UW Medicine
UNIVERSITY OF WASHINGTON MEDICAL CENTER

Financial Planning

For a liver transplant

Liver transplants are costly. Planning for your transplant also means planning how you will pay for your surgery and ongoing medical bills.

As you plan for your transplant, you will need to think about your sources of income and your health insurance coverage. You will need to decide about both short-term and long-term issues.

As you plan for your transplant, you will need to decide about many financial issues.

Short-term issues include:

- Paying for transplant surgery
- Covering living expenses while you cannot work
- Paying for living expenses while you stay in the Seattle area, if you live outside the area

Long-term issues include:

- Paying for the many different medicines you will need to take after your transplant
- Transportation and living expenses for follow-up care at UWMC after your surgery, if you live outside the Seattle area

Paying for Your Transplant

Health Insurance: Group and Individual Policies

Most health insurance plans will pay for a liver transplant. But, there are many types of plans, and they have different coverage and limits. Some plans may cover most of your transplant expenses, and others may require you to pay large amounts of the costs. Be sure to call your Transplant Financial Counselor if you are thinking about changing your health insurance.

Check Your Plan

Check your insurance plan carefully to find out about:

- **Your stay in the hospital:** Will your policy cover your inpatient medical bills? Does it pay a percent of the total, such as 80% or 90%? Or do you pay a set co-pay per day in the hospital, such as $100 per day, up to a certain maximum, such as $300? Note that if your policy pays a percent of the costs, you will have a larger bill to pay.
- **Waiting periods:** Some insurance plans require you to be covered by the plan for at least 1 year before it will cover transplant-related expenses. Find out about these waiting periods any time you change insurance companies.
- **Skilled nursing care:** Does your policy pay for a skilled nursing facility after transplant, if it is needed?
- **Coordination of benefits:** Some people are covered by more than one insurance plan, such as through their employer as well as their spouse's employer. If you have 2 insurance plans, you will need to check with the secondary policy to find out its rules on coordination of benefits. Ask how and if the secondary policy will cover expenses left over after your primary coverage pays.
- **Pre-approvals:** Some insurance plans require that you get a pre-approval before a major surgery.

Medicare

Medicare is a health insurance plan managed by the U.S. government. It covers people who have been on Social Security Disability for at least 2 years, or who are age 65 or older.

There are 2 parts of Medicare – Part A and Part B:

- **Part A** may cover inpatient hospital stays, including a liver transplant.
- **Part B** may cover doctor fees, both inpatient and outpatient, as well as other approved outpatient expenses.

Medicare has many deductibles, co-pays, and 20% co-insurance. With a liver transplant, these can add up to thousands of dollars that you will need to pay yourself. Most people cannot afford a liver transplant with Medicare coverage only and will need other insurance, too.

Medicare Supplements or "Medigap" Policies

These policies supplement your Medicare coverage. Most times, they pay the Medicare co-pays and deductibles, but nothing extra. Having Medicare and a supplement will likely cover most costs of a liver transplant.

You will need to check with your supplemental insurance to find out how it coordinates benefits with Medicare. When you choose your supplemental insurance, be sure to find out how transplant medicines are covered.

Medicaid and Health Insurance Exchange

The plans in the table below are offered by the State of Washington as of November 2014. Medicaid plans differ from state to state. (Please note that Medicaid in Washington state is now called "Washington Apple Health" and may have different medical benefits.)

Payor	Plan - Plan ID
Regence Blue Shield of Washington	Regence Bridgespan
First Choice Health Network	CHPW Community Health Essentials
Molina Healthcare of Washington	Molina Marketplace (H/O Blind & Disabled) - Apple Health
First Choice Health Network	CHPW Community Health Essentials
Amerigroup	Amerigroup Amerivantage (Medicare Advantage)
Amerigroup	Amerigroup Healthy Options (H/O Blind & Disabled) - Apple Health
Amerigroup	Amerigroup Healthy Options (H/O) - Apple Health
Kaiser Permanante	Kaiser Community Health
Coordinated Care Health Plan (managed by Centene Corporation)	Coordinated Care Corporation Ambetter
Premera Blue Cross	Lifewise Essential Health
Premera Blue Cross	Premera Heritage Signature
Group Health Cooperative	Group Health Core

Medicaid plans are for people who meet the income and resources requirements and who are medically disabled. The plan will pay 100% of covered medical expenses.

To see if you qualify, apply to your local health and social services office. Your social worker can give you contact information for the office in your state.

Please note that Health Insurance Exchange (HIX) plans have deductibles, co-pays, co-insurances, out-of-pocket costs, and a monthly premium. You will need to pay these fees.

The liver transplant financial staff will review your medical insurance to make sure you have enough coverage for your transplant.

Paying for Medicines

Most times, out-of-pocket expenses for medicines are too high for patients to afford without help from their health insurance. Medicine costs can be $12,000 to $15,000 per year. Make sure you know what your expected co-pays or deductibles will be for your prescription medicines.

