NATIONAL ENDOWMENT FOR FINANCIAL EDUCATION

A SERIOUS ILLNESS WILL PUT
YOUR HEALTH INSURANCE TO THE TEST

Make Sure You Know What Your Plan Covers, and What to do if it Comes Up Short

ENGLEWOOD, COLORADO—If you or a close family member is suddenly stricken with a serious illness, medical coverage can become one of your most important assets. However, if you find yourself without adequate coverage, or if you are uninsured, the thought of paying for extensive medical care out of your own pocket can be overwhelming.

"When people are healthy, it's easy to take a medical plan for granted," says William L. Anthes, Ph.D., president and CEO of the Colorado-based National Endowment for Financial Education® (NEFE®), an independent, nonprofit foundation devoted exclusively to helping Americans learn about personal financial management. "Often we don't bother to read the fine print to learn exactly what's covered—and what isn't—until we get sick. And then, the task of evaluating the plan can appear even more daunting than it otherwise would."

In the work that NEFE has done in partnership with the American Cancer Society, the Epilepsy Foundation, the American Stroke Association and many other health organizations, the foundation's staff have found that consumers ask similar questions about insurance and paying for a serious or long-term illness. A number of these questions are presented below, along with methods you can use to get the most out of your policy and actions you can take if your policy falls short, or you find yourself without insurance.

What should I look for in my policy?

Find out what the plan covers and what your out-of-pocket costs will be before you incur them so you can budget accordingly. Ask your employer or insurance agent for a copy of the booklet that describes your plan in detail (not the short summary of benefits) and read it to find out:

- If your illness or condition is covered by the plan, and whether the plan includes prescription drugs, experimental therapies, rehabilitation and home care
- Which treatments or tests must be approved by the insurance company before the company will pay for them (called pre-authorization)
- If you must go to doctors, hospitals and other providers within a network or health maintenance organization (HMO) to receive the maximum payment from the plan

- If and how much you must pay each year before your medical plan starts paying a portion of the bill (your deductible)
- What portion of each medical expense you must pay (your out-of-pocket limit) if your plan has a co-insurance provision
- If your plan has a co-payment—and, if so, the dollar amount, if any, you must pay each time you go to the doctor
- The lifetime maximum amount the insurance company will pay

Health care plans can be difficult to read and understand, but there are people who can help. To start, check the back of your health care card. It may list telephone numbers to call with questions. The booklet that describes your plan also may list resources you can contact for more information.

Prior to a hospitalization or costly treatment, you can call the insurance company directly to find out what it will cover, how much it will pay and if the medical provider is in the plan's network. "Don't assume that your doctor will handle this chore," Anthes advises. "Ask to speak with a manager and keep notes of telephone conversations. If a plan representative offers a verbal interpretation of your benefits over the phone, make sure to ask for it in writing."

My plan has a pre-existing condition clause. What does that mean?

A pre-existing condition is a medical problem you had before you joined a health care plan. Different plans use different definitions for pre-existing conditions. One definition is that you have been diagnosed with the illness or condition prior to joining a new health care plan. Another states that your condition must have "manifested itself," whether it was diagnosed or not, before you enrolled in the new plan. The most restrictive definition simply states that a pre-existing condition is any illness or condition that existed prior to the beginning of coverage, whether known or not. When you have a pre-existing condition, you may have to wait before the new plan will help pay the cost of treating that medical condition. The length of time varies from plan to plan, up to a maximum of one year. However, if you meet certain criteria, a pre-existing condition exclusion period should not apply to you. If you have had medical coverage for a total of 12 to 18 months, and you have not had a lapse in coverage greater than 62 days, a pre-existing condition exclusion period should not apply. Or, if you have already met the requirements of a pre-existing condition exclusion period, and you have not been without medical coverage for 62 days, then an exclusion period should not apply.

"The most important thing to remember about a pre-existing condition exclusion period is how to avoid it," Anthes says. "This means making sure you never go without medical coverage for more than 62 days."

My plan won't cover everything. Now what?

