



Health Insurance and Financial Assistance for the Cancer Patient

Covering the costs of cancer treatment

When you're told you have cancer, how to pay for your care is not usually the first thing that comes to mind. But having health insurance coverage for your cancer treatment and all of the needed follow-up care is critical for most people.

Some people must work out money issues before they can even start treatment. For others, affording care can become a problem after treatment begins. Either way, it takes time and energy to manage your medical bills, insurance, and finances. This can be especially hard when you have cancer.

Here, we'll look at some of the new and existing resources that may be available to help people with cancer afford the care they need. Some of these resources can be helpful if you don't have health coverage. They include government programs that help low-income people get cancer screenings or treatment, disability benefits, aid from voluntary organizations, and living benefits from life insurance policies, including viaticals (these will be explained later on). Even if you have health insurance, you may find out that it doesn't cover all the costs involved. And even if you are well-insured, cancer can still cause financial problems.

It's important to have accurate, up-to-date information and a good understanding of your financial situation and insurance coverage. And, if your monthly health insurance premiums are not deducted from your paycheck, it's important to make sure you pay them on time to keep the coverage you have. Having no health insurance can be scary, but there are still options.

Here we will cover:

- Private health insurance options
- Government programs (Medicare, Medicaid, CHIP, VA, NBCCEDP)
- Options if you are uninsured

- Financial issues and help with living expenses
- Other resources

Private health insurance options

The health care law known as the Affordable Care Act (ACA) is intended to make private health insurance more affordable, especially for people with serious diseases such as cancer. The law also ensures that most insurance plans cover the health care that cancer patients and survivors might need. This section looks at the law's specific impact on different types of private health insurance.

For an overview of the new law, please read our brochure called *The Health Care Law: How It Can Help People With Cancer and Their Families*. You can also call us anytime at 1-800-227-2345 for the most up-to-date information and for answers to questions about health insurance.

Group health plans

Group health plans cover a group of people, usually employees of the same company, and often their dependents. Some employers pay part of employee health care *premiums*, which are the monthly payments required to continue coverage.

Many people get insurance coverage through a group plan offered by their employer. Under the new health care law, employers with 50 or more full-time workers must offer health insurance as of January 1, 2015 or pay a penalty. Employers with less than 50 full-time workers are not required to offer health insurance.

The law allows employees whose health insurance is too expensive (more than 9.5 percent of their income for the employee's coverage) to buy a different plan through their state's health insurance marketplace and receive financial assistance to help pay for it. Most people who now get their health coverage through work will likely continue to do so under the health care law.

Individual health plans

Individual health plans are sold by insurance companies directly to a person, not through an employer. Some individual plans also cover family members, or dependents. For many years, individual health plans could vary a lot by the types of health care services they covered, the amount of care they would pay for, how much they charged, and the types of people they covered. For example, insurance companies could look at your personal and family health history, and require physical exams or lab tests when deciding whether to insure you. Based on the results, they could decide not to offer you a health plan, or they could charge you higher monthly premiums than they did to younger, healthier people. They could require people who were sick or injured to pay more for their care or turn them down for coverage altogether. They also offered different levels of coverage, with most plans not covering the care needed by someone with a serious illness such as cancer.

The ACA makes major changes to individual health plans, many of which are designed to improve the coverage these plans offer and to make these plans more affordable for people with cancer or another serious illness. For instance, the law:

- Requires health plans to cover people with a pre-existing condition such as cancer
- Makes cancer screening tests, such as mammograms and colonoscopies, available at little or no cost to patients
- Prohibits insurance plans from canceling coverage if patient gets sick
- Requires that most individual health plans cover 10 categories of essential health benefits
- Prohibits insurance plans from charging sick people – including those with cancer – more for coverage than healthy people
- Prohibits annual and lifetime dollar limits on the amount of a patient’s care the plan will pay for
- Requires insurers to provide current policyholders and people shopping for coverage with a short and simple summary of their coverage
- Allows young adults to stay on their parents’ health insurance until age 26
- Makes sure that patients who take part in clinical trials are covered for their other health needs
- Helps individuals with low or moderate incomes buy health insurance
- Requires that most Americans buy health insurance or pay a penalty with their income taxes

Grandfathered health plans, exceptions, and cancellations

Individual health plans that do not meet the requirements of the new law, including those listed above, can continue to be sold if they existed before the law was signed in March 2010 and have stayed essentially the same since then. (These are called “grandfathered” plans.)

Health plans that have made substantial changes to their coverage since March 2010, or have been created since then, must adapt to the law’s requirements, with some exceptions. One important exception applies to health plans that aren’t technically grandfathered but still do not meet the law’s requirements for coverage. These non-grandfathered plans, which apply to individual and small-group plans, may continue to be sold through Oct. 1, 2016.

Insurance companies can cancel a health plan for several reasons. However, plan cancellations have received more attention than usual since the health care law went into effect. People across the country have received notice from insurers that their individual

plan has been or will be canceled. State insurance commissioners were given the option to allow health plans scheduled for cancellation at the end of 2013 to be sold for another year. In states where insurance commissioners approved, insurers were given the option to keep selling these plans to current policyholders. Keep in mind that these plans can still discriminate based on health status or history by charging more or denying coverage, because they are not required to comply with all of the patient protections included in the health care law. The plans cannot continue to offer coverage beyond the end of 2015.

It's important to note that several insurers are offering people whose insurance was canceled a different plan that does meet the law's requirements. Whether or not insurers offer policyholders this option, people whose individual plans are canceled can shop for coverage on the health insurance marketplace offered in their state, and may be able to receive financial help to pay for it (see below for more information on the marketplaces).

Where to get private coverage: the health insurance marketplaces

You can buy your insurance coverage (online, by phone, mail or in person) through health insurance marketplaces in each state. All plans sold in the marketplaces must meet the requirements of the ACA that make sure plans cover certain benefits. Patients receive straightforward information about the coverage offered. Individual health plans can still be sold outside the marketplaces, but the financial help that the law provides to help low- and middle-income people pay for coverage is only available with marketplace plans.

If you are under 65 and can't get health coverage through your employer, you may be able to buy a health plan through your state's health insurance marketplace. Low- and middle-income people and families can get financial help through the marketplace to help them afford a plan. People with health coverage through work whose health care premiums are too high compared to their income may also be able to buy coverage through a marketplace.

The health care law requires all health plans sold in a marketplace to cover essential health benefits, such as cancer screenings, treatment, and follow-up care. Each state's marketplace puts the health plans into groups, or "tiers," based on the level of coverage they offer and their cost to consumers. The highest tier is platinum, followed by gold, silver, and bronze. The platinum level is more costly up front, but tends to pay higher percentages and has lower deductibles. The bronze level is less expensive, but the out-of-pocket costs are higher in case of an illness.

After you give your information, the marketplace will tell you if you qualify for financial help to buy a plan. People who make up to \$46,680 per year and families of 4 with a combined income of up to \$95,400 a year should qualify for some help to buy a health plan through the marketplace. The marketplace will also tell you if you qualify for Medicaid, a government program that offers health coverage to low-income people.

The ACA gives states the choice to enroll more people in Medicaid coverage than ever before, but not all states have decided to do so. In those states, some very low-income people also won't qualify for help paying for insurance in the marketplace. For details on

whether you qualify and for how much, visit www.HealthCare.gov or CuidadoDeSalud.gov, or find your state marketplace by calling 1-800-318-2596.

Enrolling in a Marketplace Plan

The next open enrollment period is scheduled to start November 15, 2014 and end February 15, 2015. This is an opportunity for individuals to enroll in a new plan or choose a different plan. After February 15, 2015, people with a life-changing event such as the birth of a child can enroll in a marketplace plan at times outside of the open enrollment period. There are a few ways to enroll:

- Visit www.HealthCare.gov, the federal government’s official marketplace website. Whether your state offers the federally run marketplace or is operating its own marketplace, you’ll be directed to the right website through www.HealthCare.gov. The Spanish version can be found at www.CuidadoDeSalud.gov.
- Call the federal toll-free number at 1-800-318-2596 to enroll over the phone (TTY: 1-855-889-4325). Information about your state’s marketplace and the plans sold on it is offered 24 hours a day, 7 days a week in more than 150 languages.
- Apply in person with the help of a trained counselor in your community. Find help in your area at localhelp.healthcare.gov.
- Complete a paper application and mail it in. You can download the paper application form and instructions from www.HealthCare.gov or www.CuidadoDeSalud.gov.

Types of private health plans, and what you must pay

There are many types of health insurance and health service plans. Most of them require that you pay a monthly fee, called a premium. Most of them also require that you pay either a flat fee for doctor’s office visits and other services (called a co-pay), or a percentage of the cost (called co-insurance). Each year, you likely will also have to pay a certain dollar amount of your medical costs, known as the deductible, before your insurance will start to pay. After you have met your deductible, your insurance will pay a set percentage of your bills for medical care for the rest of the year.

You may have to pay your medical bills yourself and then fill out forms and send them to your insurer to get paid back. If your doctor “accepts” your insurance, their office will often bill the insurance company for you, and then send you a bill for the amount your insurance didn’t cover. You must keep track of your own medical expenses and payments that are made by you and your insurance company. This can help you greatly if there’s a dispute about payments or other problems in the future.

Here are very brief descriptions of private plans that used are most often:

Managed care plans

These types of plans typically coordinate or “manage” the health care of enrollees. There are different types of managed health care plans. Some plans – like health maintenance

organizations or HMOs – have a more limited network of providers and hospitals while other models like Preferred Provider Organizations (PPOs) have a wider provider network.

Most managed care plans have lower premiums, co-pays, and/or co-insurance than traditional fee-for-service insurance. Premiums, co-pays, and co-insurance amounts can differ between managed care companies and even between services within the same company. There's usually no need to file claim forms.

Some managed care plans require members to use a primary care provider who coordinates all of the patient's care and serves as a "gatekeeper" for care from specialists. The gatekeeper is usually a primary care doctor who's responsible for the overall medical care of the patient. This doctor organizes and approves medical treatments, tests, specialty referrals, and hospitalizations. For example, if you need to see an expert like a lung specialist, you would need a referral from your primary care doctor before the specialist sees you. Otherwise your plan might not pay.

