

Q&A:

What Breast Cancer Patients/Survivors Need to Know About the Health Care Reform Law

I. How Will the Health Care Reform Law Help Me With My Health Insurance Concerns?

1. I AM CURRENTLY UNINSURED BECAUSE OF MY HISTORY OF BREAST CANCER. WILL I NOW BE ABLE TO GET INSURANCE?

YES. As of July 2010, if you have been denied coverage due to a pre-existing condition such as breast cancer, you may be eligible to enroll in the temporary Pre-Existing Condition Insurance Plan (PCIP). The PCIP program, which is administered by either your State or the Federal government, will provide a new option for you if you are a U.S. citizen or legal resident who has been uninsured for at least six months, have a pre-existing condition, and have been unable to obtain health coverage because of your health condition.

The premium cost for high-risk pool coverage is established for a standard population in the non-group market and will not be based on the health status of enrollees. Premiums will be allowed to vary by age (by a 4 to 1 ratio), geographic area, and family composition. Under a PCIP, you will receive coverage for a broad range of benefits, including those necessary to treat the pre-existing condition.

Then in 2014, a range of new and more affordable health insurance options will become available for individuals and small businesses. The establishment of state-based health insurance exchanges will enable people to shop for standardized health insurance packages where you can no longer be discriminated against because of your breast cancer or any other pre-existing condition you may have.

Pre-Existing Condition Insurance Plan (PCIP)

<http://www.healthcare.gov/news/factsheets/2010/07/preexistingconditioninsuranceplan.html>

2. WHAT HAPPENS TO PEOPLE WHO ARE ALREADY IN HEALTH RISK POOLS? WILL INSURANCE COMPANIES BE ABLE TO CONTINUE CHARGING THEM A SURCHARGE FOR THEIR PRE-EXISTING CONDITIONS?

Due to the eligibility requirement for participation in the new Pre-Existing Condition Insurance Plans (PCIPs)—that participants not have had creditable health coverage for the previous six months—people who currently obtain health coverage through a state high-risk pool will most likely need to maintain their current coverage. Nothing in the health care reform law would make changes or restrictions on the premiums/surcharges charged by these pools.

In 2014, these individuals will likely transition into the state-based American Health Benefit Exchanges. Given that the Exchanges would prohibit people from being denied coverage or charged more based on health status and would limit cost-sharing, current state high-risk pool enrollees may receive more affordable coverage in the Exchanges than they currently have in the high-risk pool.

3. WILL I BE ABLE TO AFFORD THE PREMIUMS?

Currently, the Patient Protection and Affordable Care Act (ACA) attempts to make premiums more affordable under the new, temporary Pre-Existing Condition Insurance Plan (PCIP) by requiring that the premium cost for coverage be based on the rates of an average healthy person in the individual insurance market. Premiums will only allowed to vary based on age, where you live and how many

people are covered by it (whether just you or your family). In addition, the law requires greater transparency and tighter scrutiny on insurance premium and rate increases by private insurers. It also allows states to begin expanding Medicaid eligibility to non-elderly individuals at 133 percent of poverty (up to about \$15,000) or below. Beginning in 2014, all states must be in compliance with this Medicaid expansion, and federal subsidies will be available to low income individuals and families for the purchase of health insurance.

Medicaid Expansion

<http://www.healthcare.gov/using-insurance/low-cost-care/medicaid>

4. I HAVE INSURANCE, BUT I WORRY THAT MY INSURER WILL FIND A REASON TO TAKE AWAY MY COVERAGE IF I NEED TREATMENT AGAIN. AM I PROTECTED UNDER THE LAW?

YES. As of September 2010, insurers are prohibited from rescinding insurance coverage except in cases of fraud or misrepresentation. This applies to all health plans, whether you get coverage through your employer or purchase it yourself.

5. I HAVE METASTATIC BREAST CANCER. WILL MY INSURANCE COMPANY BE ABLE TO PLACE A LIFETIME CAP ON THE AMOUNT OF COVERAGE THEY WILL PROVIDE ME? WHAT ABOUT AN ANNUAL CAP?

The law prohibits the use of lifetime limits in all individual and group health plans and insurance policies issued or renewed on or after September 23, 2010.

It also restricts the use of annual dollar limits for all group plans and new individual market plans (except for individual market plans that are grandfathered). Plans issued or renewed beginning September 23, 2010, will be allowed to set annual limits no lower than \$750,000. This minimum limit will be raised to \$1.25 million beginning September 23, 2011, and to \$2 million beginning on September 23, 2012. For plans issued or renewed beginning January 1, 2014, all annual dollar limits on coverage of essential health benefits will be prohibited.

