ISSUE BRIEF

OUT OF POCKET MAXIMUMS

Out of Pocket Maximums and the 2014 Transition Year

In 2014, the Affordable Care Act (ACA) sets maximum limits on how much a person can be required to pay out-of-pocket annually for his or her health care. Under the law, the maximum amount a person with single coverage will pay out-of-pocket will generally be **$6,350**, while a family could pay up to **$12,700**.

One year later, *in 2015*, health plans must have one, combined out-of-pocket maximum. Out-of-pocket maximums include copayments, deductibles, and coinsurance, and these maximums apply only to plans that are not grandfathered under the law. Premiums are not counted in calculating out-of-pocket maximums.

> A **copayment** is a fixed amount you pay for a covered health care service, usually when you receive the service (e.g., when you go to the doctor and pay $15 before your appointment). The amount can vary by the type of covered health care service.
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> A **deductible** is the amount you owe for health care services your health plan covers before it begins to pay (e.g., if your deductible is $1,000, your plan will not pay anything until you have met your $1,000 deductible for covered health care services subject to the deductible). The deductible may not apply to all services.
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> **Coinsurance** is your share of the costs of a covered health care service, calculated as a percentage (e.g., 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health plan's allowed amount for an office visit is $100 and you have met your deductible, your coinsurance payment of 20% would be $20. The health plan pays the rest of the allowed amount.
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> A **premium** is the amount that must be paid for your health insurance or plan. You usually pay it monthly, quarterly or yearly.

Please note the significant issue with how this policy applies *in 2014*. According to guidance from the federal government, a health plan *with more than one benefits administrator* does not have to combine out-of-pocket limits into one total until 2015. An example of a health plan with more than one benefits administrator is if your health insurance is administered by Yellow Star Health Insurance Company and your pharmacy benefit is administered by Medicine Company.

Practically speaking, health insurance plans will cap the amount that consumers pay out-of-pocket for major medical expenses. However, if a health plan uses more than one company to administer its benefits – as many do for major medical and pharmacy benefits, for example – 2014 presents an unusual

situation. *Please note that this policy applies to small, large, and self-insured plans both inside and outside of the marketplace, but not to the individual market.*

To determine your potential out-of-pocket maximum cost for a plan that *currently* has more than one benefit administrator (e.g., one for medical and one for pharmacy), ask yourself the following:

- Do each of my two benefits *currently* have a cap on out-of-pocket spending?
- If they do, then you could face *separate* caps in 2014, for a total of up to $12,700 for individual coverage and $25,400 for family coverage.
- If one benefit, such as the pharmacy benefit, *currently* has no cap, then you could face *no* cap on that benefit (in this example, pharmacy spending) in 2014.
- If you do not know whether your health plan currently has more than one benefits administrator, it is important to find this out by asking someone from the health plan.

For example, a plan with a separate cap on pharmacy benefits today can keep that limit in 2014, with the limit capped at $6,350 for individual coverage or $12,700 for family coverage. But a plan with *no* drug spending limit today does not have to cap your out-of-pocket spending on pharmacy at all in 2014.

An exception to the new rule exists for plans that use a separate provider to run their behavioral health benefits. Under the Mental Health Parity and Addiction Equity Act of 2008, health plans cannot apply separate out-of-pocket limits for those benefits. This exception is applicable in 2014 only, when plans could otherwise impose two out-of-pocket maximums. Additionally, if dental and/or vision insurance is an "excepted benefit" (i.e., has a separate premium charge) or is part of a grandfathered plan, the out-of-pocket limit does not apply.

HFA is here to support your advocacy! Contact us at advocacy@hemophiliafed.org