

How to choose a health plan in Covered California: Do it before January 31, 2017!

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Covered California (CC) is the state's health insurance marketplace where qualified, lawfully present residents of California can purchase affordable health insurance. Individuals with "pre-existing" conditions — such as HIV/AIDS, hepatitis B (HBV), and hepatitis C (HCV) — cannot be denied health insurance and their premiums must be the same as other individuals in their age group. Many Californians will also qualify for financial assistance to help pay for premiums and other out-of-pocket (OOP) costs. **Although there are concerns about the long-term future of CC following the 2016 election, open enrollment for CC continues and you can renew or enroll in a new health insurance plan through January 31, 2017.**

General Information

You can enroll in a CC health plan between November 1, 2016 and January 31, 2017. However, if you want your coverage to start January 1, 2017, then you must enroll by December 19, 2016, as well as pay your first premium by the due date. If you don't enroll and don't have other comprehensive health insurance, you may have to pay a tax penalty.

Once open enrollment closes on January 31, 2017, you can only enroll through a Special Enrollment Period (SEP), which occurs if you

have a "qualifying life event" such as loss of a job, birth of a child, divorce, or loss of insurance. A complete list of qualifying life events can be found at <http://tinyurl.com/CClifeevents>, or search online "Covered California Qualifying Life Events".

If you qualify for Medi-Cal you can enroll at any time during the year. Medi-Cal provides free or low-cost health coverage to Californians with limited incomes.

Before enrolling, there are important things that you should consider if you're living with HIV, HBV, and/or HCV. There are also important things to keep in mind if you're HIV-negative and considering pre-exposure prophylaxis (PrEP). This guide is designed to help you choose a health plan that best meets your individual health needs and budget. Remember to look for special considerations for your particular health needs in each section.

Whenever possible, you should also talk with a Certified Enrollment Counselor (CEC) or Certified Insurance Agent (CIA) who understands your individual needs before selecting a CC plan. It may be difficult to find a counselor with enough knowledge about HIV, HBV, and/or HCV, so it's important to educate yourself.

► **If you already have a health plan through CC:**

Review your plan and decide if you want to make changes for 2017. Premiums have increased for 2017 and benefits and provider networks may also have changed. Changing plans may limit your premium costs, but could force you to change providers.

If you currently receive an advance premium tax credit (APTC) to help pay your insurance premium, it's extremely important to give your consent for CC to verify your income via the federal Internal Revenue Service (IRS). If you don't, you may lose your APTC in 2017. Information about the renewal process can be found at <http://tinyurl.com/CCaboutrenew>, or search online at "Covered California Questions about Renewal".

► **If you're on a limited income:**

Californians with limited incomes may qualify for Medi-Cal, which is public health insurance that provides coverage at very low or no cost. If your annual Modified Adjusted Gross Income (MAGI) is below 138% of the Federal Poverty Level (FPL) based on family size (\$16,242 for individuals), you can probably get health insurance through Medi-Cal. For more information, visit www.dhcs.ca.gov or consult your local county social services office.

► **If you're living with HIV:**

Some Californians living with HIV can get their medications covered and/or additional help paying for their medications through the state AIDS Drug Assistance Program (ADAP). They may also be able to have their insurance premiums and medical OOP costs paid by the Office of AIDS Health Insurance Premium Payment program (OA-HIPP). Undocumented individuals living with HIV can qualify for both of these programs.

If you're currently enrolled in ADAP, it's important to consider all of your health care needs and costs before deciding to purchase a plan through CC. There are many good reasons for having health insurance, but if you choose not to enroll, ADAP will continue to serve you as long as you meet the

eligibility criteria. In general, if you're eligible for Medi-Cal, you must enroll in Medi-Cal and disenroll from ADAP.

ADAP is not considered comprehensive health insurance and if you don't purchase a plan through CC or enroll in Medi-Cal, you may have to pay a tax penalty. These tax penalties increase each year, so be certain to check how much it will cost you if you choose not to get insurance. More information about the tax penalty, ADAP and OA-HIPP is found below.

► **If you're living with Hepatitis B Virus (HBV) and/or Hepatitis C Virus (HCV):**

Some people living with HBV require ongoing treatment with medication to manage the virus. Treatment for HBV is not a cure, but can help people live a long and healthy life with HBV. Some people experience challenges affording the medications they need due to prescription copays.

Most people living with HCV can be cured in as few as 8-12 weeks using easy-to-take regimens with few side effects. However, given the high cost of HCV medication, some people experience challenges affording the medications they need due to prescription copays and/or experience challenges accessing the medications due to insurance prior authorization requirements.

If you are living with HBV and/or HCV and want to be treated, you need to carefully consider all the options available within CC in order to minimize your OOP costs. This guide will help you understand how to pick a plan that best fits your health needs and reduces those costs.

