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Cancer Rights:

Navigating Employment, Insurance, & Finances

A guide to the legal and practical issues that may affect individuals who are diagnosed with cancer, their caregivers, and the professionals who treat them.

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Everyone should have access to the resources they need to manage their life beyond diagnosis, regardless of their type of cancer, where they live, or their financial situation.

Triage Cancer is a national, nonprofit organization that provides free education on the practical and legal issues that may impact individuals diagnosed with cancer and their caregivers, through free events, materials, and resources.

As long as there are questions, we'll have answers.

Educational Events

Animated Videos

Quick Guides & Checklists

CancerFinances.org

All of these resources and more can be found at TriageCancer.org.

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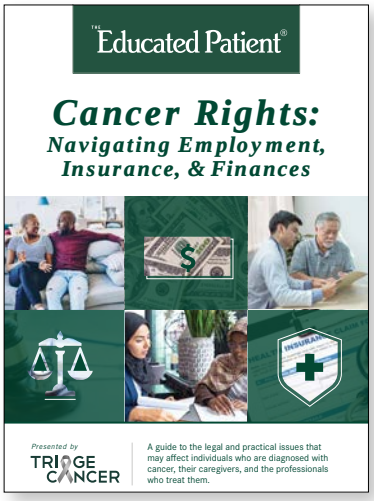

What is Cancer Rights Law?

Cancer rights law includes a number of separate areas of law, including employment, insurance, government benefits, consumer rights, and estate planning.

Some of the topics discussed in this guide are not even thought of as legal issues by most people, such as health insurance. But, getting health insurance coverage, consumer protections in the use of coverage, and the right to appeal denials of coverage are all rooted in laws. Lack of awareness of the law and failure to recognize its power to help people, has been a barrier to people getting their needs met, and contributes to the financial burden of a cancer diagnosis.

An understanding of your rights can improve your quality of life, reduce stress and anxiety, and can mean the difference between losing your job, your health insurance, or even your home.

This guide is meant to serve as an introduction to some of the cancer rights law topics that most people have to deal with in some way after a cancer diagnosis: employment, insurance, and finances.

The details about these laws and programs may change frequently. The most up-to-date information about these topics and many others can be found at **TriageCancer.org**.

Disclaimer: This guide is intended to provide general information on the topics presented. It is provided with the understanding that Triage Cancer is not engaged in rendering any legal, medical, or professional services by its publication or distribution. Although this content was reviewed by a professional, it should not be used as a substitute for professional services.

Cancer Rights: Navigating Employment, Insurance, & Finances

Your Rights at Work

If you have been diagnosed with cancer or if you are a caregiver to someone with cancer, you may need to figure out how to continue working, take time off, return to work, or even retire. Understanding employment laws can help you navigate these options and make decisions.

Americans with Disabilities Act

The Americans with Disabilities Act (ADA) is a federal law that provides eligible individuals with disabilities protection against discrimination. Title I of the ADA protects individuals with disabilities and caregivers from discrimination at work and gives individuals with disabilities access to reasonable accommodations.

Employers Covered by Title I of the ADA

- Private employers with 15 or more employees.
- Employment agencies, labor organizations, and joint labor-management committees.
- State and local governments of any size.
- Employees of the federal legislative branch (e.g., employees of the Senate, House of Representatives, and agencies that support Congress).
    - Employees of the federal executive branch (e.g., United States Postal Service, federal agencies, etc.) are covered by Rehabilitation Act of 1973 (similar to ADA).

Requirements for Employees Covered by the ADA

- Must be "qualified" (i.e., you can perform essential functions of the job, with or without reasonable accommodations) **and**
- Must have a disability (i.e., a physical or mental impairment that substantially limits one or more major life activities).

Major life activities, according to the ADA, are "activities that an average person can perform with little or no difficulty." Activities include physical functions (breathing, hearing, seeing, talking, walking, other motor movements), mental functions (concentrating and learning) and social/professional functions (working or caring for oneself).

When Are You Protected by the ADA?

The ADA provides protections during all phases of employment (including during the job application process) and when all employment-related decisions are being made, including hiring, firing, pay, benefits, promotions, job assignments, bonuses, training opportunities, and leaves of absence.

You are protected against discrimination at work if you currently have a disability, if you have a history of having a disability, if your employer regards you as having a disability, or if you have a family, business, social, or other relationship with a person with a disability (e.g., you are a caregiver). You also are entitled to reasonable accommodations if you currently have a disability or you have a history of a disability.

What Are Reasonable Accommodations?

According to the ADA, "an accommodation is any change in the work environment or in the way things are customarily done that enables an individual with a disability to enjoy equal employment opportunities." Reasonable accommodations are anything that can help you continue to do your job or return to work, such as:

- Changing work schedule (e.g., flex time, additional breaks).
- Changing workspace (e.g., telecommuting, ergonomic chair, hand controls on cars, a different office).

- Using technology (e.g., tablet, smart phone, screen reading software, speak-type software).
- Changing workplace policies (e.g., allowing an employee with a scar to wear a scarf or hat, allowing more breaks).
- Shifting nonessential job duties to other employees.
- Moving to a vacant position, if one is available (Note: employers are not required to create a new position for an employee with a disability, but you still may make a request).

The reasonable accommodations that will work best for you will depend on the side effects that you are experiencing, your job responsibilities, and your workplace. Remember that when thinking about accommodations you may need, they must still be "reasonable." One accommodation might not address all of the challenges you are facing, so you can request additional accommodations, if needed.

Does an Employer Have to Provide a Reasonable Accommodation?

Yes, if you are eligible under the ADA or a state fair employment law. However, an employer does not have to accommodate you if the employer can show that the accommodation you are requesting would be an undue hardship or would pose a direct threat. An undue hardship is when providing the reasonable accommodation would cause the employer significant difficulty or expense. A direct threat is when there is a "significant risk of substantial harm to health or safety of self or others that cannot be eliminated or reduced by reasonable accommodation."

How Should You Ask for a Reasonable Accommodation?

The ADA does not require that you ask for a reasonable accommodation from a specific person, such as a supervisor, another superior, or a human resources (HR) representative. However, it is a good idea to check your employers' policies, often found in the employee handbook, to see whether your employer has a specific process to request reasonable accommodations.

When you make your request, you do not have to specifically mention the ADA or use the words "reasonable accommodation." Your request does not need to be in writing, but having a written record of your request, either by following up the conversation with an email, formal letter, or contract confirming what was agreed upon, may be useful for future reference. Remember, your current supervisor may not always be your supervisor.

Once you make a request, you and your employer should engage in the "interactive process," which involves negotiating and agreeing on an effective reasonable accommodation. Your need for an accommodation may change over time. For example, you may need a flexible work schedule while in treatment, but after treatment you may need additional rest periods during the day. You and your employer should monitor accommodations to ensure they are still effective. If not, restart the process.

When Should You Ask for a Reasonable Accommodation?

Generally, you should ask for a reasonable accommodation when you realize that you need one to effectively complete your job responsibilities. If you delay the request and your job performance suffers, your employer may decide to let you go based on your poor job performance. But you may avoid this situation if you ask for a reasonable accommodation to help you effectively complete your job responsibilities.

Example: Reasonable Accommodations

Jenny has been working during her chemotherapy treatment but has been finding it hard to concentrate and remember things. She is concerned it is affecting her work. Jenny works for a sales company and her desk is in a cubicle on a floor of the building with an open floor plan with offices circling the cubicles. There are 2 desks per cubicle with low partitions between the cubicles. What reasonable accommodations could help Jenny continue to do her job effectively?

Jenny may be able to continue her job effectively with the following reasonable accommodations:

- Move to an office with closed door.
- Move to a desk in the corner of the floor plan with less surrounding noise.
- Have only one desk in the cubicle, instead of two.
- Create higher partitions (e.g., wall or bookcase barrier).
- Wear noise-cancelling headphones.
- Allow headphones if not normally allowed.
- Allow access to an office regardless of seniority.
- Telecommute (work from home).
- Shift work hours to 7 a.m. to 3 p.m., when the office is quieter and has fewer distractions.

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Is Your Request for Reasonable Accommodations Confidential?

