“Health Care Reform: How Does It Affect Me?”

National Teleconference and Webinar Transcript
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Presented by:

SHARSHERET
Your Jewish Community Facing Breast Cancer

I. Introduction

Moderator: Good evening, and welcome to the Sharsheret National Webinar. At this time all participants are in a listen-only mode, but later you'll have the opportunity to ask questions during the Question-And-Answer Session. It is now my pleasure to turn the call over to the Director of Clinical Support, Ms. Shera Dubitsky. Please go ahead, ma'am.

Shera: Thank you, Keith. Good evening, everyone. Welcome to Sharsheret's National Webinar, Health Care Reform, How Does It Affect Me? On the call tonight are women, family members, and health care providers from all across the country. Sharsheret is a national not-for-profit organization supporting young Jewish women and their families facing breast cancer.

Our mission is to offer a community of support to women of all Jewish backgrounds diagnosed with breast cancer, or at an increased genetic risk by fostering culturally relevant individualized connections with networks of peers, health professionals and related resources.

As women are coping with illness, they are increasingly concerned about insurance coverage, financial planning, and general issues of financial and legal wellness. As with all of Sharsheret's programs we begin with our callers. Every day we are hearing about your financial and insurance concerns, and we are determined to respond to your needs. We hosted a focus group to explore specific areas that are triggering the highest anxieties across the board. The loudest message from the focus groups, and also from the calls that we get every day, is that managing the financial aspects of illness feels like a full time job that begins at the time of diagnosis, and it's one of those issues that continue to linger far beyond treatment.

We hosted a roundtable discussion called, “Taking Control of Your Financial Health During and After Health Crisis.” Our expert panel addressed insurance coverage, disability, financial planning, and estate planning. I encourage you to visit Sharsheret's website at www.sharsheret.org to watch the video of that discussion.

After hearing from you and our experts, we created a Financial Wellness Toolkit that offers tools to record and organize your personal information, and includes vital resources and helpful tips from other Jewish women who have faced illness. Hundreds of women have received this resource. If you are interested in receiving the Financial Wellness Toolkit, please call us at 866-474-2774, or you can go to our website and we will be sure to get you this kit.

You could actually begin the process of accessing resources immediately by going to Sharsheret's website, where you will find web-based resources. I'd like to share some feedback that we've received from Sharsheret callers, who have received the kit. "After attending Sharsheret's financial roundtable discussion, I realized there was so much more I could be doing to safeguard my financial

health and that of my family after cancer. The very next day I began to gather important documents, reached out to a financial advisor, and organized a conference call with my financial and legal team members. To say I feel empowered is an understatement. I feel knowledgeable, proactive, and in control of financial matters for the first time." That was from Susan.

Another caller said, "I received the Financial Wellness Toolkit and I want to thank you so much, it is really great. I think it definitely will be of help to me, I am so glad that I found it."

Tonight we will review the provisions of the Affordable Care Act as they apply to you and how you can access health insurance coverage through the new health insurance options. Before I hand the discussion over to our expert speaker, who will address the general provisions of the Affordable Care Act, and the information about accessing health insurance, I wanted to highlight the portions of this Bill that are particularly relevant to those of you in the Jewish community.

As many of you may know, in the general population 1 in 345 individuals carry the BRCA mutation. For those of Ashkenazi Jewish descent, that number is 1 in 40. This means that for those individuals who carry the BRCA mutation, there is as high as an 80 percent lifetime risk of being diagnosed with breast cancer, and as high as a 44 to 60 percent lifetime risk of developing ovarian cancer. Because of this elevated risk, the access to breast and ovarian preventive care, access to health care insurance coverage for cancer treatment, and the rules of our pre-existing conditions related to access to coverage, are all critical pieces of the Affordable Care Act for Jewish women and families.

Following the presentation from our expert speaker, we will have a question-and-answer session where you can ask your individual questions to panelists. We had Joanna Morales scheduled to join us this evening, but unfortunately she's not feeling well, so we have Monica Bryant who is joining us, so without further ado I'd like to introduce our speaker for the evening.

Monica Bryant is a cancer rights attorney, speaker, and author, dedicated to improving access to, and availability of, quality information on cancer survivorship issues. Ms. Bryant is the Chief Operating Officer for Triage Cancer, a non-profit organization that provides education and resources on the entire continuum of cancer survivorship issues. Throughout her career, Ms. Bryant has provided numerous educational seminars, written articles and blogs, and appeared on community television and radio shows discussing health-care-related legal issues.

Additionally, Ms. Bryant is an Adjunct Law Professor at John Marshall School of Law, in Chicago, teaching a class on cancer rights, and serves as principal of North Star Alliances, a business, non-profit consulting and service firm.

Ms. Bryant, the floor is yours.

II. Understanding the Affordable Care Act

Monica: Thank you so much for that great introduction, and for inviting me to speak with all of you today. I'm delighted to be here. Before I get started into the nitty-gritty, I just wanted to tell you all a little bit about Triage Cancer, so if after this call you're still looking for additional resources you know where to find us.

