Medical Insurance Programs for the Disabled

COBRA

COBRA is a federal law that allows persons on Long-term Disability (LTD) or Unemployment Compensation to purchase medical insurance at a Group rate, thus reducing the cost one would pay for an individual policy.

Medicare

Medicare is the federal health insurance system for people on Social Security Retirement and Disability Insurance. For those on disability insurance, an individual becomes eligible for Medicare two years after the date s/he became disabled as determined by Social Security. For instance, Social Security might determine a person became disabled one year before they applied. It may actually have taken eight months for the application to be approved, so after approval the wait might actually only be four months.

Once the waiting period is over, an individual will receive a letter of notification of eligibility for Medicare. No matter what a person does next, s/he will automatically be signed up for Medicare Part A, which is the hospitalization portion of the insurance.

What happens next with the other portions and options of Medicare becomes the decision of the individual. This next section will summarize the various choices involved in obtaining Medicare.

Obtaining Medicare means making a choice between two different Medicare Medical Insurance systems: Original Medicare, and Medicare Advantage.

Original Medicare

Original Medicare works directly through Social Security Medicare and consists of Part A — Hospitalization; Part B—Doctors' visits and outpatient services; and Part D— Prescription Drug benefits.

Under this Original Medicare system you can choose any doctor who is "Medicare approved." About 80% of all doctors in the U.S. are Medicare approved. Most doctors affiliated with hospitals take Medicare patients. Doctors are paid a fixed amount for each medical service as determined by Medicare. They agree, under most circumstances, to accept the fee Medicare will pay. These fees are generally lower than what a doctor will charge privately on a fee-per-service basis. Yet doctors participate because so many patients are covered, or because of medical institutional imperatives.

Unlike a Managed Care system or HMO you can choose any doctor or specialist that you wish to see. There is no necessity for choosing an in-plan doctor, or needing a plan referral for a specialist. In many cases, you can go to a doctor yourself; in other cases you simply need your own doctor to say that a procedure or a visit to a specialist is "medically-necessary." This is one of the advantages of Original Medicare as opposed to Medicare Advantage; see below.

Medicare Supplement policies

Part A and Part B cover only 80% of covered medical costs. Hence a person would be required to pay 20% of most medical bills. To meet these extra costs, private insurance companies offer what are generically called Medicare supplement policies. These policies for a premium cost paid by you cover the 20% gap, as well as deductibles, and offer some extra services as well. To be effectively covered, one should, if possible, buy a Medicare supplement policy. Under Medicare Parts A and B, with a Medicare supplement policy, most medical procedures and visits are covered. Institutional nursing home care, except for skilled nursing care, is not covered.

Prescription Drug Coverage—Part D

The last part of Original Medicare is *prescription coverage—Part D.* When you are accepted by Medicare, you will be given an opportunity to purchase, for a monthly premium, Medicare Part D prescription drug coverage from a private insurance company.
You should do so if at all possible, since to do so at a later time incurs significant financial penalties.
Some companies offer only one plan; other companies have different plans at different costs which offer a either decreased or increased benefit options.

Most prescription drug plans offer 3 levels of coverage. The costs can vary considerably amongst the Medicare contracted companies and by plan selected.

These plans use formularies (preferred drug and price lists) and a tier system, usually 3 tiers, with an additional top tier for specialty drugs (advanced treatments for illnesses like cancer or MS) which are paid at a determined percentage of cost. It is important to compare coverage for your routine medications under several company plans, because some plan formularies can be quite limited.

Co-payments can also vary by plan and increase by each tier, and those in the highest tier can be quite costly. This is another important consideration or even challenge when doctors might like to try you on some of the newly released drugs. Bring your formulary book with you to appointments, so you can determine whether you can afford a particular medication.

There is cap on the money spent by yourself and your plan towards covered drugs—this amount can change (in 2009, the cap was $2700), at which point, you enter "coverage gap" (aka a "donut hole"). You will then have to pay approximately the next $3,000 out-of-pocket. After this threshold is reached, you will obtain comprehensive coverage. Some "premier" plans provide some coverage within the "donut hole."

Paying for Medicare

Under Original Medicare, in addition to the cost for a Medicare supplement policy, Social Security deducts money from your Social Security check as a payment for Part B. When you are first offered Medicare insurance, you are given an option whether or not to take Part B. Some people who are insured on another policy or feel they cannot afford the deduction will consider not accepting Part B. However, it must be considered that there will be a heavy dollar penalty which increases with each month, should the person later want or need Part B. The same is the case with Part D. There is a premium for Part D. If you do not take Part D when it is first offered, again there will be a serious penalty should you want it or need it in the future.

