Disability Rights Legal Center
CLRC
Cancer Legal Resource Center

CLRC National Office
800 S. Figueroa Street, Suite 1120 ◆ Los Angeles, CA 90017

CLRC Midwest Regional Office
c/o McDermott Will & Emery LLP
227 West Monroe Street, 44th Floor ◆ Chicago, IL 60606

Toll Free: 866.THE.CLRC (866.843.2572)
TDD: 213.736.8310 Fax: 213.736.1428
Email: CLRC@LLS.edu
Web: www.CancerLegalResourceCenter.org

The CLRC is a joint program of the Disability Rights Legal Center & Loyola Law School Los Angeles

Guide to Navigating Breast Health Care Options in Los Angeles County

Helping You
Navigate Through
Cancer-Related Legal Issues

INTRODUCTION

The Cancer Legal Resource Center has designed this manual to provide you with information and resources on health insurance options, navigating insurance, and health care reform in Los Angeles County. This guide should be a starting point to help you to find the specific information you need. Please feel free to contact the Cancer Legal Resource Center at (866) THE–CLRC (866-843-2572), CLRC@.lls.edu, TTY (213) 736-8310, video relay 866-912-8193 or visit www.CancerLegalResourceCenter.org, for additional assistance. The CLRC offers services in English, Spanish, or any language through our language line.

Funding for the preparation of this manual was provided by Susan G. Komen for the Cure: Los Angeles County.

ABOUT THE CANCER LEGAL RESOURCE CENTER

The Cancer Legal Resource Center (CLRC) is a national, joint program of the Disability Rights Legal Center and Loyola Law School Los Angeles. The CLRC provides free information and resources on cancer-related legal issues to patients, survivors, caregivers, health care professionals, employers, and others coping with cancer.

The CLRC has a national, toll-free Telephone Assistance Line (866-THE-CLRC or 866-843-2572; TTY (213) 736-8310, video relay 866-912-8193) where people receive information about relevant laws and resources for their particular situation. They can receive this information in English, Spanish, or any language through our language line.

Since it opened in 1997, the Cancer Legal Resource Center has assisted over 310,000 people through telephone assistance, Cancer Rights Conferences, seminars, workshops, outreach programs, other cancer community activities, and online resources.

CONTRIBUTORS

Monica Fawzy Bryant, Esq.
Jennifer Chayo Fenton, J.D.
Shawn Kravich, Esq.
Jamie Ledezma, Esq.
Joanna L. Morales, Esq.
Anya Prince, Esq.
Laura Riley, Esq.
Jacquelyn Baylon, J.D. Candidate 2012
Kelly Nugent, J.D. Candidate 2013

DISCLAIMER

This publication is designed to provide general information on the topics presented. It is provided with the understanding that the author is not engaged in rendering any legal or professional services by its publication or distribution. It is not intended to be legal advice or establish an attorney-client relationship. Although these materials were reviewed by a professional, they should not be used as a substitute for professional services. The author of this manual has made every attempt to verify the accuracy of the information in this document but assumes no liability for use of any information or resource. The resources are provided for informational purposes only. No endorsement of any agency or individual is intended or implied. This manual is intended to include agencies and organizations in the United States, and any omissions are unintentional and do not reflect adversely on the merits of such an omitted program.

We recommend that individuals with questions or concerns about their legal options act immediately, as there may be specific legal time limitations that could affect the validity of any case and any possible legal options they may have.

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Powered By a Grant From: 

In April of 2011, the Cancer Legal Resource Center (CLRC) received a grant from the **Central Valley Affiliate of Susan G. Komen for the Cure®** to educate breast cancer patients, survivors, caregivers, and health care professionals about cancer-related legal issues. The grant partially funded the development of this guide.

Helpful Hints about Breast Self-Awareness: Except for skin cancers, breast cancer is the most common cancer in women, but it can be successfully treated. Screening tests can find cancer early, when it's most treatable.[1]

Susan G. Komen for the Cure® recommends that you:

1. Know your risk

- Talk to your family to learn about your family health history
- Talk to your provider about your personal risk of breast cancer

2. Get screened

- Ask your doctor which screening tests are right for you if you are at a higher risk
- Have a mammogram every year starting at age 40 if you are at average risk
- Have a clinical breast exam at least every 3 years starting at age 20, and every year starting at age 40

3. Know what is normal for you

See your health care provider if you notice any of these breast changes:

- Lump, hard knot or thickening inside the breast or underarm area
- Swelling, warmth, redness or darkening of the breast
- Change in the size or shape of the breast
- Dimpling or puckering of the skin
- Itchy, scaly sore or rash on the nipple
- Pulling in of your nipple or other parts of the breast
- Nipple discharge that starts suddenly
- New pain in one spot that doesn't go away

4. Make healthy lifestyle choices

- Maintain a healthy weight
- Add exercise into your routine
- Limit alcohol intake
- Limit postmenopausal hormone use
- Breastfeed, if you can

For more information about breast health and breast cancer, visit www.komenlacounty.org.

[1] Susan G. Komen for the Cure®. Understanding Breast Cancer: Your Breast Self-Awareness. www5.komen.org/BreastCancer/BreastSelfAwareness.html

Cancer Legal Resource Center

2012 CANCER RIGHTS CONFERENCES

Visit www.CancerRightsConference.org for more information on CLRC's 2012 Conferences in:

- Boston, MA (5/29/12)
- Central Valley, CA (10/5/12)
- Chicago, IL (9/7/12)
- Houston, TX (10/19/12)

For more information about cancer-related legal issues . . .

Find us on Facebook www.facebook.com/CancerLegalResourceCenter

follow us on twitter @CancerLegalHelp

YouTube www.youtube.com/user/CancerLRC

CASE STUDIES

In order to make this information more accessible, below are some case studies based on real callers* who the Cancer Legal Resource Center has worked with. We hope that these experiences will help serve as useful examples, illustrating the various issues that people face while navigating breast healthcare options. In addition to explaining the individuals' experiences, we present options that they might have, along with sections of the guide that would be helpful to review if your situation is similar.

We do not intend these scenarios to be all-inclusive; we are aware that each person's situation is unique and does not necessarily fall within these categories. We hope that these examples help point you to content in this guide that is relevant to you, with the knowledge that each person's story is unique. If your experience doesn't fall within these categories, or even if it does and you have questions, feel free to call us at 1-866-THE-CLRC (843-2572). We will be happy to help.

*Names have been changed to preserve individuals' confidentiality.

Case Study 1: Prevention (Health Insurance and Genetics)

Situation

Clara just turned 24. She had a one-year fellowship position after college but is now unemployed. Her mother was recently diagnosed with breast cancer, and her mother's sister is a breast cancer survivor; one of her uncles had breast cancer as well. She has never had a mammogram, but wants to know whether she should, or if there are any other preventive measures she should take.

Possible Options

Under the Affordable Care Act, young adult children may remain covered under their parent's plan until they reach the age of 26 years old unless the young adult child is eligible for employer-sponsored health insurance offered through their own job. If Clara is not offered employer-sponsored health insurance when she turns 26, she could turn to the California Health Benefit Exchange to compare the costs (premiums, co-payments, and deductibles) and benefits (covered versus excluded services, prescription benefits, etc.) of private health insurance plans to see what plan fits her needs. For more information about the Health Insurance Options, see the sections on **Health Insurance & Health Care Options** and **Health Insurance Coverage Options.**

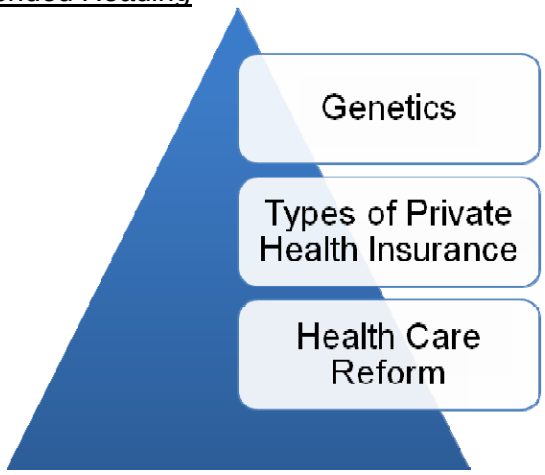
In California, Clara might be entitled to a baseline mammogram through her insurance between the ages of 35-39, a mammogram every two years or more frequently if their physician recommends it between the ages of 40 and 49, and a mammogram every year age 50 and over. There are also additional patient protections provided under the Affordable Care Act for insurance policies issued on or after September 23, 2010, which include preventive services such as genetic counseling about BRCA (but not necessarily genetic *testing*) for women at higher risk for breast and ovarian cancer, breast cancer mammography screenings every 1-2 years for women over 40, and breast cancer chemoprevention counseling for women at higher risk.

The BRCA1 and BRCA2 genetic tests are available to test for genetic predispositions for breast and ovarian cancer. To learn more about any risks associated with an individual's family history and the genetic tests that may be available, Clara could speak to a doctor or a certified genetic counselor. The cost of genetic testing can range from under $100 to more than $3,000, depending on the nature and complexity of the test. Every insurance policy is different in their coverage of genetic testing. Some private insurers cover genetic testing, but others do not. Additionally, some insurers will cover some genetic tests, but not others. Individuals should check with their insurance

company for more information. For more information on Genetics, see the section on **Genetic Testing.**

Clara could speak with her doctor if she has any questions or concerns about breast cancer screening and preventive care options because some options may remain available to her regardless of how old she is if her doctor decides a test or procedure is medically necessary. For more information about the Affordable Care Act, see the section on **Health Care Reform.**

Recommended Reading



Case Study 2: Before Treatment (Health Insurance Options)

Situation

Mai worked for a communications company for 15 years. She is 52 years old and was just diagnosed with Stage III breast cancer. Her employer does not have any short or long term disability benefits, so she thinks it is likely that she will be terminated from her position after taking a 12-week Family and Medical Leave Act (FMLA) leave. She would like to know what her health insurance options will be if she is indeed terminated.

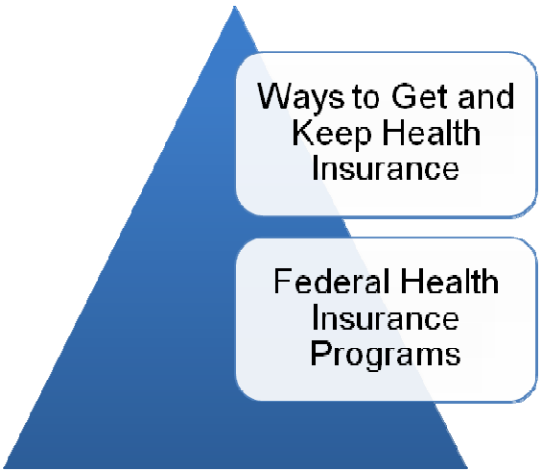
Possible Options

The most common way that people obtain health insurance coverage is through their employer or a family member's employer. These types of employer-sponsored plans are known as "group" plans. Plans that a person buys directly from an insurance company are known as "individual" plans. If Mai loses her job, she may be eligible for COBRA, a federal law that gives employees the right to continue the same group health insurance coverage that they had while they were working. California also has a mini COBRA law, Cal-COBRA, that might allow her additional time to remain covered on the same insurance policy. For people with chronic health conditions such as breast cancer, keeping the same health insurance is important because it means they do not have to change their health care providers. For more information on COBRA, Cal-COBRA, and the specific requirements, see the sections on **Ways to Get and Keep Health Insurance: COBRA.**

COBRA premiums can be very expensive, especially if individuals are not working. If Mai cannot afford to pay the COBRA premiums and is eligible for Medi-Cal, then Health Insurance Premium Program (HIPP) will pay her COBRA premiums to help Mai keep her private health insurance coverage. For more information about HIPP, see the section on **Ways to Get and Keep Health Insurance: HIPP.**

Once COBRA coverage is exhausted, HIPAA is a federal law that prohibits health insurance discrimination against individuals based on their pre-existing medical conditions, when individuals are moving from a group plan to another group plan or from a group plan to a HIPAA guarantee issue plan. In order to take advantage of HIPAA protections, there cannot be a recent break in health insurance coverage that lasts more than 63 days. For more information about HIPAA, see the section on
Ways to Get and Keep Health Insurance: HIPAA.

Recommended Reading



Case Study 3: During Treatment (Access to Healthcare)

Situation

Teresa came to the United States on a visa to visit family, and after experiencing abnormal symptoms, went to a community clinic where she was diagnosed with breast cancer, but it was a very small clinic and she would like a second opinion. Since then, she overstayed her visa and is no longer in the U.S. legally. She is worried that if she returns to her home country, she will neither be able to receive a second opinion, nor proper treatment, nor be able to get another visa to return to the U.S. Teresa would like to know what options, if any, she has to receive a second opinion, treatment, or health insurance.

Possible Options

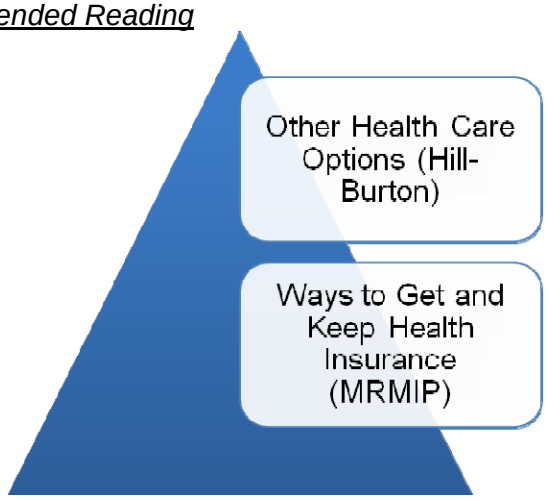
There are some options for breast cancer screening for undocumented persons in in California. If Teresa had not been diagnosed at a community clinic, she could have received screening through the Breast and Cervical Cancer Screening and Treatment Program (BCCTP); in California that is called *Every Woman Counts*. She still has the option of going through *Every Woman Counts* to get screened through that program. Then, she will be eligible to receive free treatment for 18 months through the state BCCTP regardless of her immigration status- the only requirement is that Teresa lives in California. For more information see the section on **Other Health Care Options.**

Teresa might be eligible for a high-risk insurance plan; in California this is called the Major Risk Medical Insurance Program (MRMIP). For more information see the section on **Ways to Get and Keep Health Insurance: High Risk Insurance Pools/Major Risk Insurance Plans**.

There are also some hospitals that offer free medical care to individuals with lower incomes, regardless of immigration status. For more information on Hill-Burton facilities nearby, please visit: www.hrsa.gov/gethealthcare/affordable/hillburton/.

This is an area where there is a significant legislative advocacy opportunity. For more information about legislative advocacy or the bills that the CLRC supports, please visit: www.CancerLegalResourceCenter.org.

Recommended Reading



Case Study 4: During Treatment (Health Care Options and Medicare)

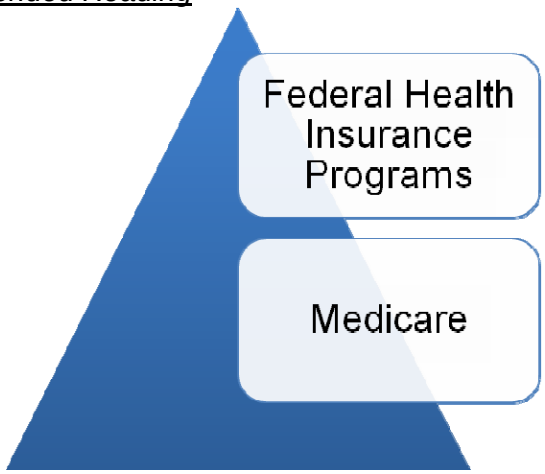
Situation

Cassandra had a recurrence of breast cancer a month before turning 65. She knows that Medicare should kick in soon, but does not know what she has to do, if anything, in order to sign up for Medicare and what costs it covers.

Possible Options

Medicare is a health insurance program for people age 65 or older who are eligible for Social Security retirement benefits; people under age 65 who have received Social Security Disability (SSDI) benefits for 2 years; and people of all ages with End-Stage Renal Disease and Lou Gehrig's disease. Therefore, when Cassandra turns 65 she should be eligible for Medicare. Medicare has four parts, each with different services and coverage. Part A is considered "hospital insurance" and can include coverage for in-patient hospital stays, skilled nursing facilities, and some home health care or hospice care. Cassandra will most likely be automatically enrolled in Part A when she turns 65, and assuming that she has had sufficient work history, it would be free. In order to enroll in Parts B-D, Cassandra would have to apply and pay a monthly fee. For more information about Medicare and the timing to apply for Parts B-D see the section on **Federal Health Insurance Programs: Medicare.**

Recommended Reading



Case Study 5: During Treatment (Health Insurance Options and Financial Assistance)

Situation

Betty was self-employed and a few years ago she purchased an individual health insurance plan. Unfortunately, because of her cancer treatment program, she is no longer able to work, her medical expenses have become very high, and her assets have dwindled. She would like to know what her health insurance options are and what financial planning resources might be available to her.

Possible Options

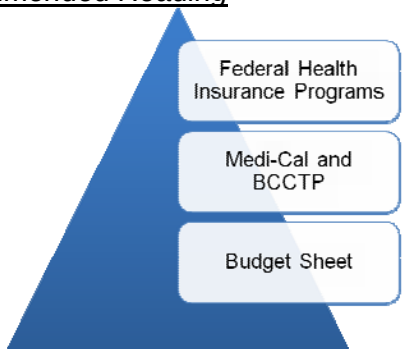
Medi-Cal provides health insurance for certain people who have low incomes, have limited resources, and meet other eligibility requirements. Individuals with cancer often qualify for Medi-Cal through the Aged, Blind and Disabled Program, which provides coverage to individuals with low incomes who are over 65 or who have a disability. After 2014, the Affordable Care Act is set to expand Medicaid eligibility to include all low-income individuals below 138% of the Federal Poverty Line. For more information on Medi-Cal, see the section on **Federal Health Insurance Programs: Medi-Cal.**

The Breast and Cervical Cancer Treatment Program (BCCTP) provides low-income California residents who have breast and/or cervical cancer the opportunity to enroll at a doctor's office to get no-cost cancer treatment coverage as soon as possible after diagnosis. While the BCCTP has specific eligibility requirements, men with breast cancer and undocumented persons may qualify for no-cost cancer treatment through the state program. For more information on BCCTP, see the section on **Other Health Care Options: Screening and Treatment Programs.**

Betty is likely concerned about maintaining her income since she is no longer working. There are various disability insurance options and resources that may be available to Betty; however, private disability insurance plans can exclude individuals with pre-existing conditions, so it's important to get a private disability insurance plan before you need it. In California, there is a state-sponsored State Disability Insurance (SDI) program with specific eligibility requirements. Betty may also have a family member, in California, who may qualify for paid family leave if the family member is taking time off work to provide caregiving services to Betty.

In addition, the federal government offers two long-term disability benefit programs known as Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). In order to receive these benefits, a person must meet the Social Security Administration's definition of disability. The key to qualifying for federal disability benefits is to show how a person's medical condition and the side effects from its treatment are expected to keep them from working for a year or more. For further information and resources on disability insurance options, please refer to www.CancerLegalResourceCenter.org, or call the CLRC at 866-THE-CLRC.

Recommended Reading



Case Study 6: Post Treatment (Managing the Cost of Care)

Situation

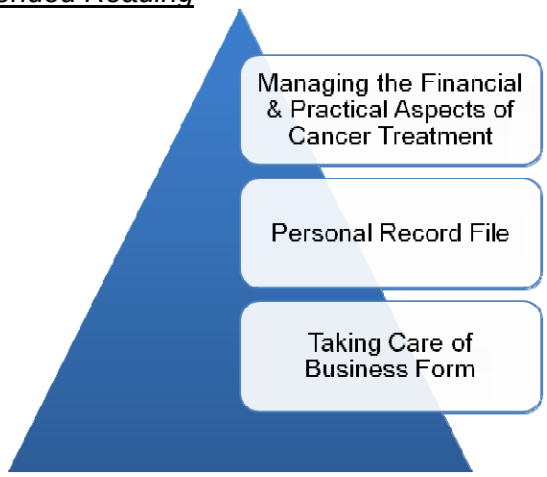
Valerie just found out the great news that her breast cancer is in remission. She is looking forward to establishing a "new normal" routine, but realizes that she still has follow up obligations related to her cancer, including organizing and paying outstanding bills. She would like to know how to properly read the bills that have come in, and deal with some bills that do not seem correct.

Possible Options

Valerie could start a file for the paperwork related to her treatment, including medical bills, prescriptions, explanations of benefits (EOB), and medical records. She could use any system that she is comfortable with, and there are existing tools to help her. For example, some cancer organizations, such as LIVE**STRONG,** have a number of useful tools, and there are computer programs, such as Quicken Medical Expense Manager that are also available.

There may also be some things that Valerie can do to reduce her bills and, depending on the complexity of Valerie's case, she may want to consider contacting a company that will help her organize, understand, and if necessary, deal with her insurance company to dispute non-payment of claims. For more information see the section on **Managing the Financial & Practical Aspects of Cancer Treatment** and **Appendices B & C.**

Recommended Reading



HEALTH INSURANCE & HEALTH CARE OPTIONS

INTRODUCTION:
The best way to avoid potential issues with insurance coverage is to know what is in an insurance policy and to follow the policy's procedures. This will help avoid issues before they arise. The first thing individuals should do is find out what type of health insurance coverage he or she has. For instance, whether or not it is a group or individual plan and whether or not their employer-sponsored group plan is insured or self-insured. This information is important, because different laws apply depending on the type of plan in which individuals are enrolled.

An individually purchased plan is health insurance purchased directly from a health insurance company, and individuals pay the entire premium themselves. Most people with private insurance are covered by an employer-sponsored group health plan. This is where employees and their family members enroll in a plan through work and the employer generally pays a portion or all of the cost of coverage. If enrolled in an employer-sponsored health plan, the right to appeal disagreements about benefits through the plan's internal appeals process is determined by the federal Employee Retirement Income Security Act, or ERISA. Individuals may have other rights under state laws depending on whether the health plan is *insured* or *self-insured (a.k.a. self-funded)*.

An employer-sponsored health plan is insured if the employer purchased health coverage from an insurance company. An employer-sponsored health plan is self-funded if the employer pays for the health care costs of its employees directly, rather than purchasing insurance from an insurance company. It is sometimes difficult for employees to know whether their employer-sponsored plan is insured or self-funded, because employers often contract with third parties to administer their self-funded plan. Those third parties are often insurance companies. Sometimes these third parties are called Administrative Service Organizations (ASO). Typically, ASO services include network provisions and claims processing, and the ASO is not responsible for the payment of the costs of services. Therefore, to find out whether their employer-sponsored plan is self-funded or not, employees should ask the person who administers the employee benefits at work (i.e., an HR representative). Another way to find this information is to look in the Summary Plan Description or Evidence of Coverage (EOC), the book an employee receives from an employer when he or she signs up for a health plan. If an individual cannot find out from the employer, the Summary Plan Description, or the EOC, they can contact the Employee Benefits Security Administration at the U.S. Department of Labor. This agency enforces ERISA's provisions and should be able to provide additional information.

Remember, federal and state legislation regarding health care reform may provide new access to healthcare, payment, or appeals options. For updates to information call the CLRC at 1-866-THE-CLRC.

I. TYPES OF PRIVATE HEALTH INSURANCE

A. **Group vs. Individual Insurance:** *Group insurance* is usually offered through an employer or some form of a trade association (e.g., a union, etc.). *Individual insurance* means that an individual purchased a policy directly from an insurance company (e.g., when an individual purchases a plan from Blue Cross or Blue Shield, etc.). People who have group or individual health insurance plans are called "members" of that insurance company.

B. **HMO, PPO, and POS Plans:** There are three types of managed care plans.

1) **HMO Plans:** HMO stands for a Health Maintenance Organization. There are generally two forms of HMOs: independent physician associations (IPAs) and stand alone facilities. IPAs have physicians who practice in their own offices and sometimes join with other providers to form a medical group. Examples of IPAs are Blue Cross, Blue Shield, and Aetna. Stand alone facilities are HMO's hospitals that provide all care within that HMO's facilities. Kaiser Permanente is an example of a stand alone HMO facility.

2) **PPO Plans:** PPO stands for Preferred Provider Organization. A PPO is a group of health care providers who have agreed to provide services to an insurance company's members at a reduced rate.

3) **POS Plans:** POS stands for Point of Service Plan. A POS Plan is a combination of an HMO and a PPO. Members of a POS plan decide when they want to use the PPO part of their plan or the HMO option.

HMO	PPO	POS
Participating doctors and hospitals. Generally have a primary care physician who coordinates care	Usually many health care provider and hospital choices	Can see providers in- or out-of-network
Generally have to select doctors and hospitals from within the participating group	Can select from all participating providers	If selecting within network, generally have a minimal co-pay. If selecting from larger group, member pays more
Limited choices	More choices in doctors, specialists, overall providers	More choice when needed
Usually less expensive	Usually more expensive	Cost is between that of a PPO and an HMO

C. **What to Consider When Choosing a Health Insurance Plan:**

1) **Look at the Summary of Benefits:** What benefits are included? What benefits are excluded?
2) **Look at the Cost:** How much are the monthly premiums, annual deductibles for the individual or the family, maximum out-of-pocket costs, and co-payments for different types of services?
3) **When Are the Enrollment Periods?** Do they offer annual open enrollment periods for individuals to make changes to their policy?
4) **How Much Flexibility Do They Offer?** Can individuals change plans if they need to? If so, how?
5) **Guaranteed Renewability:** Under federal law and some state laws, health insurance companies are required to renew an individual's existing health coverage, as long as premium payments are made in full and on time. This is called guaranteed renewability. However, there is no cap on the rate increases companies may impose at the time of renewal. Guaranteed renewability is not portable, so the individual does not have the right to switch to another company or even another plan offered by the same company.

