SF HIV FOG
Open Enrollment Bootcamp IV

UCSF Mission Hall -550 16th Street
San Francisco, CA 94143

Friday, October 5, 2018

8:30	**Registration and Breakfast**	
9:00	**Welcome** **Icebreaker**	**Room 1400**
9:30	**Choosing a Plan: Open Enrollment Basics Overview** Lisa Kohli, Staff Attorney, PRC	**Room 1400**
10:30	**BREAK**	
10:45	**Covered CA Updates for 2019** Marc Ross, Bay Area Regional Field Representative, Covered CA	**Room 1400**
12:00 pm	**LUNCH**	
12:45 pm	**SF HIV FOG Announcements**	**Room 1400**
1:00 pm	**Policy Updates: FED, ADAP, and PrEP and the PrEP Assistance Program** Courtney Mulhern-Pearson, Senior Director of Policy and Strategy, SFAF	**Room 1400**
2:00 pm	**BREAK**	
Breakout Session A **2:15 pm**	1. **SF HIV Systems of Care Options** Andy Scheer, Medical Social Worker, SF City Clinic	**Room 2100**
	2. **Alternative Healthcare Options for Categorically Ineligible Clients** Tanya Broder, Senior Staff Attorney, National Immigration Law Center	**Room 2109**
	3. **Medi-Cal Eligible! Now What?** Tiffany Huyenh-Cho, Supervising Attorney, Health Consumer Center, Bay Area Legal Aid	**Room 2107**
	4. **ADAP/OA-HIPP and the New Programs from the Office on AIDS** Amy Cuckovich, ADAP Region 1 Unit Chief; Tracy Lee, ADAP Region 2 Unit Chief; Jeanene Robinson, ADAP Program Advisor; ADAP, California Department of Public Health	**Room 2110**
3:15 pm	**BREAK**	
Breakout Session B **3:30 pm**	1. **Starting the U=U Conversation . . .** Dianne Georgetti, RN/PHN, Westside Community Services, AMC program & Matt Spinelli, MD, Clinical Fellow, UCSF	**Room 2110**
	2. **A, B, C of Medicare** Miguel Martinez, HICAP San Francisco Manager & Charito Aquino HICAP SF Outreach Coordinator, Self-Help for the Elderly	**Room 2109**
	3. **Alternative Healthcare Options for Categorically Ineligible Clients** Tanya Broder, Senior Staff Attorney, National Immigration Law Center	**Room 2017**
	4. **Behavioral Health Care through Insurance Plans** Andy Scheer, Medical Social Worker, SF City Clinic	**Room 2100**
4:30 pm	**Farewell**	

Open Enrollment
Boot Camp IV
Oct 5, 2018

WELCOME

Alynia Phillips, AIDS Legal Referral Panel
Amanda Newstetter, UCSF Bay Area & North Coast AETC
Andy Scheer, SF City Clinic/SFDPH
Ande Stone, SF AIDS Foundation
Beth Mazie, PRC
Chuan Teng, PRC
Dawn Evinger, PRC
Dianne Georgetti, Westside Community Services
Jessica Price, UCSF Bay Area & North Coast AETC
Jordan Akerly, Shanti
Joseph Cecere, SFDPH
Kevin Hutchcroft, SFDPH
Pamela Brown, Larkin Street Youth Services
Rebecca Levin, PRC

What Do We Do?

Capacity building

Practical tools

Cross agency collaboration

Open Enrollment 2019

OCT 15 – JAN 15

Agenda

9:30 am	Choosing a Plan: Open Enrollment Basics
10:45	Covered CA Updates for 2019
12 pm	Lunch
12:45	SF HIV FOG Announcements
1:00	Policy Updates
2:15	Breakout Session A
3:30	Breakout Session B
4:30	End and Thank You

Learning Objectives

1. Describe the health insurance options available for HIV care and medication.

2. Explain how to navigate clients through enrollment in health care coverage.

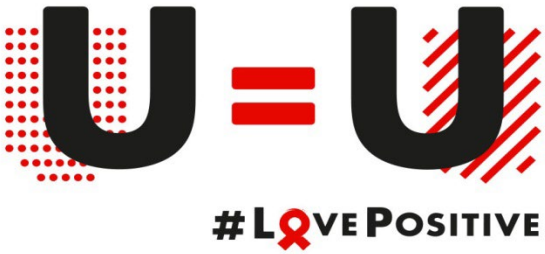
3. Describe the programs available to help clients pay for HIV care and medication costs.

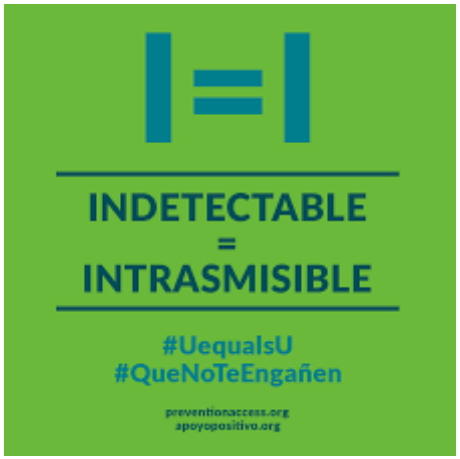
Housekeeping

- Restrooms
- Water fountains
- HIV & Health Insurance 101
- Resource Guide and presentation slides
- CEUs
- Evaluations—please complete both!


EQUALS


equals
SAN FRANCISCO
Undetectable = Untransmittable


U=U
#LoVePositive


I=I
INDETECTABLE
=
INTRASMISIBLE
#UequalsU
#QueNoTeEngañen
preventionaccess.org
apoyopositivo.org


HAGAMOS LAS CUENTAS
Una persona VIH
con carga viral Indetectable
es
a
Intransmisible
CAS


hiv
NIET DETECTEERBAAR
BETEKENT
NIET OVERDRAAGBAAR
n=n
UNDETECTABLE
MEANS
UNINFECTIOUS

#UequalsUSF


U=U
CAMPAIGN

Thank You!

- Getting to Zero San Francisco
- SF Department of Public Health
- Speakers
- Volunteers
- UCSF Mission Bay

Open Enrollment Basics

Open Enrollment Bootcamp IV
October 6, 2018

Lisa Kohli, Esq

Goals

- Understand Open Enrollment period for Covered California and Medicare
- Review related benefits
- Describe penalties for missing Open Enrollment

Who Cares about Open Enrollment?

We do!

- Open Enrollment is the *only* period during the year when individuals can enroll in a health plan without a Qualifying Life Event
- This is to ensure that people aren't signing up only when they get sick
- Medicare, Covered CA, private insurance, and employers all have Open Enrollment periods
- Missing Open Enrollment can mean Medicare penalties or reduced coverage

Covered California

Covered California Open Enrollment

October 15, 2018 to January 15, 2019

During open enrollment you can:

- Enroll in a health plan for the first time
- Renew your health plan
- Change your health plan

If you sign up October 15 through December 15, coverage will be effective **January 1, 2019**

If you sign up December 16 through January 15, coverage will be effective **February 1, 2019**

Covered California Eligibility

- US Citizens, Qualified Immigrants, and applicants for certain legal statuses
- NOT eligible for MAGI Medi-Cal
- NOT enrolled in Medicare
- To be eligible for tax credits, must NOT have an offer of affordable group insurance through and employer

Medi-Cal vs. Covered California

- One streamlined application through the Covered California website
- Medi-Cal enrollment is year-round with no Open Enrollment period
- MAGI Medi-Cal and Covered CA use *Modified Adjusted Gross Income* to determine eligibility
  - <138% FPL (<$1396/month for an individual): eligible for MAGI Medi-Cal
  - 138-250% (up to $2529/mo): eligible for Covered CA with APTC and CSR
  - 250-400% (up to $4046/mo): eligible for Covered CA with APTC

Picking a Covered California Plan

- Best Practice: call doctor's billing office and ask which Covered CA plans they accept, including metal tier
- Use the "Shop and Compare" tool to compare plans
- Considerations:
  - Doctor and hospital choice
  - Pharmacy
  - Drug formulary
  - Anticipated health services and associated costs
  - Premiums and co-pays
  - Out of pocket maximums

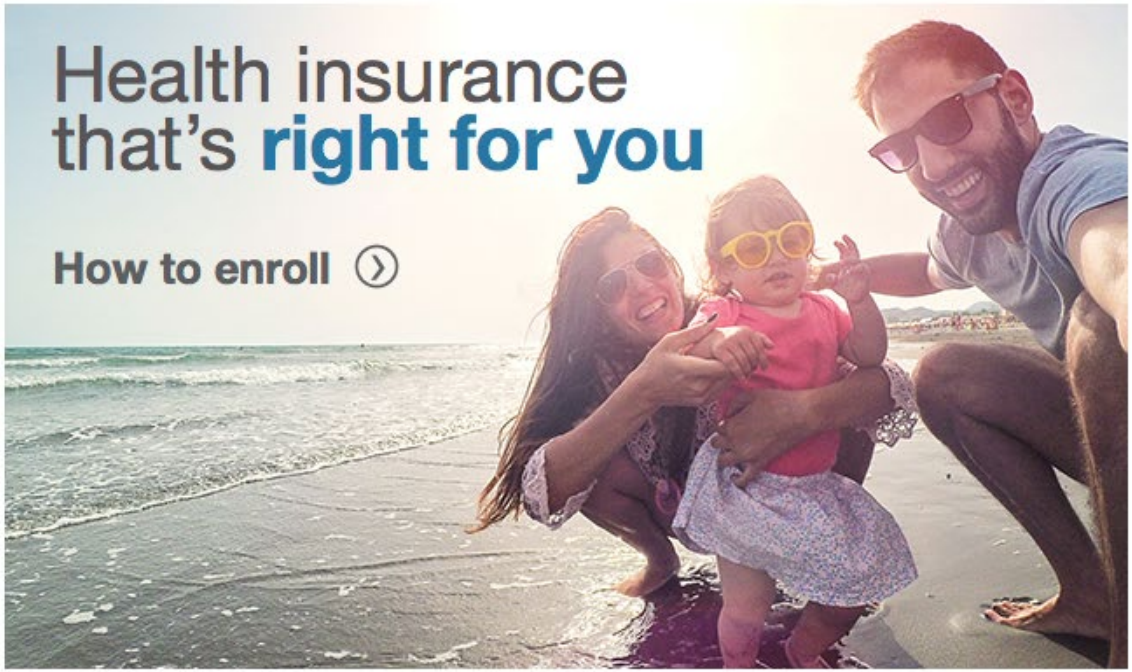
COVERED CALIFORNIA

INDIVIDUALS AND FAMILIES | SMALL BUSINESS

Account Sign In | Español

Search

Get Coverage | Members | Find Help



- See If You Qualify for Financial Help
- Shop and Compare
- Apply for Special Enrollment
- Medi-Cal Information

Enrolling in Covered California

- Online at www.coveredca.com or by phone at 1-800-300-1506
- You don't have to be an agent to help your client enroll
- Individual Mandate eliminated for 2019
- Covered CA vs. private individual plans: Covered CA has appeal rights, APTC, CSR, no restrictions based on pre-existing conditions. Private plans still have open enrollment periods.

