Clinical Trial Coverage Mandate

- Federal provision does not preempt the (35) states with existing clinical trial coverage standards in place - establishes a universal, minimum rule.
- Health plans or issuers cannot deny participation in an approved trial
- Costs for routine care consistent with plan coverage ARE COVERED
- Plan will require trial participation through a NETWORK Provider
- Patients are still responsible for co-payments, deductibles, and travel costs
- Trial sponsors: Pharma./Tech. Companies, NCI/NIH/DOD/CMS (.gov trials)
- Medicare covers routine costs of qualifying clinical trials – (including reasonable/necessary services used to diagnose and treat complications)
- Medicaid: ACA does not apply to state Medicaid coverage for clinical trials

Affordable Care Act

- Cannot be denied coverage due to pre-existing conditions
- Cannot be charged higher premiums due to health status or gender (but can for smoking or age)
- Includes coverage of routine care costs for approved clinical trials
- No more lifetime or annual limits on coverage for essential services
- Coverage of preventive services at no out-of-pocket cost
- 10 categories of Essential Health Benefits coverage
- You have the right to appeal a health insurance company's decision to deny payment of a claim

QUALIFIED HEALTH PLANS

- Insurance that 'counts' as acceptable
  - Any plan purchased on the Marketplace
  - Retiree plans
  - COBRA coverage
  - Medicare part A or C, or Advantage
  - CHIPS plans for children
  - most Medicaid plans
  - TRICARE
  - Comprehensive group coverage through employer
  - Grandfathered plans

Insurance plans that do NOT count as coverage
- Vision or Dental policies
- Workers' compensation
- Coverage only for a specific disease or condition
- Plans that offer only discounts or cash payments to reimburse a certain defined list of services
- Catastrophic coverage (except for <$30/yr)
Insurance Marketplace

Allows consumers to research and compare plans directly.

One-stop shopping for those looking to enroll in plans or those that may be eligible for Medicaid or CHIPs.

Plans are grouped by category to help sort options, called Bronze, Silver, Gold, Platinum.

If your family is enrolling in a marketplace plan—everyone does not have to enroll into the same plan.

Can be individually based.

**NOT** for those who are enrolled in Medicare or Medicare-eligible.

You have the right to appeal a decision from the marketplace (ex: decision on financial assistance, eligibility for Medicaid, penalty exemption).

Direct Enrollment with Insurance Company

- Many insurance companies are also matching Marketplace open enrollment period in the fall with limited enrollment at other times.
- You can compare and research among that Insurer’s products only.
- May be able to offer you Marketplace plans and other non-marketplace plans in their portfolio.
- Web brokers: getinsured.com, healthsherpa.com, ehealth.com, gohealth.com

Calculating the Fee

If you don’t have coverage in 2016, you’ll pay the **higher** of these two amounts:

2.5% of your yearly household income. Only the amount of income above the tax filing threshold, (about $10,150 for an individual), is used to calculate the penalty.

$695 per person for the year ($347.50 per child under 18). The maximum penalty per family using this method is $2,085.

Examples: If your annual income is $35,000 a year and have a $75,000 income threshold, the penalty will be $250.

Exemptions from the Fee

- Income-related exemptions
- Health Coverage-related exemptions
- Group membership Exemptions
- Hardship Exemptions
- Other exemptions

*Grandfathered plans still in existence may not have to follow all ACA rules and provisions, including offering the Essential Health Benefits.*
Financial Challenges

Those diagnosed with chronic conditions frequently have challenges balancing financial obligations

- Medical Visits & Care
- Tests, Laboratory, Radiology
- Medication Costs
- Monthly Premium
- Over-the-counter needs
- Medical equipment
- Food & nutrition

Combined with:
- Decreased income due to time away from work

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Insurance Networks

Insurance plans vary in terms of network and covered services.

- Providers
- Specialists
- Facilities
- Diagnostics / Labs / Radiology
- Pharmacy

Network is constantly changing, provider relationships with insurer occur regularly with limited notice

Plans may have limited or no Out-of-Network coverage

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Choosing a Plan

Read the Plan Summary:
- Compare cost-sharing elements (co-pays, co-insurance, deductibles, out-of-pocket max)
- Review Non-Covered Benefits or Exclusions
- Perform sample calculations for various scenarios
- Know the difference in plan types (HMO, PPO, etc.)
- Understand your “typical” medical needs

Prescription coverage:
- May need you to research on Insurer’s website
- List of covered drugs (“formulary”)
- Prescription tiers – medications are assigned to a category based on drug usage, cost and clinical effectiveness
- Specialty drug tiers – the highest drug category, typically with the highest copayment or coinsurance amount
- Review network pharmacy and or mail pharmacy options

Cost Comparison:
**Keep in mind that your annual total cost of care goes beyond the monthly premium**

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Insurance Plan Transitions

When:
- Your plan is ending its plan term
- Your employer-based plan is ceasing
- You are researching plan options and looking to transition to a new plan
- Your eligibility for Medicaid/Medicare is changing
- You no longer meet coverage under family plan as dependent
- You have a life event affecting your insurance (marriage, divorce)

Why?
- Better reimbursement for treatment
- Better reimbursement for medications
- Different network of providers
- Lower out of pocket costs / deductibles
- Health Savings Accounts / Flexible Savings Plans

Treatment may be long-term, so review insurance plan options each open enrollment period....