Generally, your employer cannot share information about your medical condition or why you have asked for, or received, a reasonable accommodation. But keep in mind that if you ask your supervisor for an accommodation, your supervisor may take your request to HR. And, in turn, HR might share information with company leaders as appropriate. If you start with HR, because you do not want your supervisor to know about your medical condition, then HR can only share with your supervisor that you are getting an accommodation, not why. Coworkers may ask why you are receiving an accommodation, but your employer can only share that you are getting an accommodation, not share information about your medical condition.

Are Caregivers Eligible for Reasonable Accommodations?

Employers are not legally required to provide reasonable accommodations to employees who are acting as caregivers. However, many employers recognize the benefit of keeping a valued employee and avoiding the costs associated with finding a replacement. Therefore, many of the strategies discussed above can be useful options for caregivers as well.

State Fair Employment Laws

Most states have a state fair employment law. Many provide similar protections to the ADA, but some have a broader definition of disability, and some cover private employers with fewer than 15 employees.

Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) is a federal law that allows eligible employees to take up to a total of 12 weeks of unpaid, job-protected, and health insurance-protected leave per year:

- For their own serious medical condition.
- For the care of a parent, child, or spouse with a serious medical condition.
- For the birth of a son or daughter, and for bonding time with that child.
- For placement of a child with the employee for adoption or foster care, and for bonding time with that child.
- For any qualifying exigency (such as deployment) when a spouse, son, daughter, or parent is a military member on covered active duty or call to covered active-duty status.
- For any combination of the qualifying reasons above.

Employers Covered by the FMLA

- Private employers that have or had 50 or more employees during 20 or more workweeks in the current or preceding calendar year.
- Public agencies, including local, state, or federal agencies, regardless of number of employees.
- Public or private elementary or secondary schools, regardless of the number of employees.

Employees Eligible for Leave Under the FMLA

- Work for an employer that has at least 50 employees within 75 miles of the employee's worksite **and**
- Have worked for a covered employer for at least 12 months in the last seven years (note: the 12 months don't have to be in a row) **and**
- Have worked at least 1,250 hours for the employer during the 12 months immediately before taking leave.

What Activities Count as Caregiving?

Caregiving can include helping with activities of daily living, such as providing basic medical, hygienic, nutritional, or safety needs; providing transportation to and from medical appointments; providing psychological comfort; assisting with housework or paperwork; organizing prescription medication or grocery shopping; and assisting in chores.

What Happens to Your Health Insurance if You Take Time Off Under the FMLA?

If you receive health insurance coverage from your employer, your employer must continue to offer you that coverage under the same terms and conditions that were in place before taking leave. For example, if your employer pays 50% of your monthly premium while you are working, they must continue to do so while you are on FMLA leave.

When Should You Ask for FMLA Leave?

Generally, employees should request FMLA leave as soon as they know they need time off work. If the need for leave is foreseeable, employees must provide employers with at least 30 days' notice. If the need for leave is unforeseeable, employees must provide employers with notice "as soon as practicable," usually within one to two days of when the need for leave arises. You should follow your employer's rules for absences unless you are receiving emergency medical care.

How Do You Ask for FMLA Leave?

Check your employee handbook to see if your employer has a process for requesting FMLA leave. Your request for leave does not necessarily have to mention a cancer diagnosis but does need to contain enough information so the employer can determine if you are eligible for FMLA leave.

If you are eligible for FMLA leave, your employer cannot interfere with your right to take leave. An employer cannot retaliate against you because you are taking FMLA leave. An employer cannot use your FMLA leave against you in decisions related to your job, such as attendance policies, promotion, or discipline.

How Does the FMLA Work With Other Types of Leave?

The ways that federal laws, state laws and employer policies work together are similar to puzzle pieces fitting together. Except that everyone's puzzle looks different, depending on which laws apply to you, which state you live in, and what benefits are offered by your employer.

When thinking about taking time off work, you may have multiple options available to you.

- Some states have passed leave laws, which may offer more protection than the FMLA.
- Your employer can require you to substitute unpaid leave under the FMLA with paid leave or disability insurance benefits that you have available. Even if your employer does not require that you use your paid time off at the same time as the FMLA, you have the option to do so.

The FMLA and the ADA also can work together to give you time off work. For example, if you have used up your 12 weeks of FMLA leave during a 12-month period, you may be eligible for additional time off as a reasonable accommodation under the ADA. Court cases have suggested that additional time off as a reasonable accommodation will be considered reasonable only if the additional leave is for a definite period of time. How long is considered reasonable will depend on your job responsibilities and your workplace. The ADA only applies to private employers with 15 or more employees, as well as state or local governments. If you work for a smaller employer, you may be covered by a state fair employment law.

What Can You Expect When You Return to Work from FMLA Leave?

When you return from FMLA leave, your employer must reinstate you to the same or an "equivalent" job. An equivalent job is one with the same responsibilities, pay, and benefits as the original job.

Your employer can require a medical certification that you are able to return to work, as long as that requirement would be applied to any employee in a similar situation. If at the end of 12 weeks of FMLA leave you are not ready to return to work, you may be able to request additional time off as a reasonable accommodation under the ADA.

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Disclosure, Privacy, and Medical Certification Forms

Choosing to disclose your cancer diagnosis in the workplace is a personal decision and should be made only after thoughtful consideration of many factors. Some individuals feel very confident that sharing their diagnosis in the workplace and in other arenas is right for them. Others have concerns about sharing their diagnosis for a variety of reasons. There is no "one size fits all" answer to disclosure.

- **Online**: Social media platforms and online tools can be a source of information and support. However, it is important to remember that disclosing a cancer diagnosis online makes the information public, and many employers search social media platforms and the internet in order to research job applicants and employees.

- **With family, friends, and others**: Once you decide with whom to share your diagnosis, you need to tell family and friends your preferences about what you are choosing to disclose, so that they don't share your information with others against your wishes. These disclosure decisions can arise when a family member or a friend wants to host an online fundraiser on your behalf, for example. While crowdfunding may be a useful tool to cope with the financial burden of a cancer diagnosis, there are some possible ramifications to consider before starting a campaign.

- **At work:** Whether you already have a job or are looking for a job, you need to make some decisions about what, if anything, you will share at work. Making educated, proactive decisions about disclosure is one way to regain some of the control you may have felt you lost when you were diagnosed.

Legal Protections

You have privacy rights relating to your medical information, and these laws protect your rights in different ways:

- **Health Insurance Portability and Accountability Act (HIPAA)**: HIPAA is a federal law that requires your health care providers to get your permission before giving your personal health information to third parties.

- **ADA**: The ADA has specific rules about an employer's access to your medical information. Prior to receiving an employment offer, potential employers may not ask any questions about your medical condition or general health. After a job offer has been made, employers are allowed to ask you questions about your health history or to complete a medical exam, but only if they would be required of anyone entering a similar job. Employers are not allowed to rescind a job offer based on the results of a medical exam, unless the results show that you cannot perform the essential functions of that job, with or without a reasonable accommodation. Once you are working for an employer, you can be asked only to complete a medical exam or questions about your health history when it is "job-related and consistent with business necessity" or if there is a "direct threat" (e.g., requiring an eye exam for a school bus driver).

  Your employer is entitled to a medical certification from a health care provider to show why you need a reasonable accommodation. However, your employer doesn't necessarily need to know about your cancer diagnosis if you don't want to share that information. Your employer only needs as much information as necessary to show that you are eligible for a reasonable accommodation. For example, if you are experiencing neuropathy as a side effect, the health care provider could focus on discussing the neuropathy on the medical certification form and not include information about your cancer diagnosis.

- **FMLA**: Your employer is entitled to medical certification from a health care provider to show you are eligible for FMLA leave. However, your employer doesn't necessarily need to know about your cancer diagnosis if you don't want to share that information.

    - Employers may contact the health care provider who completed the medical certification form, as long as the employee's direct supervisor is not the one contacting the health care provider. But the employer is only allowed to ask the health care provider for clarification (e.g., what does line two say) or authentication (e.g., did you sign the form) of the certification form. The employer is not entitled to additional information other than what is included on the certification form.

Be careful of medical certification forms created by employers, which may request more information than what they are entitled to, such as a specific diagnosis. The U.S. Department of Labor has model forms that can be used for guidance as to what information an employer can request. Note that even the model form asks for the specialization of the health care provider completing the form. So, if you prefer to keep your cancer diagnosis confidential, you may not want to have your oncologist complete the form. Under the FMLA, there are multiple health care providers who can complete the form, including primary care physicians or clinical social workers.