Lifetime and Annual Limits

<http://www.healthcare.gov/law/features/costs/limits/index.html>

6. WHAT HAPPENS IF MY INSURANCE COMPANY DOESN'T FOLLOW THE LAW? WHAT CAN I DO?

Your current state regulatory agency (such as the Department or Division of Insurance) will continue to retain their enforcement authorities under the law and you should contact them if you have concerns. The health care reform law also provides health insurance consumers the right to appeal decisions, including claims denials and rescissions, made by their health plans both through the plan's internal process and for the first time also to an outside, independent decision-maker, no matter what state they live in or what type of health coverage they have. In addition, resources are available to states to establish and strengthen consumer assistance programs designed to ensure consumers have access to accurate information about plans, rights and responsibilities.

Internal/External Appeals

<http://www.healthcare.gov/law/features/rights/appealing-decisions/index.html>

Consumer Assistance Programs

<http://www.healthcare.gov/law/features/rights/consumer-assistance-program/index.html>

7. AS A BREAST CANCER PATIENT SHOULD I BE WORRIED ABOUT COMPARATIVE EFFECTIVENESS RESEARCH AND HOW IT COULD NEGATIVELY IMPACT MY INSURANCE COVERAGE?

NO. Comparative Effectiveness Research (CER) is the evaluation of different options available for how to treat a particular medical condition or how care for a medical condition is delivered. CER can use a range of research tools. It can be a systematic review of existing evidence, a head-to-head clinical trial, or an innovative trial design that can inform coverage and other policy decisions. The purpose of CER is to gather the information we need to determine best care. For breast cancer patients, CER will

mean improved access to the best care available, care that is based on sound scientific evidence and delivered in a respectful and timely manner. NBCC knows that more care is not always better care and CER will help avoid costly, ineffective and potentially harmful treatments from being administered.

II. How Will the Health Care Reform Law Help Me Make My Own Decisions About My Health Care?

1. I WOULD LIKE TO PARTICIPATE IN A CLINICAL TRIAL BUT MY INSURANCE WON'T COVER MY CARE IF I DO. WILL THIS CHANGE UNDER THE LAW?

YES. Beginning in 2014 all group and individual plans will be required to cover the routine patient costs for clinical trial participants and may not discriminate against an individual based on participation in a clinical trial.

2. I HAD GOOD INSURANCE COVERAGE DURING MY BREAST CANCER TREATMENT. WILL I BE ABLE TO KEEP THE SAME PLAN I HAVE NOW?

YES. The law 'grandfathers' many existing group and individual health insurance plans—which can be both good and bad. While this means that your plan can stay the same, it also means that you do not get all of the benefits under the new health care reform law (for example, a grandfathered plan could still charge co-pays for preventative services where other plans could not). ALL plans however, grandfathered or not, are required to extend dependent coverage to adult children up to age 26 and prohibit rescissions of coverage. Grandfathered group plans are required to eliminate lifetime limits on coverage and beginning in 2014, eliminate annual limits on coverage. Prior to 2014, grandfathered group plans may only impose annual limits as determined by the Secretary of HHS.

And if your insurance plan starts to make big changes—such as significantly cutting or reducing benefits (i.e. can't eliminate care for people with a specific disease such as breast cancer) or significantly raising co-payment charges or deductibles it could lose its grandfathered status and be required to come into compliance with all provisions of the health care reform law.

Grandfathered Plans

<http://www.healthcare.gov/law/features/rights/grandfathered-plans/index.html>

3. WILL I BE ABLE TO CONTINUE GOING TO MY CURRENT DOCTORS UNDER THE HEALTH CARE REFORM LAW?

The rules under the law make clear that health plan members are free to select any available participating primary care provider, and they prohibit insurers and employer plans from requiring a referral for obstetrical or gynecological (OB-GYN) care. These requirements apply to all individual market and group health insurance plans except those that are grandfathered. If you are in a grandfathered plan, the rules currently in place under your insurance plan regarding the ability to designate your provider or directly access an OB-GYN will continue to apply.

III. How will the Health Care Reform Law Help Me Maintain or Expand Coverage Options for Myself and My Family?

1. AS A BREAST CANCER SURVIVOR DIAGNOSED AT A YOUNG AGE, I WANT TO ADD MY 24 YEAR OLD UNINSURED DAUGHTER TO MY HEALTH INSURANCE PLAN - CAN I?

YES. Young adults under age 26 can now be insured under a parent's insurance if their policy allows for dependent coverage. This rule applies to all plans in the individual market and to new employer plans. It also applies to existing employer plans unless the adult child has another offer of employer-

based coverage (such as through his or her job). Beginning in 2014, children up to age 26 can stay on their parent's employer plan even if they have another offer of coverage through an employer.

