

PAYING FOR CANCER

Paying For Cancer Care

As we travel down the path of life, little thought is given to the devastating financial effects of serious, long-term illness. Our optimistic mindset relegates such possibilities to the distant future, if at all.

Thus, such circumstances are often met with fear, bewilderment and lack of sufficient knowledge. This especially holds true when the diagnosis is cancer.

This year alone, more than 2 million newly diagnosed Americans will be challenged with paying for medical care. Understanding what your federal and private insurances will cover, knowing the right questions to ask, and having a plan in place, will go a long way in alleviating some of the stress and overwhelming concern.

Some of the most important things to understand about cancer care are: 1) each treatment strategy is unique to the individual, and is contingent upon the type and stage of cancer, as well as age and physical well-being; 2) some treatments may require lengthy hospital stays and/or home nursing care; 3) therapies such as radiation or chemotherapy may be given daily over the course of several weeks; 4) most insurances will cover a percentage, but not all of the cost involved in receiving care; 5) some insurances may limit your care to those physicians participating in their program; 6) relatively new or experimental procedures may not be covered at all; and 7) procedures, such as reconstructive surgery following a mastectomy may be deemed an elective, and therefore also not covered by some plans.

Most insurance plans have a yearly annual deductible, which must be accrued (and paid by the beneficiary) before coverage payments begin. Additionally, plans may only pay a percentage of the cost, leaving the remaining portion to be paid out-of-pocket by the beneficiary. Many times, co-pays must also be paid for each office visit. These accumulated costs can exact a burden on family budgets.

The best course of action is to thoroughly research an insurance plan before joining. Become familiar with aspects such as deductibles, maximum lifetime coverage, percentages paid by the insurance, co-pays, Hospice and home care coverage.

Medicare

Medicare is a federal health insurance for those ages 65+, as well as those with certain disabilities. This program requires the beneficiary to pay for the first \$100 in approved yearly charges before coverage intercedes.

Medicare has two program tiers. The first is called **Part A**. Part A is free to those who either have worked and paid Medicare taxes for at least 10 years, or have a spouse who has done so. Those who have not met this requirement may be eligible by paying a monthly premium.

This plan covers hospital stay(s), limited skilled nursing, part-time home health care and Hospice care.

Part B is an elective program, which has a current premium of \$54 per month. This premium is deducted from the beneficiary's Social Security check.

In order to avoid paying higher premiums (additional 10\$ per year after eligibility and before joining), beneficiaries must elect this plan no later than 7 months after turning age 65.

The benefit of Part B lies in its coverage of 80% of an array of cancer treatment-related services, including: doctor's services; outpatient hospital care; diagnostic tests; radiology and pathology services; medical and surgical services; drugs and biologicals which cannot be self-administered; outpatient prescription drugs, which although limited, does cover cancer-related oral pharmaceuticals; prosthetic devices, including breast prosthesis after mastectomy; durable medical equipment (i.e. wheelchairs, hospital beds, oxygen, walkers).

Among costs not covered by Part B are deductibles, co-insurance (the amount not covered by Medicare) and co-payments.

Medigap

Many private insurance carriers offer plans to assist seniors in providing for the 20% not covered by Medicare.

Medicaid

Funded by both the state and federal governments, this program is designed to assist the economically disadvantaged who are too young to receive Medicare. Coverage includes inpatient and outpatient services, diagnostic testing, nursing care and drugs.

Private Insurances

These include traditional insurances, as well as managed care plans, such as HMOs, PPOs and IPAs. The important features to be aware of include the plan's deductible, maximum annual and lifetime coverage, percentage paid by insurance, prescription coverage, co-pays, Hospice care and home care.

Claim Submission

Most medical offices will do all claim submission for their patients.

Claim Denials

Claims may be denied due to lack of coverage for the type of care, missing information and/or incorrect documentation. Also preexisting conditions may disqualify the beneficiary from being eligible for related treatments. Insurance companies may refuse to cover procedures they deem experimental, investigational or unnecessary. It is therefore often best to contact your insurer before proceeding with treatments and tests.