

## Health Coverage & Disability Benefits

Dealing with health insurance issues can be confusing and frustrating. This information is to help you understand some of the basics of public and private benefits and to help you avoid some common problems. Benefit programs and health insurance policies vary in terms of what they provide or cover. Take the time to learn about your benefits and call your insurance representative to make sure you understand how your policy works. This will be extremely helpful and will save you from a great deal of frustration. Keep in mind that your prescription coverage may function differently than your regular health coverage.

If you're having trouble navigating your benefits, the Cancer Resource Center hosts benefits counseling sessions. To sign up for a free one-on-one consultation with a benefits counselor, call the Cancer Resource Center at (415) 885-3693.

## General Categories of Private Health Coverage

### Health Maintenance Organization Plans

Health maintenance organization (HMO) plans usually contract with a specific list or panel of doctors from which you must choose. As an HMO member, you have a primary care physician who is responsible for your care. To receive care from a specialist, you must get a referral from your primary care physician. As long as you see doctors within the HMO network, you will be required to pay only a small co-payment per visit. The co-payment generally ranges from \$5 to \$25. Most other charges are covered by the plan. There are no deductibles or claim forms as long as the care is received from providers within the plan.

If you want to see a medical provider that is not within the HMO network for a second opinion or for other medical care, you will need written authorization from the HMO medical group. If you do not get authorization for the visit, the HMO will not pay for the costs of the visit. The authorization process can sometimes take up to a week, so plan ahead. If your request to receive a particular treatment or to see a specialist outside of the plan is denied by the HMO, it is worthwhile to appeal the decision (see section on Appealing Rejections).

### Indemnity Plans

Indemnity plans allow you to choose any doctor or hospital when seeking medical care. However, these plans typically have a deductible, which you have to pay before the plan will pay for any medical expenses. Once you have paid the deductible, the health plan will pay a percentage of the medical expenses. Many plans pay about 70 percent to 80 percent of the bill. The percentage of a medical bill that the health plan will pay is called co-insurance. You are responsible for paying the remainder of the bill. The amount that you need to pay is called patient liability. Indemnity plans vary greatly and you need to check the particulars of the plan as it relates to you.

Although many plans require you to pay a co-insurance of 20 percent, you only have to pay this percentage until you reach your annual out-of-pocket maximum. If you have an out-of-pocket maximum of \$2,000, for example, the insurance plan will pay 100 percent of your claims after you have spent this amount.

## Preferred Provider Organization Plans

Preferred provider organization (PPO) plans combine some elements of HMO plans with elements of indemnity plans. Like the HMO, PPO plans have contracts with a specific list of medical providers. If you see a doctor who is in the network, the PPO generally will pay 80 percent to 100 percent of the medical bills after you pay the deductible. If you use providers that are outside the PPO network, the plan will pay a lower percentage of the bill than if you use a provider within the network. When you receive care outside of the network, the plan will require you to pay a certain amount, called a deductible, before it will cover any of the medical expenses you incur outside of the plan.

Although many plans require you to pay a co-insurance, you only have to pay this percentage until you reach your annual out-of-pocket maximum. If you have an out-of-pocket maximum of \$2,000, for example, the insurance plan will pay 100 percent of your claims after you have paid this amount.

## Point of Service Plans

A point of service (POS) plan is the most versatile plan, providing three types of coverage – one that functions like an HMO, another that functions like a PPO and a third that functions like an indemnity plan. As a member of a POS plan, you can use all of these different types of coverage at any time, switching back and forth between different forms of coverage depending on the doctor or type of care you wish to receive. Each level of coverage is called a tier.

**Tier 1** functions just like an HMO. If you choose to receive your care through your primary care physician in your HMO, you will be responsible for only a small co-payment and no annual deductible. Your primary care physician can refer you to other specialists within the HMO.

**Tier 2** functions like a PPO. You can self-refer to any provider in the PPO network of physicians. The insurance will pay for a certain percentage of the medical charge. You will be responsible for an annual deductible and for co-payments.

**Tier 3** functions like an indemnity plan. You can self-refer to a provider of your choice outside the network. The insurance will pay for a lower percentage of the medical charge than in tier 2. You will be responsible for an annual deductible and a higher co-payment that is greater than that of tier 2. Although many plans require you to pay a co-payment, you only have to pay this percentage until you reach your annual out-of-pocket maximum. If you have an out-of-pocket maximum of \$2,000, for example, the insurance plan will pay 100 percent of your claims after you have paid this amount.

