



**MEDICAL INSURANCE GUIDE
FOR
CANCER PATIENTS**

**A PUBLICATION OF THE
CANCER ADVOCACY PROJECT
OF THE CITY BAR JUSTICE CENTER**

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INTRODUCTION

The Cancer Advocacy Project is a legal services program of the City Bar Justice Center. Our health law component provides assistance to cancer patients and survivors facing the challenges that surround access to health care, including unjust denials of coverage and understanding and querying medical bills. Our employment discrimination component provides information, advice and counseling on issues relating to workplace discrimination and employee rights. Experienced volunteer attorneys with the life-planning section counsel clients and prepare documents such as simple Wills and advance directives (e.g. Health Care Proxies, Living Wills and Powers of Attorney).

Following the implementation of the Affordable Care Act, (2010), we have substantially revised and updated this guide to help cancer survivors, patients and their families answer basic questions about health insurance in New York State. Through our legal work on insurance and employment matters, we speak to many cancer patients and survivors who are uninsured, under-insured or who are unsure of which type of insurance policy would best suit their particular situation. These individuals and their families often do not know where to turn for assistance. We hope this guide will provide a helpful starting point for navigating their way through their health insurance choices and the appeals process.

About This Guide

This guide is not intended to serve as legal advice and the Cancer Advocacy Project is not responsible for the accuracy or adequacy of any of the information contained in the guide or your reliance on this information.

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HEALTH INSURANCE OVERVIEW

Among the many concerns faced by anyone who is diagnosed with cancer is accessing quality medical care. In past years, those who were uninsured at the time of their diagnosis, generally found it impossible to purchase individual medical insurance; either they would be denied outright for having a ‘pre-existing condition’ or the premiums would be so costly as to be unaffordable. Even those with employer-provided insurance were at risk; extended medical leave, reduced work hours, amended job duties, etc., sometimes resulted in the employee being “let go” and, as a result, losing access to crucial insurance coverage. Another concern was the ability of insurers to impose lifetime and annual caps on their coverage – which, for someone with a cancer diagnosis and reliant on costly treatment and medications, was particularly perilous.

The Affordable Care Act (ACA) was phased in gradually after its implementation in 2010 but, for many, its impact was not felt until the Health Insurance Exchanges (“Marketplaces”) became active in October 2013 and the new policies went into effect in January 2014. The ACA introduced major changes to the health insurance sector, with the key goals being to increase access to affordable health care and to require insurers to offer plans that provide a core list of essential benefits in their coverage. Many of the resulting changes directly impact the insurance coverage and treatment options of cancer patients and survivors.

There is no shortage of insurance companies offering numerous plan choices to residents and employees in New York State. Sorting through all the options takes time and approaching the task in an organized and methodical way will improve your chances of finding the right plan. The plan choices available will depend on whether your insurance is employer-based - where you are part of a group, or you research specific insurers and contact them directly to purchase a plan as an individual, or you use the Marketplace. The Marketplace (or “Exchange”) in New York is ‘New York State of Health’ where individuals, families and small businesses can compare plan options and purchase health insurance. You can visit their website at: <http://info.nystateofhealth.ny.gov/>.

Key provisions of the ACA of particular relevance to cancer patients are:

- A. Insurers cannot deny, limit benefits or charge higher premiums for people with pre-existing medical conditions.
- B. Annual out-of-pocket (OOP) costs (deductibles, copayments and coinsurance) have been capped. In 2019, the maximum OOP cost is \$7,900 for an individual and \$15,800 for a family. In 2020, the maximum will be \$8,200 for an individual and \$16,600 for a family.
- C. Insurance companies cannot impose lifetime or annual limits on insurance costs.

- D. Insurers cannot arbitrarily cancel coverage, e.g. because an individual has been diagnosed with cancer which will result in an increased use of medical services. Withdrawal of coverage is only permitted in cases of fraud.
- E. All plans must cover screening and preventive services without co-pays.
- F. Coverage of routine costs for patients who participate in approved clinical trials.
- G. Young adults can stay on, or join, their parents' employer-based health insurance up to age 26. This remains the case even if the young person is living away from home, financially independent or married. The cost of the coverage does not differ by the age of the child; it will be the same whether the child is 5 or 25.
- H. Additional health insurance coverage may be available to some young adults in New York State. Under New York law, a young adult between ages 26 and 29 may be covered under a parent's employer-based medical insurance if he or she:
 - a) is unmarried;
 - b) is not insured or eligible to be insured by his/her own employer;
 - c) lives, works, or resides in New York State or the health insurance company's service area;
 - d) is not covered under Medicare.
- I. Immigrants who are lawfully present in the United States (including Legal Permanent Residents/green card holders, refugees and asylees) can apply for health insurance through the Marketplace or, if eligible, through Medicare or Medicaid. Undocumented immigrants cannot purchase insurance through the Marketplace but, if able to meet the eligibility criteria, may qualify for Emergency Medicaid. Low-cost or free health care may also be available at safety net hospitals and community clinics.
- J. The coverage gap (or "donut hole") in Medicare is being gradually closed. In 2019, Medicare will pay 63% of the price for generic drugs during the coverage gap. For 2020 and beyond, Medicare will pay 75% of the price for generic drugs during the coverage gap.

