FIND THE MISSING PIECES...

NATIONAL UNDERINSURED RESOURCE DIRECTORY

ACKNOWLEDGEMENT

The National Underinsured Resource Directory has been prepared by the Patient Advocate Foundation (PAF), a national network for healthcare reform and patient services located in Hampton Roads, Virginia.

It is the intention of Patient Advocate Foundation that this publication be an educational tool to inform consumers about the topic of the underinsured. It is designed to offer insight into resources offered to you should you be one of the many underinsured individuals.

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HOW TO USE THIS GUIDE

This publication is intended to help underinsured individuals and families locate valuable resources and seek alternative coverage options or methods for better reimbursement.

Information is being provided in three ways:

- A brochure that outlines recommendations.
- A series of pull-out cards with suggestions for resolving specific issues.
- A list of useful resources.

Having these suggestions handy will be helpful when speaking to your providers or insurance representatives. Each pull-out card includes space for note taking if necessary.

For those with access to the Internet, a more comprehensive model is offered through an interactive tool at http://www.patientadvocate.org/help4u.php.

INTRODUCTION

Patient Advocate Foundation published *The National Financial Resources Guidebook for Patients: A State by State Directory* after identifying the need for a comprehensive resource to provide information for people seeking relief for a broad range of needs. Some of these included housing, utilities, food, transportation to medical treatment, and children's resources. An interactive online tool was developed in 2001. The most current version of this information can be found on our website at http://www.patientadvocate.org/report.php.

In 2008, PAF noted a growing trend within its annual Patient Data Analysis Report, the annual statistical report compiled from the records of families who were served by PAF's patient service division. Of the patients who contacted PAF in 2008, more than 60% reported debt crisis issues as their primary concern. Further research revealed that 56% of those were related to healthcare expenses incurred by a person after the onset of an illness. We found that nearly 94% of these patients were fully insured. This last statistic is important as it reflects a growing crisis among America's ***underinsured*** population. These individuals are most frequently working, middle class Americans who are covered by a health insurance plan but cannot sustain financial stability after they have been diagnosed with a serious illness.

SECTION 1:

Health Insurance and the Underinsured

The numbers are in. An estimated 25 million Americans are reported to be underinsured. (*CNN Money*, 2009) Many people are finding that they are faced with obstacles associated with high medical costs despite having some sort of medical coverage. These people are underinsured.

Health insurance comes in many forms:

- Employer sponsored plans
- Individual/privately purchased plans
- Health Savings Accounts/High-Deductible Health Plans
- Risk pool or guaranteed issue plans
- Catastrophic/Limited benefit plans
- Military/TRICARE
- Medicare Entitlements
- Medicaid Entitlements

When a patient is diagnosed with an illness, he or she may quickly learn that their insurance coverage is inadequate and they are "underinsured." For this publication, *underinsured* is defined as having some insurance coverage but not enough, or when one is insured yet unable to afford the out-of-pocket responsibilities not covered by his or her insurer.

Insurance issues faced by consumers can go full circle, from benefit exclusions to running out of a specific benefit. We will be discussing issues commonly reported to Patient Advocate Foundation, including a brief definition of each term in the back of the publication. Following the terms, recommendations will be made to help find a positive outcome on your issues.

In order to help you navigate the healthcare system, we will divide the issues into two groups: financial and access to care. While you may be impacted by both, we will try to give specific recommendations to help overcome each of these obstacles.

SECTION 2:
Financial Issues

Financial issues often are a result of:

- Inability to afford out-of-pocket costs.
- Higher out-of pocket expenses related to out-of-network care.
- Pharmacy or medication related issues.
- Inability to afford COBRA premiums.

There are actions to consider if you are having difficulty affording your out-of-pocket responsibilities. Your goal is to find a positive resolution to your issue. These suggestions may help you achieve success.