Under most plans, members must use only the services of certain providers and institutions that have contracts with the plan. These plans may require that members choose providers from a particular list or network of providers. When you choose to go outside the network for care, you generally have to pay more, or even pay for the full service with no help from your health insurance plan. Some of these plans will pay at least part of the cost to see someone outside the network if you get approval from the plan before the visit or service (also called *pre-authorization*).

Many different types of institutions and agencies sponsor managed care plans, not just insurance companies. These include employers, hospitals, labor unions, consumer groups, the government, and others. It helps to know all the ins and outs of the plan and how it will affect your care.

These are the most common types of managed care plans:

- **Health maintenance organizations (HMOs):** The HMO will usually cover most expenses after a modest co-pay. HMOs often limit your choice of providers to those within their approved provider network. This means you have to check their listing to be sure the doctor you want to see is one of their doctors. If not, the bill may not be covered in full or at all. You might have to change to a different type of health plan to have your doctor's services paid. Or, you may have to switch to one of the approved doctors on their list.
- **Point-of-service plans:** A point-of-service plan (POS) is a type of HMO. The primary care doctors in a POS plan usually refer you to other doctors in the plan or network. If your doctor refers you to a doctor who's not in the plan (out of network), you should check to see if the plan will pay all or part of the bill before you go. But if you choose a doctor outside the network, you will have to pay co-insurance, even if the service is covered by the plan. Co-insurance is what you must pay in addition to what the insurance company pays for each service. It's usually a certain percentage of the cost. For example, the insurance company may pay 80% of the bill and you have to pay the other 20%.

- **Preferred provider organization:** The preferred provider organization (PPO) is a hybrid of fee-for-service (below) and an HMO. Like an HMO, there are only a certain number of doctors and hospitals you can use to get the most coverage. When you use those doctors (sometimes called *preferred* or *network* providers), most of your medical bills are covered. When you don't use these providers, the PPO makes you pay more of the bill out of your own pocket. So you pay more to choose providers that are not in the network.

Getting the most from your managed care plan: Sometimes you must go out of network for care. You may be able to reduce your costs if you discuss and negotiate costs up front with doctors, clinics, and hospitals when surgery, procedures, or other treatments are planned. You may want to contact your insurer to find out what the company will pay and how much you'll have to pay, or if you can get prior authorization from them to get out-of-network care.. You can use this information to find out if the medical facility or clinic will be willing to accept the amount paid by insurance as full payment. If not, ask if they're willing to discount the portion you're asked to pay.

Fee-for-service plans

Fee-for-service plans are the least restrictive plans that offer the most choice in medical providers. They are also called *traditional* health plans. If you have this type of health insurance, you can choose any doctor who accepts your particular health insurance plan, change doctors any time, and go to any hospital anywhere in the United States.

Things to consider when shopping for health insurance

For people living with cancer it's especially important to choose a health insurance plan that best meets your needs. When comparing plans, consider a number of factors, including:

- What are the total benefits covered by the plan?
- What are all of the costs associated with the plan, including premiums, deductibles and co-pays?
- Are your providers included in the network of doctors and hospitals covered by the plan?
- Does the plan cover the prescription drugs you take? For some ideas on looking at this, see the American Cancer Society Cancer Action Network (ACS CAN) document *Tips for Choosing a Health Insurance Plan with the Best Prescription Drug Coverage for You*.

For more on selecting an insurance plan, see "Shopping for insurance coverage" in the section "Health insurance options for the uninsured."

Other things to know about health insurance

Fake health insurance and other deceptions

There have always been people who look to profit from the needs and hardships of others. Now they're exploiting the health care law in many different ways. They may advertise on hand-lettered signs, post ads on Internet sites, or go door-to-door. They may be completely fly-by-night or they may have a legitimate-sounding 800 number. There are 3 basic approaches:

A common tactic is to offer a **stripped-down insurance policy** that doesn't meet the law's requirements for covering major illness. These policies are cheap because they make you pay for most of your own care. By the time you find out you have a serious illness it may be too late to get real coverage.

Another way is to offer a **medical discount card** that gives you minor discounts but leaves the big payments up to you. Sellers might call this "coverage" or "protection," but it's neither. Discount cards can be helpful, but they don't take the place of health insurance.

The third offers completely **fake health insurance**. The seller takes your money and gives you a piece of paper. They may promise lower rates if you buy now. The seller might say that they're "required" to offer this great, low-cost coverage by the Affordable Care Act. Sometimes scammers say that it's government-sponsored insurance or that they work for the government. Or they'll use a well-known insurance company's name, even though they don't work for the company.

Some fraudsters have gone to great lengths to create **websites that mimic official marketplace websites**. These sites are designed to fool people into thinking they are on an official marketplace site. They may offer anything from fake health insurance to a policy that doesn't cover serious illnesses. Be sure you are on healthcare.gov, your state's official website, or a site they refer you to before entering any personal information.

Identity theft scams

A final way that scammers may exploit you is by trying to get your personal and financial information for identity theft. Some might even call and pose as government workers looking to "update" your information, asking for your date of birth, Social Security number, or bank account numbers. According to the Federal Trade Commission, federal government employees never call you to update your insurance data. If you get such a call, do not provide any of your personal information. Instead, contact your plan directly to see if they called. You can get your plan's toll-free phone number by going to www.healthcare.gov or calling 1-800-318-2596. If you get a call from a scammer, notify the FTC online at www.ftccomplaintassistant.gov or call 1-877-FTC-HELP (1-877-382-4357).

How to spot scammers

The best way to avoid scammers is to shop for your insurance at www.healthcare.gov or by calling 1-800-318-2596. Scammers may still call, but your insurance choices can be safely made on the marketplace without regard to the scammers' efforts.

If you want to hear from non-marketplace plans, watch out for aggressive sales people, very low premiums and a push for you to sign up today. They may try to evade your questions, and often don't have the full policy details in writing. Some offer you coverage only if you join an association, union, or other group. You may not get an insurance card and policy for some time after you sign up, if ever. And when you file a claim, there's no response or a very slow response; when you call they explain it's a glitch or processing error – if they answer at all. Here are some tips to help you protect yourself.

- Don't give them money, but especially don't give them credit card information, birth date, Social Security number, or bank account numbers unless you are sure exactly who they are and what you're getting.
- Ask for the Summary of Benefits and read it carefully (See "How to manage your health insurance" in this section.) If you're in doubt, read the full policy or have someone read it for you.
- Check out any association you have to join to get insurance – go online, be sure they have a street address, and find out if they have any legitimate activity besides selling insurance.
- Call your state insurance department to be sure the plan is licensed in your state. Also ask if the plan has had complaints made against it. (See the "To learn more" section to find your state insurance department.)
- Finally, check with your doctor and pharmacist to be sure they accept the plan.

Catastrophic coverage

Treating and managing most cancers costs a lot of money. Some insurance plans offer supplemental coverage called "catastrophic" coverage with high deductibles and fairly low premiums.

Catastrophic illness insurance is sometimes called a *hospital-only* or *short-term plan*. The plans often won't cover doctor visits, medicines, or routine care, but kick in when you are hospitalized and have very high expenses. Depending on the policy, expect to pay a few thousand dollars for the deductible alone and some percentage of co-insurance on the rest of the bill plus the total cost for any items and services not covered by the plan.

Even though they can be called "hospital-only," the plans won't necessarily cover all or even most of your hospital bill. It is important to understand exactly what the plan will cover and not rely on catastrophic plan for your primary coverage. These plans will not provide comprehensive coverage to treat a disease such as cancer and do not meet the requirement of the health care law to have insurance. If this is your only form of

coverage, you will likely still face a penalty at tax time unless you're exempted from the requirement to buy health insurance.

Catastrophic coverage plans may be offered in the state health care marketplaces for people with low incomes or who are exempt from having to get standard health coverage. The marketplace plans have some advantages over catastrophic coverage plans not sold in the marketplaces, in that they cover 3 annual doctor visits and preventive benefits. People with this exemption don't have to pay a penalty at tax time. But a person who requests an exemption from buying a regular health plan can't get help paying the premiums for catastrophic coverage, even if their income is very low.

Health Savings Accounts

If you have enrolled or plan to enroll in an insurance plan with a high deductible, you may be able to set up a Health Savings Account (HSA). You don't have to pay federal income taxes on the contributions you make to the HSA if the money is used to pay for qualified medical expenses. If you use it for anything else, you will be required to pay the tax and a penalty.

Note that an HSA is different from a Flexible Spending Account (FSA); for instance, you can have an FSA even if you don't have a high-deductible health plan. FSA funds are set up to be used for both medical and child care expenses. But the FSA money you don't use goes away at the end of each year, while the HSA money is yours until you take it out. For more information about setting up an HSA contact your employer, bank, or credit union.

Pre-existing condition exclusions

A *pre-existing condition* is a health issue that you had *before* you joined your health plan. Before the new health care law went into effect, health plans could impose a *pre-existing condition exclusion period* on patients, meaning that the patient would have to wait a certain amount of time before the plan would pay any health care costs related to the pre-existing medical problem. The wait could be as long as a year for employer plans, and some individual plans refused to cover certain pre-existing conditions such as cancer at all.

The health law prohibits most health plans from imposing pre-existing condition exclusion periods, or from refusing to cover people with a pre-existing condition at all. However, some health plans, including some "grandfathered" plans that were in existence when the law was signed in March 2010, can still include exclusion periods for pre-existing conditions.

"Grandfathered" employer plans: Federal law has long prevented employers from applying exclusion periods for a pre-existing condition in some situations, a policy that still applies to grandfathered employer plans. You may be able to avoid the exclusion period in a grandfathered plan if you have had health insurance with a previous employer and have not been without health insurance coverage for more than 63 days. Some states require employer plans to cover pre-existing conditions even for people who were

without insurance for more than 63 days. You can call the US Department of Labor at 1-866-444-3272 to find out more about your specific situation. (See the section called “The Health Insurance Portability and Accountability Act of 1996” for more information.)

“Grandfathered” individual policies: Grandfathered policies in the individual market can still impose exclusion periods on people with pre-existing conditions. If you have a grandfathered individual plan, the pre-existing condition exclusion period could still be many years or even unlimited. Such plans can also continue to impose an *elimination rider* that keep that disease, body part, or body system from ever being covered by that policy. It’s important to know these things before you sign up. (See “High-risk pools and Pre-Existing Condition Insurance Plans” in the section “Health insurance options for the uninsured.”)

