

HEALTH INSURANCE & HEALTH CARE OPTIONS

INTRODUCTION:

The best way to avoid potential issues with insurance coverage is to know what is in an insurance policy and to follow the policy's procedures. This will help avoid issues before they arise. The first thing an individual should do is find out what type of health insurance coverage they have. For instance, whether or not they have a group or individual plan and whether or not an employer-sponsored group plan is insured or self-insured. This information is important because different laws apply depending on the type of plan in which individuals are enrolled.

An individually purchased plan is health insurance purchased directly from a health insurance company, and individuals pay the entire premium themselves. Most people with private insurance are covered by an employer-sponsored group health plan. This is where employees and their family members enroll in a plan through work and the employer generally pays a portion or all of the cost of coverage. If enrolled in an employer-sponsored health plan, the right to appeal disagreements about benefits through the plan's internal appeals process is determined by the federal Employee Retirement Income Security Act, or ERISA. Individuals may have other rights under state laws depending on whether the health plan is *insured* or *self-insured* (a.k.a. *self-funded*).

An employer-sponsored health plan is insured if, the employer purchased health coverage from an insurance company. An employer-sponsored health plan is self-funded if the employer pays for the health care costs of its employees directly, rather than purchasing insurance from an insurance company. It is sometimes difficult for employees to know whether their employer-sponsored plan is insured or self-funded because employers often contract with third parties to administer their self-funded plan. Those third parties are often insurance companies. Sometimes these third parties are called Administrative Service Organizations (ASO). Typically, ASO services include network provisions and claims processing, and the ASO is not responsible for the payment of the costs of services. Therefore, to find out whether their employer-sponsored plan is self-funded or not, employees should ask the person who administers the employee benefits at work (i.e., an HR representative). Another way to find this information is to look in the Summary Plan Description or Evidence of Coverage (EOC), the book an employee receives from an employer when they sign up for a health plan. If an individual cannot find out from their employer, the Summary Plan Description, or the EOC, they can contact the Employee Benefits Security Administration at the U.S. Department of Labor. This agency enforces ERISA's provisions and should be able to provide additional information.

Remember, federal and state legislation regarding health care reform may provide new access to health insurance, health care, payment, or appeals options. Look for updates to this manual online at www.CancerLegalResourceCenter.org.

I. TYPES OF PRIVATE HEALTH INSURANCE

- A. **Group vs. Individual Insurance:** *Group insurance* is usually offered through an employer or some form of a trade association (e.g., a union, etc.). *Individual insurance* means that an individual purchased a policy directly from an insurance company (e.g., when an individual purchases a plan from Blue Cross or Blue Shield, etc.). People who have group or individual health insurance plans are called "members" of that insurance company.

B. HMO, PPO, and POS Plans: There are three types of managed care plans.

- 1) **HMO Plans:** HMO stands for a Health Maintenance Organization. There are generally two forms of HMOs: independent physician associations (IPAs), and stand alone facilities. IPAs have physicians who practice in their own offices and sometimes join with other providers to form a medical group. Examples of IPAs are Blue Cross, Blue Shield, and Aetna. Stand alone facilities are HMO's hospitals that provide all care within that HMO's facilities. Kaiser Permanente is an example of a stand alone HMO facility.
- 2) **PPO Plans:** PPO stands for Preferred Provider Organization. A PPO is a group of health care providers who have agreed to provide services to an insurance company's members at a reduced rate.
- 3) **POS Plans:** POS stands for Point of Service Plan. A POS Plan is a combination of an HMO and a PPO. Members of a POS plan decide when they want to use the PPO part of their plan or the HMO option.

HMO	PPO	POS
Participating doctors and hospitals. Generally have a primary care physician who coordinates care	Usually many health care provider and hospital choices	Can see providers in- or out-of-network
Generally have to select doctors and hospitals from within the participating group	Can select from all participating providers	If selecting within network, generally have a minimal co-pay. If selecting from larger group, member pays more
Limited choices	More choices in doctors, specialists, overall providers	More choice when needed
Usually less expensive	Usually more expensive	Cost is between that of a PPO and an HMO

C. What to Consider When Choosing a Health Insurance Plan:

- 1) **Look at the Summary of Benefits:** What benefits are included? What benefits are excluded?
- 2) **Look at the Cost:** How much are the monthly premiums, annual deductibles for the individual or the family, maximum out-of-pocket costs, and co-payments for different types of services?
- 3) **When are the Enrollment Periods?** Do they offer annual open enrollment periods for individuals to make changes to their policy?
- 4) **How Much Flexibility Do They Offer?** Can individuals change plans if they need to? If so, how?
- 5) **Guaranteed Renewability:** Under federal law and some state laws, health insurance companies are required to renew an individual's existing health coverage, as long as premium payments are made in full and on time. This is called guaranteed renewability. However, there is no cap on the rate increases companies may impose at the time of renewal. Guaranteed renewability is not portable, so the individual does not have the right to switch to another company or even another plan offered by the same company without going through the medical underwriting process (see below).

II. WAYS TO GET AND KEEP HEALTH INSURANCE

- A. **Individual Health Insurance:** Typically when a person applies for an individual health insurance plan, they are required to go through a process called medical underwriting. During this process, the insurance company looks at the individual's past and current medical conditions in order to decide whether or not they want to issue the individual a health insurance policy. If the individual currently has, or has had in the past, a serious medical condition (known as a pre-existing condition), the insurance company will likely decide that it is not worth the risk to them to insure this person, and will deny the individual a health insurance plan. However, even if the individual with a pre-existing condition, such as cancer, is offered an individual health insurance policy, it may be very expensive.
- B. **Employment-Based Health Insurance:** The most common way that people obtain health insurance coverage is through their employer or a family member's employer. There are certain rights that are guaranteed to people who are insured through their employment. These rights pertain to the continuation of coverage during certain leaves of absence (under the Family and Medical Leave Act) or upon termination of employment (see COBRA, discussed below). Individuals with employment-based health insurance are also protected from health insurance discrimination based on their pre-existing conditions under the Health Insurance Portability & Accountability Act (see below). For example, one important protection under HIPAA for individuals with group health insurance is that insurance companies can only look back into medical records 6 months to impose pre-existing condition exclusions that "relate to a condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on the enrollment date."⁹⁰
- C. **COBRA:** Employees who lose their jobs or have their work hours reduced are often concerned about how to keep their health insurance. COBRA is a federal law that allows employees to continue the same employment-based health insurance coverage that they had while they were employed, which means they do not have to change their health care providers.
- 1) **Who can elect COBRA?:** COBRA is available to employees or their family members after employees have left their job voluntarily, been terminated from their employment, or have reduced their work hours to a point that they are no longer eligible to receive coverage from their employers (e.g., moving from full-time to part-time, and the employer only offers health insurance to full-time employees). This termination or reduction in hours is referred to as a "qualifying event." Other COBRA qualifying events are divorce or death of a spouse (when the person seeking COBRA coverage was insured by a plan provided through the spouse's employment), or a child aging out of a parent's health insurance policy. This chart below demonstrates the maximum COBRA coverage an individual can receive:

Qualifying Event	Qualified Beneficiaries	Maximum Coverage
Termination of employment or reduction of hours	Employee, Spouse, Dependent Child	18 months
Employee enrollment in Medicare	Spouse, Dependent Child	36 months
Divorce or legal separation	Spouse, Dependent Child	36 months
Death of employee	Spouse, Dependent Child	36 months
Loss of dependent child status	Dependent Child	36 months

⁹⁰ Health Insurance Portability and Accountability Act of 1996, 29 U.S.C. § 701(a)(1)

2) Requirements of COBRA:

- (i) COBRA applies to employers with 20 or more employees;
- (ii) COBRA coverage generally lasts for 18 months or 36 months, depending on the qualifying event;⁹¹
- (iii) The monthly premium paid by the employee can be up to 102% of what the employer was paying for the same benefits;
- (iv) The person insured is responsible for the full premium for the coverage;
- (v) Responsibility for notifying the health plan of the qualifying event depends on which qualifying event has occurred;
- (vi) A health plan has 14 days after the plan administrator is notified of the qualifying event to notify the employee of the right to elect COBRA; and
- (vii) Employees must elect COBRA within 60 days after being notified of their rights. Employees then have 45 days after electing coverage to pay the initial premium.

