Questions & Answers
Q. What is difference between Medicare and Medicaid?

Medicare is the federal health insurance program that covers the elderly (>65) as well as people with permanent disabilities. The program pays for health care services, but there are gaps in Medicare’s benefits package. It does not cover all medical expenses (for example, it does not cover dental or vision services) or the cost of most long-term care. Medicare consisted of 3 parts, and the establishment of Medicare prescription drug coverage added a fourth part. Part A pays for hospital, short term skilled nursing home care and hospice. Part B is voluntary, although nearly all Medicare beneficiaries participate. It requires paying a monthly premium ($78.20 in 2005) and pays for doctor’s visits, lab tests and supplies. Part C consists of Medicare managed-care plans known as Medicare Advantage. Medicare beneficiaries can voluntarily enroll in a Medicare Advantage plan as an alternative to receiving services through Part A and B, although participants still must pay the Part B premium. Part D is new and will, for the first time starting January 1, 2006, provide prescription drug coverage to Medicare beneficiaries.

Medicaid is a federal-state program in which the federal government matches state spending, and states must follow federal rules to participate. Since Medicaid is administered (and partly funded) by the states, each state Medicaid program looks a little different. The federal government requires that all states cover low-income families, the disabled, and the elderly. All Medicaid programs provide prescription drug coverage. The broad flexibility in the Medicaid law has permitted states to respond to the needs of their low-income residents by providing coverage for a broad range of acute and long-term services—these services have been especially critical to people with disabilities (including many people with HIV/AIDS).

Q. Who qualifies for Medicare versus Medicaid?

All people with disabilities must be unable to work to qualify for either Medicare or Medicaid. Medicare requires individuals to have a sufficient work history (during which time individuals paid into the Social Security system through payroll deductions)—or they qualify on the basis of a spouse or parent’s work history. Medicaid, on the other hand, requires individuals to have low-incomes. In most states, individuals with disabilities with income below the Supplemental Security Income (SSI) level of 74% of the federal poverty level qualify for Medicaid. Individuals can receive both Medicare and Medicaid. In this case, Medicare acts as the primary payor and Medicaid supplements Medicare coverage by filling in for gaps in coverage and by paying Medicare Part B premiums and other Medicare cost-sharing. Roughly 2/3 of the Medicare beneficiaries with HIV/AIDS are dually eligible.

Q. What exactly will these first CMS mailings, sent out in May, tell Medicare beneficiaries?

Two different letters are being sent. Which letter a patient receives will depend on whether they are a dual eligible (as described above), or whether they are low-income but not qualified for Medicaid, primarily because their income is not quite low enough.

Those receiving the “dual eligible” letter will be informed that beginning January 1, 2006, their drug coverage under Medicare will end and instead their drug coverage will be provided through the new Medicare drug benefit. These patients do not need to do anything at this time. Individuals receiving this letter will automatically be enrolled in the low-income subsidy program and automatically assigned to a Medicare Prescription Drug Plan later this fall (although they will still be given an opportunity to select their own plan).
What you need to know.. (Continued)

To qualify for the low-income subsidy, annual income must be below 150% of the poverty level ($14,355 for a single person, or $19,245 for a couple) and they must have limited assets. A letter containing individualized applications for the low-income subsidy will be sent to eligible patients. These applications will be mailed out over an 8-week period starting at the end of May 2005.

Sometimes patients don’t know if they are in a Medicare Savings program and may wonder if they should still apply for the low-income subsidy. When in doubt, patients should be told to apply for the low-income subsidy. (When in doubt – fill it out!)

Q. What should patients do if they do not receive an application for the subsidy, but perhaps would qualify?

If patients do not receive an application for the low-income subsidy, but feel they may qualify, they should apply for the extra help. Applications will be accepted at Medicaid offices and at Social Security offices. Each state has its own Medicaid office to call, so you are encouraged to identify the number for Medicaid in your state. To get information regarding individual State Medicaid Programs, find your state at: http://www.cms.hhs.gov/states/default.asp. Individuals can reach Social Security at 1-800-772-1213. Beginning on July 1, patients can also apply online at www.socialsecurity.gov.

The Social Security Administration is the primary administrator of the low-income subsidy (extra help) program. Federal officials are clearly trying to steer all applications for the low-income subsidy to Social Security offices. While there is nothing wrong with applying at a Social Security office, Social Security will not screen individuals for Medicaid or the Medicare Saving programs. Individuals have a right to apply for the low-income subsidy at the Medicaid office. Medicaid programs, though often short-staffed, have an obligation to also screen applicants for Medicaid and the Medicare Saving programs. Therefore, you may wish to encourage individuals to apply for extra help and Medicaid at the Medicaid office.

You may also wish to advise your patients that Social Security and CMS are not sending out all letters about the low-income subsidy/extra help program at the same time. They begin going out May 27th and the ‘roll-out’ will last until mid-August. Thus, patients shouldn’t worry if their letters don’t arrive right away.

Also, the low-income application is designed with security in mind. Only original applications will be accepted; they cannot be photocopied! While another application can be mailed, it’s obviously good advice to tell patients not to lose the original application they receive.

