

Collaborative For Palliative Care

**Thursday, April 3,
2014**

***Another Kind of Pain: Economic,
Insurance and Resource Issues
for the Seriously Ill***

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Overview

The word “cancer” is a frightening word for anyone to hear. It is a signal that life is about to change dramatically. The changes are not only health related and affect the entire family.

The changes may include:

1. Possible profound physical disability for a temporary or more prolonged period of time
2. Loss of independence
3. Reduction in income or loss of income
4. Loss of employment
5. Loss of insurance benefits for self/
family
including loss of pharmacy benefits

6. Changes in family circumstances including family members inability to adjust to needs of ill family member
7. Transportation issues including difficulty getting to and from numerous appointments
8. Possible need to change medical providers if insurance is changed. This is especially upsetting if the client is in the midst of treatment

CST Services Model



We have patient education tools to teach clients about their options and how to navigate within the healthcare system.

Samples will be shown throughout this presentation.



How to communicate with client

1. Communicating with clients is a skill requiring professional level preparation. It is not a clerical task. Generally this is a task performed by Nurses, Social Workers or Case Managers.



2. Be a good listener!!! Hear the story and encourage the client to express all concerns and fears.

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- 
3. Use the most supportive approach possible
- Do not interrupt the client's narrative
 - Make quick notes of questions you have and ask when client has explained their concerns and needs



4. Ask questions to identify the issues that seem to be of greatest concern to the client.
5. Address those issues first. There are usually numerous concerns and they must be addressed in a systematic fashion.



6. Remember that no matter how many stories you have heard, every story is unique and important to the person needing help.



7. Remember that client priorities change as circumstances change.



8. Before your first contact have as much knowledge as you can about the services you are requesting including guidelines and income requirements. Example: Medicaid spend- down (surplus)

How to Communicate With Government Agencies

1. Explain as briefly as possible the mission of your organization. You are not serving yourself or your organization and you need to be sure that you are seen as a credible provider.

2. If needed have a signed consent form to act as a representative on behalf of client

Sample:

- a) Forms
- b) 3 way Conference call

CancerSupportTeam

AUTHORIZATION TO ACT AS REPRESENTATIVE

I, _____ authorize _____
name of applicant/recipient name of representative



from Cancer Support Team, 2900 Westchester Avenue, Suite 103, Purchase, New

York 10577 to represent me pertaining to _____ and

follow-up activities including representation at Fair Hearings as needed.

Signature

Date


- 
- 
3. Get a “toe in” with someone at the highest level that you can find.
- You can invite key members of government and or private organization to meet with your agency personnel
 - You can also seek opportunities to meet with representatives of these organizations at their work site



4. Always get names and telephone numbers



- create a log

Sample:

- Name and date of contact
- person contacted, role and phone number
- issue
- Outcome or plan

- 
- 5. Always be respectful even if you feel you are not receiving the help you want for the client.
 - 6. Don't be afraid to ask to speak with someone at a higher level if you think you are receiving inadequate assistance.
 - Make sure that you do not alienate worker, but explain need to clarify process

- 
- 
7. If you can't get in the front door try the back door or even a window
 - i.e. Contact colleagues in other agencies to see if they can help you to find a resource or alternative process



How to communicate/collaborate with colleagues from other organizations and agencies in an effort to obtain other kinds of assistance for patient (such as financial assistance, transportation, legal assistance, etc.)

- You can seek opportunities to participate in other organization meetings if it is supportive of the mission of your organization.

Examples:

Medicare 101

Senior Law Day

Affordable Housing Expo

Health Insurance

Private Health Insurance

- Group vs. Individual Policies including COBRA
- Types
 - Health Maintenance Organization (HMO)
 - Point Of Service (POS)
 - Preferred Provider Organization (PPO)
 - Fee For Service (FFS)

Note: Client can apply thru a Health Insurance broker

HMO

- HMO- Health Maintenance Organization networks coordinate all services and billing through one central organization. Services are provided under contract, so all facilities and health care providers either work for the network or are under contract with the network. Members pay a set premium every month. Eligible members can receive both inpatient and outpatient care at any hospital, pharmacy or clinic that is a part of the network.

POS

- POS plans combine elements of both HMO and PPO plans. Like an HMO plan, you will likely be required to designate a primary care physician who will then make referrals to network specialists when needed. Services rendered by your PCP are typically not subject to a deductible and preventive care benefits are usually included. Like a PPO plan, you may receive care from non-network providers but with greater out-of-pocket costs. You may also be responsible for co-payments, coinsurance and an annual deductible.