TYPES OF PRIVATE HEALTH INSURANCE

Although there is an abundance of private insurance choices available, in reality, these choices may be limited by your specific situation. For instance, not all of the insurance providers or plans that are available will be included in the Marketplace. Similarly, employers are likely to offer their employees coverage through only one or two designated insurers, with a limited choice of plan options. Despite the narrower options, there will still be important factors for you to consider before making a selection, e.g.: Is there a choice of plan type (HMO, PPO, EPO, etc.)? What benefits are offered under each care level (e.g. bronze, silver, gold, platinum)? Before purchasing a plan, it is crucial to read and fully understand its benefits and restrictions – and how they will impact your own medical needs. This section provides a brief overview of some of the available plan options.

Fee-for-Service (FFS)

There are generally two approaches to this type of plan: 1) *FFS – non-Preferred Provider Organization (PPO)*.and, 2) *FFS with a Preferred Provider Organization (PPO)*. With both versions, you choose your doctors and hospitals without the need for a referral, and your insurer pays all or part of the cost according to your policy. Most insurers set permissible reimbursement rates for a service. If your provider charges more than the set rate, you may be responsible for the difference, in addition to your deductible and co-insurance.

1) *FFS – non-PPO*: This model is what most people think of as traditional insurance; it provides the most comprehensive option for choosing medical providers. You can visit the doctor, hospital or clinic of your choice and the insurer will either pay the medical provider directly, or you will pay the provider and be reimbursed by the insurer after filing a claim. The unlimited access to providers of your choice must be balanced against the likely higher medical expenses that you will ultimately have to pay.

2) *FFS with PPO*: With this option, your medical providers must be a part of your plan's 'preferred provider organization' network. Because the providers in the network have reduced their charges to meet the plan requirements, your out-of-pocket costs are likely to be lower than with the non-PPO version. The networks generally provide a wide choice of doctors and hospitals, but may not have all of the doctors, facilities or other medical service providers that you would prefer. You should also be aware that using a hospital within the plan's PPO network does not guarantee that every doctor or service provided by the hospital will also be in the network; your radiology services or lab work may be provided by independent practitioners working within the facility.

Health Maintenance Organization (HMO)

This type of health insurance involves a health insurer that directly contracts with a network of service providers. With an HMO, you choose your primary care physician (PCP) from an approved network and all of your health care services go through that doctor. If you need to see a specialist, you must first obtain a referral from your doctor. One exception to this framework is that women do not need a referral from their PCP in order to see an in-network obstetrician/gynecologist (OB/GYN) for routine screening services and obstetrical care. The aim of an HMO is for you to receive all of your medical care from doctors within your network. Out-of-network (OON) providers are not typically covered by your insurance, except in an emergency, so you will probably have to pay all of the cost for any OON services you receive.

An HMO may require you to live or work in its service area in order to be eligible for coverage. As a member of an HMO, you pay a monthly premium and a co-payment for each visit, but there is typically no deductible. You will generally not be required to submit any claim forms unless you visit doctors who are OON.

Preferred Provider Organization (PPO)

PPO plans do not require the designation of a Primary Care Physician as a ‘gatekeeper’ for accessing specialist care and are, therefore, more flexible in this regard. Similar to an HMO, the plan is based on a network of “preferred” providers and specialists, but no referral is needed to see a specialist within network. If you receive services from an out-of-network (OON) specialist, you will have to pay all, or a higher percentage of the costs of that service than if you had remained within network.

PPO plans generally have a higher cost-sharing element than HMOs, with some combination of co-payments, deductibles and co-insurance and, consequently, higher out-of-pocket costs. Some PPO plans fall into the High Deductible Health Plan (HDHP) category, requiring enrollees to pay a very high deductible before the insurer begins to share the costs. If the HDHP deductible is above a certain amount (\$1,350 for an individual and \$2,700 for a family in 2019 and \$1,400 and \$2,800 for a family in 2020) it is often combined with a Health Savings Account, which allows an individual to pay for current health expenses and save for future qualified medical expenses on a pre-tax basis.

Exclusive Provider Organization (EPO)

EPOs are very similar to HMOs, except that you may not need a referral in order to see a specialist. Enrollment in an EPO plan may, in effect, require you to stay within their network of medical providers by providing very limited, or no coverage for out-of-network services. Premiums for EPO plans are lower than for PPOs.

Point-of-Service (POS)

This type of plan combines elements of an HMO and a PPO. Similar to an HMO, you are encouraged to choose one doctor who will have overall knowledge of your medical care, and can provide guidance and referrals to specialists. Medical care provided by your PCP will not generally be subject to a deductible. On the other hand, like a PPO, a POS plan allows you to go out-of network (OON) for treatment. If your OON treatment is for a service that is covered by your insurance policy, a percentage of the cost will likely be paid by your insurer, but your share will be higher than if you stayed in-network. In general, when you use OON services you will be subject to higher out-of-pocket costs, including higher deductible and co-insurance requirements.