► **If you're HIV-negative and considering PrEP:**

Pre-exposure prophylaxis, or PrEP, is taking a medication every day to help prevent you from getting HIV. Currently, the only FDA-approved medication for PrEP is Truvada.

Most health insurance plans in California, including Medi-Cal, will cover Truvada for PrEP. However,

not all doctors are familiar with PrEP and may resist prescribing it. If you're interested in PrEP, it's important to choose a CC plan carefully in order to reduce your OOP costs and ensure you can find a doctor who will prescribe PrEP. Before you make any final decisions, be sure that the primary care doctor you are considering takes the plan you want and is willing to prescribe PrEP.

This guide will help you understand how to pick the plan that is right for your needs and keep your OOP costs as low as possible. The California HIV/AIDS Research Program has also developed a guide to help you choose a CC plan if you are interested in PrEP. The guide can be found here: <http://chprc.org/publications/#2038>. More information about PrEP, including effectiveness and side effects, can be found here: www.projectinform.org/prep, and <http://prepfacts.org>.

Standard Covered California benefits:

All CC plans must provide comprehensive services, known as *essential health benefits*. These include coverage for prescription drugs, doctor visits, hospitalizations, labs, and behavioral health services (i.e., mental health and substance abuse services). This doesn't mean that all of the drugs and services you need are included in every plan, so you should research plans before making a final enrollment decision.

Each CC plan has four "metal levels" of coverage: Bronze, Silver, Gold and Platinum. These refer to how much you must pay for your health care and how much the plan covers. A Minimum Coverage plan is also available to those who are under 30 years old, can certify they don't have affordable coverage, or are experiencing a hardship. Each option is explained in depth below.

Tax Penalty:

If you can afford health insurance but don't purchase coverage in 2017, you may have to pay a tax penalty. In 2017, the annual penalty is 2.5% of your annual income or \$695/person (adjusted for inflation), whichever is greater. However, some people may be exempt from the penalty. A list of exemptions can be found at [http://www.coveredca.com/individuals-and-families/getting-](http://www.coveredca.com/individuals-and-families/getting-covered/tax-penalty-details-and-exemptions/)

[covered/tax-penalty-details-and-exemptions/](http://www.coveredca.com/individuals-and-families/getting-covered/tax-penalty-details-and-exemptions/), or search online "Covered California Tax Penalty Exemption".

Assistance with Premiums and OOP Costs:

You may be able to get help paying for premiums and OOP costs, such as medications, routine tests, and copays or coinsurance for doctor visits through the programs listed below.

PREMIUM ASSISTANCE:

The federal government's advance premium tax credit (APTC) will pay a portion of your monthly premium if you qualify. The amount of help you get is based on your income. You may qualify if your MAGI is between 138–400% FPL (\$16,242–\$47,520 for individuals). You can choose any metal level plan and you get the same amount of premium help. You can choose to receive it in one of two ways: 1) as an advance each month which lowers your monthly payments, or 2) at the end of the year when you file your taxes. (If you are using the OA-HIPP program you must take option 1 – see below.) This assistance cannot be used to pay for a Minimum Coverage plan.

COST-SHARING SUBSIDIES:

Cost-sharing subsidies reduce your OOP costs, including copays, coinsurance, and deductibles. They may also reduce your OOP maximum (the most you have to spend in a plan year). In order to receive these subsidies, you must be eligible for premium assistance and your annual household MAGI must be between 138–250% FPL (\$16,242–\$29,700 for individuals). Cost-sharing subsidies only apply in a Silver plan, also known as an Enhanced Silver plan. Under an Enhanced Silver plan your subsidies are built into your plan. Most people who qualify for cost-sharing subsidies should enroll in Enhanced Silver plans.

PHARMACEUTICAL ASSISTANCE PROGRAMS:

Drug companies have patient assistance programs (PAPs) that may help you with the cost of the drugs you take. If you don't have health insurance or if the drug you need has been denied by your health plan's appeals process, then PAPs may cover the cost of the drug. If the drug is not covered by your insurance

plan you will have to go through your plan's appeals process before using the PAP. PAPs may offer assistance with the appeals process. If you have health insurance, copay programs may help pay for your OOP costs.

Be aware that Kaiser doesn't currently accept copay cards, but you should still be able to get reimbursed by the copay program once you pay for your medications. Kaiser does have its own medical assistance program that can help people at or below 350% FPL (\$41,580 for individuals) with OOP costs.

If you're living with HIV, HBV, and/or HCV:

A list of PAPs and copay programs for HIV, HBV, and HCV can be found here: <http://fairpricingcoalition.org/projects/>.