II. <u>WAYS TO GET AND KEEP HEALTH INSURANCE</u>

A. **Individual Health Insurance:** Typically when a person applies for an individual health insurance plan, that person is required to go through a process called medical underwriting. During this process, the insurance company looks at the individual's past and current medical conditions in order to decide whether or not it wants to issue the individual a health insurance policy. If the individual currently has, or has had in the past, a serious medical

condition (known as a pre-existing condition), the insurance company will likely decide that it is not worth the risk to them to insure this person, and will deny the individual a health insurance plan. However, even if the individual with a pre-existing condition, such as cancer, is offered an individual health insurance policy, it may be very expensive.

B. **Employment-Based Health Insurance:** The most common way that people obtain health insurance coverage is through their employer or a family member's employer. There are certain rights that are guaranteed to people who are insured through their employment. These rights pertain to the continuation of coverage during certain leaves of absence (under the Family and Medical Leave Act) or upon termination of employment (see COBRA, discussed below). Individuals with employment-based health insurance are also protected from health insurance discrimination based on their pre-existing conditions under the Health Insurance Portability & Accountability Act (see below). For example, one important protection under HIPAA for individuals with group health insurance companies can only look back into medical records six months to impose pre-existing condition exclusions that "relate to a condition for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollment date."[2]

C. **COBRA:** Employees who lose their jobs or have their work hours reduced are often concerned about how to keep their health insurance. COBRA is a federal law that allows employees to continue the same employment-based health insurance coverage that they had while they were employed, which means they do not have to change their health care providers.

1) **Who Can Elect COBRA?:** COBRA is available to employees or their family members after employees have left their job voluntarily, been terminated from employment, or have reduced their work hours to a point that they are no longer eligible to receive coverage from their employers (e.g. moving from full-time to part-time, and the employer only offers health insurance to full-time employees). This termination or reduction in hours is referred to as a "qualifying event." Other COBRA qualifying events are divorce or death of a spouse (when the person seeking COBRA coverage was insured by a plan provided through the spouse's employment), or a child aging out of a parent's health insurance policy. Below is a chart demonstrating the maximum coverage an individual can receive under COBRA, after a specific qualifying event:

Qualifying Event	**Qualified Beneficiaries**	**Maximum Coverage**
Termination of employment or reduction of hours	Employee, Spouse, Dependent Child	18 months
Employee enrollment in Medicare	Spouse, Dependent Child	36 months
Divorce or legal separation	Spouse, Dependent Child	36 months
Death of employee	Spouse, Dependent Child	36 months
Loss of dependent child status	Dependent Child	36 months

2) **Requirements of COBRA:**
   (i) COBRA applies to employers with 20 or more employees;
   (ii) COBRA coverage generally lasts for 18 months or 36 months, depending on the qualifying event;[3]

[2] Health Insurance Portability and Accountability Act of 1996, 29 U.S.C. § 701(a)(1).
[3] COBRA coverage can last up to 29 months if the person insured has a qualifying disability, or up to 36 months if the person became eligible for COBRA coverage because of certain qualifying events or a combination of qualifying events.

(iii) The monthly premium paid by the employee can be up to 102% of what the employer was paying for the same benefits;
(iv) The person insured is responsible for the full premium for the coverage;
(v) Responsibility for notifying the health plan of the qualifying event depends on which qualifying event has occurred;
(vi) A health plan has 14 days after the plan administrator is notified of the qualifying event to notify the employee of the right to elect COBRA; and
(vii) Employees must elect COBRA within 60 days after being notified of their rights. Employees then have 45 days after electing coverage to pay the initial premium.

3) **Cal-COBRA:** Cal-COBRA is California's state version of COBRA and serves the same purpose, allowing individuals to keep their health insurance when they experience a "qualifying event." For employers with 2-19 employees, California extends Cal-COBRA coverage up to 36 months. Cal-COBRA also provides that if individuals have federal COBRA and they have exhausted their 18 months, they can extend it for an additional 18 months under Cal-COBRA.[4] These extensions do not apply to self-insured employer-sponsored health plans.

(i) **Terms of Cal-COBRA:** State law defines the terms of Cal-COBRA coverage and its availability as follows:

- Cal-COBRA applies to employers with 2-19 employees;
- Cal-COBRA a maximum length of COBRA & Cal-COBRA coverage at 36 months; and
- The cost of the monthly premium paid by the employee can be up to 110% of what the employer was paying for the same benefits.

D. **COBRA Premium Subsidy:** On February 17, 2009, President Obama signed the American Recovery and Reinvestment Act of 2009 (ARRA), as part of an economic stimulus plan. ARRA was amended by the Department of Defense Appropriations Act of 2010, which extended the subsidy to cover people who were involuntarily terminated from their jobs between September 1, 2008, and May 31, 2010. This subsidy is no longer available to those who newly elect COBRA coverage.

E. **Health Insurance Premium Payment Program (HIPP):** COBRA premiums can be very expensive, especially if individuals are not working. In California, HIPP may pay the health insurance premiums of eligible individuals to help them keep their private health insurance coverage.

1) **To qualify for HIPP:**
(i) Beneficiaries must:

- Be eligible for full scope Medi-Cal;
- Have a medical condition;
- Have either current health coverage or access to health coverage through an employer at the time of application (the policy must cover the medical condition);

[4] Some employers do not contract with an insurance company to insure their employees, but pay directly for their employees' health care costs. These employers are "self-insured," and not subject to state insurance regulations that have been preempted by a federal law called ERISA. Therefore, Cal-COBRA is not available to employees who are covered by an employer's self-insured plan. These employees are only eligible for 18 months under federal COBRA and only if they meet the federal requirements.

- Not be enrolled in a Medi-Cal managed care plan;
- Not be enrolled in a county organized health plan;
- Not be eligible for Medicare; and
- Not have a MRMIP or a MRMIP graduate plan.

(ii) It must be determined cost-effective for HIPP to pay the private health insurance premiums.

F. **Health Insurance Portability & Accountability Act (HIPAA):** HIPAA is a federal law that prohibits health insurance discrimination against individuals based on their pre-existing medical conditions, when individuals are moving from a group health insurance plan to another group health insurance plan or from a group plan to a HIPAA guarantee issue plan.

1) In order to take advantage of HIPAA protections, there cannot be a recent break in health insurance coverage that lasts more than 63 days.

2) **HIPAA Protections:**
   (i) Provides a federal right to an individual health insurance plan ("guarantee issue plan");
   (ii) Reduces the maximum pre-existing condition exclusion period to 12 months; and
   (iii) Gives individuals credit for the time that they had health insurance coverage in the past ("creditable coverage") to eliminate or reduce a pre-existing condition exclusion period.

3) **Guarantee Issue Plan:** A guarantee issue plan, also known as a "federally insured plan" or "HIPAA plan," is an individual health insurance plan that an individual has a right to purchase under federal law. A HIPAA plan is not a specific plan – rather it is a right to purchase an individual plan. In California, HIPAA plan options are available in two forms. First, every health insurer who offers individual health insurance policies in the state also has to offer a HIPAA plan option. All insurance companies that sell individual insurance policies must offer a choice of at least two policies. Companies that do not designate two specific HIPAA policies must offer a choice of all of their policies. Second, individuals may have the option to convert the group coverage that they had while on COBRA into an individual plan. An insurance company cannot deny an individual a HIPAA plan, but individuals should use the "buzz" words (guaranteed issue or HIPAA plan) when applying. Otherwise the insurance company may assume the individual wants a regular individual plan and may deny them coverage based on a pre-existing condition through the medical underwriting process.

   (i) **HIPAA vs. COBRA:** A HIPAA plan is different than COBRA coverage. Under COBRA, individuals keep the same health insurance they had through their employer. Under HIPAA, individuals are buying new insurance, and need to compare all of the available plans and pick the one that is right for them. Individuals should compare the premiums, deductibles, and co-payments. Individuals should also check to make sure their health care providers accept the insurance plan they are considering, and that their prescription drugs are on the formulary list of drugs covered by the plan. Note: There is no cap on the price of a HIPAA plan.

   (ii) **Requirements:** In order to be eligible for a HIPAA plan:
   - Individuals must exhaust COBRA or state COBRA coverage, meaning that they use all 18 or 36 months of COBRA coverage, available to them;

- There cannot be a break in their health insurance coverage longer than 63 days; and
- Individuals must be ineligible for Medicare, Medi-Cal, or any form of group coverage.

(iii) **Finding a HIPAA Plan in Your State:** In California, individuals have the right to convert the group coverage they had while on COBRA to an individual plan. In order to do that, they can contact their insurance company to find out how to convert their plan or contact the California Department of Managed Health Care (DMHC). In California, all health plans that sell individual plans must offer their two most popular individual plans to people who qualify for HIPAA. For example, the following companies are identified as providing HIPAA plans in CA:

- Aetna Health of California, Inc. at www.aetna.com/individuals-families-health-insurance/member-guidelines/member_services.html
- Anthem Blue Cross at www.anthem.com/ca/health-insurance/home/overview
- Blue Cross of California at www.anthem.com/ca/health-insurance/home/overview
- Blue Shield of California at www.blueshieldca.com/bsc/home/home.jhtml
- Care 1st Health Plan at www.care1st.com
- Cigna Healthcare of California at www.cigna.com
- Community Health Plan at www.dhs.co.la.ca.us/wps/portal
- County of Los Angeles – Dept of Health Services at www.dhs.co.la.ca.us/wps/portal
- Health Net of California, Inc. at www.healthnet.com/portal/home.do
- Kaiser Foundation Health Plan, Inc. at www.kaiserpermanente.org
- PacifiCare of California at www.pacificare.com
- United Healthcare at www.uhc.com

4) **Pre-Existing Condition Exclusion Period (PECEP):** When moving from one employer's group health plan to another employer's plan, the new plan is required to insure the individual, but may impose a PECEP, which means that for a certain period of time, the new plan will not cover any treatment or services related to the individual's pre-existing medical condition. For example, if the individual breaks his or her arm, those medical services will be covered; however, if he or she is currently undergoing cancer treatment, those services will not be covered, because the individual's cancer diagnosis is a pre-existing medical condition. Before HIPAA, a two-year PECEP was common. HIPAA limited the maximum PECEP that may be imposed to 12 months. Some states have gone further. For example, in California, employers with 2 or fewer employees have a 12 month pre-existing condition exclusion period, but only a 6 month exclusion period can be imposed for employers with 3 or more employees.

5) **Creditable Coverage:** Creditable coverage is any previous period of health insurance coverage that was not interrupted by a break in coverage of more than 63 days. HIPAA reduces any PECEP by the length of time that an individual previously had creditable coverage.

(i) Example: An individual has creditable coverage of 6 months while at a previous job. The individual is now changing jobs and the new employer's group health plan is imposing a PECEP of 6 months. Accordingly, the individual will not have a PECEP

under his or her new health insurance policy, because the previous 6 months of creditable coverage eliminates the 6 month PECEP.

6 month PECEP imposed by new group insurance plan – 6 months of previous coverage = 0 months left of a PCEP

(ii) **Qualifying for Creditable Coverage:** Almost all types of health insurance can qualify as creditable coverage. Medicare, Medi-Cal, group, individual, COBRA, and HIPAA plans can all qualify. One exception is that some student health insurance plans are not considered creditable coverage, because they do not typically provide comprehensive coverage. Also, if a particular condition was not covered by the policy that an individual is claiming as creditable coverage, then their new health plan may subject that condition to a PECEP.

(iii) **Demonstrating Creditable Coverage:** To show the health insurance company proof of creditable coverage, individuals must provide a "certificate of creditable coverage," which lists the dates that they have been insured by that company. Usually, this is mailed to individuals when their coverage ends. Individuals can also call their previous insurance company to request a certificate of creditable coverage. If individuals have been insured by multiple companies, they need certificates of creditable coverage from each one.

(iv) **Waiting Periods and Pre-Existing Condition Exclusion Periods:** Many employers will require that you wait a specific period of time after starting your employment before you are eligible for health insurance benefits. These waiting periods will run concurrently with any pre-existing condition exclusion period that your new plan is imposing.

- Example: Your new employer has a 60 day waiting period to be eligible for health benefits. Your new health plan has a 6 month (180 days) pre-existing exclusion period. These start at the same time on Day 1, so after your 60 day waiting period for benefits ends, you only have 120 days left of a pre- existing condition exclusion period.

G. **High Risk Insurance Pools/Major Risk Insurance Plans:** If an individual is not able to obtain insurance through COBRA, and is not eligible for a HIPAA plan, because they did not exhaust the available COBRA coverage or if an individual had a break in coverage of more than 63 days, then they may be eligible for a state high risk insurance pool or major risk plan. These state plans provide limited health insurance for individuals who are unable to obtain health insurance coverage in the individual insurance market due to a pre-existing condition. States are not required to provide an alternative option for medically uninsurable individuals to access coverage, but many do.

1) **Major Risk Medical Insurance Plan (MRMIP):** MRMIP provides limited health insurance for Californians who are unable to obtain coverage in the individual health insurance market due to a pre-existing medical condition.

(i) **Requirements:** In order to be eligible for MRMIP, an individual must meet the following requirements:

- Be a California resident.
- Have a pre-existing condition demonstrated by:
  ⇒ A rejection letter from a health insurance company in the last 12 months,

⇒ An offer of premiums equal to or higher than those of the individual's first MRMIP plan choice, or

⇒ Termination by an insurance carrier for reasons other than fraud or non-payment of premiums, ineligibility.

- Be ineligible for COBRA, Cal-COBRA, Medicare (Part A and B, except for end stage renal disease), or Medi-Cal.[5]

(ii) **Plans Offered Through the MRMIP:** Four plans are offered through the MRMIP[6]: Anthem Blue Cross (PPO), Contra Costa Health Plan (HMO), Kaiser Permanente Northern California (HMO), and Kaiser Permanente Southern California (HMO). The premiums for the coverage depend on location, age, and the plan chosen. If subscribers and dependents are enrolled in a PPO, there is a PECEP of three months, during which they must pay the premiums, but do not receive coverage for their pre-existing conditions. The HMO has a three-month, post-enrollment waiting period, during which subscribers and dependents do not pay premiums. They also do not have access to MRMIP coverage until the waiting period is over.

(iii) **Duration of MRMIP Coverage:** Prior to September 30, 2007, subscribers were disenrolled from the MRMIP after 36 months of continuous coverage, at which time they would be considered MRMIP Graduates and able to apply for guaranteed coverage through a MRMIP Graduate Program plan. Currently, however, subscribers are not disenrolled from the MRMIP, even after being enrolled for 36 months, provided that they are still eligible and pay their premiums. Therefore, the MRMIP Graduate Program plans are no longer available, except to those who are already on the program.[7]

H. **California Pre-Existing Condition Insurance Plans (PCIP):** The recently enacted Patient Protection and Affordable Care Act (ACA) created a way for many individuals with pre-existing conditions to get insurance by mandating that states offer Pre-Existing Condition Insurance Plans (PCIP). As a result, California established its PCIP plan on October 25, 2010. PCIP is a federally-funded program that is run in California by the Managed Risk Medical Insurance Board (MRMIB) and provides health coverage to medically-uninsurable Californians. The plan will last until December 31, 2013. After that date, the plan will no longer be required since federal rules will prohibit insurers from rejecting individuals with pre-existing conditions or forcing them to pay more than those without such conditions. PCIP does not provide dependant coverage.

1) **Requirements:** In order to be eligible for PCIP, an individual must meet the following requirements:
   (i) Be a California resident.
   (ii) Have a pre-existing condition demonstrated by:
   - A rejection letter from a health insurance company in the last 12 months, or

[5] Pre-Existing Condition Insurance Plan. "Pre-Existing Condition Insurance Plan (PCIP) and Major Risk Medical Insurance Program (MRMIP) Differences." www.pcip.ca.gov/PCIP_Program/PCIP_MRMIP_Comparison.aspx. --
[6] MRMIP Frequently Asked Questions. http://www.mrmib.ca.gov/MRMIB/MRMIP_FAQ's_11_09_2011.pdf.
[7] MRMIP 36-Month Limit Ends 12/31/07, Managed Risk Medical Insurance Board, www.mrmib.ca.gov/MRMIB/MRMIPProg36.pdf; Department of Managed Health Care, "MRMIP." www.hmohelp.ca.gov/dmhc_consumer/hp/hp_mrmip.aspx.

- Offered coverage with premiums higher than those of the MRMIP PPO in the area where the individual is seeking coverage, or
- As of 2011, simply show proof of a pre-existing condition.

(iii) Be a U.S. Citizen, U.S. National, or lawfully present in the U.S.
(iv) Have had no creditable health insurance coverage in the six months prior to application.
(v) Not be enrolled in Medicare (Part A or B), COBRA, Cal-COBRA, or MRMIP.
(vi) Have a Social Security Number.[8]

I. Health Care Reform and Pre-Existing Conditions

1) **Children:** As of September 23, 2010, children under 19 cannot be denied health insurance coverage based on a pre-existing condition.

   (i) **California Implementation:** California law provides even more protections than the federal law. Through AB 2244, California eliminated pre-existing condition exclusions for children under 19, including the denial and limiting of coverage. In response to insurance company claims that they would refuse to individual policies to children, CA responded by prohibiting insurers who refuse to provide child-only policies from selling any new individual policies in the state for five years. This bill became effective on September 23, 2010.

2) **Adults:** As of January 1, 2014, adults cannot be denied health insurance coverage based on a pre-existing condition.

   (i) After 2014, when considering whether to provide health insurance coverage, insurers cannot consider:
   - Pre-existing condition (physical or mental);
   - Health status;
   - Medical history (yours or that of your family);
   - Genetic information;
   - Gender; or
   - Age.

   (ii) After 2014, in establishing premium rates, insurers may only consider:
   - If the insured is purchasing an individual or family policy;
   - Age of the insured;
   - The insured's rating area,[9] and
   - The insured's use of tobacco.

3) Applies to:
   (i) Grandfathered Plans
   - Group: Yes
   - Individual: No

[8] Pre-Existing Condition Insurance Plan. "Pre-Existing Condition Insurance Plan (PCIP) and Major Risk Medical Insurance Program (MRMIP) Differences." www.pcip.ca.gov/PCIP_Program/PCIP_MRMIP_Comparison.aspx.

[9] Rating area is a geographic area used for determining premium rates, usually by ZIP code. The premium is based on the average health care costs and the physician/hospital discounts in that area. Therefore, costs may be higher if the insured lives in a metropolitan city, as opposed to a small town. These rating areas must be approved by the HHS Secretary.

- Self-Insured Plans: Yes

III. FEDERAL HEALTH INSURANCE PROGRAMS

A. **Introduction:** While SSI and SSDI are federal disability insurance programs, Medicare and Medi-Cal are federal health insurance programs.

B. **Medicare:**

1) Medicare is a health insurance program for:
   (i) People age 65 or older who are eligible for Social Security retirement benefits;
   (ii) People under age 65 with certain disabilities who have received Social Security Disability (SSDI) benefits for 2 years; and
   (iii) People of all ages with End-Stage Renal Disease.

2) **Four Parts of Medicare:** Medicare has four parts, each with different services and coverage. Medicare requires that you join during what is known as the "open enrollment" period. There are some important implications to getting coverage during this time, especially for people with pre-existing conditions. Generally, "open enrollment" occurs every fall.

   (i) **Part A:** Everyone who is eligible for Medicare will receive Part A for free unless the individual has insufficient Social Security work history. However, if they are citizens or legal residents and have lived in the U.S. for at least 5 years, they can still obtain Part A coverage by paying a monthly premium. Part A is considered "hospital insurance" and can include coverage for in-patient hospital stays, skilled nursing facilities, and some home health care or hospice care.

   (ii) **Part B:** Part B is considered "medical insurance" and covers physician services, outpatient hospital services, x-rays, labs, tests, cancer screenings, ambulance rides, and other medical supplies and/or services. If individuals are eligible for Medicare Part A, they are entitled to receive this coverage; however, if they choose to elect Part B, they pay a monthly premium and an annual deductible.

   - Note: Assuming individuals have both Part A and Part B, then Medicare usually covers 80% of the allowable charge, making them responsible for only 20% of the bill.

   - **Covered Preventive Services:**[10] Coinsurance and/or deductibles may apply.

Abdominal Aortic Aneurysm Screening	Covered one time, if at risk
Bone Mass Measurement	Covered every 24 months (more often if medically necessary)
Cardiovascular Screening	Covered every 5 years
Colorectal Cancer Screening	Fecal Occult Blood Test: Covered once every 12 months if 50 or older

[10] Medicare.gov. "Preventive Services." www.medicare.gov/navigation/manage-your-health/preventive-services/preventive-service-overview.aspx.

	Flexible Sigmoidoscopy: Covered once every 48 months if 50 or older, or 120 months after a previous screening colonoscopy for those not at high risk Colonoscopy: Covered once every 120 months, or 48 months after a previous flexible sigmoidoscopy; covered every 24 months, if high risk Barium Enema: Covered once every 48 months if 50 or older when used instead of a sigmoidoscopy or colonoscopy; covered every 24 months, if high risk
Diabetes Screening	Covered up to twice a year, if high risk Diabetes Self-Management Training is also covered for individuals with diabetes.
Flu Shots	Covered once a flu season in the fall or winter
Glaucoma Tests	Covered once every 12 months, if high risk
Hepatitis B Shots	Covered, if high or medium risk
HIV Screening	Covered once every 12 months or up to 3 times during a pregnancy
Mammogram	Covered once every 12 months for all women with Medicare age 40 and older; covers one baseline mammogram for women between ages 35–39
Medical Nutrition Therapy	Covers medical nutrition therapy and certain related services if individuals have diabetes or kidney disease, or they have had kidney transplants in the last 36 months, and their doctors refer them for the service
Pap Test and Pelvic Exam	Covered once every 24 months; covered once every 12 months if high risk and for women of child-bearing age who have had an exam that indicated cancer or other abnormalities in the past 3 years
Physical Exam	One-time “Welcome to Medicare” physical exam: covered one time within 12 months of your Medicare Part B effective date Yearly “Wellness” exam: covered once a year if individuals have had Part B for longer than 12 months
Pneumococcal Shot	Covered
Prostate Cancer Screening	Digital rectal exam and Prostate Specific Antigen (PSA) test covered once every 12 months for all men with Medicare over age 50
Smoking Cessation	Covered up to 8 face-to-face visits in a 12-month period whether or not individuals are

	diagnosed with an illness caused or complicated by tobacco use, or if they take a medicine that is affected by tobacco

- **Clinical Trials:** Part B helps to cover some clinical trial expenses. Clinical trials test new types of medical care, like how well a new cancer drug works.
  ⇒ In general, Medicare will pay for the routine costs of items and services for an individual participating in a qualified clinical trial, including:
  1. Visits to the doctor's office
  2. Medically necessary tests
  3. Procedures needed to get the new care, such as an operation to implant an item that is being tested
  4. Hospital stays that Medicare would normally cover if the patient were not in a study
  5. Treatment of any complications or side effects that occur as a result of trial care

(iii) **Part C:** Previously called Medicare Plus Choice, Part C is now referred to as Medicare Advantage Plans with coordinated care of Part A, B, and D together through a Medicare HMO or PPO. Part C plans are offered by private insurance companies approved by Medicare and cover all of the services that Original Medicare covers except hospice care, and may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. However, if individuals go to health care providers who do not belong to the plan, the services may not be covered, or the costs could be higher. Individuals may not be excluded from these Advantage Plans due to a pre-existing condition, with the exception of End-Stage Renal Disease. Examples of plans under Part C include Kaiser Senior Advantage and SCAN.

(iv) **Part D:** Individuals can get Medicare prescription drug coverage by (1) joining a Medicare Prescription Drug Plan that adds drug coverage to the Original Medicare Plan (Medicare Part A or Part B) or (2) join a Medicare Advantage plan (Medicare Part C HMO or PPO) that includes prescription drug coverage as part of the plan. As of January 1, 2006, Medicare prescription drug plans became available to all Medicare beneficiaries. Plans vary from state to state. Some states have over 50 plans to choose from. For more information about the prescription drug plans available in each state, visit www.Medicare.gov.

- Part D plans may not cover all drugs, but they must cover:
  ⇒ Cancer medications;
  1. Note: oral chemotherapy drugs and anti-nausea drugs have been covered by Part B since 1999
  ⇒ HIV/AIDS treatments;
  ⇒ Antidepressants;
  ⇒ Anticonvulsant treatments for epilepsy and other conditions;
  ⇒ Immunosuppressant drugs;
  ⇒ Anti-psychotics; and
  ⇒ All commercially-available vaccines when medically necessary to prevent illness, except for vaccines covered under Part B.