For additional resources, visit:
TriageCancer.org/Employment
TriageCancer.org/Caregiving

- Quick Guides & Checklists
- Animated videos
- Chart of state laws
- State resources
- Webinars
- **CancerFinances.org**

Disability Insurance Options

If you have been diagnosed with cancer and are undergoing treatment, you may find that you are no longer able to work and earn a living the way that you did before your diagnosis. Disability insurance may provide you with income if you are unable to work because of your medical condition. Disability insurance benefits are offered by the federal government and some state governments or through a private insurance company.

Federal Disability Insurance

Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) are federal programs that provide financial assistance to individuals with disabilities. Both are administered by the Social Security Administration (SSA).

If you qualify for disability benefits from the SSA, you must have a disability within the SSA's definition of disability:

- You cannot do your job; **and** you cannot adjust to a new job; **and** your disability has lasted, or is expected to last, for at least one year or will result in death.

SSA will use this process to see if you qualify for disability benefits:

Step 1. Are you working and is your earnings average more than the Substantial Gainful Activity (SGA) threshold this year?
If yes, you will not be deemed disabled for SSDI.
If no, proceed to step 2.

Step 2. Is your medical condition severe?
If yes, proceed to step 3.
If no, you will not be deemed disabled.

Step 3. Is your medical condition found in the list of disabling conditions/impairments?
If yes, then you are deemed disabled.
If no, then the SSA will look at the severity of your condition. If the SSA deems the condition severe enough, you are deemed disabled. If the SSA does not deem the condition severe enough, proceed to step 4.

Step 4. Can you do the work you did previously?
If yes, you will not be deemed disabled.
If no, proceed to step 5.

Step 5. Can you do any other type of work?
If yes, you will not be deemed disabled.
If no, you will be deemed disabled.

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SSI

You may qualify for SSI benefits if you have a low income level (income limit can vary) **and** are 65 and older, **or** blind, **or** "disabled." The monthly payment for SSI is capped. Most states provide a supplemental payment in addition to that amount. You will receive payments beginning the first full month after becoming disabled. Some states automatically provide Medicaid to individuals eligible for SSI. You may be able to receive both SSDI and SSI benefits at the same time.

SSDI

You may qualify for SSDI benefits if you are "insured," meaning that you have worked long enough and have paid Social Security taxes to earn work credits. SSDI work credits are based on your total yearly wages or self-employment income. You can earn a total of four credits each year. You can register for a "My SSA" account online to track your credits at ssa.gov/myaccount. Your SSDI monthly benefit is proportional to your salary history, but it is capped at a certain amount each year. You will receive health insurance through Medicare after you have received SSDI benefits for two years.

How Do You Decide Whether to File for Disability Benefits or Retire?

If you are considering filing for Social Security disability benefits but are also close to your Social Security early retirement age or full retirement age, you should consider checking your Social Security statement to compare the amount of your monthly payments if you were to receive SSDI, retire early, or wait until you reach your full retirement age. This information can be found on your annual Social Security statement, which you can view in your "My SSA" account online.

Can You Receive Back Payments or Retroactive Payments?

The approval process for SSDI and SSI can take several months. To make up for the time it takes to approve an SSI or SSDI application, SSA makes back payments, which cover the time between the application date and the approval date. SSA also understands that individuals may not apply until after their disability began, so it also provides retroactive payments for SSDI. Retroactive payments cover up to 12 months from the date of application back to the disability onset date, after a five-month waiting period.

Do You Have to Pay Taxes on Social Security Disability Benefits?

SSI payments are not taxed. You may be responsible for paying federal and state income taxes on SSDI benefits, depending on your total household income level.

Can You Receive SSDI and Private Long-Term Disability Insurance?

If you have a private long-term disability insurance policy (LTD) that you either bought directly from an insurance company or that you have access to through an employer, that LTD policy may require you to apply for SSDI. Usually, the LTD policy will begin paying benefits without a waiting period and before the SSA decides whether you are eligible for SSDI. If you are denied SSDI benefits, the LTD company may offer to help you with the appeals process, including hiring an attorney for you.

If you qualify for SSDI, you may be eligible for back payments or retroactive payments. If an LTD policy has been paying benefits to you for the same months that SSDI makes back payments or retroactive payments, then the LTD policy will likely require you to repay them for those months. So, it is important for you to wait to see if you need to pay back to your LTD policy before spending the back payments or retroactive payments from SSDI.

It is possible to receive benefits from both SSDI and a private LTD policy. However, the amount received from the private policy will be prorated. For example, if your LTD policy pays 80% of your salary and the amount that you receive from SSDI is only 60% of your salary, then moving forward, SSDI will pay 60% of your salary and the LTD policy will pay 20%.

Can You Apply for Social Security Disability Benefits and Unemployment Benefits?

Generally, you cannot be eligible for both Social Security disability benefits and unemployment benefits. Every state's unemployment program requires individuals to certify that they are able to work and actively looking for work, while the SSA requires individuals to be unable to work because of a medical condition. But there are limited exceptions where you may be able to receive both:

- If you are seeking work but the type of work is limited due to your disability and will pay you less than the annual SGA threshold, you may be able to collect unemployment and SSDI.
- If you are collecting unemployment and then become disabled, you may be able to continue collecting unemployment while you apply for SSDI
- If you receive SSDI, start working through the Ticket to Work program for at least six months and are then laid off, you may be entitled to collect unemployment benefits while receiving SSDI.

Are There Programs to Help You Return to Work?

Some individuals who receive SSDI or SSI have concerns about trying to return to work but being unable to work at the same capacity they could prior to a cancer diagnosis. They also may be concerned how that will affect their disability and health insurance benefits. SSA has programs to help you try to return to work while protecting your access to disability benefits and the health insurance programs that are tied to those benefits. These programs are called "work incentives," and they vary depending on whether you are receiving SSI or SSDI. The programs include a trial return to work period, vocational rehabilitation and the Ticket to Work Program.

What Happens When You Reach Retirement Age?

For most SSDI beneficiaries born after 1960, full retirement age is 67. Once you turn 67, your benefits will switch from SSDI to Social Security retirement benefits. In most cases, the amount will remain the same.

Do You Have to Report Changes to SSA?

If you are receiving SSDI or SSI, you are responsible for reporting any changes in your situation to SSA as soon as possible and no later than 10 days after the end of the month in which the change occurred. The types of changes that should be reported to SSA include any changes in work status, household size, address, immigration status, income, marital status, or health status. Failing to report changes in a timely manner could result in underpayment, overpayment (which must be paid back plus a penalty), or payments withheld by the SSA for up to 12 months.

What Happens if Your SSDI or SSI Application Is Denied?

Many applications are initially denied. You can appeal the denial, but make sure to follow the instructions for appealing and any deadlines. Work with your health care team to gather information for your appeal.

There are four levels to the appeal process:

- **Request for reconsideration:** A social security agent who did not take part in the first decision will do a complete review of your claim. The following states skip this level: Alabama, Arkansas, California (Los Angeles North/Los Angeles West only), Colorado, Louisiana, Missouri, New Hampshire, New York, and Pennsylvania.
- **Administrative law judge hearing:** This is conducted by an administrative law judge and is usually held within 75 miles of your home.
- **Review by Appeals Council:** The Appeals Council may deny a request if it believes the administrative law judge hearing decision was correct.
- **Federal district court review:** If you disagree with the Appeals Council's decision, or if the Appeals Council decides not to review your case, you may file a lawsuit in federal district court.

State Disability Insurance

California, Hawaii, New Jersey, New York, and Rhode Island, plus the territory of Puerto Rico, offer state short-term disability programs that last from six to 12 months. You may be able to receive both SSDI and state disability but check your state rules.

For information about state disability insurance programs:

- California: (800) 480-3287 or **www.edd.ca.gov**
- Hawaii: (808) 586-9188 or **www.labor.hawaii.gov/dcd/home/about-tdi**
- New Jersey: (609) 292-7060 or **www.nj.gov/labor**
- New York: (800) 353-3092 or **www.wcb.ny.gov**
- Puerto Rico: (787) 754-5353 or **www.trabajo.pr.gov**
- Rhode Island: (401) 462-8420 or **www.dlt.ri.gov/tdi**

Private Disability Insurance

You can purchase short-term and/or long term disability insurance directly from a private insurance company. Private disability insurance also may be offered by your employer as an employee benefit.