.....even if you have been happy with your insurance.

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Plan Vocabulary to Know During Enrollment

- **Premium** – the amount that must be paid for your health plan benefits to be active. Usually paid monthly.
- **Out-of-pocket costs** – Your expenses for medical care that aren’t reimbursed by insurance. Out-of-pocket costs include deductibles, copayments, and coinsurance, and copayments for covered services plus all costs for services that aren’t covered.
- **Out-of-pocket maximum/limit** – the most you could pay during a plan year for covered services.
- **Deductible** – the amount you owe for health services before your plan begins to pay. During this period you pay 100% of all costs for care that is received.
- **Copayment** – a defined fixed amount you pay for covered health care services, for example $15 for office visit. This amount can vary by type of covered service.
- **Coinsurance** – your share of the cost of a covered health service, calculated as a percent of the allowed amount.
- **Formulary** – a list of approved drugs covered by a prescription drug program.

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What can you do?

Dealing with Your Insurance Network

- Become familiar with insurance-specific terminology (co-payment, deductible, etc.)
- Know your insurance plan language.
- Always check if your provider, facility or lab work is in-network beforehand.
- Obtain needed referrals if necessary
- Look for plan with out-of-network coverage in future
- Be familiar with insurance paperwork formats like EOBs, claims, prior authorizations, etc.
- Appeal if needed to treat out-of-network provider with in-network rates
- Call Insurer if any questions

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Example Comparison

<table>
<thead>
<tr>
<th>Molina Marketplace Gold HMO</th>
<th>Aetna Silver POS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Premium</td>
<td>$251 / month</td>
</tr>
<tr>
<td>Deductible</td>
<td>$1,000</td>
</tr>
<tr>
<td>Out of Pocket Maximum</td>
<td>$6,810</td>
</tr>
<tr>
<td>Primary Care Visit</td>
<td>$15</td>
</tr>
<tr>
<td>Specialist Visit</td>
<td>$25</td>
</tr>
<tr>
<td>Outpatient Facility Visit</td>
<td>$30 Co-insurance</td>
</tr>
<tr>
<td></td>
<td>35% out of network benefit</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Molina Marketplace Gold HMO</th>
<th>Aetna Silver POS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Drugs - Generic</td>
<td>$5</td>
</tr>
<tr>
<td>Prescription Drugs - Preferred and Non-preferred Brand</td>
<td>$50/100% co-insurance</td>
</tr>
<tr>
<td>Prescription Drugs - Specialty Drugs</td>
<td>20% co-insurance</td>
</tr>
<tr>
<td>Prescription Drugs Out-of-Pocket Maximum</td>
<td>Included in plan’s out-of-pocket maximum; $50 deductible</td>
</tr>
</tbody>
</table>

**Why are Specialty Drugs Challenging?**

**Not a “typical prescription” experience —**

- Special handling, administration or monitoring
- Terminology, process, reimbursement
- Limited distribution sites
- Prior authorization required; increasing number not covered
- Higher patient financial responsibility
- For chronic or difficult health conditions

**Insurance Appeals**

**Identifying the Reason for the Denial**

- Services are deemed not medically necessary
- Services are no longer appropriate in specific health care setting or level of care
- Services are considered experimental/investigational for this condition (off-label use of prescribed therapy)
- Clinical effectiveness of the procedure or therapy has not been proven
- Not eligible for the benefit requested under your health plan (Pre-authorization criteria not met)

**Preparing Your Appeal**

- Letter of medical rationale/necessity from your treating provider
- Chart Notes from your treating physician (outlining failed alternatives or effectiveness of service in question)
- Results of any relevant tests or procedures
- Current peer-reviewed literature, studies, clinical trial data from your doctor or well-recognized journals (documenting the medical effectiveness of the requested services)
- Your own personal narrative or the narrative of an authorized representative describing the need for the requested service
Employer-based Plans

Many employers will cover a portion of the monthly premiums on behalf of employee (not always for family or dependents).

May have workplace requirements for eligibility (e.g., hours worked each week)

Other benefits may go along with health plan options including:
- Health Savings Accounts along with High Deductible Plans
- Flexible Spending Accounts / Cafeteria Plans
- Supplemental benefits (e.g., vision or dental plans)
- *Additional pressure for supplemental plans

If you decline employers insurance, you may not be eligible for financial assistance through the Marketplace

Medicare Drug Coverage

- Part B covers outpatient injectable and infusion drugs administered as part of a physician service
- Part D covers oral or other self-administered drugs, certain vaccines
  - Drug Utilization Rules
  - Prior authorization: Medical Necessity
  - Quantity/Dosage limits
  - Step therapy: Requires trial of lower cost alternatives before the plan will cover the prescribed drug.
  - Plans have process in place to request exceptions to formulary