As mentioned, we are a national non-profit organization that is dedicated to providing information and resources on all sorts of cancer survivorship issues. We do that in several different ways. We look to speakers who are experts and survivors available to anyone hosting an educational event, and you can just fill out a Speaker Request Form on our website which is just www.triagecancer.org. We also have an educational blog on online resources, all of which can be found on our website.

Now we know that in 2010, 49.9 million people in the United States were uninsured, so that begs the question, why should it have been so hard to get health insurance in the past? One reason that was alluded to earlier was that if you have a pre-existing condition. Now this term used to only be used by people in the health insurance industry, but lately it's become much more commonplace. Now a pre-existing condition can be almost anything from a serious illness to something that might actually seem a little bit mundane, like acne.

Studies have shown us that roughly half of adults under the age of 65 say that they, or somebody in their household, would be considered by an insurance company as having a pre-existing condition; and 25 percent of those people say that they or a family member has been unable to get health insurance in the past because of a pre-existing condition. We know that pre-existing conditions have definitely been a barrier in the past. Other factors include cost and how confusing it is to search for and purchase health insurance.

Now before I get into specifics of health care reform I just want to make sure that we are all on the same page with respect to some terminologies. When we talk about a premium, we are talking about the amount that you're going pay monthly just to have health insurance, so you're actually going to pay this amount whether or not you go to the doctor. Then there are costs that you are going to incur when you actually use your health insurance. The first thing is the deductible, and this is an amount that you're going to have to pay before your health insurance company will cover the cost for your medical care.

The co-payment is the amount that you're going to have to pay when you get care. For example, many policies have $25 co-pay that you pay every single doctor visit. Co-insurance, otherwise known as cost share, is the amount that you're responsible for paying after the insurance company covers their portion. If you have a plan that has a 20 percent co-insurance, it means that your health insurance company is going to pay 80 percent of the cost of your care, and you are going to pay the other 20 percent.

Finally, when we talk about out-of-pocket maximum, we are talking about your deductible, plus your co-payments, plus any co-insurance you might have, so your monthly premiums are not going to be included in an out-of-pocket maximum.

This is just an example of how this would all work. Let's say, for example, your plan has a $2,000 deductible, the cost share is 80/20, so your plan covers 80 percent and you cover 20 percent, but the plan has an out-of-pocket maximum of $4,000. Let's say that you have $102,000 hospital bill. What would you actually pay? First you pay your deductible of $2,000, which leads us to $100,000 left. If your cost share, otherwise known as co-insurance is 20 percent, then you're responsible for $20,000, which is still a lot of money, right? But considering that your plan has an out-of-pocket maximum, you are only responsible for that additional $4,000.

You've paid $2,000 as the deductible, plus $2,000 of your cost share, until you get to your $4,000. I know that's a lot of math, but I hope that that will kind of clear things up a little bit.

That brings us to the heart of the matter and why we are all here today, to talk about the Patient Protection and Affordable Care Act, otherwise known as the ACA, Healthcare Reform, and, sometimes Obama Care. Today we'll be talking about it as the ACA. This Bill was signed into law on March 23, 2010, and it's a provision to be implemented at different times. However, on January 1st of this year, we saw some of the biggest changes. The changes that I'm going to talk about tonight fit into two main baskets. First, we are going to go over the new benefits and protections afforded to consumers. Then later we are going to talk about some of the new health insurance options.

When we talk about consumer protection and benefits, we are talking about things that are going to implement large businesses, small businesses, and individuals and families in some ways, and because of the focus of the call today, we are really going to hone in on the benefit of protections for individuals and families.

One of the ACA's overarching goals was to make health insurance coverage more adequate, and when I use the word adequate this is what I mean. We know that in the United States 62 percent of all bankruptcies are due to medical debt. What's even more disturbing about that statistic is that 78 percent of those individuals had health insurance coverage and still ended up having to file bankruptcy. This tells us that our health care system wasn't working. If we pay for health insurance coverage and we still end up having to file for bankruptcy because our medical costs are so high, we know it's a broken system.

Here are a few ways that the ACA made health insurance coverage more adequate. First, the ACA eliminated rescissions. Rescissions are when insurance companies cancel your policy when you try to use it. It was common practice for many insurance companies to try to find a reason to cancel your policy once you got sick. This may sound like something that would never

happen, but we knew it was happening quite frequently, especially for people who had expensive medical condition like cancer.

Under the ACA, insurance companies can now only cancel your policy if you stop paying the premium, or if you commit fraud. Really they've raised the bar on what insurance companies are able to do with respect to cancelling a health insurance policy. Also, under the ACA, lifetime and annual limits are eliminated. So previously when you reached the set amount of health care expenses, your coverage would end and then you'd be left, effectively, uninsured.

As of January 1st of this year, both lifetime and annual limits on something called essential health benefits are prohibited by the ACA. Essential health benefits are 10 categories of care that every health insurance plan will have to cover, and the specifics are different from state to state, but each state was required to pick a benchmark plan that insurance companies would use to satisfy these 10 categories of essential health benefits. We are talking about things like prescription drugs, emergency services, hospitalization, etcetera, so no more lifetime annual limits on those types of benefits.

Also with the ACA we've now seen that young adults are able to stay on their parents' health insurance plans until they turn 27. And thanks to this one provision alone, we've actually seen more than 3 million young adults who are now able to have health insurance, who previously had aged out of their parents' policies.