If you're considering PrEP:

Gilead Sciences, who makes Truvada (currently the only medication approved for PrEP), has a copay program and drug assistance program to help pay for PrEP. If you have insurance, you could receive up to \$3,600 annually to help pay for your Truvada prescription. Information about the copay program can be found at www.gileadcopay.com. If you don't have insurance and your annual income is below 500% FPL (\$59,400 for individuals), you may be able to get Truvada for free. Further information can be found at <http://tinyurl.com/GileadMAP> or search online "Gilead Medication Assistance Program". Patient Advocate Foundation's (PAF) copay relief program also provides financial assistance for people who have private insurance. Assistance is limited to \$7,500 per year for individuals with incomes below 400% of FPL (\$47,520 for individuals). More information can be found at <https://www.copays.org/diseases/hiv-aids-and-prevention> or 866-512-3861.

Choosing a Plan:

Selecting the best CC health plan to meet your needs can be challenging. Certified Enrollment Counselors (CECs) and Insurance Agents (CIAs), as well as CC call center reps are available to answer questions about financial assistance and help you compare plans.

Information about the drugs covered by each plan (its formulary) is available through the drug formulary link

in the Covered CA plan finder. In addition, each plan has a pharmacy assistance line that should be able to answer any questions you may have about drug coverage in your plan, including approximate cost-sharing requirements.

DRUG FORMULARY LINKS

Anthem Blue Cross of California

(855) 634-3381, <http://tinyurl.com/CCanthem>

Blue Shield of California

(855) 836-9705, <http://tinyurl.com/CCblueshield>

Chinese Community Health Plan

(888) 775-7888, <http://tinyurl.com/CCchcomm>

Health Net

(888) 926-5133, <http://tinyurl.com/CChealthnet>

Kaiser Permanente

(800) 464-4000, <http://tinyurl.com/CCkaiser>

L.A. Care Health Plan

(800) 788-2949, <http://tinyurl.com/CClacare>

Molina Healthcare

(888) 858-2150, <http://tinyurl.com/CCmolina>

Oscar Health Plan of California

(855) OSCAR-55 x1, x2, <http://tinyurl.com/CCoscarhp>

Sharp Health Plan

(800) 359-2002, <http://tinyurl.com/CCsharp>

United Healthcare Benefits Plan of California

(800) 260-2773, <http://tinyurl.com/CCunited>

Valley Health Plan

(888) 421-8444, <http://tinyurl.com/CCvalley>

Western Health Advantage

(888) 563-2250, <http://tinyurl.com/CCwesternhealth>

Information regarding providers and pharmacies associated with plans may be more difficult to find. It is worth the time and effort to seek help from this guide, from a CEC or CIA who understands your health needs, and when possible, from a case manager or benefits counselor. These resources will help you understand all your options before making a final decision. Once enrolled, you won't be able to change plans until the next open enrollment period unless you experience a qualifying life event.

How to Enroll:

There are several ways to enroll:

- in-person with a CEC (www.coveredca.com/get-help/local);
- online at www.CoveredCA.com, by yourself or with informal help; or
- by phone (800) 300-1506.

We recommend applying in person with a CEC if possible, particularly if this is your first time purchasing a CC plan.

CC also certifies insurance agents or brokers (CIAs). They tend to deal primarily with employer groups and may not have adequate experience helping people on an individual basis, especially those with chronic conditions like HIV, HBV, or HCV. Few are familiar with Medi-Cal or assistance programs that might be available to you. If you choose to use a CIA, try to find one who specializes in your health condition(s) and understands Medi-Cal, ADAP, OA-HIPP and other program requirements.

If you're unable to find someone who understands your health needs and assistance programs, find a case manager, benefits counselor, or other community-based assistance for your plan research. They may be able to help you compare plans and discuss any additional assistance for which you may qualify before you enroll.

Additionally, be aware of health insurance fraud: both CECs and CIAs are prohibited from charging fees for their services. CC is the only marketplace where you can take advantage of federal help with your premiums and your OOP costs, so be sure you talk with an authorized CC representative.

If you're living with HIV:

It's very important to get help from someone with knowledge of HIV programs and how they interact with insurance. If you are unable to find an HIV-experienced CEC or CIA, consult with an HIV-experienced case manager or benefits counselor. If you qualify for ADAP and OA-HIPP, make sure the health plan you select will coordinate effectively with these programs.

Plan Comparison:

Even with the help of a CEC, it's important to do your own research to make sure that you select the plan best suited to your unique needs. Here are some questions to consider:

1. Which health plans in my area are the best fit?

Some plans are easier to work with than others, and you may have heard information about some of them in a support group or from your doctor. If so, explore plans offered by the company you're hearing positive things about.

2. Which plan contracts with my doctor to be "in-network"?

CC plans are "limited network plans", which means that only a modest percentage of doctors and other providers are available within the plan. If you want to stay with your current doctor, make sure you know what CC plan(s) he or she is contracted with before picking a plan. If you're looking for a new doctor, find out what CC plan(s) he or she is contracted with before picking a plan.