Medicare Advantage

Unlike Original Medicare, which is administered through Medicare (Social Security Administration), Medicare Advantage plans are obtained through major private insurance companies. These plans roll Medicare Parts A, B, and D into one policy which you purchase for a certain amount per month. These are managed care plans of some sort, so you can only see permitted providers. Some of these plans are perferred-provider only (PPO), so the choice is wider, but the cost is more expensive. These plans may have a few more and sometimes less services than Original Medicare. You will need to check the policies and compare them carefully with original Medicare. These Advantage Plans also have deductibles and co-payments for most services, including major yearly deductibles for hospitalizations. Therefore, although the monthly premium may be less than a combined Part B, a Medex policy and the premium for Part D under original Medicare, you may end up paying more after the one premium, co-payments and deductibles. These plans may also include Part D, depending on which plan you buy. The lower the premium the less coverage and vice-versa.

Medicare Advantage Plans make money by contracting with Social Security to pay for a portion your coverage, plus your monthly premium, plus deductibles and co-payments. You should compare costs, benefits, and access to physicians carefully before choosing one of the two Medicare approaches. Many insurance companies provide a variety of plans; again for a lower premium you receive less coverage and vice-versa.

State and Federal Medicaid Insurance for the Disabled

For those on Supplemental Security Income (SSI), Medicaid coverage from the date of acceptance is automatic. Medicaid includes prescription drug coverage. Medicaid is a comprehensive medical insurance program that covers most general hospital and medical procedures. It also covers nursing home care. There are no premiums, although there may be small co-payments (not so small to a cash-strapped patient).

However, health and medical care providers may choose not to participate in Medicaid, and a majority of doctors do not "take" Medicaid patients. Hospitals do take Medicaid. So if you rely on Medicaid, you must find doctors willing to accept the coverage.

If you are on a form of state general assistance, you will also probably be covered by Medicaid.

In many states disabled persons with other income (under a certain dollar amount), not eligible

for financial assistance, may be eligible for "Medicaid only." For instance, in Massachusetts, a disabled individual with income around $1,000 per month can receive Medicaid. For persons receiving more income, there is a deductible. Residents of Massachusetts may receive benefits under the new Massachusetts Comprehensive Health Insurance Law.

Other State and Federal Health Insurance Programs

Some states have individual health insurance programs for working disabled adults. In Massachusetts such a plan is called CommonHealth. For a small monthly premium and a minimum number of working hours in a month, an individual may purchase a reasonable health insurance plan. Other states may have similar plans.

Free or sliding-scale care is mandated by federal law for hospital costs, including for doctors or health centers attached to hospitals. Depending on your income you may be eligible for free care. If you are over the eligibility amount, your cost may be reduced.

Health New State Care Laws

Some states are beginning to establish forms of universal health insurance or partial insurance. In Massachusetts, the Commonwealth has set up a mandatory universal system of coverage. All residents, unless they are covered by another "acceptable" health insurance policy, are required to participate under a system of penalties embedded in the state tax system, unless the state determines the person cannot "afford" the insurance.

In Massachusetts there are two policies. **Commonwealth Care** is low or no-cost health insurance for people who qualify. Prescription coverage is included. For those above the income limit, **Commonwealth Choice** offers many options from brand-name health plans.

Massachusetts residents can get up-to-date information on these programs from the Common wealth Connector

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So, a disabled person with or without Social Security must look at the various options and

determine what health insurance coverage is within their means and is best suited to their needs.

Free or low-cost prescription drugs for lower income individuals (Patient Assistance Programs)

Patient assistance programs (PAP's) are programs established by drug companies that provide free or low-cost drugs to individuals who are unable to pay for them. These programs may also be called charitable drug programs, indigent drug programs or medication assistance programs. Most prescribed drugs are available through these programs. All of the major drug companies offer patient assistance programs, but each company has its own eligibility requirements and application procedures.

To utilize these programs for your prescriptions, you must first find out which company manufactures each of your prescriptions. You then apply to each company for the specific medication(s) the company manufactures.

You must meet program income eligibility requirements, which may differ somewhat from company to company. Generally, individuals must have an income below 200% of the federal poverty standard, must be a U.S. resident or citizen, and must not have other prescription drug coverage.

There are two websites that provide comprehensive information on which medications are manufactured by each company, as well as how to obtain applications for each company's program. The Partnership for Prescription Assistance at www.pparx.org - phone number: 1-888-477-2669, will allow you to download company applications.

A second program, RxAssist - a Patient Assistance Program Center, www.rxassist.org - phone number, 401-729-3284, also provides comprehensive information and assistance. You must fill out each application carefully, according to instructions. Some companies require that the physician's office obtain the application form by calling the company.

After the form is completed and submitted, the company will decide if you are eligible. If an individual is approved, the medication may be sent directly to the patient, to the doctor's office, or to the patient's pharmacy - depending on the program. Most medications provided are free,

but some companies require a small co-payment.

Each company will have a different procedure for refills. These programs are extremely helpful for those who have no other means to pay for their prescriptions.

Delivery of medications-Some pharmacies may have home delivery services. If you are too sick to pick-up your medications, your local taxi company will often pick-up and deliver your medication for a fixed cost.