

# How to choose a health plan in Covered California:

Do it before January 31, 2016!

**CONTRIBUTORS:** Project Inform, APLA Health & Wellness, San Francisco AIDS Foundation, Los Angeles LGBT Center, Access Support Network, San Francisco City Clinic

November 19, 2015

Covered California 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 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 costs.

## General Information

You can enroll in a Covered CA health plan between November 1, 2015 and January 31, 2016. However, if you want your coverage to start January 1, 2016, then you must enroll by December 15, 2015, 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, 2016, you can only enroll through a Special Enrollment Period (SEP) such as the loss of

a job, move to a different coverage area, birth of a child, marriage/divorce or loss of insurance. These are called "qualifying life events" and a list can be found at <http://tinyurl.com/CClifeevents>, or search online "Covered California Qualifying Life Events".

Before enrolling, there are important things that you should consider if you're living with HIV 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 with making these decisions. 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 and/or HCV, so it's also important to educate yourself.

For a PDF of this guide, go to [www.projectinform.org/pdf/CCguide.pdf](http://www.projectinform.org/pdf/CCguide.pdf).

For an analysis of Covered California's 12 plans, go to [www.projectinform.org/pdf/CCformularies.pdf](http://www.projectinform.org/pdf/CCformularies.pdf).

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

It's important to review your plan and decide if you want to make changes for 2016. Health insurance companies can change their plans' premiums and benefits each year, so it's important to review your plan's 2016 coverage to make sure it still meets your needs.

If you currently receive an advance premium tax credit (APTC) to help pay your insurance, it's extremely important to give your consent for Covered CA to verify your income via the federal Internal Revenue Service (IRS). If you don't, you may lose it in 2016. Information about the renewal process can be found at <http://tinyurl.com/CCaboutrenew>, or search on-line "Covered California Questions about Renewal".

► **If you're on a limited income:**

If you qualify for Medi-Cal, you can enroll at any time during the year. Californians with limited incomes may qualify for Medi-Cal: public health insurance that provides coverage at very low or no cost. If your annual Modified Adjusted Gross Income (MAGI) is below 138% Federal Poverty Level (FPL) based on family size (\$16,243 for individuals), you can probably get health insurance through Medi-Cal. Qualification for Medi-Cal is based on income in the month of application so even if your annual MAGI is higher than 138% of FPL, you may qualify if your income in the month you apply meets criteria (\$1,354 monthly for household size of one). For more information, visit [www.dhcs.ca.gov](http://www.dhcs.ca.gov) or consult your local county social services office.

► **If you're living with HIV:**

Some Californians 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 paid by OA-HIPP (Office of AIDS Health Insurance Premium Payment program).

If you're currently enrolled in ADAP, it's important to consider all your health care needs and costs before deciding to purchase a plan through Covered CA. There are many good reasons for having

comprehensive 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 and will be dis-enrolled from ADAP.

If you don't purchase a plan through Covered CA 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 are found on page 3.

► **If you're living with Hepatitis C Virus (HCV):**

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

If you live with HCV and want to be treated, you need to carefully consider all the options available within Covered CA's plans in order to minimize your out-of-pocket 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 are 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 products in California, including Medi-Cal, will cover Truvada for prevention. 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 Covered CA plan carefully in order to reduce your out-of-pocket 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. A list of doctors with experience providing PrEP can be found at: [www.pleaseprepme.org](http://www.pleaseprepme.org).

Bronze plans should generally be avoided. Despite their low premiums, they have high deductibles and out-of-pocket costs that are likely to make access to medications and other benefits unaffordable.

This guide will help you understand how to pick the plan that is right for your needs and keep your out-of-pocket costs as low as possible. A PrEP Access Flow Chart can be found at [www.projectinform.org/pdf/PrEP\\_Flow\\_Chart.pdf](http://www.projectinform.org/pdf/PrEP_Flow_Chart.pdf). More information about PrEP, including effectiveness and side effects, can be found at [www.projectinform.org/prep](http://www.projectinform.org/prep), and <http://prepfacts.org>.