The CC website now includes a directory of doctors available in each plan, but these lists are not always accurate so it's important to confirm with your doctor's office that they are "in network" with the CC version of the plan you want. If you ask at the doctor's office, never say "Do you accept or take my insurance?" because a "yes" answer may not mean much. (A doctor may accept "out-of-network" payments from PPO plans and then bill you for the rest.) Instead, ask the much more specific question, "Is Dr. X contracted to be in-network with my insurance?" If you find that the plan gave you incorrect information about the doctor you chose, it is important to report that to either the Department of Managed Health Care (DMHC) or the Department of Insurance (DOI). See the section on "Know Your Rights" on pages 11–12.

3. Are my other providers in the plan "network"?

The group of available providers in each plan is called a "network", and it's important to understand which providers are in your plan's network and how it works.

Most plans limit which pharmacies you use, the hospital you can go to, and which doctors you can see without paying other fees. Some plans don't cover any costs associated with a provider not in their plan. There are three types of insurance plans: health maintenance organizations (HMOs), preferred provider organizations (PPOs), and exclusive provider organizations (EPOs).

- **HMOs** only cover visits to doctors and hospitals within their plan's network. HMOs are “managed care” and assign a Primary Care Physician (PCP) to oversee your care. HMOs usually require members to get a referral from their PCP to see specialists.
- **PPOs** are more flexible when choosing doctor(s) and specialists. PPOs cover doctor visits both inside and outside their networks. However, you pay a higher cost for out-of-network care.
- **EPOs** are similar to PPOs because members may not need a referral to see a specialist. However, EPOs do not cover visits to doctors outside the plan's network. The network is “exclusive.”

In 2017, PPOs and EPOs in CC will be required to match you with a primary care physician (PCP). The PCP is intended to be your health advocate; however, it is not a requirement that you use the PCP. Additionally, you can change to any PCP at any time. This is important as the plans may have difficulty matching you correctly during the first year.

It's important to remember that not all HMOs, PPOs, and EPOs are the same. Be sure to get all the details about a plan's network before making a decision.

If you're living with HIV:

If you participate in ADAP, it's important to make sure that the pharmacy you'll use through your insurance plan works with ADAP. Most pharmacies in California do, but double-check. It's also important to check your plan's formulary to ensure it doesn't restrict which pharmacy you get your drugs from, or to ensure you're comfortable with those restrictions.

If you are living with HBV or HCV:

Some health plans require people who take certain medications to use a specialty pharmacy or mail order service for their medications. It's important to check with your plan to ensure it doesn't restrict which pharmacy you get your drugs from, or to ensure you're comfortable with those restrictions.

4. What costs will you be responsible for?

When considering a plan, be sure you fully understand all the costs you're responsible for, including premiums, deductibles, copays, and co-insurance. You also need to know what your annual OOP maximum is.

- A **PREMIUM** is the amount you pay every month to maintain your plan.
- A **DEDUCTIBLE** is the amount you pay before the health plan begins to pay. Plans can have different deductibles—one for medical costs like doctor visits or blood work, and one for drugs, or they can combine the two.
- A **COPAY** is a fixed amount that you pay for services until you reach the OOP maximum. For example, you might pay \$20 for a doctor visit and \$40 for an x-ray.
- **CO-INSURANCE** is when you pay a fixed percentage of the cost of the service until you reach your OOP maximum. For example, you might pay 30% of the cost of your lab test. Co-insurance can make it difficult to determine the exact amount of OOP cost as it is extremely difficult to find the cost of a particular service. Some plans have online “Treatment Cost Estimators” available to their members that can provide an estimate of a procedure's cost based on claim data from providers who have performed the procedure recently. Additionally, the pharmacy assistance lines associated with each plan should be able to give you information about cost-sharing.
- The **OUT-OF-POCKET (OOP) MAXIMUM** is the most you have to pay for medical expenses above and beyond your monthly premium during the year. Depending on your plan, these expenses may include an annual deductible, co-insurance and copayments for doctor visits and prescription drugs. Deductibles, copays, and co-insurance count toward your OOP maximum, unless they are considered “out of network” or “not covered”. Premiums are not counted. In most cases, once you reach your OOP maximum, your insurance will cover 100% of the costs they consider medically necessary. However, it is important to remember

that not every OOP health expense is counted toward the OOP maximum. For example, it will not include copays for non-network providers and other out-of-network cost-sharing. Understand what OOP costs will count toward your OOP maximum before signing up for a new health plan.

The OOP maximum in California ranges from \$2,350–\$6,800 for an individual. Non-subsidized Bronze and Silver plans have an OOP max of \$6,800. If you qualify for cost-sharing subsidies (annual income of \$16,242–\$29,700 for individuals), and enroll in an Enhanced Silver plan, your OOP maximum will be lower (\$2,350–\$5,700 for individuals). The OOP maximum for Platinum plans is \$4,000 for individuals. Depending on your health needs, overall costs may be lower with a Platinum plan than Silver because of the OOP maximums, so it's important to compare your options.