PPO

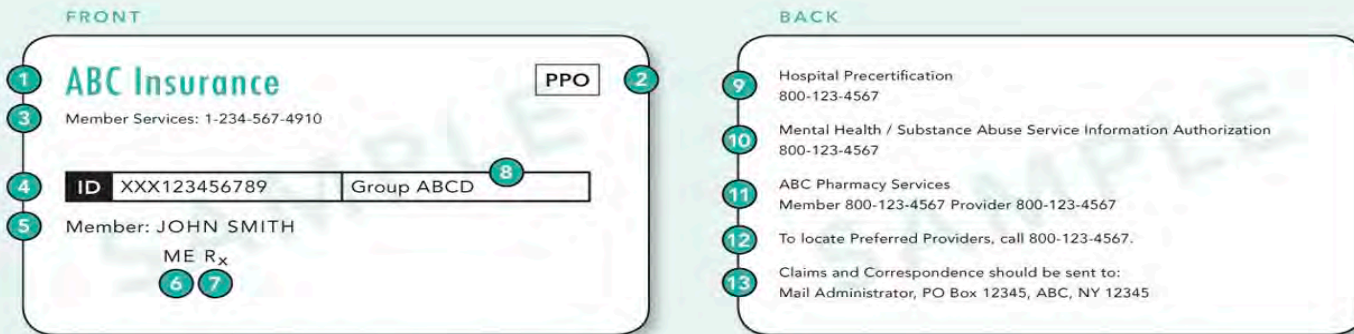
- PPO- Preferred Provider Organization plans provide health services through a network of doctors, hospitals and health care providers. They differ from HMOs in that members have the option of going outside the network. Services provided by non-network providers might still be covered under a PPO, though out-of-pocket costs will be higher, according to the American Institute of CPAs. Full coverage benefits only apply when members use providers who are contracted by the network.

FFS

- Fee-for-service plans are a straightforward type of coverage in which insurance companies pay for healthcare services provided to policyholders. With this type of coverage, you can choose any doctor you wish and change doctors any time or go to any hospital in any part of the country.

Anatomy of Health Insurance Card

Much of the information about your policy can be found on your insurance card. Some insurance companies include more information on the card; some include less. The elements noted may also be in a different place on the card.



1. Insurance company name
2. Type of policy (*HMO, POS, PPO*)
3. Phone number to call with questions
(*May be on the front or the back of the card*)
4. Member ID number
(*May include letters and/or numbers*)
5. Member name

6. Medical coverage (ME) offered under your policy
7. Prescription coverage (Rx) offered under your policy
8. Group number (If it's a group policy)
9. Phone number the hospital should call if you must be admitted

10. Phone number to call for mental health services
11. Prescription coverage information
12. Phone number to call to locate in-network providers
13. Address for written communication

Tips for Optimizing Health Insurance

Instruct client to:

- know what policy covers
- Request an insurance case manager, if available
- If not given a case manager, ask to speak with the same person each time you call, if possible
- Ask for approvals in writing, if possible
- Get pre-authorizations for care from the insurance company, if required
- Review “Explanation of Benefits” from insurance company and compare it to the bills from provider

Health Insurance Appeals

- CAN appeal a denial of coverage
- Make sure to have a copy of the denial letter with the specific reason the claim was denied
- Note the appeal deadlines
- Obtain a copy of current insurance policy or benefit plan
- Keep careful notes

Consider involving employer or human resources representative

- Consider contacting your state insurance agency for assistance with internal and external appeals

Appeals should be made to:

The NYS Department of Financial Services

Appeals and Complaints

For Appeals go to:

<http://www.dfs.ny.gov/insurance/extapp/extappqa.htm>

For Complaints and to file online go to:

<http://dfs.ny.gov/consumer/fileacomplaint.htm>

COBRA

- Consolidated Omnibus Budget Reconciliation Act of 1985
- Federal law that allows you to temporarily continue employer-based health insurance
- You will be required to pay the full premium – may be costly

COBRA

- Clients may be eligible for COBRA they have employer-based health insurance and:
 - Voluntarily leave job
 - Are laid off
 - Have work hours reduced
 - Have coverage through a loved one who becomes eligible for Medicare, dies, or is separated or divorced
 - is aging out of a parent's policy

Who Does NOT Have to Offer COBRA?

- Federal government
- Certain church-related organizations
- Employers who do not have 20 or more employees for at least 50% of the year
- New York State law also requires smaller employers (those with 2-19 employees) to provide continuation of group coverage benefits to qualifying individuals.