'Skinny' Health Plans

Since 2018, low-cost health plans have re-entered the medical insurance sphere through brokers and online advertisement as alternatives to ACA-standard plans. However, although the monthly premiums may be much lower than ACA plans, the coverage may be equally limited as a result – sometimes referred to as a 'skinny' plan. Skinny plans can take into account pre-existing health conditions and are likely to exclude individuals with a history of cancer. In addition, limitations in skinny plans may include an annual limit on hospital care coverage, a limit on the number of covered doctor visits and lab tests per year, and no coverage for outpatient drugs - including chemotherapy. It is crucial for you to read and fully understand the terms of any medical insurance policy before signing up, especially if you have, or have had, a serious health condition such as cancer.

GOVERNMENT HEALTH INSURANCE

Medicare

Medicare is federally-provided health insurance for eligible individuals.

Eligibility:

- a) age 65 or older and eligible for Social Security benefits; or
- b) disabled (any age) and have collected Social Security benefits for two years; or
- c) have been diagnosed with Amyotrophic Lateral Sclerosis (ALS/Lou Gehrig's Disease) or end-stage renal disease, regardless of age.

Medicare is divided into 'Parts':

Part A: covers care you receive from a hospital, skilled nursing facility, home health aide or other facility. For most eligible people there is no premium for Part A. However, a deductible is payable for in-patient hospital care, and co-insurance applies for longer stays in a hospital or skilled nursing facility. Part A covers chemotherapy drugs when administered in a hospital or skilled nursing facility.

Part B: covers 80% of approved medical expenses, including doctors' charges, (e.g. visits to the doctor's office) lab fees and durable medical equipment. Under the ACA, some services are fully covered and you would not be required to share the cost; these include a free yearly wellness visit, and screening tests such as annual mammograms, routine pap smears and colonoscopies. Also fully covered are screening pelvic exams every two years – or every year for women considered to be at “high risk” for ovarian cancer.

Additional cancer-related tests available under Part B include colorectal cancer screening for people age 50 and older, and prostate cancer screening for men age 50 and older.

Part C: is the Medicare Advantage Plan (like an HMO or PPO) offered by private insurance companies approved by Medicare.

Part D: Assists with the cost of prescription drugs.

If you have limited income and resources, you may be eligible for help with paying your premiums and out-of-pocket costs through Medicaid.

Medicaid

Medicaid is funded through a partnership between the federal and state governments. It is a means-tested program that covers the cost of medical care for low-income people who meet certain criteria. To qualify for Medicaid, in addition to meeting the financial eligibility income and asset levels, you:

a) receive SSI or b) are aged 65 or older or c) are blind or disabled.

In addition, you may also qualify if you meet the requirements for the Safety Net Assistance Program budget rules.

Under the ACA, New York State has expanded its Medicaid coverage to 133% of the federal poverty level.

In addition to general medical services, Medicaid also covers services beyond those provided under Medicare, including nursing facility care past the 100-day limit, and also covers long-term skilled nursing facility care. If you are eligible for both Medicare and Medicaid (“dual-eligible”) services covered by both programs are first paid by Medicare, with Medicaid covering the difference up to the state’s payment limit.

Emergency Medicaid

Emergency Medicaid is an option for people who are otherwise uninsured (e.g. undocumented immigrants, who are not eligible to buy health insurance through the Marketplace) and who have been diagnosed with an emergency medical condition. Each state has its own rules about what services will be covered under Emergency Medicaid. In New York, if otherwise eligible, undocumented immigrants who have received a cancer diagnosis may be able to receive chemotherapy and/or radiation treatment. Although coverage is provided for the treatment of an emergency medical condition, coverage of prescription drugs under Emergency Medicaid has become more tightly controlled. In order to be covered, the medications must be on the Department of Health's approved list of drugs for emergency care. Your physician can apply for an override if coverage of a prescription is denied, and the request will be evaluated.

CHOOSING A PLAN

Useful criteria for comparing managed care plans

- A. **BENEFITS OFFERED** – Determine what your needs are and whether the plan you are considering covers them. Make a list of the things that are important to you in relation to your health. Do you have a chronic medical condition? Have you been diagnosed with a serious illness such as cancer? Or are you in good health and more concerned about screening and preventive options? How does the plan define an “emergency”? Does the plan offer benefits for hospice care? Evaluate your needs and consider if they will be adequately covered.
- B. **SPECIALIST TREATMENT CENTERS** – Does the plan's network cover treatment at facilities that specialize in your illness? For instance, if you are a cancer patient, does the network include hospitals with particular expertise in cancer treatment? Will you have access to a comprehensive cancer center that may offer more advanced treatment and clinical trials of new medications?
- C. **COSTS** – Choosing a plan based solely on its low premium could prove expensive in the long run. A low premium often means high deductibles and out-of-pocket costs. You may have to pay thousands of dollars in medical bills to meet your deductible before your insurer will start to share the costs. It is important to consider, at minimum, the monthly premiums, deductibles, co-insurance and co-payments. What is the maximum annual out-of-pocket limit for the plan? Does the plan require prior authorization for certain medications? How are medications covered - is there a ‘tier’ structure? If so, what tier do your drugs fall within? Is it tier I, which generally includes ‘routine’ generic drugs, or does

the plan put most or all of its cancer-related drugs into a higher, more expensive tier?

