - Other!

Generics often bypass deductible costs

Which is the best one for me?

Step 1
- Know your drugs
- Know what drugs you may be looking at for the upcoming year

Step 2
- Plug the drugs into the computer system
  - SHIP office in your state
  - Agency on Aging

Step 3
- Determine the top three

Step 4
- Ask your providers if they can provide your therapy if you use each of the top choices

Help with Part D costs

- Help is based on Income and Assets of the beneficiary and spouse
- Resource levels are higher than those used to determine assistance through other programs
- Apply through the Social Security Office or your state Medicaid office
How Part D Assistance Works

• In 2009, for those whose income is between 135-150% of Federal poverty level and with assets below $11,990 for an individual or $23,970 for a couple:
  - Premiums on a sliding scale
  - Annual deductible of $50
  - Patient responsible for 15% up to $2250 ($380 annual out-of-pocket)
  - $5 brand / $2 generic co-pay thereafter

• In 2009, for those whose income is below 135% of Federal poverty level and with assets below $7,790 for an individual or $12,440 for a couple
  - Limited co-pays only, no premium, deductible or other out-of-pocket.

What Happened to “C”?

• Balance Budget Act of 1997 introduced “Medicare + Choice”
  - Has evolved – and now referred to as “Advantage Plans”
  - Allows beneficiaries to enroll in local private managed care plans
  - Plans must provide at least what “traditional A and B” provide plus
  - May or may not include prescription drug coverage

Notes on Advantage Plans

• Although Advantage Plans may offer more to you than traditional Medicare – beware
  - Does not play well with others
  - Be sure to investigate how your needs are covered
    • 80/20 may become 90/10 – Can you afford the 10?
    • Are your doctors in network?
    • Are other providers in network?
    • How difficult will it be to get your therapies?
    • What if you like to travel?
Medigap / Supplements

• Private Insurance policies that cover the gaps
  – Only pays the gaps for those items that the Medicare Program covers first.
  – Two broad categories:
    • Federally Standardized plans
    • Other plans allowed by some states

How do I get a Medigap Policy?
The Federal Rules Protect your right to purchase a Supplement

• You are entitled to a six (6) month open enrollment period when you become eligible for Medicare at age 65.

• You may be entitled to a “special enrollment period” when you lose other coverage - if you had other coverage through an employment policy – and you are entitled to Medicare and are over age 65.

All policies may not be available

• Not all Medigap Policies available for sale are guaranteed to you.

• Each state has chosen which policies must be made available through open and special enrollments.

• For some policies insurance companies may underwrite – look at your health condition to determine whether to sell you that policy.
For someone on Medicare due to disability UNDER age 65

Your access to a Medigap policy depends on the state in which you live

More information
• Agency on Aging
• SHIP office
• Insurance Agent
• State Insurance Commissioner

What do I do when my therapy is Denied?
• Talk with your providers!
  – They are in the best position to understand "Why" you received a denial
  – Ask the provider to appeal the decision – Most likely they already have the documentation needed to support your case
  – Ask the provider to verify it was not a clerical error.