### Standard Covered California benefits:

All Covered CA plans must provide comprehensive services, known as essential health benefits. These include coverage for prescription drugs, doctor visits, hospitalizations, labs, and behavior 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 Covered CA plan has 4 “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 2016, you may have to pay a tax penalty. In 2016, the annual penalty is 2.5% of your annual income or \$695/person, whichever is greater. However, some people may be exempt from this. A list of exemptions can be found at <http://tinyurl.com/CCavoidpenalty>, 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 out-of-pocket costs, such as medications, routine tests and co-pays or co-insurance for doctor visits through programs listed below.

#### PREMIUM ASSISTANCE:

The federal government's advance premium tax credit 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 (\$16,243–\$47,080 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. This assistance cannot be used to pay for a Minimum Coverage plan.

#### COST-SHARING SUBSIDIES:

Cost-sharing subsidies reduce your out-of-pocket costs, including co-pays, co-insurance and deductibles. They may also reduce your out-of-pocket 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 (\$16,243–\$29,425 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.

#### PHARMACEUTICAL ASSISTANCE PROGRAMS:

Drug companies have programs (PAPs) that may help you with paying for the cost of the drugs you take. If you don't have health insurance or if the drug is not covered by your plan, then PAPs may cover the cost of the drug. If your drug is not covered by an insurance plan, you will have to go through your plan's appeal process before using the PAP. PAPs may offer assistance with the appeal process. If you have health insurance, co-pay programs may help pay for your out-of-pocket costs.

***Be aware that Kaiser and some other pharmacies don't currently accept co-pay cards, but you should still be able to get reimbursed by the co-pay program once you pay for your medications.***

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

A list of PAPs and co-pay programs for HIV and hepatitis C can be found here: <http://fairpricingcoalition.org/projects/>.

***If you're considering PrEP:***

Gilead Sciences, who makes Truvada, has a co-pay 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. Information about the co-pay program can be found at [www.gileadcopay.com](http://www.gileadcopay.com). If you don't have insurance and your annual income is below 500% FPL (\$58,850 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 Access Network's (PAN) co-pay program also provides financial assistance for people who have private insurance. Assistance is limited to \$4,000 per year for individuals with incomes below 500% of FPL. More information can be found at [www.panfoundation.org/fundingapplication/welcome.php](http://www.panfoundation.org/fundingapplication/welcome.php) or 1-866-316-PANF. Also, the Patient Advocate Foundation (PAF) has a program to provide financial assistance for people who have private insurance with incomes less than 400% FPL. For those who qualify the maximum award amount is \$5,000 per year, although this amount can vary. More information can be found at [www.copays.org/diseases/hiv-aids-and-prevention](http://www.copays.org/diseases/hiv-aids-and-prevention).

## Choosing a Plan:

Selecting the best Covered CA health plan to meet your needs can be challenging. Certified Enrollment Counselors (CECs) and Insurance Agents (CIAs), as well as Covered CA 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 will have 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.

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](http://www.coveredca.com/get-help/local));
- online at [www.CoveredCA.com](http://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 Covered CA plan. In the past there have been technical problems online and/or long wait times when purchasing by phone. Systems should be much improved this year, but if you have any questions or need additional information, it is helpful to seek assistance.

Covered CA 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 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 and understands Medi-Cal, ADAP, OA-HIPP and other program requirements.

If you're unable to find someone who understands your 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. Covered CA is the only marketplace where you can take advantage of federal help with your premiums and your out-of-pocket costs, so be sure you talk with an authorized Covered CA 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. A partial list of CECs with knowledge of HIV programs in California can be found here: <http://tinyurl.com/CCentities>.

## Plan Comparison:

Even with the help of a CEC, 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 Covered CA plan(s) he or she is contracted with. If you're looking for a new doctor, make sure of that before picking a plan.