- D. **ELIGIBILITY FOR FINANCIAL ASSISTANCE** – Depending on your income, you may be eligible for financial assistance (a subsidy) that will lower the cost of your monthly premium when purchased through the Marketplace. Subsidies are based on income and size of household; it can be in the form of a tax credit, or a cost-sharing subsidy which reduces the amount that you pay when you receive health care.
- E. **SERVICES OF THE PRIMARY CARE PHYSICIAN** – How comprehensive is the plan’s network of providers and hospitals? When considering a new primary care physician, will you be able to see the same physician consistently? Will you be able to remain with your current doctor or doctors if that is your preference? What is the wait period for appointments? How do you change doctors if dissatisfied? Can you choose more than one physician for your family? What are the after-hours procedures for that medical office?
- F. **PROVIDER NETWORK AND GEOGRAPHIC SERVICE AREA** – Are the locations provided as part of the plan convenient? What is the quality of hospitals available in your area under the plan? Would you have to go to different locations for different treatments and services? Would a dependent on your plan be covered, or given an exception, if he or she needs treatment while away from home (e.g. at college)?
- G. **COMMITMENT TO QUALITY OF CARE AND SERVICE** – Is the plan accredited by the National Committee for Quality Assurance? What is the number of board certified physicians in the plan?
- H. **CUSTOMER SATISFACTION** – You may find indicators by searching online. You may also call up a plan representative and observe the responsiveness to customers through their phone system.

Additional information

For a comparison of insurer performance, including complaint and appeal information, high and low premiums by region and contact information for health insurers, refer to the *New York Consumer Guide to Health Insurance*, published annually by the New York State Department of Financial Services or Department of Health. To obtain a copy of the latest guide visit their Web site at: <http://www.dfs.ny.gov/consumer/hgintro.htm>

Another helpful publication that includes information on Medicaid Managed Care is *New York State Managed Care Performance Report* published by the New York State Department of Health. To obtain a copy, please visit the Department of Health’s Web site

at www.health.ny.gov/health_care/managed_care/reports/ or email your request to omcmail@health.state.ny.us, or call 518-486 9012.

A useful source for navigating cancer care and insurance plans is: www.cancer.net/navigating-cancer-care/financial-considerations/health-insurance

NEW YORK MANAGED CARE BILL OF RIGHTS

Rights to Disclosure

- You have a right to know what health care must be given to you by the plan, as well as any limits on care, and which types of health care are not covered.
- You have a right to know about any treatments or health care that your plan needs to approve in advance.
- You have a right to know what steps you can take if the plan will not cover a service. This includes the toll-free phone number of the person who will review the plan's action, how long it will take until the review is done, and how to appeal the plan's action. You also have a right to have someone speak for you in any disputes with the plan.
- You have a right to know, each year, how the plan decides on how much it will pay to doctors and health providers who belong to the plan.
- You have a right to know about any fees you will have to pay, any amount you have to pay yourself before the plan will start paying, and any caps (maximums) or yearly limits on plan payments. You also have a right to know what you will have to pay for health care not covered by the plan.
- You have a right to know about what you will have to pay if you go to a doctor who is not part of the plan, or if you go even though the plan has not approved this in advance.
- You have a right to know how you can change to a new doctor within the plan.
- You have a right to a list of the plan's doctors, as well as to learn which doctors are taking new patients.

- You have a right to know how the plan meets the needs of plan members who don't speak or read English.
- You have a right to know the correct mailing address and phone number to be used by plan members who need to know something or who need the plan to approve a health service.
- You have a right, as a female enrollee, to see a plan gynecologist or obstetrician for at least two exams per year and for all pregnancy care, without a referral from your primary doctor.
- You have a right to know how you can have input in how the plan makes its rules.
- You have a right to a list that the plan updates once a year, of the name, address and phone number of each health care provider who belongs to the plan. This includes special doctors (specialists). You also have a right to know the level of training that the plan's doctors have, and which ones have advanced training so they can practice in special health areas (board certification).

Rights to Action

- You have a right to file a grievance about any dispute between you and the plan, and you have a right to know just how a grievance should be made.
- You have a right to go to the emergency room 24 hours a day for any health problem that threatens your life. You do not need the plan to approve this in advance, but you must tell your plan as soon as you can.
- You have a right to see a doctor outside the plan if the plan does not have a doctor who can meet your health needs, but your primary doctor must set this up for you.
- If you need to keep on seeing a special doctor (specialist), you can ask to be allowed to see that doctor as needed, without going through your primary doctor. Your plan must explain to you how you can do this.
- If you have a very bad health problem that requires you to be seen by a special doctor for a long time, you can ask to have your special doctor be your primary doctor. The plan must tell you how to make such a request.
- If you have a very bad health problem that requires you to be seen by a special health care center (for example, a hemodialysis center) for a long time, you can ask to go there when you need to, without going through your primary doctor. The plan must tell you how to make such a request.

