Health Insurance [1]

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Many studies show that successfully managing and treating illness is highly dependent on access to high-quality health care. In the United States, getting this access usually requires having health insurance to cover or offset the costs of care. Most people obtain their insurance through their employer or through government programs such as Medicare or Medicaid. However, the Patient Protection and Affordable Care Act (often referred to as health care reform), has changed many of the rules for health care insurance coverage in the United States. Find out more about the Affordable Care Act and Cancer [3].

Types of Health Insurance

The type of health insurance coverage you have plays a big role in the amount of out-of-pocket costs you can expect to pay throughout cancer treatment and recovery. The following information will help you understand the different types of health insurance and what medical costs they usually cover. Find definitions for many of the terms used in this section in the Cost and Insurance Dictionary [4].

Private insurance

Before health maintenance organizations (HMOs) and preferred provider organizations (PPOs) were developed as systems to contain rapidly increasing health care costs (see below), most people had one option for private health insurance: fee-for-service coverage. This type of plan generally does not place any restrictions on which doctors or hospitals you choose. You simply visit the doctor, hospital, or health care center of your choice, anytime or anywhere, submit a claim form, and the health insurance company pays the bill. Typically, you share some of the cost in the form of co-payments or co-insurance, and some types of services may not be covered.

Although fee-for-service plans allow for the greatest freedom in choosing doctors and hospitals, there may be restrictions to some services, including mental health services, physical therapy, home health care, investigational treatments, or alternative medicine.

HMO

An HMO can be thought of as a health care insurance club, with patients and doctors as

members. It is set up to keep health care costs down by working with patients to comprehensively manage their health care. In an HMO, a person chooses a primary care doctor from an approved network.

As a member of an HMO, you pay a monthly premium and a small additional co-payment for each office visit. An HMO generally does not require you to submit any claim forms, unless you visit doctors who are not members of the plan.

An HMO may be an actual health care center, in which all of the doctors in the office are part of the organization. In other cases, individual doctors contract with the HMO to care for patients covered under the plan. This agreement is known as an individual practice association (IPA).

Because you pay a flat rate to your HMO, the plan will often encourage preventive care intended to avoid the need for more expensive care later. However, as with most insurance plans, covered services vary. For example, some types of mental health services, alternative medicine, and physical therapy may not be covered or covered only on a limited basis.

Restrictions

Compared with fee-for-service plans, total medical costs in an HMO are usually lower and more predictable. However, these reduced costs are typically accompanied by additional restrictions, including:

- Fewer choices of doctors and hospitals, as only doctors and hospitals that are members of the HMO are covered under the plan, although many companies make exceptions as medically necessary and for emergencies. Many HMOs allow you to visit doctors outside the plan for a higher fee (called ?out of network? care).
- Access to a specialist often requires a referral from your primary care doctor.
- Precertification is usually required before nonemergency hospital visits and some types of specialist care, and a person needs to call the HMO within 24 hours of any emergency care.
- Some types of services, such as mental health services, physical therapy, home health care, or investigational treatments, may not be covered.

PPO

A PPO is a type of health insurance in which a person is offered a network of approved doctors, and most of the medical costs are covered when visiting doctors that are part of the network. However, a PPO typically does not require you to see a designated primary care doctor who manages your care and controls your access to a specialist. A PPO may also be more flexible than an HMO in allowing visits to out-of-network doctors, although these visits usually require you to pay a larger portion of the bill. It may also require you to pay a deductible or co-insurance for some services.

Restrictions

The restrictions associated with a PPO may include:

- Doctors and hospitals that are limited to the PPO network, although this selection tends to be

larger than the network of an HMO
- Precertification may be needed for some types of care, especially if the facility or doctor is outside of the network.
- Some types of services, such as mental health services, physical therapy, home health care, investigational treatments, or alternative medicine may not be covered.

Government-sponsored insurance programs

Medicare

Medicare is health insurance provided by the federal government for people 65 and older, as well as for some disabled Americans. People over 65 who are eligible for Social Security or Railroad Retirement benefits automatically qualify for Medicare, along with their spouse. Medicare has different ?parts? that serve different, sometimes complementary, purposes.

- Medicare Part A covers inpatient care (such as hospital care), skilled nursing care, hospice care, and a limited scope of home care services. These services are free.
- Medicare Part B provides financial coverage for doctor services, outpatient care, physical and occupational therapy, and selected supplies that are deemed medically necessary.
- Medicare Part C, also called Medicare Advantage, contains insurance plans managed by private Medicare-approved companies. It combines Medicare Parts A and B and may include prescription drug coverage.
- Medicare Part D is a benefit that people can enroll in that covers prescription drugs. The Medicare Modernization Act of 2003 (MMA) provided this prescription drug benefit.

As you can see, Medicare does not cover all health care expenses. These expenses are called ?gaps,? and some people decide to purchase a Medigap policy to cover co-payments, co-insurance, deductibles, and other out-of-pocket expenses. During the past several years, there have been many revisions to the Medicare laws about what outpatient treatments are covered. Depending on a patient?s Medicare plan, they may be responsible for a 20% co-payment if no other insurance is available.

Medicaid

Medicaid is a health insurance program paid for by the federal and state governments and administered by each state. It covers people who are eligible because they are elderly, blind, or disabled, as well as certain people in families with dependent children. Each state operates the program individually and determines who is eligible and what services are covered in that specific state.

For more information about Medicare and Medicaid visit www.cms.gov [5]. Medicare information can also be found at www.medicare.gov [6]. Visit www.healthcare.gov [7] for full information about the changes made to Medicare and Medicaid under the Affordable Care Act.