In order to compare plans you're interested in, add up the premiums and expected OOP costs, including the drugs, blood work, and procedures you need, for the full plan year. Estimating your monthly OOP costs will help to ensure you don't pick a plan that is unaffordable in the first several months of the plan year. Unfortunately, calculating co-insurance costs can be difficult. For medical co-insurance costs, try calling your plan for an estimate or use the online Treatment Cost Estimator if available. For drug co-insurance information, call the health plan pharmacy assistance line.

If you're living with HIV:

Remember that OA-HIPP will now pay for your outpatient medical OOP costs that count towards your plan's OOP maximum. This may include the cost of annual deductibles, doctor visits, outpatient laboratory, or outpatient diagnostic study copays and co-insurance.

5. What level of coverage is best for you?

CC health insurance plans are sold in four levels of coverage or metal categories: Bronze, Silver, Gold, and Platinum. As the metal category increases in value (from Bronze to Platinum), so does the percentage of medical expenses that a health insurance plan covers

relative to what you are expected to pay in copays and deductibles. Typically, Platinum plans cover 90% of health care costs, while you pay 10%; Gold plans cover 80%, while you pay 20%; Silver plans cover 70%, while you pay 30%; and Bronze plans cover 60%, while you pay 40%. Plans in higher metal categories have higher monthly premiums, but when you need medical care you pay less. You can choose to pay a lower monthly premium, but when you need medical care you pay more. Minimum Coverage plans are also available to people under 30 years old or to those who can provide certification that they don't have affordable coverage or prove they're experiencing hardship. These plans have low premiums and protect from worst-case scenarios, but generally do not pay for regular coverage. You can't use financial assistance to help pay for a Minimum Coverage plan.

If your income is less than or equal to 250% FPL (\$29,700 for an individual) you may qualify for cost-sharing subsidies, which reduce your OOP costs including copays, co-insurance, and deductibles. They may also reduce your OOP maximum. Cost-sharing subsidies are only available if you select a Silver plan – known as Enhanced Silver plan. There are three categories of Enhanced Silver – Silver 73, Silver 87, Silver 94.

It's important to figure out what metal level best suits your health care needs, so don't be fooled by low premiums. Those plans will cost you much more in OOP costs than plans with higher premiums if you have health care needs like medications or lab tests. The deductibles and other cost sharing burdens in Bronze plans create real barriers to necessary care and treatment for people with significant health needs. ***People with chronic conditions and with routine medication needs, including PrEP, should avoid Bronze and Minimum Coverage plans if at all possible.*** They will not cover your medical expenses. Most people who qualify for cost-sharing subsidies (annual income of \$16,242–\$29,700 for individuals) should enroll in an Enhanced Silver plan for the cost-sharing subsidies and lower OOP maximum. The exception is some people with HIV who qualify for OA-HIPP (see below).

If you're living with HIV:

If you're enrolled in ADAP and CC, ADAP will pay the deductibles, copays, and co-insurance for drugs on the ADAP formulary. ADAP payments count towards your OOP maximum. OA-HIPP will also cover your monthly health insurance premiums and outpatient medical OOP costs, such as copays for doctor visits, lab tests, and/or a drug that is not on the ADAP formulary. More information can be found here: <http://tinyurl.com/ADAP-OAHIPP>.

Although you may qualify to have your outpatient medical OOP costs covered by OA-HIPP, there are other medical OOP costs that you may incur. Therefore, depending on your income, there are ways to lower your OOP costs. If you earn between 138–200% FPL (\$16,242–\$23,760 for individuals), you can reduce your OOP costs by choosing a Silver plan. You may also qualify for an “Enhanced Silver” plan, which offers more OOP savings. If you earn between 200% FPL (\$23,760 for individuals) or higher and qualify for the OA-HIPP Program, you can reduce your OOP costs by choosing a Platinum plan.

Others with significant medical expenses should do a plan comparison to see if a Platinum plan could decrease their overall spending. Even though Platinum plans have higher monthly premiums, they also have lower OOP maximums and cost-sharing.

6. Are my prescription drugs on the plan “formulary”?

The list of prescription drugs covered by a health insurance plan is called a “formulary.” It's extremely important to make sure any drugs you currently take or expect to take are covered by the plan you select. In order to get full information on what is on the plan formulary, how to appeal if your drug is not on the formulary, and basic information about what it should cost you, refer to the link to the plan formulary website and the plan pharmacy assistance line (page 4). Health insurance plans can change their formularies and/or cost-sharing structures at any time during the plan year—this is not only the case for CC plans, but employer-based insurance as well.

Drugs on the formulary are grouped into tiers, which gives information about how much you should have to pay for the drug. CC plans use 4 tiers:

DRUG TIER	EXPLANATION
1	Generic drugs
2	Brand name drugs, preferred
3	Brand name drugs, non-preferred
4	Specialty drugs

Generic drugs have the lowest cost sharing and each higher tier becomes more expensive. Specialty drugs are the most costly. The OOP cost for each of your medications will also vary based on the metal tier of your plan. In most plans, Tiers 1–3 drugs have copays (a fixed amount) while Tier 4 drugs have co-insurance (a percentage of the cost of the drug).