Tips About COBRA Coverage

- Depending on the “qualifying event,” COBRA coverage can last from 18 – 36 months
- Premiums can be expensive
- Some programs offer COBRA premium assistance (DSS)
- 60 days to elect COBRA coverage
- Premiums MUST be made in a timely manner
- If employer ceases group health coverage, COBRA will end
- If client becomes eligible for Medicare or Medicaid, COBRA will end
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- Premiums MUST be made in a timely manner
- If employer ceases group health coverage, COBRA will end
- If client becomes eligible for Medicare or Medicaid COBRA will end

State COBRA Plan

- For more information on NYS COBRA regulations visit:
<http://www.nyc.gov/html/hia/html/home/cobra.shtml>

Affordable Care Act

Affordable Care Act

- Benefits in 2014 and beyond
- No pre-existing condition exclusions for adults
- Expands Medicaid
 - All adults under 138% of federal poverty level
- Creates Health Insurance Exchanges
 - Subsidies to buy insurance

ACA Penalty

- The penalty in 2014 is **\$95 per person for the year (\$47.50 per child under 18)**. The maximum penalty per family using this method is \$285
- If you're uninsured for just part of the year, 1/12 of the yearly penalty applies to each month you're uninsured.

Affordable Care Act- Enrollment Periods

For coverage starting in 2015, the proposed Open Enrollment Period is November 15, 2014–January 15, 2015.

Buying a Marketplace plan outside open enrollment

- Client must have a qualifying life event.
- Qualifying life events include:
 - Getting married
 - Having, adopting, or placement of a child
 - Permanently moving to a new area that offers different health plan options
 - Losing other health coverage
 - Most special enrollment periods last 60 days from the date of the qualifying life event.

Affordable Care Act

10 basic services:

- Care at a doctor's office
- Emergency services
- Hospital care
- Pregnant mother and baby care
- Mental health and addiction treatment
- Prescription drugs
- Rehab and skill development services and devices
- Lab services
- Prevention & wellness services and long-lasting disease management
- Dental and vision care for children

Affordable Care Act Plans

Standardized Plan Options:

- Bronze 60% coverage
- Silver 70% coverage
- Gold 80% coverage
- Platinum 90% coverage
- Insurers can also offer “Catastrophic” plans.

How to Apply?

Online at:

Nystateofhealth.ny.gov

On the phone:

1.855.355.5777

Thru local navigators

ACA Westchester County Navigator information

Westchester County Department of Health

Leoni Parker (914) 813-5048

Health Insurance Access Program Director

Business Counsel of Westchester

Young Invincibles

Open Door

Planned Parenthood

Westchester Disabled on the Move

NY State Navigators

For complete listing in NY state go to:

<http://info.nystateofhealth.ny.gov/sites/default/files/IPA-Navigator%20Site%20Locations%20%28Updated%201-24-14%29.pdf>

Overview:

NY State of Health is the official online health plan marketplace for New Yorkers, and the only place where you can check your eligibility and apply for financial assistance. It is an easily accessible, one-stop-shop where you can compare costs and coverage, and buy a plan from a certified group of health issuers.

Who's Eligible:

NY State of Health is open to individuals or small business owners with 50 or fewer employees. Everyone should come to the Marketplace to see what it can offer.

Underinsured & Uninsured in New York State:

There are over 2.7 million uninsured and many underinsured in New York State. At full enrollment, nearly 1.1 million uninsured and underinsured New Yorkers will obtain health insurance through NY State of Health: 615,000 individuals and 450,000 small business members.

Mid-Hudson Specifics:

Navigators:

For a list of Navigators available in the state of New York by region, visit:
<http://info.nystateofhealth.ny.gov/IPANavigatorMap>

Underinsured & Uninsured Residents:

- There are nearly 295,000 uninsured New Yorkers in Mid-Hudson / Capital / North Country and many more are under-insured.
- At full enrollment, over 155,000 people in this region will obtain health insurance through NY State of Health: 93,000 individuals and 62,000 small business members.

Qualified Health Plans:

- | | | |
|---|--|--|
| <ul style="list-style-type: none"> - Affinity Health Plan - Today's Options - Fidelis Care | <ul style="list-style-type: none"> • CDPHP • Emblem Health • Empire Blue Cross Blue Shield • Excellus Blue Cross Blue Shield | <ul style="list-style-type: none"> • Health Republic (Freelancers) • MVP, MVP Health Plan, Inc. • United • OSCAR |
|---|--|--|

All plans include coverage in the following areas:

1) ambulatory patient services, 2) emergency services, 3) hospitalization, 4) maternity and newborn care, 5) mental health and substance use disorder services, 6) prescription drugs, 7) rehabilitative and habilitative services and devices, 8) laboratory services, 9) preventive and wellness services and chronic disease management, 10) pediatric services, including oral and vision care

Individual Marketplace: Individual Plans* - Starting Rates for Approved Monthly Premiums **

- Bronze: \$ 262
- Silver: \$ 330
- Gold: \$ 374
- Platinum: \$ 440

* Premiums starting as low as listed amount per tier.
All plans are not available in every county.
** Excludes possible tax credits

Average Plan Starting Rates, with Estimated Tax Credit (Silver Package):

Single adult earning \$30,000:	
Before estimated tax credit: \$ 330	After estimated tax credit: \$ 210
Family* earning \$60,000:	
Before estimated tax credit: \$ 661	After estimated tax credit: \$ 410

*"Family" refers to a family of four, with two adults and two children.