RIGHT TO AN INDEPENDENT EXTERNAL REVIEW

You have a right to an independent external review when your insurer denies health care services that it considers experimental or investigational, not medically necessary or that the care provided was out-of-network.

You must first appeal the denial with your plan or you and your plan must agree to waive the internal appeal process. In order to request an external appeal you or your designee must complete an external appeal application and send it to the New York State Department of Financial Services within 4 months of the date of the health plan's final adverse determination. The fee for an external review is generally \$25, not to exceed \$75 in a single year. The fee is waived if you are covered under Medicaid, Child Health Plus, Family Health Plus, or if the fee will pose a hardship.

Note that providers have their own right to an external appeal when health care services are denied concurrently or retrospectively. Providers must request an external appeal within 45 days of the plan's final adverse determination from the first level of appeal or from receipt of the plan's letter waiving the internal appeal process. Health plans can charge providers \$50 per appeal to help cover the costs of the external agent's fees. This fee will be returned if the external appeal agent overturns the denial.

Once you submit your appeal, the reviewing organization must make a determination within 30 days of receiving your request. However an expedited review may be requested if your doctor produces written testimony affirming that a delay in providing the treatment or service poses an immediate or serious threat to your health. The reviewer must produce a determination within 72 hours of receiving an expedited review request.

If the request qualifies, the consumer and insurer will be notified. The insurer must then send medical and treatment records to the review organization. Once notified that an external appeal agent has been assigned the case, the consumer and their doctor may submit additional information even if it has not been requested.

The decision of the external reviewer is final and binding on all parties and cannot be changed.

External Appeals Information: Call: 1-800 400 8882; or
Email: externalappealquestions@dfs.ny.gov

Submit Appeal Application: By Fax to 1-800 332 2729; or Certified or Registered Mail to: Department of Financial Services, PO Box 7209, Albany, NY 12224.

Expedited Appeals: By Fax to: 1-888 990 3991.

NAVIGATING THE APPEALS PROCESS

You have the right to submit an appeal if your insurer denies coverage for a procedure that your doctor believes is necessary. Your insurer may deny coverage by refusing to pre-authorize (or pre-approve) a procedure, or by declining to reimburse you or the provider (either partially or completely) for medical services that you have already received. In either case, it is crucial that you appeal the insurer's decision if you feel that your insurance plan should provide coverage for the service, as a substantial number of denials are reversed when they are challenged. The key is to understand how the appeal process works and what steps you will need to follow.

1. Know the rules and procedures to follow.

- As a first step, enrollees are usually encouraged to call the plan's Customer Service Representative or benefits manager with questions or to voice concerns.
- Obtain a copy of the plan's description of Coverage and Grievance process from your plan's benefits manager. This is known by different names in different plans ranging from "Your Health Benefit" to "Your Health Care Coverage." Steps to be followed in the appeals/grievance process are usually explained in writing as part of your policy.
- Instructions for submitting a complaint in writing should be in your plan's description of coverage and grievance process. Under the ACA, medical insurance plans are required to have a process to receive and respond to complaints and grievances. If you find any of these instructions omitted from your policy or you cannot get the complete information from your insurer, contact the

relevant government agency as provided at the end of this guide to get clarification on the procedure to follow, or obtain the proper instructions, or to make a complaint.

- A simple letter to your insurer about denied services, as well as a statement of your intent to appeal, is generally sufficient to set this process in motion. The letter should be sent to the person or persons issuing the denial. Keep a copy of your letter and follow up in a few days with a phone call to ensure receipt of your letter.

2. Summarize the problem or situation in writing.

- Describe the problem and what you think the solution should be in writing.
- Ask your treating physician to write a letter of appeal to the insurer to accompany your letter.
- Refer to this summary as a guide when you call the plan representative. Request a written response within 10 working days, as well as a phone call confirming receipt of your letter.

3. Always document the sequence of events as they occur.

- Keep written, dated, chronological notes on file from the beginning of the appeal. This helps you stay organized and is a useful reference.
- Be sure to document all contacts with the managed care plan representatives. Get the name, title, and phone number of each person with whom you talk and make a note of the time, date, and substance of the conversation.

4. Communicate clearly, concisely and calmly.

- Be persistent and methodical in following up. Remember that your goal is to get them to accept your solution.

5. Always insist on specific details: How, when, who, where, and how much.

- If a resolution is promised to you, ask for details in writing, such as a specific date by which your grievance will be resolved. If you do not understand, ask for clarification.
- Ask whom you should contact if you do not receive acknowledgment of your appeal in writing.
- Ask when and where you will have your grievance heard and ask how long it will take for a final decision. Ask who may attend the meeting, including your physician.

- Remember the cardinal rule: Always write down the name, title, date and phone number of all parties you speak with at the insurance company.

6. Be persistent if your grievance is not resolved to your satisfaction.

- Ultimately, you may choose to seek third party counsel, which may be through a board of arbitration or through an attorney.