It can be challenging to determine the exact OOP cost for your medications. The pharmacy assistance lines listed on page 4 should assist you with this information. After finding your drug(s) and the formulary tier, check your plan details at www.CoveredCA.com to determine your OOP costs. If your drug requires a copay, the cost sharing is straight forward but if your drug has co-insurance, you will need to check with the pharmacy assistance line. If you have to estimate the cost, you can check the public Average Wholesale Price (AWP) of your drug at <http://tinyurl.com/drugAWP>, or search online “AIDS Info Average Wholesale Price.” Please note that a recent California law now caps cost-sharing at \$250 per drug per 30 day supply for most plans, so no cost-sharing requirement set by an insurer may exceed that amount. However, the cap for Bronze plans is \$500 per drug per 30 day supply.

Drugs may also have other requirements attached to them such as prior authorization, step therapy, or pharmacy restrictions.

- **PRIOR AUTHORIZATION:** This means your doctor must submit a request with information about your medical needs to get approval for your insurance to cover the drug.
- **STEP THERAPY:** This means you must start with the cheapest or safest drug available to see if it works for your condition before you can get other costlier drugs or drugs that are less safe covered by your insurance.

- **SPECIALTY PHARMACY:** Some plans may restrict “specialty drugs” to a specific pharmacy, which may make it inconvenient for you to get your drugs.

If you see any of these requirements for the drugs you need in the plan formulary, check with your doctor to see if they have had experience getting these drugs through the plan. You should also check the plan’s exception and/or appeals process, which should be posted with the plan formulary. It’s also important to know that step therapy is considered medically dangerous for HIV medications and you should file a grievance with your plan if it’s ever required. Additionally, California plans are now required to provide single table regimens to treat HIV unless they can prove that a multi-tablet regimen is clinically equal in efficacy and equal or more likely to promote adherence.

► **If you’re living with HIV:**

It’s important to remember that if you qualify for ADAP, it can help you meet medication deductibles and pay for copays and co-insurance for drugs on the ADAP formulary (https://cdph.magellanrx.com/provider/external/commercial/cdph/doc/en-us/CDPH_Formulary.pdf). However, you’re still responsible for any other non-ADAP formulary drug OOP costs. If you need a drug that’s not on the ADAP formulary, you need to consider how much it will cost each month until you reach your OOP maximum. If you qualify for ADAP and all of your drugs are on the ADAP formulary, it is not as critical that you research the plan formulary extensively. Remember that OA-HIPP will also now cover your outpatient medical OOP costs, including copays for drugs that are not on the ADAP formulary.

► **If you’re living with both HIV and HCV, or HIV and HBV (or HIV, HBV, and HCV):**

It’s important to determine whether you meet the treatment guidelines for the HBV and/or HCV drugs you need. ADAP covers HBV and HCV drugs for all qualified individuals who are co-infected regardless of disease state or other considerations. However, it only covers a one-time course of treatment for HCV under most circumstances.

Checklist for choosing a Covered California plan

Consider taking this list (and publication) with you whenever you talk to someone about choosing a Covered California health care plan.

- I have created a list of questions that I need answered. YES NO
- I’ve talked to or scheduled to talk to one or more people (CIA or CEC, case manager, etc.) about my needs around HIV, HBV, HCV or PrEP. YES NO
- I know which CC plans are offered in my area. YES NO
- I want to try to stay with my current doctor. I know which plans my doctor takes. YES NO
- I have checked to see if the pharmacy I want to use is in the CC plan I want to use and that there are no pharmacy restrictions on my drugs. YES NO
- I have made a full list of my prescription drugs. YES NO
- I have looked over the formularies and know which drugs the plan I’m considering covers and how much they may cost me. YES NO
- I have made a list of the other health care services I am likely to need and know the out-of-pocket costs associated with them. YES NO
- I understand what the different metal levels mean and have an idea of which level might be best for me. If I qualify for assistance with premiums and out-of-pocket costs, I know which plan is best for me. YES NO
- I know whether the plan I am interested in has a deductible and I know what the deductible covers. YES NO
- If I am living with HIV/AIDS, HBV and/or HCV, I have read the special considerations that will help me in my plan choice and with the cost of my health insurance. YES NO
- If I am HIV-negative and considering PrEP, I have read the special considerations that will help me in my plan choice and the cost of my health insurance. YES NO

Assistance with Premiums and Out-of-Pocket Medication Costs for People with HIV

OA-HIPP PROGRAM (OFFICE OF AIDS HEALTH INSURANCE PREMIUM PAYMENT):

OA-HIPP pays the monthly health insurance premiums and outpatient medical OOP costs for eligible California residents living with HIV who have annual household MAGI below 500% FPL (\$59,400 for single households) who are enrolled in the AIDS Drug Assistance Program (ADAP), and who do not qualify for Medi-Cal. More information on MAGI can be found here: http://laborcenter.berkeley.edu/pdf/2013/MAGI_summary13.pdf.