Small Business Marketplace: Individual Plans* - Starting Rates for Approved Monthly Premiums

- Bronze: \$ 285
- Silver: \$ 348
- Gold: \$ 407
- Platinum: \$ 479

* Premiums starting as low as listed amount per tier. All plans are not available in every county.

Find Out More:

Tax Credit and Premium Estimator: <http://info.nystateofhealth.ny.gov/PremiumEstimator>

NY State of Health Plan Map: <http://info.nystateofhealth.ny.gov/PlansMap>

Website: www.nystateofhealth.ny.gov

Twitter: www.twitter.com/NYStateofHealth

Facebook: www.facebook.com/NYStateofHealth

Google+: [NY State of Health](http://www.google.com/+NYStateofHealth)

Medicaid

- Federal health insurance for low-income individuals who meet eligibility criteria
- Funded by federal and state governments
- Eligibility in one state does not guarantee eligibility in another
- Some individuals can have both Medicaid and Medicare
- Website for complete information: http://www.health.ny.gov/health_care/medicaid/

B

NEW YORK STATE
BENEFIT
IDENTIFICATION CARD



ID NUMBER: AB12345C
CARD NUMBER: 600486 8888 8888 888 88

SEX: F
DOB: 11/11/1911

LAST NAME: DOE
FIRST NAME: JOHN

*PHOTO
HERE*

SIGNATURE HERE

50488
ACCESS NUMBER:
8888 8888 888

5612
88

What do I need to apply for Medicaid?

- The necessary documentation needed to apply for Medicaid will depend on your category, whether you fall under the Modified Adjusted Gross Income (MAGI) guidelines or non-MAGI guidelines which are defined in the previous section.

MAGI Eligibility Groups include:

- Pregnant Women
- Infants and Children under age 19
- Childless Adults to include individuals who are: not pregnant, age 19-64 (age 19 – 20 living alone), not on Medicare, and could be certified disabled but not on Medicare
- Parents/Caretaker Relatives
- 19 & 20 year olds living with parents
- Family Planning Benefit Program
- Children in Foster Care (Chafee)
- Application should be submitted thru
 - NYSTATEOFHEALTH.org

Non – MAGI Eligibility Groups include:

- SSI recipients
- Individuals who are age 65 or older, unless a parent/caretaker relative, blind or disabled and do not meet the criteria of the MAGI Eligibility Groups
- COBRA
- Medicare Savings Program (MSP)
- AIDS Health Insurance Program (AHIP)
- Foster Care and Former Foster Care
- Medicaid Buy-In for Working People with Disabilities
- Medicaid Cancer Treatment Program
- Residents of Adult Home run by LDSS, OMH Residential Care Centers/Community Residences

Application for Non-MAGI

- The paper application may only be printed and completed if you are applying at a local department of social services (LDSS) for Medicaid because you are over the age of 65 or an individual in your household is deemed certified blind or disabled or you are applying for Medicaid with a spenddown.

Go to:

<http://www.health.ny.gov/forms/doh-4220.pdf>

How do I know if my income and resources qualify me for Medicaid?

The chart below shows how much income you can receive in a month and the amount of resources (if applicable) you can retain and still qualify for Medicaid. The income and resource (if applicable) levels depend on the number of your family members who live with you.

2014 Income & Resource Levels*

Family Size	Net Income for Families; and Individuals who are Blind, Disabled or Age 65+		Resource Level (Individuals who are Blind, Disabled or Age 65+ ONLY)
	Annual	Monthly	
1	\$9,700	\$809	\$14,550
2	\$14,300	\$1,192	\$21,450
3	\$16,445	\$1,371	\$24,668
4	\$18,590	\$1,550	\$27,885
5	\$20,735	\$1,728	\$31,103
6	\$22,880	\$1,907	\$34,320
7	\$25,025	\$2,086	\$37,538
8	\$27,170	\$2,265	\$40,755
9	\$29,315	\$2,443	\$43,973
10	\$31,460	\$2,622	\$47,190
For each additional person, add:	\$2,145	\$179	\$3,218

