International Myeloma Foundation

Affordable Care Act Frequently Asked Questions

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

The Affordable Care Act requires most plans to meet certain requirements 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 not 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) have to meet this requirement, 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 is 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. In 2015, the out of pocket maximum will increase to $6,600 for individual coverage and $13,200 for family coverage. In 2015, all non-grandfathered plans will have to meet this requirement (no exceptions for large group plans as has happened in 2014).

2. What are health insurance options for retirees?

Retirees 65 years of age or older are eligible to receive coverage through Medicare. Retirees often purchase supplemental insurance or select a Medicare Advantage plan through privately run Medicare exchanges during an annual open season to expand their coverage and benefits. These plans are not 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. 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.

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If you are retired and are not yet eligible for Medicare, you can explore options on the marketplaces during the next open enrollment period in November 2014.

3. 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 marketplaces.

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.

Open enrollment for the 2015 plan year will start in November 2014.

4. 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 Myeloma Insurance Questionnaire or the Cancer Insurance Checklist so that you can be sure what benefits and providers you will need next year. It may be difficult to figure out which 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 mbuzby@myeloma.org.

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