Another benefit to the ACA deals with preventative care. We would hear quite frequently somebody needed some sort of preventative care, like a mammogram, but had a very high deductible and couldn't afford to pay their whole deductible just to get their mammogram.

Thankfully, the ACA requires that most health insurance companies provide preventative care for free. By free, I mean that you don't have to pay a co-pay, a co-insurance amount, and it doesn't get applied to your deductible, so free really should mean free.

Some examples of preventative care include immunizations, cancer screening, diabetes screening, etcetera, but this is an area of law where we are still seeing some changes. For example, the original law only included genetic testing counseling. But after the advocacy community raised concerns that the actual genetic testing wasn't covered, the Center for Medicare and Medicaid Services clarified this and said that when appropriate, this provision applies to covering the tax for free as well.

This is a great example of how the advocacy community really can make a difference with respective implementation of this law. The ACA also added these three preventative provisions to Medicare, as well as the plans in the individual and group markets.

Now I mentioned earlier most health insurance companies will have to provide preventative care for free. The caveat that I want to make here is that this provision does not apply to grandfathered plans. A grandfathered plan is a plan that was in existence on or before March 23rd 2010, and hasn't made any substantial changes to that plan. Generally, the only grandfathered plans that are going to be left are employer-sponsored plans. If you're unsure if your claim is grandfathered, we recommend contacting your plan administrator and finding out.

I just want to highlight or point out some of the cancer-related preventative services that are included, but you can find the entire list at www.healthcare.gov.

Some of the new protections that I wanted to talk about that are very exciting and really change the landscape of health care law in this country, are the changes in what insurance companies can take into consideration when they decide how much to charge you for your premium. This is called is the premium rating. Prior to January 1st, insurance companies often charged women more than men for health insurance coverage, and they charged people with pre-existing conditions much more than someone who was healthy.

As of January 1st of this year, insurance companies can only use four factors to decide what to charge you: (1) whether you're buying an individual policy or a family policy, because family policies are going to be more expensive, (2) your geographic location, (3) your age, generally the older you get the more expensive it's going to be, and (4) your tobacco use in most states. Some states have actually eliminated this as a factor and just left the first three. As of January 1st of this year, insurance companies cannot charge women more, and they cannot charge people who have a pre-existing condition more, which is a significant change.

Also perhaps most significantly, as of January 1st, insurance companies can no longer discriminate against people with pre-existing conditions. What all of this means is that not only can you not be denied coverage because of a pre-existing condition, you cannot be charged more because of your health status.

Also as of January 1st, 2014, there's a new requirement for U.S. citizens and legal residents to have health insurance or pay a penalty. For a vast number of us, nothing is going to change. That is because many types of coverage will count as health insurance, including employer-sponsored coverage, individual plans purchased in the marketplace, COBRA, Medicare, Medicaid, etcetera, all of those counts as coverage. If somebody doesn't have one of these types of coverage and chooses not to purchase health insurance, then they are going to pay a penalty.

For this year, for 2014, the penalty will be $95 or 1 percent of your family income, whichever is greater. You can see the amount goes up year-by-year, and the penalties will be collected through the IRS.

There are some exceptions to this new requirement to have health insurance. First, you can have one gap in coverage of up to three months during the year without paying for a penalty. Maybe you're changing jobs, and your new employer has a 90-day-waiting period before you're eligible for benefit. You will not be forced to pay a penalty for being without coverage for those three months. However, it's incredibly important to remember that even if you aren't subject to paying the penalty for those three months, you won't have health insurance. If something happens to you and you need medical care, you're going to end up paying for that care 100 percent out-of-pocket.

There are also some exceptions for financial hardships. Financial hardships is that if the cheapest plan in your marketplace, which we are going to talk about in a few minutes, would cost you more than 8 percent of your household income, or if you have an annual income of below $9,750…If you fall into that category, you will be exempt from this mandate, where you don't have to buy insurance and you won't have to pay a penalty. Then also certain members of particular religions, Indian Tribes, undocumented individuals and incarcerated individuals are exempt from this rule.

III. Accessing Health Insurance Options

That brings us to the idea that now that most of us have to have health insurance, it's a great thing that the ACA also created some new health insurance options for us.

Many people were surprised to learn that in most states, childless adults, no matter how low their incomes are, are currently not eligible for Medicaid. So you have individuals with very low incomes who don't have access to any sort of preventative services, screenings, or health care if they are diagnosed with something. The ACA changed that by creating a new category of eligible adults who have incomes at or below 138 percent of the Federal Poverty Level; which, in 2013 is about $15,000. When the law was passed in 2010, the idea was that this new category would exist in all 50 states. However, the Supreme Court decision in 2012 essentially ended up making this program voluntary per state.

As you can see this is a fluid process with states making decisions on an ongoing basis, and this is where we stood at the end of 2013. You can see that states like Arizona, California, Illinois, are all expanding Medicaid. There are a couple of states who have waivers pending, and then we have 23 states that are not expanding for one reason or another.

