Financial Obligations of Liver Transplantation

Planning for Financial Obligations

There is a definite need to have a plan going into transplant. That need applies to the financial side of transplant as well.

Transplant/Outpatient Coverage

The first step in financial planning is finding out what your insurance covers. You will need to call your insurance customer service line and ask what your benefits are **specific to transplant**. There are many phases of transplant, such as transplant admission, outpatient appointments, medical procedures and prescriptions, and each may have a separate level of coverage. To help you in communicating with your insurance company, we have provided a questionnaire to guide you in your coverage discussions for each phase of transplant. The questionnaire can be found at the end of this Financial Information section.

Referrals and Authorizations

If you have coverage through a Health Maintenance Organization (HMO), you should be familiar with the process of obtaining referrals. It will be your responsibility to obtain all referrals for your appointments and procedures. This is especially important if you are coming here "out-of-network" as your HMO **MUST** approve all care done here **PRIOR** to the appointment. If you fail to obtain a referral before the appointment (many insurance carriers do not allow a referral after the appointment has occurred), you would be responsible for all costs of treatment.

Change of Insurance

Due to the incredible importance of having continual insurance coverage for all of these costs, it is extremely important – from this point forward – that you notify your financial coordinator of **ANY** insurance changes. This includes changes to the policy you currently have as well as getting a new policy. Even seemingly small changes to an existing contract will require us to re-verify your benefits. We also stress the importance of consulting with us when you're considering changing insurance and you have a choice on what you can choose. This will allow us to review with you the various coverages available to you, considering the benefit levels specific to transplantation. It is important to note that some coverages may require you receive a transplant at a center within their network and may **NOT** allow you to receive a transplant here. Finally, if you fail to let us know about changes to your insurance, you risk being placed on hold on the transplant wait list until your new insurance can be re-verified and a new authorization for transplant obtained.

For Michigan residents who have no health insurance, or insurance that's inadequate or too expensive, you can sign up for a new plan under the Affordable Care Act (ACA, also known as Obamacare). For help signing up for a new plan under the ACA, please contact our patient financial counselors here at University of Michigan Health. They can be reached at **(877) 326-9155** between 9 a.m. and 8 p.m. You can also visit the exchange website directly at **www.healthcare.gov** or call the exchange help line at **(800) 318-2596**.

Prescription Coverage and the Cost of Anti-Rejection Medications

Prescription coverage is also extremely important. Your medications after transplant are expected to cost between $5,000 and $7,000 per month. You will need to take approximately 10 medications during the initial period following transplant. After transplant the medications may decrease in the dose and number of medications taken may gradually decrease.

Transplant patients must take immunosuppressive drugs for life and the cost of these medications is very high. Therefore, it is important to have insurance coverage for prescriptions and a financial plan that allows you to access the drugs necessary following transplant.

We have attempted to share some estimated costs for the most frequently used transplant immunosuppressive medications. It is important to understand that many patients must take many medications beyond their immunosuppressive medications.

Each patient needs to discuss their insurance coverage for medications and their financial plan with the financial coordinator before and after their transplant.

Assistance Programs

Medicare

We strongly suggest that all patients pursuing a transplant apply for Social Security Disability Income. If patients are approved, they will begin to receive a monthly income. Patients will become eligible for Medicare coverage after they have had a documented disability for two years. Once you have started receiving your Social Security Disability Income, you will want to request an extension on any COBRA policies to keep them active until you are eligible for Medicare coverage.

Medicare Part A

Medicare Part A pays for facility charges during an admission. It has a deductible for the first 60 days of admission and a copay per day thereafter. There is no premium payment for Part A.

Medicare Part B

Medicare Part B pays for the physician fees and clinic appointments at 80% after your deductible. It also pays for 80% of the anti-rejection medication coverage, if on Medicare at the time of transplant and if Medicare is primary. If Medicare Part B is paying for your immunosuppressive medications, your supplemental medical insurance would pay the other 20%.

Medicare Part D

Below is an example showing what costs were in 2020 for covered drugs with a Medicare plan that has a coverage gap. It is important to remember that these figures change annually.

- Patient pays their **monthly premium**.
- The patient pays the first $435 of the cost of covered drugs. This is the amount of their **annual deductible** and once it's met, the plan will begin to pay a portion of the costs.
  - The cost of the covered drug is now paid for by a combination of the plan and the patient's **co-payment.** The copayment is about 25% of the actual drug cost.
- Once the combined amount paid by the plan and the patient (plus the $435 annual deductible) reaches $4,020, a period of no coverage starts. This time is called a **coverage gap** or **donut hole**. Once in the donut hole:
  - The patient will be responsible for 25% of drug costs (generic or brand). This amount will be approximately $2,000 to $2,500.
  - The patient will receive a discount on covered brand-name prescription drugs. The amount paid counts as out-of-pocket spending, helping the patient get out of the donut hole.
  - The patient will pay 100% of the drug costs for all prescription drugs that are not name-brand during this period. Keep in mind that even with the 50% discount, brand-name prescription drugs may still result in a higher out-of-pocket cost. Many plans may not cover brand medications when there is a generic equivalent.
- Once the patient and plan have spent a combined total of $6,350 for the year, the donut hole will end. Now the patient will only pay a small co-payment for each drug through the end of the year.