For additional resources, visit:
TriageCancer.org/DisabilityInsurance

- Quick Guides & Checklists
- Animated videos
- Chart of state laws
- State resources
- Webinars
- **CancerFinances.org**

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Health Insurance Basics

Health insurance can be confusing. To understand your options and find coverage that is appropriate for you, there are some health insurance basics that are helpful to know.

Types of Health Insurance Plans

There are two main payment systems when you receive medical care:

- **Fee for service:** A health care provider is paid a fee for each service provided. With these plans, you can go to any provider willing to see you. You pay for a portion of your care and the insurer pays the rest.

- **Managed care:** Health care providers contract with a health insurance company to be a part of its network. If you go to a provider in the network, the provider has agreed to a certain payment rate for treating you (i.e., allowed amount). Regardless of what the provider bills, it's that "allowed amount" that will determine your final cost. You typically pay a portion of the allowed amount, depending on your plan.

Common types of managed care plans are:

- **Health Maintenance Organizations (HMOs):** Your health care services start with your primary care physician, and you usually need a referral to see another health care provider, except in an emergency. For example, if you have a skin rash, you first go to your primary care physician. If needed, that physician will refer you to a dermatologist in your network. Generally, HMOs have smaller networks of providers, and providers outside of your network will not be covered by your HMO. While you may have less choice in providers, HMOs are often less expensive.

- **Exclusive Provider Organizations (EPOs):** Generally, you do not need to start with your primary care physician. Typically, EPOs have larger provider networks than HMOs, but will not pay for any services obtained outside of the network.

- **Preferred Provider Organizations (PPOs):** These plans have the largest network of providers, and generally you do not need to start with your primary care physician. While most PPOs have some out-of-network coverage, staying inside your network means lower out-of-pocket costs. Typically, PPOs cost more than HMOs, but you have more choice and control.

When choosing a plan, you should consider your personal needs and the options available in your area.

Health Insurance Cost Terms

Here are terms related to the cost of health insurance that you should understand. First there are the costs you pay for coverage.

- **Monthly premium:** This is what you pay each month to have coverage; you pay these costs even if you never receive medical care. It's similar to paying for car insurance all year but never filing a claim.

Then there are costs that you have to pay when you receive medical care, often called "out-of-pocket" costs. The specific amount of those costs will depend on your plan.

- **Annual deductible:** This is the amount you have to pay out-of-pocket each year before your health insurance policy kicks in. This fixed dollar amount could be any amount, such as $500 or $5,000. Some plans have a $0 deductible.

- **Co-payment:** A fixed dollar amount you pay when you get medical care. For example, when you visit the doctor's office, you might have a $20 co-payment; if you go to see a specialist, you might have a $40 co-payment. You usually pay your co-payment at the time you receive care.

- **Co-insurance (aka cost-share):** A percentage difference in what the insurance company pays for your medical expenses and what you pay for your medical expenses. For example, if you have an 80/20 plan, the insurance company pays 80% of your medical expenses and you are responsible for 20% of your medical expenses.

- **Out-of-pocket maximum:** A fixed dollar amount that is the most that you will have to pay for your medical expenses out-of-pocket during the year. Your out-of-pocket maximum will depend on your plan. It is a very important thing to find out! Generally, you reach your out-of-pocket maximum by paying your deductible, plus any co-payments that you make during the year, plus any co-insurance payments you make. So, it's everything that you pay, except your monthly premiums. Once you reach your out-of-pocket maximum, your insurance pays 100% of your medical expenses for the rest of the year. Most insurance companies only count expenses toward the out-of-pocket maximum that are from in-network providers. Also, some employer-sponsored plans may carve out expenses from the out-of-pocket maximum (e.g., co-payments won't count toward your out-of-pocket maximum).

Prescription Drug Terms

Here are some helpful terms to understand prescription drug coverage:

- **Brand-name drugs:** A prescription drug with a specific name from the company that sells the drug. A generic version of a drug may be available and sold by other companies, usually after a patent expires.

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Example: Out-of-pocket Maximums

Mark was in an accident. He went to the emergency room and then spent a week in the hospital that is in his plan's network. Mark ends up with a $102,000 hospital bill. His health insurance plan has an emergency room co-payment of $250, a deductible of $2,000, an 80/20 co-insurance, and an out-of-pocket maximum of $4,000. How much of that does Mark actually have to pay?

- Mark pays his co-payment of $250 at the time of his emergency room visit, which leaves $101,750.
- Then he has to pay the rest of his $2,000 deductible ($2,000-$250=$1,750), which leaves $100,000.
- Then the insurer will pay 80% of the bill. Mark is responsible for 20% of $100,000, which is $20,000.

However, Mark's plan has an out-of-pocket maximum of $4,000. Because he has already paid his $2,000 deductible out-of-pocket, Mark only needs to pay another $2,000 to reach his $4,000 out-of-pocket maximum and the health insurance company will pay the rest.

- **Generic drugs:** A prescription drug that contains the same chemical substance as a brand-name drug.
- **Specialty drugs:** Prescription drugs that have a high cost, high complexity and/or require a high touch. Many drugs for cancer are considered specialty drugs.
- **Formulary:** A list of prescription drugs that a health plan will cover and for how much. Using a plan's formulary will help you save money on medications. Some plans have formularies with two or more cost levels, known as tiers. A drug on a higher tier will have higher out-of-pocket costs for you. The highest tier in most formularies is the "specialty" tier, which includes many cancer drugs. The co-payment and co-insurance amounts will depend on the tier of the prescription drug you are taking. For example, a tier 1 drug may have a $10 co-payment, while a specialty tier drug may have a 30% co-insurance amount.
- **Step therapy:** When an insurance company requires patients to try a generic or lower cost drug before getting a brand-name or more expensive drug. If the lower cost drug doesn't work or causes a bad reaction, the patient would be allowed to "step up" to another medication. If your insurance company uses step therapy, it is important to work with your health care team to show that taking a specific drug is medically necessary for you and why the insurance company should make an exception to its process.

Generally, if a drug isn't on formulary the insurance company will not cover it. But you may be able to file an appeal called an "exception request" based on medical necessity. There are different types of exception requests:

- **Nonformulary drug exception:** A request to cover a nonformulary drug.
- **Tier exception:** A request to treat a drug as if it were in a lower tier, reducing your out-of-pocket costs.
- **Brand exception:** A request to cover a higher-cost brand name drug even if a generic is available.

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Example: Prescription Drug Costs

Noah's Plan:
- Deductible = $1,000
- Co-payment = $50
- Co-insurance = 70/30 plan
- Out-of-pocket maximum = $1,500

If Noah has a prescription for a drug that costs $10,000, how much does he pay?

- His co-payment of $50: $10,000 - $50 = $9,950 left
- His remaining deductible of $950: $9,950 - $950 = $9,000 left
- His co-insurance amount of 30%: 30% of $9,000 = $2,700

But his out-of-pocket maximum is only $1,500. So, after paying the $50 co-payment and the remaining $950 of the deductible, he has paid $1,000 in out-of-pocket expenses and only needs to pay another $500 of the $2,700 co-insurance amount to reach his $1,500 out-of-pocket maximum. His plan will pick up the rest of the costs.

- What does Noah pay next month for his prescription? $0

Picking a Health Insurance Plan

Finding the right health insurance plan can feel overwhelming. There are a few key things to consider when picking a health insurance plan:

- What will the plan actually cost me?
- Are my health care providers and facilities included in the plan's network?
- Does the plan cover my prescription drugs and the pharmacies I use?

When comparing plans, it can be tempting to just choose the one with the lowest monthly premium. But to figure out the total cost for the year in a worst-case scenario, including your out-of-pocket expenses, you have to do some math:

(Plan's monthly premium x 12 months) + Plan's out-of-pocket maximum = Total annual cost

Choosing health insurance is not a one-time activity. You should review your options every year to ensure your plan meets your needs. A plan that met your needs in the past may not meet your needs in the future as your health changes over time. Open enrollment is the time of the year when you can change plans without penalty. The dates for open enrollment will depend on what type of health insurance coverage you have. For example, if you have an employer plan, it will vary, but many employers have open enrollment in the fall for the plan year to start on January 1.

