# Frequently Asked Questions About Health Insurance

***Q #1: My employer doesn't offer health coverage.  Where else can I get health insurance?***

A #1:  A good place to start your research is www.healthinsuranceinfo.net, which provides Health Insurance Consumer Guides arranged by state.  (If you do not have access to the web, ask your chapter to print out the section relating to your state and mail it to you.)  The Consumer Guides provide concise, easily readable information about the laws and programs existing in each state, and reviewing it first can save you a lot of time talking to insurance companies, brokers, HMOs or others.  Read the guide with this question in mind—"What coverage might I be entitled to?"

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The options available to an individual are based on federal and/or state law, an individuals' employment status, age, medical history, income and more.  For example, you may be able to convert your previous group coverage to an individual policy, enroll in a high risk pool, receive coverage

through a family member’s policy, enroll in a state pharmaceutical assistance program, or obtain care through the Veterans’ Administration. Making sense of your options can be challenging, but do not rule yourself (or loved one) out of anything. If you are unsure, ask for help.

***Q #2. When do employers have to offer health insurance benefits to their employees?***

A #2. At present, employers do not have to offer health coverage as a benefit to their employees and/or their dependents. However, most employers do offer health plan enrollment as an optional benefit and pass some of the premium costs on to any eligible employees who choose to enroll. Note also that even when employers offer health benefits, the employer determines the benefit package and eligibility requirements for employees and/or their dependents. For example, an employer is free to provide benefits to full time employees who have successfully passed a probationary period of employment for six months.

***Q #3: Can I find out about a prospective employer's health benefits before I take a job?***

A #3: Yes, and you should. These days, health coverage is an important consideration for almost everyone, and inquiring about health benefits is normal whether or not a job applicant has a chronic health concern. Ask if there is any information about the health plan you can see in writing before you make a commitment. Try to be casual about your questions, and suggest that you want to compare the plan's benefits with those of your current plan or other options for coverage open to you. Keep in mind that an employer cannot base a job offer to you on the knowledge or even perception of a disability.

***Q #4: Can I be excluded or dropped from my group health plan due to my MS?***

A #4: No. If you, your spouse and/or dependent(s) are eligible for group health benefits from an employer, a federal law known as HIPAA (The Health Insurance Portability and Accountability Act of 1996) guarantees that no individual can be singled out and excluded from the group health

plan due to their health status or history. The same law also guarantees that an individual eligible for group health benefits cannot be charged more in premiums due to a medical condition.

***Q #5: What is a preexisting condition? Does taking medication qualify as "treatment"?***

A #5: Federal law defines a preexisting condition as either a physical or mental condition, regardless of the cause, for which medical advice, diagnosis, care or treatment were recommended or received within the six month period ending on the date of enrollment in a new plan. The legal definition is intentionally broad in scope to include virtually anything for which an individual saw or consulted with a health professional, or received treatment. "Treatment" includes any type of therapy, diagnostic test, consultation, and medication.

***Q #6:  How would a health plan find out about my pre-existing condition?***

A #6:  When you first enroll in a group health plan, the employer or insurance company may ask if you have any pre-existing conditions.  Or, if you make a claim during the first twelve months of coverage, the plan may "look back" to see whether it was for such a condition.  Insurers and HMOs share claims data and routinely look back into these records for preexisting conditions as their way of protecting everyone against fraud.  Fraud is a serious offense, which can lead to the loss and future ineligibility of coverage for you and your dependents.  Failure to disclose information about your medical history or preexisting condition if or when asked is simply not worth that risk.

***Q #7: How long can I keep my group health benefits under COBRA?***

A #7:  Under normal circumstances, a qualified beneficiary (former employee, and/or a spouse or dependent child) who "elects coverage" under COBRA (and/or a spouse or dependent child) may continue with a group health plan for up to 18 months.  For COBRA qualifying events

affecting the spouse or dependent children, such as separation, divorce, death or children leaving the plan due to age, the period is up to 36 months. Disabled individuals may extend their group benefits to 29 months if the Social Security Administration determines they had a disability at the time they left work.

***Q #8: I did not continue my health benefits under COBRA when I left my job a few weeks ago because I couldn't afford it. But now my parents are offering to help me out by paying the COBRA premiums. Can I still get the group health benefits?***

A #8: Yes, but contact your former employer to tell them you want to "elect COBRA" without further delay. Anyone eligible for COBRA continuation benefits has only 60 days to elect their COBRA benefits.