Medicare Part D is the prescription drug plan rolled out by the federal government on Jan. 1, 2006. If you are on Medicare and do not have prescription coverage, you should enroll in Part D. If you do not enroll in Part D when eligible, and do not have better prescription coverage than they offer, they will penalize you 1% of the premium payment for each month you do not enroll. So for example, if you are eligible and wait a year, you will pay a premium that is 12% higher than if you enroll at the time of eligibility. If on Medicare at the time of transplant, Part D will only be paying for your non-immunosuppressive medications. Medicare Part B would pay for the immunosuppressive medications. If you are **NOT** on Medicare at the time of transplant, but obtain it later with Part D, then Part D would pay for both immunosuppressive and non-immunosuppressive medications. This is a very important point to understand about Medicare coverage for medications.

If you sign up for Medicare Part D, you may also qualify for extra help through Medicare. This is a low income subsidy set up through the federal government to help with Part D premiums and copays. To see if you qualify, call **(800) 722-1213,** or you can apply online at **www.socialsecurity.gov/extrahelp**.

Medicaid

If you find that your current insurance coverage does not cover you sufficiently, or if you are losing your coverage, Medicaid may be an option for you.

Medicaid is an option that has been expanded recently due to changes contained in the Affordable Care Act (ACA). You may qualify for Medicaid coverage based on household income and size. If your income is at or below 133% of the federal poverty level for the number of people in your family, you may be eligible.

Beginning in 2014, certain criteria no longer affects eligibility including being disabled, the amount of household financial assets and whether or not you care for minor children.

Qualifying for Medicaid is now be based on ACA guidelines. Please contact our patient financial counselors to see if you qualify at **(877) 326-9155** between 9 a.m. and 8 p.m., or go online at **https://secure.ssa.gov/apps6z/il020/main.html**.

MSupport

MSupport is the name of University of Michigan Health's financial assistance program. It covers services performed by University of Michigan Health providers at University of Michigan Health facilities. MSupport may be available to you if you are:

- Uninsured
- Insured but cannot afford your out-of-pocket costs
- Insured but receiving services that are not a benefit of your insurance plan

Eligibility for MSupport is determined by:

- Income and assets
- Michigan residence
- Medical necessity

To apply for MSupport and to explore other financial options that may be available to you:

- Contact our financial counselors by phone at **(855) 855-0863** or **(734) 615-0863**, Monday-Friday, 8 a.m.-4 p.m.
- Complete an MSupport application at **http://www.med.umich.edu/pdf/finance/MSupport_Application.pdf** (link is external)
- Visit the Patient Portal (link is external), 24 hours a day, seven days a week at **MyUofMHealth.org**
- Email us at **PFC-Counselors@med.umich.edu**

This type of assistance would be help patients with high deductibles, high out-of-pocket costs and Medicaid Spenddowns, and is all based on income.

Financial Planning

Developing a Financial Plan for Out-of-Pocket Expenses

Being prepared by having a financial plan is the key to minimizing the financial strain and stress to you and your family as you go through the transplant process.

Once you have determined what your insurance covers, you'll have a better understanding of the "out-of-pocket" medical expenses you should anticipate. Other expenses, often considered "non-medical" that you may need to pay for include:

- Out-of-pocket amounts for insurance such as deductibles and copays
- Travel expenses
- Meals
- Lodging
- Telephone calls
- Babysitters
- Post-transplant clinic and prescription costs

Fundraising

If you struggle with the costs associated with your transplant for any reason, you may need to consider doing some fundraising. Fundraising is best done before the transplant when you are feeling better, instead of while you are trying to recover from major surgery. There are groups that specialize in helping patients in raising funds to cover their expenses. A huge benefit to using a fundraising group is to protect the money you raise from being taxed. If you directly accept funds that have been raised, they are considered taxable income. While the fundraising groups do retain a small percentage of the funds donated for their operating costs, the amount they retain is significantly less than you would pay in taxes. Funds raised by these groups allow more of the funds to be available for your transplant costs. Also, if you are on Medicaid, monies accepted directly by you will be considered income and will affect your financial eligibility, possibly disqualifying you for Medicaid. Using a fundraising group would eliminate this issue.

There are two main groups that our patients use to assist them in their fundraising efforts:

- Help Hope Live – **(800) 642-8399**
- National Foundation for Transplants – **(800) 489-3863**

Stay in Contact With Your Financial Coordinator

It is very important that you stay in contact with your transplant financial coordinator, not only in regard to a change in insurance, but for any insurance or financial issues.