- If individuals are denied coverage for specific drugs and will have to pay for them out-of-pocket, they have three options:
  - ⇒ Switch to a covered drug if their doctors think that is appropriate.
  - ⇒ Change to another Medicare drug plan as soon as possible and ask their doctors for samples until their new coverage is effective.
  - ⇒ Have their doctors help them with an "exception request" to cover the drug, because it is medically necessary. An exception request is simply a formal request to the insurance company that it makes an exception to cover the drug in question, because it is medically necessary.

(v) Some of the items and services that Medicare does not cover include the following:

- Long-term care
- Routine dental care
- Dentures
- Cosmetic surgery
- Acupuncture
- Hearing aids
- Exams for fitting hearing aids[11]

3) **The Affordable Care Act and Changes to Medicare**

(i) The ACA made several changes to the way that Medicare will operate.

- **Part B:** Starting in 2007, Medicare Part B premiums were tied to an individual's income level, so higher income Medicare beneficiaries have been paying a higher amount for their Part B premium. Each year, those income levels were decreasing so that more people were paying a higher Part B premium. The ACA froze the income threshold for Part B premiums to 2010 levels, through 2019, at $85,000 for those who are single, and $170,000 for those who are married. Although the premiums amounts may increase each year, fewer people will have to pay the higher premium rates based on their income levels.

- **Part C (Medicare Advantage Plans):** There are no significant changes in the ACA for enrollees in Medicare Advantage Plans. However, some Advantage Plan providers were receiving a reimbursement of approximately $1,000 more per patient than Medicare fee-for-service providers. Under the ACA, those reimbursement rate gaps for Medicare fee-for-service providers and Advantage Plan providers will be closed.

- **Part D and the Prescription Drug "Donut Hole:"**

  - ⇒ Starting in 2010, a $250 rebate was available for any Part D enrollee who entered the donut hole in 2010. Rebate checks were sent automatically. If you believe you should have received a rebate check, but did not, contact Medicare at (800) 633-4227.

[11] Medicare & You. Centers for Medicare & Medicaid Services (2011). www.medicare.gov/publications/pubs/pdf/10050.pdf.

⇒ Starting on July 1, 2010: In order for a drug to be covered by Medicare Part D, the drug company must enter into an agreement with the HHS Secretary to provide a significant discount (up to 50%) on name brand drugs to Part D enrollees who enter the donut hole.[12]

⇒ Between 2011 and 2020: The prescription drug donut hole will progressively decrease, eventually requiring enrollees to only pay 25% of the cost of their brand name and generic drugs.[13]

4) **How Much Does Medicare Cost?:**[14]

(i) **Part A:** Medicare Part A is free unless an individual has insufficient Social Security work history. Legal residents who have lived in the U.S. for at least five years may also receive Part A coverage, but they will have to pay a monthly premium.

- Note: If individuals are eligible for Part A but do not have sufficient work history, their monthly premium will be $451.
- Note: Although Part A coverage is free, there is a $1,100 deductible for the first day of a hospital stay.

- **Enrollment:**[15] There are a few ways individuals can enroll in Part A.

⇒ **Automatic Enrollment:** In most cases, if individuals are already getting benefits from Social Security or the Railroad Retirement Board (RRB), they will automatically get Part A starting the first day of the month they turn 65 and should receive their Medicare cards three months before their 65th birthdays.

1. Example: If an individual turns 65 on February 20, 2011, his or her Medicare effective date would be February 1, 2011.
2. If individuals have not received their cards by the beginning of the month of their birthdays, they should contact the Social Security Administration at 1-800-MEDICARE or visit www.medicare.gov.

⇒ **Signing Up:** If individuals are not getting Social Security or RRB benefits, because they are still working, and they want Part A, they will need to sign up (even if you're eligible to get Part A premium-free). To avoid late enrollment penalties, they should sign up during the initial enrollment period or a special enrollment period.

1. **Initial Enrollment Period:** Individuals can sign up when they are first eligible for Medicare. This is a seven-month period that begins three months before the month they turn 65, includes the month they turn 65, and ends three months after the month they turn 65.

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[12] Closing the Coverage Gap—Medicare Prescription Drugs Are Becoming More Affordable Centers for Medicare and Medicaid Services (2010). www.medicare.gov/Publications/Pubs/pdf/11493.pdf.
[13] *Id.*
[14] Figures are based on 2011 requirements as reported by www.medicare.gov.
[15] Medicare & You. Centers for Medicare & Medicaid Services (2011). www.medicare.gov/publications/pubs/pdf/10050.pdf.

2. **Special Enrollment Period:** If individuals did not sign up for Part A when they were first eligible, because they were covered under a group health plan, they can sign up for Part A during the eight-month period that begins the month after the employment ends or the group health plan coverage ends, whichever happens first.
    i. Example: An employee is eligible for Medicare, because the employee has turned 65, but is still working and has health insurance through his or her employer. The employee chooses to stay with the employer's plan while still working. When the employee decides to stop working, the employee may elect COBRA, but has up to eight months during the COBRA period to enroll in Medicare before a penalty fee is imposed.
    ii. Note: If individuals have COBRA coverage and then --become eligible for Medicare, they may lose their COBRA coverage. If they have Medicare and then elect COBRA coverage, they can keep their COBRA coverage.

⇒ **Late Enrollment Penalty:** If individuals do not enroll in Part A during the initial or special enrollment period, their monthly premiums may go up 10%. They will have to pay the higher premiums for twice the number of years they could have had Part A, but did not enroll.
1. Example: If an individual was eligible for Part A for 2 years but did not enroll, he or she will have to pay the higher premium for 4 years.

(ii) **Part B:** As mentioned above, Part B is optional and individuals may choose to decline coverage. If individuals elect Part B benefits, then they must pay a monthly premium based on their income (see chart below) and a $110.50 annual deductible before Medicare will pay its share of the health care costs.

Individual Income	Joint (Married) Income	Your Cost:
$85,000 or below*	$170,000 or below	$99.90
$85,001 - $107,000	$170,000 - $214,000	$139.90
$107,001 - $160,000	$214,001 - $320,000	$199.80
$160,001 - $214,000	$320,001 - $428,000	$259.70
$214,000+	$428,000+	$319.70

- **Enrollment:**[16] There are a few ways that individuals can enroll in Part B.

⇒ **Automatic Enrollment:** In most cases, if individuals are already getting benefits from Social Security or the Railroad Retirement Board (RRB), they will automatically get Part B, along with Part A, starting the first day of the month they turn 65 and should receive their Medicare Cards three months before their 65th birthdays. If individuals do not want Part B, they should follow the instructions that come with the cards, and send the cards back. If they keep the cards, they keep Part B and will be required to pay Part B premiums.

⇒ **Signing Up:** If individuals are not getting Social Security or RRB benefits, because they are still working, and they want Part B, they will need to sign

[16] Medicare & You. Centers for Medicare & Medicaid Services (2011). www.medicare.gov/publications/pubs/pdf/10050.pdf.

up. To avoid late enrollment penalties, they should sign up during the initial enrollment period or a special enrollment period.

1. **Initial Enrollment Period:** Individuals can sign up when they are first eligible for Medicare. This is a seven-month period that begins three months before the month they turn 65, includes the month they turn 65, and ends three months after the month they turn 65.

2. **Special Enrollment Period:** If individuals did not sign up for Part B when they were first eligible, because they were covered under a group health plan, they can sign up for Part B during the eight-month period that begins the month after their employment ends or the group health plan coverage ends, whichever happens first.

⇒ **Late Enrollment Penalty:** If individuals do not enroll in Part B during the initial or special enrollment period, they may be subject to a 10% late enrollment penalty for each complete 12-month period that the individuals could have enrolled in Part B, but chose not to.

1. Example: An individual was eligible in 2005, but did not sign up until 2010. The 2010 Part B premium was $96.40. Ten percent of $96.40 is $9.64. Since the individual did not enroll for five years, $9.64 is multiplied by five, equaling $48.20. This amount ($48.20) will be added to the individual's monthly Part B premium for life.

(iii) **Part C:** Out-of-pocket costs in a Medicare Advantage Plan depend on:

- Whether the plan charges a monthly premium.
- Whether the plan pays part of the Part B premium.
- Whether the plan has an annual deductible or any additional deductibles.
- How much individuals pay for each visit or service (copayments or coinsurance).
- The type of health care services individuals need and how often they get them.
- Whether individuals follow the plan's rules, like using network providers.
- Whether individuals need extra benefits and if the plan charges for them.
- The plan's yearly limit on the out-of-pocket costs for all medical services.[17]

- **Enrollment:**[18] There are a few times when individuals can choose to join, switch, or drop a Part C plan.

⇒ **Initial Enrollment:** Individuals can join, switch, or drop a Part C plan at these times:

1. When they are first eligible for Medicare. This is a seven-month period that begins three months before the month they turn 65, includes the month they turn 65, and ends three months after the month they turn 65.

[17] Medicare.gov. "Medicare Advantage (Part C)." www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-c.aspx.
[18] Medicare & You. Centers for Medicare & Medicaid Services (2011). www.medicare.gov/publications/pubs/pdf/10050.pdf.

2. If individuals get Medicare due to a disability, they can join during the three months before to three months after their 25th month of disability.
3. Between October 15 and December 7 in 2011. Their coverage began on January 1, 2012, as long as the plan got their enrollment requests by December 7.

⇒ **Special Enrollment:** In certain situations, individuals may be able to join, switch, or drop a Part C plan at other times. Some of these situations include:
1. If they move out of their plan'' service area
2. If they qualify for Extra Help
3. If they live in an institution (e.g., a nursing home)

(iv) **Part D:** Part D is optional, but if individuals select this prescription drug coverage they will pay a national average premium of $31.08 in 2011. The exact amount depends on the specific plan chosen. Plans range from $14.80 - $133.40, and have an annual deductible from $0 - $320.

- Additionally, beginning in 2011, Part D enrollees who have income that exceeds threshold amounts will pay a monthly adjusted amount, in addition to their regular Part D premium.[19]

Estimated Part D Monthly Premium for higher income levels:[20]

Individual Income	Joint (Married) Income	Your Cost:
$85,000 or below	$170,000 or below	Your Plan Premium
$85,001 - $107,000	$170,000 - $214,000	$11.60 + Your Plan Premium
$107,001 - $160,000	$214,001 - $320,000	$39.90 + Your Plan Premium
$160,001 - $214,000	$320,001 - $428,000	$48.10 + Your Plan Premium
$214,000+	$428,000+	$66.40 + Your Plan Premium

- **Enrollment:**[21] There are a few times when individuals can choose to join, switch, or drop a Part D plan.

⇒ **Initial Enrollment:** Individuals can join, switch, or drop a Part D plan at these times:
1. When they are first eligible for Medicare. This is a seven-month period that begins three months before the month they turn 65, includes the month they turn 65, and ends three months after the month they turn 65.
2. If individuals get Medicare due to a disability, they can join during the three months before to three months after their 25th month of disability. They will have another chance to join during the three months before the month they turn 65 to 3 months after the month they turn 65.

[19] Medicare Fact Sheet: Medicare Premiums, Deductibles for 2011. Centers for Medicare and Medicaid Services (November 4, 2010). www.nasuad.org/documentation/ship/2011PremiumsFinal.pdf.
[20] Medicare Fact Sheet: Medicare Premiums, Deductibles for 2011. Centers for Medicare and Medicaid Services (November 4, 2010). www.nasuad.org/documentation/ship/2011PremiumsFinal.pdf.
[21] Medicare & You. Centers for Medicare & Medicaid Services (2011). www.medicare.gov/publications/pubs/pdf/10050.pdf.

3. Between October 15 and December 7 in 2011. Their coverage began on January 1, 2012, as long as the plan got their enrollment requests by December 7.
4. Anytime, if they qualify for Extra Help.

⇒ **Special Enrollment:** In certain situations, individuals may be able to join, switch, or drop a Part D plan at other times. Some of these situations include:
1. If they move out of their plan's service area
2. If they lose other creditable prescription drug coverage
   a. Note: If employees are eligible for Part D, but have a prescription drug plan through private insurance (e.g., their employer or COBRA), the employer will notify the employees each year to let them know if they have creditable prescription drug coverage and do not need to enroll in a Part D plan. Employees then have a special enrollment period to elect a Part D plan, if they chose to do so, without incurring a late penalty fee for not enrolling when initially eligible for Part D.
3. If they live in an institution (e.g., a nursing home)

⇒ **Late Enrollment Penalty:** If individuals do not enroll in a Part D plan during the initial or special enrollment period, they may be subject to a late enrollment penalty. Those who are required to pay the penalty, pay 1% of the average national Part D premium for the year that they joined, times the number of months they were eligible to join a Medicare Part D drug plan, but did not.
1. Example: If an individual was eligible for a Part D plan in January 2006, but did not sign up until January 2011, he or she would be required to pay the penalty. The 2011 average national Part D premium is $32.34 x 1% = 32 cents. 32 cents x 60 months = $19.20, which will be added to the individual's monthly Part D premium for life.

- **Coverage Gap:**[22] Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that after individuals and their drug plans have spent a certain amount of money for covered drugs, individuals have to pay all costs out-of-pocket for their prescriptions up to a yearly limit. Once they reach their plan's out-of-pocket limit, then Medicare will begin to cover prescription drug costs at 75% and the individual is responsible for only 25%.

  ⇒ **What counts toward the out-of-pocket limit?:**
  1. Yearly deductible
  2. Coinsurance or copayments
  3. Amounts paid in the coverage gap

  ⇒ **What does not count toward the out-of-pocket limit?:**
  1. Part D plan monthly premiums
  2. Amounts paid for drugs that are not covered by the Part D plan

  ⇒ If individuals reach the coverage gap in 2012, they will get a 50% discount on covered brand-name prescription drugs at the time they buy them. There

[22] Medicare & You. Centers for Medicare & Medicaid Services (2011). www.medicare.gov/publications/pubs/pdf/10050.pdf.

will be additional savings in the coverage gap each year through 2020, when they will have 75% coverage in the gap.[23]

- **Extra Help:**[24] Individuals may qualify for Extra Help, also called the Low-Income Subsidy (LIS), from Medicare to pay prescription drug costs.

  ⇒ **Benefits:** Individuals who qualify for Extra Help and join a Medicare Part D drug plan will get:
  1. Help paying their Medicare drug plan's monthly premium, any yearly deductible, coinsurance, and copayments
  2. No coverage gap
  3. No late enrollment penalty

  ⇒ **Qualification:** To qualify, individuals must have a yearly income and resource level below these limits in 2011 (these amounts may change; visit http://www.ssa.gov/prescriptionhelp/ for updated information):

  1. Single Person:
     a. Income less than $16,335
     b. Resources less than $12,640
  2. Married Person Living with a Spouse and No Other Dependants:
     a. Income less than $22,065
     b. Resources less than $25,260
  3. Resources include:
     a. Money in a checking or savings account
     b. Stocks
     c. Bonds
  4. Resources do not include:
     a. An individual's home
     b. Car
     c. Household items
     d. Burial plot
     e. Up to $1,500 for burial expenses
     f. Life insurance policies
  5. Individuals automatically qualify for Extra Help if they have Medicare and:
     a. They have full Medi-Cal coverage
     b. They get help from Medi-Cal paying their Medicare Part B premium.
     c. They get Supplemental Security Income (SSI) benefits
     d. Note: If individuals automatically qualify for Extra Help, Medicare will send them a purple letter
  6. Individuals who do not automatically qualify for Extra Help can apply by:
     a. Visiting www.socialsecurity.gov to apply online
     b. Calling Social Security Administration at (800) 772-1213 to apply by phone or to get a paper application

[23] Closing the Coverage Gap—Medicare Prescription Drugs Are Becoming More Affordable. Centers for Medicare & Medicaid Services (2012). http://www.medicare.gov/publications/pubs/pdf/11493.pdf.
[24] Medicare & You. Centers for Medicare & Medicaid Services (2011). www.medicare.gov/publications/pubs/pdf/10050.pdf.

c. Visiting their State Medical Assistance (Medi-Cal) office

- **Choosing a Plan:** When choosing a plan, individuals should consider the following factors:
  - ⇒ Cost: What individuals pay in premiums, deductibles, and copayments
  - ⇒ Coverage: What benefits are provided, which drugs are covered, and the rules for getting those drugs (e.g., pre-authorization)
  - ⇒ Convenience: Which pharmacies are part of the plan and is there a mail-order option

5) **Appeals Process:**[25] Medicare beneficiaries have certain guaranteed rights, including the right to a fair process to appeal decisions about their health care coverage or payments.

(i) Individuals can appeal, if:

- A service or item they received is not covered, and they think it should be;
- A service or item is denied, and they think it should be paid;
- They question the amount that Medicare paid; or
- If their application to enroll in Medicare was denied.

(ii) There are five levels to the appeals process:

- **Redetermination:** A redetermination is an examination of a claim.
  - ⇒ **Part A and Part B:**[26] Request must be filed within 120 days of the date the initial claim determination was received
  - ⇒ **Part C**[27] **and Part D:**[28] Request must be filed within 60 days of the date the initial claim determination was received

- **Reconsideration:** If an individual is dissatisfied with the redetermination, he or she may request a reconsideration, which is an independent review by a panel of physicians or other health care professionals.
  - ⇒ **Part A and Part B:**[29] Request must be filed within 180 days of the date the redetermination was received
  - ⇒ **Part C**[30] **and Part D:**[31] Request must be filed within 60 days of the date the redetermination was received

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[25] Department of Health and Human Services. "Office of Medicare Hearings and Appeals (OMHA): Understanding the Appeals Process." www.hhs.gov/omha/process/index.html.
[26] The Medicare Appeals Process. Centers for Medicare and Medicaid Services (January 2011). www.cms.gov/MLNProducts/downloads/MedicareAppealsprocess.pdf.
[27] Medicare Advantage (Part C): Appeals Process. U.S. Department of Health & Human Services. www.hhs.gov/omha/files/c_chart.pdf.
[28] Medicare Prescription Drug Plan (Part D): Appeals Process. U.S. Department of Health & Human Services. www.hhs.gov/omha/files/d_chart.pdf.
[29] The Medicare Appeals Process. Centers for Medicare and Medicaid Services (January 2011). www.cms.gov/MLNProducts/downloads/MedicareAppealsprocess.pdf.
[30] Medicare Advantage (Part C): Appeals Process. U.S. Department of Health & Human Services. www.hhs.gov/omha/files/c_chart.pdf.
[31] Medicare Prescription Drug Plan (Part D): Appeals Process. U.S. Department of Health & Human Services. www.hhs.gov/omha/files/d_chart.pdf.

- **Administrative Law Judge (ALJ) Hearing:** If at least $130 remains in controversy following the reconsideration, an individual has 60 days from when he or she received the reconsideration notice to request an ALJ hearing.

- **Appeals Council Review:** If an individual is dissatisfied with the ALJ's decision, he or she may request a review by the Appeals Council. The individual has 60 days from when he or she received the ALJ's decision to submit a written request for the review. A minimum monetary threshold is not required to request an Appeals Council review.

- **Judicial Review in U.S. District Court:** If at least $1,260 or more is still in controversy following the Appeals Council's decision, an individual may request judicial review before a U.S. District Court judge. The individual has 60 days from when he or she received the Appeals Council's decision to file the request for review.

6) **Medigap:**[32] A Medigap policy, also known as Medicare Supplemental Insurance, is health insurance sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. If individuals are in the Original Medicare Plan and have a Medigap policy, then Medicare and the Medigap policy will both pay their shares of covered health care costs. Generally, when individuals buy Medigap policies, they must have Medicare Part A and Part B. They will have to pay the monthly Medicare Part B premiums and also have to pay premiums to the Medigap insurance companies. Medigap policies are guaranteed renewable as long as the premium is paid.

   (i) **Cost:** Medigap policies are priced in 3 ways.

   - **Community-Related ("not-age-rated"):** The same monthly premium is charged to everyone who has that Medigap plan, regardless of age

   - **Issue-Age-Related:** Premiums are based on the age at which individuals buy the policy. The younger individuals are when they buy-in, the lower their premiums will be

   - **Attained-Age-Related:** Premiums are based on individuals' current ages, so premiums increase as they get older

   - Note: Community Related and Issue-Age-Related policy premiums may go up because of inflation, but not because of age

   (ii) **Enrollment Period:** The enrollment period lasts up to six months and starts on first day of the month in which individuals are both:
   - Age 65 or older; and
   - Enrolled in Medicare Part B.
   - Example: If an individual turns 65 in January, but waits until March to enroll in Part B, his or her 6 month enrollment period for Medigap would begin in March.

[32] Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare. Centers for Medicare and Medicaid Services (2011). www.medicare.gov/Publications/Pubs/pdf/02110.pdf.

(iii) **People with Disabilities or End-Stage Renal Disease (ESRD):** Federal law does not require insurance companies to sell Medigap policies to individuals under age 65 who have Medicare coverage because of a disability or ESRD. However, this does not mean that individuals with Medicare who are under 65 do not have access to Medigap policies. California law provides broader coverage than federal law, requiring insurance companies to offer at least one kind of Medigap policy to Medicare beneficiaries who are under 65 (excluding those with ESRD). Insurance companies may also voluntarily sell Medigap policies to those with disabilities or ESRD who are under 65, thus giving them additional policy options. However, these policies would likely cost more than those sold to individuals over the age of 65, and they can use medical underwriting.

(iv) **Coverage:** The below chart shows the benefits covered under each of the various Medigap policies available after June 1, 2010. If an "X" appears in the column that means the Medigap policy covers 100% of the benefit listed. If a column has a percentage in it, that means that the Medigap policy covers the percentage listed. If the column is blank, then Medigap does not cover the described benefit. It is important to remember that the Medigap policy covers coinsurance only after the yearly deductible is met.

- Note: Plans E, H, I, and J are no longer sold. However, if individuals already have one of these plans, they may keep it.

Benefit	Policy									
	A	B	C	D	F	G	K	L	M	N
Medicare Part A Coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	X	X	X	X	X	X	X	X	X	X
Medicare Part B Coinsurance or Copayment	X	X	X	X	X	X	50%	75%	X	X
Blood (First 3 Pints)	X	X	X	X	X	X	50%	75%	X	X
Part A Hospice Care Coinsurance or Copayment	X	X	X	X	X	X	50%	75%	X	X
Skilled Nursing Facility Care Coinsurance			X	X	X	X	50%	75%	X	X
Medicare Part A Deductible		X	X	X	X	X	50%	75%	50%	X
Medicare Part B Deductible			X		X					
Medicare Part B Excess Charges					X	X				
Foreign Travel Emergency (Up to Plan Limits)			X	X	X	X			X	X

- None of these policies provide prescription drug coverage.
- Medigap policies only cover one person.
  ⇒ Example: If an individual and his or her spouse both want Medigap coverage, they each must buy separate Medigap policies.

- California requires insurance companies to offer at least one kind of Medigap policy to people with Medicare under 65. This does not include people with End-Stage Renal Disease.

- It is important to compare Medigap policies, because while the benefits are the same for each insurance company, the costs may vary and increase with age. Each insurance company decides which Medigap policies it wants to sell and the price for each plan.

- Note: If individuals have Medicare Advantage Plans, they may not use Medigap policies to cover deductibles, copays, or coinsurance costs.

7) **Steps to Help You Choose a Medicare Plan:**

(i) **Step 1:** Decide which Medicare health plan you want, either the Original Medicare Plan (Part A and Part B) or a Medicare Advantage Plan (Part C, which includes BOTH Parts A & B).

(ii) **Step 2:** Decide if you want prescription drug coverage (Part D). If you chose the Original Medicare Plan you must choose and join a Medicare Part D Prescription Drug Plan. However, if you go with a Medicare Advantage Plan (Part C), most Part C plans include prescription drug coverage at an extra cost, eliminating the need for a Part D plan.

(iii) **Step 3:** Decide if you want supplemental coverage. In addition to your Medicare coverage, you can choose to buy private supplemental coverage (Medigap plan).

C. **Medi-Cal:** The Medicaid program in California is called Medi-Cal. Medi-Cal provides health insurance for certain people who have low incomes, have limited resources, and meet other eligibility requirements. Individuals with cancer often qualify for Medi-Cal through the Aged, Blind and Disabled Program, which provides coverage to individuals with low incomes who are over 65 or who have a disability.

1) **Eligibility:** Applicants must meet income and asset eligibility requirements (i.e., have low income and limited resources to pay for the cost of their health care), AND fit into one of these categories:

(i) Individuals who are "aged, blinded or disabled" according to the Social Security Administration's standards;

(ii) Families with children as long as a deprivation exists. A deprivation exists if a parent is absent from the home, incapacitated, disabled, or deceased;

(iii) Children or pregnant women without regard to deprivation or poverty; or

(iv) Individuals with specific health needs. These needs include dialysis, tuberculosis services, total parental nutrition services, breast and cervical cancer treatment, certain services for minors, and nursing home care.