“Grandfathered” plans going away: The health care law defines grandfathered plans as those that were being sold when the law began to go into effect in March 2010 and that haven’t made significant changes to the coverage they offer or the prices they charge. Because health plans frequently change their coverage and/or price from year to year, many plans lose their grandfathered status over time. The total number of grandfathered plans is shrinking, and eventually there will be few, if any, grandfathered plans left. If you have had your insurance plan since at least 2010, it’s important to find out if it is a grandfathered plan.

Hospital indemnity policies and other supplemental insurance

Hospital indemnity policies, sometimes called *supplemental medical policies*, pay a fixed amount for each day a person is in the hospital. There may be a limit on the total number of days it will pay for in a calendar year, or a cap on the total number of days it will ever pay. The money received from this type of policy can be used however the insured wishes. It’s often used for medical costs not paid by the insurance company, or the other expenses that families face when one member is ill.

These supplemental plans don’t provide comprehensive coverage to treat a disease such as cancer and don’t meet the requirement of the health care law to have insurance. So, if this is your only form of coverage, you will likely still face a penalty at tax time. You could also be liable for significant out-of-pocket costs if you have a serious illness.

Critical-illness policies: There are other types of policies that offer extra money in case a person gets one certain kind of health problem such as cancer, stroke, or an accident. You can’t buy these critical-illness policies after you are diagnosed, and there are often conditions and waiting periods. The limitations on these types of policies mean that for many people with health insurance, they are not worth the expense.

Long-term-care insurance: This is not health insurance, but includes long-term medical and non-medical care given to people who need help performing basics like eating, dressing, walking, toileting, or bathing. Long-term services might be given at home, or in community, assisted living, or nursing homes. Unpaid family members often provide this kind of care in the home.

Terms of long-term-care insurance policies vary. For instance, most policies don't start paying until more than 90 days of such care are needed, but some wait up to a year to start covering it. Home care may be covered separately or not covered at all in some policies. Long-term-care insurance can be very expensive. Medicare and most health insurance plans don't pay for long-term care.

National law prohibits discrimination based on genetic testing or test results

The Genetic Information Nondiscrimination Act (GINA) does not allow health insurers to turn down individuals or charge higher premiums for health insurance based on genetic information or the use of genetic services, such as genetic counseling. GINA defines genetic information as any of these:

- A person's own genetic tests
- The genetic tests of family members
- One or more family members with a genetic disease or disorder

GINA bars group health plans, individual plans, and Medicare supplemental plans from using genetic information to limit enrollment or change premiums. It also forbids these insurers to request or require genetic tests. GINA applies to all health insurance plans (including federally regulated plans, state-regulated plans, and private individual plans).

The law also forbids discrimination by employers based on genetic test results or genetic information. GINA states that employers must not discriminate on the basis of genetic information (no matter how they got the information) in hiring, firing, layoffs, pay, or other personnel actions such as promotions, classifications, or assignments.

How to manage your health insurance

- **DO NOT** let your health insurance expire.
- If you are changing insurance plans, don't let one policy lapse until the new one goes into effect – this includes when you are switching to Medicare.
- Pay your health insurance premiums and other costs in full and on time. New insurance can be hard to get and can cost a lot.
- Know the details of your individual insurance plan and its coverage. Ask for a Summary of Benefits and Coverage (SBC), an easy-to-understand description of a plan's benefits and the costs you will have to pay. If you think you might need more coverage than a plan offers, ask your insurance carrier if it's available.
- When possible, call the insurer to make sure that any planned medical service (such as surgery, procedures, or treatments) does not require prior authorization.

- If a bill looks odd or wrong, make sure to call or email your insurer to avoid being mistakenly charged more than you should.
- Submit claims for all medical expenses, even when you're not sure if they're covered.
- Keep accurate and complete records of claims submitted, pending (waiting), and paid.
- Keep copies of all paperwork related to your claims, such as letters of medical necessity, explanations of benefits (EOBs), bills, receipts, requests for sick leave or family medical leave (FMLA), 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 special payment arrangements if you let them know about your situation.
- Send in your bills for reimbursement as you get them. If you become overwhelmed with bills or tracking your medical expenses, get help from trusted family and friends. Contact local support organizations, such as your American Cancer Society or your state's government agencies, for extra help.

Getting answers to insurance-related questions

Questions about insurance coverage often come up during treatment. Here are some tips for dealing with insurance-related questions:

- Speak with the insurer or managed care provider's customer service department.
- Ask the cancer care team social worker for help.
- Hospitals, clinics, and doctors' offices often have someone who can help you fill out claims for insurance coverage or reimbursement. A case manager or a financial assistance counselor may be able to help guide you through what can be a complicated process.
- Talk with the consumer advocacy office of the government agency that oversees your insurance plan. (See the section "Who regulates insurance plans?")
- Learn about the insurance laws that protect the public. Call your American Cancer Society National Cancer Information Center at 1-800-227-2345. You might also visit www.healthcare.gov/using-insurance/understanding/rights/index.html for more information.

Keeping records of insurance and medical care costs

It can be hard to keep track of all the bills, letters, claim forms, and other papers that begin flowing into your home after a cancer diagnosis. But keeping careful records of medical bills, insurance claims, and payments helps families manage their money better and lower their stress levels. Some families already have a system for tracking their finances and records and only need to expand it and create new files. Others may have to come up with a plan to handle all of the paperwork. One method is to keep a simple notebook with tabs for each month. It's an easy way to track bills, insurance, Explanation of Benefits forms, and payments.

Record-keeping is also important for those who wish to take advantage of the deductions available in filing itemized tax returns. The Internal Revenue Service (IRS) has information and free publications about tax deductions for cancer treatment expenses (see the "To learn more" section). These rules change from time to time, so the IRS is the best source for timely information.

Keep records of the following:

- Medical bills from all health care providers – write the date you got the bill on each one
- Claims filed, including the date of service, the doctor, and the date filed
- Reimbursements (payments from insurance companies) received and explanations of benefits (EOBs)
- Dates, names, and outcomes of calls, letters, or emails to insurers and others
- Medical costs that were not reimbursed, those waiting for the insurance company, and other costs related to treatment
- Meal and lodging expenses
- Travel to and from doctor's appointments, treatments, or the hospital (including gas, mileage, and parking for a personal car; and taxi, bus, medical transportation, or ambulance)
- Admissions, clinic visits, lab work, diagnostic tests, procedures, and treatments
- Drugs given and prescriptions filled

Here are some ideas to help you with record-keeping:

- Decide who in the family will be the record-keeper or how the task will be shared.
- Get the help of a relative or friend, if needed. This may be especially important for people who are single or who live alone.

- Set up a file system using a file cabinet, drawer, box, binders, or loose-leaf notebooks.
- Review bills soon after getting them and note any questions about charges.
- Check all bills and explanations of benefits (EOBs) paid to be sure they are correct.
- Some people prefer to pay bills by check so they have a clear record of payment. If you pay bills online, you can save electronic copies of payment documents on your computer, or print out proof of payment.
- Save and file all bills, payment receipts, and explanations of benefits (EOBs). If you use checks, your bank or credit union can tell you how to get copies of canceled checks if needed. If you have to get canceled checks or proof of online payments from banks or credit card companies, you may be charged a fee.
- Keep a daily log of events and expenses; a calendar with plenty of writing space is useful.
- Keep a list of cancer care team members and all other contacts with their phone and fax numbers and email addresses.
- Find out what is tax deductible and be sure to keep the originals of those records. (See the “To learn more” section for the IRS phone number.)

When you have problems paying a medical bill

Many people go through times when they find it hard to pay their bills on time. Most hospitals and agencies are willing to discuss and help resolve these problems. To keep a good credit rating, pay attention to notices that say the bill will soon be turned over to a collection agency. You want to avoid this if at all possible.

When a medical bill comes that can't be paid right away, families can try the following:

- Explain the problem to the hospital or clinic financial counselor or the doctor's office secretary.
- Work out a payment delay or an extended payment plan.
- Talk with the team social worker about sources of short-term help.
- Think about asking relatives or friends to help out with money on a short-term basis.

Handling a claim denial

It's not unusual for some claims to be denied or for insurers to say they will not cover a test, procedure, or service that your doctor ordered. The new health care law gives

consumers more information and the right to appeal a claim denial. For example, an insurer must notify you in writing of a claim denial within 30 days after a claim is filed for medical services you've already gotten, and within 72 hours for urgent care cases.

Under the health care law, health plans that are not "grandfathered" (those that began on or after September 23, 2010, or began before then but have made significant coverage changes) must have an internal appeals process that:

- Allows consumers to appeal when a health plan denies a claim for a covered service or rescinds (takes back) coverage
- Gives consumers details about the reasons for the denial of claims or coverage
- Requires plans to notify consumers about their right to appeal and how to begin the appeals process
- Offers consumers a way to speed up the appeal in urgent cases

If the insurer denies a claim, it must explain your right to appeal the decision. If you ask for it, the insurer must give you all the information about the decision. Plans that were started before September 23, 2010, are still covered by the old rules ("grandfathered"), although the way you appeal the denial will be the same as for newer plans.

Before you appeal, you may want to take these steps:

- Ask your customer service representative for a full explanation of why the claim was denied.
- Review your health insurance plan's benefits. This may require looking at the more detailed Summary of Benefits notice.
- If your plan is through your or your spouse's employer, contact your health plan administrator at work to find out more about the refusal.
- Ask the doctor to write a letter explaining or justifying what has been done or has been requested. Keep a copy of this letter in case an appeal is needed later.
- Ask your insurer if your employer's health plan is self-insured, and on what date the plan started (to learn if the new law's requirements apply or if the plan is "grandfathered"). This will help you figure out which rules apply and which appeals process to follow.
- Talk to your state insurance department or the agency that regulates your insurance company to verify that the insurance company has acted properly and that the denial has not been made in error. (See the section "Who regulates insurance plans?")