3) Extension of COBRA

- (i) **Disability:** Individuals who are determined to be disabled under the Social Security Administration standards within the first 60 days of COBRA coverage and continue to be disabled for the rest of the 18 month period, are entitled to an 11 month extension of COBRA, for a total of 29 months. In addition, all the qualified beneficiaries in the family are entitled to the extension. However, during this time the plan can charge premiums up to 150 percent of the cost of coverage. Plan beneficiaries are responsible for notifying the plan of the Social Security Administration's determination and the plan can set a time limit for providing the notice.
- (ii) **Second Qualifying Event:** An individual who is currently on an 18 month COBRA continuation may be entitled to an 18 month extension, for a maximum period of 36 months, if he or she experiences a second qualifying event.
 - Example: Your spouse quit his or her job and elected COBRA with you as a dependent. Then, if during the COBRA period, that spouse becomes eligible for Medicare, you would be eligible for an 18 month COBRA extension. It is your responsibility to notify the plan of the second qualifying event. An event only counts as a second qualifying event if it would have caused you to lose coverage under the plan in the absence of the first qualifying event.

4) State COBRA Plans: Most states have some type of state COBRA coverage requirements for employers with 2-19 employees, but they vary greatly. Additionally, some states offer coverage for more time than under COBRA.

- (i) **Example:** In California, the state COBRA plan, called Cal-COBRA, adds an additional 18 months of coverage to federal COBRA for a total of 36 months of coverage, unless an employer is self-insured. In Texas, the state continuation of group coverage only provides an additional 6 months of coverage to federal COBRA for a total of 24 months.

⁹¹ COBRA coverage can last up to 29 months if the person insured has a qualifying disability, or up to 36 months if the person became eligible for COBRA coverage because of certain qualifying events or a combination of qualifying events.

D. **COBRA Premium Subsidy:** On February 17, 2009, President Obama signed the American Recovery and Reinvestment Act of 2009 (ARRA), as part of an economic stimulus plan. ARRA was amended by the Department of Defense Appropriations Act of 2010, which extended the subsidy to cover people who were involuntarily terminated from their jobs between September 1, 2008, and May 31, 2010. Although this subsidy is no longer available to those who newly elect COBRA coverage, there are some individuals who are still receiving the subsidy.

E. **Health Insurance Premium Payment Program (HIPP):** COBRA premiums can be very expensive, especially if individuals are not working. If individuals have health insurance coverage (i.e., COBRA), cannot afford to pay the premiums, and are eligible for Medicaid, then HIPP will pay their health insurance premiums to help them keep their private health insurance coverage. HIPP programs are not offered in every state and eligibility requirements vary. For more information about HIPP and to find out if the HIPP program is available in a particular state, contact the state's insurance agency or Medicaid program (**see the STATE APPENDICES**).

1) The following states currently have HIPP programs:

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|--------------|-----------------|-----------------|
| • Alabama | • Iowa | • Oregon |
| • California | • Kansas | • Pennsylvania |
| • Colorado | • Kentucky | • Texas |
| • Georgia | • Missouri | • Virginia |
| • Idaho | • Nevada | • West Virginia |
| • Illinois | • New Hampshire | • Wisconsin |

F. **Health Insurance Portability & Accountability Act (HIPAA):** HIPAA is a federal law that prohibits health insurance discrimination against individuals based on their pre-existing medical conditions, when individuals are moving from a group health insurance plan to another group health insurance plan or from a group plan to a HIPAA guarantee issue plan.

1) In order to take advantage of HIPAA protections, there cannot be a recent break in health insurance coverage that lasts more than 63 days.

2) **HIPAA Protections:**

- (i) Provides a federal right to an individual health insurance plan (“guarantee issue plan”);
- (ii) Reduces maximum pre-existing condition exclusion period to 12 months; and
- (iii) Gives individuals credit for the time that they had health insurance coverage in the past (“creditable coverage”) to eliminate or reduce a pre-existing condition exclusion period.

3) **Guarantee Issue Plan:** A guarantee issue plan, also known as a “federally insured plan” or “HIPAA plan,” is an individual health insurance plan that an individual has a right to purchase under federal law. A HIPAA plan is not a specific plan – rather it is a right to purchase an individual plan. Depending on the state, there are 3 ways to access a HIPAA plan: 1) every insurance company that offers individual health insurance policies in that state also has to offer a HIPAA plan option; 2) insurance companies will allow individuals to convert their group plan to an individual plan; or 3) individuals can access a HIPAA plan through a state's major risk insurance plan or high risk pool. An insurance company cannot deny individuals a HIPAA plan, but individuals should use the “buzz” words (guaranteed issue or HIPAA plan) when

applying. Otherwise the insurance company may assume the individual wants a regular individual plan and may deny them coverage based on a pre-existing condition through the medical underwriting process.

(i) **HIPAA vs. COBRA:** A HIPAA plan is different than COBRA coverage. Under COBRA, individuals keep the same health insurance they had through their employer. Under HIPAA, individuals are buying new insurance, and need to compare all of the available plans and pick the one that is right for them. Individuals should compare the premiums, deductibles, and co-payments. Individuals should also check to make sure their health care providers accept the insurance plan they are considering, and that their prescription drugs are on the formulary list of drugs covered by the plan. Note: There is no cap on the price of a HIPAA plan.

(ii) **Requirements:** In order to be eligible for a HIPAA plan:

- Individuals must exhaust COBRA or state COBRA coverage, meaning that they use all 18 or 36 months of COBRA coverage, available to them;
- There cannot be a break in their health insurance coverage longer than 63 days; and
- Individuals must be ineligible for Medicare, Medicaid, or any form of group coverage.

(iii) **Finding a HIPAA Plan in Your State:** In order to determine the HIPAA Plan options available in each state, individuals can contact the state insurance agency, contact the CLRC, or see the CLRC handout, "HIPAA Plan Options by State," available online at www.CancerLegalResourceCenter.org.

4) **Pre-Existing Condition Exclusion Period (PECEP):** When moving from one employer's group health plan to another employer's plan, the new plan is required to insure the individual, but may impose a PECEP, which means that for a certain period of time, the new plan will not cover any treatment or services related to the individual's pre-existing medical condition. For example, if the individual breaks his or her arm, those medical services will be covered; however, if they are currently undergoing cancer treatment, those services will not be covered, because the individual's cancer diagnosis is a pre-existing medical condition. Before HIPAA, a two-year PECEP was common. HIPAA limited the maximum PECEP that may be imposed to 12 months. Some states have gone further. For example, in California, employers with 2 or fewer employees have a 12 month pre-existing condition exclusion period, but only a 6 month exclusion period can be imposed for employers with 3 or more employees.

5) **Creditable Coverage:** Creditable coverage is any previous period of health insurance coverage that was not interrupted by a break in coverage of more than 63 days. HIPAA reduces any PECEP by the length of time that an individual previously had creditable coverage.

(i) **Example:** If individuals previously had group health insurance coverage for four months, have not had a break in coverage of more than 63 days, and their new group insurance plan has a PECEP of 12 months, then they get a credit for their 4 months of previous coverage. The individual subtracts the 4 months of previous coverage from the 12 month exclusion period, leaving them with only 8 months left on their PECEP. So, if the individual has 12 months or more of

previous creditable health insurance coverage, and they do not have a break in coverage of more than 63 days, they will not face a PECEP when moving between group plans or a group plan to a HIPAA plan.

12 month PECEP imposed by new group insurance plan – 4 months of previous coverage = 8 months left of a PECEP

- (ii) **Example:** An individual has creditable coverage of 6 months while at a previous job. The individual is now changing jobs and the new employer’s group health plan is imposing a PECEP of 6 months. Accordingly, the individual will not have a PECEP under their new health insurance policy, because the previous 6 months of creditable coverage eliminates the 6 month PECEP. .

6 month PECEP imposed by new group insurance plan – 6 months of previous coverage = 0 months left of a PCEP

- (iii) **Qualifying for Creditable Coverage:** Almost all types of health insurance can qualify as creditable coverage. Medicare, Medicaid, group, individual, COBRA, and HIPAA plans can all qualify. One exception is that some student health insurance plans are not considered creditable coverage, because they do not typically provide comprehensive coverage. Also, if a particular condition was not covered by the policy that an individual is claiming as creditable coverage, then their new health plan may subject that condition to a PECEP.

- (iv) **Demonstrating Creditable Coverage:** To show the health insurance company proof of creditable coverage, individuals must provide a “certificate of creditable coverage,” which lists the dates that they have been insured by that company. Usually, this is mailed to individuals when their coverage ends. Individuals can also call their previous insurance company to request a certificate of creditable coverage. If individuals have been insured by multiple companies, they need certificates of creditable coverage from each one.