*Effective January 1, 2014

Types of Medicaid

- Community Medicaid
- Medicaid (nursing Home Level)
- Medicaid with Spend- Down (Surplus)
- Medicaid with Supplemental Needs Trust
- “Emergency” Medicaid
- Medicaid thru Cancer Services Program (can only register if they have no other insurance and under 65. Income eligibility varies depending on diagnosis)

Medicaid Managed Care

- Clients need to choose an HMO at time of application or will be enrolled automatically
 - Affinity Health Plan
 - Fidelis Care NY
 - HIP (Emblem Health)
 - Hudson Health Plan
 - United Health care Community Plan
- Client should check with providers before making a choice

Medicaid Managed Long Term Care

- All Medicaid beneficiaries 21 years of age or older who require community-based long term care services for longer than 120 days will be required to enroll in **MLTC**, **PACE**, **MAP** or other acceptable Care Coordination Model.
- Mandatory enrollment began in 2012 and will be implemented over a 3 year period.
 - MANAGED LONG TERM CARE (**MLTC**) does not cover acute care hospital and physician services but provides care coordination for all health benefits for enrollees.
 - PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (**PACE**) adult day health centers where clients attend regularly and receive a variety of services.
 - MEDICAID ADVANTAGE PLUS (**MAP**) provide long-term and acute care services to Medicare/Medicaid recipients
 - FULLY INTEGRATED DUALS ADVANTAGE PROGRAM (**FIDA**) provide same services as **MAP** but with capitated rate to cover Medicare/Medicaid services.

Medicaid information

Patient name	
DOB	
Address	
SS#	
Case #	
Medicaid #	
Worker Name	
Worker phone #	
Worker fax #	
Date of application	
Case effective since	
Date of recertification	
Spenddown amount (If applicable)	
Supplemental needs trust? (If applicable)	

Emergency Medicaid information

Patient name	
DOB	
Address	
Case #	
Medicaid #	
Worker Name	
Worker phone #	
Worker fax #	
Date of application	
Case effective since	
Date of recertification	

For more information

Go to:

http://www.health.ny.gov/health_care/medicaid/

Medicaid Long Term Home Care Services Authorized

Home care:

- Personal Care (home attendant)
- Consumer-Directed Personal Assistance Program (CDPAP)
- Home Health Aide, PT, OT, (CHHA Personal Care)
- Private Duty Nursing

- Adult day care-medical and social
- PERS, home-delivered meals, congregate meals
- Medical equipment, supplies, prostheses, orthotics, hearing aids, eyeglasses, respiratory therapy, Home modifications
- Four medical specialties (podiatry, Audiology, Dental, Optometry)
- Non-emergency medical transportation
- Nursing home



"For me, crime pays for what Medicare doesn't cover."

GIN
COLLECTION

Medicare

- Federal health care insurance for:
 - Most US citizens 65 and over
 - Individuals who have been entitled to SSDI benefits for at least 24 months
 - Individuals entitled to Railroad Retirement benefits
 - Individuals with end-stage renal disease
 - Individuals with Amyotrophic Lateral Sclerosis (ALS)
- www.Medicare.gov

MEDICARE



HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY

JANE DOE

MEDICARE CLAIM NUMBER

000-00-0000-A

SEX

FEMALE

IS ENTITLED TO

**HOSPITAL
MEDICAL**

**(PART A)
(PART B)**

EFFECTIVE DATE

**07-01-1986
07-01-1986**

SIGN
HERE →

Jane Doe

Fee for Service Medicare

- Medicare Part A
- Medicare Part B
- Medicare part D

- 80/20 coverage
- Medigap supplemental plans- covers 20% not covered by Medicare

Medicare- Part A

Free for most Medicare beneficiaries

In general, Part A covers:

- Hospital care
- Skilled nursing facility care
- Nursing home care (as long as custodial care isn't the only care you need)
- Hospice
- Home health services

Medicare- part B

- Must pay for coverage \$104.90 monthly (premium depends on income)
 - Option to decline
 - Covers outpatient care (Doctor's Visits)
 - Premium usually deducted from Social Security check
 - Help may be available for low income individuals

Medicare- part B Covers

- **Medically necessary services**: Services or supplies that are needed to diagnose or treat your medical condition and that meet accepted standards of medical practice.
- **Preventive services**: Health care to prevent illness (like the flu) or detect it at an early stage, when treatment is most likely to work best.