Health insurance marketplaces

On October 1, 2013, the health insurance marketplaces, or exchanges, opened for enrollment. Created as part of the 2010 Patient Protection and Affordable Care Act, the exchanges represent

a new way for individuals and families to choose and purchase health insurance. Depending on where you live within the United States, you can compare different health insurance plans and prices and find one that works best for you. For people who do not currently have health insurance or are not covered by an employer, this marketplace may be helpful. For 2014, the open enrollment period runs through March 31, 2014. For coverage starting in 2015, the open enrollment period is November 15, 2014 through January 15, 2015.

To explore and compare health insurance plans and learn more, visit the official resource for health insurance marketplaces, www.HealthCare.gov [7], or call 800-318-2596 (TTY: 855-889-4325). You may also sign up to receive health insurance options and updates by email and text message by subscribing at HealthCare.gov. Other resources that can help you understand more about your insurance options under the Affordable Care Act include the Health Law Helper [8] and the Cancer Insurance Checklist [9].

Insurance examples

Understanding the benefits and limitations of your health insurance policy can be challenging, but it is important to learn exactly what your coverage provides. The following examples help illustrate how co-pays, co-insurance, and deductibles work. You are strongly encouraged to talk with a representative of your insurance provider, who can explain the details of your specific plan.

Example #1: Co-pays

Anna needs to see two specialists this week: Dr. Smith and Dr. Jones. Dr. Smith charges $100 a visit, and Dr. Jones charges $500 a visit. If Anna?s insurance requires her to pay a $20 co-pay for specialist visits, how much does she pay out-of-pocket at the appointments?

Answer:

Anna will pay $20 at each doctor?s office ($40 total). Because a co-pay is a set amount of money, the patient?s payment doesn?t depend on the amount of the bill.

Example #2: Co-insurance

Martin needs to see two specialists this week: Dr. Andrews and Dr. Adams. Dr. Andrews charges $100 a visit, and Dr. Adams charges $500 a visit. If Martin?s insurance states he must pay 20% co-insurance for visits, how much does he pay out-of-pocket at the appointments?

Answer:

Multiply each bill by the co-insurance percentage.

- Martin?s payment to Dr. Andrews would be $20 since $100 x 20% = $20
- Martin?s payment to Dr. Adams would be $100 since $500 x 20% = $100

Example #3: Co-insurance and deductibles

Kathy has a deductible of $2,000 a year, and her co-insurance for a hospital visit is 20%. She recently had a surgery that cost $10,000. How much does she have to pay out-of-pocket?

Answer:

STEP ONE. Subtract the deductible from the total bill: $10,000 ? $2,000 = $8,000.

STEP TWO. Multiply the difference by the co-insurance percentage: $8,000 x 20% = $1,600. This gives Kathy?s co-insurance amount.

STEP THREE. Add together the deductible ($2,000) and the co-insurance amount ($1,600) to find the total amount that Kathy would pay: $2,000 + $1,600 = $3,600.

Other types of insurance

Although health insurance covers some of the costs of cancer care, other costs are not covered. Many of these additional expenses may be covered if you have purchased other types of insurance.

Supplemental insurance. A supplemental insurance policy helps cover expenses not covered by your primary insurance or the costs you pay as part of your existing plan. This policy generally covers deductibles, co-insurance, co-payments, and other out-of-pocket expenses. It may also offer additional benefits, such as compensation for lost earnings due to missed work.

Disability insurance. Disability insurance replaces income lost if you are unable to work due to a long-term illness or injury. Such coverage is often provided through your employer or government-sponsored programs, although individual policies are also available.

Hospital indemnity insurance. Hospital indemnity insurance provides limited coverage for hospital stays, usually a fixed amount each day up to a maximum length of stay. People may decide to purchase this type of insurance if their basic insurance plan limits coverage of hospital care.

Long-term care insurance. Because most basic private insurance plans and Medicare generally provide very limited coverage for long-term care, such as nursing home care, some people decide to get additional coverage to offset the costs of such care.

Taxes

Some medical expenses not covered by insurance, including mileage for trips to and from appointments, prescription drugs, and meals during lengthy medical visits, can be deducted from federal income taxes. A tax advisor can help clarify these rules.

More Information

Health Insurance Coverage of Clinical Trials [10]

Understanding the Costs Related to Cancer Care [11]

Financial Resources [12]

Managing Your Care [13]

Additional Resources

Allsup [14]

American Cancer Society: Health Insurance and Financial Assistance for the Cancer Patient [15]

Cancer*Care*: Sources of Financial Assistance [16]

America's Health Insurance Plan (AHIP): The Issues [17]

Links:
[1] http://www.cancer.net/navigating-cancer-care/financial-considerations/health-insurance
[2] http://www.cancer.net/about-us
[3] http://www.cancer.net/node/24921
[4] http://www.cancer.net/node/24917
[5] http://www.cms.gov/
[6] http://www.medicare.gov/
[7] http://www.healthcare.gov/
[8] http://www.healthlawhelper.org
[9] http://www.cancerinsurancechecklist.org
[10] http://www.cancer.net/node/30756
[11] http://www.cancer.net/node/24922
[12] http://www.cancer.net/node/25370
[13] http://www.cancer.net/node/25015
[14] http://www.allsup.com/
[15] http://www.cancer.org/treatment/findingandpayingfortreatment/managinginsuranceissues/healthinsuranceandfinancialassistance insurance-and-financial-assistance-toc
[16] http://www.cancercare.org/publications/62-sources_of_financial_assistance
[17] http://www.ahip.org/Issues/