Covered CA has not posted a directory of doctors included in each plan, so check with the plan itself to confirm that you can see the doctor you want. However, the plans have also made mistakes in their provider networks, so it's important to confirm with your doctor that they are "in-network" with the

Covered CA 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", 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."

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.

**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, co-pays and co-insurance. Know what your annual out-of-pocket maximum is. Covered CA has recently made several changes to help consumers better understand and manage their prescription drug costs. In the 2016 plan year, all Covered CA health insurance plans will charge no more than up to \$250 per month for one 30-day supply of prescription drugs for Silver, Gold and Platinum plans and no more than up to \$500 per 30-day supply for Bronze plans. These costs apply to Tier 4 (specialty drugs). Drugs in lower tiers have lower costs

- 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 another one for drugs, or they can combine the two.
- A **CO-PAY** is a fixed amount that you pay for services until you reach the out-of-pocket 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 out-of-pocket 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 out-of-pocket 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. A CIA may be able to access this Treatment Cost Estimator for you. Additionally the pharmacy assistance lines associated with each plan should be able to give you information about cost sharing.

- The **OUT-OF-POCKET MAXIMUM** is the most you have to pay for medical expenses during the year above and beyond your monthly premium. Depending on your plan, these expenses may include an annual deductible, co-insurance and co-pays for doctor visits and prescription drugs. Deductibles, co-pays and co-insurance count toward your out-of-pocket maximum, unless they are considered "out of network" or "not covered". Premiums are not counted. In most cases, once you reach your out-of-pocket maximum, your insurance will cover 100% of the costs they consider medically necessary. However, it is important to remember that not every out-of-pocket health expense is counted toward the out-of-pocket maximum. For example, it will not include co-pays for non-network providers and other out-of-network cost-sharing. Understand what out-of-pocket costs will count toward your out-of-pocket maximum before signing up for a new health plan.

The out-of-pocket maximum in CA for most Covered CA plans is \$6,250 for individuals. Bronze plans have an out-of-pocket max of \$6,500. If you qualify for cost-sharing subsidies (annual income of \$16,243–\$29,425 for individuals) and enroll in a Silver plan, your out-of-pocket maximum will be lower (\$2,250–\$5,450 for individuals). The out-of-pocket maximum for Platinum plans is \$4,000 for individuals. Depending on your health needs, overall costs may be lower, even though premiums are higher, with a Platinum plan than Silver because of the out-of-pocket caps, so it's important to compare your options.

In order to compare plans you're interested in, add up the premiums and expected out-of-pocket costs, including the drugs, blood work and procedures you need, for the full plan year. Estimating your

monthly out-of-pocket 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 plan pharmacy assistance line.

### 5. What level of coverage is best for you?

The four “metal tiers” of coverage refer to how much you must pay for your health care and how much the plan will cover. For example, Bronze plans have lower premiums than Platinum plans but higher deductibles, co-pays and other out-of-pocket expenses. Covered CA also allows two types of plans at each metal tier: one that mostly uses co-pays and one that mostly uses co-insurance. All plans are not available in all areas. 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. You can't use financial assistance to help pay for a Minimum Coverage plan.

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 out-of-pocket costs than plans with higher premiums if you have routine 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 health needs. People with chronic conditions and with routine medication needs, including PrEP, should avoid Bronze and Minimum Coverage plans. They will not cover your medical expenses. Most people who qualify for cost-sharing subsidies (annual income of \$16,243–\$29,425 for individuals) should enroll in a Silver plan for the cost-sharing subsidies and lower out-of-pocket 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, co-pays and co-insurance for drugs on the ADAP formulary. ADAP payments count towards your OOP maximum. However, you will still be responsible for any other OOP costs such as co-pays for doctor visits, lab tests and/or a drug that is not on the ADAP formulary. If you earn between 138–200% FPL (\$16,243–\$23,540 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 out-of-pocket savings. If your income is 201% FPL or higher (\$23,541 for individuals), the Platinum plan is usually most cost-effective. Please note that OA-HIPP is working towards paying outpatient medical out-of-pocket costs. The effective date is expected to be sometime in mid-2016.