- (v) **Waiting Periods and Pre-Existing Condition Exclusion Periods:** Many employers will require that you wait a specific period of time after starting your employment before you are eligible for health insurance benefits. These waiting periods will run concurrently with any pre-existing condition exclusion period that your new plan is imposing.

- Example: Your new employer has a 60 day waiting period to be eligible for health benefits. Your new health plan has a 6 month (180 days) pre-existing exclusion period. These start at the same time on Day 1, so after your 60 day waiting period for benefits ends, you only have 120 days left of a pre-existing condition exclusion period.

- G. **High Risk Insurance Pools/Major Risk Insurance Plans:** If individuals are not able to obtain insurance through COBRA, and are not eligible for a HIPAA plan because they did not exhaust the available COBRA coverage or if individuals have a break in coverage of more than 63 days, then they may be eligible for a state high risk insurance pool or major risk plan. These state plans provide limited health insurance for individuals who are unable to obtain health insurance coverage in the individual insurance market due to a pre-existing condition. States are not required to provide this

alternative option for medically uninsurable individuals to access coverage, but many do.

- 1) **High Risk Insurance Pools Available in Your State:** Currently 35 states have major risk health insurance pools. Of those 35 states that offer high-risk policies, 27 states offer multiple plans for people who are unable to obtain individual health insurance policies due to a pre-existing condition. For information about plans available in each state, contact the state's insurance agency (**see the STATE APPENDICES**) or view the CLRC's fact sheet available at www.CancerLegalResourceCenter.org.
- 2) **Applying for High-Risk Health Insurance:** Individuals can apply for high-risk pool coverage through an insurance agent or directly with the state. Generally, there is a choice of health plan options and individuals receive an enrollment card, as well as other information, just like another health plan. High-risk pools normally contract with a health insurance carrier or third-party administrator to administer paperwork and claims. Once enrolled, benefits can be used like any other health insurance plan.
- 3) **Pre-Existing Condition Exclusion Periods and Waiting Periods:** High-risk pools may impose pre-existing condition exclusion periods and/or waiting periods. However, many pools give individuals credit against the exclusion and/or waiting period if they have previous creditable health insurance coverage.

H. **Pre-Existing Condition Insurance Plans:** The recently enacted Patient Protection and Affordable Care Act (health care reform) created a way for many individuals with pre-existing conditions to get insurance by mandating that states offer Pre-Existing Condition Insurance Plans. Some states have opted to administer those plans through a state agency and some states have opted to let the federal government administer their state plan. For more information, see the Health Care Reform section of this manual or visit www.pcip.gov.

- 1) **Requirements:** In order to be eligible for PCIP, an individual must meet the following requirements:
 - (i) Have a pre-existing condition demonstrated by:
 - A rejection letter from a health insurance company in the last 12 months, or
 - Certification from a medical provider
 - (ii) Be a U.S. Citizen, U.S. National, or lawfully present in the U.S.
 - (iii) Have had no health insurance coverage in the six months prior to application.

III. **FEDERAL HEALTH INSURANCE PROGRAMS**

A. **Introduction:** While SSI and SSDI are federal disability insurance programs, Medicare and Medicaid are federal health insurance programs.

B. **Medicare:**

- 1) Medicare is a health insurance program for:
 - (i) People age 65 or older who are eligible for Social Security retirement benefits;
 - (ii) People under age 65 with certain disabilities who have received Social Security Disability (SSDI) benefits for two (2) years; and
 - (iii) People of all ages with End-Stage Renal Disease.

2) **Four Parts of Medicare:** Medicare has four parts, each with different services and coverage. Medicare requires that you join during what is known as the “open enrollment” period. There are some important implications to getting coverage during this time, especially for people with pre-existing conditions. Generally, “open enrollment” occurs every fall.

- (i) **Part A:** Everyone who is eligible for Medicare will receive Part A for free unless the individual has insufficient Social Security work history. However, if they are citizens or legal residents and have lived in the U.S. for at least 5 years, they can still obtain Part A coverage by paying a monthly premium. Part A is considered “hospital insurance” and can include coverage for in-patient hospital stays, skilled nursing facilities, and some home health care or hospice care.
- (ii) **Part B:** Part B is considered “medical insurance” and covers physician services, outpatient hospital services, x-rays, labs, tests, cancer screenings, ambulance rides, and other medical supplies and/or services. If individuals are eligible for Medicare Part A, they are entitled to receive this coverage; however, if they choose to elect Part B, they pay a monthly premium and an annual deductible.
 - Note: Assuming individuals have both Part A and Part B, then Medicare usually covers 80% of the allowable charge, making them responsible for only 20% of the bill.
 - **Covered Preventive Services:**⁹² Coinsurance and/or deductibles may apply.

Abdominal Aortic Aneurysm Screening	Covered one time, if at risk
Bone Mass Measurement	Covered every 24 months (more often if medically necessary)
Cardiovascular Screening	Covered every 5 years
Colorectal Cancer Screening	<p>Fecal Occult Blood Test: Covered once every 12 months if 50 or older</p> <p>Flexible Sigmoidoscopy: Covered once every 48 months if 50 or older, or 120 months after a previous screening colonoscopy for those not at high risk</p> <p>Colonoscopy: Covered once every 120 months, or 48 months after a previous flexible sigmoidoscopy; covered every 24 months, if high risk</p> <p>Barium Enema: Covered once every 48 months if 50 or older when used instead of a sigmoidoscopy or colonoscopy; covered every 24 months, if high risk</p>
Diabetes Screening	<p>Covered up to twice a year, if high risk</p> <p>Diabetes Self-Management Training is also covered for individuals with diabetes.</p>
Flu Shots	Covered once a flu season in the fall or winter

⁹² Medicare.gov. “Preventive Services.” www.medicare.gov/navigation/manage-your-health/preventive-services/preventive-service-overview.aspx.

Glaucoma Tests	Covered once every 12 months, if high risk
Hepatitis B Shots	Covered, if high or medium risk
HIV Screening	Covered once every 12 months or up to 3 times during a pregnancy
Mammogram	Covered once every 12 months for all women with Medicare age 40 and older; covers one baseline mammogram for women between ages 35–39
Medical Nutrition Therapy	Covers medical nutrition therapy and certain related services if individuals have diabetes or kidney disease, or they have had kidney transplants in the last 36 months, and their doctors refer them for the service
Pap Test and Pelvic Exam	Covered once every 24 months; covered once every 12 months if high risk and for women of child-bearing age who have had an exam that indicated cancer or other abnormalities in the past 3 years
Physical Exam	One-time “Welcome to Medicare” physical exam: covered one time within 12 months of your Medicare Part B effective date Yearly “Wellness” exam: covered once a year if individuals have had Part B for longer than 12 months
Pneumococcal Shot	Covered
Prostate Cancer Screening	Digital rectal exam and Prostate Specific Antigen (PSA) test covered once every 12 months for all men with Medicare over age 50
Smoking Cessation	Covered up to 8 face-to-face visits in a 12-month period whether or not individuals are diagnosed with an illness caused or complicated by tobacco use, or if they take a medicine that is affected by tobacco

- **Clinical Trials:** Part B helps to cover some clinical trial expenses. Clinical trials test new types of medical care, like how well a new cancer drug works.
 - ⇒ In general, Medicare will pay for the routine costs of items and services for an individual participating in a qualified clinical trial, including:
 1. Visits to the doctor's office
 2. Medically necessary tests
 3. Procedures needed to get the new care, such as an operation to implant an item that is being tested
 4. Hospital stays that Medicare would normally cover if the patient were not in a study
 5. Treatment of any complications or side effects that occur as a result of trial care

(iii) **Part C:** Previously called Medicare Plus Choice, Part C is now referred to as Medicare Advantage Plans with coordinated care of Part A, B and D together through a Medicare HMO or PPO. Part C plans are offered by private insurance companies approved by Medicare and cover all of the services that Original Medicare covers except hospice care, and may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. However, if individuals go to health care providers who do not belong to the plan, the

services may not be covered, or the costs could be higher. Individuals may not be excluded from these Advantage Plans due to a pre-existing condition, with the exception of End-Stage Renal Disease. Examples of plans under Part C include Kaiser Senior Advantage and SCAN.

(iv) **Part D:** As of January 1, 2006, Medicare prescription drug plans became available to all Medicare beneficiaries. Plans vary from state to state. Some states have over 50 plans to choose from. For more information about the prescription drug plans available in each state, visit www.Medicare.gov. Individuals can get Medicare prescription drug coverage by (1) joining a Medicare Prescription Drug Plan that adds drug coverage to the Original Medicare Plan (Medicare Part A or Part B) or (2) join a Medicare Advantage plan (Medicare Part C HMO or PPO) that includes prescription drug coverage as part of the plan.