Medicare- part B Covers

- Clinical research
- Ambulance services
- Durable medical equipment
- Mental health
 - Inpatient
 - Outpatient
- Second opinion
- Initial outpatient physical (1 time only). Then “Wellness visit”

Enrollment for Part B

- Should enroll before 65 years old
- Penalty for not enrolling in timely manner
- Do not need to enroll until employer insurance is terminated
- Open enrollment Period for part B is January 1st thru March 31st

Medicare Part C

- Also known as Medicare Advantage Plans
 - Private insurance company coverage**
- Managed Care
 - For example: HMOs or PPOs
- Limited out of pocket expense (usually over \$6,000 annually)

Medicare Part C

- Eligibility
 - Must have part A and B
 - Must not have End Stage Renal disease
 - Must live in service area of plan
- Open Enrollment- October 15- December 7th
- January 1st- Feb 14th can disenroll or change plans

Medicare Savings Program

Funded by the state Medicaid program, **Medicare Savings Programs (MSPs)** help eligible individuals meet some or all of their cost-sharing obligations under Medicare.

There are three separate MSP

- There are three separate MSP programs,
- The Qualified Medicare Beneficiary (QMB)
 - \$978 monthly individual income
 - Covers A and B premiums
- The Specified Low Income Medicare Beneficiary (SLMB) Program
 - \$1169 monthly individual,
 - Covers B premium only
- The Qualified Individual (QI) Program.
- \$1313 monthly individual
 - Covers B premium only
 - Note: Will not qualify for Medicaid with spend-down

No resources limits

...but don't
ask me to
explain the
Medicare
drug
benefit
program...