Enrollment Steps

- Decide which tier and plan is best for you
- Add the plan to your cart and proceed with enrollment. Requires:
  - Income information
  - ID
  - Proof of citizenship etc
  - SSN
  - Zip code
- Enrollment Summary will direct you to insurance carrier website, where you can make binder payments
- Make the binder payment to the insurance company
  - BINDER PAYMENT MUST BE RECEIVED BY HEALTH PLAN BEFORE COVERAGE GOES INTO EFFECT

Enrollment Practice Tips

- During Open Enrollment have the client make you a delegate so you can get information on their behalf in the future
  - For ADAP EWs: this comes in handy when completing OA-HIPP enrollment
- If your client's income is above 138% FPL and they are not enrolled in Medicare…DO NOT answer "yes" to question about disability
  - If you answer yes, your client will be directed to apply for Medi-Cal
  - You won't be able to move forward with Covered CA application online, and will need to call the hotline
  - If they do not have Medicare, and are between 138%-400% FPL, they are still eligible for Covered CA regardless of disability
- If the client is eligible for OA-HIPP, be sure to print plan information including the premium amount and amount of any APTC and submit to OA-HIPP **ASAP**
  - If they are not yet enrolled in ADAP they can do that after the Covered CA enrollment but be sure they have all of the ADAP enrollment information ready to go

Special Enrollment

What if you don't sign up during Open Enrollment and then your situation changes?

- If you have a Qualifying Life Event you will have a Special Enrollment Period. QLEs include:
  - Loss of coverage
  - Moved to or within California
  - Marriage or Domestic Partnership
  - Having a baby
  - Gaining citizenship/lawful permanent residency
- Must report changes and select a plan within 60 days of the QLE

Like Your Plan? Keep Your Plan!

- Renewal occurs automatically for most health plans
  - However, it is still important to meet with your client!
- When renewing a plan, it is important to update Covered CA regarding:
  - Address change
  - Income change
- Make sure to note any premium increases in the plan
- If the client is enrolled in OA-HIPP, the enrollment worker will need to submit renewal verification and new premium information
  - Do the same if the client is enrolled in dental insurance!

Hate Your Plan? Change Your Plan!

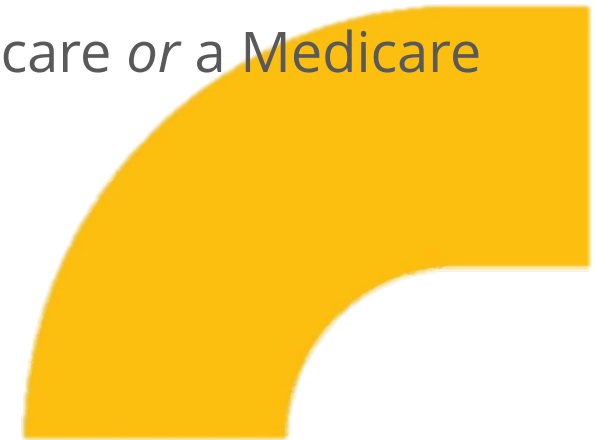
- Why might a client change their plan?
  - Their doctor left the network
  - The plan's formulary changed
  - They want to see a different doctor or attend a different hospital network
  - They were defaulted into a plan they don't like
- If your client wants to change their plan, the steps are the same
  - Review plan's provider network and formulary
  - Complete application online or over the phone
  - Submit new plan and premium information to ADAP/OA-HIPP ASAP if client has ADAP/OA-HIPP coverage

Medicare

Medicare Parts

- Part A = inpatient hospital insurance, SNF, hospice
- Part B = outpatient care, durable medical equipment
- Part D= prescription drug coverage
- Part C (Medicare Advantage) = a way to bundle all three and have it managed by a private company

- “Original Medicare” or “Traditional Medicare” refer to Parts A, B, and D
- You can enroll in *either* Original Medicare *or* a Medicare Advantage Plan



What is Part C?

- Part C plans are also called Medicare Advantage Plans
- Coverage is provided by private insurance companies approved by Medicare
- They include Parts A & B. All California plans include prescription drug coverage also
- There is often a monthly premium in addition to the Part B premium
- May have cost savings
- Many offer supplemental benefits such as dental, vision, health and wellness

You MUST be enrolled in Parts A and B to enroll in Part C

Medicare Enrollment Periods

October 15 to December 7— Parts C and D Open Enrollment

- Three types of enrollment periods:
  - Initial Enrollment Period
  - Open Enrollment
  - Special Enrollment Period

- Initial Enrollment Period
  - For all parts— A, B, C, D
  - A 7-month period that starts three months before the eligibility month, includes the eligibility month, and ends three months after the eligibility month
  - The eligibility month is the month of your 65th birthday. Or, if you are disabled, it is the 24th month after you are first eligible for SSDI benefits
  - ***There can be permanent premium penalties for Original Medicare if you don't enroll when you are first eligible***

- Open Enrollment
  - October 15 to December 7 for Parts C and D

- Special Enrollment Period
  - Triggered by certain life events, like if you move to an area with different plan coverage, lose other coverage like Medi-Cal or employer-based coverage

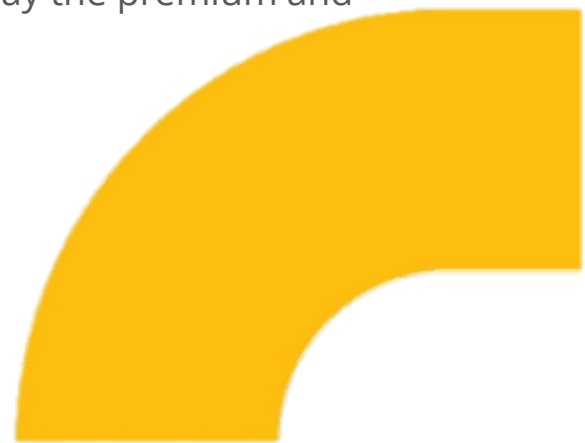
What Can I Do During Open Enrollment?

- Switch from Original Medicare to a Medicare Advantage Plan (Part C)
- Switch from a Part C plan to Original Medicare
- Switch from one Part C plan to another
- Enroll in a Part D plan
- Change Part D plans
- Drop your Part D plan

Changes, or new enrollment, become effective January 1

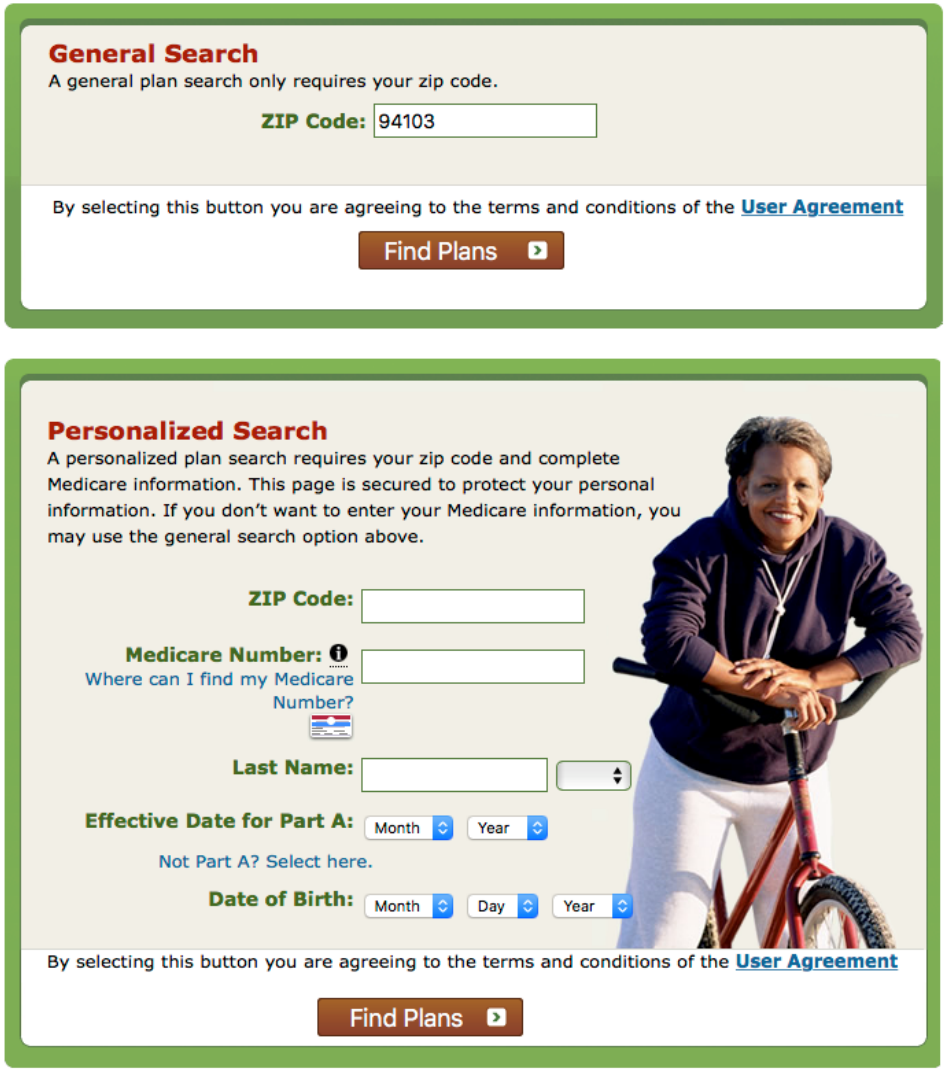
Part D Plans

- **Remember, there may be *permanent premium penalties* if you don't enroll in Part D when first eligible**
  - Exception if you have creditable coverage when you are first eligible
- Considerations when choosing a Part D plan
  - Check the formularies for the client's prescription medications
  - Check any restrictions on the medication, such as prior authorization or step therapy
  - Check that the client's pharmacy is in-network if the client is attached to their pharmacy
  - Review the premium price and cost-sharing associated with each plan
- ADAP can help with Part D premiums too!
- Benchmark Plans
  - Plans with premiums below the CA average
  - If a client receives Extra Help (LIS), Extra Help will pay the premium and deductible for Benchmark plans