Health Insurance Options

The health insurance options available to you depend on where you live, your age, your employment, your income level, and a number of other factors. Here are some of the main options for health insurance coverage.

Health Insurance Marketplaces

The Patient Protection and Affordable Care Act (ACA) created a new way to find and buy private health insurance coverage for individuals and families: state health insurance marketplaces. Originally called "exchanges," the term "marketplace" refers to a place where you can find health insurance options from private insurance companies. These marketplaces have

been compared to an insurance shopping mall. The marketplaces for most states are operated by the federal government at HealthCare.gov. Some states run their own marketplaces.

There are real benefits to shopping for coverage through the marketplace.

- **Out-of-pocket maximum cap**: There is a cap on the out-of-pocket maximum for plans sold through the marketplace, which is often lower than some employer plans. Also, out-of-pocket maximums for all marketplace plans must include everything you spend for deductibles, co-payments, and co-insurance for in-network providers.

- **Standardized plans**: Plans sold through the marketplace are standardized by their level of cost-sharing:

  - **Bronze plans** have a 60/40 cost-share, meaning that the insurance company pays for 60% of your medical expenses and you are responsible for 40% of your medical expenses. Bronze plans generally have lower monthly premiums but higher out-of-pocket costs.

  - **Silver plans** have a 70/30 cost-share.

  - **Gold plans** have an 80/20 cost-share.

  - **Platinum plans** have a 90/10 cost-share, with higher monthly premiums but lower out-of-pocket costs.

- **Financial assistance**: Based on your household income level, you may qualify for one or both forms of financial assistance. You may receive "premium tax credits," which lower your monthly premium based on the plan you choose. And "cost sharing subsidies" can lower co-payment amounts, deductibles, and co-insurance amounts.

The marketplace open enrollment period is usually from November 1 from December 15 for plans that begin the following January 1. States that run their own marketplaces may have open enrollment periods that last longer.

If you lose coverage or have a life-changing event, you may qualify to enroll during a special enrollment period. You can enroll in a marketplace plan through a 60-day special enrollment period for reasons that include:

- Loss of health insurance (including coverage through work; end of COBRA; or loss of eligibility for Medicaid, Medicare, or Children's Health Insurance Program).

Example: Picking a Plan

- *Plan A* is an HMO with a monthly premium of $25, an annual deductible of $2,500, a 70/30 co-insurance and an out-of-pocket maximum of $7,000.
- *Plan B* is a PPO with a monthly premium of $100, an annual deductible of $1,500, an 80/20 co-insurance and an out-of-pocket maximum of $4,000.

At first glance, it may seem that *Plan A* is less expensive because of its low monthly premium. But you have to do the math!

- *Plan A:* ($25 premium x 12 months = $300) + out-of-pocket maximum of $7,000 = Total cost of $7,300.
- *Plan B:* ($100 premium x 12 months = $1,200) + out-of-pocket maximum of $4,000 = Total cost of $5,200.

After doing the math, *Plan B* is actually the more affordable plan if your medical expenses reach the out-of-pocket maximum.

- Loss of coverage through a family member.
- Change in residence (e.g., moving to a new ZIP code or county).
- Move to/from school.
- Changes in household.
- Marriage (choose plan by last day of month and coverage will start first day of next month).
- Birth of a baby, adoption of a child, or placement of a child in foster care (coverage starts day of event, even if you enroll in plan up to 60 days later).
- Divorce or legal separation (if this results in losing health insurance).
- Death of someone on your marketplace plan.

If you lose employer-sponsored coverage, you may have a number of options for comprehensive health insurance coverage, even if you have a pre-existing medical condition such as cancer. These options include a marketplace plan, COBRA, another group health plan, Medicaid, or Medicare. Because you may be eligible for more than one of these options, it is important to compare your options to determine which plan is best for you.

COBRA

COBRA is a federal law that allows eligible employees to keep their existing employer-sponsored health insurance plan after experiencing a "qualifying event." **Table 1** lists the qualifying events that may entitle you to continue coverage under COBRA and the maximum length of time you can keep your plan.

COBRA applies to private employers with 20 or more employees and to state and local governments. Federal employees have similar protections under a different law. Many states also have a COBRA law that covers employers with two to 19 employees.

A main barrier to COBRA coverage is cost. Typically, you pay 100% of what your employer was paying for your coverage, plus a possible 2% administrative fee (for a total of 102%). But there may be some benefits to COBRA. For example, if you are in the middle of treatment, with COBRA coverage, you wouldn't have to find a new insurance plan that has the same coverage for your doctors, hospitals, and prescription drugs. Also, if you have already met your out-of-pocket maximum or deductible for the year, it may be less expensive to pay the higher COBRA premiums and not have any out-of-pocket costs for the rest of the year. You should do the math to figure out which option would cost you less.

You must choose COBRA within 60 days of your qualifying event. If you wait until the 59th day, you may have to back pay the premiums for the two prior months, but any medical care that you received during that time should be paid for by your COBRA plan. If you need financial assistance to pay your COBRA premiums, Medicaid's Health Insurance Premium Payment Program may help. If you qualify for Medicaid but have access to a group plan through an employer (e.g., COBRA), Medicaid may pay your monthly premium for the group plan.

TABLE 1. Qualifying Events for COBRA Coverage

COBRA Qualifying Event	Maximum COBRA Coverage*
Employment ends or hours reduced	18 months
Loss of dependent child status (i.e., turning 26)	36 months
Covered employee enrolls in Medicare	36 months
Divorce or legal separation from covered employee	36 months
Death of covered employee	36 months

*There are two times when you may be able to extend COBRA coverage. There are also a few times when COBRA coverage may end early, such as when an employer stops offering health insurance coverage to all employees or when an employer goes out of business.

Another Group Health Plan

You may be eligible for a special enrollment period to move to a group plan that is available to you through another job that you might have, your spouse's group plan, or a parent's group plan (if you are under 26). Check the other employer's plan for additional rules.

Medicaid

You may be eligible for Medicaid in your state. Medicaid is a federal health insurance program that provides coverage to individuals with a low income level. If you live in a state that expanded its Medicaid program under the Affordable Care Act and you have a household income under 138% of the federal poverty level (FPL), you may be eligible for Medicaid. If you live in a state that has not expanded Medicaid, eligibility is based on having a low income level, having a low resource level (e.g., assets), and meeting another category of eligibility, such as receiving SSI. Currently, 38 states and Washington, DC, have expanded their programs and 12 states have not. Medicaid applications are accepted year-round.

Qualifying for Medicaid Coverage Based on Income Level

If you live in a state (or Washington, DC) **with expanded Medicaid**, and your household income is:

- Up to 138% of the FPL: You have access to Medicaid.
- Between 138% and 250% FPL: You have access to marketplace premium tax credits and cost-sharing subsidies (if you pick a silver health insurance plan).
- Between 250% and 400% FPL: You have access to marketplace premium tax credits.
- Above 400% FPL: You can buy a marketplace plan, but you do not qualify for financial assistance in most states. Some states provide additional assistance. For example, in California you can qualify for premium tax credits up to 600% FPL.

If you live in a state **without expanded Medicaid**, and your household income is:

- Between 100% and 138% FPL: You have access to marketplace cost-sharing subsidies (for silver plans only).
- Between 138% and 250% FPL: You have access to marketplace premium tax credits and cost-sharing subsidies (if you pick a silver health insurance plan).
- Between 250% and 400% FPL: You have access to marketplace premium tax credits.
- Above 400% FPL: You can buy a marketplace plan but do not qualify for financial assistance.

Note: Under the American Rescue Plan Act, if your household income is above 400% FPL, you may qualify for marketplace premium tax credits to lower your health insurance costs to 8.5% of your household income. This additional benefit is set to expire December 31, 2022.

TABLE 2. Benefits Available by Household Income in States With Expanded Medicaid

Benefits Available by FPL			
100% FPL	**138% FPL**	**250% FPL**	**400% FPL**
	Cost-Sharing Subsidies (Silver Plans Only) ➡ ➡ ➡		
Medicaid ➡ ➡	Premium Tax Credits ➡ ➡ ➡ ➡ ➡ ➡		

FPL, federal poverty level.