- Make sure you are getting all the health insurance benefits you are entitled to by reading and following the specific requirements of your health insurance plan. Be sure to pay attention to what services are covered as well as excluded under the definition portion of your plan.
- Review your plan language for a complete list of participating providers and facilities to avoid additional expenses often associated with out-of-network care.
- Seek coverage options through personal or alternatively-sponsored plans for better coverage (example employer or spousal coverage).
- Apply for Medicaid programs if you meet the eligibility criteria. In the event you are determined not to be eligible for regular Medicaid, you may be able to qualify for other programs available through Medicaid such as Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiary program (SLMB), or a Medicaid Spend down (you pay a share of cost). You can obtain information on these programs and how to apply by contacting your local Medicaid office.

- Apply for county medical assistance programs when denied Medicaid. This program is not available in every county. However, when available, the program is a coordinated system for the low-income, uninsured of the county of residence to access needed medical care on a sliding scale or no cost. Contact your local Medicaid office to learn more.
- Seek financial assistance through state, national, or disease-specific co-pay assistance programs listed under the resource section of this book.

In addition to the information above, if the issues you are seeking assistance with involve co-payments, co-insurance or deductibles, you may want to try the following action step: inquire through treating hospitals, facilities, or providers about available assistance programs such as prompt-pay discounts, self-pay discounts, partial and full-charity care or reasonable payment arrangements.

Consider the following when you are approaching or have exceeded an annual, lifetime, or specific cap as outlined in your health insurance plan.

- Inquire through treating hospitals, facilities, or providers about available assistance programs such as prompt-pay discounts, self-pay discounts, partial and full-charity care or reasonable payment arrangements.
- Search for a Clinical Trial that is specific to your diagnosis. Clinical trials are a way for those to access other therapy after they have exhausted traditional or standard care. Clinical trials also provide an avenue to care for the uninsured or underinsured. Some trials absorb most or all of the treatment cost and can be a cost effective way to access care. The National Institute of Health (NIH) and National Cancer Institute (NCI) offer a broad range of clinical trials. NIH offers a broad range of trials whereas, NCI only offers cancer related trials. In order to be prescreened for these trials you must

call NCI at 1-888-624-1937 and NIH at 1-800-411-1222 to determine if you fit their criteria.
- Emergingmed offers a free online tool that helps cancer patients find appropriate clinical trials. They may be contacted at 1-877-601-8601 or on their website at www.emergingmed.com.
- Seek care through community health facilities, free clinics and your local health department.

You may find the following action steps helpful when you are seeking assistance with pharmacy or medication related issues.

- Explore discount drug options through large retailers, supermarket or pharmacy chains such as Walgreen's, Wal-Mart, CVS, or Target. Contact your closest retailer to see if a comparable program exists.
- Consider generic-equivalent medications with your doctor approval.
- Explore mail order options offered by your health insurance plan.
- Check with your provider to see if he/she can offer you samples of the medication.
- Apply for national or disease specific co-pay assistance programs. There are also free or low-cost drug programs. A complete listing is available in the resource section of this publication.
- Apply for state drug assistance programs by contacting your local state insurance commissioner's office. You can find a link to state specific programs at www.needymeds.com.
- Drug replacement programs may be available to assist you by providing medications directly to your physician's office for your use. Discuss these programs with your treating physician.
- Medicare Part D beneficiaries can call RxAssist at 401-729-3284 or link to www.rxassist.org link for a comprehensive database of patient assistance programs.

- Medicare beneficiaries can apply for a low-income subsidy (LIS), also known as Extra Help, to help cover full or partial costs of Medicare Part D. Additional information and eligibility requirements are available on the Social Security Administration website, https://secure.ssa.gov/ or by calling 1-800-772-1213.

SECTION 3:
Access

Even if you have health insurance, there may be times that you find yourself having problems being able to access necessary treatments or procedures due to your insurance plan, denying coverage. In this section we will be discussing access to care issues which you may be experiencing as a result of the following:

- Capped benefits
- Non-covered service or insurance denial
- Catastrophic health insurance plan coverage

You may find yourself in a situation where your insurance company is denying payment on your claim or not giving approval for services being ordered for you due to a specific benefit being exhausted or "capped out." If this is an issue for you, first review your health insurance policy to determine the length of any benefit cap limitation period. You need to determine if the specific benefit has an annual limit or a life time maximum. Depending on the medical urgency and with the approval of your physician, you may want to consider delaying treatment until such time as the benefit renews. If the benefit does not renew or it is not in your best interest to postpone treatment, you would need to consider self-paying for the treatment. Negotiate with your provider for a self-pay or prompt-pay discount.