You can then re-submit the claim with a copy of the denial letter and your doctor's explanation, along with any other written information that supports using the test or treatment that has been denied. Sometimes the test or service will only need to be "coded" differently. If questioning or challenging the denial in these ways doesn't work, you may need to:

- Put off payment until the matter is resolved. Keep the originals of all the letters you get; your cancer care team may be able to help you make copies if you need them.
- Keep a record of dates, names, and conversations you have about the denial.
- Formally request an *internal appeal* (or *internal review*) by the insurance company. Complete any forms the insurer requires, or write them a letter explaining that you're appealing the insurer's denial. Include your name, claim number, and health insurance ID number, along with any extra information such as a letter from your doctor. Your cancer care team may be able to help with this.
- You have 6 months (180 days) from receiving your claim denial to file an internal appeal.
- Find out if you live in one of the US states that have a special Consumer Assistance Program (CAP) that can help you file an appeal.
- If you don't live in a CAP state, get help from the consumer services division of your state insurance department or commission. Check the blue pages of your phone book or contact the National Association of Insurance Commissioners online at http://naic.org/state_web_map.htm, or you can call them at 1-866-470-6242.
- Be persistent. Do not back down when trying to resolve the matter.
- Find out about getting an external review (see "The external appeals process" below).

The external appeals process

If your internal appeal is denied, you may be entitled to an independent *external review*, by people outside of your health plan. Note that if you have employer-sponsored coverage, you may have to file a second internal review before you can file for an external one. Check with your insurance company about the process. For urgent health matters, the timelines are shorter, and you may be able to ask for an external review at the same time you ask for an internal one.

Outside or commercial health plans: Most commercial health plans (those offered by insurance companies) take part in the federal external review process. Find out if yours does, and if so you can call the US Department of Health and Human Services (www.healthcare.gov) at 1-877-549-8152 for an external review request form. Or, you can visit <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/csg-ext-appeals-facts.html> to learn more about internal and external appeals. There you can also get a tracking form to help you keep up with each step of the appeals process.

Self-insured health plans: If your plan is self-insured (see section called "Who regulates insurance plans?"), you can ask your insurer how to start an independent external review. Or you can contact the Employee Benefits Security Administration at the US Department of Labor. You can find contact information in the "To learn more" section.

If all the internal and external appeals are exhausted, and the claim is still denied, ask the health care provider if the cost of the bill can be reduced. Many providers are willing to reduce the bill to get paid faster.

Keeping employer-sponsored health insurance coverage

Federal laws give people the chance to continue employer-sponsored medical insurance coverage when a person has a qualifying event (defined in the “COBRA” section). In 2014, the health care law began offering the option to purchase new coverage through health insurance marketplaces (which may have different names in different states and are also called “exchanges”.) These plans may offer more affordable coverage options than an employer plan through COBRA. This is more important to people who make less money, since they may be able to get financial help in the marketplace to pay for their insurance coverage.

COBRA (Consolidated Omnibus Budget and Reconciliation Act of 1986)

COBRA gives you the right to choose to keep your health insurance coverage at the employer’s group rates. Because the employer usually covers a portion of the plan cost when you’re employed, you usually pay much more than you paid while employed. In most cases, you can keep the insurance for up to 18 months. Some people may be able keep it a few months longer.

COBRA is available when insurance coverage is lost due to certain qualifying events. These events are:

- Stopping work
- Reducing work hours
- Divorce or legal separation
- The covered person becoming eligible for Medicare
- A dependent child no longer considered to be dependent according to the terms of the plan
- Death of the employee

How long COBRA allows people to keep their group medical insurance depends on the qualifying event. For example:

- Up to 18 months of coverage is allowed if you stop working or reduce the number of hours you work.

- 29 months of coverage is possible if a beneficiary is considered disabled. (This determination of disability is made by the Social Security Administration.)
- 36 months of coverage is available for the spouse or child in cases of divorce or legal separation, the covered person becoming eligible for Medicare, death of the employee, or when a dependent child is no longer considered to be a dependent.

If a person is fired for gross misconduct, he or she is not eligible for COBRA.

COBRA is not provided automatically but must be chosen by the former employee within 60 days of getting the written COBRA “election notice” (this is not always within 60 days of when you stopped working). The employer must notify an employee in writing that COBRA is available after work is stopped or hours are reduced. If you elect to keep your insurance through COBRA during that 60 days, it will retroactively cover you back to the date your insurance ended.

But there’s also a deadline for notifying the plan administrator of qualifying events that don’t directly involve the employer, which varies according to the qualifying event. Whose responsibility it is to notify the plan administrator also depends on the qualifying event. In cases of family changes, the beneficiary must do it, as in these situations:

- Divorce
- Legal separation
- An employee’s child reaches the status of non-dependent

This means it may be the employee, the employee’s spouse, or the employee’s adult child who needs to notify the plan administrator of a qualifying event. If this notice is not given within the deadline, the spouse or child may lose their COBRA rights. But if a family member gets COBRA because of one of these changes in family situation, it can be extended to 36 months. Contact the employer’s human resources person, your insurance company, or check your policy to find out the details of what must be done and who should do it.

You can keep your health insurance 1) if the premium is paid, 2) until the person becomes covered under another group policy, and 3) up to a certain time limit. Premiums cannot be more than 102% of the cost of the plan for employees in similar situations who have not had a “qualifying event.” COBRA coverage may be lost if you go above the limits of the coverage (which can only happen if your plan is grandfathered), your former employer stops offering all health plan coverage, or you become eligible for Medicare after you choose COBRA.

COBRA is administered by the US Department of Labor and they can give you more details on how it works. (See the section called “To learn more.”) Families often are concerned about being able to pay the premiums for COBRA. If this is the case, talk to your team social worker who may have suggestions about how to help with these costs.

For more information, read our document *What is COBRA?*

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA is a federal law with many clauses that can help cancer patients. This law applies only to “grandfathered” plans that were in existence when the Affordable Care Act went into effect in March 2010 and have not been changed significantly since then. HIPAA allows a person who has had a grandfathered health insurance for at least 12 months with no long loss of coverage (usually more than 63 days) to change jobs and be guaranteed other coverage with a new employer, as long as that new employer offers group insurance. In this case there may be no waiting period and the pre-existing condition exclusion may be reduced or not applied. Also, the employee and his or her dependent cannot be denied coverage because of a pre-existing health problem. (See “Pre-existing condition exclusions” in the section “Other things to know about health insurance.”)

HIPAA requires insurers to renew coverage for all employers and individuals as long as premiums are paid on time. It also guarantees that group insurance coverage is available for employers with 2 to 50 employees. But it does not require these small employers to buy and offer the insurance to their employees.

For more information about HIPAA see our document *What is HIPAA?* or contact your state department or commission of insurance. See the section called “To learn more” for contact information.

The Family and Medical Leave Act of 1993

The Family and Medical Leave Act (FMLA) requires employers (with at least 50 employees) to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for certain family and medical reasons. Employees are eligible if they have worked for a covered employer for at least 1,250 hours in the previous 12 months. For the time period of the FMLA leave, the employer must maintain the employee’s health coverage.

This act is regulated by the US Department of Labor’s Wage and Hour Division. They can give you more information. Check your local phone book under US Government, Department of Labor for contact information, or find it in the “To learn more” section.

Our document called *Family and Medical Leave Act (FMLA)* also gives you more details on this option.

The Americans With Disabilities Act of 1990

The Americans With Disabilities Act (ADA) helps to protect anyone who has, or has had, certain disabilities, including any diagnosis of cancer, against discrimination in the workplace. Parents of dependent children with cancer and spouses of people with cancer are also protected under this law.

The ADA requires private employers who employ 15 or more people, labor unions, employment agencies, and government agencies to treat employees equally, including the benefits offered them, without regard to their disabling condition or medical history. It also does not allow employers to screen out potential employees who have children with disabilities.

This act, along with the Health Insurance Portability and Accountability Act (HIPAA) makes it easier to change jobs and move from one group insurance plan to another. The ADA is administered by the US Equal Employment Opportunity Commission (EEOC). They can answer questions and give you more information by phone at (1-800-514-0301). You can also get more information in our document called *Americans With Disabilities Act: Information for People Facing Cancer*.

Government-funded health plans

Medicare

Medicare is a federal health insurance program for people age 65 and older and those under 65 with certain disabilities. To qualify for Medicare you must be a US citizen or qualified legal immigrant who meets certain criteria. Young people with cancer may get Medicare benefits after collecting Social Security benefits for 2 years under the Supplemental Security Income program. Each year – October 15th through December 7th – people with Medicare can review and change their Medicare choices.

You can get more information from the Social Security Administration (check the blue pages of your phone book or the “To learn more” section in this document), or by talking with your cancer care team social worker.

Medicare is offered to people who meet one or more of these requirements:

- Age 65 or older
- Have been permanently disabled and are getting disability benefits from Social Security (after a 2 year waiting period)
- Have permanent kidney failure treated with dialysis or a transplant

There are two types of Medicare plans:

- Original (traditional) Medicare

OR

- Medicare Advantage Plans – which are offered by private insurers.

Medicare has 4 parts

Part A pays for hospital care, home health care, hospice care, and care in Medicare-certified nursing facilities. For most people, there's no monthly premium, but you pay a yearly deductible before Medicare pays anything. After that's paid, Medicare pays its share, and you pay your share (your co-insurance or co-pay) for covered services and supplies. You can go to any doctor or supplier that accepts Medicare and is accepting new Medicare patients, or to any hospital or other facility. You may have a Medigap policy or other supplemental coverage that may pay deductibles, co-insurance, or other costs that aren't covered by Medicare Part A. (See below, "Private insurance coverage that can be added to Medicare.")

Part B covers diagnostic studies, doctors' services, durable medical equipment used at home, some home care, and ambulance transportation. Part B is optional, and there's a monthly premium, with higher-income beneficiaries paying a higher Part B premium. However, if you do not sign up for Part B when you are first eligible, you will pay a late enrollment penalty unless you were covered by another form of insurance that is at least as good as Medicare. Each year, before Medicare pays anything, you must pay your own medical expenses to equal the deductible, based on Medicare's approved "reasonable charge," not on the provider's actual charge. And you must still pay co-insurance or a co-pay on the rest of the covered charges for that year.

Part C is actually a combination of Parts A and B and is provided by private insurers. It's called *Medicare Advantage*. The private insurance companies must be approved by Medicare, and must provide all hospital and medical benefits covered by Medicare. The private insurers in Medicare Advantage charge a monthly premium, and some include the Part D prescription drug coverage (see "Part D" next paragraph), as well as extra benefits like vision, hearing, and dental coverage. Part C is not available everywhere. Medicare Advantage plans can be PPOs, HMOs, or fee-for-service plans. (See the section "Types of health plans" for more on these different plans.) There's also a *Part C Medicare Special Needs* plan, which is designed for people with long-term health problems. These plans must include Parts A, B, and D coverage.