TABLE 3. Benefits Available by Household Income in States Without Expanded Medicaid

Benefits Available by FPL			
100% FPL	**138% FPL**	**250% FPL**	**400% FPL**
Cost-Sharing Subsidies (Silver Plans Only) ➡ ➡ ➡ ➡ ➡ ➡			
~~Medicaid~~ ➡ ➡	Premium Tax Credits ➡ ➡ ➡ ➡ ➡ ➡		

FPL, federal poverty level.

Note that the FPL numbers for the current year are used to determine Medicaid eligibility. The FPL numbers for the previous years are used to determine marketplace financial assistance. Refer to **Table 2** and **Table 3** to determine available benefits.

Medicare

Medicare is a government health insurance program. To be eligible you must be 65 or older, have collected SSDI for more than 24 months, or have been diagnosed with end-stage renal disease or amyotrophic lateral sclerosis. There are currently about 62 million Americans enrolled in Medicare.

Medicare coverage is broken down into four parts:

- **Part A**: **Hospital Insurance.** Includes hospital care, skilled nursing facilities, nursing homes, hospice, and home health care.
- **Part B**: **Medical Insurance.** Includes outpatient care from doctors, preventive care, lab tests, mental health care, ambulances, and durable medical equipment.
- **Part D**: **Prescription Drug Coverage.** Plans have options depending on where you live, with different premiums and formularies offered by private insurance companies.
- **Part C**: **Advantage Plans.** An alternative to Parts A and B, it includes the benefits and services covered under Parts A and B, and usually Part D. You can select a PPO or HMO plan that is run by a Medicare-approved private insurance company.

Parts A and B together are referred to as Original Medicare.

Medicare Costs

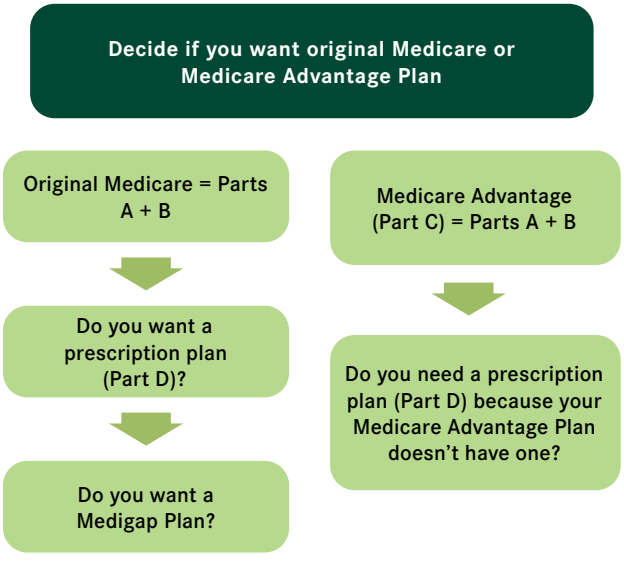
- **Part A:** If you have paid into Medicare while working over your lifetime, the monthly premium is free. If you didn't pay into the system, you will pay a monthly premium. There is an annual deductible. You may also be responsible for paying a cost-share amount depending on the number of days spent in a hospital.
- **Part B:** There is an annual deductible plus a monthly premium that is based on your income. The cost-share for Part B coverage is 80/20, which means that once you have paid your deductible, Medicare will cover 80% of your health care costs and you will be responsible for 20%. With Part B coverage, there is not an out-of-pocket maximum. If you enroll in Part B late, there will be a 10% penalty for each year you wait to enroll. (Example: Phil's initial enrollment period ended December 1, 2018, but he waited until December 1, 2020, to sign up for Part B. His Part B penalty is 20%). You also may have to wait until the general enrollment period to sign up.

- **Part C:** The premiums for this plan are usually at least the same as Part B or more, but they vary based on the plan you choose. The deductibles, cost-share, and out-of-pocket maximums will vary.

- **Part D:** The premiums for prescription drug coverage vary by plan and are higher for those with higher income levels. After paying the annual deductible, Medicare pays 75% of the cost of your brand-name and generic drugs, and you pay 25% until you reach a certain amount in total out-of-pocket drug costs. At that point, you enter "catastrophic coverage," and Medicare pays 95% of your drug costs. If you do not sign up for a Part D plan when first eligible, you will pay a late enrollment penalty for life.

Medigap Plans

A Medigap plan is a supplemental insurance plan that will help pay for your deductibles, co-payments, and cost-share amounts. Plans are labeled as A through N, and each plan with the same letter must offer the same basic benefits in most states. The premiums and deductibles vary with each plan. If you chose Original Medicare (Parts A and B), there is a 20% cost-share amount for Part B, so a Medigap plan can help pay for that expense. If you have Medicare Part C, you are not eligible to buy a Medigap plan.



How to Enroll

You can sign up for Medicare during a seven-month initial enrollment period, which begins three months before the month you turn 65, includes the month you turn 65 and ends three months after the month you turn 65. If you didn't sign up during your initial enrollment period, there is a general enrollment period from January 1 to June 30, but your coverage will not begin until July 1 and you may face late enrollment penalties. You can also make changes to your coverage every year during an open enrollment period that runs from October 15 to December 7.

Medicare Savings Programs

You may qualify for one of the four Medicare Savings Programs. Each program has different income and resource limits and provides different levels of help.

- **Qualified Medicare Beneficiary Program**: This program has the lowest income limits but covers the most out-of-pocket costs. It helps pay for Part A premiums, Part B premiums, deductibles, co-insurance, and co-payments.

- **Specified Low-Income Medicare Beneficiary Program**: This program only helps pay for Part B programs but has slightly higher individual and married couple income limits than the Qualified Medicare Beneficiary program. It helps pay for Part B premiums.

- **Qualifying Individual Program**: To qualify for this program, you must apply every year. Applications are approved on a first-come, first-serve basis, but individuals who received benefits in the previous year are prioritized. If you qualify for Medicaid, you cannot qualify for this program. This program has higher monthly income limits than the Specified Low-Income Medicare Beneficiary and Qualified Medicare Beneficiary programs. The Qualifying Individual Program helps pay for Part B premiums.

- **Qualified Disabled and Working Individuals Program**: This program accepts applicants who are working, disabled and under 65; have lost their premium-free Part A after returning to work; are not getting medical assistance from their state; and meet the income and resource limits for their state. This program has higher income limits than other programs, but lower resource limits. It helps pay for Part A premiums.

The **Extra Help Program** helps individuals with limited income and resources pay Medicare's prescription drug program costs, such as premiums, deductibles and co-insurance. Extra Help also is referred to as the low-income subsidy. If you qualify for the Specified Low-Income Medicare Beneficiary or Qualifying Individual programs, you automatically qualify for Extra Help. In addition, you may be able to receive Medicare and Medicaid, depending on your income and resources.

For additional resources, visit:
TriageCancer.org/HealthInsurance

- Quick Guides & Checklists
- Animated videos
- Chart of state laws
- State resources
- Webinars
- **CancerFinances.org**

Accessing Medical Records

It is important to have a complete copy of your medical records. Having a copy will help you ensure the information in your records is correct, coordinate your medical care between your different providers, share information with your family and caregivers, and appeal denials of health insurance coverage.

When Can I Request My Medical Records?

HIPAA is a federal law that gives you the right to receive, inspect and review copies of your medical records and billing records from health plans and health care providers that are covered by HIPAA. You can request a copy of your medical records from your health care provider and/or health plan at any time, for any reason. A health care provider may not withhold access to your medical records even if you have an outstanding medical bill. Under HIPAA, providers must provide a patient with a copy of their medical records within 30 days of their request, or 60 days if records are kept off-site. If the provider cannot either respond or provide the records within this time frame, they can use one 30-day extension.

How Much Does it Cost to Request a Copy of My Medical Records?

HIPAA allows providers to charge reasonable, cost-based fees related to providing you with a copy of your medical records (including the cost of supplies, labor, and postage). You may not be charged if someone else searches for your medical records. Per page fees are not allowed if records are stored electronically. Note: some state laws also allow for fees, and the amounts vary by state.

What Do I Do if I Want to Correct Something in My Records?