Your insurance company may deny reimbursement for a specific treatment or service. Every insurance plan contains a definition or list of services they will not allow payment for due to being a "non-covered" service.

As a consumer, you have the right to appeal any insurance denial and provide additional information that may allow the insurance carrier to reverse their original determination. In order to do this, you will need to determine the specific reason for the denial. You will need to submit

your appeal based on that specific reason. For example, if the denial is based on not being a covered benefit under your insurance plan, trying to convince the insurance plan that the requested procedure or treatment is medically necessary will not affect the final outcome of the appeal. PAF has a publication entitled *Your Guide to the Appeal Process* that may be beneficial if you are finding it necessary to submit an appeal.

You may have purchased a health insurance plan that only offers **limited benefits** or what is known as **"Catastrophic"** health benefits. You may want to consider the following action steps if your health insurance plan provides limited or no benefit coverage:

- Utilize resources that provide a "cost calculator" for common procedures when negotiating a discounted rate. (Example: http://www.consumerreports.org/health/insurance/health-insurance.htm or http://www.lifehappens.org).
- Use free clinics for routine and primary care.
- Utilize state and federal programs for free pap and mammograms, breast and cervical cancer screening, and diagnostic services.

Below are resources that may be beneficial in securing coverage or access to care:

- **Conversion Plan:** Upon termination of the 18 month period of COBRA coverage, the plan member may be able to convert the policy to a private limited benefit policy. Contact your health plan.
- **Group Health Benefits/COBRA:** Determine if health coverage is available through you or your partner's employment or through a COBRA plan if you or your partner has recently left employment. For additional information you can visit www.dol.gov or call 1-866-444-3272.
- **Risk Pool Coverage:** Apply for Risk Pool Coverage which provides health insurance options for high risk individuals. These are

state programs that serve people who have pre-existing health conditions that often are denied or find it difficult to obtain affordable coverage in the private market. Contact your State Commissioner or access the following link www.naschip.org to determine which states offer such coverage. Some states have a waiting period.

SECTION 4:
Protections

The need to maintain or secure health coverage is a concern to everyone, but when you are diagnosed with a progressive or chronic disease, it is critical. Having insurance coverage ensures that you are able to continue necessary medical treatment both now and in the future. There are laws that have been put in place that provide protection to qualified individuals. Under the Health Insurance Portability and Accountability Act (HIPAA), beneficiaries covered by group health plans are safeguarded. Under private or individual plans, the insurer may impose a complete pre-existing exclusion of anything related to your diagnosis.

Health Insurance Portability and Accountability Act (HIPAA)
You have privacy rights under this federal law, passed in 1996, that protects your health information. These rights are important for you to know. As a consumer, you can exercise these rights, ask questions about them, and file a complaint if you think your rights are being denied or your health information is not being protected.

Who must follow this law?

- Most doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and many other healthcare providers.
- Health insurance companies, HMOs, most employer group health plans.
- Certain government programs that pay for healthcare, such as Medicare and Medicaid.

HIPAA provides insurance protections for beneficiaries covered by group health plans. It accomplishes this by:

- Limiting exclusions for pre-existing conditions.
- Prohibiting discrimination against employees and dependents based on their health status.

- Guaranteeing renewability and availability of health coverage to certain employees and individuals.

In order to be protected against pre-existing condition exclusions under HIPAA, there can be no lapse or break in health insurance coverage of more than 62 consecutive days, and you must have 12 months of continuous coverage prior to the effective date of a new group policy. You may be eligible for partial credit against pre-existing conditions if you have less than 12 months continuous coverage.

Once you are no longer covered by a health insurance plan, a certificate of credible coverage will be issued for you to provide to your new insurance company. To learn more about the protections under HIPAA, visit http://www.dol.gov/ or call 1-866-444-3272.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA is a federal law that requires certain employers with 20 or more full-time employees or equivalent in the previous 12 months to offer continuation of healthcare coverage to qualified beneficiaries.