Q. What do Medicare and Medicare/Medicaid patients need to do now?

If a patient receives a low-income subsidy application, they should fill it out and send it in. They should save any and all letters or information they receive from Medicare. They may need this information when they are enrolling in the actual pharmacy plans in the Fall of 2005. Mailing in the applications sooner will provide a quicker answer about whether they qualify for extra help when coverage begins on January 1. When in doubt, fill it out.

Q. Will the new Medicare drug benefit use the same formulary available now under Medicaid?

While the exact formularies will not be made public until the fall, it’s expected there will be differences. They will be offered by competing for-profit prescription drug plans, and some people believe they will be less generous than what is currently available under Medicaid. Medicare beneficiaries are promised that they will have the opportunity to pick from at least 2 different plans and most will have many choices of plans (possibly 10 or more).
Once federal officials announce which prescription drug plans are approved to participate in the Medicare prescription drug program, your patients may need assistance deciding which plan is right for them. Most individuals can switch plans only once per year, during the open enrollment period. Dual eligibles can switch from one plan to another every month.

Q. What about HIV antiretrovirals? Will they all be covered?

It appears all antiretrovirals will be covered. Federal officials have publicly stated that they will not approve any plan that does not have every currently approved antiretroviral on the formulary. This does not mean that plans cannot place restrictions on antiretrovirals. As with the private sector and Medicaid, plans remain free to restrict access to antiretrovirals through the use of prior authorization requirements, tiered cost-sharing (e.g. co-pays), and other techniques.

Q. What about other drugs?

CMS will require that formularies cover — at the basic coverage level — at least two drugs in each therapeutic class. Those classes are defined in new U.S. Pharmacopoeia Guidelines, available for review at: http://www.usp.org/pdf/drugInformation/mmg/draftModelGuidelines.pdf.

Drugs may be offered by plans at different co-pay levels and more generous plans may be available to patients willing/able to pay a higher monthly premium. Plans may have more restrictive policies with respect to commonly prescribed drugs—and drugs for which there is evidence of clinical equivalency. Since HIV therapy may necessitate access to specific drugs within a class that are otherwise interchangeable, formulary access to (and cost-sharing requirements for) non-HIV medications may be a particularly important consideration when advising patients on the selection of a prescription drug plan.

Q. Will I be able to appeal for formulary coverage on behalf of a patient if a drug is medically necessary?

Yes, although details of how the exception and appeals process will work are still unclear and may vary from plan to plan.

Q. My Medicaid/Medicare patients currently have no (or very limited) co-pays for their drugs; is this changing?

Yes. All dual eligibles, regardless of income, will be required to make co-pays of between $1 and $5 per prescription, per month. Further details of this will follow in future educational mailers from the AAHIVM.

Q. Today, if a Medicare/Medicaid patient can't afford their required co-pays, the pharmacist can't refuse to fill the prescription, will that change?

Yes. Under the new benefit, pharmacists can refuse to fill a prescription if the co-pay is not paid. Pharmacies are permitted to waive cost-sharing on an individual basis if they do not always waive the cost-sharing and if they have made a good faith effort to determine that the beneficiary is unable to pay their cost-sharing. It is uncertain how many pharmacists would waive the cost-sharing. State ADAPs are trying to figure out what they can or are willing to do to help with the co-pay situation. Federal funds may not be used to cover cost-sharing such as co-payments. Further details of this will follow in future educational mailers from the AAHIVM.
Q. How could these changes affect patient health?

The obvious fear is that patients unable to afford even these small co-pays may not take their medications as prescribed. Many studies have shown that when nominal co-pays are instituted in Medicaid, they present a significant barrier to access and adherence. HIV advocates, including state ADAP programs and the AAHIVM, are aggressively working on this looming problem. Further details of this will follow in future educational mailers from the AAHIVM.

Q. What's next?

May 2005 – Low-income subsidy letters and applications mailed to eligible clients over an 8-week period July 2005 – Dual eligibles, Medicare Savings Program participants and other eligible individuals will be notified that they are approved for the low-income subsidy October 2005 – CMS will release a list of approved prescription drug plans October-November 2005 – Dual eligible individuals will be automatically assigned randomly to a local plan. November 15 2005-May 15, 2006 – Open enrollment period for all Medicare patients. Dual eligibles may elect to switch their randomly assigned plan before January 1, 2006 and once per month thereafter. January 1 2006 – Medicare Part D prescription drug coverage goes into effect. Dual eligible patients will lose their Medicaid drug coverage and start their newly assigned Medicare Part D drug coverage.

Throughout this time, you will receive further information from AAHIVM. If you have specific question you would like answered in future additions of this Q&A, please, send your questions to Greg Smiley, Director of Public Policy, at greg@ahivm.org.

FOR MORE INFORMATION ON THE MEDICARE MODERNIZATION ACT AND DUAL ELIGIBLES, go to:

www.kff.org, the Henry J. Kaiser Family Foundation or www.cms.gov, The Centers for Medicare & Medicaid Services