- Part D plans may not cover all drugs, but they must cover:
 - ⇒ Cancer medications;
 - 1. Note: oral chemotherapy drugs and anti-nausea drugs have been covered by Part B since 1999
 - ⇒ HIV/AIDS treatments;
 - ⇒ Antidepressants;
 - ⇒ Anticonvulsant treatments for epilepsy and other conditions;
 - ⇒ Immunosuppressant drugs;
 - ⇒ Anti-psychotics; and
 - ⇒ All commercially-available vaccines when medically necessary to prevent illness, except for vaccines covered under Part B.
- If individuals are denied coverage for specific drugs and will have to pay for them out-of-pocket, they have three options:
 - ⇒ Switch to a covered drug if their doctors think that is appropriate.
 - ⇒ Change to another Medicare drug plan as soon as possible and ask their doctors for samples until their new coverage is effective.
 - ⇒ Have their doctors help them with an “exception request” to cover the drug, because it is medically necessary. An exception request is simply a formal request to the insurance company that it makes an exception to cover the drug in question, because it is medically necessary.

(v) Some of the items and services that Medicare does not cover include the following:

- Long-term care
- Routine dental care
- Dentures
- Cosmetic surgery
- Acupuncture
- Hearing aids-
- Exams for fitting hearing aids⁹³

⁹³ Medicare & You. Centers for Medicare & Medicaid Services (2011). www.medicare.gov/publications/pubs/pdf/10050.pdf.

3) How Much Does Medicare Cost?:⁹⁴

(i) **Part A:** Medicare Part A is free unless an individual has insufficient Social Security work history. Legal residents who have lived in the U.S. for at least five (5) years may also receive Part A coverage, but will have to pay a monthly premium.

- Note: If individuals are eligible for Part A, but do not have sufficient work history, their monthly premium will be \$451.
- Note: Although Part A coverage is free, there is a \$1,100 deductible for the first day of a hospital stay.

• **Enrollment:**⁹⁵ There are a few ways individuals can enroll in Part A.

⇒ **Automatic Enrollment:** In most cases, if individuals are already getting benefits from Social Security or the Railroad Retirement Board (RRB), they will automatically get Part A starting the first day of the month they turn 65 and should receive their Medicare cards three months before their 65th birthdays.

1. Example: If an individual turns 65 on February 20, 2011, his or her Medicare effective date would be February 1, 2011.
2. If individuals have not received their cards by the beginning of the month of their birthdays, they should contact the Social Security Administration at 1-800-MEDICARE or visit www.medicare.gov.

⇒ **Signing Up:** If individuals are not getting Social Security or RRB benefits, because they are still working, and they want Part A, they will need to sign up (even if you're eligible to get Part A premium-free). To avoid late enrollment penalties, they should sign up during the initial enrollment period or a special enrollment period.

1. **Initial Enrollment Period:** Individuals can sign up when they are first eligible for Medicare. This is a seven-month period that begins three months before the month they turn 65, includes the month they turn 65, and ends three months after the month they turn 65.

2. **Special Enrollment Period:** If individuals did not sign up for Part A when they were first eligible, because they were covered under a group health plan, they can sign up for Part A during the eight-month period that begins the month after the employment ends or the group health plan coverage ends, whichever happens first.

- i. Example: An employee is eligible for Medicare, because the employee has turned 65, but is still working and has health insurance through his or her employer. The employee chooses to stay with the employer's plan while still working. When the employee decides to stop working, the employee may elect COBRA, but has up to eight months during the COBRA period to enroll in Medicare before a penalty fee is imposed.

⁹⁴ Figures are based on 2011 requirements as reported by www.medicare.gov.

⁹⁵ Medicare & You. Centers for Medicare & Medicaid Services (2011). www.medicare.gov/publications/pubs/pdf/10050.pdf.

- ii. Note: If individuals have COBRA coverage and then -- become eligible for Medicare, they may lose their COBRA coverage. If they have Medicare and then elect COBRA coverage, they can keep their COBRA coverage.

⇒ **Late Enrollment Penalty:** If individuals do not enroll in Part A during the initial or special enrollment period, their monthly premiums may go up 10%. They will have to pay the higher premiums for twice the number of years they could have had Part A, but did not enroll.

- 1. Example: If an individual was eligible for Part A for 2 years but did not enroll, he or she will have to pay the higher premium for 4 years.

(ii) **Part B:** As mentioned above, Part B is optional and individuals may choose to decline coverage. If individuals elect Part B benefits, then they must pay a monthly premium based on their income (see chart below) and a \$110.50 annual deductible before Medicare will pay its share of the health care costs.

Individual Income	Joint (Married) Income	Your Cost:
\$85,000 or below*	\$170,000 or below	\$99.90
\$85,001 - \$107,000	\$170,000 - \$214,000	\$139.90
\$107,001 - \$160,000	\$214,001 - \$320,000	\$199.80
\$160,001 - \$214,000	\$320,001 - \$428,000	\$259.70
\$214,000+	\$428,000+	\$319.70

- In addition, if individuals do not elect Part B when they first become eligible for it, they may be subject to a penalty for late enrollment (10% for each complete 12-month period that the individual could have enrolled in Part B but chose not to), unless they have creditable coverage. When an individual loses that creditable coverage, they have an 8-month special enrollment period to elect Part B without being charged a penalty.

⇒ Example: An employee is eligible for Medicare because the employee has turned 65, but is still working and has health insurance through their employer. The employee chooses to stay with the employer's current plan until the employment period ends. At that point, the employee may elect COBRA, but has up to 8 months during the COBRA period to enroll in Medicare before a penalty fee is imposed.

- **Enrollment:**⁹⁶ There are a few ways that individuals can enroll in Part B.

⇒ **Automatic Enrollment:** In most cases, if individuals are already getting benefits from Social Security or the Railroad Retirement Board (RRB), they will automatically get Part B, along with Part A, starting the first day of the month they turn 65 and should receive their Medicare Cards three months before their 65th birthdays. If individuals do not want Part B, they should follow the instructions that come with the cards, and send the cards back. If they keep the cards, they keep Part B and will be required to pay Part B premiums.

⁹⁶ Medicare & You. Centers for Medicare & Medicaid Services (2011). www.medicare.gov/publications/pubs/pdf/10050.pdf.

⇒ **Signing Up:** If individuals are not getting Social Security or RRB benefits, because they are still working, and they want Part B, they will need to sign up. To avoid late enrollment penalties, they should sign up during the initial enrollment period or a special enrollment period.

1. **Initial Enrollment Period:** Individuals can sign up when they are first eligible for Medicare. This is a seven-month period that begins three months before the month they turn 65, includes the month they turn 65, and ends three months after the month they turn 65.
2. **Special Enrollment Period:** If individuals did not sign up for Part B when they were first eligible, because they were covered under a group health plan, they can sign up for Part B during the eight-month period that begins the month after their employment ends or the group health plan coverage ends, whichever happens first.

⇒ **Late Enrollment Penalty:** If individuals do not enroll in Part B during the initial or special enrollment period, they may be subject to a 10% late enrollment penalty for each complete 12-month period that the individuals could have enrolled in Part B, but chose not to.

1. Example: An individual was eligible in 2005, but did not sign up until 2010. The 2010 Part B premium was \$96.40. Ten percent of \$96.40 is \$9.64. Since the individual did not enroll for five years, \$9.64 is multiplied by five, equaling \$48.20. This amount (\$48.20) will be added to the individual's monthly Part B premium for life.

(iii) **Part C:** Out-of-pocket costs in a Medicare Advantage Plan depend on:

- Whether the plan charges a monthly premium.
- Whether the plan pays part of the Part B premium.
- Whether the plan has an annual deductible or any additional deductibles.
- How much individuals pay for each visit or service (copayments or coinsurance).
- The type of health care services individuals need and how often they get them.
- Whether individuals follow the plan's rules, like using network providers.
- Whether individuals need extra benefits and if the plan charges for them.
- The plan's yearly limit on the out-of-pocket costs for all medical services.⁹⁷
- **Enrollment:**⁹⁸ There are a few times when individuals can choose to join, switch, or drop a Part C plan.

⇒ **Initial Enrollment:** Individuals can join, switch, or drop a Part C plan at these times:

⁹⁷ Medicare.gov. "Medicare Advantage (Part C)." www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-c.aspx.

⁹⁸ Medicare & You. Centers for Medicare & Medicaid Services (2011). www.medicare.gov/publications/pubs/pdf/10050.pdf.