If you think there is information in your medical or billing record that is incorrect, you can ask your health care provider or health plan to make a change to your record. Your health care provider or health plan must respond to your request and make the change or addition. If they refuse, you have the right to submit a statement of disagreement that the provider or plan must add to your record.

Who Do I Contact if Denied Access to My Medical Records?

If a health care provider or health plan denies you access to your medical records, contact the U.S. Department of Health & Human Services' (HHS) Office for Civil Rights at (800) 368-1019.

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TABLE 4. Rules for Filing Appeal for Insurance Coverage Denial

Type of Appeal	Reason for Appealing	When Patient Should Submit Appeal	Timeline for Decision from Insurer
Pre-Authorization Appeal	Denial before services rendered. Denial prevented patient from receiving care.	Within 180 days	Within 30 days of initial appeal
Post-Treatment Appeal	Denial for payment of care received, meaning patient is 100% responsible for any charges.	Within 180 days	Within 60 days of appeal
Urgent Care (or Expedited) Appeal	Delay in treatment would seriously jeopardize life and overall health, affect patient ability to regain maximum function, or subject patient to severe and intolerable pain.	Within 180 days, but if urgent care, patient can ask for external review at same time as internal review	Within 72 hours of receiving appeal

Understanding Appeals

At some point during cancer treatment, you may experience a denial of coverage from an insurance company, whether for an imaging scan, prescription drug, treatment, procedure, or genetic test. And most of us may take "no" for an answer. But those who don't accept the denial and file an appeal may actually win and get coverage for the care prescribed by their health care team.

There are different rules for filing appeals depending on the type of health insurance coverage that you have (**Table 4**). Medicare, Medicaid, military, and veterans plans all have specific rules. If you have a private individual health insurance policy or a health insurance policy through work, you generally have two opportunities to appeal a denial of coverage via an internal appeal and an external appeal.

Internal Appeal

When an insurance company has denied coverage for care, you can file an "internal appeal" within your insurance company. Each insurance company has its own internal appeals process, so contact your insurance company for details or look for instructions on how to file an appeal on your denial letter. There are time frames related to filing an internal appeal. If your insurance company denies your internal appeal, you can request an external appeal.

External Appeal

Under the Affordable Care Act, all states must have an external appeals process; this is sometimes referred to as an External Medical Review or Independent Medical Review. State insurance agencies or the HHS administer external appeals through independent review organizations that determine if the insurance company should pay for your medical care. Decisions are binding on the insurance company.

If urgent, reviews can be expedited, filed at the same time as an internal appeal and decided within 72 hours. The HHS process is free, but states can't charge more than $25 for an external appeal.

Appeals Before Care Versus After Care

You can file appeals both before and after you receive medical care. The processes for filing an appeal before care and after care are slightly different. An example of when you might get a denial of coverage before you even receive care is when your insurance company requires a pre-authorization before getting care. If your insurance company denies pre-authorization, you can appeal that decision.

For additional resources, visit:
TriageCancer.org/Navigating-Cancer-Health-Care

- Quick Guides & Checklists
- Animated videos
- Chart of state laws
- State resources
- Webinars
- **CancerFinances.org**

Managing Medical Bills

Cancer treatment is expensive. But here are key tips on how to manage your medical bills to help you avoid unnecessary expenses.

Ways to Avoid Higher Medical Bills Before Care

While it is impossible to completely avoid out-of-pocket medical costs related to a cancer diagnosis, you can take steps to avoid higher-than-necessary medical bills.

- **Have the right insurance.** You may tend to look only at a plan's monthly cost when choosing a health insurance policy. However, you should also look at the out-of-pockets costs that you have to pay when you get medical care, such as co-payments, deductibles, and out-of-pocket maximums. You also need to make sure the plan covers your providers, hospitals, and prescription drugs. Reviewing your health insurance coverage is something you should do each year to make sure you have the best coverage for your current needs.

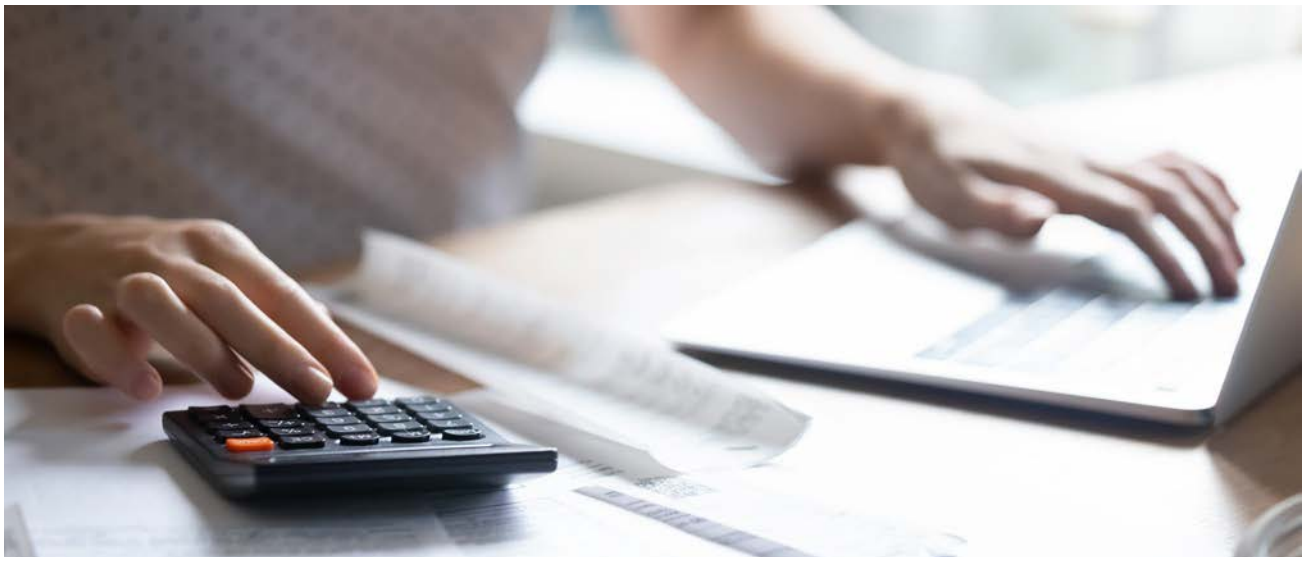
- **Discuss costs with your health care team before treatment.** Your health care team may have suggestions for reducing costs; for example, grouping health care appointments together helps you avoid extra co-payments for office visits. Furthermore, you might be able to negotiate your medical bill before you receive care. Ask for upfront pricing for all nonemergency tests and procedures and ask if there are any discounts available.

- **Get any necessary pre-authorization.** Many health insurance companies require you to obtain prior approval (also called pre-authorization, prior authorization, or pre-certification) before you receive medical care. If you don't get the pre-authorization, your health insurance company may deny your claim. Make sure your health care team contacts your health insurance company before treatments, testing, surgery, or hospitalization to check if you need a pre-authorization. If your health care team does not request a pre-authorization for you, you are responsible for getting approval from your insurance company. Also, even if you receive approval, it does not guarantee that your insurance will cover your care.

- **Go to in-network providers when possible.** To be a part of a plan's network, doctors and facilities contract with the plan and agree to accept a specific rate for their services under the plan. These doctors and facilities are considered "in network." Doctors and facilities that do not have a contracted relationship with an insurer are considered "out of network." Some PPO plans have limited coverage for out-of-network providers (e.g., 50%). Most HMO and EPO plans pay 0% for out-of-network providers.

- **Keep track of your out-of-pocket payments.** While your insurance company usually keeps track of what you have paid for out-of-pocket medical care and may even list that on each explanation of benefits (EOB) that you receive, it can be helpful to keep track on your own to ensure those amounts match. Mistakes happen, and you don't want to pay more than you are required to under your plan. Also, when you visit a provider, you may be asked to pay a co-payment when you check in. If you have an insurance plan that includes your co-payments in your out-of-pocket maximum, your provider may not know that you have already reached your out-of-pocket maximum and, therefore, aren't responsible for paying any more co-payments for the rest of your plan year.

- **Leverage out-of-pocket maximums.** If you've reached your maximum for the year, consider addressing any other health care needs you have, rather than waiting until the new plan year, where you will have to meet your deductible and out-of-pocket maximum again.