2) To apply for Medi-Cal benefits, Californians can visit their local Department of Public and Social Services Medi-Cal office. Medi-Cal offices in Los Angeles County* include:

District	Address	Phone
Belvedere	5445 Whittier Blvd., Los Angeles, CA 90022	(323) 727-4314
Civic Center	813 E. Fourth Place, Los Angeles, CA 90013	(213) 974-0201
Compton	211 E. Alondra Blvd., Compton, CA 90220	(310) 603-8401
Cudahy	8130 S. Atlantic Ave., Cudahy, CA 90201	(323) 560-5001
East Valley	14545 Lanark St., Panorama City, CA 91402	(818) 901-4101
El Monte	3350 Aerojet Ave., El Monte, CA 91731	(626) 569-3677
Exposition Park	3833 S. Vermont Ave., Los Angeles, CA 90037	(323) 730-6148
Florence	1740 E. Gage Ave., Los Angeles, CA 90001	(323) 586-7001
Glendale	4680 San Fernando Road, Glendale, CA 91204	(818) 546-6100

Hawthorne	12000 S. Hawthorne Blvd., Hawthorne, CA 90250	(310) 349-5880
Lancaster	349-B East Ave. K-6, Lancaster, CA 93535	(661) 723-4021
Lincoln Heights	4077 N. Mission Rd., Los Angeles, CA 90032	(323) 342-8142
Metro East	2855 E. Olympic Blvd., Los Angeles, CA 90023	(323) 260-3501
Metro Family	2615 S. Grand Ave., Los Angeles, CA 90007	(213) 744-6601
Metro North	2601 Wilshire Blvd., Los Angeles, CA 90057	(213) 639-5455
Metro Special	2707 S. Grand Ave., Los Angeles, CA 90007	(213) 744-5601
Northridge	9451 Corbin Ave., Northridge, CA 91324	(818) 717-2101
Norwalk	12727 Norwalk Blvd., Norwalk, CA 90650	(562) 807-7820
Paramount	2961 E. Victoria St., Rancho Dominguez, CA 90221	(310) 603-5000
Pasadena	955 N. Lake Ave., Pasadena, CA 91104	(626) 791-6302
Pomona	2040 W. Holt Ave., Pomona, CA 91768	(909) 397-7901
Rancho Park	11110 W. Pico Blvd., Los Angeles, CA 90064	(310) 481-3115
San Gabriel Valley	3352 Aerojet Ave., El Monte, CA 91731	(626) 569-3611
Santa Clarita	27233 Camp Plenty Rd., Canyon Country, CA 91351	(661) 298-3387
South Central	10728 S. Central Ave., Los Angeles, CA 90059	(323) 563-4156
South Family	17600 A Santa Fe Ave., Rancho Dominguez, CA 90221	(310) 761-2000
Southwest Family	8300 S. Vermont Ave., Los Angeles, CA 90044	(323) 549-5674
Southwest Special	1819 W. 120th St., Los Angeles, CA 90047	(323) 420-2918
West Valley	21415-21615 Plummer St., Chatsworth, CA 91311	(818) 718-5000
Wilshire	2415 W. 6th St., Los Angeles, CA 90057	(213) 738-4311

*locations and contact information subject to change

Organizations that help people determine Medi-Cal eligibility and work with Medi-Cal benefits include:

L.A. Care Health Plan
(888) 452-5437 – general assistance line
www.lacare.org

Dept. of Public Social Services
(877) 481-1044
dpss.lacounty.gov

Seniors:
Senior Legal Hotline
(800) 222-1753 or (916) 551-2140
www.seniorlegalhotline.org

WISE & Healthy Aging
1527 4th Street, 2nd Floor
Santa Monica, CA 90401
855-636-7655
855-6-ENROLL
http://www.wiseandhealthyaging.org/cms/1280.html

3) **Share of Cost:** California has a "Share of Cost" program that refers to the amount of health care expenses individuals must pay out of pocket each month before Medi-Cal begins to offer assistance. If individuals fit into one of the Medi-Cal eligibility categories and have incomes below a certain level, they are considered "categorically needy" and need not pay a Share of Cost to receive Medi-Cal benefits. However, if their incomes or property exceed the categorically needy levels, they are considered "medically needy" and must accumulate a predetermined amount of health care expenses before Medi-Cal will pay for any additional covered expenses that month. Share of Cost is an amount that is owed to the provider of health services, not to Medi-Cal.
   (i) Note: Share of Cost is not a monthly premium. It is an amount that a recipient is responsible for paying only during a month in which Medi-Cal's assistance with health care expenses is needed.

4) **Buy-In Program:** California offers a Medi-Cal Buy-In Program which allows individuals of any age with a disability and who are working, to receive Medi-Cal by paying a monthly premium based on income.

5) **The Affordable Care Act and Changes to Medicaid Eligibility**

   (i) As of January 1, 2014, states are required to expand Medicaid coverage to include:

   - "Newly-Eligible" Adults: Adults at the income level of 133% of the Federal Poverty Level (FPL).

     ⇒ In 2010, 133% FPL for an individual was $14,403.90 per year or $1,200.33 per month. For a family of four, 133% of the FPL was $29,326.50 per year or $2,443.88 per month.

   - Children ages 6 to 19 at 133% of FPL.

   (ii) Note: States have the option to expand Medicaid eligibility in 2010, but most states will not, because they cannot afford it due to budget crises. In 2014, when it becomes mandatory for states to expand their Medicaid programs, the federal government will pay for the costs associated with the expansion of eligibility. However, some states, such as California, have applied for state waivers to pilot early implementation programs.

   (iii) **California Implementation:** On November 2, 2010, California's five-year $10 billion "Bridge to Reform" Waiver proposal, known as California's 1115 Medi-Cal Waiver, was approved. This Waiver builds a bridge to full federal health reform implementation by early expansion of Medi-Cal coverage of childless adults with federal matching funds, allocating the following:

   - $3.3 billion for investments in public hospital safety net
   - $2.9 billion for additional coverage for low-income individuals
   - $3.9 billion for uncompensated care costs

   - **Mandatory Enrollment of Seniors and Persons with Disabilities into Managed Care:** Under SB 208, in June 2011 California began to mandatorily

enroll Seniors and Persons with Disabilities (SPDs) who only have Medi-Cal into Medi-Cal managed care plans. This change affects individuals in Los Angeles County, as well as several others. However, individuals will not be mandatorily enrolled if they belong to one or more of the following groups:

⇒ Dual eligibles, or those with Medicare
⇒ Foster children
⇒ Those identified as receiving long term care
⇒ Those with other health insurance
⇒ Those with Share of Cost Medi-Cal
⇒ Those receiving California Children's Services (CCS) – although currently excluded Medi-Cal notes that CCS may become mandatory in the future[33]\

- Medi-Cal beneficiaries who normally would be mandated to go to a Medi-Cal managed care plan may file a Medical Exemption Request (MER). For information on the MER process, call Health Care Options (HCO) at 1-800-430-4263 or visit the HCO website at http://www.healthcareoptions.dhcs.ca.gov/HCOCSP/Enrollment/Exception_to_Plan_Enrollment_Forms.aspx.

(iv) **Low Income Health Programs (LIHPs):** In 2007, under California's previous 1115 Medicaid Waiver, ten California counties were selected to receive federal funds to expand care to low-income childless adults through programs called Health Care Coverage Initiatives. However, as of 2011, under the new 1115 Medicaid Waiver, all California counties are eligible to receive federal reimbursement funds for Low Income Health Programs (LIHPs), referred to in AB 342 as Coverage Expansion and Enrollment Demonstration (CEED) projects.[34]

- These programs provide a broad range of services to low-income childless adults:

⇒ between the ages of 19 and 64
⇒ who are citizens or qualified immigrants
⇒ who are ineligible for public health benefit programs, such as Medicare, Medi-Cal, and the Children's Health Insurance Program (CHIP).

- Specific eligibility requirements and application procedures are developed by each LIHP in compliance with Medicaid rules. Each individual enrolled in these programs will be assigned to a medical home, which is a single provider, facility, or health care team who serves as the enrollee's primary health care contact.

- There are two components of LIHPs:

[33] California Department of Health Care Services. "MMCD - Seniors & Persons With Disabilities (SPD)." www.dhcs.ca.gov/individuals/Pages/MMCDSPDEnrollment.aspx.
[34] Rev. Program Requirements and Application Process Low Income Health Program (LIHP). Department of Health Care Services (2011). www.dhcs.ca.gov/provgovpart/Documents/LIHP/Applications/ProgramRequirementsandApplicationProcessREV01-25-11.pdf.

⇒ **Medicaid Coverage Expansions (MCEs):** These programs serve childless adults ages 19 to 64 with family incomes up to 133% of the Federal Poverty Line and will transition them to Medi-Cal in 2014. Individuals enrolled in MCEs will not be charged any premiums or co-payments, except for minimal copayments comparable to those allowed in Medi-Cal.[35]

⇒ **Health Care Services:**

1. Medical equipment and supplies;
2. Emergency care services, including transportation;
3. Acute inpatient hospital services;
4. Laboratory services;
5. Mental health benefits
6. Prior-authorized non-emergency medical transportation when medically necessary
7. Outpatient hospital services;
8. Physical therapy;
9. Physician services
10. Podiatry
11. Prescription and limited non-prescription medication;
12. Prosthetic and orthotic appliances and devices; and
13. Radiology.

(v) **Health Care Coverage Initiatives (HCCIs):** These programs serve uninsured childless adults ages 19 to 64 with family incomes between 134% and 200% of the Federal Poverty Line and will transition them to Health Insurance Exchanges in 2014.[36] Individuals enrolled in this program may pay some premiums and co-payments. HCCI enrollees may also be required to pay 5% of their income towards health care costs.

- **Health Care Services:**
  - ⇒ Medical equipment and supplies;
  - ⇒ Emergency care services;
  - ⇒ Acute inpatient hospital services;
  - ⇒ Outpatient hospital services
  - ⇒ Physical therapy;
  - ⇒ Physician services;
  - ⇒ Prescription and limited non-prescription medications;
  - ⇒ Prosthetic and orthotic appliances and devices; and
  - ⇒ Radiology.
  - ⇒ Note: Counties with existing HCCI programs may provide services to existing enrollees who were enrolled in HCCI on November 1, 2010. Once the MCE is implemented, the existing HCCI enrollees will be redesignated as either

[35] There is no cap on federal funding for MCEs, but amount of federal reimbursement is dependent on the amount of local non-federal funds provided to the programs.

[36] Unlike MCEs, there is a cap on federal funding for HCCIs, and the amount of funding they receive is determined by the state and federal governments. A county may not implement an HCCI program if an MCE program is not implemented or if the MCE upper income limit is below 133% of the Federal Poverty Line. If a county has already implemented an HCCI program when the MCE upper income limit falls below 133%, new applicants may not enroll in HCCI, but existing enrollees may continue to receive services.

MCE or HCCI based on their incomes.

(vi) As of July 1, 2011, Los Angeles County Health Services implemented its LIHP, which is called Healthy Way L.A. (HWLA).[37]

- Healthy Way L.A. covers both outpatient and inpatient services. It can also cover the following benefits:
  - ⇒ Primary Care by Appointment
  - ⇒ Access to in-house pharmacies to fill prescriptions
  - ⇒ Assigned "Medical Home" at a location near your home or work
  - ⇒ Preventive Care & Mental Health Services
  - ⇒ Access to Specialists
  - ⇒ Care Management Services for chronic illnesses like CHF & Diabetes
  - ⇒ Urgent & Emergency Medical Care Coverage
  - ⇒ 24/7 Nurse Advice Line
  - ⇒ Translation Services
  - ⇒ Caring, Multi-cultural staff[38]

- The following are the eligibility requirements to enroll in Healthy Way L.A.:
  - ⇒ **Residency:** Los Angeles County
  - ⇒ **Age**: Adult, 19 to 64 years of age
  - ⇒ **Citizenship**: U.S. Citizen/National or Legal Permanent Resident of 5 + years
  - ⇒ **Income**: Monthly income limit ($1,207 or less for a family of one)
  - ⇒ **Pregnancy**: Not pregnant or eligible for Medi-Cal or Healthy Families[39]

- To apply for Healthy Way L.A.[40]:
  - ⇒ If you have had medical care at a County Department of Health Services (DHS) or a Community Partner facility in the past, or want to in the near future, go to that location to apply.
  - ⇒ If you have never had medical care at a county DHS or Community Partner facility, or you are not sure, you may apply at one of the six enrollment locations between 8:00a.m. to 4:30p.m. Monday through Friday:

Harbor/UCLA Medical Center Patient Financial Services 1000 West Carson Street Building 3-South Torrance, CA 90509 (310) 222-3012	Rancho Los Amigos National Rehabilitation Center 7601 E. Imperial Hwy. Bldg. 602 Downey, CA 90242 (562) 401-7320

[37] http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Resources/Nm_Impl-Dt_IPL_12-29-11.pdf.

[38] http://www.ladhs.org/wps/portal/!ut/p/c1/04_SB8K8xLLM9MSSzPy8xBz9CP0os_hAFz8jl2AXYwOLMCNTA89QY0-_AH8XAwMLA6B8pFm8n79RqJuJp6GhhZmroYGRmYeJk0-Yp4G7izEB3eEg-_DrB8kb4ACOBvp-Hvm5qfoFuREGWSaOigCBH-rd/dl2/d1/L0lDU0NTSUpKZ2tLQ2xFQSEvb01vUUFBSVFKQUFNWXhpbE1RWndYQk00L1lCSkp3NDU0NTAtNUY0a3N0eWp3LzdfUUROMkRTRDMwMEE2MjBJVTNRTDBQRzAwMDYvem1Cek4yNTA4MDE1Ny9iZl9hY3Rpb24vZGVmYXVsdDE!/#7_QDN2DSD300A620IU3QL0PG0006

[39] *Id.*

[40] http://www.ladhs.org/wps/PA_1_QDN2DSD30OTBC0IU3AR62I1000/DhsSites/HWLA/pdf/Enrollment%20Info%20Sheet%20english.pdf

LAC+USC Medical Center 1100 N. State Street, Room A6F Los Angeles, CA 90033 (323) 409-4383 (323) 409-4779 Olive View/UCLA Medical Center 14445 Olive View Drive 2nd Floor, Room 2D142 Sylmar, CA 91342 (818) 364-4217	High Desert Health System Munsie Building - ORSA/HWLA Office 44900 North 60th St. West Lancaster, CA 93536 (661) 945-8227 Martin Luther King, Jr. Multi-Service Ambulatory Care Center 12021 S. Wilmington Ave., Floor 5A, Room 7 Los Angeles, CA 90059 (310) 668-3200

IV. **OTHER HEALTH CARE OPTIONS**

A. **Screening Legislation:** California requires insurance companies to cover all generally medically accepted cancer screening tests,[41] such as the following:
   1) Mammography for breast cancer;[42]
      (i) Note: Insurance companies in California must also provide coverage for the diagnosis of and treatment for breast cancer, which includes coverage for prosthetic devices or reconstructive surgery to restore and achieve symmetry for patients following mastectomies.
   2) Prostate-specific antigen (PSA) tests and digital rectal exams (DRE) for prostate cancer;[43]
   3) Pap smears for cervical cancer;[44] and
   4) Colonoscopies, flexible sigmoidoscopy, and fecal occult blood tests (FOBT) for colorectal cancer.

B. **Screening and Treatment Programs:** A number of screening and treatment programs are available to Californians. The Cancer Detection Section (CDS) of the California Department of Public Health's Chronic Disease and Injury Control Division manages screening and treatment programs for specific types of cancer in California.

   1) **National Breast and Cervical Cancer Early Detection Program (NBCCEDP):** The NBCCEDP is a program run by the Centers for Disease Control and Prevention (CDC) that funds all 50 states, the District of Columbia, 5 U.S. territories, and 12 American Indian/Alaska Native tribes or tribal organizations to provide screening services for breast and cervical cancer. The program helps low-income, uninsured, and underinsured women gain access to breast and cervical cancer screening and diagnostic services. For eligibility requirements or to find out where to get screened for this program, call (800) 511-2300.

      (i) **Available services include:**
      - Clinical breast examinations;
      - Mammograms;
      - Pap tests;

[41] Cal. Health & Safety Code § 1367.65; Cal. Health & Safety Code § 1367.665.
[42] Cal. Health & Safety Code § 1367.6.
[43] Cal. Health & Safety Code § 1367.64.
[44] Cal. Health & Safety Code § 1367.66.

- Pelvic examinations;
- Diagnostic testing if results are abnormal; and
- Referrals to treatment.

(ii) **Eligibility:** An estimated 8%–11% of U.S. women of screening age are eligible to receive NBCCEDP services. Women may qualify for screening if they are:

- Uninsured or underinsured, meaning they are at or below 250% of Federal Poverty Level.
- Ages 18-64 for cervical screening.
- Ages 40-64 for breast screening.[45]

2) **Cancer Detection Programs: Every Woman Counts:** The CDP:EWC is California's NBCCEDP and offers free clinical breast exams, mammograms, pelvic exams, and Pap tests to qualifying women in California.

(i) **Breast Cancer Screening Eligibility:** Women may qualify for free breast cancer screenings if they:

- Are 40 years old or older; and
- Have low income according to the CDP: EWC criteria; and
- Are not getting these services through Medi-Cal or another government-sponsored program; and
- Live in California; and
- Have medical insurance that does not cover breast cancer screening; or
- Have a high insurance deductible or co-payment[46]

(ii) **Cervical Cancer Prevention Screening Eligibility:** Women may qualify for free cervical cancer prevention screenings if they:

- Are 25 years old or older; and
- Have low income according to the CDP:EWC income criteria; and
- Are not getting these services through Medi-Cal or another government-sponsored program; and
- Live in California; and
- Have medical insurance that does not cover cervical cancer prevention screening; or
- Have a high insurance deductible or co-payment[47]

3) **Family Planning Access, Care, and Treatment (Family PACT):** Family PACT provides free or low cost family planning services, STD/HIV screening, pregnancy testing, counseling, and breast and cervical cancer screening for low-income, California residents who are uninsured or underinsured.

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[45] Centers for Disease Control and Prevention. "National Breast and Cervical Cancer Early Detection Program (NBCCEDP): About the Program." www.cdc.gov/cancer/nbccedp/about.htm.
[46] California Department of Public Health. "Cancer Detection Programs: Every Woman Counts." www.cdph.ca.gov/programs/cancerdetection/pages/cancerdetectionprogramseverywomancounts.aspx.
[47] *Id.*

(i) **Eligibility:** Women, men, and teens able to become pregnant or cause a pregnancy may qualify for Family PACT, if they:

- Have no medical insurance or cannot get Medi-Cal;
- Have insurance, but it does not cover family planning or birth control methods;
- Have insurance, but they have not met their deductibles;
- Have Medi-Cal with Share of Cost, but they have not met Share of Cost;
- Have Medi-Cal but, it does not cover family planning; or
- Have insurance or Medi-Cal, but they need to keep family planning services confidential.[48]

(ii) To find Family PACT providers in your area, visit www.familypact.org/en/Clients/nearest-family-pact-provider.aspx, call (800) 942-1054, or email fampact@cdph.ca.gov.

4) **Breast and Cervical Cancer Treatment Program (BCCTP):** Medi-Cal services are provided to qualifying individuals who have been diagnosed with breast or cervical cancer by the CDP:EWC or Family PACT.[49]

(i) **Federal BCCTP:** Women may qualify for full-scope Medi-Cal at no cost throughout the duration of their cancer treatments, as long as they remain qualified to receive BCCTP. Women may qualify for federal BCCTP if they:

- Have been screened and found to be in need of treatment for breast and/or cervical cancer (women only), follow-up care for cancer or precancerous cervical lesions/conditions by a CDP:EWC or Family PACT provider;
- Under age 65 who have satisfactory immigration status or are citizens or nationals of the United States;
- Are California residents;
- Have monthly gross family incomes at the time of screening and diagnosis, that are at or below 200 percent of the Federal Poverty Level for the family size; and
- Have no other health insurance including full-scope no share-of-cost Medi-Cal or Medicare.[50]

(ii) **State BCCTP:** If individuals do not qualify for Federal BCCPT, they may be eligible for State-funded BCCTP, which provides breast cancer treatment services for up to 18 continuous months and cervical cancer treatment services for up to 24 continuous months. State BCCTP may also cover related services and payment of insurance premiums under certain circumstances. Individuals may qualify for State-funded BCCTP if they:

- Have been screened and found in need of treatment for breast (men and women) and/or cervical cancer (women only), follow-up care for cancer or precancerous cervical lesions/conditions by a CDP:EWC or Family PACT provider;

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[48] Family Planning Access, Care, and Treatment, "What is Family PACT?" www.familypact.org/en/Clients/what-is-family-pact.aspx.

[49] Family PACT provides family planning services to qualifying men and women. For more information, please visit www.familypact.org/en/home.aspx.

[50] Department of Health Care Services. "Breast and Cervical Cancer Treatment Program (BCCTP)." www.dhcs.ca.gov/services/medi-cal/Pages/BCCTP.aspx.

- Are California residents (residence here means living in with an intent to remain in California, not legal residence in the state);
- Are males of any age or any immigration status;
- Are females under 65 years of age with non-citizen or unsatisfactory immigration status;
- Are females 65 years of age or older; and/or
- Have health insurance, including share-of-cost Medi-Cal and/or Medicare.[51]

(iii) To find a BCCTP provider near you, call (800) 824-0088.

C. **Women's Health and Cancer Rights Act (WHCRA):** WHCRA is a federal law that requires health insurance companies whose policy covers a mastectomy to also cover reconstruction of the breast on which the mastectomy was performed, surgery or reconstruction of the other breast to produce a symmetrical appearance, prostheses and/or implants, and treatment for physical complications of a mastectomy, such as lymphedema. Additionally, if a patient is between mastectomy and reconstruction and moves from one plan to another, the new plan is obligated to pay for the reconstruction if the new plan would have covered the original mastectomy.
   1) Note: WHCRA does not apply to federal health insurance plans, such as Medicare or Medi-Cal, as they have specific coverage rules.
   2) Note: WHCRA does cover lumpectomies, as well as mastectomies.

D. **Medically Indigent Adult Programs:** Every county in California is required by state law to have a Medically Indigent Adult (MIA) program that will serve those who have no other source of medical insurance. There are two MIA categories: County Medical Service Program (CMSP) counties and Medically Indigent Service Program (MISP) counties. Los Angeles is a MISP county that administers its own MIA program. The following programs are available in Los Angeles County:

   1) **Ability to Pay Plan (ATP):** Provides sliding scale inpatient/outpatient services for persons not covered by Medi-Cal, Medicare, or private insurance.[52] More information about ATP can be found at www.old.dhs.lacounty.gov/clinics/docs/ATP_RevPg1.pdf.
   2) **Outpatient Reduced-Cost Simplified Application (ORSA):** Provides outpatient services for persons not covered by Medi-Cal, Medicare, or private insurance, with incomes at 133.33% of the Federal Poverty Level.[53] More information about ORSA can be found at www.old.dhs.lacounty.gov/clinics/docs/ORSAFlye%28Eng%290107rev..pdf.
   3) **Public/Private Partnership Plan (PPP):** A collaboration between the Department of Health Services and private providers that provides outpatient services only for persons at 133.33% of the Federal Poverty Level.[54]

   Applications for ATP and ORSA are only accepted at certain locations. To see a list of Los Angeles locations, please visit www.old.dhs.lacounty.gov/clinics/docs/FacilityListing0107.pdf.

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[51] *Id.*
[52] Department of Public Social Services. "Ability-to-Pay Plan (ATP) Plan." http://dpss.lacounty.gov/dpss/health_care/adults/atp.cfm.
[53] Department of Public Social Services. "Outpatient Reduced-Cost Simplified Application (ORSA) Plan." http://dpss.lacounty.gov/dpss/health_care/orsa.cfm.
[54] Department of Public Social Services. "Other No-Cost or Low-Cost Plans." http://dpss.lacounty.gov/dpss/health_care/adults/other_no_cost_low_cost.cfm.

E. **Breast Health Care Community Resources:** The Los Angeles County Affiliate of Susan G. Komen for the Cure® is a generous source of funding for local breast cancer programs. Donations raised at events like the Los Angeles County Race for the Cure help provide the funds for these programs. Listed below are the Los Angeles County Affiliate 2011-2012 Community Grant recipients, organizations that serve as breast health care community resources in Los Angeles County.