1. When they are first eligible for Medicare. This is a seven-month period that begins three months before the month they turn 65, includes the month they turn 65, and ends three months after the month they turn 65.
2. If individuals get Medicare due to a disability, they can join during the three months before to three months after their 25th month of disability.
3. Between October 15 and December 7 in 2011. Their coverage will begin on January 1, 2012, as long as the plan gets their enrollment requests by December 7.

⇒ **Special Enrollment:** In certain situations, individuals may be able to join, switch, or drop a Part C plan at other times. Some of these situations include:

1. If they move out of their plan's service area
2. If they qualify for Extra Help
3. If they live in an institution (e.g., a nursing home)

(iv) **Part D:** Part D is optional, but if individuals select this prescription drug coverage they will pay a national average premium of \$31.08 in 2011. The exact amount depends on the specific plan chosen. Plans range from \$14.80 - \$133.40, and have an annual deductible from \$0 - \$320.

- Additionally, beginning in 2011, Part D enrollees who have income that exceeds threshold amounts will pay a monthly adjusted amount, in addition to their regular Part D premium.⁹⁹

Estimated Part D Monthly Premium for higher income levels:¹⁰⁰

Individual Income	Joint (Married) Income	Your Cost:
\$85,000 or below	\$170,000 or below	Your Plan Premium
\$85,001 - \$107,000	\$170,000 - \$214,000	\$11.60 + Your Plan Premium
\$107,001 - \$160,000	\$214,001 - \$320,000	\$39.90 + Your Plan Premium
\$160,001 - \$214,000	\$320,001 - \$428,000	\$48.10 + Your Plan Premium
\$214,000+	\$428,000+	\$66.40 + Your Plan Premium

- **Enrollment:**¹⁰¹ There are a few times when individuals can choose to join, switch, or drop a Part D plan.

⇒ **Initial Enrollment:** Individuals can join, switch, or drop a Part D plan at these times:

1. When they are first eligible for Medicare. This is a seven-month period that begins three months before the month they turn 65, includes the month they turn 65, and ends three months after the month they turn 65.

⁹⁹ Medicare Fact Sheet: Medicare Premiums, Deductibles for 2011. Centers for Medicare and Medicaid Services (November 4, 2010). www.nasuad.org/documentation/ship/2011PremiumsFinal.pdf.

¹⁰⁰ Medicare Fact Sheet: Medicare Premiums, Deductibles for 2011. Centers for Medicare and Medicaid Services (November 4, 2010). www.nasuad.org/documentation/ship/2011PremiumsFinal.pdf.

¹⁰¹ Medicare & You. Centers for Medicare & Medicaid Services (2011). www.medicare.gov/publications/pubs/pdf/10050.pdf.

2. If individuals get Medicare due to a disability, they can join during the three months before to three months after their 25th month of disability. They will have another chance to join during the three months before the month they turn 65 to 3 months after the month they turn 65.
 3. Between October 15 and December 7 in 2011. Their coverage will begin on January 1, 2012, as long as the plan gets their enrollment requests by December 7.
 4. Anytime, if they qualify for Extra Help.
- ⇒ **Special Enrollment:** In certain situations, individuals may be able to join, switch, or drop a Part D plan at other times. Some of these situations include:
1. If they move out of their plan's service area
 2. If they lose other creditable prescription drug coverage
 - a. Note: If employees are eligible for Part D, but have a prescription drug plan through private insurance (e.g., their employer or COBRA), the employer will notify the employees each year to let them know if they have creditable prescription drug coverage and do not need to enroll in a Part D plan. Employees then have a special enrollment period to elect a Part D plan, if they chose to do so, without incurring a late penalty fee for not enrolling when initially eligible for Part D.
 3. If they live in an institution (e.g., a nursing home)
- ⇒ **Late Enrollment Penalty:** If individuals do not enroll in a Part D plan during the initial or special enrollment period, they may be subject to a late enrollment penalty. Those who are required to pay the penalty, pay 1% of the average national Part D premium for the year that they joined, times the number of months they were eligible to join a Medicare Part D drug plan, but did not.
1. Example: If an individual was eligible for a Part D plan in January 2007, but did not sign up until January 2012, they would be required to pay the penalty. The 2012 average national Part D premium is $\$31.08 \times 1\% = 32$ cents. 31 cents $\times 60$ months = $\$18.60$, which will be added to the individual's monthly Part D premium for life.
- **Coverage Gap:**¹⁰² Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that after individuals and their drug plans have spent a certain amount of money for covered drugs, individuals have to pay all costs out-of-pocket for their prescriptions up to a yearly limit. Once they reach their plan's out-of-pocket limit, then Medicare will begin to cover prescription drug costs at 75% and the individual is responsible for only 25%.
- ⇒ **What counts toward the out-of-pocket limit?:**
1. Yearly deductible
 2. Coinsurance or copayments
 3. Amounts paid in the coverage gap

¹⁰² Medicare & You. Centers for Medicare & Medicaid Services (2011). www.medicare.gov/publications/pubs/pdf/10050.pdf.

- ⇒ **What does not count toward the out-of-pocket limit?:**
 1. Part D plan monthly premiums
 2. Amounts paid for drugs that are not covered by the Part D plan

- ⇒ If individuals reach the coverage gap in 2011, they will get a 50% discount on covered brand-name prescription drugs at the time they buy them. There will be additional savings in the coverage gap each year through 2020, when they will have 75% coverage in the gap.¹⁰³

- **Extra Help:**¹⁰⁴ Individuals may qualify for Extra Help, also called the Low-Income Subsidy (LIS), from Medicare to pay prescription drug costs.
 - ⇒ **Benefits:** Individuals who qualify for Extra Help and join a Medicare Part D drug plan will get:
 1. Help paying their Medicare drug plan's monthly premium, any yearly deductible, coinsurance, and copayments
 2. No coverage gap
 3. No late enrollment penalty

 - ⇒ **Qualification:** To qualify, individuals must have a yearly income and resource level below these limits in 2011 (amounts may change in 2012):
 1. Single Person:
 - a. Income less than \$16,335
 - b. Resources less than \$12,640
 2. Married Person Living with a Spouse and No Other Dependents:
 - a. Income less than \$22,065
 - b. Resources less than \$25,260
 3. Resources include:
 - a. Money in a checking or savings account
 - b. Stocks
 - c. Bonds
 4. Resources do not include:
 - a. An individual's home
 - b. Car
 - c. Household items
 - d. Burial plot
 - e. Up to \$1,500 for burial expenses
 - f. Life insurance policies
 5. Individuals automatically qualify for Extra Help if they have Medicare and:
 - a. They have full Medicaid coverage
 - b. They get help from Medicaid paying their Medicare Part B premium
 - c. They get Supplemental Security Income (SSI) benefits
 - d. Note: If individuals automatically qualify for Extra Help, Medicare will send them a purple letter

¹⁰³ Closing the Coverage Gap—Medicare Prescription Drugs Are Becoming More Affordable. Centers for Medicare & Medicaid Services (2010). www.medicare.gov/Publications/Pubs/pdf/11493.pdf.

¹⁰⁴ Medicare & You. Centers for Medicare & Medicaid Services (2011). www.medicare.gov/publications/pubs/pdf/10050.pdf.

6. Individuals who do not automatically qualify for Extra Help can apply by:
 - a. Visiting www.socialsecurity.gov to apply online
 - b. Calling Social Security Administration at (800) 772-1213 to apply by phone or to get a paper application
 - c. Visiting their State Medical Assistance (Medicaid) office
 - **Choosing a Plan:** When choosing a plan, individuals should consider the following factors:
 - ⇒ Cost: What individuals pay in premiums, deductibles, and copayments
 - ⇒ Coverage: What benefits are provided, which drugs are covered, and the rules for getting those drugs (e.g., pre-authorization)
 - ⇒ Convenience: Which pharmacies are part of the plan and is there a mail-order option
- 4) **Appeals Process:**¹⁰⁵ Medicare beneficiaries have certain guaranteed rights, including the right to a fair process to appeal decisions about their health care coverage or payments.
- (i) Individuals can appeal, if:
 - A service or item they received is not covered, and they think it should be;
 - A service or item is denied, and they think it should be paid;
 - They question the amount that Medicare paid; or
 - If their application to enroll in Medicare was denied.
 - (ii) There are five levels to the appeals process:
 - **Redetermination:** A redetermination is an examination of a claim.
 - ⇒ **Part A and Part B:**¹⁰⁶ Request must be filed within 120 days of the date the initial claim determination was received
 - ⇒ **Part C¹⁰⁷ and Part D:**¹⁰⁸ Request must be filed within 60 days of the date the initial claim determination was received
 - **Reconsideration:** If an individual is dissatisfied with the redetermination, he or she may request a reconsideration, which is an independent review by a panel of physicians or other health care professionals.
 - ⇒ **Part A and Part B:**¹⁰⁹ Request must be filed within 180 days of the date the redetermination was received
 - ⇒ **Part C¹¹⁰ and Part D:**¹¹¹ Request must be filed within 60 days of the date the redetermination was received

¹⁰⁵ Department of Health and Human Services. "Office of Medicare Hearings and Appeals (OMHA): Understanding the Appeals Process." www.hhs.gov/omha/process/index.html.