Under COBRA, the status of the qualifying beneficiary and the qualifying event determines the length of time COBRA coverage is available. The usual length of COBRA coverage is 18 months unless there are other circumstances or state laws that would require the employer to extend the benefits to a maximum of 36 months. Some of these circumstances include:

- A Social Security Disability award is a requirement for patients seeking 11 month COBRA extension. To qualify you would need to be deemed disabled by Social Security Administration (SSA) within 60 days of enrolling in COBRA and you must notify your previous employer.
- Divorce, death, legal separation or when a dependent child grows older and is no

longer considered a dependent, may qualify you for the full 36 months. If the employee becomes entitled to Medicare coverage prior to leaving employment their family members can qualify for up to 36 months of COBRA coverage.

- If a worker becomes entitled to Medicare prior to leaving employment, his/her family member may qualify for up to 36 months of coverage.

If an individual is eligible for coverage under a COBRA plan, the state may provide benefits in the form of premium payments and allow the individual to maintain current coverage rather than be covered by Medicaid benefits. To find out if your state offers this benefit you can contact your local Medicaid office. Some states have rules in place that require employers with less than 20 employees to offer "mini-COBRA". The amount of coverage varies upon state and you must contact the insurer directly to enroll. For more information, contact your human resource department or visit www.cobrahealth.com.

Cost of COBRA:

You will find that the premium for COBRA is more expensive than you were paying while employed, as the employer no longer pays their portion of the premium payment. Under COBRA you have to pay up to 102% of the premium, including an administration fee. Some states offer premium assistance through their Medicaid program; this may be an option if you qualify for Medicaid and are struggling to afford your COBRA premiums. You can find out whether your state has a provision that allows this by contacting your local Medicaid office. There may be other programs offered through your state or federal government inquire with your Department of Labor or local state Department of Insurance.

It is your responsibility to pay your premiums. Read all paperwork you receive carefully. This will tell you where to send your insurance premium payments and whether or not you will receive monthly bills. Failure to pay the premium on time will cancel the coverage with no option for reinstatement.

For additional information on COBRA you can link to the Department of Labor at www.dol.gov/ebsa or call 1-866-444-3272.

SECTION 5:
Definitions

BENEFIT LIMITS also known as Capped Benefits can come in many ways such as annual, lifetime, or limit on a specific treatment. A benefit limit states how much the health plan will pay for a specific product or service, or the number of services a consumer may receive, an example would be the number of visits allowed for specialty physicians. Consumers are responsible to pay for products or services that are considered benefit exclusions and not covered by their insurance plan.

BENEFIT EXCLUSIONS are a healthcare product or service that is not considered eligible for coverage (payment) by health insurance plan.

CATASTROPHIC PLAN may be referred to as a Limited Benefit Plan. It is an insurance policy that provides minimal or "bare bones" coverage for an unexpected illness or injury with lower monthly premiums and caps on out-of-pocket expenses. The limitation on the benefit may be daily or per incident.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) This federal law ensuring that employers with 20 or more employees allow for continuation of group health benefits for a temporary period of time under certain circumstances (such as loss or change of employment, reduction in hours worked, death, divorce or other life events). A qualified beneficiary is any individual covered by the plan the day before the qualifying event. Each beneficiary can elect COBRA independently.

CO-INSURANCE An insurance policy provision under which both the insured person and the insurer share the covered charges in a specified ration (e.g. 80% by the insurer and 20% by the enrollee).

CO-PAYMENT A cost-sharing arrangement in which the managed care enrollee pays a

specified flat amount for a specific service (such as $15.00 for an office visit or $10.00 for each prescription drug). Typically it does not vary with the cost of the service, unlike co-insurance, which is based on a percentage of charges. You may see a variation in non-formulary drug co-pays which are based on a percentage of the total cost.

DEDUCTIBLES: Amounts required to be paid by the insured under a health insurance contract before benefits become payable.

DISCOUNTED FEE-FOR-SERVICE An agreed-upon rate for service between the provider and payer that is usually less than the provider's full fee. This may be a fixed amount per service or a percentage discount. Providers generally accept such contracts because they represent a means of increasing their volume or reducing their chances of losing volume.