It is important to keep your health insurance coverage after your transplant. But even with insurance, you may have to pay some of the prescription drug costs.

Talk with your insurance company and make sure you know the answers to these questions:

- Does your policy cover prescriptions at a certain percent, such as 50%, 80%, or 90%? Or, do you pay a set co-pay per prescription, such as $10 per prescription per month?
- Does your policy have different coverage for generic or name-brand prescription medicines? People with transplants are often prescribed name-brand medicines, such as Prograf and Cellcept, that do not have generic versions. These can be some of the most costly medicines you will need to take. Find out if your policy requires you to pay a higher co-pay or percent of the cost for name-brand medicines.
- Does your insurance offer a mail-order pharmacy for medicines? Mail-order pharmacies often allow you to buy a 3-month supply of medicines for a lower co-pay than if you buy them at your local pharmacy.

After you talk with your insurance company, add up the co-pays or the percentages for all medicines you will be responsible for. This will give you a good estimate of your out-of-pocket costs.

If you do not have insurance coverage for certain medicines, some drug companies have financial aid programs that may help you. See the "Resources" section of this manual, or ask your pharmacist or social worker for more information.

Medicare Part B

If you are eligible for Medicare and have signed up for Part B, you will have limited coverage of your outpatient prescription drugs after transplant. Here is how Medicare's prescription coverage works:

- **Immunosuppressants:** Medicare Part B covers immunosuppressive drugs at 80% for at least 3 years after a transplant. You or your other insurance (if you have it) will be responsible for the 20% co-pay. Medicare will not cover any other outpatient medicines.

If your transplant was covered by Medicare, you will be covered for your immunosuppressive drugs for at least 3 years after your transplant, as long as you remain eligible for Medicare coverage. This prescription coverage does not include many other drugs you will need.

- **For the first 30 months:** If you have other insurance coverage, such as through your employer or your spouse, Medicare will be your secondary insurance for the first 30 months of Medicare coverage. This means your other insurance pays first. If there are portions of the medicine bill left over, those amounts can be billed to Medicare.
- **After 30 months:** After 30 months of Medicare coverage, Medicare will become your primary coverage. This means all your medical bills will need to be billed to Medicare first, and any portions of the bill left over can be sent to your other insurance.
- **Billing for prescription medicines:** Most local pharmacies are not set up to bill Medicare for prescription medicines. If your pharmacy wants to learn how to bill for immunosuppressive medicines, or if you are willing to submit your own billing, call your local Social Security Administration office for more information.
- **Mail-order pharmacies:** Mail-order pharmacies that specialize in transplant medicines will do all your billing for you, including billing to Medicare. If you have other insurance besides Medicare, the mail-order pharmacies will check to see if they can bill that insurance for you, too.

Income While off Work

If you are working, find out if your employer provides disability income insurance. There are 2 types of income insurance: short-term and long-term.

Short-term

Short-term disability insurance pays part of your salary, often around 60%, while you are off work for a medical reason. Short-term disability usually covers this part of your salary for 3 to 6 months. Find out if there is a waiting period before benefits will begin.

Long-term

Long-term disability insurance pays part of your salary, often 60%, for as long as you are considered disabled and cannot work. But, you will usually need to be disabled for a minimum length of time, such as 90 days, before benefits will begin.

Social Security Disability

The Social Security Administration has its own definition of disability for various illnesses. The application process for Social Security Disability

(SSD) coverage can take many months. If you are approved, the monthly amount you receive is based on how much money you have paid into the Social Security system through payroll taxes over the course of your work life.

Social Security must consider you disabled for at least 5 months before benefits can begin. Also, your condition must be expected to last at least 1 year for you to be eligible for SSD. Most transplant patients are not disabled for that long and should not rely on SSD to provide income while off work after a transplant.

Supplemental Security Income

Supplemental Security Income (SSI) is a disability income program through Social Security for disabled people who have not earned enough to pay much into the Social Security System. Because of this, they are not eligible for SSD. The disability rules are the same as for SSD. But, SSI has strict income and financial limits.

If you are already on SSD or SSI before your transplant, you may lose these benefits afterward. Depending on why you were originally declared disabled, Social Security could decide you have recovered enough after your transplant to return to work. This would happen only after Social Security does a formal review.

Planning Ahead

If you are not eligible for any of the disability resources listed in this section, you will need to plan ahead for your financial needs after transplant and before you return to work. You may choose to:

- Put aside money to help pay bills.
- Borrow money from friends and family.
- Try fundraising. There are charitable organizations that help transplant patients raise funds for uncovered expenses such as medical co-pays, travel, lodging, and lost income. Talk with your social worker if you want to learn more about fundraising.

Questions?

Your questions are important. Call your doctor or healthcare provider if you have questions or concerns.

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