Celebrate Life Cancer Ministry
Breast Cancer Navigation Program for South L.A.
Patient Navigation to promote early detection, treatment and the control of cancer among African American and Latina women.
2313 W. 109th St.
Inglewood, CA 90303
Support and Navigation: (323) 242-0222

Family Health Care Centers of Greater Los Angeles
Breast Cancer Outreach and Education Collaborative
Breast health education to low-income uninsured/underinsured Latinas through in-clinic and off-site presentations.
6501 S Garfield Ave.
Bell Gardens, CA 90201
Education: (562) 928-9600 x3061

Glendale Memorial Health Foundation
Diagnostic Breast Project for Women Under 40
Diagnostic-testing program for approximately 120 women with a breast mass under the age of 40, living in LA County.
1420 S. Central Ave.
Glendale, CA 91204
Diagnostic Services: (818) 502-2323

Korean Health Education, Information & Research Center
Project Hope
Diagnostic exams, treatment and culturally and linguistically tailored psychosocial counseling. 3727 W. 6th Street, Suite 210
Los Angeles, CA 90020
Advocacy/Support: (213) 427-4000 x201

Methodist Hospital
The Year Beyond
Breast cancer survivorship series of classes to support to Asian and Latina breast cancer survivors in the San Gabriel Valley.
300 West Huntington Dr.
Arcadia, CA 91007
Support: (626) 574-3515

My Sister My Friend Breast Cancer Support Group
Peer Professional Support
Psycho -social supportive services for African American women within a peer professional led support group setting.
P.O. Box 3272
Long Beach, CA 90803
Support: (866) 542-6312

OCAPICA: Orange County Asian & Pacific Islander Community Alliance
Thai Women's Health Support
Provides referrals, linkages, outreach and education, and patient navigation services to Thai women in LA County to increase access and utilize breast cancer screening, diagnostic, and treatment services.
12900 Garden Grove Blvd., Suite 214A
Garden Grove, CA 92843
Advocacy/Navigation: (714) 636-9095

The Saban Free Clinic
Collaborative Diagnostic Breast Cancer Project
Underwrites breast health screening and diagnostic procedures for 300 low-income women under age 40 who do not qualify for publicly-funded cancer detection programs, as well as referral services.
8405 Beverly Blvd.
Los Angeles, CA 90048
Diagnostic Services: (323) 330-1663

Sheila R. Veloz Breast Imaging Center (Henry Mayo)
Imaging for Symptomatic Women and Men Under 40
Provides screening and diagnostic procedures for 150 uninsured and underinsured women and men who do not qualify for other programs.
23929 McBean Parkway, Suite 101
Valencia, CA 91355
Diagnostic Services: (661) 253-8824

Special Service for Group/Pals for Health
Project L.A.C.E.
Provides culturally sensitive and language specific outreach and education to women in SPAs 3,4,7 and 8; trains providers on culturally competent care and their legal language access obligations; and provides no-cost interpretation services to improve access to care.
605 W. Olympic Blvd., Suite 600
Los Angeles, CA 90015
Education/Advocacy: (213) 553-1818

Special Service for Groups/SAATH
Well Done Masi!
Aims to increase awareness of breast cancer among eligible South Asian women, age 40 and over in LA County. Using evidence-based techniques of motivational interviewing, 200 eligible women will be counseled to move along the stages of change towards screening.
605 W. Olympic Blvd., Suite 600
Los Angeles, CA 90015
Education/Advocacy: (213) 553-1875

St. Mary Medical Center
St. Mary Breast Cancer Support Program
Provides outreach, education, breast health screening and diagnostic exams for 200 low-income, uninsured women under 40, who do not qualify for other free or low-cost programs.1050 Linden Ave.
Long Beach, CA 90813
Diagnostic Services: (562) 491-9248

T.H.E. Clinic
The Clinic Cares for Health Awareness Program

Provides preventative breast health workshops, educational materials, and presentations at Town Hall Meetings to raise community awareness and increase opportunities for early diagnosis within the African American community, targeting 300 or more younger women ages 18-39.
3834 S. Western Ave.
Los Angeles, CA 90062
Education: (323) 730-1920 x3102

UCLA Jonsson Comprehensive Cancer Center/Olive View
Caring Through Access and Education
Provides access to general relief, education, and psychosocial support for low-income, uninsured patients who are undergoing breast cancer treatment. To augment these efforts, two 6-to-8 week health education series (in English & Spanish) will also be implemented.
14445 Olive View Drive, Rm 1D103
Box 951780
Sylmar, CA 91342
Education/Advocacy/Support: (818) 364-3562

USC Norris Comprehensive Cancer Center
Fortaleciendonos: Spanish Language Education and Support for Women with Hereditary Breast Cancer
Provides Spanish language educational and support outreach activities about hereditary breast cancer and necessary resources, including the development of a website, an educational DVD, and educational folders that can be used by the participants to educate their family, friends, medical staff, and others subsequently identified to have familial risk.
Medical Oncology Cancer Genetics
2020 Zonal Ave. IRD, Suite 408
Los Angeles, CA 90033
Education/Support: (323) 226-2289

Venice Family Clinic
Breast Cancer Screening and Detection Program
Provides breast health screening for 261 low-income, uninsured and homeless women under 40, and diagnostic services and case management for women with positive screening results for whom the Clinic has no other source of funding.
604 Rose Ave.
Venice, CA 90291
Diagnostic Services: (310) 664-7927 or (310) 664-7648

Worksite Wellness LA
Workplace Breast Cancer Education
Delivers breast health education directly to a minimum of 300 low-income, uninsured, mostly immigrant Latino workers at 16 small to medium jobsites.
5955 S. Western Ave.
Los Angeles, CA 90047
Education: (323) 758 -9480

YWCA of the Harbor and South Bay
Breast Cancer Early Detection and Support Services
Provides emotional support to Spanish and English speaking women diagnosed with breast cancer and breast cancer survivors as well as those who have abnormal results but have not yet been diagnosed. Increases breast cancer awareness among the Samoan, Filipino and Cambodian communities and provides patient navigation for those who do not know how to access the health system; particularly seniors.

437 W. 9th Street
San Pedro, CA 90731
Education/Advocacy/Support: (310) 547-0831

F. **Hill-Burton Facilities:** In 1946, Congress passed a law that gave hospitals, nursing homes, and other health care facilities grants and loans for construction and modernization. In return, these facilities agreed to provide a reasonable volume of services to persons unable to pay and to make their services available to all persons residing in the facility's area. In Los Angeles County, Hill-Burton facilities are available in the following cities: Los Angeles, San Fernando, Torrance, and West Hollywood.

Alta Med Health Services Corporation
500 Citadel Dr., Suite 490
Los Angeles, CA 90040

Alta Med Senior Health
5425 East Pomona Blvd.
Los Angeles, CA 90022
(213) 728-0411

California L.A. Gay & Lesbian Health Services Center
1625 North Schrader Blvd.
Los Angeles, CA 90028
(323) 464-1319

Los Angeles County & University of Southern California Medical Center
1300 North Mission Rd., Room 1112
Los Angeles, CA 90033

San Fernando Clinic
1600 San Fernando Rd.
San Fernando, CA 91340
(818) 365-8086

For up-to-date information on Hill-Burton facilities, please visit www.hrsa.gov, or call (800) 638-0742.

1) Note: Most hospitals to not disclose this payment option, so patients should be persistent to see if they are eligible.

Note: Other health care providers may offer free or reduced-cost care for persons meeting their programs' particular requirements. Individuals should check for providers that offer free or sliding-scale services in their areas. Individuals who have low incomes, have limited resources, and meet other eligibility requirements may also be eligible for government assistance with their medical expenses through Medi-Cal.

V. ADDITIONAL PROTECTIONS IN CALIFORNIA AND LOS ANGELES COUNTY

A. California has also provided health consumers with additional protections. For example, when individuals would like to receive care outside of their health insurance plans' network of providers, California has required insurance companies to pay for these services in some

circumstances. To find out about the health consumer protections available in California, contact the California Department of Managed Health Care, the California Department of Insurance or the CLRC.

1) **Access to Medical Records:** Individuals, or their representatives, are entitled to inspect their medical records under HIPAA, but many states also have statutes that limit what a health care provider can charge patients for copies of their medical files. In California, individuals must be granted access to view their medical records within five working days after making a written request for medical records, subject to payment of reasonable clerical costs. Patients are also entitled to copies of their medical records, to be sent within 15 days of the provider's receipt of a written request, subject to copying costs not over 25 cents per page plus reasonable clerical costs. Finally, providers may not withhold a patient's records for failure to settle an unpaid bill. For more information, contact the CLRC

2) **Clinical Trials:** California requires insurance companies to cover the routine costs of care while an individual is participating in a clinical trial. Medicare also covers routine care costs. Additionally, effective January 1, 2014, under the Patient Protection and Affordable Care Act (ACA), insurance companies may not deny or limit or impose additional conditions on "the coverage of routine patient costs for items and services furnished in connection with participation in the [clinical] trial."[55] For more information, about the ACA, see the Health Care Reform section of this manual.

   (i) **What is a clinical trial?:** A clinical trial is a research study in which people volunteer to test new treatments, drugs, or procedures. Researchers use clinical trials to learn whether a new treatment works and is safe for people. This research is needed to develop new treatments, and clinical trials often provide patients with access to the highest quality of cancer care and new treatments before they are widely available.

   (ii) **How are clinical trials conducted?:** Clinical trials are usually conducted in a series of four phases, or research testing steps.

   - Phase I: This is the first step in testing a new drug or procedure with people. Researchers test safe dosages and methods of delivery (ex: given orally or injected into a vein or muscle). The researchers carefully observe any side effects.
   - Phase II: These trials study both the safety and effectiveness of a treatment and evaluate how it affects your body. These studies are usually specific to one type of cancer, and often have less than one hundred patients.
   - Phase III: These trials compare the new treatment with the current standard treatment. Participants are randomly assigned to the new treatment group or to the standard treatment group. Random assignment helps to avoid bias and ensures that other factors do not affect study results.
   - Phase IV: These trials are useful in researching the long-term safety and overall effectiveness of treatment. These studies take place after a treatment has been approved for widespread use.

   (iii) **Who sponsors cancer clinical trials?:** These are a few examples of agencies and companies that sponsor cancer clinical trials:

[55] Public Law 111-148, 124 STAT. 893 §2709.

- National Cancer Institute
- National Institutes of Health
- Pharmaceutical & Biotechnology Companies
- U.S. Department of Defense
- U.S. Department of Veterans Affairs
- U.S. Food & Drug Administration

(iv) **What are the costs of participating in a clinical trial?:** Routine care costs are for care that is not dependent on a clinical trial and occurs when receiving standard treatment or participating in the study. Routine care costs can include lab tests, x-rays, blood work, and doctor visits. Costs that are typically not covered by health insurance include the drugs or procedures being tested in the clinical trial, items or services used solely for the data collection needs of the trial, and anything being provided for free by the clinical trial sponsor. Some health insurance plans will also not provide coverage for routine care costs, because they consider clinical trials to be "experimental" treatment.

- **Does California require insurance coverage for clinical trials?:** For more information on a California regulation of health insurance coverage for clinical trials, please contact the CLRC or the California Department of Insurance.
- Under California law,[56] unspecialized health insurance plans are required to cover the routine care costs associated with Phase I, II, III, and IV cancer clinical trials. Covered costs may include, but are not limited to, hospitalization, physician visits, X-rays, blood tests, CAT scans, and PET scans. In addition, some costs may be covered by the clinical trial sponsor, such as a pharmaceutical company.

  ⇒ **Clinical Trial Requirements:** To receive coverage under this law, the trial must:
  1. Involve a drug that is:
     a. Exempt under federal regulations from a new drug application, or
     b. Approved by the:
        i. National Institutes of Health,
        ii. U.S. Food and Drug Administration,
        iii. U.S. Department of Defense, or
        iv. U.S. Department of Veterans Affairs.
  2. Have a "therapeutic intent" for patients.
  3. Be recommended by the patient's physician.

  ⇒ Note: In many cases, the patient must get clinical trial care from a doctor or hospital within the state. However, health plans must pay for care at treatment centers outside the state if there is no provider in California taking part in the study.

(v) **Do Medicare and Medi-Cal cover clinical trials?:** Medicare Part B covers the routine costs of clinical trials.[57] For more information visit

[56] Cal. Health & Safety Code §1370.6.
[57] Medicare & You. Centers for Medicare & Medicaid Services (2011). www.medicare.gov/Publications/Pubs/pdf/10050.pdf.

www.cancer.gov/cancertopics/factsheet/support/medicare. Additionally, California covers clinical trials under Medi-Cal.[58] For more information, contact the California Medi-Cal program.

(vi) **What if an insurance company denies coverage for the clinical trial?:**

- Contact the health care provider team to see if it can assist the patient.
- Contact the insurance company to find out why it denied coverage.
- Go through the insurance internal appeals process.
- Contact the California Department of Managed Health Care to see if the patient is eligible for an external appeals process or independent medical review.
- Contact the CLRC for assistance.

(vii) **Patient Protection and Affordable Care Act (Public Law 111-148):** Also known as healthcare reform, this law was passed on March 23, 2010, and states that beginning in 2014, insurance companies will be required to cover the costs associated with routine care for individuals who are enrolled in a clinical trial to treat cancer or other life-threatening diseases.

3) **Second Medical Opinions:** In California, individuals have the right to a second medical opinion and to have it paid for by their health plans.[59] If they are in an HMO, the HMO may offer them a second opinion within their network. However, if there is not a second specialist in the network, the insurance company may have to pay for them to go out of network to receive the second opinion. Individuals are only responsible for any applicable co-payments. For more information, contact the CLRC.

4) **Oral Chemotherapy Legislation:** Currently, nine states (Hawaii, Iowa, Indiana, Oregon, Vermont, Colorado, Connecticut, Minnesota, and Kansas) and the District of Columbia have enacted statutes that require health insurance policies to cover oral chemotherapy at the same level as they would cover chemotherapy administered intravenously.[60] There are also several other states, including California, with similar pending legislation. For more information about legislation in a particular state, please contact the CLRC.

5) **Fertility Legislation:** As many as 90% of young cancer patients may be at risk of permanent infertility after undergoing treatment. Although insurance plans vary in the amount of infertility treatments they cover, currently, there are fourteen states, including California, that require insurance companies to cover some form of infertility diagnosis and treatment. For more information about specific laws, contact the California Department of Managed Health Care or visit www.asrm.org/insurance.aspx.

(i) **California Bill:** In February 2011, AB 428 was introduced in California. Enacted in April 2011, it requires health care service plans to cover medically necessary expenses for fertility preservation services when a necessary medical treatment

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[58] Chemotherapy: An Overview, Department of Health Care Services (2010). http://files.medi-cal.ca.govpublications/masters-mtp/part2/chemoanover_m01o03.doc.

[59] Cal. Health & Safety Code § 1383.15; *see also* Cal. Ins. Code § 10123.68 (applies to disability insurers).

[60] Haw. Rev. Stat. § 431:10A-126; Iowa Code § 514C.24; Ind. Code § 27-8-32-5; Or. Rev. Stat. § 743A.068; Vt. Stat. Ann. tit. 8, § 4100h; Colo. Rev. Stat. § 10-16-104; Conn. Gen. Stat. § 38a-504; Minn. Stat. § 62A.3075; Kan. Stat. Ann. § 40-2,184 (applies to policies issued for delivery, amended, or renewed on and after July 1, 2011); D.C. Code § 31-2995.02.

(e.g., radiation, chemotherapy, or surgical removal of reproductive organs) may cause iatrogenic infertility.

RESOURCES

For all PPO insurance questions: California Department of Insurance 300 South Spring Street Los Angeles, CA 90013 (213) 897-8921 or (800) 927-4357 www.insurance.ca.gov **For all HMO, Blue Cross, or Blue Shield insurance questions:** California Dept. of Managed Health Care (DMHC) California HMO Help Center 980 Ninth Street, Suite 500 Sacramento, CA 95814-2725 (888) 466-2219 or www.hmohelp.ca.gov	**For COBRA questions:** U.S. Department of Labor Employee Benefits Security Administration (866) 444-3272 or www.dol.gov/ebsa 1055 E. Colorado Blvd., Suite 200 Pasadena, CA 91106 (626) 229-1000 or (866) 444-3272 (Southern CA)
For HIPP questions: Department of Health Services – Health Insurance Premium Payment (HIPP) Program (866) 298-8443 www.dhcs.ca.gov/formsandpubs/forms/Documents/CobraEnglish.pdf **For a HIPP application:** www.dhcs.ca.gov/services/Documents/HIPP%20Application%20(DHCS%206172)%20ENG%20(1.09).pdf	**For HIPAA questions:** California Department of Managed Health Care (DMHC) (888) 466-2219 www.dmhc.ca.gov/coverage/conversion/hp_default.aspx
For high risk insurance questions: California Major Risk Medical Insurance Program (MRMIP) (916) 324-4695 or www.mrmib.ca.gov • Lifetime Cap: $750,000 • Waiting Period as of 11/10: 3 months • Average Monthly Cost: Varies by location, age, and plan. • Multiple Plans: Yes **For a MRMIP application:** www.pcip.ca.gov/Publications/MRMIP_App.pdf	Federal Pre-Existing Condition Insurance Plan (PCIP) California Managed Risk Medical Insurance Board (877) 428-5060 or www.mrmib.ca.gov • Lifetime Cap: None • Average Monthly Cost: Varies **For a PCIP Supplemental application:** www.pcip.ca.gov/Publications/PCIP_Supplemental_Application.pdf
For assistance with Medicare: Center for Medicare & Medicaid Services (CMS) (800) 633-4227 or www.medicare.gov **To find and compare Medicare**	**For assistance with Medicare and Medi-Cal:** State Health Insurance Assistance Program California Health Advocates (800) 434-0222 www.cahealthadvocates.org

Prescription Drug Plans in your area: www.medicare.gov/find-a-plan/questions/home.aspx	Center for Health Care Rights Sandy Risdon 520 S. Lafayette Park Place, Ste. 214 Los Angeles, California 90057 (213) 383-4519 (800) 824-0780
For assistance with Medi-Cal: Center for Medicare & Medicaid Services (CMS) (800) 633-4227 or www.cms.gov Department of Health Care Services (916) 552-9200 www.medi-cal.ca.gov	**For information about how to apply for Medi-Cal in Los Angeles:** Department of Public Social Services http://dpss.lacounty.gov/dpss/maps/default.cfm Belvedere 5445 Whittier Blvd. Los Angeles, CA 90022 (323) 727-4314 Participant Help Line: (323) 727-4542 or (323) 727-4541 Civic Center 813 E. Fourth Place Los Angeles, CA 90013 (213) 974-0201 Participant Help Line: (213) 974-4301 Compton 211 E. Alondra Blvd. Compton, CA 90220 (310) 603-8698 Participant Help Line: (866) 613-3777 Cudahy 8130 S. Atlantic Ave. Cudahy, CA 90201 (323) 560-5001 Participant Help Line: (323) 560-5192 East Valley 14545 Lanark St. Panorama City, CA 91402 (818) 901-4101 Participant Help Line: (818) 901-4228 or (818) 901-4293 El Monte 3350 Aerojet Ave. El Monte, CA 91731 (626) 569-3677 Participant Help Line: (866) 613-3777 Exposition Park 3833 S. Vermont Ave.

	Los Angeles, CA 90037 (323) 730-6148 Participant Help Line: (323) 730-6188 Florence 1740 E. Gage Ave. Los Angeles, CA 90001 (323) 586-7001 Participant Help Line: (323) 586-6176 Glendale 4680 San Fernando Rd. Glendale, CA 91204 (818) 546-6100 Participant Help Line: (818) 546-6200 Hawthorne 12000 S. Hawthorne Blvd. Hawthorne, CA 90250 (310) 349-5880 Participant Help Line: (800) 834-9408 Lancaster 349-B East Ave. K-6 Lancaster, CA 93535 (661) 723-4021 Participant Help Line: (661) 951-3450 Lincoln Heights 4077 N. Mission Rd. Los Angeles, CA 90032 (323) 342-8142 Participant Help Line: (323) 342-8143 Metro East 2855 E. Olympic Blvd. Los Angeles, CA 90023 (323) 260-3501 Participant Help Line: (323) 260-3718 Metro Family 2615 S. Grand Ave. Los Angeles, CA 90007 (213) 744-6601 Participant Help Line: (213) 744-3627 Metro North 2601 Wilshire Blvd. Los Angeles, CA 90057 (213) 639-5455 Participant Help Line: (213) 639-5491

	Metro Special 2707 S. Grand Ave. Los Angeles, CA 90007 (866) 613-3777 Participant Help Line (310) 258-7400 or (626) 569-1399 Northridge 9451 Corbin Ave. Northridge, CA 91324 (818) 717-2101 Participant Help Line: (818) 717-2101 or (800) 901-4088 Norwalk 12727 Norwalk Blvd. Norwalk, CA 90650 (562) 807-7820 Participant Help Line: (562) 807-7840 Paramount 2961 E. Victoria St. Rancho Dominguez, CA 90221 (310) 603-5000 Participant Help Line: (310) 603-5250 or (310) 603-5100 Pasadena 955 N. Lake Ave. Pasadena, CA 91104 (626) 791-6302 Participant Help Line: (626) 791-6730 or (626) 791-6333 Pomona 2040 W. Holt Ave. Pomona, CA 91768 (909) 397-7901 Participant Help Line: (909) 868-6499 Rancho Park 11110 W. Pico Blvd. Los Angeles, CA 90064 (310) 481-3115 Participant Help Line: (310) 481-5378 San Gabriel Valley 3352 Aerojet Ave. El Monte, CA 91731 (626) 569-3611 or (866) 613-3777 Santa Clarita

	Canyon Country, CA 91351 (661) 298-3387 Participant Help Line: (661) 298-3402 South Central 10728 S. Central Ave. Los Angeles, CA 90059 (323) 563-4156 Participant Help Line: (323) 563-4601 South Family 17600 A Santa Fe Ave. Rancho Dominguez, CA 90221 (310) 761-2000 Participant Help Line: (866) 613-3777 Southwest Family 8300 S. Vermont Ave. Los Angeles, CA 90044 (323) 549-5674 Participant Help Line: (323) 549-7655 or (323) 549-7655 Southwest Special 1819 W. 120th St. Los Angeles, CA 90047-5102 (323) 420-2918 Participant Help Line: (323) 420-2833 West Valley 21415-21615 Plummer St. Chatsworth, CA 91311 (818) 718-5000 Participant Help Line: (818) 718-5228 Wilshire 2415 W. 6th St. Los Angeles, CA 90057 (213) 738-4311 Participant Help Line: (213) 738-4290
For Improving Access, Counseling and Treatment for Californians with Prostate Cancer (IMPACT) questions: IMPACT Program P.O. Box 957180 Los Angeles, CA 90095 (800) 409-8252 www.california-impact.org	**For Breast and Cervical Cancer Treatment Program (BCCTP) questions:** (800) 824-0088 www.dhcs.ca.gov/services/medi-cal/Pages/BCCTP.aspx **Medically Indigent Adult Program Questions:** Los Angeles County Department of Health Services 313 N. Figueroa St.

	Los Angeles, CA 90012 (800) 427-8700
For Family Planning Access, Care, and Treatment (Family PACT) questions or to find a provider in your area: (800) 942-1054 http://www.familypact.org/en/Home/ProviderSearch (there are over 100 in Los Angeles County; enter your zip code or call the number provided to find the one nearest to you)	**For possible legal and advocacy assistance:** California Women's Law Center 5670 Wilshire Blvd., Suite 460 Los Angeles, CA 90036 (323) 951-1041 http://www.cwlc.org Los Angeles Gay & Lesbian Center 1625 North Schrader Blvd. Los Angeles, CA 90028 (323) 993-7400 http://laglc.convio.net Asian Pacific American Legal Center of Southern California 1145 Wilshire Blvd, 2nd Floor Los Angeles, CA 90017 (213) 977-7500 www.apalc.org/ Bet Tzedek Legal Services 145 S. Fairfax Avenue, Suite 200 Los Angeles, CA 90036 (323) 939-0506 www.bettzedek.org Bet Tzedek Legal Services 12821 Victory Blvd. North Hollywood, CA 91606 (818) 769-0136 www.bettzedek.org Bet Tzedek Legal Services 3435 Wilshire Boulevard, Suite 470 Los Angeles, CA 90010 (213) 384-3243 www.bettzedek.org Legal Aid Foundation of Los Angeles 1102 Crenshaw Blvd. Los Angeles, CA 90019 (323) 801-7989 or (800) 399-4529 www.lafla.org *Gov't benefits, CalWorks, SS, SSI, Medicaid* (323) 801-7989 press 2 Legal Aid Foundation of Los Angeles 5228 Whittier Blvd.

	Los Angeles, CA 90022 (213) 640-3883 or (800) 399-4529 www.lafla.org Legal Aid Foundation of Los Angeles 1640 5th Street, Suite 124 Santa Monica, CA 90401 (310) 899-6200 www.lafla.org Legal Aid Foundation of Los Angeles 70000 S. Broadway Los Angeles, CA 90003 (213) 640-3950 www.lafla.org Legal Aid Foundation of Long Beach 601 Pacific Avenue Long Beach, CA 90802 (562) 435-3501 www.lafla.org Neighborhood Legal Services of LA County/Family Law Center of San Fernando Valley 13327 Van Nuys Blvd. Pacoima, CA 91331-3099 (800) 433-6251 Health Consumer Center: (800) 834-3203 http://www.nls-la.org Public Counsel 610 South Ardmore Ave. Los Angeles, CA 90005 (213) 385-2977 http://www.publiccounsel.org/ Community Legal Services 725 West Rosecrans Avenue Compton, CA 90222 (800)-834-5001 or (714)-571-5200 http://www.legal-aid.com Community Legal Services 11834 East Firestone Blvd. Norwalk, CA 90650 (800)-834-5001 or (714)-571-5200 http://www.legal-aid.com

HEALTH CARE REFORM

INTRODUCTION:
On March 23, 2010, the Patient Protection and Affordable Care Act (Public Law 111-148) was signed into law, making some significant changes to the health care system in the United States. One week later, the Patient Protection and Affordable Care Act was modified by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152). These two bills together are commonly referred to as t he Affordable Care Act or the ACA. Changes made by this law will occur gradually from 2010 to 2020, with the biggest changes to be implemented in 2014.

