

#### Affordable Care Act FAQ - November 2013

# 1. Why are insurers canceling plans now? I thought President Obama said that if you like your plan, you can keep it. What change did he just announce to try to solve this problem?

Some people have recently received notifications that their insurers are canceling their plan for next year. This is happening in part because of the new requirements that the Affordable Care Act requires plans to meet next year, and so insurers aren't allowed to offer plans that don't meet the new rules. Some of this can be attributed to the fact that there is typically a lot of turnover in plans every year, particularly in the individual market, where people have always had to pick a new plan each year.

But, since President Obama had said to folks that they could keep their plans if they like them (this was said to ease concern about the effects of the ACA when it was under consideration), the recent policy cancellations have caused uproar. As a result, President Obama has just announced that the federal government is giving states the option to allow 2013 plans to be offered next year if they choose. This announcement was also criticized by insurers (who anticipated that these plans would go away and these people would go to the new health insurance marketplaces to choose plans) and others. How many states will choose to allow plans to continue to be offered and how many insurers will take them up on that offer is still unknown.

### 2. What are the limits on out-of-pocket expenses that plans can charge next year? Does my plan have to offer the maximum?

The Affordable Care Act requires most plans to meet certain requirements next year about the maximum amount of out-of-pocket spending they can charge patients before covering 100% of benefits. For 2014, the maximum out-of-pocket costs are \$6,350 for an individual plan and \$12,700 for a family plan. This maximum includes deductibles, co-payments and co-insurance on any services included in the "essential health benefits" bundle, but it does <u>not</u> include any spending on out-of-network providers. So, if your oncologist is out-of-network, any spending on his or her services would be in addition to the max amount.

Nearly all private insurance plans (those offered by insurance companies and not Medicaid or Medicare) will have to meet this requirement next year, with a few caveats: 1. "Grandfathered" plans that have existed since before March 2010 (when the ACA was signed into law) do not have to comply – your insurer has to tell you if you are in a grandfathered plan; and 2. Large-group (employer-sponsored) plans that use two companies to administer the benefits (such as a pharmacy benefit manager and a medical services manager) can have multiple out-of-pocket maxes just for 2014. If you are in a large-group, private plan and have questions about what your out-of-pocket max will be for 2014, please contact your benefits administrator.



Please note that plans can impose a lower threshold than this maximum, and that the amount of money you will spend out-of-pocket will depend on your health plan and the health services you use. Also, the out-of-pocket max will be lower for individuals with lower incomes who choose marketplace plans.

#### 3. What are health insurance options for retirees?

Retirees 65 years of age or older are eligible to receive coverage through Medicare. Often times to expand their coverage and benefits, retirees purchase supplemental insurance or select a Medicare Advantage plan through privately run Medicare exchanges during an annual open season. These plans are <u>not</u> part of the new insurance marketplaces created by the Affordable Care Act, which are only open to people not eligible for Medicare (under 65 years of age and/or not disabled). In fact, Medicare insurance exchanges have existed for years.

Many large companies provide insurance coverage for their retiree population as part of the retirement package offered to longtime employees. This insurance is in addition to the coverage and benefits they receive through Medicare. Recently, many of these companies, including IBM, General Electric and Time Warner, announced that they intend to cancel the insurance plans offered to their Medicare-eligible retirees. Instead, annually, they will fund a Healthcare Reimbursement Account (HRA) which retirees can use to purchase Medicare insurance through privately-owned Medicare exchanges. Other companies have explored offering a "buy out" or one-time payment to the retiree to use to purchase their Medicare insurance for the rest of their life.

### 4. Who should go to a new health insurance marketplace to pick a plan?

In general, anyone who has an insurance plan that they like – and remains available to them – does not need to go to the marketplace. This means that people with private insurance through their employer, individual or family coverage they bought themselves, TRICARE and any other health plans can stick with their current insurance and don't need to do anything. Those eligible for Medicare cannot purchase insurance through the public exchanges.

But – anyone who is uninsured or is unhappy with their health insurance can go to the marketplace and explore their plan options. Some people may be eligible for subsidies to purchase health insurance based on income. Also, some states require small employers to obtain insurance through the marketplace, but this will likely happen behind the scenes by the HR department. In future years, more and more employers may have employees choose plans through the marketplace.

# 5. I read that some major hospitals and oncology groups are opting out of accepting ACA insurance policies. Is this true?

Yes, this is true. The ACA doesn't change the fact that health insurers and health care providers like doctors and hospitals negotiate with each other about how much they will be paid, which providers will



be included in-network and other issues. Plus, since health insurance plans have to meet so many new rules, while trying to keep premiums low enough that people will choose their plan, some insurers are setting up very narrow networks that don't include a lot of providers as a way to control costs.

If you are exploring choosing a new plan, it is very important that you ensure that the doctors and hospitals that you use are included in-network. Please consider using a tool like the <a href="Myeloma Insurance Questionnaire">Myeloma Insurance Questionnaire</a> or the <a href="Cancer Insurance Checklist">Cancer Insurance Checklist</a> so that you can be sure what benefits and providers you will need next year. It may be difficult to figure out what providers are in-network from the marketplace website so you will likely need to call plans directly to ask them. While it can be frustrating and take some time on the front end, this effort is much better than choosing a plan that doesn't cover what you need.

Please send any additional questions that you may have to Meghan Buzby at <a href="mbuzby@myeloma.org">mbuzby@myeloma.org</a>.