MEDICAID is a federal and state-funded program that administered by the individual states. You must meet one of the eligibility criteria (aged, blind or disabled, or under 19) for the program, as well as the income and asset requirements. There are no national guidelines governing the program, so eligibility requirements vary from state to state. For further information you can contact your local Medicaid office or visit www.cms.hhs.gov to research the benefits available in your state.

NON-COVERED SERVICE OR INSURANCE denials can be a result of a pre-existing health condition, benefit exclusion of the plan or not obtaining pre-authorization prior to receiving a service.

OUT-OF-NETWORK issues occur when a member uses a hospital, physician or other providers that do not have a contract with the insurance plan. Depending on the provider you would be subject to balance billing, the difference between what the provider charges and your insurance pays. If you belong to a HMO health plan there is no benefit if you use

non-participating providers unless an exception is made by the health insurance plan.

OUT-OF-POCKET COSTS are the amounts for healthcare products or services which members are responsible to pay. Out-of-pocket costs include co-payments, co-insurance and deductibles as well as the insurance premium.

PHARMACY BENEFITS describe how your insurance will cover prescription medications. There are a variety of pharmacy benefits such as:

- Benefit Limits or Caps determine how much the insurance plan will pay for specific healthcare products or services, or the quantity of services a consumer may receive.
- Generic only coverage which does not cover brand name drugs but allows for medicine that is the chemical equivalent of a brand-name drug.
- Off-Formulary drugs are medications being prescribed for you but are not on your insurance formulary.
- Off-Label drugs are medications being prescribed for you but that have received FDA approval but not your specific diagnosis.
- Non-covered benefits are for a requested medication not eligible for payment through the health insurance plan.
- Specialty or high-tier drugs is a list of medications determined by the insurance plan that are assigned different levels of cost share and co-payments.

PRE-AUTHORIZATION (PRIOR AUTHORIZATIONS) is determined by each health insurance plan and requires that their members receive approval before undergoing specific medical treatments, tests or surgical procedures.

PRE-EXISTING CONDITIONS are a prior medical condition for which a plan member has received, or was recommended to receive, medical advice or treatment before the effective date of the health insurance plan.

PREMIUM The amount paid to an insurer for providing coverage, typically paid on a periodic basis (monthly, quarterly, etc.).

PREVAILING CHARGE This is a fee based on the customary charges for covered medical insurance services. In Medicare payments for services or items, it is the maximum approved charge allowed.

REASONABLE CHARGE A method used by Medicare to determine reimbursement for items or services not yet covered under any fee schedule. Reasonable charges are usually determined by the lowest of the actual charge, the prevailing charge in the locality, the physician's customary charge, or the carrier's usual payment for comparable services.

REIMBURSEMENT Refers to the actual payments received by providers or patients for benefits covered under an insurance plan.

USUAL, CUSTOMARY, AND REASONABLE (UCR) CHARGES Are a calculation by a managed care plan of what it believes is the appropriate fee to pay for a specific healthcare product or service, in the geographic area in which the plan operates. "Usual" refers to the individual physician's fee profile, equivalent to Medicare's "Customary" charge screen. "Customary," refers to a percentile of the pattern of charges made by physicians in a given locality. "Reasonable" is the lesser of the usual or customary screens.

SECTION 6:
Patient Resources

PAF seeks to empower patients across the country to take control of their healthcare. Since you are reading this book, you may find yourself in a position the same as many other American's that are having difficulty affording their high out-of-pocket medical costs. The following section will offer resources to help you locate assistance programs that may be able to assist you offset these cost.

A more comprehensive interactive tool is available on the Patient Advocate Foundation website at http://www.patientadvocate.org/help4u.php. You can log in and register and by answering a few simple questions obtain a personalized listing of specific resources matched to your needs.