As of January 1st, there's also a new way for individuals, families, and small businesses to get health insurance, and it's called Health Insurance Marketplace. Whether you're uninsured now, or you just want to explore new options, the Marketplace is designed to give you more choices and control over health insurance coverage. Again, it's designed to help you find health insurance to fit your budget, with less confusion and hassle. This is the goal of these Marketplaces, which have also been referred to as Exchanges.

Every state will have a Health Insurance Marketplace, but each state's Marketplace may offer it a little differently. States had a couple of options of how to do this. Some states decided to create and run their own Marketplace, some states will have a Marketplace run by the Department of Health and Human Services, so the federal government, and some states chose to partner with HHS to run their Marketplace with the eventual goal of running their own marketplace completely in future years.

When we talk about these marketplaces, we like to think about it as a health insurance shopping mall. This is a place where you can go and see your options, compare and purchase health insurance. You may have heard us refer to these marketplaces like Travelocity, or Amazon for health insurance, but it's important to remember that it's not just online. Individuals can actually complete a paper application and mail or fax it in, apply over the phone, or apply in person. So while it's easy to talk about it as Amazon, we'd just like to point out to those people who aren't comfortable with the Internet for whatever reason, there are other options.

Now in 1014, the Marketplaces are open to individuals and small businesses that have less than 50 employees. In 2017, the Marketplaces will be open for larger businesses. Also, in addition to this being a place where you can shop for, and purchase insurance in a secured and easy-to-understand manner, the Marketplaces may also be able to provide financial assistance for individuals who are buying plans.

There are two types of financial assistance. The first is going to be a tax credit that is designed to lower the cost of your monthly premium. The second type of assistance is a cost-sharing subsidy which will lower the cost of health care expenses that you have to pay when you actually visit your medical care, for example, that $25 that you pay when you go to the doctor's office. The amount of credit or subsidy you receive will be based on your family size and income level.

This chart is just a visual demonstration of the various financial assistance options that I covered up until this point. Individuals who are at or below 138 percent of the Federal Poverty Level will be eligible for Medicaid in states that choose to expand. Individuals between 138 percent and 250 percent of the Federal Poverty Level will be eligible for cost-sharing subsidies, and those between 138 percent and 400 percent will be eligible for premium tax credit.

Hopefully, as you can see, there are going to be some people who are eligible to receive both the premium tax credit and the cost-sharing subsidies. Now, we've heard from some people that they are very concerned about the fact that they have to include their financial information in their Marketplace application. But the reason that they have to do so is so that the system can figure out what financial assistance options they might be eligible for.

What's actually available in these Marketplaces? The first open enrollment period for these Marketplaces began October 1st, 2013, and will go all the way

through March 31st of this year. In order for insurance companies to sell plans in the Exchanges, they must meet certain requirements. For example, the plans must cover those essential health benefits that I mentioned earlier like emergency services, hospitalization, mental health, etcetera.

In addition, each company must offer four main levels of plans, with a standardized cost-share. For the lowest level plan, it's called the Bronze Plan, the insurance company is responsible for 60 percent of the cost, and the patient is responsible for 40 percent, and it goes up by 10. So Silver is the 70/30 plan, Gold is an 80/20 plan, and the highest level, Platinum, is the plan that covers 90 percent and the individual will cover 10 percent. The maximum out-of-pocket expenses for all of these plans is going to be $6,350 for an individual, and $12,700 for a family.

Now, I also just want to briefly mention a fifth level of coverage called catastrophic coverage. These are plans that cover the bare minimum and are only offered to people who are under 30 years old who have had their health plan cancelled, or who qualify as having a financial hardship that we talked about earlier, are therefore exempt from the individual mandate. For most individuals that are high-risk or have had a cancer diagnosis, these catastrophic plans are likely not going to be a great option because they cover very little.

In addition to the cost being different between each plan, what are some of the other differences? You're going to see a different set of networks of doctors and hospitals when you're shopping for plans, so we really recommend that if you have a particular doctor or hospital that you feel is very important to continue to see, make sure that those people are in your network and are covered by the plan that you choose. Also, each plan is going to have a different co-payment amount, and different prescription drug coverage. If you are on an existing medication, or you anticipate having to take a medication, please make sure those are covered by whatever formulary of plan that you're choosing.

These are just a couple of other facts about the Marketplaces that I want to make note of. The cost-sharing subsidies that I mentioned previously are only available if you're purchasing a Silver Plan. The tax credit, the credit to reduce your monthly premium amount, is valid for any level of coverage as long as you meet the financial requirements.

Also, I wanted to mention that if you have a Pre-Existing Condition Insurance Plan, otherwise known as the PCIP Plan, these were plans the ACA created for individuals who have the same conditions and weren't able to get health insurance any other way. Originally, the PCIP Plans were going to run until the end of this month, but we actually have late breaking news that you can now keep these plans until April 30th, 2014, and then the idea is that you'll be able to transition back into a plan purchased in your state marketplace. So I'm sorry that the date on the slide is incorrect, this was actually just announced by HHS yesterday. For more information about this if this applies to you, you can go to www.pcip.gov.

Lastly, when applying for Marketplace plans and you're trying to figure out if you're eligible for financial assistance, you will need to project your income out for 2014.