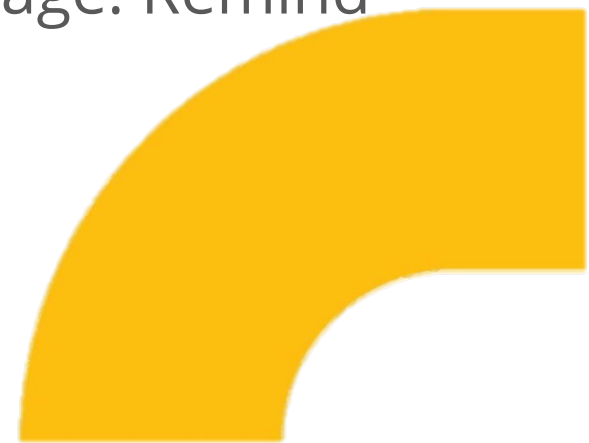
Plan Finder for Parts C and D

www.medicare.gov/find-a-plan



Helping Clients During Open Enrollment

- Use the Plan Finder Tool to review plans, enroll in Part C or D, or change Part C or D plans
- No action needed if client does not wish to enroll in Part C or D, or change Part C or D plans
- However…
  - Best practice is to review current coverage!
  - Check for changes to formulary or provider network
  - Check for changes in premium amount
- Medicare is required to send clients notices of changes or cancellation of coverage. Remind clients to check their mail!



Medicare and Medi-Cal

- Clients who are Medi-Medi have additional protections
- If clients have full-scope Medi-Cal (no share of cost) they are automatically enrolled in Extra Help and will receive Medi-Cal buy in
  - Medi-Cal pays for Parts A, B, and D premiums
  - Clients qualify for low, or no, co-pays/cost-sharing for prescription drugs
- Medi-Medi clients can change plans at any time
- Medi-Medi clients can enroll in Special Needs Part C Plans
  - SNP are intended to better serve a targeted population. Medi-Medi SNP may cover care-coordination services that help members better manage their Medicare and Medi-Cal benefits.
- Medi-Medi clients can still enroll in ADAP if otherwise eligible

Plan of Action

- Identify what type of enrollment your client needs
  - Medicare? Covered CA? Something else?
- Find the relevant Open Enrollment period
- Review the different plan options and choose the one that best fits the client's needs
- Enroll in a plan
- Pay the premium
  - Or notify ADAP/OA-HIPP immediately if the client qualifies for coverage

Questions?

- Call PRC and the Equal Access to Healthcare Program (EAHP)!
  - 415.777.0333
  - prcsf.org

- Call HICAP!
  - 415.666.7520

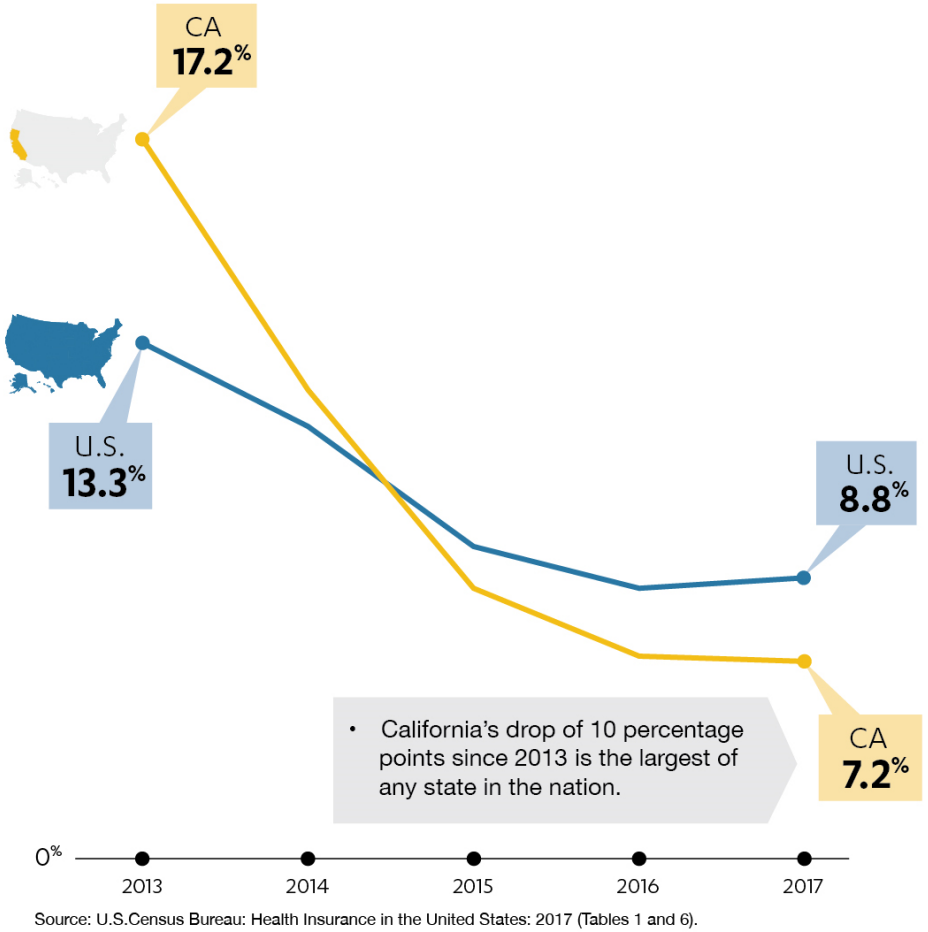
Covered California
Marc Ross, Bay Area Representative

Individual Market **Updates**

Individual Market

STRONG, STABLE AND SUCCESSFUL

The Rate of Uninsured Is Dropping Faster in California Compared to the Nation



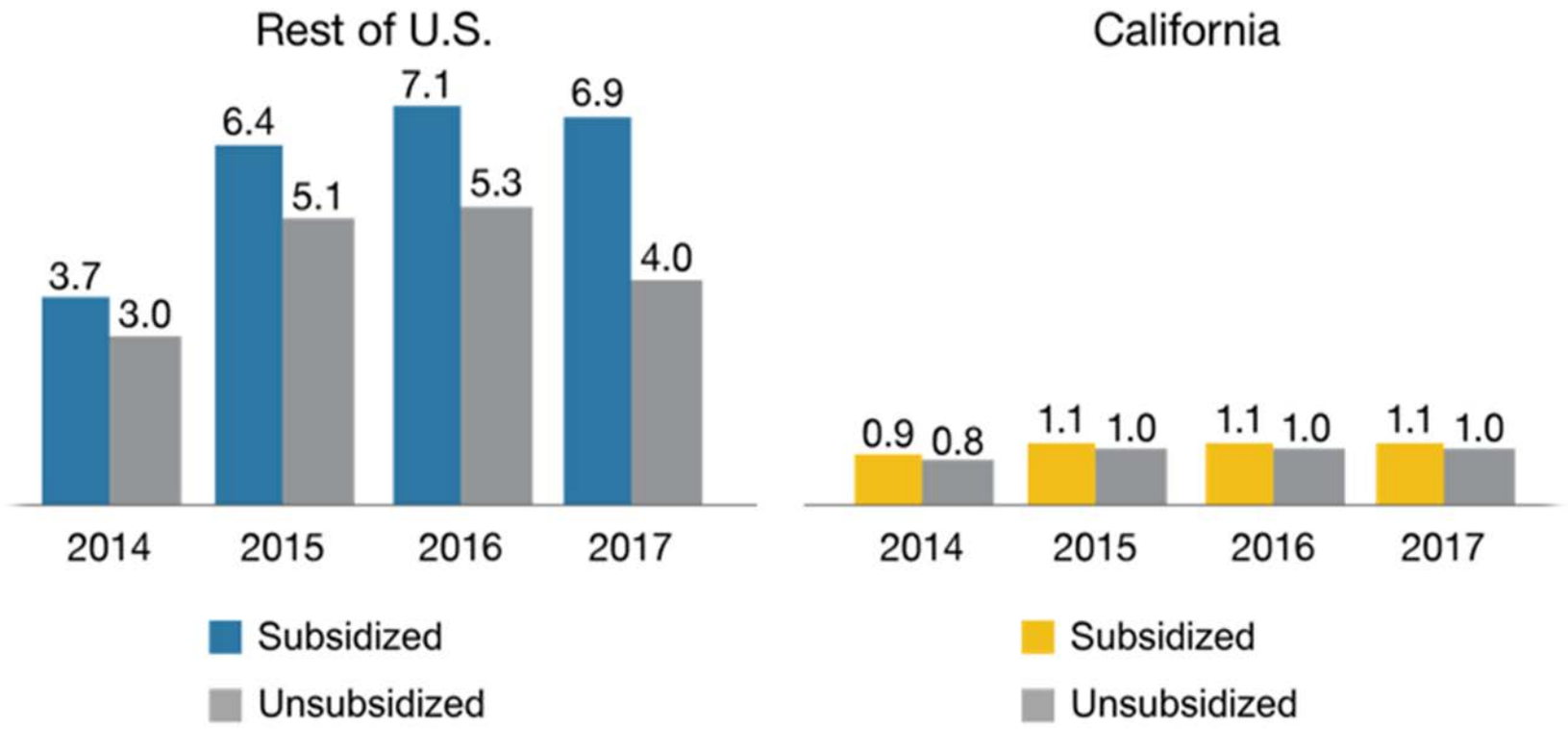
Source: U.S.Census Bureau: Health Insurance in the United States: 2017 (Tables 1 and 6).

- More than **3.7 million** Californians have gained health care coverage since 2013.
- When you exclude individuals who are **ineligible for coverage** rate is roughly **3 percent.**

HEALTHY RISK MIX: INDIVIDUAL MARKET

California's Individual Market:

- **On and Off Exchange:** **20% lower than other states'** average risk scores from 2015-2017
- **On-exchange:** **Lower than the national average** across every metal tier
- **Off-exchange:** **Enrollment remained relatively constant** from 2015-2017.