Part D is optional. It helps pay for prescription drugs that are usually bought at a retail pharmacy. You can enroll in Part D through a Medicare Advantage plan or, if you are in traditional Medicare, you can buy a separate drug coverage policy. You pay a monthly premium, which varies by plan, and a yearly deductible. People with higher incomes will pay a higher Part D premium. You will pay a higher premium if you didn't sign up for Part D when you first became eligible, unless your drugs were covered by another plan ("creditable" prescription drug coverage). You will also pay a part of the cost of your prescriptions through co-pays or co-insurance. Costs vary based on which drug plan you choose. Some plans may offer more coverage and a wider choice of drugs for a higher monthly cost. If you have limited income and resources, you may qualify for extra help, so that you don't have to pay a premium or deductible. You can apply or get more information about the extra help by contacting the Social Security Administration (see "To learn more" for contact information). You can find out more about Medicare Part D

and how it applies to people with cancer in our document *Medicare Part D: Things People With Cancer May Want to Know*.

The health care law makes some important changes to Medicare. For example, it gradually closes the “donut hole” in Part D that forced some seniors to pay high costs for prescription drugs. For more on this, see our document called *Medicare Part D: Things People With Cancer May Want to Know*.

The new law also makes proven cancer screenings, such as mammograms and colonoscopies, and other preventive care available at low or no cost to people in Medicare if it is provided based on accepted guidelines. And it makes sure that Medicare covers a yearly check-up to discuss disease prevention and ways to stay healthy. (See our document called *Medicare Coverage for Cancer Prevention and Early Detection* for more details).

Medicare provides basic health coverage, but it won't pay all of your medical expenses. For example, it may cover the costs of prostheses (substitute body parts) or bras, but the number covered per year can vary from state to state. Medicare also limits the number of ostomy supply items it covers each month.

A lot of confusing information and rumors about how Medicare benefits change (or don't change) under the health care law have been going around. If you have Medicare questions, call 1-800-633-4227 or contact your local Social Security office. You can also go online to www.medicare.gov to find the annual Medicare handbook, access a tool that will help you choose a Medicare Part D plan, or get personalized Medicare counseling at no cost to you through the State Health Insurance Assistance Program (SHIP). Contact information for each state SHIP is included in the back of the printed Medicare handbook or online at www.medicare.gov.

Private insurance coverage that can be added to Medicare (Medicare Supplement Insurance or Medigap)

If you are enrolled in standard Medicare, you may be able to add more coverage with a Medicare Supplement Insurance policy (commonly called *Medigap*). There are standard Medigap policies, identified by letters A through N. Each offers a different combination of benefits and is offered in all 50 states, but the plans may not be the same in all states, and not all states offer all plans. . It's important to compare Medigap policies because premiums and other costs can vary, and some of the plans expect you to use only certain doctors or hospitals.

Medicaid

Medicaid is a joint state and federal government program that covers much of the cost of medical care for people with income below a certain level. These levels can vary from state to state. Not all health providers accept Medicaid.

In past years, Medicaid covered specific groups of people, including:

- Low-income families with children
- Supplemental Security Income (SSI) recipients
- Children under age 6 from low-income families may be eligible in some states (even if other family members are not)
- Pregnant women whose income is below the family poverty level
- Infants born to Medicaid-eligible pregnant women
- Low-income women with breast or cervical cancer who were diagnosed through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP)

Several states still limit Medicaid to the above groups of people, but the health care law now gives states the choice to cover more low-income people through Medicaid. States that take this option (see the Kaiser Family Foundation website for updates) have extended Medicaid coverage to everyone earning up to a certain amount, whether or not they fall into one of the specific categories listed above. The law offers federal funds to pay all of a state's costs to increase Medicaid coverage at the start, with the federal share slowly going down to 90%.

Unfortunately, in the states that have decided not to cover more people through Medicaid, many low-income people will remain uninsured because they won't qualify for it. And many of those with incomes below the poverty level will also learn that they can't get help paying for private insurance in the health insurance marketplace either. If this happens to you and your income later increases, you might want to re-apply during open enrollment to find out if you qualify for help buying private insurance. If your income drops lower or your situation changes, you can re-apply for Medicaid any time.

For details on whether you qualify for Medicaid, visit www.healthcare.gov or CuidadoDeSalud.gov, or find your state marketplace by calling 1-800-318-2596. States can decide at any time to extend Medicaid coverage as allowed under the health law. If you live in a state that has broadened its Medicaid coverage, it's a good idea to re-apply for 2015, even if you've been turned down before.

The "newly eligible" Medicaid beneficiaries are those who will benefit from their state's decision to cover more people under the program. They are covered for the law's essential health benefits to prevent and treat serious diseases such as cancer. The law also ensures that anyone can learn whether they are eligible for Medicaid through their state's health insurance marketplace. The marketplace is a website where people can look for health coverage on their own. You also can get information on the marketplace by phone (see "Where to get private coverage: the health insurance marketplaces" in the "Private health plans" section).

Medicare plus Medicaid: People on Medicare who also have a low income and limited resources may get help paying for their out-of-pocket medical expenses from their state Medicaid program. For more information, contact your state Medicaid office (see the "To learn more" section).

State-sponsored children's health insurance programs

A special state/federal partnership pays for medical services for children, called the Children's Health Insurance Program (CHIP). CHIP offers some type of low-cost health insurance to uninsured children and pregnant women in families with incomes too high to qualify for state Medicaid programs, but too low to pay for private coverage.

Within federal guidelines, each state sets up its own CHIP program, including eligibility guidelines, benefits offered, and cost. The program covers doctor visits, medicines, hospitalizations, dental care, eye care, and medical equipment. It's funded by state tax dollars. People enrolled in Medicaid usually are not eligible for state sponsored health insurance programs.

To find out more about CHIP, call 1-877-543-7669. You can also go to the CHIP website, www.insurekidsnow.gov, to learn more about the program and find your state's CHIP.

Veterans' and military benefits

Veterans: If you have ever been on active duty in the military, you might qualify for Veterans Administration (VA) health benefits. The VA looks at how long you served, the type of discharge you received, disability, income, availability of VA services in your area, and other factors to decide if you are eligible. Veterans' benefits change often, and the number of veterans' medical facilities has been declining in recent years. See the "To learn more" section to learn how to contact the Department of Veterans Affairs to get the latest information.

Active duty, reservists, retirees, survivors, and family: TRICARE is the Department of Defense's health insurance program for those in the military, as well as some family members, survivors, and retirees. It offers a number of different plan options to cover people in the US and overseas, and includes family plans as well as plans for certain reservists. Pharmacy plans, dental plans, and other special services are available for some beneficiaries. If you were or are married to a veteran who retired from the military you may be eligible for Tricare.

Each TRICARE plan has its own limits and requirements. Choose your plan carefully and know how it works. Contact TRICARE for complete and current information on TRICARE benefits for those who have been in the military and their families, including eligibility, plan details, and cost, as well as how to find providers in your area. You can find this information online, including the number to call in your area, at www.tricare.mil.

Widows or widowers, and spouses or children of military members with service-related disabilities: Another program called Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is available to certain spouses or widows(ers) and their children who are not eligible for TRICARE. CHAMPVA can cover the spouse or widow(er) and the children of a veteran who:

- Is permanently and totally disabled due to a service-connected disability as determined by a VA regional office
- Was rated permanently and totally disabled due to a service-connected condition at the time of death
- Died from a service-connected disability
- Died in the line of duty and the family members are not eligible for TRICARE benefits

CHAMPVA is a comprehensive health care program in which the VA shares the cost of covered health care services and supplies with eligible beneficiaries. The program is administered by the VA Health Administration Center. You can find out more about CHAMPVA, including things like eligibility, benefits, finding a provider, and filing claims by calling 1-800-733-8387, or visiting their website, www.va.gov/hac (select CHAMPVA under “Special Programs”).

Activated reservists and their employee health benefits: Members of the military reserve units who are called up for active duty from private employment have specific rights about the health care coverage they get from their employers. They are allowed to pay the full cost of insurance, very much like COBRA, during their time away. When they return to work, their coverage must be reinstated without any waiting period. See the “To learn more” section for US Department of Labor contact information.

Breast and cervical cancer screening and treatment for low-income women

Medically underserved women can get tested for breast cancer for free or at very little cost through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). This program provides breast and cervical cancer early detection testing for women who are uninsured, or in some cases under-insured. Every state offers the program, and the Centers for Disease Control and Prevention (CDC) helps support the program.

Although the NBCCEDP can help women find cancer early, uninsured women still need help getting treatment. The Breast and Cervical Cancer Prevention and Treatment Act provides money to pay for breast and cervical cancer treatment for certain uninsured women who are under age 65. As in the NBCCEDP, each state must adopt the program to get the matching federal funds. Even though the money is channeled through each state’s Medicaid program, it helps women who would not otherwise be eligible for Medicaid.

This program continues to be necessary even with the new health care law, especially in states that choose not to cover more people through Medicaid. The program also serves as a critical safety net even in states that choose to increase access to Medicaid coverage.

Some states are considering phasing out their NBCCEDP programs, so it’s important to check on the status of the program in your state. Information on the NBCCEDP can be

found on the CDC website at www.cdc.gov/cancer/nbccedp/index.htm, or you can call the CDC at 1-800-232-4636 to learn more.

Who regulates insurance plans?

It's important to know who regulates a health plan if you have a problem that you can't resolve directly with the plan. You have the option of talking to the government group that regulates the health plan to find out if they can offer more information or extra help.

- **Private group plans (or fully insured plans)** purchased from insurance carriers by employers as a benefit for employees are usually overseen by the insurance commissioner or department of insurance in each state. You can find your state's insurance department in the blue pages of your local phone book, or contact the National Association of Insurance Commissioners (see the "To learn more" section for contact information).
- **Self-funded plans (or self-insured plans)** are health plans that employers or unions create just for their employees and their families. They are overseen by the US Department of Labor's Employee Benefits Security Administration. (See the "To learn more" section for the website and phone number.) You may have to ask your employer if their health plan is fully insured or self-insured.
- **Individual plans sold through the health insurance marketplaces** are regulated by a marketplace board in every state. This state board oversees the function of the marketplace and the plans sold within it.
- **Managed care plans** are regulated by several state and federal agencies. Your state insurance commissioner or department of insurance can provide specific information about an individual plan.
- **Medigap policies** (Medicare Supplement Insurance policies) are regulated by federal agencies, as well as some state laws. Contact the Centers for Medicare and Medicaid Services (CMS) and/or your state department of insurance for information.
- **Medicaid** is a joint program that is controlled by your state health department and the federal Centers for Medicare and Medicaid Services.
- **Medicare** is run by the federal Centers for Medicare and Medicaid Services.
- **TRICARE** is overseen by the US Department of Defense.
- **The Veteran's Health Care system (including CHAMPVA)** is regulated by the US Department of Veteran's Affairs.