RESOURCES FOR DENTAL

- National Foundation of Dentistry for the Handicapped
  303-534-5360
  www.nfdh.org

- American Dental Association
  Provides a listing of accredited dental schools. Maybe an option for discounted service.
  312-440-2500
  www.ada.org

RESOURCES FOR VISION

- EyeCare America
  Provides free eye care educational materials and facilitates access to eye care—at no out-of-pocket cost.
  1-800-222-3937
  www.eyecareamerica.org

- New Eyes for the Needy
  Helps improve the vision of poor children and adults in the United States by providing new or recycled donated glasses
  1-973-376-4903
  www.neweyesfortheneedy.org

- Vision USA
  Provides basic eye health and vision care services free of charge to uninsured, low-income people and their families.
  1-800-766-4466
  www.aoa.org/visionusa.xml

RESOURCES FOR HEARING

- Hear Now
  Hear Now is a national non-profit program committed to assisting those permanently residing the in the U.S. who are deaf or hard of hearing and have no other resources to acquire hearing aids.
  1-800-328-8602
  www.starkeyhearingfoundation.org

CO-PAY ASSISTANCE PROGRAMS

These programs are set up to assist patients with insurance that have co-pays for chemotherapy or prescription medications. Every program has its own guidelines. You can contact the organization for eligibility criteria. The contact information is provided below.

- Patient Advocate Foundation's
  Co-Pay Relief
  1-866-512-3861
  www.copays.org

- Healthwell Foundation
  1-800-675-8416
  www.healthwellfoundation.org

- Patient Access Network Foundation
  1-866-316-7263
  www.patientaccessnetwork.org

- Chronic Disease Fund
  1-877-968-7233
  www.cdfund.org

- Patient Services Incorporated
  1-877-968-7233
  www.uneedpsi.org

- Leukemia and Lymphoma Society
  1-877-557-2672
  www.lls.org/copay

- Cancer Care Co-Pay Assistance Foundation
  1-866-552-6729
  www.cancercarecopay.org

- Caring Voice Coalition, Inc
  1-888-267-1440
  www.caringvoice.org

- National Organization of Rare Disorders, Inc.
  1-800-999-6673
  www.rarediseases.org

OTHER CO-PAY OPTIONS

- Managed RX
  A pharmacy program that will waive your co-payment on medications and ship them to you at no cost if you meet certain eligibility requirements.They do not assist with Medicare or Medicaid patients.
  1-800-799-8765
  www.managedrxplans.com

- Needy Meds
  Informational website that has up-to-date contact and instructions about various pharmaceutical manufacturers' drug assistance programs and a listing of co-pay and state programs.
  www.needymeds.com

FEDERAL PROGRAMS

- Veterans' Administration
  Provides a broad spectrum of medical, surgical and rehabilitation care to its qualified veterans and their dependents. Treatment for services is based on the veteran's financial need.
  1-877-222-VETS
  www.va.gov

- U.S. Department of Health & Human Services
  United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. The office of the Inspector General U.S. Government Hotline is for individuals to call for complaints regarding Medicare or Medicaid, as well as providing assistance with entitlements, benefits, insurance and resources.
  1-877-696-6775
  www.cms.hhs.gov

COMMUNITY RESOURCES

- United Way
  Call 2-1-1 for help with food, housing, employment, healthcare, counseling and more.
  calling 2-1-1
  www.211.org

- American Cancer Society
  Offers numerous resources, including printed materials, counseling for patient and their families and information on lodging for people who may require treatment far from home. Contact your local chapter to find out about resources available in your community. Local ACS office may offer reimbursement for expenses related to cancer treatment including transportation, medicine and medical supplies. Financial assistance is available in some areas.
  1-800-227-2345
  www.cancer.org

- Catholic Charities
  Provides assistance for meeting basic needs—mortgage and rent assistance, utility assistance, food, clothing, medical supplies and prescription drug assistance, shelter, transportation. Online resource provides local phone number.
  1-703-549-1390
  www.catholiccharitiesusa.org.

- Salvation Army National Headquarters
  Provides assistance on a case-by-case basis
  1-800-378-7272
  www.salvationarmyusa.org

Contact your local house of worship to inquire for any relief programs

- National Patient Travel Center
  Provides information about all forms of charitable, long-distance medical air transportation and provides referrals to all appropriate sources of help to patients who cannot afford travel for medical care.
  1-800-296-1217
  www.patienttravel.org

- National Association of Hospital Hospitality Houses, Inc.
  Provides information on free or low-cost temporary lodging to families or patients who are undergoing treatment away from home.
  1-800-542-9730
  www.nahhh.org

HEALTH INSURANCE RESOURCES:

The following resources can provide additional guidance on locating state laws and health insurance options.