SIGN UP FOR 2019 PLAN YEAR

October 15, 2018

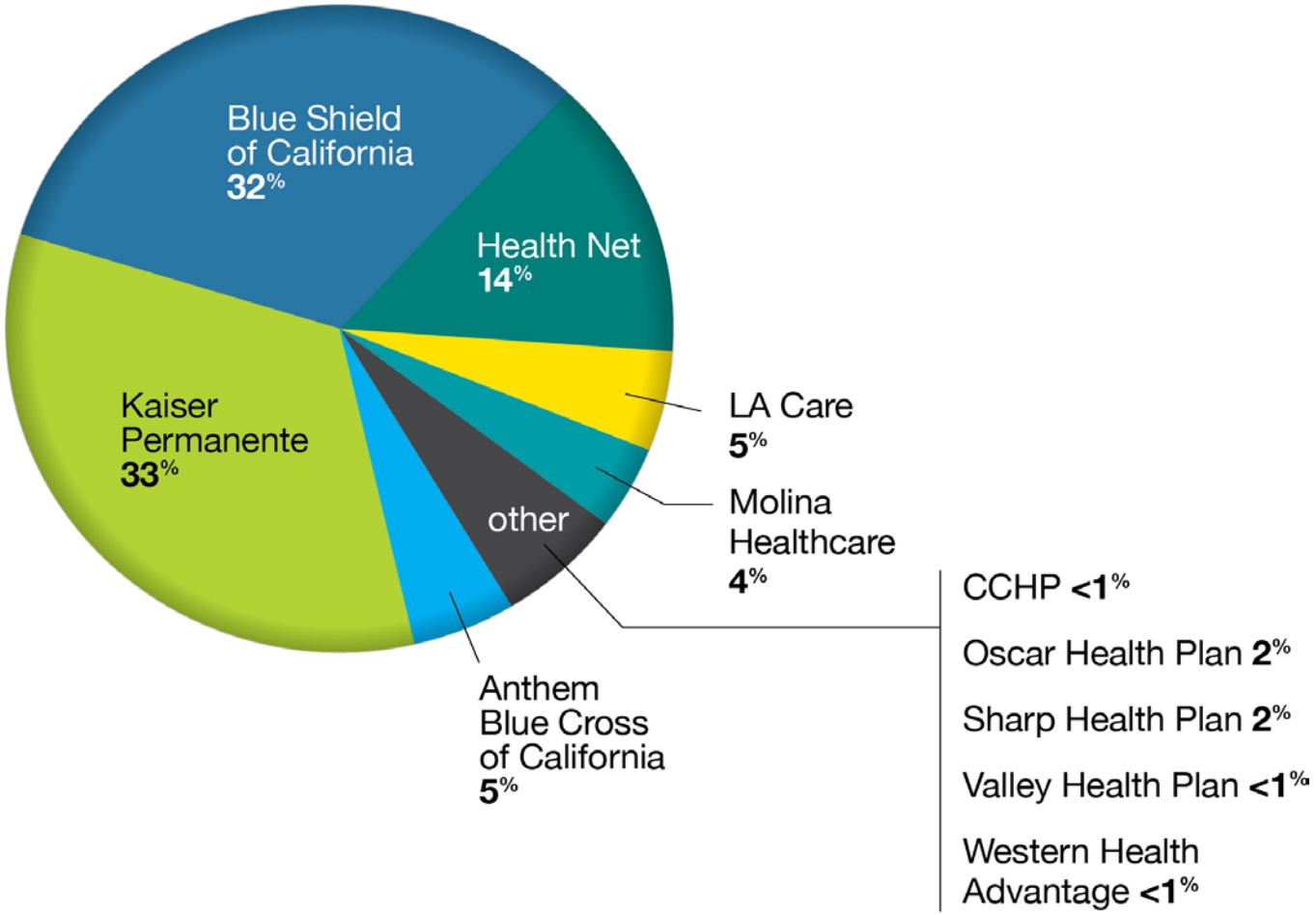
through

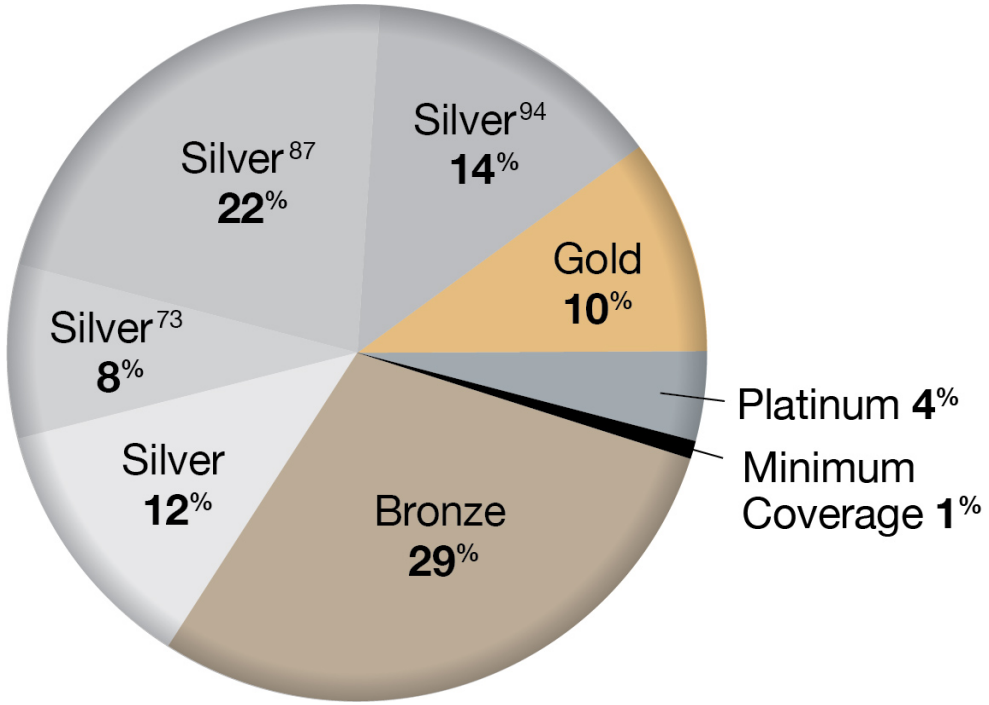
January 15, 2019

Covered California
2019 Plan Year

COVERED CALIFORNIA 2018 ENROLLMENT

(subsidized and unsubsidized)





Enrollment represents effectuated individuals with coverage for June 2018. Enrollment percentages may not total 100 percent due to rounding.

ALL 11 HEALTH CARRIERS RETURN FOR 2019

COVERED CALIFORNIA

Individual Market

Anthem BlueCross

blue of california

健華人計保 CCHP Health Plan

Health Net

KAISER PERMANENTE®

L.A. Care HEALTH PLAN

MOLINA HEALTHCARE

oscar

SHARP HEALTH PLAN

Valley Health Plan

Western Health Advantage

ALL 7 DENTAL CARRIERS RETURN FOR 2019

COVERED CALIFORNIA

https://www.coveredca.com/individuals-and-families/getting-covered/dental-coverage/family/

2019 VISION CARRIERS

Pathway to Quality Vision Coverage

http://www.coveredca.com/individuals-and-families/getting-covered/vision/

http://coveredca.eyemed.com/

https://www.vspdirect.com/4CA/welcome

Covered California
Removal of the Individual Mandate

INDIVIDUAL MANDATE

- Several factors that will have an impact on rates in 2019, including the federal decision to eliminate the individual mandate penalty.

- **Carriers added between 2.5 and 6 percent to their rates, with an average of 3.5 percent**, due to concerns that the removal of the penalty will lead to a less healthy and costlier consumer pool.
  - Without the elimination of the penalty, Covered California's rate change would be closer to 5 percent

- Higher rates will also mean unsubsidized consumers will be faced with paying more for coverage and the federal government will be forced to spend more on tax credits as premiums go up.
  - We are likely see a decrease in enrollment both in California and across the nation and the increase in premiums and decrease in enrollment will lead to future rate increases, particularly if those who leave are healthier than the average consumer.

- Covered California estimates the 3.5 percent increase in rates will mean **Californians will be spending $400 million more** for their health care coverage in 2019

INDIVIDUAL MANDATE

- Subsidized consumers will be protected from this increase, since the amount of financial help they receive will also increase, the federal government will end up paying an estimated $250 million more in higher tax credits
    - **Unsubsidized consumers on and off the exchange will bear the full brunt of the increase**

- Covered California projects enrollment in California's individual market could be reduced by 262,000 consumers in 2019
    - 162,000 consumers from Covered California and 100,000 from the off-exchange market

- Analysis conducted by PricewaterhouseCoopers found that the removal of the individual mandate penalty could also result in uncompensated care rising by $1,000 per newly uninsured person.
    - **If these costs were shifted to private insurance, the cost of employer-sponsored coverage could increase by between 2 and 4 percent, a cost that would most likely be shared between the employer and the employee.**

- In addition, medical trend accounts for 7.5 percent of the rate change. Medical trend is the general change in the unit cost of medical services or products combined with how often those services and products are used and any change in the intensity or amount of services for a condition.

2019

Preliminary Regional Rates

PRICING REGIONS 4-8

- 4-San Francisco County
- 5-Contra Costa County
- 6-Alameda County
- 7-Santa Clara County
- 8-San Mateo County

Pricing Region	4	5	6	7	8
Regional Rate Change (weighted average)	**9.4%**	**8.4%**	**9.4%**	**6.3%**	**9.3%**
Statewide Rate Change (weighted average)	8.7%	8.7%	8.7%	8.7%	8.7%
Net Rate Change (weighted median net percent increase)	20.5%	0.0%	4.3%	1.9%	0.0%
Lowest-price Bronze plan (unweighted average)	11.2%	13.5%	13.5%	-1.0%	13.5%
Lowest-price Silver plan (unweighted average)	6.0%	3.4%	3.4%	-2.0%	3.4%
Weighted rate change if consumers switch to lowest-price plan available in the same metal tier	**1.5%**	**1.7%**	**4.4%**	**-12.2%**	**2.7%**

PRICING REGION 4

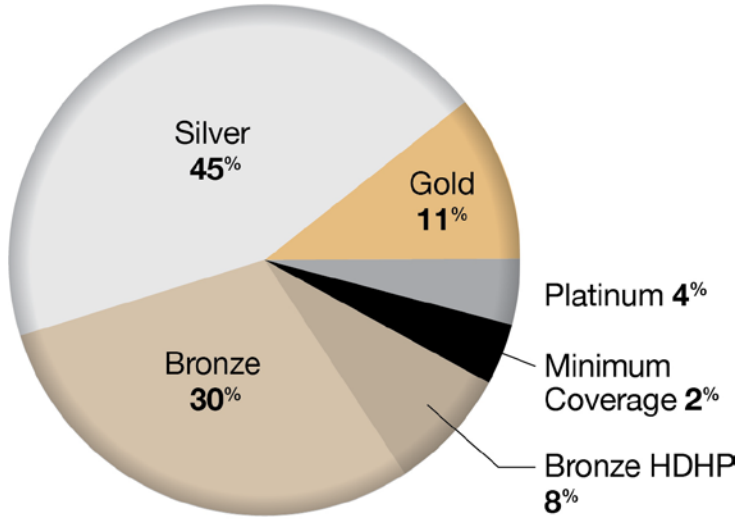
- San Francisco County

Regional Observations

- **36,099** individuals renewed their coverage or signed up
- **82%** are receiving financial assistance
- **Choice** of **five** insurance companies.