Coverage of Adult Children

<http://www.healthcare.gov/law/features/choices/young-adult-coverage/index.html>

2. I'M WORRIED THAT SOME BREAST CANCER TREATMENTS WILL NO LONGER BE COVERED. WILL THERE BE RATIONING? WHO DECIDES WHAT WILL BE COVERED?

Patients with breast cancer will continue to have access to the most appropriate treatment and services, as determined by the medical professionals overseeing their care. The law also attempts to get the best medical and scientific evidence available directly into the hands of providers through widespread adoption of health information technology. Having access to sound information will help inform decision making and better tailor the most effective course of treatment for women with breast cancer based upon their individual needs and circumstances.

3. WILL MAMMOGRAPHY SCREENING BE COVERED?

YES. Mammography screening was included as part of a package of essential preventive benefits that private plans and Medicare must make available to enrollees at no cost.

4. I'M AFRAID MAMMOGRAPHY SCREENING WON'T BE COVERED FOR ME ANYMORE SINCE I AM UNDER 50 YEARS OLD. IS THIS TRUE?

NO. Your mammogram will still be covered

5. I RECEIVED TREATMENT THROUGH THE BREAST AND CERVICAL CANCER TREATMENT PROGRAM (BCCTP). WHAT WILL HAPPEN TO THE PROGRAM NOW AND WILL I STILL BE COVERED IF I HAVE A RECURRENCE?

YES. The law makes no changes to the BCCTP, and uninsured women who are diagnosed with breast or cervical cancer are encouraged to continue to apply for this Medicaid coverage option. Women who don't have insurance coverage and have a recurrence could regain Medicaid coverage under the BCCTP.

6. I AM A BREAST CANCER PATIENT WHO DEPENDS UPON COBRA FOR MY HEALTH INSURANCE. DID THE HEALTH CARE REFORM LAW ELIMINATE COBRA? CAN I LEAVE MY COBRA PLAN AND JOIN THE PRE-EXISTING CONDITION INSURANCE PLAN (PCIP) IN MY STATE?

NO. The health care reform law did not eliminate COBRA or change the COBRA rules. Due to the eligibility requirement for participation in the Pre-Existing Condition Insurance Plans (PCIPs)—that participants not have had creditable health coverage for the previous six months—people who currently obtain health insurance coverage through COBRA will not be eligible and need to maintain their current coverage.

Additional Information about COBRA

<http://www.dol.gov>

7. WILL ALTERNATIVE THERAPIES, SUCH AS ACUPUNCTURE, BE COVERED UNDER THE HEALTH CARE REFORM LAW?

What exact benefits will be required to be covered is unknown at this time and will likely differ by state. However, an "essential benefits package" that all qualified health plans available on the state run insurance exchanges must cover will be determined prior to 2014. This package must include, at a minimum, ambulatory patient services; emergency services; hospitalizations; maternity and newborn care; mental health and substance use disorder services, including behavioral health; prescription drugs; rehabilitative services and devices; laboratory services; preventive services, including services

recommended by the Task Force on Clinical Preventive Services and vaccines recommended by the Director of the Centers for Disease Control and Prevention; and chronic disease management. In addition, the plans must cover pediatric services, including vision and oral care. These benefit requirements do not apply to grandfathered plans or self-insured plans.

It will then be up to the individual insurer to decide what additional benefits it will offer.

8. WILL THERE BE DIFFERENCES UNDER THE HEALTH CARE REFORM LAW DEPENDING ON WHAT STATE YOU LIVE IN?

YES. While bound by the legal principles and basic elements of the health care reform law, a large amount of how this law will be implemented will be based on decisions made by the individual states. Most significantly, states will be required to design an insurance purchasing mechanism for the residents of their states called an Exchange, which is required to be operational by the beginning of 2014. But they will also be responsible for many other aspects of implementing the health care reform law, such as the creation of high risk pools or Pre-Existing Condition Insurance Plans (PCIPs). How these elements are designed could vary significantly by state.

IV. How Will the Health Care Reform Law Help Me Have a Voice in Continuing to Improve Our Health Care System for Breast Cancer Patients/Survivors?

1. WILL WOMEN WITH BREAST CANCER HAVE A VOICE IN THIS HEALTH CARE SYSTEM?

YES. Women with breast cancer have the opportunity to comment on the new rules that are taking shape, participate on advisory committees, boards, panels and commissions established under the law, as well as take part in state initiatives that will contribute to the health care reform process. NBCC advocates worked hard to ensure that language was included in the legislation to require consumer representation on any committees, boards, panels or commissions formed under the law.