Now, I talk a lot about your income level and what percentage of the Federal Poverty Level you need to be at for certain ACA provisions. Specifically what we are talking about when we talk about income level is your modified, adjusted gross income, otherwise known as MAGI. This chart may help you figure out what your MAGI is. I know it's a little bit hard to see on the slide, so I actually provided you with the link the Labor Center at Berkeley who created this chart, so that you can download a full-size version if you are interested.

There are also several online tools including at www.healthcare.gov, where you can plug in this information and it can do the math for you. If you don't feel like you have to go do the full chart, to figure it all out, but I did want to show you what types of things are included in your MAGI and how you go about figuring that that out.

Now some of you might be thinking, "Well, I have insurance through my employers so why is any of this important to me?" Well, we like to tell everybody about it because there may be some people who have insurance through jobs, who aren't necessarily happy with their insurance. We get asked the question all the time, "Am I able to buy insurance in the Marketplace even if I have an employer-sponsored plan?" The answer is, yes. No matter what, you have the right to opt out of your employer's coverage and purchase insurance individually.

You may even be eligible for financial assistance to purchase the plan if you're offered insurance through your job, but only in two circumstances. Those two circumstances are, (1) that the coverage that your employer provided is not affordable, which means that it will cost more than 9.5 percent of your income, so your portion that you pay costs more than 9.5 percent of your income, or (2) the plan is inadequate, which means that it covers less than 60 percent of your health care cost. To recap that, you can always choose to opt out of your employer plan and buy in the Marketplace, but the only time you're going to be eligible for financial assistance in those circumstances are if your employer's coverage is not affordable, or inadequate.

Now this chart just shows where each state stands for 2014 with respect to running their own Marketplaces, partnering with federal government, or being completely run by the federal government. For states running their own plans, they have separate websites where people can go to apply. People who live in states that are partnering or defaulting to the federal marketplace will apply through www.healthcare.gov.

We just wanted to show you all of the different logos and names for the state-run Marketplaces, but don't feel like you have to memorize your state's name. You can always start at www.healthcare.gov, and once you plug in your state, if you live in one of these states, www.healthcare.gov will actually provide you with a link to redirect.

To tie all of this together, this map shows where each state stands with respect to both Medicaid expansions and their health insurance Marketplaces. The states here in dark-blue are the ones that are expanding Medicaid to include this newly eligible group of people who have incomes at or below 138 percent of the Federal Poverty Level, and they are running their own Marketplaces. The states in orange are states that have defaulted to a federally-run Marketplace and are not moving forward with Medicaid expansion.

Let's get into the nitty-gritty of it. When you are ready to shop for health insurance, you, as I mentioned, can start off at www.healhcare.gov, and if you click on the tab at the top that says, “Get Insurance”. So while I was filling this out, I live in Illinois, so that’s what I picked.

I also just want to remind everybody that to actually enroll in health insurance, you can go to your state Marketplace website, or if you live in one of those orange states, you can go to www.healthcare.gov.

Despite some of the early problems with the website that I'm sure you all heard about, things seem to be running a little bit more smoothly these days, and as I mentioned before, the website is not your only option for enrolling. You can use the paper application, or enroll in person. There are Marketplace Assisters organizations designed to help you choose and enroll in a plan.

If you actually go to the Contact Us page on Healthcare.Gov and type in your zip code, you can find the Assisters near you and make an appointment to go in and work with somebody.

When you actually go to apply for coverage in the Health Insurance Marketplace you will need to provide some information about you and your household, including your income and any insurance you currently have. So Healthcare.Gov has actually created this checklist to help you gather what you need to apply for coverage. You're going to need your social security number, or if you're a legal immigrant, your document number. You're going to need your employer and income information, please remember they have to figure out if you're eligible for the financial assistance option, and what’s called the, “Completed Employer Coverage Tool.”

This is just a snapshot of the Employer Coverage Tool, and it's to help the Marketplace determine if you're eligible for financial assistance even if your employer offers coverage through the Marketplace. And the checklist and the Coverage Tool can be found on www.healthcare.gov.

As I mentioned before, the first open enrollment period started on October 1st and is going to go through the end of the month. So you still have a little bit of time if you're interested in coverage for this year. You must enroll by March 31st to avoid a penalty for this year if you haven’t had any other coverage, because remember: you’re only allowed one three-month gap in coverage to avoid that penalty if you’re subject to it.

Also, because we know that there's been a lot of changes with implementation of certain ACA provisions, we just wanted to highlight that this week we did hear from HHS Secretary Sebelius, that they will not be expanding this open enrollment period. If you need health insurance for this year and you don't currently have any, please enroll before March 31st.

Moving forward, we have been told that the open enrollment period for 2015 plans will start November 15th of 2014, and will go through February 15th of 2015. Please note that those open enrollment periods are just for purchasing through the Marketplaces, and that Medicaid applications will actually be accepted year round.

Now just because the open enrollment period ends on March 31st, doesn't mean that you won't be able to purchase insurance any other time of the year because there is something called a special enrollment period. And this is when you have an experience or a life-changing event like changing jobs, moving to a new state, adopting a child, that changes, perhaps, your health insurance status. If any of these things happen to you, you actually have 60 days to shop for, and enroll in a Marketplace Plan.