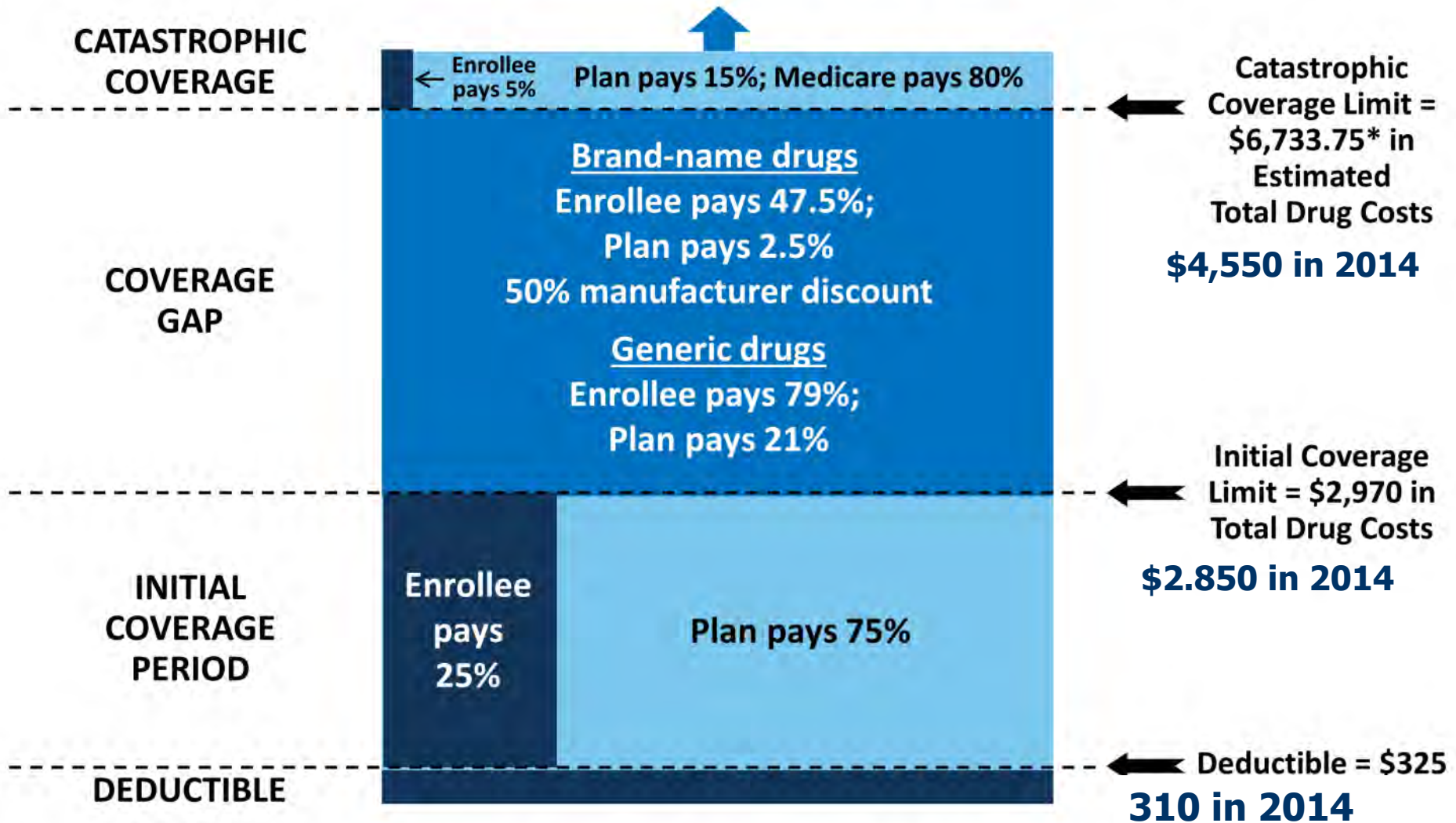
$$E=mc^2$$

MARGULIES
©2005 THE RECORD NEW JERSEY
www.northjersey.com/margulies

Medicare Part D

- Prescription coverage through Medicare
- Must enroll – not automatic

Standard Medicare Prescription Drug Benefit, 2013



NOTE: *Amount corresponds to the estimated catastrophic coverage limit for non-LIS enrollees (\$6,734 for LIS enrollees), which corresponds to TrOOP spending of \$4,750.

SOURCE: Kaiser Family Foundation illustration based on CMS standard benefit parameter update for 2013. Amounts rounded to nearest dollar.

Medicare Part D

- Ask pharmacist to see which local Medicare D plan covers your medications

Resources for MEDICARE

- For more information:
- [Medicare.gov](https://www.Medicare.gov)
- [Medicarerights.org](https://www.Medicarerights.org)
- Senior benefits information Centers at your local library Call 1800-333-4114

Obtaining Prescription Medications

Prescription Insurance

- Most insurance policies include a prescription drug benefit
- Often it is managed by a company other than client insurance company
 - Check with insurance company regarding coverage
 - Coverage differs from company to company
 - Keep careful notes when calling company including name of contact person and time and date of call as well as topics discussed

Formulary

- Each plan has a formulary or list of approved medications
- Formulary medications can usually be prescribed without pre-authorization
- The insurance company, not physician, decides what is on their formulary
- Some drugs have different levels of coverage
- Basic cost of drug defines the amount covered by insurance company

What is a formulary tier?

- A formulary tier tells you how much, if any, you will have to pay for a drug. Plans differ in the number of tiers they use. Most plans use 3 tiers; some use 4, and some have specialty tiers. In most cases, the tiers are defined as follows:
- Tier 1 – Generic drugs. Tier 1 drugs usually cost the least.
- Tier 2 – Preferred, brand name drugs. These are brand name drugs which cost more than tier 1 drugs.
- Tier 3 – Non-preferred, brand name drugs. These are also brand name drugs but are “non-preferred” in much the same way that a doctor might not be included in the list of “preferred” doctors on a managed care plan’s roster. Tier 3 drugs cost more than tier 1 and tier 2 drugs.
- Tier 4 – Some plans use this tier for specialty drugs, while others have a separate “specialty” tier. The drugs in these tiers are often very high-cost, name-brand drugs. Many times chemo drugs that you take by mouth can be found in these tiers.

If Your Provider Prescribes a Non-Formulary Medication

- Check to see if there is a formulary equivalent
- If not, talk with health care provider about requesting special formulary coverage from insurance company
- Step-therapy is often involved-
 - Step Therapy is a process whereby prescriptions are filled with an effective, but more affordable medication (Step 1). When appropriate, a more costly (Step 2) medication can be authorized if the Step 1 prescription is not effective in treating the condition. In other words, Step 2 prescription drugs will not be covered until Step 1 prescription drugs are first tried.
- Can appeal denials

Patient Assistance Programs

Assistance may be available if:

- Have no prescription coverage
- Have limited prescription coverage
- Cannot afford co-pays
- Have Medicare Part D and have hit the “donut hole”



NeedyMeds

Find help with the cost of medicine

[Home](#)
[Patient Savings](#)
[Advocates](#)
[Getting Started](#)
[NeedyMeds Services](#)
[More Info](#)
[About](#)

Drug Pricing Calculator

Find drug prices and pharmacies

[search »](#)

NeedyMeds Drug Discount Card

BIN: 600428
RX PCN: 05080000
RX GRP: 05380001
ID: NM0903150000



This is a drug discount program, not an insurance plan.

NeedyMeds Drug Discount Card App

- Download the card for savings
- Includes Pharmacy Finder
- Updated for iPhone and Android

This is a drug discount program, not an insurance plan.

NeedyMeds Has a New Look!

We invite you to navigate and explore the new site. In addition to the design change, we've added some new and improved features:

- Home page slider keeps you up-to-date on new announcements
- Drug pricing calculator tool on home page
- New subscription center, a one-stop registration for our services
- Add-a-program form to alert NeedyMeds on new programs

We hope you enjoy our new site. We want our users to have the best experience possible, so we welcome comments or suggestions. Please send them to webmaster@needymeds.org.