If enrolled, the OA-HIPP program will pay:

1. Your monthly health insurance premiums
2. Outpatient medical out of pocket costs that count towards your medical insurance policy's annual maximum. This may include the cost of annual deductibles, doctor visits, outpatient laboratory or outpatient diagnostic study copays, and co-insurance. More information can be found here: <http://www.cdph.ca.gov/programs/aids/Documents/ADAPMM2016-13OA-HIPPMedicalOutOfPocket.pdf>.

In order to enroll in OA-HIPP, you must meet all the eligibility criteria for ADAP and have private health insurance with prescription drug coverage obtained through CC, California Continuation Benefits Replacement Act (COBRA), or directly from an insurer. OA-HIPP will be expanding to cover people with employer-based coverage, but that will not happen until sometime in 2017. If insurance is obtained through CC, enrollees must take the full Advanced Premium Tax Credit (APTC), awarded on a monthly basis, rather than at year's end. Application and related forms can be found by conducting an internet search for "CA OA-HIPP"

There are two ways to apply for the OA-HIPP program:

1. You may apply for OA-HIPP assistance via the electronic A.J. Boggs Portal (www.CAMedAssist.org). If you have your log-in information for your online

portal with A.J. Boggs, you may enroll on your own, or you may work with your enrollment worker. You will need to update the "Health Coverage" and "Insurance Assistance" tabs in the Update Form. You will also need to upload the following documents:

- a. Health insurance plan billing statement, and
- b. Covered California Welcome Letter or coverage summary page.

2. You may also apply via mail or fax to:

Mail: A.J. Boggs & Company
4660 S. Hagadorn Rd. Suite 290
East Lansing, MI 48823
Fax: (844) 666-1411

You will need to send the following documents:

1. OA-HIPP Program Application
2. Health insurance plan billing statement
3. Covered California Welcome Letter or coverage summary page. The documentation should include the premium amount, health plan, APTC taken, enrollment confirmation number, and a health plan billing address (if available).

To avoid having to pay premiums and medical OOP costs on your own, you should work with an enrollment worker who is both a CC enroller and an ADAP enrollment worker. The enrollment worker will ensure timely enrollment in CC and the OA-HIPP program. To find an enrollment worker near you, please call (844) 550-3944 or visit www.CAMedAssist.org. In order for OA-HIPP to pay your initial CC health plan premium on your behalf, your enrollment worker will need to ensure enrollment in the OA-HIPP program 24 to 48 hours after enrollment in CC.

If enrolling in OA-HIPP more than 48 hours after enrollment in CC, you may likely need to make the initial premium payment on your own to secure your health insurance. You have to contact your health plan

directly to get reimbursed for any premium(s) you pay out of pocket. Unfortunately, not everyone gets a refund for their paid premiums as some plans only apply those amounts to future premiums. For complete OA-HIPP applications received by February 28, 2017, the OA-HIPP program will pay back to the 2017 coverage effective month. For applications that are received on or after March 1, 2017, the OA-HIPP program will pay starting the month the complete application is received.

OA-HIPP enrollment workers are available to answer your questions and help you apply. Call an ADAP enrollment site to find out how to apply for OA-HIPP. A list of them can be found at <http://tinyurl.com/ADAPsites>, or search online “ADAP Enrollment Sites PDF”.

AIDS DRUG ASSISTANCE PROGRAM:

ADAP may also be able to help meet medication deductibles, and pay medication copays and coinsurance associated with your HIV medications and other drugs on the ADAP formulary (https://cdph.magellanrx.com/provider/external/commercial/cdph/doc/en-us/CDPH_Formulary.pdf, or search online “Magellan CA ADAP Formulary PDF”). If your annual Modified Adjusted Gross Income (MAGI) based on household size is less than 500% of FPL (\$59,400 for single households) you may qualify for ADAP. ADAP enrollment workers are available to answer your questions and help you apply. A list of ADAP enrollment sites can be found at <http://tinyurl.com/ADAPsites>, or search online “ADAP Enrollment Sites PDF”. For eligibility and enrollment information, the ADAP formulary, and a list of ADAP pharmacies, call (844)-550-3944 or go to www.CAMedAssist.org.

Know Your Rights!

It’s important to understand your rights related to health insurance. You have the right to receive a broad range of services, and the ability to protect your rights by challenging insurer decisions with which you and your health provider disagree. The goal of challenging decisions is to: 1) get you the health insurance you’re entitled to under federal and state law, and 2) get the benefits, such as doctor’s visits, medications, and labs that you need.