Health insurance options for the uninsured

Shopping for insurance coverage

The health insurance law requires that most people have insurance coverage. If you don't have health insurance, here are some things to think about when looking for coverage:

Look carefully at health insurance options at work

If you or your spouse is employed, sometimes it's possible to add yourself, a spouse, or a child to a work health insurance policy during your employer's open enrollment period. It can also be done at other times than the open enrollment period if you've had a major change in situation; for instance, if you've gotten married or legally separated, or one of you is laid off or lost health insurance for another reason. Check with your health insurance administrator at work about this. This person is usually in the human resources or employee benefits department.

Look closely when choosing among health insurance and managed care options. Sometimes there's a chance to compare different types of coverage during open enrollment periods. (Open enrollment is the time employees can make changes in health insurance coverage. It usually happens once a year.)

Some workplace plans may be one of the grandfathered plans in which coverage is limited (with things like annual caps and pre-existing condition exclusions). Check before you sign up. (See "Grandfathered employer plans" in the section "Other things to know about health insurance.")

If you get insurance through your job (or your spouse/partner's job), you may want to keep the administrator's phone number and email address handy. Group insurance is better for most people than individual insurance. But if you learn that your coverage will cost you more than 9.5% of your income, you may find a better deal in your state's marketplace.

If you can't get health insurance from an employer

- Under the health care law, people looking for health coverage will be able to compare plans and select the best one for them on new online health insurance marketplaces in each state. Your state's marketplace will collect information from you to find out if you qualify for Medicaid or financial help to pay for coverage. Each marketplace will have trained navigators to help you in the process. Visit www.healthcare.gov or www.CuidadoDeSalud.gov for information on your state.
- You can also get marketplace information by phone. For the phone number of your state marketplace, visit www.healthcare.gov or www.CuidadoDeSalud.gov, or call 1-800-318-2596.
- You can buy individual insurance outside the marketplace. Most plans will meet the requirements for sufficient coverage so that you avoid the penalty at tax time, but some won't. Be sure to ask whether it meets the minimum requirement.

- An independent insurance broker may be able to help you find a reasonable benefit package.
- You or your spouse getting a job with a large company or a government agency is the surest way to get access to group insurance.
- If you have been covered under your employer-sponsored plan for at least one day you should be able to keep your medical insurance through COBRA. Your employer must tell you, in writing, about your COBRA option. For more information, please see the section “COBRA (Consolidated Omnibus Budget and Reconciliation Act of 1986).”
- Look into Medicare, which covers most people who are 65 or older, as well as those under 65 who are disabled and have been getting Social Security disability benefits for 2 years.
- If you are in a low-income bracket or are unemployed, find out if you are eligible for state or local benefits such as Medicaid.
- If you are employed, before you leave your job, find out if you can convert your group insurance to an individual plan. Some group plans have a clause that allows people to convert to individual plans, but premiums may be much higher. You usually must apply for these individual plans within 30 days of leaving a job. (This is different from COBRA, which allows you to stay with the group insurance but only for a limited time.)

In looking at insurance options, find out about differences in coverage. The health care law requires plans to provide a Summary of Benefits and Coverage (SBC). The SBC is an easy-to-understand document with details on the benefits and the costs you are responsible for. It includes specific disease examples to help compare which plan may be right for you. Look into these things:

- Choice of doctors
- Protection against cancellations
- Premium costs
- What the plan really covers, especially in the event of a catastrophic illness (a serious illness, like cancer, that can add up bills quickly)
- How much the deductibles and co-pays will cost you

See the “Things to consider when shopping for health insurance” under “Private health insurance options” for more on this.

Be wary of ads or agents offering government-issued or low-cost health insurance. See “Fake health insurance” in the “Other things to know about health insurance” section for more on this.

If you think an insurance company has treated you unfairly, contact your state insurance commissioner. See the “To learn more” section to find your state insurance department.

Health insurance options for young adults

If you’re young and healthy, you may think you don’t have to worry about health insurance. But the new health law requires most Americans to have coverage. Even young adults have accidents and serious illnesses, and find themselves unexpectedly needing health care. There are health insurance options for this age group.

When choosing a plan, ask about coverage for common tests young people need, like preventive services, annual physicals, blood tests or x-rays. Be sure you’re not getting into a “grandfathered” plan that limits what is offered.

Here are some health insurance options for young adults:

Through your parent’s health coverage

The new health care law allows young adults to stay on their parents’ health plan up to the age of 26, if the plan has dependent or family coverage. This means that adult children can join or stay on a parent’s plan whether or not they are:

- Married
- Living with a parent
- In school
- Financially dependent on a parent (the young adult does not have to be listed as a dependent on the parent’s tax return)

The only exception is if the parent has an existing job-based plan and the young adult can get their own job-based coverage. If they can’t get their own job-based coverage, young adults who lose dependent coverage may qualify for COBRA even at age 26.

The insurance for young adults cannot cost any more than for dependent children under the age of 18.

Individual insurance

There are individual health insurance plans from private companies that are offered to young adults. The new health care law makes sure that insurers selling individual plans through the health insurance marketplace can no longer turn you down, charge more, or not offer certain benefits if you have a pre-existing health condition. The law now prevents insurers from denying coverage to people with pre-existing conditions. (See the section “Private Health Plans.”)

Visit www.healthcare.gov or www.CuidadoDeSalud.gov, or contact your State Department of Insurance for more information. You can find your state’s insurance

department in the blue pages of your local phone book, or see the “To learn more” section to contact the National Association of Insurance Commissioners. If you qualify, you may also look at catastrophic health coverage from your state’s marketplace (see “Catastrophic coverage” in the section “Other things to know about health insurance”). Be sure you understand the coverage offered, including benefit limits, before you buy it.

Through your work or your spouse’s work

If your employer offers coverage, you generally can’t be turned away or charged more because of your health status. But employers can refuse or restrict coverage for other reasons (such as part-time employment), as long as these reasons are not related to your health and are applied to all employees.

Student health insurance programs

Some colleges or universities may offer reduced-cost student health insurance plans. These plans used to limit the amount of coverage they would pay for in a given year, but as of 2014, dollar limits are not allowed under the new health care law. If student plans are self-funded or offered by a student association, the rules may be different. Because of this, students need to be sure what they are buying. It’s also important to understand important coverage details, including how long you are covered and whether you must be attending classes to be covered. Sometimes a serious illness can keep you from going to class, and that’s when you need insurance.

One advantage of college plans is that they’re often integrated to cover any charges from Student Health Services, which may provide basic health care on campus. Keep in mind that many colleges and universities even offer counseling centers where students can get short-term therapy at no cost or for low cost co-pays at each visit. But Student Health Services, while good for minor illnesses, wouldn’t likely be very helpful for a person with a serious illness such as cancer.

State high-risk pools

State high-risk pools: Before the new health care law went into effect, people with a serious illness like cancer who didn’t have insurance through their job could look into a *high-risk pool* in most states. High-risk pools are private, self-funded health insurance plans organized by state to serve high-risk people who meet enrollment criteria and can’t get group insurance. Because the health law now requires most health plans to cover people with pre-existing conditions, several states have been considering whether or not to close their high-risk pools.

Medicaid, Indian Health Services, dependents of active duty US military, or other government aid programs

These types of programs are available for young adults who meet the requirements for them. Still, some states exclude full-time students from these programs if the programs work mostly with low-income people.

While you are looking for health insurance

One of the most important things a patient can do before a procedure or treatment is to discuss costs and negotiate a price for the care up front. Don't be afraid to ask your doctor or hospital for a discount – reducing your health care costs by any amount will help, even if you have insurance. Start with your hospital billing office, and find out who else besides the hospital might bill their services. This is most important for people who aren't insured, because they typically don't get the discounts that are negotiated by insurance companies and are often charged the highest prices.

Check into Hill-Burton funds

A few hospitals and other non-profit medical facilities get Hill-Burton funds from the federal government so they can offer free or low-cost services to those who can't pay. Each facility chooses which services it will provide at no or lowered cost. Medicare and Medicaid services aren't eligible for Hill-Burton coverage. But Hill-Burton may cover services that other government programs don't.

Eligibility for Hill-Burton is based on family size and income, and availability of a Hill-Burton facility. You will first need to find out if there's a facility in your area that has any Hill-Burton obligation for which you may qualify. If you are cared for at such a facility, you may apply for Hill-Burton help at any time, either before or after you receive care. For more information, visit their website, www.hrsa.gov/hillburton. There you can find a listing of Hill-Burton-obligated facilities, eligibility criteria, and frequently asked questions about the program. Or you can call 1-800-638-0742 for a packet of information.

Compare your drug list to low-cost prescription programs

Some drugstores, grocery store pharmacies, and discount stores now offer certain generic drugs at very low prices. Most of the time, these do not include cancer drugs – although some offer tamoxifen and other such drugs in their programs. Even people with insurance may be able to lower their co-pays and save money by getting some generic medicines at very low cost (often \$4 to \$10 for each refill).

Financial issues: Getting help with living expenses

The major costs of a cancer diagnosis and treatment are for things like time in the hospital, clinic visits, medicines, tests and procedures, home health services, and the services of doctors and other professionals. Insurance, managed care, or public health care programs pay most of these costs if you are covered in such a plan.

But families face many indirect costs and other expenses because of cancer and its treatment, along with their usual bills. These costs can be for things like:

- Travel (gas and parking) to doctor visits, clinics, hospitals, and treatment appointments
- Lodging (a place for the patient and/or family to stay) during treatment away from home
- Meals during travel or clinic visits
- Extra child care costs
- Communication (phone calls, faxes, copies of medical records, etc.) with doctors, friends, and relatives
- Special foods and nutritional supplements
- Special equipment or clothing

Also, a cancer treatment plan can cause family members to lose time at work and, in some cases, all or part of their salary. Even more money is lost if a family member has to quit a job or take an extended leave of absence. Of course, costs increase as treatment is extended, if there are treatment complications, or if the cancer comes back (recurs). This section offers just a few ideas of where you might be able to get some help dealing with the costs of cancer. See the “To learn more” section for other resources that may be useful to you.