¹⁰⁶ The Medicare Appeals Process. Centers for Medicare and Medicaid Services (January 2011). www.cms.gov/MLNProducts/downloads/MedicareAppealsprocess.pdf.

¹⁰⁷ Medicare Advantage (Part C): Appeals Process. U.S. Department of Health & Human Services. www.hhs.gov/omha/files/c_chart.pdf.

¹⁰⁸ Medicare Prescription Drug Plan (Part D): Appeals Process. U.S. Department of Health & Human Services. www.hhs.gov/omha/files/d_chart.pdf.

¹⁰⁹ The Medicare Appeals Process. Centers for Medicare and Medicaid Services (January 2011). www.cms.gov/MLNProducts/downloads/MedicareAppealsprocess.pdf.

- **Administrative Law Judge (ALJ) Hearing:** If at least \$130 remains in controversy following the reconsideration, an individual has 60 days from when he or she received the reconsideration notice to request an ALJ hearing.
 - **Appeals Council Review:** If an individual is dissatisfied with the ALJ's decision, he or she may request a review by the Appeals Council. The individual has 60 days from when he or she received the ALJ's decision to submit a written request for the review. A minimum monetary threshold is not required to request an Appeals Council review.
 - **Judicial Review in U.S. District Court:** If at least \$1,260 or more is still in controversy following the Appeals Council's decision, an individual may request judicial review before a U.S. District Court judge. The individual has 60 days from when he or she received the Appeals Council's decision to file the request for review.
- 5) **Medigap:**¹¹² A Medigap policy, also known as Medicare Supplemental Insurance, is health insurance sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. If individuals are in the Original Medicare Plan and have a Medigap policy, then Medicare and the Medigap policy will both pay their shares of covered health care costs. Generally, when individuals buy Medigap policies, they must have Medicare Part A and Part B. They will have to pay the monthly Medicare Part B premiums and also have to pay premiums to the Medigap insurance companies. Medigap policies are guaranteed to be renewed as long as the premium is paid.
- (i) **Cost:** Medigap policies are priced in 3 ways.
- **Community-Related ("not-age-rated"):** The same monthly premium is charged to everyone who has that Medigap plan, regardless of age
 - **Issue-Age-Related:** Premiums are based on the age at which individuals buy the policy. The younger individuals are when they buy-in, the lower their premiums will be
 - **Attained-Age-Related:** Premiums are based on individuals' current ages so premiums increase as they get older
 - Note: Community Related and Issue-Age-Related policy premiums may go up because of inflation, but not because of age
- (ii) **Enrollment Period:** The enrollment period lasts up to six months and starts on first day of the month in which individuals are both:
- Age 65 or older; and
 - Enrolled in Medicare Part B.
 - Example: If an individual turns 65 in January, but waits until March to enroll in Part B, the 6 month enrollment period for Medigap would begin in March.

¹¹⁰ Medicare Advantage (Part C): Appeals Process. U.S. Department of Health & Human Services. www.hhs.gov/omha/files/c_chart.pdf.

¹¹¹ Medicare Prescription Drug Plan (Part D): Appeals Process. U.S. Department of Health & Human Services. www.hhs.gov/omha/files/d_chart.pdf.

¹¹² Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare. Centers for Medicare and Medicaid Services (2011). www.medicare.gov/Publications/Pubs/pdf/02110.pdf.

(iii) **People with Disabilities or End-Stage Renal Disease (ESRD):** Federal law does not require insurance companies to sell Medigap policies to individuals under age 65 who have Medicare coverage because of a disability or ESRD. However, this does not mean that individuals with Medicare who are under 65 do not have access to Medigap policies. California law provides broader coverage than federal law, requiring insurance companies to offer at least one kind of Medigap policy to Medicare beneficiaries who are under 65 (excluding those with ESRD). Insurance companies may also voluntarily sell Medigap policies to those with disabilities or ESRD who are under 65, thus giving them additional policy options. However, these policies would likely cost more than those sold to individuals over the age of 65, and they can use medical underwriting.

(iv) **Coverage:** The below chart shows the benefits covered under each of the various Medigap policies available after June 1, 2010. If an “X” appears in the column, that means the Medigap policy covers 100% of the benefit listed. If a column has a percentage in it, that means that the Medigap policy covers the percentage listed. If the column is blank, then Medigap does not cover the described benefit. It is important to remember that the Medigap policy covers coinsurance only after the yearly deductible is met.

- Note: Plans E, H, I, and J are no longer sold. However, if individuals already have one of these plans, they may keep it.

Benefit	Policy									
	A	B	C	D	F	G	K	L	M	N
Medicare Part A Coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	X	X	X	X	X	X	X	X	X	X
Medicare Part B Coinsurance or Copayment	X	X	X	X	X	X	50%	75%	X	X
Blood (First 3 Pints)	X	X	X	X	X	X	50%	75%	X	X
Part A Hospice Care Coinsurance or Copayment	X	X	X	X	X	X	50%	75%	X	X
Skilled Nursing Facility Care Coinsurance			X	X	X	X	50%	75%	X	X
Medicare Part A Deductible		X	X	X	X	X	50%	75%	50%	X
Medicare Part B Deductible			X		X					
Medicare Part B Excess Charges					X	X				
Foreign Travel Emergency (Up to Plan Limits)			X	X	X	X			X	X

- None of these policies provide prescription drug coverage.
- Medigap policies only cover one person.
⇒ Example: If an individual and his or her spouse both want Medigap coverage, they each must buy separate Medigap policies.
- It is important to compare Medigap policies, because while the benefits are the same for each insurance company, the costs may vary and increase with age. Each insurance company decides which Medigap policies it wants to sell and the price for each plan.
- Note: If individuals have Medicare Advantage Plans, they may not use Medigap policies to cover deductibles, copays, or coinsurance costs.

6) **Steps to Help You Choose a Medicare Plan:**

- (i) **Step 1:** Decide which Medicare health plan you want, either the Original Medicare Plan (Part A and Part B) or a Medicare Advantage Plan (Part C, which includes BOTH Parts A & B).
- (ii) **Step 2:** Decide if you want prescription drug coverage (Part D). If you chose the Original Medicare Plan you must choose and join a Medicare Part D Prescription Drug Plan. However, if you go with a Medicare Advantage Plan (Part C), most Part C plans include prescription drug coverage at an extra cost, eliminating the need for a Part D plan.
- (iii) **Step 3:** Decide if you want supplemental coverage. In addition to your Medicare coverage, you can choose to buy private supplemental coverage (Medigap plan).

C. **Medicaid:** Medicaid provides health insurance for certain individuals who have low incomes, have limited resources, and meet other eligibility requirements. Individuals with cancer often qualify for Medicaid through the Aged, Blind and Disabled Program, which provides coverage to individuals with low incomes who are over 65 or who have a disability. Medicaid may be called by other names in different states. For example, in California, Medicaid is referred to as Medi-Cal and in Tennessee, Medicaid is referred to as TennCare.

1) **Eligibility:** Applicants must meet income and asset eligibility requirements (i.e., have low income and limited resources to pay for the cost of their health care), AND fit into one of these categories:

- (i) Individuals who are “aged, blinded or disabled” according to the Social Security Administration’s standards;
- (ii) Families with children as long as a deprivation exists. A deprivation exists if a parent is absent from the home, incapacitated, disabled, or deceased;
- (iii) Children or pregnant women without regard to deprivation or poverty; or
- (iv) Individuals with specific health needs. These needs include dialysis, tuberculosis services, total parental nutrition services, breast and cervical cancer treatment, certain services for minors, and nursing home care.

2) **Share of Cost:** Some states have a “Share of Cost” program that refers to the amount of health care expenses an individual must pay out of pocket each month before Medicaid begins to offer assistance. Once a recipient’s health care expenses reach a predetermined amount, Medicaid will pay for any additional covered expenses that month. Share of Cost is an amount that is owed to the provider of health services, not to Medicaid.