This is what you'll see if you go in and look for plans in your state. This is an example, off of Healthcare.Gov, for a 40-year-old individual who lives in Cook County, Illinois, which is Chicago.

As you can see, there are 65 different health insurance plans available to this individual. Of those 65 plans, we have all of these different health insurance companies offering them. So there has been quite a bit of information in the news and newspapers about how these Marketplaces are limiting choice, and what we've really seen as a reality is that people still have quite a bit of choice within each state's marketplace.

I also just wanted to point out that on this page we've put in that this individual has a household income of $30,000, and on this page you can actually see that they would eligible for a $2 a month tax credit. You can actually go to www.healthcare.gov and explore your options without putting in any personally identifiable information, and get exactly the information that I'm showing you right now. You really can shop before you buy.

I just wanted to show you the most expensive Silver Plan available to the same individual and the least expensive plan available to this individual, and I also wanted to show you how these plans were laid out. So these are just screen shots that you can look at, and on the actual website all of these underlying things actually are links that you can click to.

On this page you can see, on the top, is the PPO plan of Blue Cross Blue Shields for $209 a month, the deductible $6,000, and the out-of-pocket maximum is $6000. You can also see information about co-payments and co-insurance. And from here if you wanted to know more information about this particular plan, you could click the Details button.

This is what you would see if you click the Details button, and what's fantastic about this, is everything is laid out the same way for every single plan. If you were trying to figure out the differences between two plans, you could literally print out these two pages and put them side-by-side, and compare apples to apples.

On top, I also wanted to point out other information that you can find. Previously, it was very challenging, when shopping for insurance, to figure out what providers were covered by a particular plan, what prescription drugs were covered by a particular plan, until you actually purchase the plan. The ACA really changes that, so now we can see all of that information before we commit to buying a plan. If you remember earlier when I said that when you're shopping for insurance, it's important not just to look at the cost differences, but to make sure that your doctors at hospitals, and prescriptions are covered, this is how you can do that. You can actually click on List of Covered Drugs, and make sure that whatever prescription you are taking is covered by that plan.

Again, this was just a side-to-side comparison of the two plans that you can do yourself, but I just wanted to point out that all of this information is laid out in exactly the same way. No more hunting and hoping to find the information that you need.

Just to recap a little bit, I wanted to show you this visual demonstration of everything we've talked about. All of the options listed on the right-hand side in light-green are going to continue to exist. So there will still be employer plans, there will still be individual plans outside of the Marketplace. Medicare, Medicaid, etc.

However, as of this year, there are going to be some new options for people. For individuals who are at or below 138 percent of the Federal Poverty Level, you may be eligible for Medicaid if your state expands. Now, if you're between 138 percent and 400 percent of the Federal Poverty Level, you may be eligible for financial assistance to help you buy a plan in your state's Marketplace. For individuals over 400 percent of the Federal Poverty Level, you will be able to purchase plans in the Marketplace and have extra protection, like ensuring that all 10 of those essential health benefits will be included, and protections like caps on deductibles, and out-of-pocket limits.

Now I know I've thrown a ton of information at you today in a short amount of time, so I just wanted to highlight some other upcoming events for you to learn more about the legal, practical, and financial issues surrounding cancer, and the first is an event where we are partnering with our friends at Cancer and Careers on April 11th, in Chicago. If you aren't physically in Chicago, I definitely recommend that you take a look at www.cancerandcareers.org because they have tons of online resources that talk about a lot of these issues. Then, next week, Triage Cancer is doing a webinar all about how to manage your finances before, during and after a cancer diagnosis.

Here I've just left you with some more resources on the ACA. Triage Cancer has a blog where we try to kind of put up the late breaking news, and happenings on the entire spectrum of cancer survivorship issues, and get asked all the time about a quick way for people to educate their friends and family about what's actually in the Affordable Care Act. And we found that one of the best ways to do that is through the Kaiser Family Foundation, a cartoon series called, “The You Toons,” and I've left the links here, so I'm sure if you just Google, “Kaiser Family Foundation Cartoon,” they will come up. They are short, little cartoons that do a great job in explaining the overview of Health Care Reform.

This is just how you can find us. If you're on social media and would like to connect us, we'd love to hear from you, and we will even take questions about the ACA via Twitter and Facebook if you use the hash tag, “Get the Facts ACA” (#Getthefactsaca).

Thank you so much for being here tonight, and I'll turn it back over to you guys.

IV. Question & Answer

Shera: Great. Ms. Bryant, thank you so much for the comprehensive overview of the ACA, and you're right - there was a lot of information to take in this evening, so I want to encourage those of you who are joining us this evening to go to our website in a couple of weeks, and we will have this webinar available both on audio and in transcript.

I want to say that because of the elevated risk to Ashkenazi, Jewish individuals that I had mentioned earlier in tonight's webinar, I think that there are tremendous concerns again about access to breast and ovarian preventative care, access to health insurance coverage for cancer treatment. There's also concerns about the rules about pre-existing conditions related to access to coverage, and it's interesting that as you were speaking we did receive several questions that had to do with concerns that are particular those in the Jewish community.

