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HOW WILL THE NEW HEALTH CARE REFORM LAW HELP ME MAINTAIN OR EXPAND COVERAGE OPTIONS FOR MYSELF AND MY FAMILY?

1. I am a breast cancer patient who depends upon COBRA for my health insurance. Did the new health care reform law eliminate COBRA? Did it extend the COBRA premium subsidy? Can I leave my COBRA plan and join the new Pre-Existing Condition Insurance Plan (PCIP) in my state?

No, the new health care reform law did not eliminate COBRA or change the COBRA rules. It also did not extend the eligibility time period for the COBRA premium reduction. Eligibility for the subsidy ends May 31, 2010; however, those individuals who become eligible on or before May 31, 2010 can still receive the full 15 months as long as they remain otherwise eligible. No, due to the eligibility requirement for participation in the new Pre-Existing Condition Insurance Plans (PCIPs) – that participants not have had creditable health coverage for the previous six months – people who currently obtain health coverage through COBRA will not be eligible and need to maintain their current coverage. Additional information about COBRA can be found at *www.dol.gov*.

2. As a breast cancer survivor diagnosed at a young age, I want to add my 24 year old uninsured daughter to my health insurance plan – can I?

Yes. Young adults under age 26 can be insured under a parent's insurance beginning September 2010 if their policy allows for dependent coverage and the young adult doesn't otherwise have access to insurance coverage.

Coverage of adult children
http://www.hhs.gov/ociio/regulations/adult_child_fact_sheet.html

3. I'm worried that some breast cancer treatments will no longer be covered. Will there be rationing? Who decides what will be covered?

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

4. Will mammography screening be covered?

Yes, mammography screening was included as part of a package of essential preventive benefits that private plans and Medicare should make available to enrollees at no cost. It will also likely be covered under the Essential Benefits requirements that will be crafted as part of the new Health Insurance Exchange system.

5. I'm afraid mammography screening won't be covered for me anymore since I am under 50 years old. Is this true?

No, your mammogram will still be covered.

6. I received treatment through the Breast and Cervical Cancer Treatment Program (BCCTP). What will happen to the program now and will I still be covered if I have a recurrence?

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

7. Will alternative therapies, such as acupuncture, be covered under the new health care reform law?

What exact benefits will be required to be covered is unknown at this time. An "essential benefits package" that all qualified health plans available on the state run insurance exchanges must cover will be determined by the HHS secretary prior to 2014. This package must include, at a minimum, ambulatory patient services; emergency services; hospitalizations; maternity and newborn care; mental health and substance use disorder services, including behavioral health; prescription drugs; rehabilitative services and devices; laboratory services; preventive services, including services recommended by the Task Force on Clinical Preventive Services and vaccines recommended by the director of the Centers for Disease Control and Prevention; and chronic disease management. In addition, the plans must cover pediatric services, including vision and oral care. These benefit requirements do not apply to grandfathered plans or self-insured plans.

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

8. Will there be differences under the new health care reform law depending on what state you live in?

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