

INSURANCE ISSUES

INTRODUCTION

The following information regarding insurance coverage is based upon the Health Insurance Portability and Accountability Act of 1996 (also known as “HIPAA”), a federal law which sets forth standards for health insurance in the United States. In many instances, HIPAA supercedes or “trumps” conflicting state law. Therefore, the requirements for health insurance coverage may vary widely from state to state. You can consult your state Department of Insurance, your health care provider, your company’s benefits coordinator, a local attorney, and/or cancer patient advocate regarding the specific rules and regulations which govern health insurance coverage in your state. It is also important to note that significant differences often exist between group and individual policies.

Does my insurance policy cover treatment for cancer?

Review the “exclusions” section of your policy. Some policies explicitly state whether certain illnesses, such as cancer, are covered or not (excluded). If you have any questions contact your health insurer.

Can my insurance company raise my premium if I need cancer treatment?

No. Your group health insurer may not require you (as a condition of enrollment or continued enrollment under the plan) to pay a premium, which is greater than the premium for a similarly situated individual enrolled in the plan on the basis of any health status-related factor such as cancer.

Can my insurance company cancel my policy or refuse to renew my policy if I am diagnosed with cancer?

No. Your health insurance may not be canceled or not renewed by the health insurance issuer based on the fact that you have been diagnosed with cancer.

What is a “pre-existing condition” provision and how does that affect my insurance coverage?

If you were diagnosed with cancer *before* your **group** health insurance coverage became effective, your insurer may consider you to have a pre-existing condition. A “pre-existing condition” provision is defined as an exception in your insurance policy that excludes or limits coverage for a disease or condition, such as cancer, for a specified period after the effective date of coverage.

Policies can differ with regard to pre-existing conditions, and the specific wording of that provision of the policy can greatly impact what is covered or excluded. For example the provision might only apply to coverage for a disease or condition during a specific time period (for example 6 months prior to the enrollment date of the new policy). In these situations if you previously received a diagnosis, care, or treatment for a disease or condition within the specified time-frame, the insurer can consider it a pre-existing condition, which will likely preclude coverage for 12 months, or 18 months if you did not enroll in the plan when first eligible. Be aware that providing false misleading information on an insurance application constitutes fraud, which could render your policy void, or result in cancellation of all benefits and/or criminal charges.

My policy excludes cancer treatment

Some **individual (non-group)** insurance plans contain a provision, which denies coverage completely for specific diseases or conditions which can include cancer. If possible, it is better to identify such exclusions as soon as possible and obtain supplemental coverage. Obtaining additional coverage after a diagnosis of cancer will likely be very difficult.

My policy excludes cancer treatment for a specified period of time

Some insurance plans contain a pre-existing condition provision, which denies coverage for a specified period of time if you received medical advice, diagnosis, care, or treatment for cancer for a period of time prior to the effective date of your coverage. Under federal law this waiting period may be no longer than one year. Some plans may also require that you be “treatment free” during this waiting period before you qualify for coverage.

However, according to HIPAA any pre-existing condition exclusion period must be reduced by the period of time the individual has maintained health insurance coverage without a break of 63 consecutive days or more immediately before enrolling in the new health insurance plan.

So, for example, if your current policy has a pre-existing provision that has a 6 month waiting period before you qualify for coverage, and you had insurance coverage without a break for 90 days immediately before you enrolled in your current policy, you would qualify for coverage under your current policy in 3 months instead of 6 months because you would get credit for the 90 days of coverage under your previous plan. If you only had 62 days (or less) of coverage without a break immediately before enrolling in your current plan, you would still have to wait 6 months before you qualified for coverage under the pre-existing provision of your current policy.

But, if your current policy had a pre-existing provision with a 6 month waiting period before you qualify for coverage, and you had insurance coverage without a break for 180 days immediately before you enrolled in your current policy, you would qualify for coverage for treatment right away because you would get “credit” for your 180 days of previous coverage.

If my new policy has a waiting period, is that a break in my coverage?

No. If your current group health plan or group health insurance coverage has a waiting period (i.e., a period of time you must wait until you are eligible to be covered for benefits under the plan), that waiting period does not count against you as a break in coverage for purposes of a pre-existing condition provision in your policy.

For example, let’s say the health insurance through your new employer requires you to wait 90 days before you are covered by the insurance. At your old job, you had health insurance for a year and were still covered when you started your new job (no break in coverage). Your new policy contains a pre-existing condition provision that has an exclusion period of one year. Since the waiting period does not count as a break in coverage, your exclusion period for any pre-existing condition in this example would be reduced by one year.

What happens if I “max out” my existing policy?

Since most policies provide benefits up to a stated dollar amount, make sure you carefully review your policy, so you are aware of what the benefit cap is on your plan and monitor your use of those benefits. If you think you will exhaust your benefits, start looking for new or supplemental insurance. You may not be able to obtain additional coverage for ongoing or recent treatment.