EMPLOYER-BASED COVERAGE

Many large employers that offer health coverage to their employees self-insure their health benefits. Under federal law, if you receive health coverage through a self-insured plan (sometimes referred to as an ERISA plan), state protections, such as the ones listed above, do not apply. If you have a complaint regarding a self-insured plan, call: 1-866-444 3272. Or write to:

EASTERN NY AND NYC:

Employee Benefits Security Administration
U.S. Dept of Labor
New York Regional Office
33 Whitehall Street, Suite 1200
New York, NY 10004

CENTRAL AND WESTERN NY:

Employee and Benefits Security Administration
U.S. Dept. of Labor
Boston Regional Office
J.F.K. Federal Building, Room 575
Boston, MA 02203

GLOSSARY OF COMMON HEALTH INSURANCE TERMS

Benefit – Services rendered by the insurer: an amount payable by the insurance carrier, a medical service, test or treatment, a medical device or a prescription drug.

Capitation – Capitation represents a set dollar limit that you or your employer pay to a health maintenance organization (HMO), regardless of how much you use (or don't use) the services offered by the health maintenance providers.

Catastrophic Insurance – Version of limited insurance geared towards covering very high medical expenses. Deductibles are very high and premiums are low.

Comprehensive Coverage – Insurance is either comprehensive or limited. Comprehensive means broader coverage and/or higher indemnity payments than limited coverage.

Co-insurance – Money that an individual is required to pay for services, after a deductible has been paid. In some health care plans, co-insurance is called "co-payment." Co-insurance is often specified by a percentage. For example, the employee pays 20 percent toward the charges for a service and the employer or insurance company pays 80 percent.

Complaint – Occurs when a consumer or provider complains to the State of New York.

Copayment – A predetermined (flat) fee that an individual pays for health care services, in addition to what the insurance covers. For example, some HMOs require a \$50 "copayment" for each office visit, regardless of the type or level of services provided during the visit. Copayments are not usually specified by percentages.

Cost Sharing – Under the health plan, beneficiaries are required to pay a portion of the costs of their care. This may include co-payments, coinsurance and annual deductibles.

Coverage for Cancer Survivors– Health plans are required to cover at least 60 percent of expected health costs for their population of enrollees, which is known as the health plan’s *actuarial value*. This means that health insurers may design policies with considerable deductibles or cost-sharing requirements – and therefore offer coverage very similar to a catastrophic policy. You will want to assess these plans’ deductibles and cost-sharing requirements carefully. However, under the Affordable Care Act, there is now an annual limit on the total out-of-pocket costs that cancer survivors and other covered persons will have to pay under their health insurance policy.

In addition, under the ACA, catastrophic coverage policies sold to people under 30 years old qualify as sufficient coverage under the individual mandate, even though they do not provide comprehensive coverage or meet other requirements of the ACA. Members of this young group who purchase health insurance plans that do not cover any services, other than three primary care visits per year, until the enrollee has paid a deductible equal to \$6,850 in 2016, (\$7,150 in 2017) will satisfy the requirements of the individual mandate.

Catastrophic policies and other high-deductible policies are usually not a good deal for cancer patients or others with serious or chronic diseases. Again, you will want to carefully compare plans and your potential risk for high cost sharing.

Deductible – The amount an individual must pay for health care expenses before insurance (or a self-insured company) covers the costs. Often, insurance plans are based on yearly deductible amounts.

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.

Employer Based/Employer-Sponsored Insurance – Insurance coverage provided to employees and, in some cases, their spouses and children, through an employer.

Essential Health Benefits – A package of core benefits set by the government that insurance providers are required, under the ACA, to offer in plans included in the Marketplace.

Exclusions – Medical services that are not covered by an individual's insurance policy. These are illnesses, injuries, and conditions not covered which are specifically not covered. Experimental therapies are a typical example.

Explanation of Benefits (EOB) – Form sent by insurer that explains what portion of the submitted bill was covered and why. If the patient has more than one policy, the form serves as proof of the amount that their primary coverage paid.

External Review – Independent external review when you are denied health care services on the basis that those services are experimental, investigational, or not medically necessary. The reviewer is an external organization not affiliated with the insurer, the doctor, or the patient’s family.

Family and Living Expenses – This includes costs related to running your household and caring for your family during cancer treatment, such as childcare, elder care, and coping support.

Grandfathered Plan – A group health plan that was created or an individual health insurance plan that was purchased on or before March 23, 2010. Such plans are exempted from many changes required under the ACA.

Grievance – A complaint to a managed care organization by a member or provider about an action or decision. Decisions regarding the medical necessity of a service are not considered grievances and are instead handled as utilization review appeals.

Health Insurance Marketplaces– Marketplaces were established as part of the Affordable Care Act (2010) to enable individuals, families and small businesses to choose and purchase medical insurance. In New York, the Marketplace is New York State of Health, where you can compare different health insurance plans and prices.

To explore and compare health insurance plans and learn more, visit the official resource for health insurance marketplaces, www.HealthCare.gov, 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.

Health Maintenance Organization (HMO) – Health Maintenance Organizations represent "pre-paid" or "capitated" insurance plans in which individuals or their employers pay a fixed monthly fee for services, instead of a separate charge for each visit or service. The monthly fees remain the same, regardless of types or levels of services provided, services are provided by physicians who are employed by, or under contract with, the HMO. HMOs vary in design. Depending on the type of the HMO, services may be provided in a central facility or in a physician's own office (as with IPA’s).