- (i) Note: Share of Cost is not a monthly premium. It is an amount that a recipient is responsible for paying only during a month in which Medicaid’s assistance with health care expenses is needed.

3) **Buy-In Program:** Some states offer a Medicaid Buy-In Program which allows people of any age with a disability and who are working, to receive Medicaid by paying a monthly premium based on income.

- (i) Example: In Texas, if an individual is eligible for the Medicaid Buy-In Program (i.e., that person has resources less than or equal to the SSI resource limit), that

person is given optional dates to start their Medicaid coverage, and premium amounts depending on the date their Medicaid coverage begins. Once enrolled in the Medicaid Buy-In program, the individual will have the same services available to them as other Medicaid recipients (including office visits, hospital stays, x-rays, etc.).

IV. **OTHER HEALTH CARE OPTIONS**

- A. **Screening Legislation:** Many states require insurance companies to cover specific cancer screening tests, such as mammography for breast cancer, prostate-specific antigen (PSA) tests and digital rectal exams for prostate cancer, pap smears for cervical cancer, and colonoscopies, flexible sigmoidoscopy and fecal occult blood tests (FOBT) for colorectal cancer. Contact the CLRC for questions about what is covered in your state.
- B. **Screening and Treatment Programs:** Many states have also enacted screening and treatment programs for specific types of cancer.

1) **Breast Cancer:**

(i) **National Breast and Cervical Cancer Early Detection Program (NBCCEDP):**

The NBCCEDP is a program run by the Centers for Disease Control and Prevention (CDC) that funds all 50 states, the District of Columbia, 5 U.S. territories, and 12 American Indian/Alaska Native tribes or tribal organizations to provide screening services for breast and cervical cancer. The program helps low-income, uninsured, and underinsured women gain access to breast and cervical cancer screening and diagnostic services.

- **Available services include:**

- ⇒ Clinical breast examinations;
- ⇒ Mammograms;
- ⇒ Pap tests;
- ⇒ Pelvic examinations;
- ⇒ Diagnostic testing if results are abnormal; and
- ⇒ Referrals to treatment.

- **Eligibility:** An estimated 8%–11% of U.S. women of screening age are eligible to receive NBCCEDP services. Women may qualify for screening if they are:

- ⇒ Uninsured or underinsured, meaning they are at or below 250% of Federal Poverty Level.
- ⇒ Ages 18-64 for cervical screening.
- ⇒ Ages 40-64 for breast screening.¹¹³

- **Example of the NBCCEDP at the State Level:** In Illinois, the Breast and Cervical Cancer Program (IBCCP) offers free mammograms, breast exams, pelvic exams, and pap smears to eligible, uninsured women in the state.

- (ii) **Example of a State Breast Cancer Treatment Program:** In California, under the Breast and Cervical Cancer Treatment Program (BCCTP) Medicaid services are provided to qualifying individuals who have been diagnosed with breast or cervical cancer.

¹¹³ Centers for Disease Control and Prevention. "National Breast and Cervical Cancer Early Detection Program (NBCCEDP): About the Program." www.cdc.gov/cancer/nbccedp/about.htm.

- 2) Prostate Cancer:
 - (i) Example: In California, under Improving Access, Counseling and Treatment for Californians with Prostate Cancer (IMPACT), state residents who are either uninsured or underinsured are eligible to receive prostate cancer treatment.¹¹⁴

C. **Women's Health and Cancer Rights Act (WHCRA):** WHCRA is a federal law that requires health insurance companies whose policy covers a mastectomy to also cover reconstruction of the breast on which the mastectomy was performed, surgery or reconstruction of the other breast to produce a symmetrical appearance, prostheses and/or implants, and treatment for physical complications of a mastectomy, such as lymphedema. Additionally, if a patient is between mastectomy and reconstruction and moves from one plan to another, the new plan is obligated to pay for the reconstruction if the new plan would have covered the original mastectomy.

- 1) Note: WHCRA does not apply to federal health insurance plans, such as Medicare or Medicaid, as they have specific coverage rules.
- 2) Note: WHCRA does cover lumpectomies, as well as mastectomies.

V. HANDLING HEALTH INSURANCE DISPUTES

A. **Handling Disputes:** Disputes with insurance companies may arise over whether or not services are covered, which treatments should be provided, which providers should be used, how much a particular service should cost, difficulties dealing with specific providers, and even billing or administrative mistakes. **If an individual disagrees with a decision that their health insurance company has made regarding coverage, they have the right to appeal that decision.** Health insurance companies are required to have their own internal appeals process to handle these disagreements, and they must provide their policy holders with that information. Some states also offer policy holders with an external appeals process. In most states, individuals must first exhaust their health plan's internal appeals process before requesting an external independent medical review of the insurance company's decision.

- 1) **Note:** Under the Patient Protection and Affordable Care Act (health care reform), there are new rules that apply to external medical review. These rules are still being finalized and are expected to be released in 2012.
- 2) **Tips on Dealing with an Insurance Company:** The following are tips for handling internal appeals with an insurance company.
 - (i) Know the policy and any deadlines that apply;
 - (ii) Get any decisions or denials in writing;
 - (iii) Keep records of all communications;
 - (iv) Get a copy of the all files from the insurance company; and
 - (v) Be persistent.
- 3) **Different Appeal Procedures:** Health plans may have different appeals procedures for different types of disputes. For instance, a health plan may have one way to resolve a complaint about appointment times and a different way to appeal the refusal to cover a specific medical procedure.
- 4) **Internal Appeals Process:** If individuals disagree with an insurance company's decision, they have the right to file an appeal. ERISA requires employer-sponsored

¹¹⁴ California Department of Public Health, "Prostate Cancer Treatment Program." www.cdph.ca.gov/programs/CancerDetection/Pages/Prostate.aspx.

health plans to let policy holders see the documents they used to make their coverage decisions, to have no more than two levels of internal appeal, and prohibits insurance companies from charging a fee for the internal appeals process. For more information, contact the state's insurance agency (see **the STATE APPENDICES**).

- 5) **External Medical Review:** Also called Independent Medical Review (IMR), this is a review of the health plan's decision by an outside, independent organization. After individuals have exhausted their plan's internal appeals process, they may be entitled to ask for an external medical review under state law. While laws vary from state to state, the process generally provides patients with the right to have an independent medical review of their health insurance company's decision. Reviews are conducted by independent review organizations that have medical experts in many specialty areas. The decision made by the independent medical review organization is usually binding on the insurance company. To find out more information about external or independent medical reviews in a specific state, contact the state's insurance agency (see **the STATE APPENDICES**).
 - (i) **When is External Review Available?:** While the legal standards for review vary from state to state, many states allow external reviews when the insurance company denies care because a particular treatment is (1) not medically necessary or (2) experimental or investigational. Issues often arise when a treatment is new or a doctor prescribes a drug that was approved to treat one type of cancer and there is evidence that it will also work to treat another type of cancer, but has not yet been approved by the FDA to treat that new type of cancer (off-label drug use).
 - (ii) Many states allow appeals for an insurance company's decision to deny, modify, or delay treatment because it is not deemed to be medically necessary. If the insured individual can show that the treatment is medically necessary, then there is a greater chance of winning the appeal. This is a good opportunity for health care providers to help their patients demonstrate that the disputed treatment is actually medically necessary by providing letters of support, adding documentation to medical records, or providing additional medical literature to support why a particular treatment is medically necessary and/or has been successful in the past.
 - (iii) **External Appeals Outcomes:** Once appeals are accepted for external medical review, patients have been relatively successful in getting their insurance company's decisions overturned. However, many individuals make mistakes with their external review appeals, including filing with the wrong state agency, failing to exhaust their health plan's internal appeals process, or failing to provide all the necessary information, such as consent forms, that is needed to investigate their case.

VI. **ADDITIONAL PROTECTIONS**

- A. States have also provided health consumers with additional protections. For example, when individuals would like to receive care outside of their health insurance plan's network of providers, some states have required insurance companies to pay for these services in some circumstances. To find out about the health consumer protections available in each state, contact the state's insurance agency (see **the STATE APPENDICES**) or the CLRC.
 - 1) **Access to Medical Records:** Individuals, or their representatives, are entitled to inspect their medical records under HIPAA, but many states also have statutes that limit what a health care provider can charge patients for copies of their medical files. In California, for example, individuals must be granted access to view their medical

records within five working days after making a written request for medical records, subject to payment of reasonable clerical costs. Patients are also entitled to copies of their medical records, to be sent within 15 days of the provider's receipt of a written request, subject to copying costs not over 25 cents per page plus reasonable clerical costs. Finally providers may not withhold a patient's records for failure to settle an unpaid bill. For more information, contact the CLRC.