## Self-Insured and Self-Funded Plans

These are plans in which a company or union covers your medical expenses with money set aside to pay health claims. Since this type of coverage is less regulated, there is a great deal of variation among the policies. A member of a self-funded plan should thoroughly review benefits to see what is covered. For most self-insured plans, benefits for pre-existing conditions are severely limited during the first year of coverage.

## Extending Your Group Health Insurance

### COBRA

**COBRA (Consolidated Omnibus Budget Reconciliation Act)** is a federal law that allows individuals working in companies of 20 or more employees to continue their health insurance benefits for up to 18 months after their employment terminates for any reason, excluding gross misconduct. During the time that you are covered by COBRA, you are responsible for paying 102 percent of the total health insurance premium, including any portion of the premium that may have been paid by your employer. If you cannot afford the monthly

payments, you might be able to use the Medi-Cal/Health Insurance Premium Payment (HIPP) program to pay your premiums (see section on Medi-Cal/HIPP). If you have a Social Security-approved disability that started within 60 days of when you elected your COBRA benefits, you are then eligible to use OBRA to continue your health insurance benefits for an additional 11 months.

## **OBRA**

OBRA is a federal law that allows individuals to extend their COBRA coverage for an additional 11 months. Only individuals who elected to use COBRA because of a Social Security approved disability are eligible for OBRA. During the time that you are covered by OBRA, you are responsible for paying 150 percent of the total health insurance premium, including any portion of the premium that may have been paid by your employer. If you are still disabled once your OBRA coverage expires, you will be eligible for Medicare, which provides health coverage for people who have been disabled for 29 months and are approved for Social Security.

## **Cal-COBRA**

Cal-COBRA is a state law enacted Oct. 3, 1997, that requires employers with more than two and less than 20 employees to provide employees the right to continue health insurance benefits for 18 months after their employment terminates for any reason, excluding gross misconduct. The employee is responsible for paying 110 percent of the total health insurance premium for the first 18 months and, if disabled (Social Security approved), a maximum of 150 percent for the remaining 11 months. This includes the portion of premium the employer may have paid.

## **Obtaining Health Insurance with a Pre-Existing Condition**

### **Professional Associations or Membership Organizations**

If you have a pre-existing medical condition and are having a difficult time obtaining health insurance, you might be able to join group health insurance through a professional association. You might already belong to an association or may be able to join one. There are many different associations, such as the American Bar Association, the Actors Association and the American Medical Association. Once you obtain health coverage through your association, you will have to pay the medical premiums yourself. If you join an association and have a choice of health care plans, keep in mind that indemnity plans and PPO plans often have a period of up to six months before they will cover you for a pre-existing condition, if you have not had previous medical coverage. HMO plans are required by law to cover your pre-existing condition immediately.

### **Health Insurance Plan of California**

Health Insurance Plan of California (HIPC) offers coverage for people who work independently or who work for small businesses. Because this plan pools together a large number of individuals, it offers many of the options previously available only to large businesses. As a HIPC member, you may be eligible to choose from many HMO or POS plans. To obtain more information, call (800) 255-4472.

### **Major Risk Medical Insurance Program**

Major Risk Medical Insurance Program (MRMIP) is a state program that provides medical insurance for people who are unable to obtain medical insurance in the open market. If you have a pre-existing condition and have been denied coverage by private insurance companies and are not eligible for Medicare, you may be eligible for MRMIP. The plan offers a wide range of medical providers with assorted plans, and offers prescription drug coverage. The annual limit is \$75,000 with a lifetime maximum of \$750,000. There is an annual deductible of \$500 and a co-payment and a maximum out-of-pocket of \$2,500 per year. At the time of this publication, there is a 12-month wait for enrollment in MRMIP. More information can be obtained by calling the California MRMIP phone number at (800) 289-6574.

# Information About Public Health Coverage

## Medi-Cal

Medi-Cal is medical coverage provided for Californians who meet the same disability standards as Social Security recipients, and is based on financial guidelines. Medi-Cal will pay health care bills incurred up to three months prior to the application date. Here are three examples how you may become eligible for this program:

**1. Supplemental Security Income (SSI)-linked Medi-Cal** is automatic medical coverage you receive once you qualify for \$1 or more of SSI income.