Carriers	Range of 2019 Rate Changes	Average Rate Change	Percent of Enrollment in 2018
Blue Shield HMO	5.5% - 7.0%	6.2%	1%
Blue Shield PPO	10.3% - 13.7%	11.5%	23%
CCHP HMO	5.8% - 11.2%	7.9%	26%
Health Net EPO	13.8% - 14.0%	13.9%	<1%
Kaiser Permanente HMO	3.4% - 13.5%	9.5%	48%
Oscar EPO	-19.1% - 14.8%	4.2%	2%

2018 Regional Enrollment by Metal Tier
(subsidized and non-subsidized)



Enrollment represents effectuated individuals as of April 2018.

San Francisco County (Pricing Region 4)

- The lowest-priced plan for each metal tier is shown in **bold green font**
- The second-lowest silver plan is shown with a red square

25-year-old Single Individual

Plan	Minimum	Bronze HDHP	Bronze	Silver	Gold	Platinum
Blue Shield PPO	$381	$387	$391	$525	$600	$802
Blue Shield HMO	-	-	-	$483	$566	$773
CCHP HMO	$288	**$296**	**$299**	**$418**	**$443**	**$489**
Health Net EPO	$330	-	$419	$628	$694	$819
Kaiser HMO Coin	$257	$298	-	-	$446	-
Kaiser HMO Copay	-	-	$307	$429	$473	$515
Oscar EPO	**$194**	$302	$320	$516	$566	$711

40-year-old Single Individual

Plan	-	Bronze HDHP	Bronze	Silver	Gold	Platinum
Blue Shield PPO	-	$493	$498	$668	$764	$1,021
Blue Shield HMO	-	-	-	$615	$721	$983
CCHP HMO	-	**$376**	**$380**	**$532**	**$564**	**$622**
Health Net EPO	-	-	$534	$799	$883	$1,042
Kaiser HMO Coin	-	$379	-	-	$567	-
Kaiser HMO Copay	-	-	$390	$546	$602	$656
Oscar EPO	-	$384	$407	$657	$720	$905

REGION 4 – San Francisco County: Hospital Network

- Hospital Network as of August 2018.
- May not be a complete list of hospitals.
- Verify with the health plan if the hospital is in-network.
- Kaiser Permanente hospitals are not listed.

Hospital	Blue Shield HMO	Blue Shield PPO	CCHP HMO	Health Net EPO	Kaiser HMO	Oscar EPO
CALIFORNIA PACIFIC MED CTR-CALIFORNIA WEST		X	X			
CALIFORNIA PACIFIC MED CTR-DAVIES CAMPUS		X	X			
CALIFORNIA PACIFIC MED CTR-PACIFIC CAMPUS		X	X			
CALIFORNIA PACIFIC MEDICAL CENTER - ST. LUKE'S CAMPUS		X	X			
CHINESE HOSPITAL			X	X		
JEWISH HOME		X				
LANGLEY PORTER PSYCHIATRIC INSTITUTE		X				
ST. FRANCIS MEMORIAL HOSPITAL	X	X	X	X	X	
ST. MARY'S MEDICAL CENTER, SAN FRANCISCO	X	X	X	X		
UCSF MEDICAL CENTER	X	X	X	X		
UCSF MEDICAL CENTER AT MISSION BAY	X	X				X
UCSF MEDICAL CENTER AT MOUNT ZION	X	X		X		X

2019

Health Plan Benefits

GETTING THE RIGHT CARE AT THE RIGHT TIME

- **Primary Care:** 99% of enrollees matched with a PCP or clinician.
- **Provider Networks Based on Quality**: issuers agreed to include quality as a priority in all provider and facility selection criteria while designing and composing Covered California networks.
- **Health Disparities:** health plans are tracking health disparities among all their patients by racial or ethnic group.
- **Consumer Tools and Telehealth:** Allow members to see plan-specific accumulations toward deductibles and out-of-pocket maximums. Plans are innovating in the area of telehealth.
- **Smart Care California**: A public-private partnership working to promote safe, affordable health care in California. The group currently focuses on three issues: C-sections, opioid overuse and low back pain. Participants purchase or manage care for more than 16 million Californians—or 40 percent of the state.

SMART CARE CALIFORNIA
Less Waste. Less Harm. Better Care.

https://www.iha.org/our-work/insights/smart-care-california

BENEFIT DESIGNS BY METAL TIER

COVERED CALIFORNIA

MEDICAL COST SHARES				
Coverage Category	Bronze	Silver	Gold	Platinum
	Covers 60% average annual cost	Covers 70% average annual cost	Covers 80% average annual cost	Covers 90% average annual cost
Annual Wellness Exam	$0	$0	$0	$0
Primary Care Visit	$75	$40	$30	$15
Specialty Care Visit	$105	$80	$55	$30
Urgent Care Visit	$75	$40	$30	$15
Emergency Room Facility	Full cost until out-of-pocket maximum is met	$350	$325	$150
Laboratory Tests	$40	$35	$35	$15
X-Ray and Diagnostics	Full cost until out-of-pocket maximum is met	$75	$55	$30
Medical Deductible	Individual: $6,300 Family: $12,600	Individual: $2,500 Family: $5,000	N/A	N/A
Pharmacy Deductible	Individual: $500 Family: $1,000	Individual: $200 Family: $400	N/A	N/A
Annual Out-of-Pocket Maximum	$7,550 individual and $15,100 family	$7,550 individual and $15,100 family	$7,200 individual and $14,400 family	$3,350 individual and $6,700 family

DRUG COST SHARES: 30-DAY SUPPLY				
Metal Tier	Bronze	Silver	Gold	Platinum
Generic Drugs (Tier 1)	Full cost up to $500, after drug deductible is met	$15 after drug deductible	$15 or less	$5 or less
Preferred Drugs (Tier 2)	Full cost up to $500, after drug deductible is met	$55 after drug deductible	$55 or less	$15 or less
Non-preferred Drugs (Tier 3)	Full cost up to $500, after drug deductible is met	$80 after drug deductible	$75 or less	$25 or less
Specialty Drugs (Tier 4)	Full cost up to $500, after drug deductible is met	20% up to $250 after drug deductible	20% up to $250	10% up to $250

All health plans offer identical patient-centered benefit designs.

COST-SHARING REDUCTION BENEFIT DESIGNS

COVERED CALIFORNIA

MEDICAL COST SHARES			
Coverage Category	Enhanced Silver 94	Enhanced Silver 87	Enhanced Silver 73
Eligibility Based on Income and Premium Assistance	Covers **94%** average annual cost	Covers **87%** average annual cost	Covers **73%** average annual cost
Single Income Ranges	up to $18,210 (≤150% FPL)	$18,211 to $24,280 (>150% to ≤200% FPL)	$24,281 to $30,350 (>200% to ≤250% FPL)
Annual Wellness Exam	$0	$0	$0
Primary Care Visit	$5	$15	$35
Specialty Care Visit	$8	$25	$75
Urgent Care Visit	$5	$15	$35
Emergency Room Facility	$50	$100	$350
Laboratory Tests	$8	$15	$35
X-ray and Diagnostics	$8	$30	$75
Imaging	$50	$100	$300
Medical Deductible	Individual: $75 Family: $150	Individual: $650 Family: $1,300	Individual: $2,200 Family: $4,400
Pharmacy Deductible	—	Individual: $50 Family: $100	Individual: $175 Family: $350
Annual Out-of-Pocket Maximum	Individual: $1,000 Family: $2,000	Individual: $2,600 Family: $5,200	Individual: $6,300 Family: $12,600

DRUG COST SHARES: 30-DAY SUPPLY			
Metal Tier	Silver 94	Silver 87	Silver 73
Generic Drugs (Tier 1)	$3 or less	$5 or less	$15 after drug deductible
Preferred Drugs (Tier 2)	$10 or less	$20 after drug deductible	$50 after drug deductible
Non-preferred Drugs (Tier 3)	$15 or less	$35 after drug deductible	$75 after drug deductible
Specialty Drugs (Tier 4)	10%, up to $150 per script	15% up to $150 after drug deductible	20%, up to $250 after drug deductible

Consumers who have a **household income between 138% and 250%** of the federal poverty level are eligible to enroll in **Silver plan** with **Cost-Sharing Reduction (CSR)** benefits.

2019

Sign Up and Renewal Journey

COVERED CALIFORNIA

2019 SIGN UP & RENEWAL DATES

Sign-up Period:

Timeframe	Effective Date of Coverage
October 15, 2018 – December 15, 2018	January 1, 2019
December 16, 2018 – **January 15, 2019**	February 1, 2019

Renewal:

- Active Renewal Starts on October 1, 2018

RENEWAL:
WHAT YOU NEED TO KNOW

Renewal Timeframe	Start Date of Coverage
October 1, 2018 – December 15, 2018	January 1, 2019 start date of coverage

IMPORTANT NOTE:

- Members **must renew by December 15, 2018** for a **January 1, 2019 start date** of coverage
- **2019 Sign-ups Begin October 15, 2018 through January 15, 2019**
- Members can **make changes to their application and/or plan selection** during the **2019 Sign-ups for the 2019 benefit year**
- The **start date may change** based on the plan selection dates

RENEWAL:

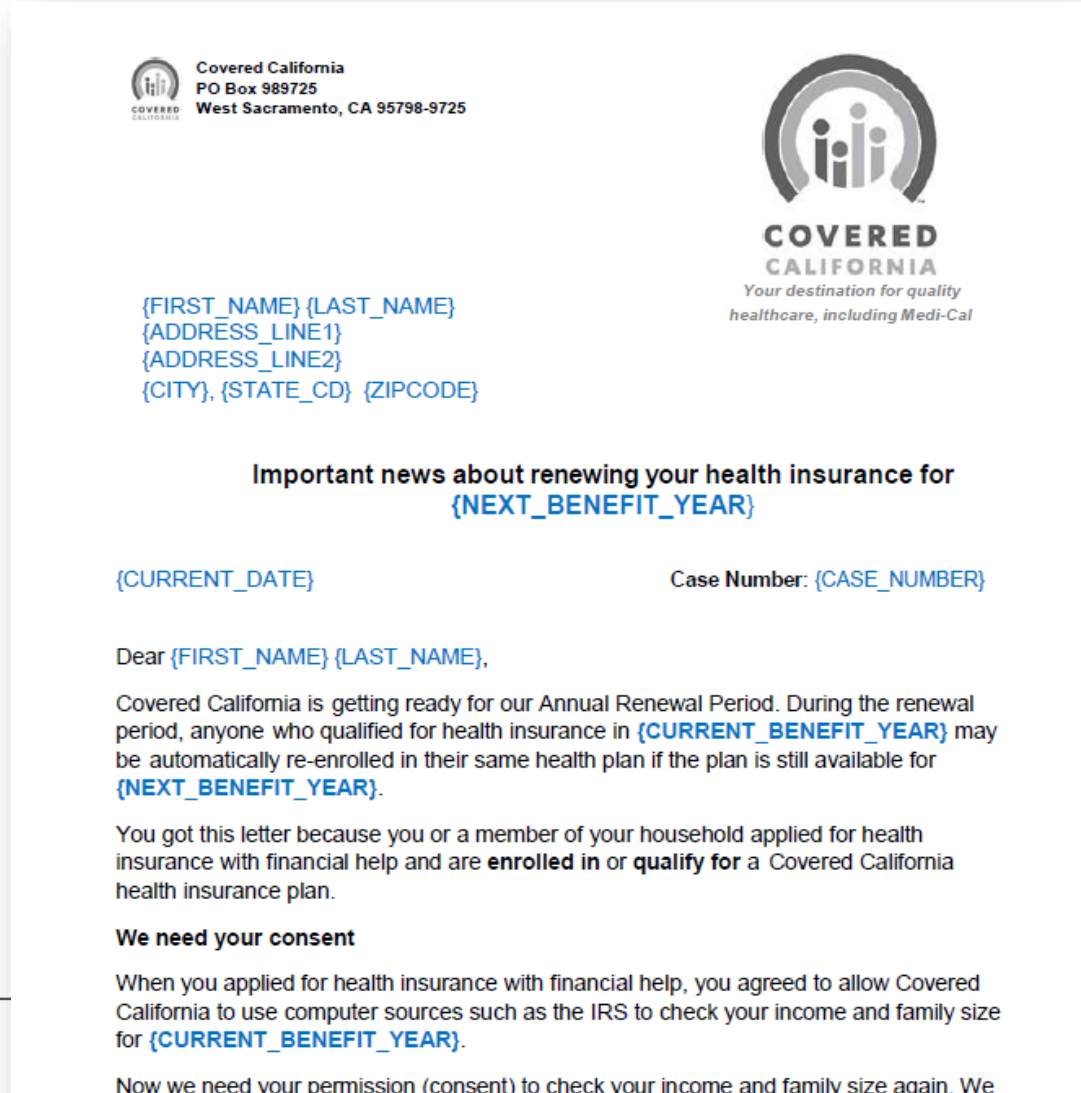
ACTIVE VS. PASSIVE

Renewal Type	Definition	CalHEERS Outcome	Start Date	End Date
Active	Consumer **actively makes a change** (changes plans or reports a change) **during the Renewal period** for the upcoming plan benefit year.	CalHEERS **accepts the changes and renews** the consumer's eligibility and enrollment for the upcoming plan benefit year.	**10/1/18**	**12/15/18**
Passive	Consumer **does not make a change during renewal** to the application information or the health plan.	CalHEERS **automatically renews** the consumer's eligibility and enrollment for the upcoming plan benefit year.	**10/31/18**	**11/21/18**

RENEWAL:

CONSENT FOR VERIFICATION NOTICE

- **August 8-15, 2018: *Mailed*** the **Consent for Verification "CalNOD11"** to members who need to provide consent.
- Members need **to provide consent** to Covered California to keep their APTC for the 2019 benefit year.



Covered California
PO Box 989725
West Sacramento, CA 95798-9725

COVERED CALIFORNIA
Your destination for quality healthcare, including Medi-Cal

{FIRST_NAME} {LAST_NAME}
{ADDRESS_LINE1}
{ADDRESS_LINE2}
{CITY}, {STATE_CD} {ZIPCODE}

Important news about renewing your health insurance for {NEXT_BENEFIT_YEAR}

{CURRENT_DATE} **Case Number**: {CASE_NUMBER}

Dear {FIRST_NAME} {LAST_NAME},

Covered California is getting ready for our Annual Renewal Period. During the renewal period, anyone who qualified for health insurance in **{CURRENT_BENEFIT_YEAR}** may be automatically re-enrolled in their same health plan if the plan is still available for **{NEXT_BENEFIT_YEAR}**.

You got this letter because you or a member of your household applied for health insurance with financial help and are **enrolled in** or **qualify for** a Covered California health insurance plan.

We need your consent

When you applied for health insurance with financial help, you agreed to allow Covered California to use computer sources such as the IRS to check your income and family size for **{CURRENT_BENEFIT_YEAR}**.

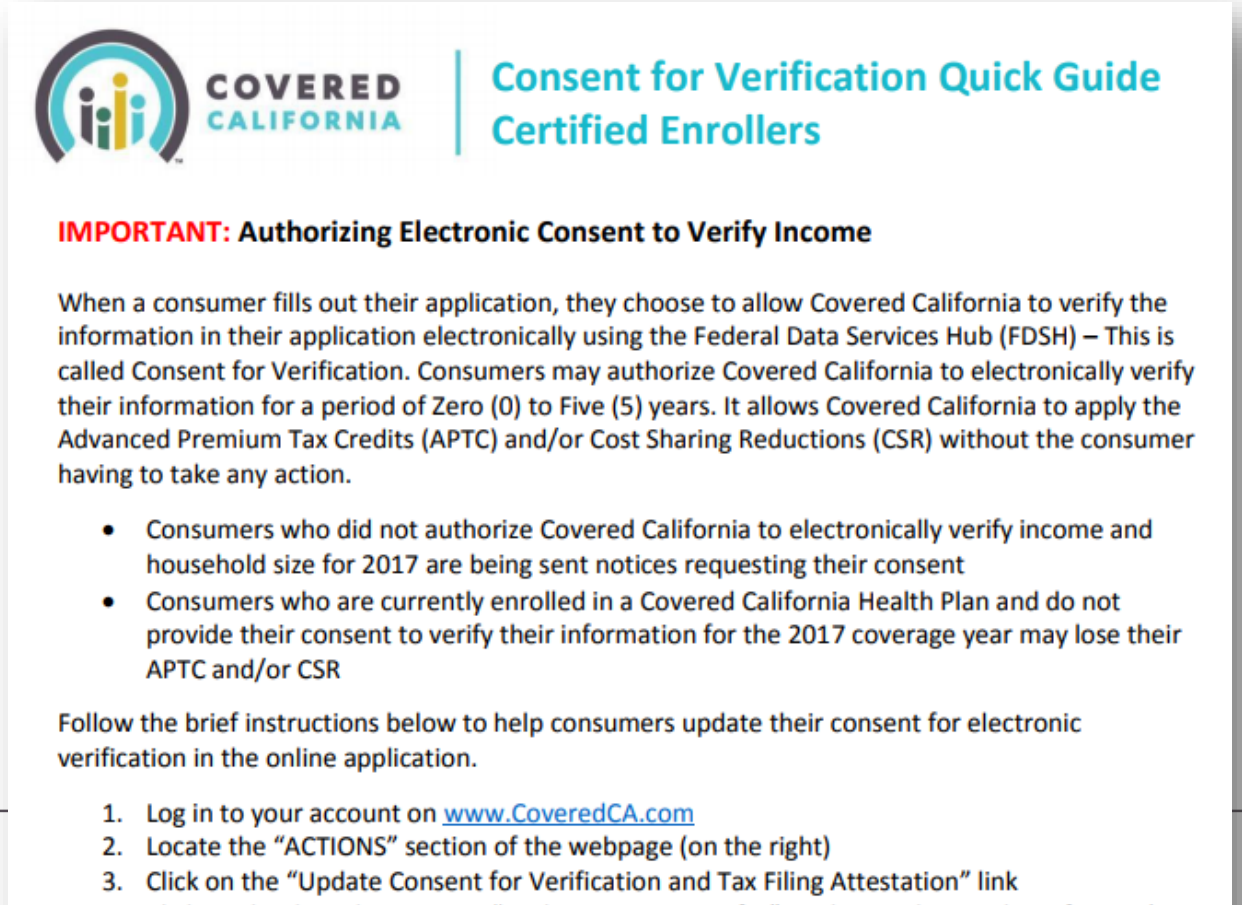
Now we need your permission (consent) to check your income and family size again. We

RENEWAL:

CONSENT FOR VERIFICATION TIPS

- **Review** the Consent for Verification Notice & Consent for Verification Quick Guide for more information.

- **Update** **consumer's account** contact and demographic information!
  - Residence (Mailing) address
  - Email
  - Phone number



COVERED CALIFORNIA

Consent for Verification Quick Guide
Certified Enrollers

IMPORTANT: Authorizing Electronic Consent to Verify Income

When a consumer fills out their application, they choose to allow Covered California to verify the information in their application electronically using the Federal Data Services Hub (FDSH) – This is called Consent for Verification. Consumers may authorize Covered California to electronically verify their information for a period of Zero (0) to Five (5) years. It allows Covered California to apply the Advanced Premium Tax Credits (APTC) and/or Cost Sharing Reductions (CSR) without the consumer having to take any action.