Indemnity Insurance – Pays providers on a “fee for service” basis. Usually the consumer pays a pre-determined percentage of the cost of health care services, and the insurance company (or self-insured employer) pays the other percentage.

Indemnity health plans offer individuals the freedom to choose their health care professionals. 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.

Independent Practice Association (IPA) – IPA’s are similar to HMO’s, except that individuals receive care in a physician's own office, rather than in an HMO facility. (Also Provider Sponsored Organization PSO).

Long-term Care Insurance – Provides insured with a daily benefit when they can no longer take care of themselves. Medicare typically provides very limited coverage for long-term care, such as nursing home care. Some individuals decide to get additional coverage to offset the costs of such care.

LOS - Refers to the “length of stay.” It is a term used by insurance companies, case managers and/or employers to describe the amount of time an individual stays in a hospital or in-patient facility.

Managed Care Plan – A medical delivery system that attempts to manage the quality and cost of medical services that individuals receive. Most managed care systems offer HMO’s and PPO’s that individuals are encouraged to use for their health care services. Some managed care plans attempt to improve health quality, by emphasizing prevention of disease.

Medical Savings Account (MSA) – Savings account where individuals can accumulate funds to pay for medical care or insurance costs.

Medicaid – A joint federal and state health insurance program that assists low-income individuals. Varies by state. Medicaid is a government program that provides health insurance for low-income people and families. Today, each state has its own Medicaid program with its own rules about whom and what it covers, although in general, in addition to meeting income requirements, you must be a child, a parent of dependent children, elderly, or an individual with a disability to qualify for Medicaid coverage. However, because the federal government helps states fund their Medicare programs, there are some national rules that apply everywhere.

Medicare – A federal health insurance program for citizens 65 years or older, certain younger people with disabilities, and those with end-stage renal disease. You may be eligible if you are disabled (regardless of age) and have collected Social Security benefits for two years, or if you have been diagnosed with permanent kidney failure or Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig’s Disease) regardless of your age. Medicare will not refuse you coverage or charge you more because of where you live, your age, or how sick you are.

Medigap – “Medigap” insurance is offered by private insurance companies, not the government. It is not the same as Medicare or Medicaid. Medigap policies are designed to pay for some of the costs that Medicare does not cover and they generally do not cover long-term care, vision or dental care, hearing aids, eyeglasses, or private-duty nursing.

Open Enrollment – Time period during which eligible persons may enroll in, or transfer between, health care insurance programs. Plans must accept all individuals who enroll during open enrollment.

Out-of-Pocket Maximum – A yearly cap on the amount of money that individuals must pay out-of-pocket for health costs. Beyond that amount, the plan will provide full coverage for all costs for the remainder of the year.

Outpatient – Patient that does not stay overnight in a hospital or inpatient facility. Many insurance companies have identified a list of tests and procedures (including surgery) that will not be covered (paid for) unless they are performed on an outpatient basis. The term outpatient is also used synonymously with ‘ambulatory’ to describe health care facilities where procedures are performed.

Participating Provider – Service provider (e.g. doctor) who has joined a managed care plan and accepts its contracts.

Portability – Whether insurance may be retained even if consumer leaves their employer or group plan.

Pre-existing Condition – A medical condition that is excluded from coverage by an insurance company, because the condition was believed to exist prior to the individual obtaining a policy from the particular insurance company. Under the ACA, insurers can no longer deny coverage or charge higher premiums because of a pre-existing condition.

Preferred Provider Organization (PPO) - You or your employer receive discounted rates if you use doctors from a pre-selected group. If you use a physician outside the PPO plan, you must pay more for the medical care.

Premium – Amount paid to an insurance company for providing insurance coverage.

Primary Care Provider (PCP) – Health care professional (usually a physician) who is responsible for monitoring an individual's overall health care needs. Coordinates health care needs and refers patients to specialty physician for specialized care. Managed care organizations often require the PCP to pre-approve referrals to specialists and use of services, including emergency room care.

Prior Authorization – You may need to obtain approval from your health plan before you obtain a service or fill a prescription in order for the service or prescription to be covered.

Provider - Health professionals who provide actual care. Usually providers refer to doctors or hospitals. Sometimes the term also refers to nurse practitioners, chiropractors and other health professionals who offer specialized services.

Self-Insured Health Plan – Employer pays for employees’ health care costs out of a company medical fund. Typically the employer contracts with an outside organization to administer the plan. Under ERISA, the federal government has sole jurisdiction over these plans through the U.S. Department of Labor, and New York consumer protection and insurance laws do not apply.

Subscriber – Person who holds an insurance policy. Also known as the enrollee, member, insured, certificate holder, or policyholder.

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.

Usual, Customary and Reasonable (UCR) or Covered Expenses – An amount customarily charged for or covered for similar services and supplies which are medically necessary, recommended by a doctor, or required for treatment.

Utilization Review – Process used by plans to decide whether or not a benefit is “medically necessary.” UR appeal occurs when a consumer asks their insurer to reconsider its refusal to pay for a medical service the insurer considers experimental, investigational, or not medically necessary.