2) **Clinical Trials:** Some states require insurance companies to cover the routine costs of care while an individual is participating in a clinical trial. Medicare also covers routine care costs. Additionally, effective January 1, 2014, under the Patient Protection and Affordable Care Act (ACA), insurance companies may not deny or limit or impose additional conditions on "the coverage of routine patient costs for items and services furnished in connection with participation in the [clinical] trial."¹¹⁵ For more information, about the ACA, see the Health Care Reform section of this manual.

(i) **What is a clinical trial?:** A clinical trial is a research study in which people volunteer to test new treatments, drugs, or procedures. Researchers use clinical trials to learn whether a new treatment works and is safe for people. This research is needed to develop new treatments, and clinical trials often provide patients with access to the highest quality of cancer care and new treatments before they are widely available.

(ii) **How are clinical trials conducted?:** Clinical trials are usually conducted in a series of four phases, or research testing steps.

- **Phase I:** This is the first step in testing a new drug or procedure with people. Researchers test safe dosages and methods of delivery (ex: given orally or injected into a vein or muscle). The researchers carefully observe any side effects.
- **Phase II:** These trials study both the safety and effectiveness of a treatment and evaluate how it affects your body. These studies are usually specific to one type of cancer, and often have less than one hundred patients.
- **Phase III:** These trials compare the new treatment with the current standard treatment. Participants are randomly assigned to the new treatment group or to the standard treatment group. Random assignment helps to avoid bias and ensures that other factors do not affect study results.
- **Phase IV:** These trials are useful in researching the long-term safety and overall effectiveness of treatment. These studies take place after a treatment has been approved for widespread use.

(iii) **Who sponsors cancer clinical trials?:** These are a few examples of agencies and companies that sponsor cancer clinical trials:

- National Cancer Institute
- National Institutes of Health
- Pharmaceutical & Biotechnology Companies
- U.S. Department of Defense
- U.S. Department of Veterans Affairs
- U.S. Food & Drug Administration

¹¹⁵ Public Law 111-148, 124 STAT. 893 §2709

(iv) **What are the costs of participating in a clinical trial?:** Routine care costs are for care that is not dependent on a clinical trial and occurs when receiving standard treatment or participating in the study. Routine care costs can include lab tests, x-rays, blood work, and doctor visits. Costs that are typically not covered by health insurance include the drugs or procedures being tested in the clinical trial, items or services used solely for the data collection needs of the trial, and anything being provided for free by the clinical trial sponsor. Some health insurance plans will also not provide coverage for routine care costs because they consider clinical trials to be “experimental” treatment.

- **Which states require insurance coverage for clinical trials?:** Currently there are **35 states** that require health insurance plans to cover the routine care costs of a clinical trial, including: Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Missouri, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, Ohio, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, Wisconsin, Wyoming, and the District of Columbia. However, each state’s law is different. For more information on a state’s regulation of health insurance coverage for clinical trials, please contact the CLRC or the state’s insurance agency.

⇒ **Example:** In **California**, health insurance plans are required to cover the routine care costs associated with cancer clinical trials.¹¹⁶ Covered costs may include, but are not limited to, hospitalization, physician visits, X-rays, blood tests, CAT scans, and PET scans. In addition, some costs may be covered by the clinical trial sponsor, such as a pharmaceutical company.

(v) **Do Medicare and Medicaid cover clinical trials?:** Medicare Part B covers the routine costs of clinical trials.¹¹⁷ For more information visit www.cancer.gov/cancertopics/factsheet/support/medicare. Additionally, some states cover clinical trials under Medicaid. For more information, contact the state’s Medicaid program (see the **STATE APPENDICES**).

(vi) **What if an insurance company denies coverage for the clinical trial?:**

- Contact the health care provider team to see if they can assist the patient.
- Contact the insurance company to find out why they denied coverage.
- Go through the insurance internal appeals process.
- Contact the state insurance agency to see if the patient is eligible for an external appeals process or independent medical review.

⇒ Ex: California Department of Managed Health Care of California Department of Insurance

- Contact the CLRC for assistance.

¹¹⁶ CA Health & Safety Code §1370.6

¹¹⁷ Medicare & You. Centers for Medicare & Medicaid Services (2011). www.medicare.gov/Publications/Pubs/pdf/10050.pdf.

- (vii) **Patient Protection and Affordable Care Act (Public Law 111-148):** Also known as health care reform, this law was passed on March 23, 2010, and states that beginning in 2014, insurance companies will be required to cover the costs associated with routine care for individuals who are enrolled in a clinical trial to treat cancer or other life-threatening diseases.
- 3) **Second Medical Opinions:** Some states allow patients to have second medical opinions covered by their insurance company. If a second provider is not available within the network, the insurance company must cover a second opinion from a provider outside the network. For more information, contact the CLRC.
- 4) **Oral Chemotherapy Laws:** Currently, 11 states (Hawaii, Iowa, Indiana, Oregon, Vermont, Colorado, Connecticut, Minnesota, New Hampshire, and New York) and the District of Columbia have enacted statutes that require health insurance policies to cover oral chemotherapy at the same level as they would cover chemotherapy administered intravenously.¹¹⁸ There are also several other states with similar pending legislation. For more information about legislation in a particular state, please contact the CLRC.
- 5) **Fertility Legislation:** As many as 90% of young cancer patients may be at risk of permanent infertility after undergoing treatment. Although insurance plans vary in the amount of infertility treatments they cover, currently, there are fourteen states that require insurance companies to cover some form of infertility diagnosis and treatment. These states are Arkansas, California, Connecticut, Hawaii, Illinois, Maryland, Massachusetts, Montana, New Jersey, New York, Ohio, Rhode Island, Texas, and West Virginia. For more information about specific laws, contact the state's insurance agency or visit www.asrm.org/insurance.aspx.
- (i) **Note:** Currently, no states require insurers to cover fertility preservation methods for new cancer patients.
- **California Bill:** In February 2011, AB 428 was introduced in California. If enacted, health care service plans would be required to cover medically necessary expenses for fertility preservation services when a necessary medical treatment (e.g., radiation, chemotherapy, or surgical removal of reproductive organs) may cause iatrogenic infertility.

¹¹⁸ Haw. Rev. Stat. § 431:10A-126; Iowa Code § 514C.24; Ind. Code § 27-8-32-5; Or. Rev. Stat. § 743A.068; Vt. Stat. Ann. tit. 8, § 4100h; Colo. Rev. Stat. § 10-16-104; Conn. Gen. Stat. § 38a-504; Minn. Stat. § 62A.3075; Kan. Stat. Ann. § 40-2,184 (applies to policies issued for delivery, amended, or renewed on and after July 1, 2011); D.C. Code § 31-2995.02.

VII. RESOURCES

<p>For insurance questions: State insurance agency See the STATE APPENDICES</p>	<p>For COBRA questions: U.S. Department of Labor Employee Benefits Security Administration (866) 444-3272 or www.dol.gov/ebsa</p>
<p>For state COBRA and HIPAA questions: State insurance agency See the STATE APPENDICES</p>	<p>For major risk insurance questions: State insurance agency See the STATE APPENDICES</p> <p>Also see the CLRC fact sheet on high risk insurance options available at www.CancerLegalResourceCenter.org</p>
<p>For assistance with Medicare: Center for Medicare & Medicaid Services (CMS) (800) 663-4227 www.medicare.gov</p>	<p>State Health Insurance Assistance Program (SHIP) (800) 633-4227 www.medicare.gov/Contacts/staticpages/ships.aspx</p>
<p>To find and compare Medicare Prescription Drug Plans in your area: www.medicare.gov/find-a-plan/questions/home.aspx</p>	<p>For information on Pre-Existing Condition Insurance Plans (PCIP): www.healthcare.gov or www.pcip.gov</p>
<p>For assistance with Medicaid: Center for Medicare & Medicaid Services (CMS) (800) 633-4227 www.cms.gov</p>	<p>State Medical Assistance (800) 633-4227 or www.cms.hhs.gov/apps/contacts/Default.aspx</p>
<p>For National Breast and Cervical Cancer Early Detection Program (NBCCEDP) questions: Centers for Disease Control and Prevention Division of Cancer Prevention and Control 800-CDC-INFO (800-232-4636) www.cdc.gov/Features/CancerScreeningWomen</p>	