As with all legislation, some details of these changes will remain undetermined until: 1) federal agencies, such as the U.S. Department of Health and Human Services (HHS) release federal regulations (e.g., official rules); 2) states pass laws to implement certain provisions; and 3) insurance companies and employers re-write their policies to comply with the ACA. Furthermore, some states[61] have filed lawsuits in federal court, charging that Congress was overstepping its right to regulate commerce under Article 1 of the U.S. Constitution and that the ACA is a violation of the Tenth Amendment. The outcome of that litigation, any changes in the members of Congress or the presidency, and the actions of insurance companies, employers, and government agencies may change how the ACA is implemented over the next few weeks, months, and years.

I. WHICH POLICIES MUST COMPLY WITH THE ACA

A. How to figure out if the ACA applies: Different types of policies have to comply with certain provisions of the ACA at different times. In order to figure out which reforms apply to a particular health insurance plan, we must first look at when the plan was issued, and second, we must find out if the employer-sponsored health plan is self-insured (aka self-funded) or insured (aka fully funded).

i. Date the policy was issued:

1. **Policies issued prior to March 23, 2010**: These policies are considered "grandfathered plans," meaning that they do not have to comply with many of the reforms discussed below. Plans may retain their grandfathered status indefinitely, so long as they do not make substantial changes to the plan.
    - **a.** Plans will lose grandfathered status if they:
        - **i.** Significantly cut or reduce benefits;
        - **ii.** Raise co-insurance or co-payment changes;
        - **iii.** Significantly raise deductibles;
        - **iv.** Lower employer contributions;
        - **v.** Add or tighten annual limits; or
        - **vi.** Change insurance companies.

2. **Policies issued on or after September 23, 2010**: These policies must immediately comply with many of the reforms discussed below.

[61] As of January 22, 2011, the following states are involved in litigation: Alabama, Alaska, Arizona, Colorado, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Nebraska, Nevada, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Virginia, Washington, Wisconsin, and Wyoming.

ii. **Self-Insured vs. Insured Health Plans:** Employer-sponsored health plans are plans where employees and their dependants enroll in a health plan through work, and the employer generally pays a portion of all of the cost of coverage. Compare this to an individually purchased plan, which is health insurance that is purchased directly from an insurance company and the individual purchasing the policy pays the entire premium.

1. There are two types of employer-sponsored health plans:
    a. Self-Insured Plan: Employers provide health care coverage by directly paying for employee's health care.
    b. Insured Plan: Employers contract with insurance companies to provide employees with health care coverage.

2. It is sometimes difficult for employees to know whether their employer-sponsored plan is insured or self-insured, because employers often contract with third parties to administer their self-funded plan. Those third parties are often insurance companies. Sometimes these third parties are called Administrative Service Organizations (ASO). Because some of the reforms in the ACA do not apply to self-insured plans, it is important to find out what type of plan a person holds. To find out whether their employer-sponsored plan is self-insured or not, employees should ask the person who administers the employee benefits at work (i.e., an HR representative).

II. THE PORTAL

A. **Statute:** The ACA required HHS to create a website portal to provide consumers with information about the ACA and health insurance options at the federal and state level. By answering a few basic questions, individuals can obtain information on the health insurance options available to them based on their specific situations. The Portal went live on July 1, 2010, and is available in both English (www.healthcare.gov) and Spanish (www.CuidadoDeSalud.gov).

B. **Available Information:** Although the Portal will continue to evolve over time, it now includes detailed information about the provisions in the ACA, pricing information on insurance options available to individuals and small businesses, and state-specific information on:
   1) Individual health coverage offered by insurance companies;
   2) Medicaid coverage;
   3) Children's Health Insurance Program (CHIP) coverage;
   4) State high risk pool coverage;
   5) Federal Pre-Existing Condition Insurance Plan options; and
   6) Coverage options for small businesses and their employees.

C. **California Website:** California launched its own website at www.healthcare.ca.gov. This site provides information on the ways in which California has implemented the new federal health care law as well as information on how it will continue to implement it in the future. It also provides links to information about California's current health care options, protections, and resources in addition to those that will be available in the future as a result of recent health care reform efforts.

III. HEALTH INSURANCE REFORMS

a. Lifetime and Annual Limits: Previously, insurance companies had the ability to establish lifetime and annual caps that limit the total dollars in benefits paid out per year or over the lifetime of an enrollee. The annual limits could be as low as $50,000. People whose claims exceeded health plan limits were forced to find other ways to pay for their medical costs. The ACA will eventually eliminate lifetime and annual limits on all insurance plans.

i. Lifetime Limits: As of September 23, 2010, insurance companies may no longer impose lifetime limits on "essential health benefits."

1. Essential Health Benefits include:

- Ambulatory
- Emergency
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse
- Prescriptions
- Rehabilitative services and devices
- Lab services
- Preventive and wellness services and chronic diseases management
- Pediatrics[62]

(i) HHS has decided to allow states to determine what else would be included in an essential health benefits package for their residents, by selecting an existing health plan as the "benchmark." States may choose a benchmark plan from:

- One of the three largest small group plans in the state;
- One of the three largest state employee health plans;
- One of the three largest federal employee health plan options; or

[62] ACA § 1302, adding 42 USCS 18022.

- The largest HMO plan offered in the state's commercial market.

Although states would have the option to change the benefits package from the one they selected, they cannot reduce the value of benefits.[63]

1. Applies To:
   - Grandfathered Plans: Yes
   - Self-Insured Plans: Yes

ii. Annual Limits: As of September 23, 2010, insurance companies may only impose annual limits on essential health benefits. If insurance companies do impose these annual limits, they must comply with the minimum limits for all employer-sponsored plans and all new individual market plans.

1. Minimum Annual Limits:
   - September 23, 2010: $750,000
   - September 23, 2011: $1.25 million
   - September 23, 2012: $2 million[64]

2. Exceptions: Restrictions on annual limits do not apply to Flexible Spending Accounts (FSA), Medical Savings Accounts (MSA), or Health Savings Accounts (HAS).

3. Elimination of Annual Limits: On January 1, 2014, insurance companies will no longer be permitted to impose annual limits on the total dollars in benefits paid out to a beneficiary per year.

4. Applies to:
   a. Grandfathered Plans:
      i. Group: Yes
      ii. Individual: No
   b. Self-Insured Plans: Yes

b. Rescissions: Previously, some insurance companies would review an individual's original insurance application to look for any mistakes or omissions, intentional or not, and then retroactively cancel (rescind) the individual's policy if the individual became ill, leaving the individual uninsured.

i. As of September 23, 2010, an insurer may not rescind an individual's policy as long as the premiums are being paid, <u>unless</u> the individual:
   1. Commits fraud; or
   2. Makes an intentional misrepresentation of a material fact (i.e., lied) on the application.[65]

ii. Applies to:
   1. Grandfathered Plans: Yes
   2. Self-Insured Plans: Yes

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[63] HHS Essential Health Benefits Bulletin http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.
[64] HealthReform.gov. "Fact Sheet: The Affordable Care Act's New Patient's Bill of Rights." www.healthreform.gov/newsroom/new_patients_bill_of_rights.html.
[65] ACA § 2712, amending 42 USC 300gg-12.

iii. **California Implementation:** Through AB 2470, California implemented this new federal standard and improved upon the federal law by requiring insurers to continue coverage pending the determination of rescission and to send notice of any cancelation to the insured at least 30 days prior to the effective date of the cancelation. It was signed into law in California on September 30, 2010.

c. **Preventive Care:** For insurance policies issued on or after September 23, 2010, health insurance plans must cover preventive services.[66]

i. A complete list of preventive services can be found at: www.healthcare.gov/law/about/provisions/services/lists.html
   1. Examples:
      a. Covered Preventive Services for Adults
         i. BRCA counseling about genetic testing for women at higher risk
         ii. Breast cancer mammography screenings every 1-2 years for women over 40
         iii. Breast cancer chemoprevention counseling for women at higher risk
         iv. Cervical cancer screening for sexually active women

ii. Deductibles and Co-Payments: If the individual uses an in-network provider to receive preventive services, those services will be exempt from deductibles and co-payments.

iii. Applies to:
   1. Grandfathered Plans: No
   2. Self-Insured Plans: Yes

iv. **California Implementation:** Through AB 2345, California law requires health plans and insurers to cover preventive services without co-pays or deductibles. It was signed by the governor on September 30, 2010 and is effective for contracts and policies issued, amended, renewed, or delivered on or after September 23, 2010.

d. **Cancer Clinical Trials:** As of January 1, 2014, all group health plans or group or individual health insurance policies:

i. May not deny an individual's participation in a clinical trial;

ii. May require the individual to use a participating provider in the network, if the provider will accept the individual;

iii. Allow an individual to participate in a clinical trial out of state, unless there is a doctor in his or her network participating in the clinical trial in state and that doctor will accept the individual; and

iv. May not deny, limit, or impose additional conditions on "the coverage of routine patient costs for items and services furnished in connection with participation in the trials."

[66] ACA § 1001, amending PHSA §2712.

1. Routine patient costs do not include:

- Investigational item device or services
- Items and services provided solely to satisfy data collection and analysis needs and are not used in direct clinical management of the patient

v. May not discriminate against the individual for participating in the clinical trial.

vi. **California Implementation:** California law currently requires unspecialized health insurance plans to cover the routine care costs associated with Phase I, II, III, and IV cancer clinical trials.

e. **California Denial of Coverage and Premium Rates:** On September 30, 2010, the governor signed SB 1163, which requires that:

i. Individuals who are denied health insurance coverage or enrollment, or offered coverage at a rate higher than the standard rate, be provided with the specific reason(s) for that decision in writing, in clear, easily understandable language

ii. Notice be given of a change to the premium rate of coverage at least 60 days prior to the effective date of the change

iii. Rate information be filed with the Department of Managed Health Care or the Department of Insurance and that such information be certified by an independent actuary and made available to the public

California Medical-Loss Ratio: In January 2011, California Insurance Commissioner, Dave Jones, announced that California health insurers in the individual market must spend at least 80% of their revenue on medical claims. This means that 80% of premiums must be spent on patient care, rather than administrative costs. This is a change from the 70% that was previously required and aligns California with rules contained in the ACA.

IV. HEALTH INSURANCE COVERAGE OPTIONS

A. Please refer to the chapter on Health Insurance & Health Care Options for more information about current options.

B. **ACA Expansion of Coverage for Children and Young Adults:**[67] Most people who attend college graduate by the age of 23. This typically means that they lose their full time student status and are no longer eligible for health insurance coverage through their parent's health insurance plan. Finding a job after graduation that offers health insurance can be very difficult. Under the ACA, young adults have access to health insurance coverage through their parent's health insurance policy longer than they would have previously.

1) **As of September 23, 2010:** Children may remain covered under their parent's plan until they reach the age of 26 years old.

(i) **Requirements:** Children cannot be eligible for employer-sponsored health insurance offered through their own jobs.

[67] §1201 of P.L. 111-148 (new PHSA §2704), as amended by § 2301 of P.L. 111-152.

(ii) **Note:** The "child" does not need to be claimed as a dependant under IRS standards. Also, the child can be married; however, the plan's coverage will not extend to the child's children or spouse.

2) **Implementation Timeline:** Although this provision went into effect on September 23, 2010, the implementation time is up to the employer.

(i) Private employers have the option to implement this provision:

- Immediately after March 23, 2010 (early implementation)
- Immediately after September 23, 2010 (when the provision went into effect)
- At the beginning of the next plan year after September 23, 2010 (e.g., when the parent's plan is renewed). Therefore, the latest possible implementation date is September 22, 2011.

(ii) Plans must give written notice of the option to enroll children on the employee's plan by the first day of the plan year, and coverage for the dependant must start the first day of the plan year.

(iii) If parents are not enrolled through their employers, they will be given a one-time option to enroll (or change plans) for both themselves and their dependents.

3) Applies to:
(i) Grandfathered Plans: Yes
(ii) Self-Insured Plans: Yes

4) **California Implementation:** Through SB 1088, California law prohibits health plans and insurers from limiting the age of dependent children covered by their parents' health insurance policy to an age less than 26 years old. This bill was signed into law on September 30, 2010, and is effective for plan or policy years beginning on or after September 23, 2010.

C. **Pre-Existing Condition Insurance Plans**[68]

1) For background information on high risk insurance pools see the Health Insurance & Health Care Options chapter.

2) If an individual currently has a pre-existing medical condition, and is over the age of 19, then he or she may not be able to purchase individual health insurance. Until the ACA protections for adults with pre-existing conditions are fully implemented in 2014, the federal government has provided high risk insurance plans to individuals with pre-existing conditions, which will remain in existence until 2014, when new options will be available.

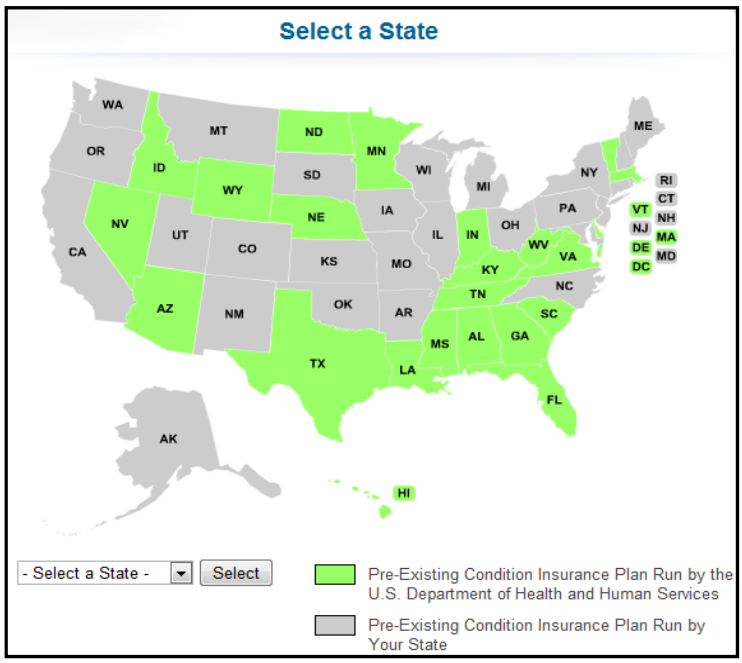
(i) The ACA requires all states to have a Pre-Existing Condition Insurance Plan (PCIP). Some states opted to run their own plans, funded by the federal government, and some states chose to have the federal government administer their states' plans.

(ii) States began collecting applications for the PCIP plans on July 1, 2010. As of January 2012, all states are still accepting applications.

[68] ACA §1101, adding 42 USC 18001.

(iii) Eligibility:

- U.S. citizens or persons who are lawfully present;
- Who have a pre-existing illness or condition; and
- Who have had no creditable coverage for 6 months or more



(iv) Maximum Out-of-Pocket Costs (excluding premiums):

- Individuals: $5,950
- Families: $11,900

(v) Premiums: Monthly premiums for the PCIP plans will vary from state to state and by county. For example, Los Angeles County in 2011:

Age	**0-34**	**35-44**	**45-54**	**55+**
California (Los Angeles County)	$110-$218	$244-$269	$306-$381	$455-$494

(vi) For more information on PCIP plans available in California, go to http://www.pcip.ca.gov, or contact the CLRC.

(vii) **California Implementation:** Though SB 227 and AB 1877, California became the first state to create a PCIP plan. This law created a temporary high-risk pool to provide health insurance coverage to specified individuals whose health conditions make it difficult or impossible to otherwise purchase health insurance (does not include dependent coverage). The bill was signed into law and became effective on June 29, 2010. It expires December 31, 2013, as the state health insurance exchanges will begin on January 1, 2014.

- Eligibility: To be eligible for California's PCIP, an individual must:
  - ⇒ Be a California resident;
  - ⇒ Be a U.S. citizen, U.S. national, or person who is lawfully present;
  - ⇒ Have a pre-existing condition;
  - ⇒ Have had no creditable coverage for six months or more;
  - ⇒ Not be enrolled in Medicare Part A and Part B, COBRA, or Cal-COBRA; and
  - ⇒ Have a Social Security number.
- Premiums: The premium that a California PCIP Subscriber pays depends on his or her age and region. To view a chart of 2011 premium rates, visit http://www.pcip.ca.gov/Publications/PCIP_MRMIB_Handbook.pdf.

- For more information on PCIP plans available in California, visit www.pcip.ca.gov.

D. **Health Insurance Exchanges:** The PCIP plans established by the ACA will only last until July 1, 2014. After this date, individuals will have the option to purchase health insurance through the health insurance exchanges. The actual details of health insurance exchanges will vary state to state, but generally, they are supposed to provide an easier way for people to research options and obtain health insurance. States are required to have a baseline plan for their exchange by January 1, 2013. Some states, such as California, have already passed legislation to implement their state health insurance exchange.

1) Generally, the exchanges will provide:
   (i) A standardized format for presenting plan options;
   (ii) An internet portal for search, selection, purchase, and enrollment;
   (iii) A toll-free telephone hotline to call for assistance;
   (iv) A calculator to determine the actual cost of coverage for each plan option.

2) Five Plan Options in the Health Insurance Exchanges
   (i) Bronze
   - Represents the minimum creditable coverage
   - Provides the essential health benefits
   - Covers 60% of the benefit costs of the plan

   (ii) Silver
   - Provides the essential health benefits
   - Covers 70% of the benefit costs of the plan

   (iii) Gold
   - Provides the essential health benefits
   - Covers 80% of the benefit costs of the plan

   (iv) Platinum
   - Provides essential health benefits
   - Covers 90% of the benefit costs of the plan

   (v) Catastrophic Plan
   - Provides catastrophic coverage to people up to age 30; or
   - Those who are exempt from the individual mandate (e.g., religious objections)
   - This plan will only be available in the individual market

3) Implementation Timeline:
   (i) 2014: Exchanges will be open to individuals and small businesses (50 and fewer employees).
   (ii) 2017: States may allow employers with up to 100 employees to participate in exchange.

4) **California Implementation:** Though SB 900 and AB 1602, California became the first state to create a health benefit exchange. The California Health Benefit Exchange ("the Exchange") will make health plans available to qualified individuals and small businesses at competitive prices. Purchases will be facilitated by the California Health Benefit Advisers (CAHBA). This law also authorizes appointment of a five-member governing board and specified the powers and duties of such board (e.g., determining eligibility for enrollment in the Exchange and arranging for coverage under qualified

health plans). It was signed into law on September 30, 2010, and will be effective on January 1, 2014. For additional and up to date information on the California Health Benefit Exchange, visit: http://www.healthexchange.ca.gov/Pages/Default.aspx.

E. **Individual Mandates:** As of January 1, 2014, the ACA requires all US citizens and legal residents to have health insurance or pay a penalty.[69]

1) Exceptions:
   (i) A break in coverage of less than 3 months;
   (ii) Religious objections; and
   (iii) Financial hardship (i.e., the required contribution to pay premiums would exceed 8% of household income).

2) Penalties for Non-Compliance: Those who choose not to buy health insurance will have to pay a penalty on their taxes. The amount of the penalty increases each year:
   (i) 2014: ~$95
   (ii) 2015: ~$325
   (iii) 2016: ~$695
   (iv) 2017: The penalty will be adjusted for inflation, but can never cost more than the national average cost of a bronze plan.[70]

F. **Early Retiree Reinsurance Program:** The ACA gives employers a way to recoup some expenses for providing insurance to certain retirees. These are individuals who retire before the age of 65 and are not yet eligible for Medicare.

This program allows approved companies to use federal funds to lower premiums for employees and other health care cost relief to their retirees and workers and their families, to offset increases in their own health care premiums or costs, or for combination of these purposes. This plan will reimburse employers or insurers for 80% of retiree claims between $15,000 and $90,000. This program will run until January 1, 2014, when the health insurance exchanges begin.
For more information, visit www.errp.gov.

IV. RESOURCES

For information about the ACA: www.HealthCare.gov **For information about the ACA in CA:** www.HealthCare.CA.gov	**For information on the federal Pre-Existing Condition Plan options available in each state:** www.pcip.gov
For information on the California Health Benefit Exchange: California Health Benefit Advisers www.californiahealthbenefitexchange.com	**For information on the California Pre-Existing Condition Plan:** www.pcip.ca.gov
For information on CA programs related to the Medicaid Section 1115 Waiver: Department of Health Care Services (916) 552-9200 or www.medi-cal.ca.gov	**Kaiser Family Foundation Video, "Healthcare Reform Hits Main Street:"** healthreform.kff.org/the-animation.aspx

[69] ACA §§ 1501, 1502, and 10106, adding §§ 5000A and 6055 to the Internal Revenue Code; § 1002 of Reconciliation Bill.
[70] IRC § 5000A(c)(3).

GENETICS AND CANCER

INTRODUCTION:
Genetics is a topic of concern for many cancer survivors, people coping with genetic risk, and their relatives. It can be important to learn about risk factors for cancer so that individuals can have control over and be proactive about their health. Understanding individual risk factors, family history, or genetic predisposition for cancer lets individuals take charge of their health through potential preventive measures and early detection.

This can be very empowering, but it can also be scary, raise many questions, and pose some legal concerns. Several issues can arise from genetic information in the employment and insurance realms. For example, may an employer use genetic information to discriminate against a potential employee or current employee? Or, may an insurance company use genetic information to determine whether or not to insure someone, increase premiums, or impose a pre-existing condition exclusion period?

You may be asking yourself why an insurance company or employer would want to treat an individual differently based on their genetics. Imagine a young woman named Lucy. She has a family history of breast cancer. First, she applies for health insurance. Because her health insurance company wants to maximize profits, they could be motivated to see what risks they are taking on if they were to insure Lucy. By knowing Lucy's family medical history, they may decide that Lucy may cost the company more money in the future, because she is more likely to get cancer than the average person her age. Second, Lucy applies to work at a small business. The company may want to learn about Lucy's family medical history to see if she may cost them more in insurance premiums or if she is more likely to take time off work in the future. But, can these two companies legally access Lucy's family history or use this information against her? To address these questions and concerns, this chapter will cover the basics of genetic testing and the laws that protect people against genetic discrimination.

I. UNDERSTANDING GENETICS

Scientists estimate that approximately 5% of all cancers are strongly hereditary.[71] In these cases, a gene mutation that is associated with an increased risk of cancer passes from one generation to another. The abnormal gene is not cancer itself, nor is it a guarantee that an individual will develop cancer. It is a gene abnormality, whose presence puts an individual at a higher risk for getting cancer. This increased risk is called a genetic predisposition. Although many types of cancer can run in the family, the most common of these are breast, ovarian, prostate, and colon cancer.

A. Risk Factors for Hereditary Cancer

1) **Introduction:** There are many factors that are common indicators of hereditary cancer. These include:

   (i) Multiple cases of a type of cancer within a family (e.g., if a patient's aunt and grandmother on one side of the family both had breast cancer, it could indicate that hereditary breast cancer runs in the family);

   (ii) Family members with cancer occurring at younger than average ages for that cancer (e.g. the average age of a prostate cancer diagnosis is 70 years old,

[71] American Cancer Society, *Cancer Facts and Figures 2010, page 1*.

however, if a patient is diagnosed with prostate cancer at 50, this could be an indicator that the cancer is hereditary);

(iii) Family members with cancer not commonly associated with that sex (e.g., a male patient with breast cancer is more an indication of hereditary cancer);

(iv) Family members with multiple primary tumors in the same organ or bilateral primary tumors in paired organs (e.g., a patient has multiple tumors within one organ that are not caused by the original tumor spreading or the patient has had primary tumors in paired organs such as tumors in both breasts or both kidneys).

2) Note: when examining a patient's family history of cancer, it is important to look at each side of the family separately, since the gene for increased risk for cancer can come from either a patient's mother's or father's side. Do not forget to consider both sides of the family for all types of cancer. For example, a woman can inherit a predisposition for breast cancer from either her mother's or her father's side of the family.

II. GENETIC TESTING

A. **Introduction:** For some cancers there are genetic tests available to determine whether an individual has inherited the altered gene that is associated with the increased risk for cancer. Genetic tests are laboratory tests that examine an individual's DNA to identify any changes in chromosomes, genes, or proteins. In some circumstances, the test can find alterations that are associated with an increased risk of cancer. For example, the BRCA1 and BRCA2 genetic tests are available to test for genetic predispositions for breast and ovarian cancer. Additionally, there are genetic tests available to test for genetic predispositions for colon cancer, such as the test for hereditary non-polyposis colorectal cancer (HNPCC).

1) Note: To learn more about any risks associated with an individual's family history and the genetic tests that may be available, speak to a health care provider or consider communicating with a certified genetic counselor.

B. **Costs of Genetic Testing:** The cost of genetic testing can range from under $100 to more than $3,000, depending on the nature and complexity of the test. The costs increase if more than one test is necessary or if multiple family members are tested to obtain a meaningful result. Additionally, the length of time it takes to receive results can range from a few weeks to several months. The doctor or genetic counselor who orders a particular test can provide specific information about the cost and time frame associated with that test.

1) Does insurance pay for genetic testing?

(i) Every insurance policy is different in their coverage. Some private insurers cover genetic testing, but others do not. Additionally, some insurers will cover some genetic tests, but not others. Individuals should check with their insurance company for more information.