Navigating appeals and grievance processes can be daunting and frustrating. In addition to some of the resources listed below, it can be very helpful to contact the Health Consumer Alliance (HCA) for assistance. HCA is a network of legal advocates who contract with CC to help with these issues (HCA services are also available for anyone having health care access issues in California, regardless of insurance type). You can access free, confidential, and local help with the grievance, appeals, and exceptions processes from HCA by calling (888) 804-3536 or visiting www.healthconsumer.org. HCA also has a wealth of resources in many languages about how to work with your plan if you’re denied coverage, a service, or a medication. You can learn more here: www.healthconsumer.org.

Denied coverage under Covered California?

If you’re denied health care coverage under CC, you’re entitled to a State Fair Hearing to appeal the eligibility determination. Information regarding how to make such appeals and the forms to file can be found online at www.coveredca.com/PDFs/HearingRequestFormCC.pdf. If you have coverage in place, you may ask to keep it while your appeal is reviewed. If you have a premium you must continue to pay it during an appeal. You may ask for an expedited appeal, and you may ask to be re-enrolled retroactively into your prior plan. You can also appeal your Advanced Premium Tax Credit or Cost-Sharing Reduction amount. There are forms on the CC website to help you. You can also call 1-800-300-1506 (TTY 1-888-889-4500).

Can’t get a service once you are enrolled?

You can challenge decisions regarding coverage and payments by first filing a grievance/complaint/appeal with your health plan. The type of issues you might challenge include: you can’t get the medicine or treatment you need; you have to wait too long for a referral, authorization, test or appointment; you’re being sent home from

the hospital too soon; you have a problem with a bill, claim, or copay; services are not accessible for you due to a disability or you cannot get services in your own language. It's important to know that CC plans can't deny you medically necessary medications even if they are not "covered" by your plan. If you have coverage problems and are engaging in an appeal or a grievance, it is critical to keep all correspondence, keep notes of all phone calls, and be aware of deadlines. If you miss a deadline you may lose your ability to protect your rights

To get started, contact your health plan using the information on your insurance card and file a complaint, orally or in writing. If you're dissatisfied with the plan response time and/or their decision, contact the state regulator for help. Most plans are regulated by the Dept of Managed Health Care (Help Center line 888-466-2219). PPO and EPO plans are regulated by the CA Department of Insurance. If your CC plan is a PPO or EPO plan, call (800) 927-HELP (4357). These help lines can help you file for an Independent Medical Review (IMR) or external review. An IMR is performed by experts not connected to your health plan. If you disagree with the IMR, you should consult legal help.

Mixed immigration status families applying for health insurance and seeking health care:

Since the 2016 presidential election, questions have arisen about whether it is safe for families to apply for health coverage through CC if they include members who are not authorized to be in the U.S. Some individuals and families have even decided not to seek health care because they fear that their immigration status might be discovered or shared with immigration enforcement agents. The National Immigration Law Center has developed a factsheet with information that all families should have when they apply for and enroll in health insurance programs or seek health care services. You can learn more here: <https://www.nilc.org/issues/health-care/health-insurance-and-care-rights/>.

If you're living with HIV:

If you have a local legal advisor specializing in HIV-

related health care issues, you might consult them on plan issues first as they are more likely to understand the interactions among the various programs you use. If you need medications urgently and the health insurance plan is not responding, contact the California Department of Public Health, Office of AIDS, ADAP advisor assigned to your Local Health Jurisdiction: <http://www.cdph.ca.gov/programs/aids/Documents/ADAPStaffLHJAssignments.pdf>.

If you have any questions or concerns regarding pharmacy services, contact the Office of AIDS at (844) 421-7050. If you are having issues accessing your ADAP medications, you should contact your local Enrollment Worker directly. You may also complete the ADAP Grievance Form found here: <http://www.cdph.ca.gov/pubsforms/forms/CtrldForms/cdph8542.pdf>.

If you're living with HCV:

It's important to note that some insurance plans have restricted people's access to HCV treatment based on many factors including, but not limited to, the degree of fibrosis (scarring of the liver), substance use history, symptoms, and provider type. It is not uncommon for people who want treatment and are motivated to take it to be denied by their insurance plans.

As frustrating as this might be, you and your medical provider can appeal denials, and — depending on the medication(s) you are prescribed — you may be able to get medication through the drug company's PAP if your appeal is denied. If you have questions about HCV coverage, accessing PAPs, or have been denied for treatment by your insurance, call 1-877-HELP-4-HEP (1-877-435-7443) and talk to a counselor about your situation. Also be aware of the services offered through HCA (888-804-3536).

▶▶ STAYING INSURED ◀◀

Once you enroll and pay the first month's premium, it is important to ensure you receive your ID cards, pay attention to bills, cancellation notices, and other correspondence from your insurance company. Under CC rules, it may be very difficult or impossible to re-enroll/reinstate your policy if it is canceled for non-payment of premium.

**The following organizations have contributed
to the production of this publication.**



**LOS
ANGELES
LGBT
CENTER**



If you would like to suggest changes or report errors in this publication,
please email support@projectinform.org.