- Guide to finding health insurance coverage in your state by Robert Wood Johnson Foundation.
  http://covertheuninsured.org/stateguides
- A state by state consumer guide for getting and keeping health insurance by Georgetown University Health Policy Institute.
  http://www.healthinsuranceinfo.net
- A comprehensive state by state guide to find your rights to specific coverage such as guaranteed issued plans, pre-existing medical conditions, prompt-pay laws and if your state offers high risk health insurance coverage.
  http://www.insure.com/articles/interactive-tools/lawtool/lawtool.jsp

ACCESS TO CARE RESOURCES:

Clinical Trials: Clinical trials are a way to access care and provide an option for care for the uninsured or underinsured. Some trials absorb most or all of the treatment cost and can be a cost effective way to access care.

- The National Institute of Health (NIH) offers a broad range of trials
  1-800-411-1222
  www.nih.gov
- National Cancer Institute (NCI) only offers cancer related trials.
  1-888-624-1937
  www.nci.gov
- EmergingMed offers a free online tool that helps cancer patients find appropriate clinical trials.
  1-877-601-8601
  www.emergingmed.com

- The U.S. Department of Health & Human Services, Health Resource and Services Administration (HRSA)
  This link will connect you to federally-funded health centers regardless of your ability to pay.
  1-877-464-4772
  www.findahealthcenter.hrsa.gov

- The Hill-Burton Program
  A program run by the U.S. Government that can arrange for certain medical facilities or hospitals to provide free or low-cost. These facilities are obligated to provide free or reduced cost care. Patient's should inquire about the possibility of free services before entering the hospital, as many have fulfilled or are very close to fulfilling their requirement.
  1-800-638-0742
  www.hrsa.gov

- If you are concerned by breast or cervical symptoms and need screening services, Contact the Breast and Cervical Cancer Program before you seek care.
  1-800-232-4636
  http://www.cdc.gov/cancer/nbccedp

Disclaimer:

Every effort has been made to make this guide as up-to-date as possible, however, change is inevitable. If you find any information that is not current or incorrect in this publication, please notify us and we will correct it in the next printing. Furthermore, if there are other organizations that are not listed here that you feel would be helpful to others, please contact us at 1-800-532-5274 or email your suggestions to info@patientadvocate.org.

SECTION 7:
Bibliography

The Managed Care Answer Guide. Patient Advocate Foundation. (Third Edition, 2009)

The National Financial Resource Guide for Patients: A State-by-State Directory. Patient Advocate Foundation. (Second Edition, 2002)

Your Guide to the Appeal Process. Patient Advocate Foundation. (2000)

A Greater Understanding: Help! I'm Underinsured. Publication No. 10. Patient Advocate Foundation. (2006)

A Greater Understanding: Health Insurance for Young Adults: Why you need it and How to keep it. Publication No. 6. Patient Advocate Foundation. (2003)

Patient Data Analysis Report (PDAR) for 2008. Patient Advocate Foundation. (2008)

CNN Money, Underinsured Americans: Cost to you. As the recession shrinks health care coverage for more households, experts warn of a double-whammy on all consumers. Retrieved 12/10/09 from http://money.cnn.com/2009/03/05/news/economy/healthcare_underinsured/index.htm

United States Department of Labor, Employee Benefits Security Administration. Retrieved on 11/15/09 from http://www.dol.gov/ebsa/

Centers for Medicare & Medicaid Services. Retrieved 11/22/09 from www.cms.gov

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MISSION STATEMENT

Patient Advocate Foundation (PAF) is a national non-profit organization that serves as an active liaison between the patient and their insurer, employer and/or creditors to resolve insurance, job retention and/or debt crisis matters relative to their diagnosis through professional case managers, doctors and attorneys. PAF seeks to safeguard patients through effective mediation assuring access to care, maintenance of employment, and preservation of their financial stability.

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