I just want to let our participants know that you can ask a question, by dialing *1, or you can enter your question into the chat box. We do ask that you keep your questions broad in nature, so that everyone can benefit from the discussion, and questions will be addressed in the order that they’ve been received.

The first question that we received was, "I was tested for the BRCA gene mutation positive last year," so she wanted to know, “will her BRCA positive status affect her health insurance rates?”

Monica: Absolutely not.

Shera: Is there a difference if she goes through the Marketplace or through her employer's health insurance?

Monica: No. As of January 1st, no health insurance companies can use any information other than those four things I mentioned, which include, are you buying individual

policy or family policy, the three classic locations, your age, and your tobacco use. Those are the only four things that any insurance company can use to determine your premium rate.

Shera: Okay. Sticking with the BRCA mutation that under previous insurance coverage, sometimes women had to fight to get covered for the genetic testing, under the new ACA Guidelines, is it going to be more accessible to have the genetic testing?

Monica: That's certainly the goal behind all of this. I can't promise that for everybody it's going to be easier because of course, we all know that it doesn't always work the way it's supposed to. But under the law, what is supposed to happen is that if you have a non-grandfathered plan, so a plan that began on or after March 23rd, 2010, and you fall into one of these high-risk categories, high-risk populations, that you are eligible for the genetic counseling, and the test, as a preventative service, for free.

Shera: Okay. There are some women who have called Sharsheret, who have previously tested BRCA negative, even though they have an extensive family history. Now we all know the areas they are testing for more in-depth information. The question is: I already tested BRCA negative, what is the understanding in terms of being able to now test for these new genetic tests?

Monica: I'm sorry, because you started to cut out a little bit in asking question, but I think I understood the gist, which was if you previously tested negative, but there is better testing now, can you retest and would that be considered?

Shera: Correct.

Monica: Everything is going to be a case-by-case situation, unfortunately. But what we know from CMS is what they said about these recommendations for preventative services, is that "high-risk", is determined by clinical expertise, so decisions regarding whether or not an individual is part of a high-risk population is going to be named by that attending provider. If that attending provider is deeming that that person is high-risk and should be tested, it should fall under preventative services.

Shera: The caller is asking about the separate drug coverage. Is that something you can address?

Monica: Are there any more details?

Shera: There weren't any details from this particular caller, but I do know that we have heard from women who are living with metastatic breast cancer, and are on continued treatment, and we've received some calls about their concerns that as they switch providers, is there going to be an issue in terms of their accessibility to the drugs, and will that be covered?

Monica: That's a fantastic question, and this is one of those areas where we, as consumers, have to do a little bit more work. If we stop and think about it, it's not any different than how we would purchase anything else in the world. Before we buy a car, we can totally compare many different cars and make sure if we were concerned about gas mileage, that we take the car with the best gas mileage.

The same principle is going to apply with health insurance companies, so what you need to do as a consumer is going to be to go into all of the Marketplaces and look at the different plans, and specifically check that drug formulary that I showed you, to make sure that whatever prescription you're on, is covered. It's also something that you may want to enlist your doctor with. To say, "Okay, I'm on X-drug right now, do you foresee ever having to take something in the next year that I'm not currently on?", and make sure that that drug might be covered as well. A lot of insurance companies have even made it so easy that in their drug formulary pamphlet, they list the drugs by type of diagnosis, so many of them have a block for cancer drugs.

For many people who have an existing diagnosis, or for women who have metastatic breast cancer, I definitely recommend starting to look at the Gold and Platinum-level plans, because while they might have the more expensive monthly premiums, they are going to be the plans that cover the most, and have the most options.

Shera: Great. Thank you. We received another question, "I'm currently on COBRA Insurance, are there any special rules I need to be aware of?"

Monica: Great question. COBRA was previously the only way that people could, with a pre-existing condition, maintain their health insurance. One of the downsides is that COBRA can be incredibly expensive, so what's fantastic about the ACA is that now it actually reduces the need for people to go on COBRA. For this particular individual what I would say is, you may want to look in the Marketplace and see if you can find a comparable plan offered in the Marketplace that may be cheaper.

Or, if you're eligible for financial assistance, that's another reason to maybe look in the Marketplace. But I urge you to make sure you're finding a comparable or better plan, so that everything is covered.

Now, there's something else you need to be aware of. If you think, "Right now my COBRA plan is great," and you just don't have the time or energy to shop for new insurance, "I just want to keep my COBRA," that's absolutely fine. What's important to know is once your COBRA ends, that's going to be considered a trigger for that special enrollment period that I mentioned earlier. So at that point you'll be able to go into the Marketplace and shop for insurance, and you'll have 60 days from the day that your COBRA ends to do that.

Shera: Thank you. In September 2013, a new recommendation with respect to breast cancer was put into place. What changes, if any, must health care insurance plans make to comply with new recommendations? Certainly we know these

recommendations have changed and will most likely continue to change in the future with health care reforms. What changes should we be on the lookout for in terms of coverage?