(ii) Some state Medicaid programs also cover genetic testing. For example, 17 states currently offer coverage for a genetic test for breast and ovarian cancer. These states are Alaska, Arizona, Colorado, Connecticut, Illinois, Indiana, Iowa, Missouri, New Jersey, New York, New Mexico, Ohio, Oregon, Texas, Utah, Virginia, and Washington.[72] California is not included.

[72] Financial Help. FORCE: Facing Our Risk of Cancer Empowered. www.facingourrisk.org/info_research/finding-health-care/financial-help/index.php.

C. **Positive Results:** In general, positive results indicate that the test has found a genetic alteration. This does not mean that a patient has cancer or that the patient will definitely develop cancer. A positive test result indicates that the patient is at a higher risk of developing cancer at some point in time. A negative result indicates that the test could not find a genetic alteration. This does not mean however that a patient's risk for developing that type of cancer is eliminated. In some situations this may be an inconclusive result, depending on whether a mutation has previously been identified in the patient's family. In other situations, this means that a patient's risk of developing cancer is the same as the risk for the general population.

1) **Managing Cancer Risks:** Knowledge about a patient's risk for cancer can help the patient manage his or her risk. For example, individuals with a genetic predisposition for cancer can pursue medical options such as increased surveillance or screenings, preventive drug therapy, or preventive surgery. It is important to perform regular cancer screenings in order to detect any cancer as soon as possible, as early detection is the key to improved survival rates. Prophylactic surgery, which is a preventive surgery, may also be done and involves removing as much of the "at-risk" tissue as possible in order to reduce the chance of developing cancer. Additionally, there are some FDA approved medications that help to reduce the risk of cancer in high risk patients, such as Tamoxifen for breast cancer.
   (i) Note: As indicated above, it is important to also speak with a health care provider to determine what options are best in each individual's case.

III. GENETIC DISCRIMINATION

A. **What is Genetic Discrimination:** Genetic discrimination occurs when individuals are treated differently based on their hereditary predispositions to particular diseases. There is a potential for genetic discrimination to occur in both employment and insurance contexts. Because of the fear that genetic characteristics may be used against them, some individuals decide not to disclose information to health care professionals and decline early screening and preventive measures, which may be crucial for their medical care.

B. **Genetics and the Law:** There are several federal and state laws that protect against genetic discrimination. However, these laws apply to different entities and cover different aspects of genetic discrimination. It is important to understand the complete patchwork of available protections in order to be able to weigh the legal implications of genetic testing.

Law:	**Applies to:**	**Prohibition:**
GINA (Genetic Information Nondiscrimination Act)	Employment/Health insurance	Use of genetic information
ADA (Americans with Disabilities Act)	Employment	Disability discrimination
Executive Order 13145	Federal Employment	Genetic discrimination
HIPAA* (Health Insurance Portability and Accountability Act)	Group Health Insurance	Use of genetic information to determine eligibility

*Additionally, HIPAA covers the privacy of genetic information

A. **Genetics and California Law:** In addition to federal law, California law provides many protections against genetic discrimination.

1) **Insurance:** California law applying to health, life, and disability insurance policies defines genetic characteristics as "an identifiable gene or chromosome that is known to cause a disease or disorder in a person or their offspring, or that is determined to be associated with a statistically increased risk or development of a disease or disorder, and that is presently not associated with any symptoms of any disease or disorder." This is narrower than the federal definition under GINA, because it does not include family history or the use of genetic services.

   (i) **Health Insurance:** Health insurance companies, including health care service plans, multiple employer welfare arrangements, and self-insured employee welfare benefit plans, are prohibited from denying coverage to an individual based on genetic characteristics. Additionally, these companies cannot charge a higher rate or provide different terms, conditions, or benefits on the basis of genetic characteristics. California law also prohibits disclosure of genetic test results in a manner that identifies the individual who took the test, without their written permission.

   (ii) **Long-Term Care Insurance:** As of January 2008, 15 states have restricted discrimination based on genetic information in long-term care insurance.[73] In the past, California law prohibited long-term care insurers from using genetic characteristics, but this law has expired and was not renewed.

   (iii) **Life and Disability Insurance:** As of January 2008, 14 states have restricted discrimination based on genetic information in life insurance,[74] and nine states have restricted discrimination based on genetic information in disability insurance.[75] Under California law, disability insurance policies for hospital, medical, and surgical expenses are prohibited from denying coverage or changing rates or coverage benefits due to a person's genetic characteristic. Furthermore, life and disability income insurers fall under different rules. They are prohibited from discriminating against an individual based on carrier status. For other genetic characteristics, the use of genetic information is regulated, but not prohibited. For example, life and disability income insurers must pay for a genetic test if they require it, cannot request that an applicant take a genetic test without informed written consent, and must notify the applicant of test results.

2) **Genetic Discrimination in Employment:** California law prohibits employers from discriminating based on a person's race, religion, creed, color status, sex, age, or medical condition. The definition of "medical condition" includes genetic characteristics.[76]

II. **RESOURCES**

For information about GINA and the ADA with respect to employment discrimination:	**For information about California laws that protect against genetic discrimination in employment:**
Equal Employment Opportunity Commission Roybal Federal Building	California Dept. of Fair Employment &

[73] *Id.*
[74] National Conference of State Legislatures, *Genetics and Life, Disability and Long-term Care Insurance*, January 2008, www.ncsl.org/default.aspx?tabid=14283.
[75] *Id*.
[76] Cal. Gov't Code § 12926(h)(2) (2011).

255 East Temple St., 4th Floor Los Angeles, CA 90012 (800) 669-4000 or (800) 669-6820 (TTY) www.eeoc.gov	Housing (800) 884-1684 www.dfeh.ca.gov
For information about California laws that protect against genetic discrimination in insurance: California Department of Insurance (800) 927-4357 www.insurance.ca.gov California Dept. of Managed Health Care (DMHC) California HMO Help Center 980 Ninth Street, Suite 500 Sacramento, CA 95814-2725 (888) 466-2219 or www.hmohelp.ca.gov	**For information about GINA and HIPAA with respect to health insurance:** California Department of Insurance (800) 927-4357 www.insurance.ca.gov California Dept. of Managed Health Care (DMHC) California HMO Help Center 980 Ninth Street, Suite 500 Sacramento, CA 95814-2725 (888) 466-2219 or www.hmohelp.ca.gov
For information, support, awareness, and advocacy for individuals and families affected by hereditary breast cancer: FORCE, Facing Our Risk of Cancer Empowered http://www.facingourrisk.org/support/local_groups/california_losangeles.php	**For information regarding genetic testing for the BRCA gene:** National Society of Genetic Counselors 401 N. Michigan Avenue, Suite 2200 Chicago, IL 60611 (312) 321-6834 http://www.nsgc.org/tabid/69/Default.aspx (search by zip code to find a genetic counselor near you)

MANAGING THE FINANCIAL & PRACTICAL ASPECTS OF CANCER TREATMENT

INTRODUCTION:
The financial aspects of cancer treatment can be extensive and include tests, treatment, prescriptions drugs, and appointments with healthcare providers. The purpose of this section is to provide patients with tips for understanding medical bills, negotiating payment plans, disputing a bill, options to cover health care expenses, and the consequences of unpaid medical bills.

It can be very useful for patients to start a file for the paperwork related to their treatment, including medical bills, prescriptions, explanations of benefits (EOB), and medical records. Patients should use a system that is comfortable for them, but there are a number of useful tools provided by cancer organizations, such as the American Cancer Society and LIVE**STRONG**, and there are computer programs, such as Quicken Medical Expense Manager that are also available.

When a patient receives care from a physician, there is a process for medical billing. First, the physician bills the patient's insurance company. Then the insurance company decides what it is responsible for paying and what the patient is responsible for paying. The insurance company then pays the physician and sends the patient an EOB, which indicates the amounts billed, the amounts paid by the insurance company, any amounts applied to the patient's deductible, and any amounts that the patient is responsible for paying to the physician. The EOB is not a bill, it is just an account statement provided by the insurance company. The physician should then send the patient a bill for any amount that the patient is still responsible for paying. Sometimes, a patient will receive the bill before getting the EOB. It is a good idea for patients to wait to pay the bill until receiving the EOB, to ensure that everything was billed and paid for correctly. If some time passes and patients have not received an EOB, patients can contact their insurance company directly to request another copy of the EOB.

It is also important to note that medical expenses may be tax deductible. Individuals can contact their accountant or a free tax service for information about their taxes.

I. HANDLING HEALTH INSURANCE DISPUTES

A. **Handling Disputes:** Disputes with insurance companies may arise over whether or not services are covered, which treatments should be provided, which providers should be used, how much a particular service should cost, difficulties dealing with specific providers, and even billing or administrative mistakes**. If an individual disagrees with a decision that his or her health insurance company has made regarding coverage, he or she has the right to appeal that decision.** Health insurance companies are required to have their own internal appeals process to handle these disagreements, and they must provide their policy holders with that information. In California, absent an extraordinary or compelling case, an individual must first exhaust the health plan's internal appeals process before requesting external independent medical review of the insurance company's decision.

1) **Tips on Dealing with an Insurance Company:** The following are tips for handling internal appeals with an insurance company.
   (i) Know the policy and any deadlines that apply;
   (ii) Get any decisions or denials in writing;
   (iii) Keep records of all communications;
   (iv) Get a copy of the all files from the insurance company; and

(v) Be persistent.

2) **Different Appeal Procedures:** Health plans may have different appeals procedures for different types of disputes. For instance, a health plan may have one way to resolve a complaint about appointment times and a different way to appeal the refusal to cover a specific medical procedure.

3) **Internal Appeals Process:** If individuals disagree with an insurance company's decision, they have the right to file an appeal, also known as a complaint or a grievance. ERISA requires employer-sponsored health plans to let policy holders see the documents they used to make their coverage decisions, to have no more than two levels of appeal, and prohibits insurance companies from charging a fee for the internal appeals process. In most circumstances, individuals must exhaust their health plans' internal appeals processes before they may pursue external review through the Department of Managed Health Care (DMHC) or the Department of Insurance (DOI). They may be able to file their complaints by phone, mail, or on the internet. For assistance finding a plan's contact information, go to the DMHC's website (http://wpso.dmhc.ca.gov/hpsearch/viewall.aspx) and select the plan from the provided list.
   (i) **Response Time:** If a problem is not urgent, a health plan must give a decision within 30 days. If a problem is urgent, meaning there is a serious threat to individuals' health, the health plan must give a decision within three days. If a health plan does not respond within these time frames, individuals can contact the DMHC or the DOI.

4) **External Medical Review:** Also called Independent Medical Review (IMR), this is a review of the health plan's decision by an outside, independent organization. In California, after individuals have exhausted their plans' internal appeals processes, they are entitled to ask for an external medical review under state law, if they still disagree with the insurance company's decision. If the IMR is decided in the individual's favor, the plan must provide the services or treatment requested. Individuals can file a complaint with the DMHC or the DOI, depending on which type of plan they have. Individuals pay no costs for IMR.

   (i) Individuals Can Apply for IMR if Their Health Plans:
      - Deny, change, or delay services or treatments, because the plans determine they are not medically necessary.
        ⇒ If the insured individual can show that the treatment is medically necessary, then there is a greater chance of winning the appeal. This is a good opportunity for health care providers to help their patients demonstrate that the disputed treatment is actually medically necessary by providing letters of support, adding documentation to medical records, or providing additional medical literature to support why a particular treatment is medically necessary and/or has been successful in the past.
      - Will not cover experimental or investigational treatments for serious medical conditions.
      - Will not pay for emergency or urgent medical services that individuals have already received.
      - Note: Issues often arise when a treatment is new or a doctor prescribes a drug that was approved to treat one type of cancer and there is evidence that it will

also work to treat another type of cancer, but has not yet been approved by the FDA to treat that new type of cancer (off-label drug use)

(ii) **Department of Managed Health Care:**[77] The DMHC oversees HMOs and all Blue Cross and Blue Shield plans. Individuals seeking an IMR through the DMHC must apply with the Help Center of the DMHC within six months after their health plans send them written decisions about their complaints. The IMR Application Form is available at www.hmohelp.ca.gov/dmhc_consumer/pc/pc_imrapp.aspx. The Help Center will review their applications and send them letters within five days, telling whether they qualify for IMRs. An IMR decision is then made within 30 days, or within 3 to 7 days if the problem is urgent.

(iii) **Department of Insurance:**[78] The DOI oversees all private health plans that the DMHC does not. Individuals seeking an IMR through the DOI must apply within six months of their insurance companies' final decisions in the internal appeals process. Although insurance companies are required to provide an IMR application with their denial letters, individuals who do not receive an application may request one from the DOI by calling (800) 927-HELP. After submitting an application, the DOI will determine whether the individual qualifies for IMR. If not, his or her claims review request will be referred to the complaint/mediation program within the DOI. If he or she does qualify, however, the case is sent to the IMR organization designated by the DOI. The IMR organization must then complete its review in writing within 30 days. If there is a serious or imminent threat to an individual's health, the IMR organization must make its determination within three days of receiving the proper case information.

(iv) **External Appeals Outcomes:** Once appeals are accepted for external medical review, patients have been relatively successful in getting their insurance company's decisions overturned. However, many individuals make mistakes with their external review appeals, including filing with the wrong state agency, failing to exhaust their health plan's internal appeals process, or failing to provide all the necessary information, such as consent forms, that is needed to investigate their case.

II. BEFORE TREATMENT

A. **Tips to Ensure Medical Bills Get Paid:** Individuals can save time and money by avoiding medical bills in the first place. Below are a few tips to help ensure that medical bills get paid:

1) **Show Proof of Insurance to All Providers:** If patients have health insurance, they should tell all of their providers. If they have more than one kind of insurance, they should let all providers know that as well. For example, some people have both Medicare and Medi-Cal or have a policy through their employer and also have an individual insurance policy. It is also the patient's responsibility to take the initiative and ask their providers to pass along his or her information to secondary providers like labs or imaging facilities. If the patient is in a managed health care plan, like an HMO or PPO, it is important to read the Evidence of Coverage (EOC) booklet or health plan contract, which explains the rules of the health plan. Before making an appointment,

[77] California Department of Managed Health Care. "Ask for an Independent Medical Review (IMR)." www.hmohelp.ca.gov/dmhc_consumer/pc/pc_imr.aspx.

[78] California Department of Insurance. "Consumers: IMR Program." www.insurance.ca.gov/0100-consumers/0020-health-related/0020-imr/.

the patient can determine if his or her insurance will cover the services he or she needs based on the information on the EOC. Additionally, patients should always take their insurance cards to medical appointments and to their pharmacies. Patients should show the card to the billing or front office staff. This will let them know they should send any bills to the health insurance company. Patients should also ask them to make a copy of their insurance cards to keep on file.

2) **Keep Contact Information Current:** Patients should make sure that all medical providers have their current address and contact information on file, including: doctors, pharmacies, and health plans. It is also important for patients to make sure that their current contact information is passed on to billing departments, labs, and other hospital departments being used by the patient. This will help ensure that all of the patient's providers are billed correctly.

> **Check into Health Care Options:** If patients do not have health insurance, they should try to get assistance to pay for their treatment. Some Los Angeles County hospitals and healthcare facilities offer charity care programs and negotiate payment plans for treatment expenses. For additional financial assistance resources near you, please contact the CLRC at 1-866-THE-CLRC.

(i) **AB 774:** California's Payer's Bill of Rights requires that hospitals provide information on their charity care and financial assistance programs to uninsured individuals or individuals with high medical costs who are at or below 350 percent of the Federal Poverty Level. They must also provide an application, if requested. In addition, AB 774 requires hospitals to post notices with information about the hospital's financial assistance programs in commonly used areas and must have written financial assistance policies with eligibility criteria. Individuals should apply as early as possible for charity care programs to avoid any future debt collection problems. If the bill has already gone to a collections agency, ask the hospital to rescind it if financial assistance is granted.

Effective January 1, 2011, AB 1503 requires hospital emergency room physicians to provide discounts to uninsured individuals or individuals with high medical costs who are at or below 350 percent of the Federal Poverty Level. Hospitals must include language in their fair pricing policies to notify patients that these discounts are available.

3) **Always Read Health Forms Carefully Before Signing:** Patients should not sign anything that they do not understand. If they sign something, they may be agreeing to pay for services and treatment without knowing it. It is okay for patients to ask doctors or other health care providers questions about any forms they are being asked to sign.

4) **Pre-Authorization:** Patients should ask providers if a particular treatment or service requires pre-authorization from their insurance company. Most providers have a staff person who contacts an insurance company by phone to get pre-authorization. Receiving a pre-authorization does not guarantee that an insurance company will ultimately pay for the treatment. However, getting a pre-authorization in writing will help a patient make a case to the insurance company or external medical review organization that a patient's treatment should be covered.

III. AFTER TREATMENT

A. **Introduction:** Once patients have received treatment, they are typically responsible for paying for any costs associated with that treatment. However, there are a few things that patients can do to ensure they have been billed the correct amount, that the insurance company was charged the correct amount, that the insurance company has covered the correct amount, and that the amount the patients are responsible for is correct. Additionally, it may be confusing, because patients may receive a bill from the provider before they receive the Explanation of Benefits (EOB) from the insurance company. It is a good idea for patients to wait for the EOB before paying the bill so the patients knows what they were billed and what their insurance company paid. If patients do not receive an EOB, they can contact their insurance company for a copy of one.

B. **Strategies for Reading and Negotiating Hospital Bills:** It is important for patients to carefully review their medical bills, because bills may contain errors or items that are overpriced. Also, sometimes insurance companies will incorrectly deny coverage and the provider will send the bill to the patient. It is always a good idea to check a bill before paying it.

1) **Request an Itemized Copy of the Medical Bill and Review It:** When a provider submits a bill to an insurance company, the insurance company then sends the patient an Explanation of Benefits (EOB). This explains what was billed to the insurance company, how much was applied to the patient's deductible, how much the insurance company paid the provider, and how much the patient still owes to the provider. However, this is not a bill. The provider then sends the patient a bill and the patient is responsible for paying the provider. Unfortunately, it can be hard to figure out what is being billed, because the procedures are listed as codes and often do not have descriptions. Therefore, it is a good idea for patients to request an itemized copy of their medical bill from their provider(s) and review it. By obtaining an itemized bill, patients may find some errors. Patients should check for things, such as: the dates on the bill should match the dates they actually received treatment or any other data entry errors. For example, patients may have been charged for 10 x-rays when they only received one. Look for any inconsistencies; if items seem to be excessive or inappropriate for a particular condition, then they may be wrong.

2) **Request a Copy of the Medical Record and Pharmacy Ledger:** Individuals can request a copy of their medical records and pharmacy ledger. The pharmacy ledger shows all the drugs a patient has been given. The pharmacy ledger, along with their medical records, can give patients a complete picture of their hospital stay. By comparing their medical records and the pharmacy ledger to the itemized hospital bill, patients can also determine if they are being charged for goods or services that they did not receive. Additionally, check for procedures or medications that were ordered, but then cancelled. Patients have a right to copies of all of these things, but they may be charged for reasonable copying expenses.

3) **Compare the Bill to the Hospital's Standard Charges:** California's Payer's Bill of Rights (AB 774) requires that hospitals make their standard charges, regardless of payer type (e.g., private insurance, Medicare, Medi-Cal, etc.), available to the public for all products and services. This document is typically called the "charge master." California also requires that uninsured patients with an income below the 350% of the Federal Poverty Level cannot be charged more than the highest amount the hospital would receive for the same care under a public health care program, such as Medi-Cal.

Patients can compare their bills to the hospital's standard charges to make sure they are not being over charged.

4) **Look for Items Billed Due to the Hospital's Negligence:** Generally, when a hospital makes an error, the patient usually pays for it. For example, if an x-ray is lost or the results of a blood test are misplaced, those procedures will be redone and the patient will be billed a second time. Patients may challenge these charges. Also, charges based on delays caused by the hospital can be challenged. For example, in a non-emergency situation, sometimes the hospital's own scheduling needs for tests or surgeries will result in a longer hospital stay for the patient.

5) **Hire a Professional Bill Reviewer:** If a patient has tried the techniques above, but still thinks the bill is too high, it might be time to call a professional bill reviewer, also known as a claims assistant professional. This can be helpful if patients have very high medical bills. Bill reviewers have more expertise with standard billing practices. They can check the diagnosis codes to see if a diagnosis has been "upcoded" to a more serious condition than what the medical chart states. They can determine if some charges were added that are already contained in other bundled charges and they have the expertise to know what is beyond the industry standard. Most bill reviewers will also assist in negotiating with the provider or testifying as experts in collection defense if contracted to do so. However, bill reviewers will charge for their services, so it should make financial sense for the patient.

6) **Negotiate a Payment Plan:** Setting up a payment plan with providers can be a good option when (1) the charges are legitimate, (2) an individual can make the payments, and (3) the debt will eventually be paid. If patients pay a portion of a bill, they are essentially agreeing that they owe the amount billed, so make sure to check the charges first before setting up a payment plan. If patients decide negotiating with the hospital or provider is the best avenue, try to work out a reasonable payment plan, or if it is possible, offer the hospital a lump sum. Individuals can write out agreements, which both parties sign, for payment plans or lump sum settlements that include removing any negative reports that have been submitted to credit bureaus. Once the debt is paid off, either through a lump sum or at the completion of a payment plan, the provider should send a new statement of account that reflects a zero balance. If no one at the hospital will sign or return an agreement, the individual can write a confirmation letter to the hospital referring to the agreement made and inform the hospital that they must respond within a certain number of days if the information is correct. This should be sent by certified mail.

C. **What Can Individuals Do If They Get a Medical Bill and Did Not Have Health Insurance When They Received Treatment:** If patients did not have health insurance when they received treatment, they may be able to obtain government-sponsored health insurance, such as Medicare or Medi-Cal. If they are ineligible for government assistance, consider applying for free or low-cost care, ability to pay programs through local hospitals or county programs, or private financial assistance programs.

(i) **Recently Lost Insurance through Employer:** If patients recently lost their insurance through an employer, they may be able to get COBRA coverage. If patients elect this coverage within 60 days of their involuntary termination of employment, they have to pay the health insurance premiums, which are often high, but may be less expensive than paying a large medical bill. There are also

assistance programs that help with COBRA premiums. (See the Health Insurance section above.)

- Note: If patients decide to elect COBRA, even on the 59th day, they are still required to retroactively pay the premiums from the date of termination.
  - ⇒ Example: If an employee loses his or her employer-sponsored health insurance coverage on February 28th, he or she has until April 29th to elect COBRA coverage (60 days). Upon electing COBRA, the employee is then required to pay the insurance premiums for March and April.

(ii) **Retroactive Medi-Cal:** If patients are on Medi-Cal, they may be eligible to collect benefits starting three months prior to their applications' acceptance if the patients would have been eligible for these benefits during the retroactive three month period. Patients must request coverage for this period if they wish to receive such benefits.

D. **Tips for Disputing a Bill:**

1) **Patients Who Believe Their Health Insurance Should Have Paid:** If patients believe their health insurance company should have paid the bill, and did not, patients can call the plan to determine the reason for nonpayment. The health insurance plan's contact information is usually on the patient's insurance card. The health insurance plan may have refused to pay the bill because of a mistake on the bill. Patients can also contact their providers to double-check that it was billed correctly. If patients are able to resolve the error, then they should check with their health care provider and health insurance company to make sure the bill is paid and that their account is cleared.

(i) **Send a Letter to the Health Care Provider:** Sometimes patients need to contact their providers about their bills. It is often helpful to communicate in writing. When patients send a letter to a health care provider, the letter should include:

- Specific Information: Including any information that explains why the patients believe they should not have been billed, or why the bill they received is incorrect.
- Details: Provide as much detail as possible. This is especially important if the individual is getting medical bills for multiple services.
- Copy of the Bill: Include a copy of the bill being disputed so that the provider knows which bill is being disputed.

(ii) **Double Check that the Provider Billed the Insurance Company:** If patients have health insurance at the time they received services, make sure the provider submitted the bill to the health insurance company and that the correct billing codes were used.

(iii) **Insurance Card on Record:** Patients should send a copy of their insurance card to the provider, and be sure to show that the insurance was effective on the day(s) for which they were billed. If an individual's health insurance company needs a health care provider to fill out forms, send the forms to the provider. Always keep copies of what is sent to the health care provider and the health insurance company.

E. **How to Dispute a Health Insurance Company's Decision:** If a patient disagrees with a decision that his or her health insurance company has made regarding his or her coverage, the patient has the right to appeal that decision. The appeals process varies depending on

the state in which the patient lives. For more information, see "Handling Health Insurance Disputes" in this section of the Guide

F. **Financial Assistance Resources to Help Pay Medical Bills:** There are many financial assistance resources available to help patients with their medical bills. Unfortunately, the demand placed on these resources is high. These are just a few of the types of resources available. Some people also engage in fundraising efforts to help with medical expenses. This is a good way to engage family, friends, colleagues, and others in a support network. However, it is important that patients first check to make sure that their fundraising efforts will not disqualify them from eligibility for other income-based benefits, such as Supplemental Security Income or Medi-Cal.