Getting money from life insurance policies

Life-threatening illnesses and problems that need a lot of medical care often lead to a need for immediate cash income. In many states, your life insurance policy may be a source of income through the acceleration of the policy's death benefit, known as *living benefits*. You can get these benefits in different ways, such as *viaticals* or *life settlements* (sale of the life insurance policy) and loans against the face value of the life insurance policy (from the original insurance company or from a third party). The Life Insurance Settlement Association can give you more information on ways you may be able to use your life insurance policy. Visit them online at www.thevoiceoftheindustry.com, or call 407-894-3797.

Viaticals and life settlements

A *viatical* is the sale of a life insurance policy for cash when the insured is not expected to live very long. The insured person (called the *viator*) sells his or her life insurance policy to a third party. As with any sale, both sides must agree on what's being sold and how much it's being sold for.

For a viatical transaction, the person's life expectancy may be less than 6 months or as long as several years and must be certified by a doctor. To reduce money worries, the person sells the life insurance policy for a lump-sum cash payment, which in some cases is tax-free. The payment depends on how long the person is expected to live, and is usually between 30% and 80% of policy's face value. This payment is given only to the person who holds the policy. The company buying the policy must keep paying premiums, and then collects the death benefit after the seller dies.

Life settlements are very much like viaticals, but here the life insurance policies are sold when the insured needs money more than life insurance. There's no requirement for terminal illness.

Reasons for choosing a viatical or life settlement:

- To pay for food, shelter, doctor visits, health insurance premiums, or other pressing needs
- To ease the stress of money worries
- To fulfill a life-long dream

Drawbacks of a viatical or life settlement:

- Your heirs get no insurance money.
- You may not make the best trade available.
- Decision-making may be difficult.
- Once a policy is sold, the sale is usually not reversible.

Line of credit from a finance company

People with cancer who are not expected to live a long time can transfer their life insurance's death benefit to a finance company. The company reviews your health status, then makes cash advances on the expected benefit. This is actually a loan, and as with all loans, interest rates vary. You may borrow up to 35% to 75% of your insurance's death benefit depending on your situation. The death benefit is then reduced by the loan amount, the premiums the company pays on the policy, fees, and the interest on the loans you have taken out. Not all life insurance is eligible, and this type of loan is not offered by all companies.

Living benefits and other choices

You might also have other choices. For instance, you may be able to get a personal loan, or, instead of selling your policy outright to a third-party life settlement company or transferring your death benefit, you may be able to get more money from the original insurance company. Many insurance companies make it possible for life insurance policy owners to collect part of their death benefits early – before dying – to cover extraordinary expenses. A life insurance policy usually pays benefits to a beneficiary after a policy owner dies. But in certain cases, those benefits are accelerated and are paid directly to a chronically or terminally ill policy owner before he or she dies. These are called *living benefits* or *accelerated benefits*.

In general, living benefits can range from 25% to 95% of the death benefit. The payment depends on your policy's face value, the terms of your contract, and the state you live in. Ask your insurer to give you a quote before you use your accelerated death benefit option. Living benefits are not intended to replace health insurance or long-term care insurance. But they can give you extra help with needs that result from terminal or catastrophic illness. Contact your insurance agent or life insurance company for details on your policy's accelerated benefits plan.

For more information regarding living benefits from life insurance, please see the American Council of Life Insurers website, www.acli.com, or call 202-624-2000.

Another option is to get a loan from a third party. Some companies will lend money to terminally ill people who are expected to live between 6 months and 5 years. The patient's life insurance policy is used as collateral. The company will lend a portion of the policy's face value, usually ranging from 35% to 85%, which is paid back from the payout of the policy at the time of the person's death. Any money left over goes to the original beneficiary. The interest rates on the loans are often high, but there are no restrictions on how the borrowed money may be used.

Signing a contract for a viatical or living benefits: Before you make a final decision, think about the points below. Talk to a lawyer or a financial planner to help you decide what's best in your case.

- Get a clear picture of what's involved. Read about viaticals, life settlements, loans, lines of credit, and living benefits. Ask questions.
- Get professional advice about the types of benefits available and the pros and cons of each.
- Talk to your doctor about how long you can expect to live.
- Decide whether a living benefit, viatical, or life settlement is the best course of action for you.
- Find out if Medicaid or other benefits will be affected.
- Shop around. Get several bids. Bids can vary a lot.

- Find out if the company buying your policy is a broker. Some companies use their own money to buy policies, but others are brokers. A broker gets a commission from the company and might not act in your best interest.
- Negotiate; you might get a better deal.

Other sources of financial help

Most families find it hard to turn to others or to public agencies and outside groups for financial help. The extra expenses of cancer may be the first time a family has had problems with money. Families should remember that their problems in this situation are often short-lived and not unique. In the future, they could be the ones who can offer help to others.

Here are just a few of the many possible sources of help for families who need extra financial support at this time:

- Income assistance for low-income families through Supplemental Security Income (SSI) benefits.
- Income assistance for needy families from the Temporary Assistance for Needy Families (TANF) program.
- Help with treatment-related travel, meals, and lodging from public and private programs.
- Help with basic living costs (such as rent, mortgage, insurance premiums, utilities, and telephone) from public and private programs.
- Help from church, civic, social, and fraternal groups in the community.

Help might also be available from groups like the Salvation Army, Catholic Social Services, the United Way, Jewish Social Services, and other groups that can be found in the yellow pages.

Though it's not available in all areas, the United Way of America and the Alliance of Information and Referral Systems have set up a 211 service in many parts of the country. You can call 211 to find out what help might be available in your area, or visit them online at www.211.org.

There are National Association of Area Agencies on Aging offices in many areas that can help older people with cancer. Call 1-800-677-1116 for the Eldercare Locator to learn what's in your area, and whether you might be able to get help. You can also check online at www.n4a.org.

The American Cancer Society also has many helpful services. Call us to find out more about them and to see if there are other local resources in your area.

For help finding a place to stay during treatment

Sometimes cancer treatment is not given close to home. Many treatment centers have short-term housing centers or discount programs set up with nearby motels and hotels. The clinic social worker or oncology nurse may have suggestions for low-cost housing during hospital or clinic treatment.

The American Cancer Society Hope Lodge® program can offer families a free place to stay when cancer treatment is given far from home. Contact us to find out if there's a Hope Lodge location near your treatment center.

Most major pediatric treatment centers have a Ronald McDonald House nearby. These houses provide low-cost or free housing to patients and their immediate families. Ronald McDonald houses are designed to offer a nice break to any family with a seriously ill child, not just those with limited funds. Although partly funded by McDonald's Children's Charities, each house has its own management, sets its own admission standards, and operates according to its own rules. Check with your health care team's social worker or nurse to learn more, or contact Ronald McDonald House Charities online at www.rmhc.org or call 630-623-7048. Families must be referred by medical staff and/or social workers at the treatment facility.

Another possible option is the Healthcare Hospitality Network. This group of nearly 200 non-profit organizations throughout the US provides free or low-cost family-centered lodging to families getting medical treatment far from home. You can call 1-800-542-9730 or check online at www.hhnetwork.org to see if there's a location that works for you.

For help with housing needs or mortgage payments

The extra costs of treatment or major loss of family income may make it hard for families to pay their mortgage or rent on time. To keep a good credit rating, talk with your creditor or landlord about your situation and try to make special arrangements. Family, friends, or church members may be able to give you short-term help if they are told about the problem. Also talk with your cancer team social worker who may know of special resources.

Families who need to move out of their homes after a cancer diagnosis should talk with their county department of social services to find out if they qualify for government supported housing programs.

For help with driving and ground transportation costs

People who have Medicaid may be entitled to help with travel to medical centers and doctors' offices for treatment. This may take the form of payment or being paid back (reimbursed) for gas, payment of bus fare, or may mean using a vanpool. County departments of social services in each state arrange for help with transportation, but families must ask for it by talking to their Medicaid case worker.

The American Cancer Society Road To Recovery® program is available in some areas. Trained volunteers drive patients and families to hospitals and clinics for treatment. Contact your local American Cancer Society office for more information on the type of transportation program available in your area.

Community and church groups may be sources of help with travel or its costs, too. Also, talk to your team social worker about getting help with hospital or clinic parking fees.

For help with air transportation costs

The National Patient Travel Center (NPTC) is a central clearinghouse that refers callers to over 3 dozen charitable or special discounted patient air transport service groups. NPTC can help patients find a program to assist with the costs of air travel for illness-related reasons, including air ambulance services. The National Patient Travel Helpline screens callers, verifies the illness and need for transport, and determines if the caller is eligible for help through one of the air travel programs. You can call them at 1-800-296-1217, or visit them online at www.patienttravel.org.

For help with telephone service costs

Help with the cost of basic charges for phone service may be available from Temporary Assistance for Needy Families (TANF; see “To learn more” for contact information). Speak with the eligibility worker in your county department of social services for more information. If you have a monthly mobile phone plan, call your mobile carrier before you go over your minutes limit. Sometimes they can help you avoid going over your limit for the month. Families that have problems controlling charges might want to think about buying pre-paid calling cards, pre-paid cell phones, or plans with pre-paid minutes.

The Universal Service Administrative Company (USAC) is another resource that may help if your income is very low. Visit their website at www.usac.org/li/getting-service/benefits.aspx to learn more about the home or mobile phone service help that’s available in your state. Or you can call 1-888-641-8722 and follow the low-income/lifeline prompts.

You can also call the American Cancer Society to find out about other local sources of help with telephone service.

For help with food and food costs

State and Federal government programs: Some government programs help with food and food costs for low-income people. Those listed below are offered by the US Department of Agriculture, though some are run by states, for different groups of people.

The best-known program is the Supplemental Nutrition Assistance Program or SNAP, formerly called the Food Stamp Program. It allows people to shop for food in grocery stores using a special Electronic Benefits Transfer card (much like a bank card).