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 out-of-pocket maximums and cost-sharing. If you can find a plan that relies primarily on co-pays rather than co-insurance, you will be able to better understand your cost-sharing obligations.

### 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 formulary analysis referenced below, the link to the plan formulary web site and the plan pharmacy assistance line. 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 Covered CA plans, but employer-based insurance as well.

## DRUG FORMULARY LINKS

### **Anthem Blue Cross of California, (855) 634-3381**

<https://www.anthem.com/ca/pharmacyinformation/>

### **Blue Shield of California, (855) 836-9705**

<https://www.blueshieldca.com/bsca/pharmacy/formulary/home.sp#ifp>

### **Chinese Community Health Plan, (888) 775-7888**

[https://www.cchphealthplan.com/sites/default/files/pdfs/4\\_Tier\\_Exchange\\_Formulary.pdf](https://www.cchphealthplan.com/sites/default/files/pdfs/4_Tier_Exchange_Formulary.pdf)

### **Health Net, (888) 926-5133**

[https://www.healthnet.com/portal/member/content/iwc/member/unprotected/health\\_plan/content/drug\\_list\\_ifp.action](https://www.healthnet.com/portal/member/content/iwc/member/unprotected/health_plan/content/drug_list_ifp.action)

### **Kaiser Permanente, (800) 464-4000**

[https://healthy.kaiserpermanente.org/health/care/lut/p/a0/HYrNCslwDlCfxQcoQUSQ3nbRi8q2y2xvoY21sCQjzoFv7-bx-4EID4iCSy04VxUcVw6JZCbzSRcyo4p1\\_TPb\\_dU48-l9oUBlStJsDBCEHUJ04s2Z1TWFcKtv28omqImCEPben\\_tm-Plvl8dTMyAze7H8rRFFA/](https://healthy.kaiserpermanente.org/health/care/lut/p/a0/HYrNCslwDlCfxQcoQUSQ3nbRi8q2y2xvoY21sCQjzoFv7-bx-4EID4iCSy04VxUcVw6JZCbzSRcyo4p1_TPb_dU48-l9oUBlStJsDBCEHUJ04s2Z1TWFcKtv28omqImCEPben_tm-Plvl8dTMyAze7H8rRFFA/)

### **L.A. Care Health Plan, (800) 788-2949**

<https://www.lacare.org/members/member-services/pharmacy-center>

### **Molina Healthcare, (888) 858-2150**

[www.molinahealthcare.com/members/ca/en-US/PDF/Marketplace/formulary-2016.pdf](http://www.molinahealthcare.com/members/ca/en-US/PDF/Marketplace/formulary-2016.pdf)

### **Oscar Health Plan of California, (855) OSCAR-55 x1, x2**

<https://www.hioscar.com/search/CA/drugs>

### **Sharp Health Plan, (800) 359-2002**

<https://www.sharphealthplan.com/index.php/pharmacy/>

### **United Healthcare Benefits Plan of California, (800) 260-2773**

[www.uhc.com/iex/doc?id=ca0017&st=ca](http://www.uhc.com/iex/doc?id=ca0017&st=ca)

### **Valley Health Plan, (888) 421-8444**

[www.valleyhealthplan.org/sites/ccp/pn/Pharm/Pages/Pharmacy.aspx](http://www.valleyhealthplan.org/sites/ccp/pn/Pharm/Pages/Pharmacy.aspx)

### **Western Health Advantage, (888) 563-2250**

<https://www.westernhealth.com/pharmacy-information/>

We have done a formulary analysis with the latest plan information we could find for HIV, HCV, HBV and PrEP. It includes tiering and sometimes important restrictions (see below). Consult the analysis (<http://tinyurl.com/CCformularies>) and click on the link(s) at the top of each analysis page to ensure you're looking at the most updated plan formulary.