**2. Aged and Disabled Medi-Cal** is medical coverage you apply for when your disability income (unearned income) is above SSI limits but not greater than \$966 for a single person, or \$1,298 for a couple (as of February 2001).

**3. Medically Needy Medi-Cal** is medical coverage you apply for when your disability income is above SSI limits, Aged and Disabled limits, and may require a monthly co-payment called "share of cost" if your disability income (unearned income) is above \$966 for a single person, or \$1,298 for a couple, per month. "Share of cost" is your disability income in excess of \$620 for a single person, or \$954 for a couple, per month. To apply for "Aged and Disabled" or "Medically Needy" Medi-Cal, you will need to contact the County Medical Office in your area, which is listed under the county Department of Human or Social Services. You are allowed up to \$2,000 in assets. Your home and a car valued at no greater than \$4,000, (unless used for medical appointments) are exempt for the assets.

One of the disadvantages of Medi-Cal is that not all doctors accept new Medi-Cal patients. There also may be certain limitations on covering certain treatments and prescription drugs. If you have private insurance at the time that you become disabled, you may be able to enroll in the Medi-Cal/HIPP program (see below), which will help you pay for the continuation of your private insurance while you are on Medi-Cal.

## Medi-Cal Health Insurance Premium Payment Program

Medi-Cal Health Insurance Premium Payment Program (Medi-Cal/HIPP) will pay the premiums for your private health insurance plan. In order to participate in the Medi-Cal/HIPP program, you must be eligible and enrolled in Medi-Cal, but not in any of the Medi-Cal HMO programs or MRMIP. You also must be insured under a private health insurance plan that does not exclude your serious medical condition. If you are eligible, Medi-Cal/HIPP will allow you to keep your private health insurance while you are on Medi-Cal. Unlike Medi-Cal, Medi-Cal/HIPP will not make retroactive payments. To apply for Medi-Cal/HIPP, call the Medi-Cal/HIPP office at (800) 952-5294.

## Medicare

Medicare provides health coverage for people who qualify for Social Security. Most people become eligible when they reach the age of 65, or if they have been disabled for 29 months (see section on Social Security). Medicare covers hospitalization, skilled nursing, home health and hospice care, but requires certain deductibles, premiums and co-payments. If you are receiving outpatient care, Medicare will cover 80 percent of allowable outpatient medical services after a \$100 deductible. You are responsible for 20 percent of the charge, regardless of the cost. Note that Medicare does not cover outpatient prescription drugs unless they are administered in a doctor's office or an outpatient clinic. Because of this, many patients choose to enroll in Medicare HMOs or to buy relatively inexpensive private health insurance supplements to reduce their out-of-pocket costs. If you cannot afford to buy private health insurance, you might be able to supplement your Medicare with Medi-Cal. If you would like more information about Medicare, you can contact HICAP (see below).

## Health Insurance Counseling and Advocacy Program (HICAP)

HICAP provides information to seniors and other people on Medicare. HICAP counselors can help you understand Medicare, compare private Medicare supplemental plans, review Medicare HMOs, develop a system to organize your doctor and hospital bills, file Medicare and private insurance claims, and prepare Medicare appeals or challenge claim denials. All HICAP services are provided free of charge. To speak to a HICAP counselor, call (800) 303-4477.

## Appealing Rejections for Health Coverage

If you or your medical provider is told that a particular procedure is not covered, see if you can appeal the procedure, or ask your doctor or hospital to repeat the request for an authorization. In some cases, different people at the same insurance company arrive at different conclusions. Consequently, it's often worthwhile to appeal the case. In a situation in which you think that the insurance company is treating you unjustly, involving your lawyer may lead to a quick reversal of the rejection without any need for litigation.

## If You Have Trouble Meeting Your Medical Payments

If you are having trouble paying your medical bills, speak to your social worker or to the Practice Manager to see if there is any way to accommodate you. Staff at the Cancer Resource Center and social workers may also be able to refer you to a variety of useful services to help you reduce your financial burden. These services include pharmaceutical companies that provide low-cost and free drugs to low-income patients, reduced utility rates for low-income patients and coverage for certain transportation services.

## Public Disability Income Benefit Programs

### California State Disability Insurance

The State of California administers a program called State Disability Insurance (SDI). This is a 52-week program, which issues payments every two weeks. You pay your premium for this program through your employer, unless your employer has opted out and has a superior coverage. To be eligible to access this program you must have contributed into SDI via a California employer for at least 12 months for the full 52-week benefit.