***Q #9:  I have been covered by my husband's group health plan through his job, but now we are getting divorced.  What will happen to my health benefits?***

A #9:  A divorce is a qualifying event under COBRA law, so if you were eligible for benefits before the qualifying event, you will be eligible for a continuation of benefits under the law. Divorced spouses are eligible for continued benefits for up to 36 months provided the premium (and 2% administrative fee) is paid.  You will want to review plans for COBRA payments, as well as any future plan's premiums, in your divorce negotiation.

***Q #10: Can I enroll in both my own employer's plan and my spouse's plan? Is it worth the extra cost I would have to pay in premiums? What about our dependent children?***

A #10: Spouses and dependent children may enroll in more than one plan, but the coordination of benefits, (COB, or sequence of plans to which claims will be submitted) must be indicated at the time of enrollment.  The basic advantage of multiple coverage is the possibility of reimbursement for

any portions of a covered medical service or item remaining for you to pay yourself.  For example, if (after your annual deductible is met) you get reimbursed by Insurer A approximately 70% of a medical bill you have already paid, you can submit a claim for reimbursement to Insurer B for the remaining 30% of the bill.  Of course, only claims for covered benefits qualify for reimbursement, and pre-paid health plans that do not use claim forms would not qualify. Check with your benefits administrator or coverage manual for information describing their rules for coordinating benefits and payment of premiums.  Generally, the plan covering the individual as an employee pays first and the plan covering the individual as a dependent pays second.  If both plans cover the individual as dependent child, there is a ‘birthday rule’ – the plan of the employee whose birthday occurs earliest in the year pays first.

***Q #11: My teenager has MS.  What will happen to his coverage when he goes to college?  What if he puts off college until he is 19 or older?***

A #11:  If your health plan covers your dependent children, you should examine your manual to know exactly when your child is no longer covered.  This may occur at a specific age, or when he or she enrolls in a

student health plan, or when your child moves away from home. Your child with MS will be protected under the provisions of COBRA and HIPAA if he or she has been covered under a group health plan in the past. If you were planning or assuming that a student health plan would cover your child's health care during his school enrollment, be very careful. Ask questions about the school's health plan in advance and examine the provisions of the policy to see what it offers. You may want to extend your child's coverage under COBRA instead. Also, make sure you ask if the student plan would be considered "creditable coverage" under the provisions of HIPAA. If not, your child may find him/herself joining a group health policy of a future employer and then learn that his/her MS is deemed ineligible for coverage for the first 12 months because it is considered a "pre-existing condition".

***Q #12: My employer just informed us that to save money, the company is cutting out some benefits from our health coverage, including prescription drugs. Can they do that?***

A #12: Yes, as long as the same benefits are available to all eligible plan enrollees. Employers may offer eligible employees a selection of health

plans, such as a lower-cost HMO that limits enrollees to network doctors and providers only, or a higher cost plan that allows for a wider range of providers. Besides those basic differences, however, HIPAA assures that plan enrollees are guaranteed access to the same health benefits as all other plan enrollees.

***Q #13: What happens to my group health benefits when I become eligible for Medicare?***

A #13: Generally, individuals become eligible to enroll in Medicare when they reach age 65, are disabled and have been receiving Social Security Disability Income (SSDI) checks for 24 months, or have end-stage renal disease. While the law allows people to maintain their group health coverage and coordinate it with Medicare, anyone covered by a group plan who is planning on enrolling in Medicare should check their group plan's eligibility rules to find out if or when the group coverage will end, and to determine which insurance is primary (pays first), and which is secondary. Watch the relevant dates carefully, and beware that eligible individuals only have 80 days to enroll in Medicare Part B after their group health benefits end, or face paying a higher Part B premium as penalty. (For additional

information about Medicare, see the article "FAQs About Medicare: Introduction to Medicare for People with Multiple Sclerosis" under the Living with MS, Life Planning and Independence section of the Society's web site www.nationalmssociety.org).