Waiting period - A period of time when you are not covered by insurance for a particular problem.

LIST OF GOVERNMENT AGENCY COMPLAINT CONTACTS

Who	Issue	Call	Write
Anyone	<ul style="list-style-type: none"> • Payment, reimbursement, coverage, benefits, rates, premiums • Cost of insurance policy • Health care coverage questions • Complaint against any insurance company 	<p>1-800-342-3736</p> <p>New York City:</p> <p>1-212-480-6400</p>	<p>NYS Department of Financial Services Consumer Assistance Unit One Commerce Plaza Albany, NY 12257</p> <p>Department of Financial Services NYS Department One State Street New York, NY 10004</p>

<p>Anyone enrolled in a NYS certified MCO</p>	<ul style="list-style-type: none"> • Dissatisfaction with quality of health care • Difficulty getting appointments • Denied referrals • Difficulty getting the health care or type of doctor needed • Billing concerns or plan's refusal to pay or a covered service 	<p>1-800-206-8125</p>	<p>NYS Department of Health Bureau of Managed Care Certification and Surveillance Complaint Unit Room 2019 Corning Tower ESP Albany, NY 12237</p> <p>Or Email: managedcarecomplaint@health.state.ny.us</p>
<p>Anyone</p>	<ul style="list-style-type: none"> • Health care complaints 	<p>1-800-428-9071</p>	<p>NYS Office of the Attorney General – Health Care Bureau The Capitol Albany, NY 12224-0341</p> <p>Fax: (518) 402-2163</p>
<p>NY Medicaid managed care enrollee</p>	<ul style="list-style-type: none"> • Eligibility questions • Enrollment issues 	<p>Local Department of Social Services</p> <p>Or</p> <p>NY Health OPTIONS 1-855-693-6765</p>	<p>Local Department of Social Services</p>
<p>NY Medicaid managed care enrollee</p>	<ul style="list-style-type: none"> • Fair Hearing request 	<p>1-800-342-3334</p>	<p>Fair Hearing Section NYS Office of Temporary and Disability Assistance Managed Care Hearing Unit PO Box 22023 Albany, NY 12201-2023</p> <p>Fax: (518) 473-6735</p>
<p>Anyone enrolled in a NY Managed</p>	<ul style="list-style-type: none"> • Dissatisfaction with health care 	<p>1-866-712-7197</p>	<p>NYS Department of Health Bureau of Managed Long Term Care</p>

Long Term Care Plan	<ul style="list-style-type: none"> • Difficulty getting health care needed • Enrollment issues 		Room 1911 Corning Tower ESP Albany, NY 12237
Anyone receiving services from a Worker's Compensation PPO	<ul style="list-style-type: none"> • Dissatisfaction with the Worker's Compensation PPO 	1-518-474-5515	NYS Department of Health Worker's Compensation Programs Room 2019 Corning Tower ESP Albany, NY 12237-0430
NY health care providers	<ul style="list-style-type: none"> • Termination issues • Delivery of medical care concerns • Access or availability 	1-800-206-8125	NYS Department of Health Bureau of Managed Care Certification and Surveillance Complaint Unit Room 2019 Corning Tower ESP Albany, NY 12237-0430
NY health care providers	<ul style="list-style-type: none"> • Late payments by a plan • Prompt payment law 	NYS Department of Financial Services	NYS Department of Financial Services One Commerce Plaza Albany, NY 12257
Medicare recipients	<ul style="list-style-type: none"> • Dissatisfaction with quality of care in NYS • Appeals and grievances 	1-866-334-9866	Branch Chief, Health Plan Branch Centers for Medicare and Medicaid Services 26 Federal Plaza, Room 3800 New York, NY 10278
Anyone enrolled in a self-insured/ERISA plan or through COBRA	<ul style="list-style-type: none"> • Benefit claims • Appeals information 	1-866-444-3272	Eastern NY and NYC: Employee Benefits Security Administration U.S. Department of Labor New York Regional Office 33 Whitehall Street, Suite 1200 New York, NY 10004 Central and Western NY: Employee Benefits Security Administration U.S. Department of Labor Boston Regional Office

			J.F.K. Federal Building, Room 575 Boston, MA 02203
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REFERENCES

New York State Department of Health. *Managed Care Bill of Rights*. (Oct. 1997. Revised August 2010).

New York State Department of Financial Services. *New York Consumer's Guide to Health Insurance*. (2016).

Patient Advocate Foundation. *A Patient's Guide to Navigating the Insurance Appeals Process* - (2014).

Public Policy and Education Fund of New York. *The Consumers' Guide to New York's Managed Care Bill of Rights*. (Sep. 2001).

New York State Department of Health. *Complaints and Appeals*. (Jan. 2013).

NEW YORK STATE OF HEALTH: Health Plan Marketplace

1-855-355-5777

<http://info.nystateofhealth.ny.gov/>

DEPARTMENT OF FINANCIAL AFFAIRS

1-(800)-342-3736

FOR MORE INFORMATION

If you have any questions about this guide, suggestions for improving it, or the names of other organizations that you would like to see included in future editions, please contact the Cancer Advocacy Project at:

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