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Communication About Medical Bills

The amount of paperwork generated each time you receive medical care can be overwhelming. Each time you get medical care, you can expect to receive some, or all, of the following items listed below in the mail, by email, or posted in your online insurance account or online electronic medical record offered by your provider.

From the **health insurance company**, you may get:

- A letter indicating it has received a claim from the health care provider.
- A letter saying it is processing the claim.
- An EOB, which details the claim received, how much the provider charged for the particular service (e.g., an X-ray), what the health insurance company is going to pay the provider and what the patient may owe the provider (often called the "patient responsibility"). Generally, EOBs are identified by the statement "THIS IS NOT A BILL" somewhere on the page.

From the **health care provider**, you may get:

- The bill with an amount that the patient is responsible for paying.

You should wait to send in a payment to your provider until you receive your insurance EOB to ensure that the bill and the EOB match and that they are correct. If you're concerned about missing the due date on the bill while waiting for your EOB, contact your provider and let them know that you are waiting for your EOB.

Reviewing Your Medical Bills

Once you've received a medical bill, it's important to review it to make sure it's accurate. Don't be afraid to ask your providers to explain codes or descriptions of services you received. Small errors, such as a wrong number or code, can make a big difference in your bill. Ask for an itemized list of charges, request a copy of your medical records and pharmacy ledgers, and check that everything matches up. If you need help managing your medical bills, consider asking family and friends for help. They can open mail, match EOBs to bills and put payment due dates on your calendar.

Getting Organized

There are many tools available to keep track of your medical bills, EOBs, medical records, and other paperwork related to your medical care. But the key is to use the tool that makes it easier for you to stay organized, whether that is a box with file folders or a three-ring binder. You also should keep track of any communications that you have with your provider and health insurance company. One reason

it is important to stay organized is that tracking all of your expenses related to your medical and dental care (including meals, lodging, and travel expenses related to medical care) could save you money. These expenses may be tax deductible, or possibly paid for through a Health Savings Account (HSA) or Flexible Spending Account (FSA).

Paying Your Medical Bills

If you receive a medical bill that you are unable to pay, it is important not to ignore it. Consider contacting your provider to ask for more time or see whether your provider would be willing to negotiate a payment plan or accept a lower lump-sum payment.

It is important not to wait too long to contact your provider about an unpaid medical bill. Contacting your provider before unpaid bills get sent to collection agencies can help protect your credit score.

Be careful when you're considering paying medical bills with credit cards; they usually have high interest rates, and you could end up spending more than necessary. You should also be careful when considering taking out a home loan to pay off medical debt. Using your home as collateral transfers the debt from being unsecured to secured, which means that the lender could take your home if you are unable to make payments.

You may be able to qualify for financial assistance programs to help offset the cost of your medical bills.

For additional resources, visit:
TriageCancer.org/HealthInsurance
TriageCancer.org/Financial

- Quick Guides & Checklists
- Animated videos
- Chart of state laws
- State resources
- Webinars
- **CancerFinances.org**

Conclusion

This practical guide addresses the most common issues that arise after a cancer diagnosis. However, it only scratches the surface of the legal and practical issues that individuals diagnosed with cancer and their caregivers may have to address. Estate planning, life insurance, education rights, consumer rights, and immigration status are other common topics. Triage Cancer provides information and resources on all of these topics and more for free.

We believe that when individuals with cancer, their caregivers, and their health care professionals have a better understanding of how to obtain and use insurance coverage, appeal denials of coverage, take time off work, access workplace protections and accommodations, protect estates, and manage other financial issues associated with cancer care, quality of life and cancer survivorship outcomes improve.

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CANCERFINANCES.ORG

A FREE TOOLKIT FOR NAVIGATING FINANCES AFTER CANCER

We know that cancer is expensive. This site will guide you through key topics that may impact your financial situation. Why trust CancerFinances.org?

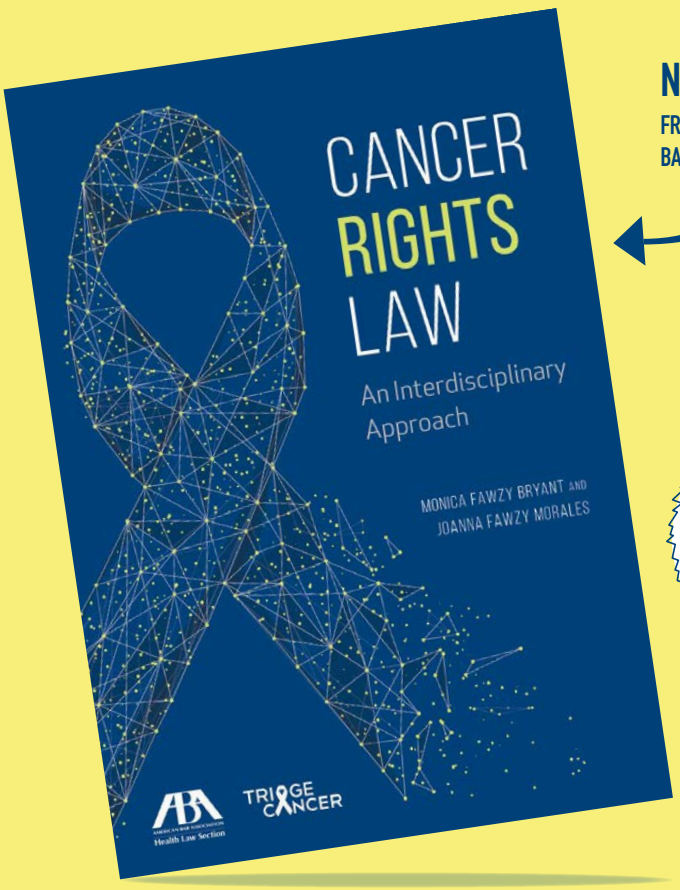
We dream of a world where everyone has access to information and resources needed to find their best path forward. Beyond diagnosis.

MADE POSSIBLE BY TRIAGE CANCER

YOU'RE NOT ALONE. WE CAN HELP.

Designed so you feel like you're getting the one-on-one help you deserve, our toolkit covers a number of topics, including:

- Health Insurance
- Employment
- Disability Insurance
- Estate Planning
- Family Planning
- Financial Assistance Resources
- Life Insurance
- Clinical Trials
- Caregiving
- Genetics & Genomics
- Education
- Managing Finances & Medical Bills



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CANCER RIGHTS LAW

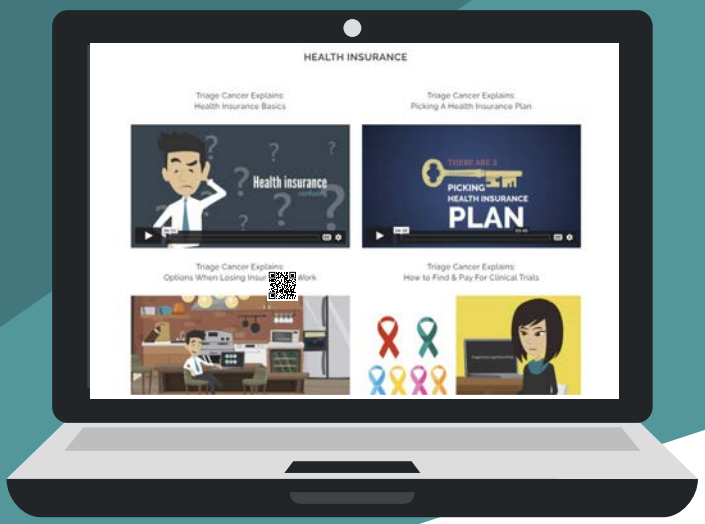
AN INTERDISCIPLINARY APPROACH

by Monica Fawzy Bryant, Esq. and Joanna Fawzy Morales, Esq.

Cancer Rights Law provides an overview of key areas of the law that often come into play for individuals who have been diagnosed with cancer and their caregivers, including health insurance, employment, disability insurance, genetics, estate planning and medical decision making, and finances and consumer rights.

Whether you teach a law school class, run a legal clinic, are interested in forming a medical-legal partnership, want to provide pro bono legal services, are responsible for navigating patients through their cancer experience, or are coping with your own cancer diagnosis, this book will provide valuable information and practical resources to effectively navigate cancer-related legal issues.

Check out our animated videos at TriageCancer.org/AnimatedVideos



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