Drugs on the formulary are grouped into tiers, which gives information about how much you should have to pay for the drug. Covered CA 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 out-of-pocket 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 co-pays (a fixed amount) while Tier 4 drugs have co-insurance (a percentage of the cost of the drug).

It's challenging to determine the exact out-of-pocket cost for your medications. The pharmacy assistance lines listed in the formulary analysis should assist you with this information. After finding your drugs and the formulary tier, check your plan details at [www.CoveredCA.com](http://www.CoveredCA.com) to determine your out-of-pocket costs. Remember, Covered CA allows two types of plans at each metal level: one that relies on co-pays and the other on co-insurance. If your drug requires a co-pay, 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 "AIDSinfo Average Wholesale Price".

Drugs may also have other requirements attached to them such as prior authorization, step therapy or pharmacy restrictions. (In the industry, this is called *utilization management*.)

- **PRIOR AUTHORIZATION:** This means your doctor must submit a request with information about your medical needs before you receive the drug.
- **STEP THERAPY:** This means you must start with the cheapest or safest drug before you can get other more costly or risky drugs.

- **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 our analysis and/or the plan formulary, check with your doctor to see if they have had experience getting these drugs through this plan. You should also check the plan’s exception and/or appeals process. This should be listed on the plan’s drug formulary beginning in 2016. 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. According to our analysis, a few of the HIV drugs in a few plans require step therapy.

► ***If you’re living with HIV:***

It’s important to remember that if you qualify for ADAP, it will pay the deductibles, co-pays and co-insurance for drugs on the ADAP formulary ([www.ramsellcorp.com/PDF/CA\\_AlphaGeneric051414.pdf](http://www.ramsellcorp.com/PDF/CA_AlphaGeneric051414.pdf)). However, you’re still responsible for any other, non-ADAP formulary drug out-of-pocket 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 out-of-pocket 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 formulary extensively.

► ***If you’re living with both HIV and HCV:***

It’s important to determine whether you meet the treatment guidelines for the HCV drugs you need. ADAP covers the hepatitis C 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 under most conditions.

## ►► 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.

### 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, 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 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 for eligible California residents living with HIV who have annual household MAGI below 500% FPL (\$58,850 for single households) who are enrolled in the AIDS Drug Assistance Program (ADAP), and who do not qualify for Medi-Cal. Income eligibility for ADAP and OA-HIPP recently changed and is now based on the Affordable Care Act definition of MAGI, as well as household size. For most people, MAGI will be equal to the old standard of Federal Adjusted Gross Income (FAGI). One notable exception for people with HIV is those who rely on social security disability income (SSDI). MAGI requires that non-taxable SSDI is added back into MAGI for eligibility determination. If you have questions about your MAGI calculation, check with a benefits or tax consultant or an OA-HIPP or ADAP Enrollment Worker (EW). Again, these programs now consider household size when calculating eligibility, so a household of three, for example, can now make up to \$100,450 MAGI annually. More information on MAGI can also be found by searching online “UC Berkeley labor center MAGI”.

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 Covered CA, COBRA or directly from an insurer. People with employer-based insurance coverage are not eligible to enroll in this program. If insurance is obtained through Covered CA, enrollees must take the full Advanced Premium Tax Credit (APTC), awarded on a monthly basis, rather than at year’s end. Submit an application and supporting documents directly to the Office of AIDS including the required Insurance Assistance Section (IAS) fax cover sheet, IAS consent

form, most recent billing statement, and CC welcome letter or plan enrollment summary. Family plans must also submit documentation that shows the relationship to the primary policy holder (e.g., marriage certificate or dependent documents). Once the Office of AIDS has received all of these documents, it can take several weeks to process the paperwork. Therefore, you will need to submit the first premium payment directly to your health plan to secure coverage and then continue to make payments on your own until receiving confirmation that a payment from OA-HIPP has been sent and posted to your account. Application and related forms can be found by searching online “CA OA-HIPP”

To minimize the number of premium payments you make on your own, submit the required OA-HIPP documents to the Office of AIDS as soon as you enroll in a new health plan.