Medicare Supplemental Plans (Medigap)

- Sold by private insurance companies to pay "gaps" in coverage
- May provide receive benefits not covered by Medicare, e.g. emergency health care outside the U.S.
- You must have Medicare Part A & Part B to be eligible for a Medigap plan
- 10 plan options (A,B,C,D,F*,G,K,L,M,N) with Plan F offering all 9 Medigap benefits
- 27 states required to offer at least one plan option for disabled Medicare eligible individuals under 65

Medicare

Part A (Hospital Insurance)
- Pays for inpatient hospital stays, skilled nursing care, home health and hospice care

Part B (Outpatient Insurance)
- Covers doctor visits, some preventative services, diagnostic tests and durable medical equipment

Part C (Medicare Advantage)
- Combines Part A & B and may include Part D
- Managed by private insurance companies
- Different copayments, coinsurance or deductibles

Part D (Prescription Drug)
- Prescription drug coverage
- Compare Medicare Advantage and Part D stand-alone plans www.q1medicare.com

Special Enrollment Circumstances
- Life circumstances may allow you to make changes to Medicare Advantage or drug coverage
- Moving in or out of current plan area
- Losing other coverage: Opt out of enrollment in other coverage equivalent to Medicare
- Becoming eligible for Extra Help – continuous special enrollment
- You enter, live in or leave a long-term care facility

Medicaid

Medicaid is state-run insurance that provides medical assistance for people with limited income and resources

(Not a cash support program; pays medical providers directly for care)

You can apply:
- Through the Insurance Marketplace and it will screen you for Medicaid eligibility
- Directly with local Medicaid offices in your area
- Enrollment can take place at any time during the year
- You may lose eligibility at any time during the year based on changes in income

Medicaid plan types differ between states:
- You may have an HMO plan, Spend-down plan or different type of plan

Medicare Savings Programs

Qualified Medicare Beneficiary (QMB) $1481 (single) $2350 (married)
Specified Low Income Beneficiary (SLIB) $1503 (single) $2350 (married)
Qualified Individual (QI) $1517 (single) $2422 (married)
*Additional limits are $7,280/$10,930
Qualified Disabled and Working Individuals (QDWI)
Income assistance set at 200% of FPL ($1,050 for Individual)

Qualifying for Extra Help

You automatically qualify for Extra Help if:
- You have full Medicaid coverage
- You receive Supplemental Security Income (SSI)
- You get help from Medicaid paying your Medicare premiums

All others must apply:
Online at www.socialsecurity.gov
Call SSA at 1-800-772-1213

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State Decisions on Medicaid Expansion

Children’s Health Insurance Program (CHIP)

- Children and teens up to age 18
- Young people up to 21 may be covered under Medicaid
- Youth who have “aged out” of foster care can be covered under Medicaid until they reach age 26
- Eligibility depends on income, number of people in the family and rules in each state.
- Preventive services for children are available at no cost.

To apply:
- InsureKidsNow.gov
- 1-877-543-7669

After Enrollment
- You should receive a confirmation of effective plan dates following enrollment
- Ability to gain electronic access to insurer’s website, with more details of plan and provider network, formulary, copy of policy numbers
- Look out for a welcome packet with plan summary, insurance cards
- You will begin to see premium invoices connected to payment details. Make your payment promptly to ensure effective coverage!
- If receiving financial assistance, you will get a statement for tax purposes

If you do not receive these things, follow up immediately to ensure enrollment was completed and processed accurately!

Get Organized
- Develop a filing system to compare Explanation Of Benefits (EOB)/bill invoices
- Make a household budget
- Track deductibles
- Estimate out of pocket costs for anticipated services - utilize cost calculators!
  - www.healthcarebluebook.com
  - www.fairhealthconsumer.org
- Record notes of all interactions with insurer and billing contacts – keep a chronology of Dates of Service (DOS)

Medication Assistance Programs
- Co-Pay Relief Program www.coopayrelief.org
- MDS Fund is currently OPEN!
- Patient Access Network www.patientaccessnetwork.org
- Chronic Osteomyelitis Fund www.copays.org
- www.mDSFoundation.org
- The Leukemia and Lymphoma Society www.lls.org
- National Org. Rare Disorders www.rarediseases.org
- Akizel (acalabrutinib) www.akizel.com/patients/support
- Thymoglobulin ATG www.sanofipatientconnection.com
- Celgene: www.celgenepatientsupport.com

My Resource Search Mobile Phone App

www.patientadvocate.org/myresources

Or from APP STORE directly from your phone
Coverage Access Guide App

Coverage Access Guide: A Consumer's Guide to Insurance is designed to answer frequently asked questions about accessing, enrolling and maintaining healthcare coverage.

FREE, user-friendly, article-based educational guide geared to help current and future patients overcome common healthcare obstacles in order to enhance their overall healthcare experience.

Available exclusively in Apple's App Store for iOS phones and tablets

Built to address the challenges that are known to frequently occur for Narcolepsy patients

Questions? Concerns?

Thank You!

Check out www.patientadvocate.org/webinars for sessions available with the Patient Empowerment Series.