Join us for our monthly webinar on Jan. 23 at 1:00PM Eastern Time to get familiar with the new site layout.

» Over \$51,215,660.46 Saved
With NeedyMeds Drug Card

Consumer

EPIC

EPIC is a free New York State program that helps income-eligible seniors aged 65 and older to supplement their out-of-pocket Medicare Part D drug plan costs. Patients must have Medicare D in order to apply for EPIC.

Epic help line 1800-332-3742

Website:

www.nyhealth.gov/health_care/epic

Employment and Disability insurance

Employment and Disability insurance

There are different types of disability insurance including:

- Short Term Disability
- Long Term Disability

Family & Medical Leave Act (FMLA)

- Must meet eligibility criteria
- 12 work weeks of unpaid leave during any 12 month period
- Job and health insurance benefits are protected
- Can be used for medical leave or to care for a spouse, parent, or minor child

FMLA eligibility

- Work for an employer with 50+ employees within 75 miles of your worksite
- Worked for 12 months
 - Does not need to be consecutive
- Worked 1,250 hours
- For more information: www.DOL.gov/WHD

White Plains New York Area Office

US Dept. of Labor
Wage & Hour Division
140 Grand Street
Suite 304
White Plains, NY 10601

Phone:

(914) 682-6348
1-866-4-USWAGE
(1-866-487-9243)
Sonia Rybak
Asst. District Director

Social Security Disability Insurance (SSDI)

- Federal, long-term disability insurance
- Client may be eligible if:
 - Worked long enough and recently enough and paid into Social Security
 - Have a medical condition that meets Social Security's definition of disability
- For more information: <http://ssa.gov/pubs/10029.html>

Applying for SSDI

- Can apply by phone, in person or on the internet
- Have ready when starting application:
 - Social Security number
 - Birth certificate or other proof of age
 - Names, addresses, and phone numbers of treatment facilities, providers
 - Dates of treatment
 - Names of all medications taken

If Approved for SSDI

- Payments usually start with 6th month of disability
- Amount of benefit is based on how much client has paid into the system over time
- After receiving approval, client may be eligible to extend COBRA coverage for an additional 18 months
- After receiving checks for 24 months, client will qualify for Medicare

If You Are Not Approved for SSDI

- It is possible to appeal
 - Reconsideration
 - Administrative Law Judge
 - Appeals Council
 - Federal Court System

Client may be referred to:

Legal Services of the Hudson Valley at
877-574-8529

- If client is approved on appeal, he/she may be eligible to receive “retroactive” benefits

Other Types of Disability Insurance

- Federal Supplement Security Income (SSI)
- Private Disability Insurance
- Employer-Sponsored Disability Insurance
- State-Funded Disability Insurance Programs
- For more information on SSD or SSI call the Social Security Administration at:
800-772-1213

Community Resources

Financial Assistance

- Nonprofits
- Local, state, and county organizations
- Community programs

Credit Counseling

- National Foundation of Credit Counseling or other accredited program
 - www.NFCC.org

Retirement Funds

- Some employers permit borrowing from retirement fund
- Unreimbursed medical bills can qualify as a “hardship”
 - Income tax
 - 10% early withdrawal penalty
- **Highly recommend discussing with financial planner or advisor**

Life Insurance

- Loans
- Accelerated Death Benefit- allows the insured to collect part of their death benefits before they die.
- Viatical Settlements : the sale of a policy owner's existing life insurance policy to a third party for more than its cash surrender value, but less than its net death benefit. Such a sale provides the policy owner with an lump sum. The third party becomes the new owner of the policy, pays the monthly premiums, and receives the full benefit of the policy when the insured dies.
- **Again, highly recommend discussing with a financial planner or advisor**

Reverse Mortgage

- 62 years old or over
- Borrow against home equity for the duration of time in home
- Third party financial counseling required by HUD
- **Essential to obtain legal advice**

RESOURCES

- Cancer Support Team-Lifelines
- Cancer Care-A Helping Hand 800-813-4673
- www.CancerInsuranceChecklist.org
- For information on Westchester County services including housing, eviction prevention, senior services, etc.

Go to: Westchestergov.com

To Download This Presentation

- Go to:

www.cpcwestchester.org

For further information

Cancer Support Team
2900 Westchester Ave. Suite 103
Purchase, NY 10577
Lucille Winton-lwinton@cancersupportteam.org
Lourdes Parra-lparra@cancersupportteam.org
(914) 777-2777
Fax (914)777-2780