Here are a few suggestions:

- If you disagree with the insurance carrier's decision, you can appeal it by following procedures outlined in the policy. As part of the appeal, you may ask your doctor to write a letter to the insurance company explaining why the treatment or drug is a medical necessity. An appeal takes time and effort, and there are no guarantees, but it can mean the difference between having your health care plan cover certain items or not. As a last resort, you can contact your state's insurance commission if you have a complaint against the carrier or HMO.
- Ask your health care team if there are less expensive alternatives. For example, if recommended prescription drugs aren't covered by your plan, or your plan does not cover prescriptions at all, can the doctor prescribe a less-expensive generic drug or help you apply for special drug-assistance programs?
- Set up a payment plan with the hospital or doctor. It's much better to negotiate a small monthly payment than to ignore the bill completely.
- Consider fund raising. You can work with an existing community organization that has experience in fund raising for medical treatments. Search on the Internet or visit your local library to find a reputable nonprofit organization.
- Contact charitable organizations that advocate for individuals with your specific illness or medical condition. These nonprofits may be able to guide you to additional sources of assistance.

"In addition, be sure to check all doctor, hospital and lab bills for accuracy before paying them," Anthes says. Question anything that appears to be in error or that you don't understand. Mistakes on hospital bills are not uncommon. Also, don't assume that a hospital bill or health care plan claims office is right, or inflexible. You can only be sure that you are receiving the best possible coverage by exhausting all options. Finally, you also can improve the likelihood of receiving payment from your health care plan if you ask your doctor to write a prescription for items you may need, such as a wheelchair or other special equipment.

Can my plan be cancelled if I file too many claims?

No. However, once you reach the lifetime maximum of the policy, it no longer will pay benefits. A good plan has a $1 million or higher lifetime maximum. Some plans may reinstate a portion of the benefits each year if you reach the maximum. However, the reinstated amount is relatively small. If you can afford it and it's available, join a plan with an unlimited lifetime maximum.

I want to change to a better plan. Can I?

If your spouse has health insurance at work, you may be able to change plans during an open-enrollment period; but keep in mind that switching plans also may require you to switch doctors and hospitals. If you have an individual insurance policy, on the other hand, it may be difficult to change to a better plan because the insurance company probably will ask you medical questions to determine your risk and, after learning of your serious illness, deny you coverage. Be especially wary if a company offers to sell you a policy at a price far lower than others. You may be dealing with a phony insurer. Check with your state's insurance commission to make sure the company is licensed to do business in your state and to find out if complaints have been filed by other consumers.

Will I lose my coverage if I quit my job?

Not necessarily. If you quit your job and you are married to a working spouse, you may be able to join your spouse's plan. Or, if your employer falls under a federal law called COBRA, you can stay on the employer's group health plan for 18, 29 or 36 months, depending on the circumstances.

In general, COBRA applies to group health plans maintained by employers with 20 or more employees. You must pay the full cost of coverage (at the group rate) plus up to 2 percent additionally to cover administrative costs.

After COBRA coverage runs out, you can convert the policy to an individual plan. The individual plan may or may not cost more. Typically, benefits are not as good as the group plan, but at least you'll have coverage. Just be sure you get coverage in place within 62 days of going off the group plan so you can avoid any exclusion for a pre-existing condition.

I don't have a health care plan. What can I do?

Here are a few options to consider:

- If you are able to work, look for a company that offers a group health care plan. Even though you may be subject to a pre-existing condition exclusion period, eventually you'll have coverage.
- If you don't work for a company that offers a group health care plan and can't get accepted by an individual plan because of your health history, check into your state's plan for hard-to-insure individuals. "The cost may be high, but paying for a serious illness without a health care plan will be even higher," Anthes says. Call your state's insurance commission to learn about the program in your area.
- Find out if you are eligible to go to a community health center or if you or your family qualifies for any other government programs, such as Medicaid, Medicare, veterans' benefits or the Children's Health Insurance Program (CHIP). A hospital social worker can point you in the right direction. Another source of information is your State Health Insurance Program (SHIP). To find a SHIP in your state, call the

Eldercare Locator at 1-800-677-1116.

What else can help?

You may need to tap into other sources of cash to pay for medical care. For example, if your life insurance has a cash value, you can use it to get a loan from the insurance company or to withdraw some of the cash value out of the policy. You also may be able to convert part of your home's equity into cash by using a reverse mortgage.

"Managing health care costs when you have a serious illness can be a daunting challenge," Anthes says. "But by knowing what costs will be covered, where you may come up short and the available alternatives, you can start making a financial plan that will give you important peace of mind as you focus on your recovery."