1) **Private Financial Assistance Programs:** There are many private financial assistance programs that help patients with expenses, such as Salvation Army, Lutheran Social Services, Jewish Social Services, and Catholic Charities. Look for programs that serve the patient's local community.

2) **Non-Profit Programs:** Non-profit organizations such as the American Cancer Society, LIVE**STRONG,** and the Patient Advocate Foundation also provide patients with financial assistance for various types of treatment expenses.

3) **Government Benefits Programs:** Government benefits programs include state disability insurance benefits, SSI, and SSDI. These programs provide individuals with income while they have a qualifying disability and are unable to work. Please note that the eligibility requirements for these programs vary, and not all programs have income and asset restrictions.

4) **Pharmaceutical Assistance:** Many pharmaceutical companies offer prescription drugs at reduced costs through a patient assistance program. For example, since 1985, Genentech has donated approximately $1.3 billion to uninsured individuals through their Access Solutions program. See the CLRC handout, "National Prescription Drug Assistance" for other available programs.[79] Additionally, patients can ask their doctors if generic alternatives are available and appropriate. Patients can also check into prescription drug mail order options, which can sometimes be less expensive.
   (i) Some states and organizations also have prescription assistance programs. California offers the following programs:
      - **Prescription Drug Discount Program for Medicare Recipients:** Prohibits a Medi-Cal pharmacy provider from charging a Medicare recipient a price that exceeds what Medi-Cal would reimburse the pharmacy for the same prescription, plus a small processing fee.

5) **Local Service Organizations:** Local service organizations such as Kiwanis, Rotary Club, or Lions Club may also provide patients with financial assistance.

[79] National Prescription Drug Assistance. Cancer Legal Resource Center - Disability Rights Legal Center (2010). www.disabilityrightslegalcenter.org/about/documents/NationalPrescriptionDrugAssistance2011.pdf

IV. RESOURCES

For information about Hill-Burton facilities: Hill-Burton (800) 638-0742 www.hrsa.gov/hillburton/default.htm **For a list of Hill-Burton facilities:** www.hrsa.gov/gethealthcare/affordable/hillburton/facilities.html http://healthcenters.usa-hospitals.com/2011/01/hill-burton-health-center-facilities-provide-free-or-reduced-cost-health-care-in-the-state-of-california/ See also p.54	**To file a complaint with your health plan or request an independent medical review:** California Department of Insurance (800) 927-4357 or www.insurance.ca.gov California Department of Managed Health Care (888) 466-2219 or www.hmohelp.ca.gov
To report a debt collector or file a consumer complaint: Federal Trade Commission (877) FTC- HELP www.ftc.gov	Attorney General's Office California Department of Justice Attn: Public Inquiry Unit P.O. Box 944255 Sacramento, CA 94244-2550 (916) 322-3360 or www.ag.ca.gov
For credit counseling information: Consumer Credit Counseling Service (CCCS) (800) 966-3328 or www.cccsstl.org	**For assistance with tax preparation and counseling:** Volunteer Income Tax Assistance (800) 285-2221 or www.abanet.org/lsd/vita
For possible legal assistance with bankruptcy: **Attorney Search Network** 16161 Ventura Blvd., Suite 672 Encino, CA 91436 (800) 215-1190 **Attorney Referral Service** 26465 Ynez Road, Suite 285 Temecula, CA 92591 (877) 277-2778 www.lawyerreferral.com **Beverly Hills Bar Association** **Lawyer Referral & Information Service** P.O. Box 2277 Beverly Hills, CA 90212 (310) 601-2440 www.bhba.org/lawyerref.htm	**Bet Tzedek Legal Services** 145 S. Fairfax Avenue, Suite 200 Los Angeles, CA 90036 (323) 939-0506 www.bettzedek.org North Hollywood Office 12821 Victory Blvd. North Hollywood, CA 91606 (818) 769-0136 Mid-Wilshire Office 3435 Wilshire Blvd., Suite 470 Los Angeles, CA 90010 (213) 384-3243 **Legal Protection for Women** 5300 E. Beverly Blvd., Suite D Los Angeles, CA 90022 (323) 721-9882

Glendale Bar Association Lawyer Referral Service 500 N. Brand, Suite 1260 P.O. Box 968 Glendale, CA 91209 (818) 956-1633 www.glendalebar.com **Lawyer Referral & Information Service of the Santa Monica Bar Association** 2530 Wilshire Blvd., 2nd Floor Santa Monica, CA 90403 (310) 581-5163 www.smba.net **Lawyer Referral Service & Legal Aid of the Burbank Bar Association** 2219 West Olive Avenue, #100-40 Burbank, CA 91506 (818) 843-0931 **Lawyer Referral Service of the Long Beach Bar Association** 3515 Linden Ave. Long Beach, CA 90807 (562) 988-1122 www.longbeachbar.org **Lawyer Referral Service of the South Bay Bar Association** 2463 Torrance Blvd., Suite D Torrance, CA 9050 (310) 787-9405 www.southbaybar.org **Lawyer Referral Service of the Southeast District Bar Association** 12749 Norwalk Blvd., Room 107 Norwalk, CA 90650-8373 (562) 868-6787 www.sedba.org **Access Legal Grind's Lawyer Referral & Information Service** 2640 Lincoln Blvd. Santa Monica, CA 90405 (310) 452-8160 www.legalgrind.com **Los Angeles County Bar Association Lawyer Referral & Information Service** P.O. Box 55020	See also legal assistance resources on p.63

Los Angeles, CA 90055-2020 (213) 243-1525 www.smartlaw.org **Los Angeles Gay & Lesbian Community Services Center Voluntary Lawyer Referral Services** 1625 Schrader Blvd. Los Angeles, CA 90028 (323) 993-7670 www.laglc.convio.net **Mexican American Bar Association of Los Angeles County Lawyer Referral & Information Service** 714 Olympic Blvd., #450 Los Angeles, CA 90015 (213) 745-6574 www.mabaattorneys.com/lawyerreferralservice.html **Lawyer Referral Service of the Legal Aid Society of Orange County** 12377 Lewis Street, Suite 105 Garden Grove, CA 92840 (714) 571-5204 www.legal-aid.com (Los Angeles, Orange) **San Fernando Valley Bar Association Lawyer Referral & Information Service** 21250 California St. #113 Woodland Hills, CA 91367 (818) 227-0490 www.sfvba.org (Los Angeles, Ventura) **San Gabriel Valley Lawyer Referral Service** 1175 East Garvey Avenue, Suite 105 Covina, CA 91724-3618 (626) 966-5530 www.sgvlawyer.org (Los Angeles, San Bernardino) **San Gabriel Valley Lawyer Referral Service Center** 1175 E. Garvey Ave, Suite 105 Covina, CA 91724 (626) 442-6973 www.svglawyer.org	

APPENDICES

INTRODUCTION:
Below are various sample letters, forms, and resources that have been referenced throughout this guide. These documents are designed to provide general information on the topics presented. They are provided with the understanding that the author is not engaged in rendering any legal or professional services by its publication or distribution. Although these materials were reviewed by a professional, they should not be used as a substitute for professional services. We recommend that individuals with questions or concerns about their legal options act immediately, as there may be specific legal time limitations that could affect the validity of any case and any possible legal options they may have. If you or your patients have additional questions, please contact the Cancer Legal Resource Center at (866) THE–CLRC or at www.CancerLegalResourceCenter.org.

APPENDIX A:
Sample Appeal Letter to a Health Insurance Company

APPENDIX B:
Personal Record File

APPENDIX C:
Taking Care of Business Form

APPENDIX D:
Budget Form

APPENDIX A

Below is a sample letter appealing an insurance company's decision to deny treatment or to refuse to cover the cost of treatment:

Date
Name of Health Care Representative
Health Plan Name
Address
City, State, Zip Code

Re: Patient's Name, Type of Coverage, Group/Policy Number

Dear _____ (Health Care Representative):

On _____ (date of diagnosis), _____ (Patient's Name), a beneficiary of your health insurance policy _____ (Group Number/Policy Number), was diagnosed with _____ (diagnosis). According to _____'s (Patient's name) physician, Dr. _____ (Physician's name), _____ (Patient's name) requires _____ (treatment that the insurance company is denying coverage for) as part of the treatment for _____ (diagnosis).

According to a letter _____ (Insurance Company's name) sent to _____ (Patient's name) on _____(date of denial letter), _____ (treatment requesting) is not covered under _____ (Patient's name) insurance plan because _____ (explanation written in denial letter).

This letter serves as an appeal to _____ (Insurance Company's name) to _____ (what you are requesting Insurance company to do – e.g., pay for treatment). Dr. _____ (Physician's name) has also submitted an appeal on behalf of _____ (Patient's name), including details of his/her medical condition, copies of his/her medical records, and a thorough explanation as to why _____ (treatment requesting) is necessary. Based on the literature _____ (Insurance Company's name) sent to _____ (Patient's name) upon enrolling in this plan, _____ (Insurance Company's name) has _____ (number of days listed in Insurance Company's handbook) days to respond to this appeal.

Please reconsider your previous decision to _____ (what the Insurance company is refusing to do), as this medical procedure is necessary in _____ (Patient's name) treatment of _____ (diagnosis).

Sincerely,

Name
Address

Cc: _____ (anyone else you are sending this letter to)
Enclosures

Below is a sample of a completed letter appealing an insurance company's decision:

January 1, 2012

Mr. Joe Health Care Representative
ABC Health Care Insurance Company
100 Main Street
Big City, CA 90000

Re: Jane Smith, PPO, Group 123 / Policy Number ABC456

Dear Mr. Health Care Representative:

On April 1, 20011, Jane Smith, a beneficiary of your health insurance policy number ABC456 was diagnosed with breast cancer. According to Jane Smith's physician, Dr. Robert Feel Good, Jane requires a mastectomy as part of the treatment for her cancer diagnosis.

According to a letter ABC Health care Insurance Company sent to Jane Smith on December 1, 2011, a bilateral mastectomy is not covered under Jane Smith's insurance plan because her diagnosis is considered a pre-existing medical condition.

This letter serves as an appeal to ABC Health care Insurance Company to pay for Jane Smith's mastectomy, which was performed on October 1, 2011. Dr. Feel Good has also submitted an appeal on behalf of Jane Smith, including details of her medical condition, copies of her medical records, and a thorough explanation as to why the mastectomy is necessary and why her diagnosis should not be considered a pre-existing medical condition. Based on the literature ABC Health care Insurance Company sent to Jane Smith upon enrolling in this plan, ABC Health care Insurance Company has 30 days to respond to this appeal.

Please reconsider your previous decision to deny coverage for the mastectomy, as this medical procedure is necessary in Jane Smith's treatment of breast cancer.

Sincerely,

Fred Smith
500 S. Longroad Way
Los Angeles, CA 10000

Cc: Dr. Robert Feel Good

Enclosures

APPENDIX B

Disability Rights Legal Center
CLRC
Cancer Legal Resource Center

CLRC National Office
800 S. Figueroa Street, Suite 1120 ◆ Los Angeles, CA 90017

CLRC Midwest Regional Office
c/o McDermott Will & Emery LLP
227 West Monroe Street, 44th Floor ◆ Chicago, IL 60606

Toll Free: 866.THE.CLRC (866.843.2572)
TDD: 213.736.8310 Fax: 213.736.1428
Email: CLRC@LLS.edu
Web: www.CancerLegalResourceCenter.org

The CLRC is a joint program of the Disability Rights Legal Center & Loyola Law School Los Angeles

Personal Record File

This Personal Record File will be helpful to your loved ones by gathering in one place, copies of important records and documents they will need. The items on the list can be kept in an envelope or other document holder and marked to show the contents and kept in a place known to your loved ones. Originals should be kept in a fireproof place, such as a safe deposit box, if appropriate.

1. Will, with name, address, and phone number of attorney.
2. Birth certificates for yourself, spouse, and children.
3. Marriage license and/or proof of divorce, if applicable.
4. Drivers' license and social security card.
5. Life, medical, dental, property, and auto insurance policies, with name, address, and phone number of insurance agent(s).
6. Proof of automobile ownership and registration, license plate number, and VIN number.
7. Real estate deed, title policies, mortgages, record of payments, tax receipts, receipts for improvements, etc.
8. Names of banks, savings, retirement and securities accounts, loans, and their account numbers.
9. Computer, voicemail, and internet user names and passwords for financial accounts, etc.
10. List of other assets and locations (including loans, deeds of trust and accounts receivable).
11. Safe-deposit box key, name and address of bank, and box number.
12. Name of credit card creditors and account numbers.
13. Veteran's discharge paper (DD-214).
14. Income tax returns for the last three years, and name and address of persons preparing the returns.
15. Name and address of broker or stock certificates and bonds you own (and purchase slips or other records of cost/date of purchase).
16. Receipts/appraisals for items of substantial value such as jewelry, furs, furniture, art, etc.
17. Name, address, and telephone number of your employer and/or supervisor.
18. Documentation of retirement benefits, pension plan, and profit sharing.
19. Business records.
20. List of close relatives, addresses, and telephone numbers.
21. Funeral or memorial instructions.
22. General instructions to surviving spouse or children, including a list of advisers.
23. **Any other information you would like to include.**

APPENDIX C

Disability Rights Legal Center
CLRC
Cancer Legal Resource Center

CLRC National Office
800 S. Figueroa Street, Suite 1120 ◆ Los Angeles, CA 90017

CLRC Midwest Regional Office
c/o McDermott Will & Emery LLP
227 West Monroe Street, 44th Floor ◆ Chicago, IL 60606

Toll Free: 866.THE.CLRC (866.843.2572)
TDD: 213.736.8310 Fax: 213.736.1428
Email: CLRC@LLS.edu
Web: www.CancerLegalResourceCenter.org

The CLRC is a joint program of the Disability Rights Legal Center & Loyola Law School Los Angeles

"Taking Care of Business"

The Cancer Legal Resource Center has designed this information sheet so that you can collect and keep personal and financial information in one place. Keep it in a safe place known to your spouse and other loved ones. Update it as needed. And, feel free to modify and/or change it to meet your particular and special needs.

1. GENERAL INFORMATION

Name: _____

Home Address: _____

_____

Phone: (Home) _____ (Work) _____

Employer/Work Address: _____

_____

Work Telephone: _____

Date of Marriage: _____

Date of Separation/Divorce (if applicable): _____

Children of this Marriage:

Name	Date of Birth
_____	_____
_____	_____

Other Children:

Name	Date of Birth
_____	_____
_____	_____

2. INVENTORY OF ASSETS

(Assets include things like homes, real estate, investments, business interests, bank accounts, pensions, retirement benefits, life insurance policies, lines of credits, and personal property such as vehicles, jewelry and furniture.)

a. Real Property

i. **Type of Property and Address:** _____

Lender (s) [Name and Address]: _____

Account Number: _____ Date of Purchase: _____

Amount of Debt Owed: _____

Your estimate of the current selling price: _____

Your estimate of the equity in the property: _____

What is your plan for the use or sale of the property: _____

Other issues regarding the property: _____

ii. **Type of Property and Address:** _____

Lender (s) [Name and Address]: _____

Account Number: _____ Date of Purchase: _____

Amount of Debt Owed: _____

Your estimate of the current selling price: _____

Your estimate of the equity in the property: _____

What is your plan for the use or sale of the property: _____

Other issues regarding the property: _____

b. Financial Assets

i. Life Insurance

Name/Address of Insurance Co.: _____

Phone: _____ Policy Number: _____

Face Value: _____ Cash Surrender Amount: _____

Insured Party: _____

Beneficiaries: _____

Discussion Issues Regarding Life Insurance: _____

Name/Address of Insurance Co.: _____

Phone: _____ Policy Number: _____

Face Value: _____ Cash Surrender Amount: _____

Insured Party: _____

Beneficiaries: _____

Discussion Issues Regarding Life Insurance: _____

ii. Pensions, Retirement Benefits, Profit Sharing

Type of Benefit: _____

Name of Administrator: _____

Address: _____

Phone: _____ Plan Number: _____

Current Amount: _____ In the Name Of: _____

Beneficiaries: _____

Type of Benefit: _____

Name of Administrator: _____

Address: _____

Phone: _____ Plan Number: _____

Current Amount: _____ In the Name Of: _____

Beneficiaries: _____

iii. Bank Accounts, Investment Accounts, Lines of Credit, Stock Certificates, Etc.

Type of Account/Name of Institution/Account Number: _____

Balance: _____ Maturity Date: _____

Number of Shares (if applicable): _____

Special Circumstances/Discussion Issues: _____
Type of Account/Name of Institution/Account Number: _____

Balance: _____ Maturity Date: _____

Number of Shares (if applicable): _____

Special Circumstances/Discussion Issues: _____

Type of Account/Name of Institution/Account Number: _____

Balance: _____ Maturity Date: _____

Number of Shares (if applicable): _____

Special Circumstances/Discussion Issues: _____

iv. Business Interests

Name and Nature of Business: _____

Ownership/Partnership/Name: _____

Date Acquired: _____ Salary: _____

Buy/Sell Agreement: _____ Insurance Policies: _____

Special Circumstances/Discussion Issues: _____

Name and Nature of Business: _____

Ownership/Partnership/Name: _____

Date Acquired: _____ Salary: _____

Buy/Sell Agreement: _____ Insurance Policies: _____

Special Circumstances/Discussion Issues: _____

c. Personal Property

(Personal property includes vehicles, jewelry, furniture, appliances, art work, etc.)

Item:	Location of Item:
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

6. 6.

7. 7.

3. INVENTORY OF DEBTS, CREDIT CARDS, ETC.

Type of Account	Number	Name of Creditor
Monthly Payment	Amount Owed	
Type of Account	Number	Name of Creditor
Monthly Payment	Amount Owed	
Type of Account	Number	Name of Creditor
Monthly Payment	Amount Owed	
Type of Account	Number	Name of Creditor
Monthly Payment	Amount Owed	
Type of Account	Number	Name of Creditor
Monthly Payment	Amount Owed	

APPENDIX D

Disability Rights Legal Center
CLRC
Cancer Legal Resource Center

CLRC National Office
800 S. Figueroa Street, Suite 1120 ◆ Los Angeles, CA 90017

CLRC Midwest Regional Office
c/o McDermott Will & Emery LLP
227 West Monroe Street, 44th Floor ◆ Chicago, IL 60606

Toll Free: 866.THE.CLRC (866.843.2572)
TDD: 213.736.8310 Fax: 213.736.1428
Email: CLRC@LLS.edu
Web: www.CancerLegalResourceCenter.org

The CLRC is a joint program of the Disability Rights Legal Center & Loyola Law School Los Angeles

Budget Sheet

For the Month of _____

MONEY COMING IN
(Income, Assets)

REGULAR RECURRING INCOME (A)

Wages _____ $ _____
Tips _____ $ _____
Child support _____ $ _____
Unemployment compensation _____ $ _____
Government benefits: State Disability Insurance _____ $ _____
Short or long term disability insurance _____ $ _____
Supplemental Security Income _____ $ _____
Social Security Disability Insurance _____ $ _____
Interest on assets _____ $ _____
Other _____ $ _____

NON-RECURRING INCOME (B)

Fundraising _____ $ _____
Inheritance _____ $ _____
Gifts _____ $ _____
Other _____ $ _____

TOTAL INCOME (A + B) = C _____ $ _____

ASSETS

401K or IRA _____ $ _____

Stocks _____ $ _____

Bonds _____ $ _____

Savings _____ $ _____

Life Insurance _____ $ _____

Other _____ $ _____

TOTAL ASSETS _____ $ _____

MONEY GOING OUT

(Expenses)

NONMEDICAL (D)

Rent or mortgage _____ $ _____

Gas _____ $ _____

Electricity _____ $ _____

Water _____ $ _____

Travel (gas and parking) _____ $ _____

Telephone/cell _____ $ _____

Food _____ $ _____

Clothing _____ $ _____

Loans _____ $ _____

Credit card payments _____ $ _____

Professional services (financial planners, attorneys) _____ $ _____

Car insurance premium _____ $ _____

Health insurance premium _____ $ _____

Life insurance premium _____ $ _____

Child care _____ $ _____

Pet care _____ $ _____

Personal care _____ $ _____

Entertainment/leisure _____ $ _____

Other _____ $ _____

MEDICAL (E)

Prescription drug costs _____ $ _____

Copayments & other experimental or other treatments not covered by insurance $ _____

Special foods and nutritional supplements _____ $ _____

Communication (phone calls, faxes, copies of medical records, etc.) with doctors, friends, and relatives _____ $ _____

Lodging (a place for the patient and/or family to stay) during treatment done away from home _____ $ _____

Meals during travel or clinic visits _____ $ _____

Extra child care costs _____ $ _____

Special equipment or clothing _____ $ _____

Other _____ $ _____

TOTAL EXPENSES (D + E) = F _____ $ _____

BALANCE YOUR BUDGET

Income – Expenses (C – F) = _____

If you have a negative balance, look at your assets (p.1) to see which if any can be tapped in to. Then, continue on to complete the irregular income and expenses portion of your budget—which can either be monthly or annual.

IRREGULAR INCOME AND EXPENSES

Examples of irregular income: bonus, tax refund, babysitting, one-time dividend payment

_____ $ _____

_____ $ _____

_____ $ _____

_____ $ _____

TOTAL _____ $ _____

Examples of irregular expenses: surgery deductible, tuition payment, car repair, vacation

_____ $ _____

_____ $ _____

_____ $ _____

_____ $ _____

TOTAL _____ $ _____

For more information on financial assistance and credit counseling resources in your area, contact the CLRC at 866-843-2572 or visit www.CancerLegalResourCenter.org.

APPENDIX E

You can stop a debt collector from contacting you by writing a letter to the collector telling them to stop. Once the collector receives your letter, they may not contact you again except to say there will be no further contact or to notify you that the debt collector or the creditor intends to take some specific action. Although the letter will stop any communication regarding the debt, it will NOT cancel the debt. You could still be sued by the debt collector or your original creditor for the total amount of the debt.

Below is a sample "Notice to Cease and Desist Communication" letter:

Date
(Debt Collector Name)
(Debt Collector Address)

RE: Creditor: (Name of Company you owe money)
Acct No.:

NOTICE TO CEASE AND DESIST COMMUNICATION

To Whom It May Concern:

This is formal notice to cease and desist any further written or oral communication with me regarding the above-referenced account. I am unable to pay the amount demanded on the account.

I receive limited income for my basic necessities and I do not own real property. My financial situation is not likely to improve. This information is provided solely to enable you to properly assess my situation.

Be advised that under both state and federal fair debt collection laws, if a consumer notifies a debt collector in writing that the consumer wishes the debt collector to cease further communication with the consumer, the debt collector SHALL NOT communicate further with the consumer with respect to such debt.

Thank you in advance for your cooperation in this matter.

Sincerely,
DEBTOR
(Your Name)

GLOSSARY

ADA	Americans with Disabilities Act
ARS	Attorney Referral Service
BCCTP	Breast and Cervical Cancer Treatment Program – California
Cal-COBRA	California Continuation Benefits Replacement Act
COBRA	Consolidated Omnibus Budget Reconciliation Act
CCCS	Consumer Credit Counseling Service
CMS	Centers for Medicare & Medicaid Services
CMSP	California Medical Services Program
DFEH	California Department of Fair Employment and Housing
DMHC	California Department of Managed Health Care
DOI	Department of Insurance
DOL	U.S. Department of Labor
DOL-EBSA	Employee Benefits Security Administration
EEOC	Equal Employment Opportunity Commission
EDD	California Employment Development Department
EWC	Every Woman Counts
FEHA	California Fair Employment and Housing Act
FMLA	Family and Medical Leave Act
FORCE	Facing Our Risk of Cancer Empowered
FTDI	California Family Temporary Disability Insurance
HIPAA	Health Insurance Portability and Accountability Act
HIPP	Health Insurance Premium Payment Program
IHSS	In-Home Support Services
JAN	Job Accommodation Network
LAF	LIVESTRONG (aka Lance Armstrong Foundation)
LAFLA	Legal Aid Foundation of Los Angeles
LBBC	Living Beyond Breast Cancer
LRS	Lawyer Referral Service
LRIS	Lawyer Referral & Information Service
MIA	Medically Indigent Adult Program
MRMIP	California Major Risk Medical Insurance Program
NBCCEDP	National Breast & Cervical Cancer Early Detection Program
OCR	U.S. Office of Civil Rights
PAF	Patient Advocate Foundation
PAI	Protection and Advocacy
SDI	State Disability Insurance
SSA	Social Security Administration
SSI	Supplemental Security Income
SSDI	Social Security Disability Insurance
WHCRA	Women's Health and Cancer Rights Act

WHO? WHAT?

EDD administers SDI in CA

EEOC regulates ADA

DFEH regulates FEHA in CA

DOI (in CA) regulates CA PPOs, HIPAA (in other states), and Life Insurance

DMHC (in CA) regulates CA HMOs, BC/BS PPOs, HIPAA, & Cal-COBRA

DOL regulates FMLA

DOL-ESBA regulates COBRA & WHCRA

CMS administers Medicare and Medicaid/Medi-Cal

HCC assists with health insurance and Medi-Cal

HICAP assists with Medicare, Medigap, & Medicaid for seniors

Legal aid programs can assist with Medicaid and SSI appeals

SSA administers SSDI and SSI