

Affordable Care Act Fact Sheet: Help for People with High Medical Expenses

Background: People with MS and their families often struggle with the costs of health care, even with health insurance. In fact, surveys of people with MS indicate that they are more likely to be under-insured than totally un-insured. (The term under-insured applies to anyone spending at least 10% of household income on medical care even with health insurance, or 5% for people with lower income). Before the Affordable Care Act, insured people with MS or other diagnosed health conditions often became under-insured for two major reasons: because health insurers were able to charge them more due to their pre-existing condition (a practice known as medical under-writing), or because their unusually high and expensive health care needs left them with high out-of-pocket costs, (deductible, co-payments and/or co-insurance).

What has changed? In addition to new requirements on health plans that will improve their value of coverage, the Affordable Care Act includes new protections for people with historically high health insurance rates and out-of-pocket expenses. Some of these changes have already taken effect, and others begin in January 2014. Although these changes may not prevent all the financial burdens you or your family may face from the costs of MS care, they should help prevent worst-case scenarios, such as having to stop treatment, taking on significant medical debt, or declaring personal bankruptcy.

- ***No More Discrimination for Pre-Existing Conditions.*** As of January 2014, insurers may no longer deny or limit health coverage, or charge people more, as a result of a pre-existing condition. Any limits or restrictions on coverage currently in place will be eliminated.
- ***Lifetime Benefits Caps Banned.*** Lifetime caps on policies and cancellations of coverage due to a pre-existing condition are now prohibited.
- ***Annual Caps Prohibited.*** Annual dollar caps on covered benefits are prohibited, and other benefit caps (such as number of specialist doctor visits per year) must be limited.
- ***Free Preventive Health Services.*** No deductible, copayment or co-insurance can be charged to patients covered through individual, job-based plans, Medicare or Medicaid for evidence-based preventive health services, such as cancer screenings, routine vaccinations, bone density tests, and more.
- ***Maximum Out of Pocket Costs.*** Enrollees of individual and group health plans will have a maximum annual cap on their out-of-pocket costs. Any healthcare included as a benefit needed in a calendar year above the annual cap must be paid for entirely by the health plan. The amount of the cap will change every year because (by law) it is linked to the rate of change in annual premiums. In 2015, the out-of-pocket cap for most "self only" coverage is \$6,600, and \$13,300 for a family.

- ***Lower Income, Lower Caps.*** People who qualify for cost-sharing subsidies will see their maximum out-of-pocket spending capped even lower: \$2250 or \$4500 for single or family coverage, respectively, if their income is less than 200% of the Federal Poverty Level, and \$5200 or \$10,400 if their incomes is between 200 and 250 percent of federal poverty. However, these cost-sharing subsidies are only available to qualified enrollees who purchase a Silver Level plan through the Health Insurance Marketplace (sometimes called Exchanges), and apply to in-network expenses only.
- ***More Money Toward Care.*** All health insurance plans must use at least 80 cents out of every premium dollar to pay for your medical claims and activities that improve the quality of care. Any amounts they collect above this so-called “80-20” threshold must be returned to the policyholders. Large employer plans (usually more than 50 employees) must spend at least 85% on care.
- ***Standard, Comprehensive Benefits.*** All health plans sold to individuals or small employer groups after 2014, as well as all Medicaid plans must cover a comprehensive package of items and services, known as essential health benefits. The essential health benefits must include items and services within the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices (durable medical equipment); laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.