Prospective OA-HIPP clients should continue to pay their monthly health insurance premiums until notified that the initial premium has been paid. OA-HIPP will send an email to notify the client or EW that the client has been approved and initial payment has been made on the client’s behalf. EWs and clients can also call the HIPP Hotline for updates on payment status: (844) 421-7050.

For more information, the CA Office of AIDS “Management Memo 2015-19 Covered California Open Enrollment Period” ([www.cdph.ca.gov/programs/aids/Documents/MM2015-19CovCAOpenEnroll.pdf](http://www.cdph.ca.gov/programs/aids/Documents/MM2015-19CovCAOpenEnroll.pdf)) outlines OA-HIPP policy for the 2016 year.

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.

OA-HIPP EWs 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”.

Your federal or state tax return is the preferred method to prove eligibility for both ADAP and OA-HIPP. Both of these programs require annual, face-to-face recertification with an Enrollment Worker up to 45 days before your birthday. For ADAP, enrollees will be mailed a Self-Verification Form from the CA Department of Public Health that they must complete no later than 6 months after their birthday. Re-certification and re-enrollment for OA-HIPP happen six months after the enrollee’s birthday and requires that enrollees with Covered CA plans (but not COBRA plans) present a federal or state tax return.

### **ADAP (AIDS DRUG ASSISTANCE PROGRAM):**

ADAP may also be able to help meet medication deductibles, and pay medication co-pays and co-insurance associated with your HIV medications as well as other drugs on the ADAP formulary (<http://tinyurl.com/RamsellADAP>, or search online “Ramsell ADAP Formulary PDF”). If your annual MAGI based on household size is less than 500% of FPL (\$58,850 for single households) you may qualify for ADAP. Individuals with income below 400% FPL get assistance at no cost. Individuals with income between 400% and 500% FPL may have a share of cost obligation. For eligibility and enrollment information, the ADAP formulary, and a list of ADAP pharmacies, call (888) 311-7632 or go to [www.ramsellcorp.com/individuals/ca.aspx](http://www.ramsellcorp.com/individuals/ca.aspx). (Ramsell Corporation is the pharmacy benefits manager for ADAP.)

## **Know Your Rights!**

It’s important to understand your rights to health insurance. You have the right to receive a broad range of services, and the ability to protect your rights by challenging decisions over 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 Health Consumer Alliance (HCA) for assistance. HCA is a network of legal advocates who contract with Covered CA to help with these issues. 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](http://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: [www.healthconsumer.org/brochures.htm#mcappeal](http://www.healthconsumer.org/brochures.htm#mcappeal).

### **Denied coverage under Covered California?**

If you’re denied health care coverage under Covered CA, 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](http://www.coveredca.com/PDFs/HearingRequestFormCC.pdf). If you have coverage in place, you may ask to keep it while your appeal is being 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 co-pay; or you cannot get services in your own language. It's important to know that Covered CA 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, 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 CC plans are regulated by the Department of Managed Health Care (Help Center line 888-466-2219). If you contact the Department of Managed Health Care and they find that your health plan is regulated by the Department of Insurance, 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.

### **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: [www.cdph.ca.gov/programs/aids/Documents/ADAP-StaffLHJAssignments.pdf](http://www.cdph.ca.gov/programs/aids/Documents/ADAP-StaffLHJAssignments.pdf).

If you have any questions or concerns regarding pharmacy services, contact Ramsell Corporation at 888-311-7632 (option 7). If you are having issues accessing your ADAP medications, you should contact your local Enrollment Worker directly. You may also inform Ramsell by calling a Customer Service Representative at 888-311-7632 (option 8) and/or completing an ADAP Member Pharmacy Services Grievance Form found here: <http://tinyurl.com/ADAPgrievance>, or search online "Ramsell ADAP Member Grievance Form 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 and symptoms. 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).

**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](mailto:support@projectinform.org).