- Consumers who did not authorize Covered California to electronically verify income and household size for 2017 are being sent notices requesting their consent
- Consumers who are currently enrolled in a Covered California Health Plan and do not provide their consent to verify their information for the 2017 coverage year may lose their APTC and/or CSR

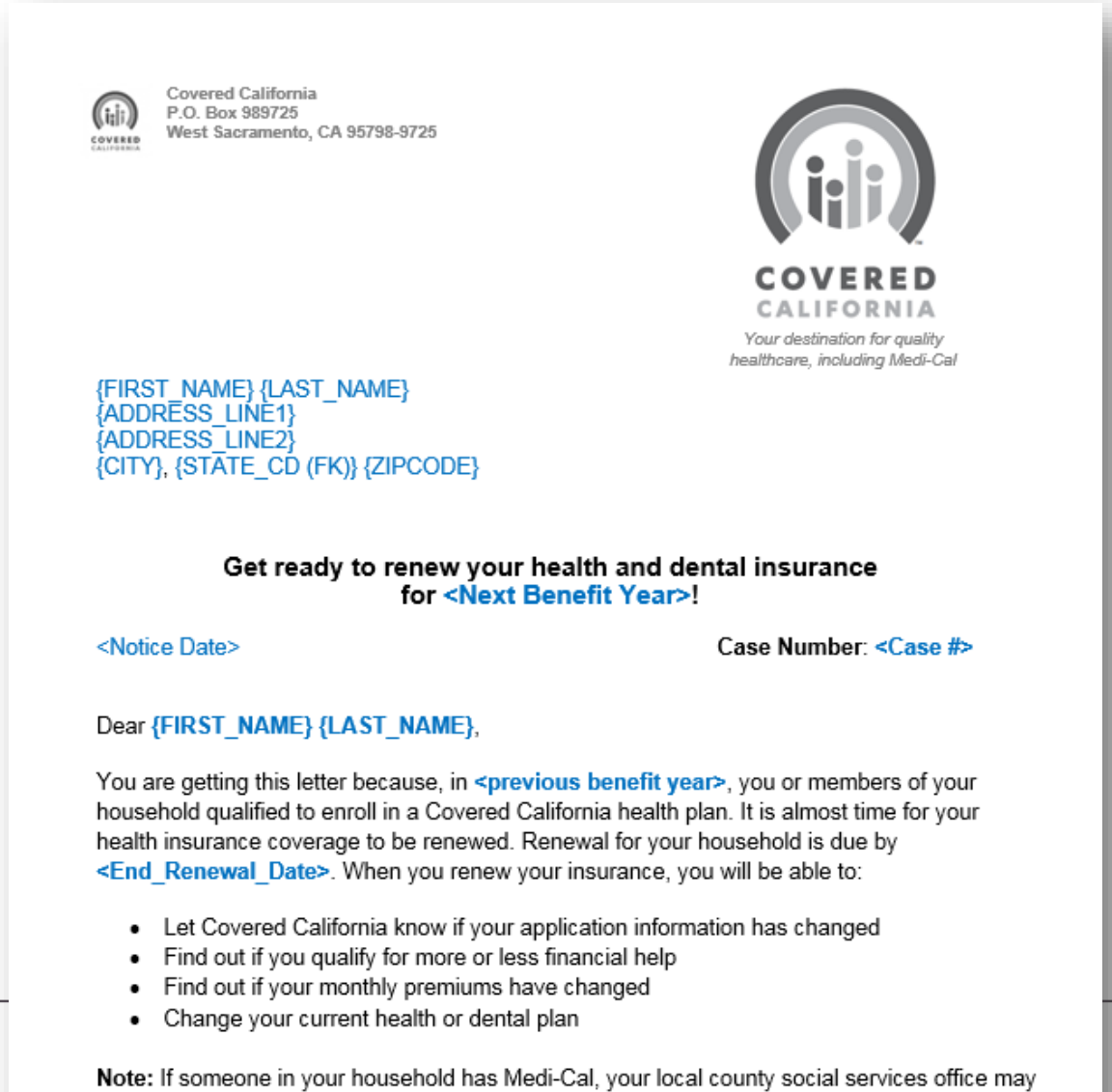
Follow the brief instructions below to help consumers update their consent for electronic verification in the online application.

1. Log in to your account on www.CoveredCA.com
2. Locate the "ACTIONS" section of the webpage (on the right)
3. Click on the "Update Consent for Verification and Tax Filing Attestation" link

RENEWAL:

NOTICE "CalNOD12"

- **Mid to Late September 2018 - Health Plans mailed** renewal notices to members.
- **Early to Mid-October 2018- Covered California mails the first batch** of renewal notices to members who are in an **enrolled or pending status**. All batches will be mailed by November.
- **Passive Renewal – starts 30 calendar days** from the date of the Renewal Notice "CalNOD12"



Covered California
P.O. Box 989725
West Sacramento, CA 95798-9725

COVERED CALIFORNIA
Your destination for quality healthcare, including Medi-Cal

{FIRST_NAME} {LAST_NAME}
{ADDRESS_LINE1}
{ADDRESS_LINE2}
{CITY}, {STATE_CD (FK)} {ZIPCODE}

Get ready to renew your health and dental insurance for <Next Benefit Year>!

<Notice Date> **Case Number**: **<Case #>**

Dear **{FIRST_NAME} {LAST_NAME}**,

You are getting this letter because, in **<previous benefit year>**, you or members of your household qualified to enroll in a Covered California health plan. It is almost time for your health insurance coverage to be renewed. Renewal for your household is due by **<End_Renewal_Date>**. When you renew your insurance, you will be able to:

- Let Covered California know if your application information has changed
- Find out if you qualify for more or less financial help
- Find out if your monthly premiums have changed
- Change your current health or dental plan

Note: If someone in your household has Medi-Cal, your local county social services office may

RENEWAL:

NEW HEALTH PLAN = NEW PCP

Members **RENEWED** into a **NEW** carrier health plan (*actively or passively*) will be **MATCHED a new primary care physician** (PCP) by the new carrier **REGARDLESS** if the member's current PCP is in the new carrier's provider network.

HOW CAN YOU HELP?

RENEWAL:

NEW HEALTH PLAN = NEW PCP

MEMBER'S **OPTION:**	MEMBER'S **ACTION :**	**2019** BENEFIT YEAR **PCP Matched**
STAY with the new PCP matched.	**Do nothing.**	Matched with the new carrier selected PCP.
CHANGE the new **PCP back to the current PCP** if the PCP is currently in the network.	**Call the carrier right away** to change the PCP back to the current PCP.	Re-matched to the current 2018 PCP if the PCP is in the network.
SELECT a new PCP in the network.	**Call the carrier right away** to select a new PCP.	Matched with the member selected PCP.

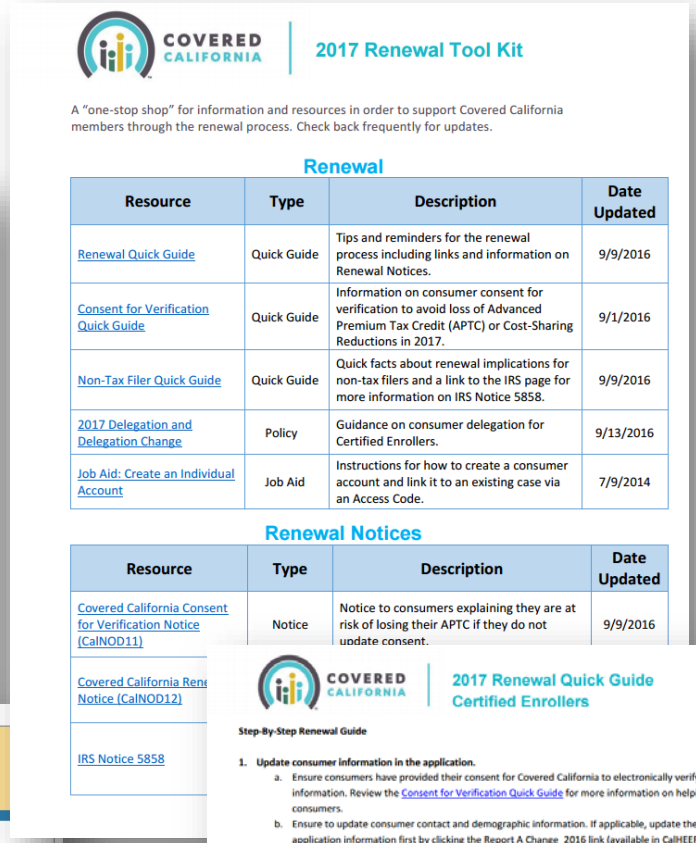
REMINDER:

BINDER PAYMENT

- **New** members **must submit a BINDER payment when enrolling.**
- **Renewing** members **must submit a NEW BINDER payment** when changing carriers or changing to or from HMO/PPO/EPO, even within the same carrier.
  - ✓ **Must** ensure their **auto-pay** settings **adjust** to the **new premium** amount.

2019 RENEWAL TOOL KIT

ONLINE TOOLS


COVERED CALIFORNIA | 2017 Renewal Tool Kit

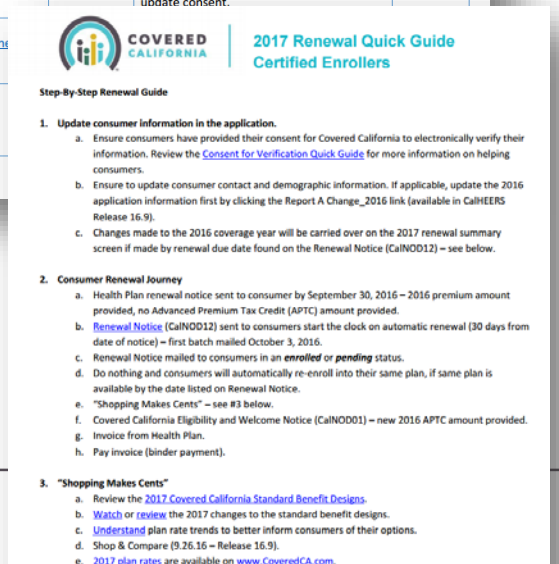
A "one-stop shop" for information and resources in order to support Covered California members through the renewal process. Check back frequently for updates.