Remember that even if your new insurance has a pre-existing condition clause which, has a waiting period of one year or less before you are eligible to receive coverage for cancer treatments, if you had continuous coverage of 63 days or more immediately preceding the effective date of your new policy, you will get “credit” for the number of consecutive days of coverage from your old policy, which could result in either immediate coverage or a shorter waiting period.

What are my insurance options if I can no longer work and lose my insurance, and what are my options if I do not have insurance?

The Consolidated Omnibus Budget Reconciliation Act or COBRA is a federal law that provides a temporary extension of health coverage for up to 29 months through an individual’s employer (with 20 or more employees) if that individual, for example:

- Works fewer hours; or

- Loses his/her job (for any reason other than gross misconduct); or
- Gets divorced from, or becomes legally separated from, a partner who has the medical insurance, or if the partner with the insurance dies; or
- Becomes eligible for Medicare benefits; or
- Loses dependent child status under an existing policy

Usually, your employer pays a part of the premium for active employees. COBRA coverage is typically more expensive because you are generally responsible for paying the entire monthly premium plus a 2% fee.

For more information, go to: http://www.dol.gov/ebsa/faqs/faq_consumer_cobra.html

IMPORTANT INSURANCE TERMS AND DEFINITIONS:

DISABILITY BENEFITS

Long-Term Disability Insurance

Long-term disability insurance typically replaces a portion of your income, sometimes for as long as five years or until you turn 65. Check to see if you have long-term disability insurance, either through your employer or under an individual policy you purchased. If you have long-term disability insurance, review the definition of “disability” under your policy to see if you qualify. Depending on how the policy defines “disability” cancer may qualify.

Social Security Disability

Social Security provides benefits to someone with a total disability. To qualify for social security disability benefits, you must have worked at a job covered by Social Security and also meet Social Security’s definition of disability.

Social Security considers you disabled if you cannot perform work that you had in the past and if Social Security decides that you cannot adjust to other work duties because of your medical condition(s). Your disability must also last or be expected to last for at least one year, or be of the type that is likely to result in death.

Social Security will generally pay monthly cash benefits to people who have been unable to work for a year or more due to disability. If you qualify, these benefits usually continue until you are able to work again on a regular basis.

Supplemental Security Income (SSI)

SSI is a federal income supplement program. Many things are considered to determine if you qualify for SSI, including, but not limited to, your age, any disabilities

you have and your income. If you qualify, SSI provides monthly assistance to cover expenses for basic needs such as food, clothing and shelter.

For more information on Social Security Disability, go to: <http://www.ssa.gov/disability/>

MEDICARE

Medicare is a government-sponsored health insurance program for people 65 and older or people younger than 65 who are disabled or have End-Stage Renal disease (permanent kidney failure requiring dialysis or transplant). You or your spouse must also have worked for at least 10 years in Medicare-covered employment, and you must be a citizen or permanent resident of the United States.

Part A

Disability Part A covers care in (i) hospitals as an inpatient, (ii) critical access hospitals (small facilities that give limited outpatient and inpatient services to people in rural areas), (iii) skilled nursing facilities, (iv) hospice facilities, and (v) some home health companies. Part A coverage is usually free. If you or your spouse did not pay Medicare taxes while you worked, and you are 65 years of age or older, you may be able to purchase Part A coverage.

Part B

Disability Part B covers doctors' services, outpatient hospital care, and some other medical services that Part A does not cover, such as the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and health care supplies when they are medically necessary. You have to pay a monthly premium for Part B coverage.

MEDIGAP

If you receive Medicare, you may be able to supplement your Medicare coverage with a Medigap policy. A Medigap policy is health insurance sold by private insurance companies to fill the "gaps" in some of the health care costs that your Medicare plan doesn't cover. There are 12 different standardized Medigap policies you may choose based on your needs. In Texas, Medigap insurance companies may reject applications from non-elderly persons with disabilities.

For more information about Medicare, go to <http://www.medicare.gov> or call 1-800-MEDICARE.

MEDICAID

Medicaid is another government-sponsored health insurance program that may help low income citizens with medical costs. Medicaid is administered by individual states and is therefore subject to state guidelines. Depending on your state's rules, you may have to make a co-payment for some medical services. Eligibility is based on factors such as your age; whether you are pregnant, disabled, blind, or aged; your income and resources; and whether you are a U.S. citizen or a lawfully admitted immigrant.