These programs distribute food to needy people:

- Commodity Supplemental Food Program (CSFP)
- The Emergency Food Assistance Program (TEFAP)

Voucher and coupon programs, such as Women, Infants and Children (WIC, for pregnant women, infants, and children) include access to fresh foods for families and seniors:

- Farmers' Market Nutrition Program
- Senior Farmers' Market Nutrition Program

These programs are for school children, for meals at school or during the summer:

- National School Lunch Program
- Fresh Fruit & Vegetable Program
- School Breakfast Program
- Special Milk Program
- Team Nutrition
- Summer Food Service Program (food for kids when school's out)

Keep in mind that some individuals and families can qualify for more than one type of help. By phone, call your local health department or social services department to learn about SNAP. See your phone book's blue pages or call 1-800-221-5689 to get the local number. You can learn more about all of these programs and others by visiting www.whyhunger.org/findfood. For more, call the National Hunger Hotline at 1-866-348-6479 (1-866-3-HUNGRY); for Spanish, call 1-877-842-6273.

Meals on Wheels: This program is designed more for people who are disabled, homebound, or elderly. Volunteers deliver ready-to-eat meals to your home. Costs or fees vary depending on your age and where you live. You can contact them at 888-998-6325 or visit their website at www.mowaa.org.

Other kinds of help

You may also get general help from special funds in your medical center or community. Or maybe you can get help through fundraising done for you or your family. Your cancer team social worker can give you more information about resources that might help. There are organizations and written materials that can give you ideas on ways to raise money, too. (See "To learn more.")

About Internet access

You may notice that many groups and organizations now have a lot of information on the Internet and it may be harder to call or reach a real person to ask questions. When you do call, you might find that their answering messages encourage you to find the information

you need on their website. For many groups, this is a way to save money and focus more funds on services for those in need. But this doesn't work for everyone who needs help.

Many people, especially families who are having financial troubles, don't have Internet access at home. This can make it harder for them to find what they need. You may want to see if your local public library offers free use of their computers and Internet access. An added benefit is that librarians may be able to help you.

Still, you don't always need Internet access to find help. Many organizations also provide toll-free phone numbers so that people without Internet access can learn about and ask for services. Don't be embarrassed to tell people that you don't have Internet access and you can't check their website.

And you can always call us, day or night, to find out about getting the help you need.

Disability benefits

Through your employer

If you get to the point that you cannot work, find out if your employer has a long-term disability insurance policy before you leave your job. This type of policy often replaces 60% to 70% of your income. Read your policy closely. Find out the definition of disabled (according to your policy), the monthly benefit amount, the benefit period, the waiting period, and whether you must pay taxes on the money you get. Some companies also have a short-term disability option that can help replace income during part or all of the waiting period of the long-term disability policy.

Social Security Disability Income

If you have been working for many years, you probably have contributed to Social Security. If so, you might qualify for disability benefits. But you must meet Social Security's definition of disability, which is very strict. If you get turned down, appeal the decision. Some cases that are turned down the first time are approved after an appeal. When approved, benefits do not begin until the sixth full month of disability.

With certain serious illnesses, including some types of cancer, it may take less time to be approved. The Social Security Administration can speed up their processing of disability applications for people with a diagnosis that's on their Compassionate Allowances list. You can check the list online at www.socialsecurity.gov/compassionateallowances.

Your income has nothing to do with whether you qualify for Social Security Disability Income (SSDI). To find out how to apply, call the Social Security Administration. (See the "To learn more" section for phone numbers.)

Keep in mind that after getting SSDI for 24 months you become eligible for Medicare. And if you have a dependent child or children, they may be eligible to receive benefits under your SSDI.

Supplemental Security Income benefits

Supplemental Security Income (SSI) is designed to supplement the income of an eligible person or family in which there is a disabled person. The family or the person must have a low income and limited assets. If you have not worked much or if your income was very low before you became unable to work, you may be eligible for SSI. To get SSI, your income and assets must fall below a certain level and you must be disabled, over 65, and/or blind. Like SSDI, certain illnesses are allowed faster processing under the Compassionate Allowances program. If you do qualify, SSI pays you a monthly income. The amount you could get varies from state to state. It also varies from year to year.

Children can qualify for SSI if they meet Social Security's definition of disability. Income criteria are checked by the local Social Security Administration office. Disability evaluation specialists at the state Social Security office decide whether you are disabled. Children with certain cancer diagnoses are considered disabled.

In many states Medicaid is given to any adult or child who gets SSI, but you may need to apply for it separately. You can get more information about SSI from your team social worker. Or you can get it from the nearest Social Security Administration office listed in the US Government section of your local phone book. See "To learn more" for more information.

Temporary Assistance for Needy Families

Temporary Assistance for Needy Families (TANF) is a grant program that provides monthly cash payments to help pay for food, clothing, housing, utilities, transportation, phone, medical supplies, and other basic needs not paid for by Medicaid. TANF also helps states provide training and jobs to the people in their welfare programs. A social worker can tell you about your state's plan or see the "To learn more" section for TANF contact information.

To learn more

More information from your American Cancer Society

The following related information may also be helpful to you. These materials may be ordered from our toll-free number, 1-800-227-2345, and many of these can be read online at www.cancer.org.

Legal, job, and employment rights

What Is COBRA? (also in Spanish)

What Is HIPAA? (also in Spanish)

Family and Medical Leave Act (FMLA) (also in Spanish)

Americans With Disabilities Act: Information for People Facing Cancer (also in Spanish)

Health insurance and finances

Children Diagnosed with Cancer: Financial and Insurance Issues

Medicare Coverage for Cancer Prevention and Early Detection (also in Spanish)

Medicare Part D: Things People With Cancer May Want To Know

In Treatment: Financial Guidance for Cancer Survivors and Their Families (also in Spanish)

Off Treatment: Financial Guidance for Cancer Survivors and Their Families

How to Find a Financial Planner Sensitive to Cancer Issues: Financial Guidance for Cancer Survivors and Their Families

Advanced Illness: Financial Guidance for Cancer Survivors and Their Families

Coping With the Loss of a Loved One: Financial Guidance for Families

Can I Be Prepared If Cancer Occurs?: Financial Guidance for Those With Concerns About Cancer

Help with medical treatment

Prescription Drug Assistance (also in Spanish)

National Breast and Cervical Cancer Early Detection Program

National organizations and websites*

Along with the American Cancer Society, other sources of information and support are listed below. Because there are so many sources, some have their full contact information listed in the text rather than here.

Health coverage

State Health Care Marketplaces – US Department of Health and Human Services

Toll-free number: 1-800-318-2596 (also in Spanish)

TTY: 1-855-889-4325

Website: www.healthcare.gov

Provides information on the new insurance law, takes you through the steps of finding insurance, and much more. If you don't have Internet access, the phone number will connect you with your state's marketplace.

Medicaid – US Department of Health and Human Services

Toll-free number: 1-877-696-6775

Website: www.medicaid.gov/index.html

To learn more about Medicaid coverage and eligibility. Your state social service or human service agency can give you the best answers to questions about your benefits, eligibility, and fraud. To get to your state's Medicaid website, go to www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State.html

Medicare – US Department of Health and Human Services

Toll-free number: 1-800-633-4227

TTY: 1-877-486-2048

Website: www.medicare.gov

Answers questions, provides literature, and gives referrals to state Medicare offices and local HMO's with Medicare contracts.

Department of Veterans Affairs

Toll-free number: 1-800-827-1000

Website: www.va.gov

For information on Veteran's medical benefits and whether you qualify for them

Toll-free number: 1-877-222-8387

Website: www.va.gov/healthbenefits/apply/veterans.asp

Getting help with insurance issues

US Department of Health & Human Services

Website: www.healthcare.gov

For the most up-to-date information on health care and insurance laws and how they might affect you

Cancer Legal Resource Center (CLRC)

Toll-free number: 1-866-843-2572 (may need to leave a number for a call back)

Website: www.cancerlegalresourcecenter.org

Provides free legal information about laws and resources for many cancer-related issues including health insurance issues, denial of benefits, and government benefits

Patient Advocate Foundation (PAF)

Toll-free number: 1- 800-532-5274

Website: www.patientadvocate.org

Works with the patient and insurer, employer and/or creditors to resolve insurance, job retention and/or debt problems related to their diagnosis, with help from case managers, doctors, and attorneys. For cancer patients in treatment or less than 2 years out of treatment

Medicare Rights Center (for those with Medicare)

Toll-free number: 1-800-333-4114

Website: www.medicarerights.org

This service can help you understand your rights and benefits, work through the Medicare system, and get quality care. They can also help you apply for programs that help reduce your costs for prescription drugs and medical care, and guide you through the appeals process if your Medicare prescription drug plan denies coverage for drugs you need

Your rights at work

US Department of Labor, Employee Benefits, Security Administration (EBSA)

Toll-free number: 1-866-444-3272

Website: www.dol.gov/ebsa

Information on employee benefit laws, including COBRA, FMLA, and HIPAA requirements of employer-based health coverage and self-insured health plans. Also has information on recent changes in health care laws. Information for military reservists who must leave their private employers for active duty can be found at: www.dol.gov/elaws/vets/userra/mainmenu.asp

US Equal Employment Opportunity Commission (EEOC)

Toll-free number: 1-800-669-4000

TTY: 1-800-669-6820

Website: www.eeoc.gov

For information on all federal equal employment opportunity regulations, practices, and policies; publications; how to file charges of workplace discrimination; and how to find EEOC offices in your area

Income sources and money management

Social Security Administration (SSA)

Toll-free number: 1-800-772-1213

TTY: 1-800-325-0778

Website: www.socialsecurity.gov

Has general information, qualification criteria, and information about how to apply for program benefits (such as Social Security Disability Income and Supplemental Security Income if you cannot work). Makes referrals to local SSA and Medicare/Medicaid offices

TANF and State Health Departments – US Department of Health and Human Services

Toll-free number: 1-877-696-6775

Website: www.acf.hhs.gov/programs/ofa/help

Provides contact information for each state's health department, including Temporary Assistance for Needy Families (TANF) in your state

Financial Planning Association

Telephone: 1-800-322-4237

Website: www.fpanet.org

Offers free information on personal finance, answers general financial planning questions, makes referrals to FPA members who are Certified Financial Planners™, and sets up free financial planning services to qualified people and families in need

Internal Revenue Service

Toll-free number: 1-800-829-1040

TTY: 1-800-829-4059

Website: www.irs.gov

Has answers to tax questions, tax forms, and referrals to free tax help for those who qualify

**Inclusion on these lists does not imply endorsement by the American Cancer Society.*

No matter who you are, we can help. Contact us anytime, day or night, for information and support. Call us at **1-800-227-2345** or visit www.cancer.org.

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