### Social Security

The Social Security Administration (SSA) oversees two programs that pay disability income benefits to individuals who are legal United States and California residents, SSDI and SSI.

**1. Social Security Disability Insurance (SSDI)** provides a benefit based on an individual's FICA contributions. This program requires that an individual pay into Social Security for at least 20 of the last 40 quarters (five of the last 10 years) for individuals age 31 or older. SSDI requires a full and unpaid five-month waiting period. Eligibility begins in the sixth month, and payment is received at the beginning of the seventh month to cover the previous month. This program has no asset limits and is solely based on contributions to FICA and medical eligibility.

**2. Supplemental Security Income (SSI)** provides a minimum monthly income for those without other resources. To receive SSI you must apply for other disability benefits if eligible, such as SDI and SSDI. Your assets must add up to \$2,000 or less. However, your assets may include a home as long as you live in it, and may include a car as long as it is valued at or below \$4,500. The value of the car can be above \$4,500 if you use it to get to and from your medical appointments. You should apply for SSI as soon as you can after becoming disabled so as to establish an "onset date" and to start an application.

Social Security's Definition of Disability is defined as a physical or emotional impairment which is severe

enough to keep a person from doing work for a continuous period of not less than 12 months or which can be expected to result in death. To apply for disability benefits, contact Social Security (800) 772-1213 or at [www.ssa.gov](http://www.ssa.gov) to find a local office.

## **Private Short-Term and Long-Term Disability Insurance**

Private benefits can include Short Term Disability Insurance (STD) that pays a benefit for usually up to one year, or Long Term Disability Insurance (LTD) that pays a benefit for several years or until retirement age. These may be provided by an employer automatically or offered to employees on a voluntary basis. Individual policies exist, but are difficult to obtain if there is a pre-existing condition in the past ten years.

### **Short Term Disability**

Short-term disability (STD) provides insurance for short-term salary continuance because of disability. This can provide a gross benefit of 40 percent – 100 percent of gross pre-disability salary (income prior to disability) or a flat dollar amount. Gross STD benefit minus SDI, SSDI or sick leave equals the net STD benefit.

### **Long Term Disability**

Long-term disability (LTD) provides insurance for long-term salary continuance because of disability. This can provide a gross benefit of 40 percent to 70 percent of gross pre-disability salary (income prior to disability) or a flat dollar amount. Gross LTD benefits minus SDI, SSDI or sick leave equal the net STD benefit.

## **Employment Laws Protecting Cancer Survivors**

The Americans with Disabilities Act and Federal Rehabilitation Act prohibit certain types of job discrimination by employers against people who have or have had cancer.

### **Reasonable Accommodation**

If you are undergoing treatment for cancer or are recovering from cancer, federal law requires an employer to provide you with reasonable accommodation such as a change in work hours or duties. The employer is only required to provide you with reasonable accommodation after being informed of your condition.

### **Family and Medical Leave Act**

The Family and Medical Leave Act requires an employer with 50 or more employees in a 75 mile radius to provide up to 12 weeks of unpaid job-protected leave for family members who need time off to address their own serious illness or to care for a seriously ill child, parent or spouse.

## **Viatical Settlements**

Usually life insurance policies are used to benefit an individual's designated beneficiary when the policyholder dies. Recent laws, however, have made it possible for individuals with a catastrophic or terminal illness to sell their life insurance policy while they are still alive. This process, called viatication, enables individuals with a terminal disease to access a crucial source of money while they are still alive. Many people use the money from the sale of their life insurance policy to pay for medical treatment or to pay other bills. Companies offering viatication services typically pay between 35 percent and 85 percent of the face value of the policy. If you are considering viatication and have a life insurance policy through your work, it is important to make provisions for the continuation of the policy once you stop working so that you have the option of viatication at a later date. Since you will only receive a certain percentage of the face value of your life insurance policy, it is important to use sound judgment when considering this option. Another option is to contact the insurer of your policy to see if the company offers an accelerated benefits program.

And if you still have questions, make an appointment with one of the benefits counselors available through the Cancer Resource Center by calling (415) 885-3693.

***For additional information or resources, please visit the Cancer Resource Center at 1600 Divisadero St. on the first floor, or call at (415) 885-3693. The information in this publication is designed for educational purposes only and is not intended to replace the advice of your physician or health care provider. We encourage you to discuss with your physician any questions and concerns you may have.***