If you are currently experiencing financial hardship, speak with your coordinator to discuss the options in managing these challenges. Please do not wait until you are overextended financially.

The financial coordinator needs to keep your authorizations current for your transplant to occur. If you have not notified your financial coordinator of changes in your insurance, they are unable to keep your authorizations current. If this happens it could result in your listing being placed on hold until the authorizations can be obtained.

After Transplant – Continuous Coverage for Life

Prescriptions

The cost of prescriptions is the number one financial strain patients have after transplant. You need continual prescription coverage after transplant. The cost of your medications immediately post transplant will run between $5,000 and $7,000 per month. If you do not have coverage and cannot pay for your anti-rejection medications, your new liver will fail.

If you anticipate changes in your current prescription coverage and do not have a planned transition to new coverage, **call your financial coordinator right away**. Do not wait. Finding a new way to pay for your medications takes time. Call as soon as possible so that you have time to develop a new plan.

Medical Coverage

It is important to call your financial coordinator with changes to your medical insurance post-transplant to ensure continual coverage for your transplant care for life.

Many employer-based insurance policies have a waiting period, which is a period of time after the employment starts and before you are eligible for insurance benefits. If you are on an assistance plan (Medicare or Medicaid), it is important to obtain new group coverage long before your assistance plan ends to avoid any periods with no coverage. Most waiting periods last for 90 days. You may need to return to work to obtain insurance coverage through your employer long before the expected loss of your Medicare and Medicaid coverage.

Life Insurance

Many life insurance companies deny coverage to patients who have received a transplant and to many patients who have donated an organ. If you are considering obtaining life insurance coverage, it is best that you obtain it before being listed as a recipient or beginning the evaluation process to become a donor.

Understanding Your Insurance Coverage — Questions to Ask Your Insurance Representative

Name of Representative _____ Date _____

BENEFITS/COVERED SERVICES	YES/NO	NOTES
Does my plan cover hospital charges?	Yes No	
Does my plan cover professional charges (also known as doctor fees)?	Yes No	
Does my plan cover prescription drugs?	Yes No	
Does my plan cover solid organ transplantation?	Yes No	
Does my plan have a "pre-existing condition" clause? If yes: How is the clause defined? If yes: Would my illness be considered a pre-existing condition?	Yes No Yes No	

BENEFITS/COVERED SERVICES	YES/NO	NOTES
For liver and kidney transplant only: Does my plan cover *living related* solid organ transplant? If yes, does my plan cover the donor medical charges? If yes, are there limits on the coverage for donor medical charges? If yes, what are the limits?	 Yes No Yes No Yes No	
Does my plan limit the number of transplants payable in a lifetime? If yes, what is the limit? If yes, does that limit apply for each organ?	Yes No Yes No	
Does my plan have a maximum *annual* amount it will pay out each year? If yes, what is the maximum amount?	Yes No	
Does my plan have a maximum *lifetime* amount it will pay out over a lifetime? If yes, what is the maximum amount?	Yes No	
Are there coverage exclusions in my plan? If so, what are the exclusions? What period of time applies to the exclusion?	Yes No	

BENEFITS/COVERED SERVICES	YES/NO	NOTES
Does my plan cover any travel, meals and lodging expenses? If yes, does it cover for a family member as well as the patient? If yes, how much does it cover?	Yes No Yes No	
OUT-OF-POCKET COSTS	**YES/NO**	**NOTES**
Does my plan have deductible amounts? If yes, what are they?	Yes No	
Does my plan have copayment amounts? If yes, what are the amounts? If yes, what services do they apply to?	Yes No	
Is there a maximum out-of-pocket amount that I would be responsible for each year? If yes, what is the limit?	Yes No	
REFERRALS/AUTHORIZATONS	**YES/NO**	**NOTES**
Does my plan have any restrictions on which medical centers I can use (designated provider network)? If yes, is University of Michigan Health an approved provider?	Yes No Yes No	

REFERRALS/AUTHORIZATONS	YES/NO	NOTES
Will my plan cover my services at an out-of-network provider? If yes, will my out-of-pocket expenses be higher?	Yes No Yes No	
Does my plan utilize a network for managing transplant services? If yes, is University of Michigan Health Transplant Center an approved provider?	Yes No Yes No	
Does my plan cover a consultation at one or more transplant centers?	Yes No	
Is a referral or authorization required for: Consultations? Transplant Evaluation/Testing? Medical Procedures?	 Yes No Yes No Yes No	
Who will be my case manager? How can I contact the case manager?		

PHARMACY	YES/NO	NOTES
Does my plan cover outpatient prescriptions? If so, how much are the copays?	Yes No	
Are prescriptions available by mail order? If so, how much are the copays?	Yes No	
Is there an approved list of covered medications? Will the plan ever approve use of medications as exceptions to the list? If yes, how is an exception requested?	Yes No Yes No	