***Q #14: My insurance plan denied a claim I (or my physician) submitted. How can I appeal their decision?***

A #14: If you believe the service, device, treatment or medication in question should have been covered by your plan, you can and should appeal. Many people do not pursue their appeal rights because they don't believe they can win. But if you are dissatisfied with the outcome of a claim for any reason, you have nothing to lose by taking advantage of your right to request a re-consideration of the original claim. Start by re-examining your plan manual to make sure what you presumed would be covered really is. It is not unusual for people to discover that a medical service or treatment is not covered by their policy. If something is specifically excluded from the policy, chances of winning coverage for it on appeal are slim to none. But if the policy does not mention the specific treatment in

question or the coverage is unclear or framed in terms of ‘medical necessity’, it is to your advantage to try the appeals process.

Carefully review the explanation of benefits (EOB) form (official response to your claim) they sent you. Make sure you understand the reason you have been denied coverage or why you are not being reimbursed more money. These explanations often appear as codes with explanatory notes at the bottom or on the back. Is there a simple explanation, such as, the claim is a duplicate? Is there a mistake in the billing code, patient identification number, date of service or other? If all this information seems in order, your next step is to understand your plan’s Appeal Procedures. Look in your manual (sometimes under “Grievances and Appeals”). Follow these procedures carefully, especially the deadlines, as well as these basic guidelines:

- Write a very clear and simple letter providing the facts and a concise explanation of why you believe your claim should be paid. Keep your letter to one page, but be sure to include your insurance ID number, the specific claim number (if applicable), the name and contact information of your health-care provider, and date of service (if applicable).

- Keep detailed records of all interactions with your insurer, including names of company representatives you speak with on the phone and relevant dates. Keep copies of claims and bills, appeal letters and any attachments, and any other relevant communications.
- Follow up. If your appeal is denied, go to the next level of appeal. Do not assume this happens automatically -- make sure you communicate your desire for a second-level appeal. This will also be an "internal appeal", but it will involve a re-consideration of your original claim among a higher level of professionals within your insurance plan. If your second internal appeal is denied, you may be eligible for an "external review" of your claim by a panel of health professionals with no affiliation to your health plan. Contact your state department of insurance to ask about any external appeal rights you may have in your state.
- Be sure to discuss your insurer's denial, or other coverage issue you are appealing with your physician (or other relevant health care provider) to solicit his/her active support. If the dispute is over the necessity or value of a medical treatment, your physician's support in the form of a letter including studies

supporting the benefit of the treatment in question could be invaluable. Provide copies of your appeal letter to your physician (or other provider) for their records.  Make sure you do not duplicate efforts.   If the dispute is over the medical necessity or value or a medical treatment, your physician is a powerful ally.  A physician's letter that refers to scientific studies supporting the benefit of the treatment in question could be invaluable.

**Q #15:  What types of services or treatments do health plans commonly deny or limit to people with MS? What can the National MS Society do to help?**

A #15: The National MS Society staff at chapters or at the national offices often hear from people with MS about disputes over coverage of specific drugs, rehabilitation therapy (including physical, occupation, speech or cognitive therapy), wheelchairs and scooters, and other durable medical equipment.  The Society produces Expert Opinion papers and other reports describing the appropriate role and value of certain therapies in the diagnosis and management of MS.  These are available on our web site www.nationalmssociety.org, under the section For Professionals. Feel free

to provide them to your insurance policy administrators as well as to your personal physician. In addition, the Society is working to provide sample appeal letters, including citations to research studies supporting the appropriateness and medical necessity of specific treatments for you and your MS provider.

**Q #16: My health plan just informed me that they would no longer be including one of my drugs on their formulary. What exactly are formularies? What can I do?**

A #16: A formulary is a list of specific prescription drugs that the plan has approved for its enrollees. Any drug that is on the formulary is approved by the plan and the cost of the medication will be covered, although co-payments and deductibles will be separate. Formularies have become increasingly common cost and quality control strategies in health plans that include prescription drug coverage. Some plans strictly limit their coverage to drugs on the plan's formulary alone, and others provide partial coverage for "non-formulary" drugs.

Some plans include their drug formularies with the information new plan enrollees receive about their plan, and update it periodically.  Keep this list with your other health plan information, or ask for it specifically if or when the need arises.

If you receive a notice that a drug your doctor has prescribed is not on the formulary or it is being taken off the formulary, show him or her the letter and review your options.  Would your doctor be comfortable prescribing a drug that is on the formulary instead?  If not, ask him to write your insurer a letter explaining why it is important for you to get the original drug he/she originally prescribed.  If your doctor believes it is important for you to get the drug he/she originally prescribed, the National MS Society may be able to help your doctor advocate with your insurance plan on your behalf.