For more information about Medicaid, call 1-800-252-8263 or go to: <http://www.cms.hhs.gov/home/medicaid.asp>

HEALTH INSURANCE RISK POOLS

Health insurance risk pools, also know as Guaranteed Access Programs, are special health insurance programs created by state legislators for individuals who cannot obtain adequate health insurance coverage as a result of their medical condition. Essentially, risk pool insurance serves as a last resort for those who cannot obtain health insurance from any other source, or only have access to private insurance that is restricted or has extremely high rates. The cost of risk pool insurance is higher than regular insurance, but states cap the amount that can be charged to keep the premium amount relatively reasonable.

The type of coverage offered through risk pool insurance - and requirements to obtain such coverage - vary from state to state. For example, in Texas to qualify for Texas Risk Pool coverage, you must have documentation of at least one of the following:

- a written refusal or rejection, based on health reasons, by a health carrier for substantially similar individual hospital, medical, or surgical coverage.
- a certification from an agent or salaried representative of a health carrier on the Health Pool's certification form, stating that the agent or salaried representative is unable to obtain substantially similar individual hospital, medical, or surgical coverage for you from a health carrier the agent or salaried representative represents because, based on that health carrier's underwriting guidelines, you will be declined for coverage as a result of a medical condition.
- an offer of substantially similar individual hospital, medical, or surgical coverage with riders excluding certain health conditions you have.
- a rate quote from a health carrier offering to provide substantially similar individual hospital, medical, or surgical coverage at rates that are higher than the rates of the Health Pool.
- diagnosis of one of the medical conditions specified by the Texas Health Pool Board of Directors.

- proof that health coverage has been maintained for the previous 18 months with no gap in coverage greater than 63 days, with the most recent coverage being with an employer-sponsored plan, government plan, or church plan. For more information, contact your state department of insurance.

LIFE INSURANCE

Living Benefits

If you need immediate financial resources, you might consider accelerating your life insurance policy's "living benefits." Life insurance policies living benefits sometimes include financial options for insureds with life threatening illnesses and conditions. Financial options could include, for example, waiver of premium, loan programs, or ways to withdraw some of the face value or cash value of your policy.

Viatical Benefits

To generate some immediate income, some patients try to sell their life insurance policies. This is known as a viatical, which means the sale of a life insurance policy, usually by an insured with a short life expectancy, to a third party for a lump sum payment. The value of a life insurance policy is negotiable, but is generally sold for between 60% - 80% of the face value of the policy.

For more information, contact your insurance agent to discuss your life insurance policy benefits.

HILL-BURTON PROGRAM

The Hill-Burton Program is a federal program that provides funds to hospitals and other medical facilities, so those hospitals and facilities are able to provide free or reduced cost medical care for patients who are unable to pay. To qualify for free Hill-Burton care, your income must be at or below the current U.S. Department of Health and Human Services poverty guidelines. You may qualify for reduced-cost Hill-Burton care if your income is as much as two times (triple for nursing home care) the U.S. Department of Health and Human Services poverty guidelines. You may apply for Hill-Burton assistance at any time before or after you have received care.

For more information, call the Hill-Burton hotline at 1-800-638-0742 or visit their website: <http://www.hrsa.gov/hillburton/>

OTHER OPTIONS TO CONSIDER

- Consult with an independent broker who might be able to find coverage for you that fits your needs.

- Try to find an employer or join a professional or fraternal organization that offers a “guaranteed issue” insurance plan. A guaranteed issue plan offers coverage regardless of health history.
- Ask about school life insurance, if you are the parent of a school-aged child.
- Contact your state department of insurance to see if your state offers an “open enrollment” period, which allows people with pre-existing conditions or who are otherwise considered high-risk to purchase individual health insurance policies.
- See if you qualify for veteran’s benefits by contacting the Department of Veterans Affairs at 1-800-827-1000 or www.va.gov

TIPS FOR MANAGING YOUR MEDICAL INSURANCE

Here are suggestions from the American Cancer Society (www.cancer.org) for managing your medical insurance:

- Become familiar with your individual insurance plan and its provisions. If you think you might need additional insurance, ask your insurance carrier whether it is available.
- Submit claims for all medical expenses even when you are uncertain about your coverage.
- Keep accurate and complete records of claims submitted, pending and paid.
- Keep copies of all paperwork related to your claims, such as letters of medical necessity, bills, receipts, requests for sick leave, and correspondence with insurance companies.
- Get a caseworker, a hospital financial counselor, or a social worker to help you if your finances are limited. Often, companies or hospitals can work with you to make acceptable payment arrangements if you make them aware of your situation.
- Submit your bills as you receive them. If you become overwhelmed with bills, get help. Contact local support organizations, such as your American Cancer Society or your state’s government agencies for additional assistance.
- Do not allow your medical insurance to expire. Pay premiums in full and on time. It is often difficult to get new insurance. Additionally, utilize COBRA to continue coverage in the event you lose or leave your job. This will provide continuity of coverage until you are employed again and can be covered by a new group or individual health plan.