Monica: That's a tricky question because it's very broad. With respect to recommendations sometimes they are just that. Sometimes they are just recommendations, and we would certainly hope that insurers and health care providers would certainly follow them, but that doesn't always translate into a change in the law. What we do know is when we are talking about preventative services and those that are covered at 100 percent with no cost-share, those are based off of the U.S. Preventive Services Task Force, or USPSTF recommendations, and so often the Task Force is the one that looks at all of those recommendations and the plans on the Marketplace will have to comply with those recommendations, but not everyone that comes out.

Again, I think this is a great opportunity for us as an advocacy community to be talking with our elected officials, both on the state and federal levels, to make sure that recommendations that are important to us as community are being implemented.

Shera: Great. Thank you so much. That seems to be the end of our questions for this evening. We want to continue this dialogue, so over the next couple of days you will be receiving an online evaluation to complete. Your feedback is invaluable to us, and we are eager to enhance our programs in the effort to provide you with tailored, high-quality support and resources that meets your needs. I would like to thank the Jewish Women's Foundation of New York for their generous grant for this evening's webinar, and for funding the Financial Wellness Toolkit.

I would also like to thank Ms. Bryant, for her expertise and insight navigating the Affordable Care Act. I would like to thank all of you for participating in this evening's event.

We are eager to continue this dialogue, and we encourage you to stay connected with Sharsheret, you can call our office at 866-474-2774. You can email us at info@sharsheret.org, or you can, again, visit our website at www.sharsheret.org. I encourage you to follow us on Facebook, on Twitter, on YouTube. And again, to be able to listen in to this webinar, you can go to the Sharsheret website and you'll be able to access the audio and the transcript.

Thank you to everyone for participating this evening and we wish you all a good night.

V. Speakers' Biographies

Shera Dubitsky, MEd, MA, Director of Clinical Support, is a graduate of Columbia University and a doctoral candidate of Adelphi University Institute of Advanced Psychological Studies. Shera supports and connects newly diagnosed young women and those at high risk of developing breast cancer or ovarian cancer with suitable peer supporters, advances and develops programs addressing the unique needs of the young women and families of Sharsheret, counsels individual members of the Embrace program, and facilitates its monthly support group teleconferences.

Monica Fawzy Bryant, Esq., Chief Operating Officer, is a cancer rights attorney, speaker, and author, dedicated to improving access to and availability of quality information on cancer survivorship issues. Ms. Bryant is the Chief Operating Officer for Triage Cancer, a non-profit organization that provides education and resources on the entire continuum of cancer survivorship issues. Throughout her career, Ms. Bryant has provided numerous educational seminars, written articles and blogs, and appeared on community television and radio shows discussing healthcare related legal issues. Additionally, Ms. Bryant is an Adjunct Law Professor at John Marshal School of Law in Chicago, teaching a class on Cancer Rights, and serves as Principal of North Star Alliances, a business and nonprofit consulting and service firm.

VI. About Sharsheret

Sharsheret, Hebrew for “chain”, is a national not-for-profit organization supporting young women and their families, of all Jewish backgrounds, facing breast cancer. Our mission is to offer a community of support to women diagnosed with breast cancer or at increased genetic risk, by fostering culturally-relevant individualized connections with networks of peers, health professionals, and related resources.

Since Sharsheret’s founding in 2001, we have responded to more than 30,000 breast cancer inquiries, involved more than 3,000 peer supporters, and presented over 250 educational programs nationwide. Sharsheret supports young Jewish women and families facing breast cancer at every stage—before, during, and after diagnosis. We help women and families connect to our community in the way that feels most comfortable, taking into consideration their stage of life, diagnosis, or treatment, as well as their connection to Judaism. We also provide educational resources, offer specialized support to those facing ovarian cancer or at high risk of developing cancer, and create programs for women and families to improve their quality of life. All Sharsheret’s programs are open to all women and men.

Sharsheret offers the following national programs:

The Link Program

- *Peer Support Network,* connecting women newly diagnosed or at high risk of developing breast cancer one-on-one with others who share similar diagnoses and experiences
- *Embrace*™, supporting women living with advanced breast cancer
- *Genetics for Life®,* addressing hereditary breast and ovarian cancer
- *Thriving Again*®, providing individualized support, education, and survivorship plans for young breast cancer survivors
- *Busy Box®,* for young parents facing breast cancer
- *Best Face Forward®,* addressing the cosmetic side effects of treatment
- *Family Focus*®, providing resources and support for caregivers and family members
- *Ovarian Cancer Program*, tailored resources and support for young Jewish women and families facing ovarian cancer
- *Sharsheret Supports*™, developing local support groups and programs

Education and Outreach Programs

- *Health Care Symposia,* on issues unique to younger women facing breast cancer
- *Sharsheret on Campus,* outreach and education to students on campus
- *Sharsheret Educational Resource Booklet Series,* culturally-relevant publications for Jewish women and their families and healthcare professionals

VII. Disclaimer

The information contained in this document is presented in summary form only and is intended to provide broad understanding and knowledge of the topics. The information should not be considered complete and should not be used in place of a visit, call, consultation, or advice of your physician or other health care professional. The document does not recommend the self-management of health problems. Should you have any health care related questions, please call or see your physician or other health care provider promptly. You should never disregard medical advice or delay in seeking it because of something you have read here.

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