Renewal

Resource	Type	Description	Date Updated
Renewal Quick Guide	Quick Guide	Tips and reminders for the renewal process including links and information on Renewal Notices.	9/9/2016
Consent for Verification Quick Guide	Quick Guide	Information on consumer consent for verification to avoid loss of Advanced Premium Tax Credit (APTC) or Cost-Sharing Reductions in 2017.	9/1/2016
Non-Tax Filer Quick Guide	Quick Guide	Quick facts about renewal implications for non-tax filers and a link to the IRS page for more information on IRS Notice 5858.	9/9/2016
2017 Delegation and Delegation Change	Policy	Guidance on consumer delegation for Certified Enrollers.	9/13/2016
Job Aid: Create an Individual Account	Job Aid	Instructions for how to create a consumer account and link it to an existing case via an Access Code.	7/9/2014

Renewal Notices

Resource	Type	Description	Date Updated
Covered California Consent for Verification Notice (CalNOD11)	Notice	Notice to consumers explaining they are at risk of losing their APTC if they do not update consent.	9/9/2016
Covered California Renewal Notice (CalNOD12)			
IRS Notice 5858			


COVERED CALIFORNIA | 2017 Renewal Quick Guide Certified Enrollers

Step-By-Step Renewal Guide

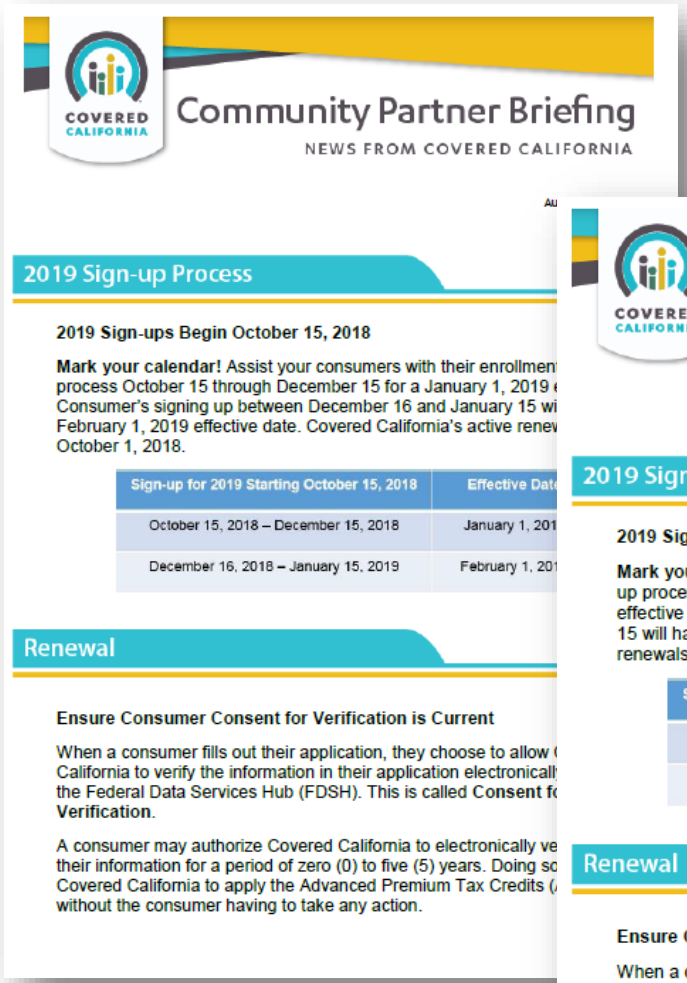
1. **Update consumer information in the application.**
   a. Ensure consumers have provided their consent for Covered California to electronically verify their information. Review the Consent for Verification Quick Guide for more information on helping consumers.
   b. Ensure to update consumer contact and demographic information. If applicable, update the 2016 application information first by clicking the Report A Change_2016 link (available in CalHEERS Release 16.9).
   c. Changes made to the 2016 coverage year will be carried over on the 2017 renewal summary screen if made by renewal due date found on the Renewal Notice (CalNOD12) – see below.
2. **Consumer Renewal Journey**
   a. Health Plan renewal notice sent to consumer by September 30, 2016 – 2016 premium amount provided, no Advanced Premium Tax Credit (APTC) amount provided.
   b. Renewal Notice (CalNOD12) sent to consumers start the clock on automatic renewal (30 days from date of notice) – first batch mailed October 3, 2016.
   c. Renewal Notice mailed to consumers in an ***enrolled*** or ***pending*** status.
   d. Do nothing and consumers will automatically re-enroll into their same plan, if same plan is available by the date listed on Renewal Notice.
   e. "Shopping Makes Cents" – see #3 below.
   f. Covered California Eligibility and Welcome Notice (CalNOD01) – new 2016 APTC amount provided.
   g. Invoice from Health Plan.
   h. Pay invoice (binder payment).
3. **"Shopping Makes Cents"**
   a. Review the 2017 Covered California Standard Benefit Designs.
   b. Watch or review the 2017 changes to the standard benefit designs.
   c. Understand plan rate trends to better inform consumers of their options.
   d. Shop & Compare (9.26.16 – Release 16.9).
   e. 2017 plan rates are available on www.CoveredCA.com.

- **Visit** www.CoveredCA.com
- In the footer, **click** "*Enrollment Partner & Agent Resources*"
- **Click** "*Partner Tool Kit*" for all Tool Kits
- **Click** "2019 Renewal Tool Kit"

BRIEFINGS & ALERTS

Agents –
Agents@covered.ca.gov

Community Partners –
OutreachandSales@covered.ca.gov



COVERED CALIFORNIA

Community Partner Briefing

NEWS FROM COVERED CALIFORNIA

2019 Sign-up Process

2019 Sign-ups Begin October 15, 2018

Mark your calendar! Assist your consumers with their enrollmen process October 15 through December 15 for a January 1, 2019 Consumer's signing up between December 16 and January 15 wi February 1, 2019 effective date. Covered California's active renew October 1, 2018.

Sign-up for 2019 Starting October 15, 2018	Effective Dat
October 15, 2018 – December 15, 2018	January 1, 201
December 16, 2018 – January 15, 2019	February 1, 201

Renewal

Ensure Consumer Consent for Verification is Current

When a consumer fills out their application, they choose to allow California to verify the information in their application electronicall the Federal Data Services Hub (FDSH). This is called **Consent fo Verification**.

A consumer may authorize Covered California to electronically ve their information for a period of zero (0) to five (5) years. Doing so Covered California to apply the Advanced Premium Tax Credits (without the consumer having to take any action.

COVERED CALIFORNIA

Agent Briefing

NEWS FROM COVERED CALIFORNIA

August 17, 2018

2019 Sign-up Process

2019 Sign-ups Begin October 15, 2018

Mark your calendar! Assist your consumers with their enrollment and sign-up process October 15 through December 15 for a January 1, 2019 effective date. Consumer's signing up between December 16 and January 15 will have a February 1, 2019 effective date. Covered California's active renewals begin October 1, 2018.

Sign-up for 2019 Starting October 15, 2018	Effective Date
October 15, 2018 – December 15, 2018	January 1, 2019
December 16, 2018 – January 15, 2019	February 1, 2019

Renewal

Ensure Consumer Consent for Verification is Current

When a consumer fills out their application, they choose to allow Covered California to verify the information in their application electronically using the Federal Data Services Hub (FDSH). This is

COVERED CALIFORNIA

Agent Alert

BREAKING NEWS FROM COVERED CALIFORNIA

August 22, 2018

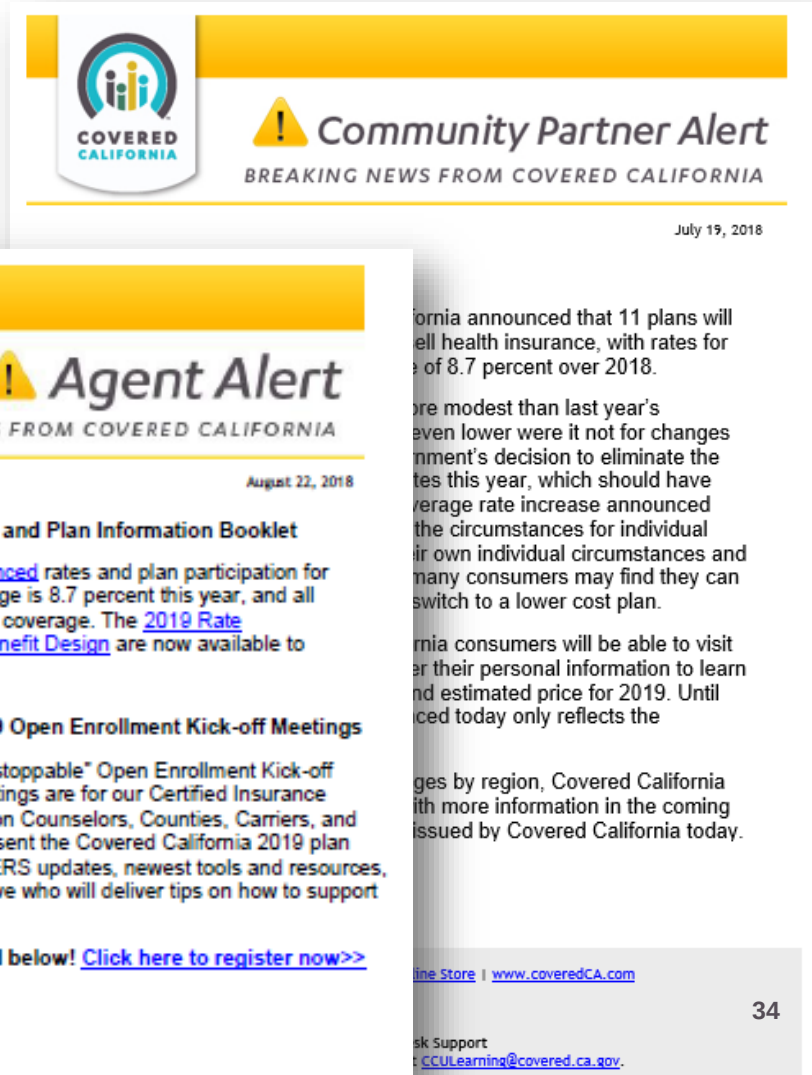
Now Available – 2019 Regional Rate and Plan Information Booklet

Last Month, Covered California announced rates and plan participation for 2019. The weighted average rate change is 8.7 percent this year, and all 11 health insurers will continue to offer coverage. The 2019 Rate Booklet and 2019 Patient-Centered Benefit Design are now available to review for more information.

Register Today! "Unstoppable" 2019 Open Enrollment Kick-off Meetings

Covered California is holding nine "Unstoppable" Open Enrollment Kick-off meetings across the state. These meetings are for our Certified Insurance Agents, Navigators, Certified Application Counselors, Counties, Carriers, and Community Groups. Join us as we present the Covered California 2019 plan year rates and offerings, latest CalHEERS updates, newest tools and resources, and hear from a Medi-Cal representative who will deliver tips on how to support your Medi-Cal enrollees.

Join us at one of the events listed below! Click here to register now>>



COVERED CALIFORNIA

Community Partner Alert

BREAKING NEWS FROM COVERED CALIFORNIA

July 19, 2018

ornia announced that 11 plans will ell health insurance, with rates for e of 8.7 percent over 2018.

re modest than last year's even lower were it not for changes nment's decision to eliminate the tes this year, which should have erage rate increase announced the circumstances for individual ir own individual circumstances and many consumers may find they can switch to a lower cost plan.

rnia consumers will be able to visit r their personal information to learn nd estimated price for 2019. Until ced today only reflects the

ges by region, Covered California ith more information in the coming issued by Covered California today.

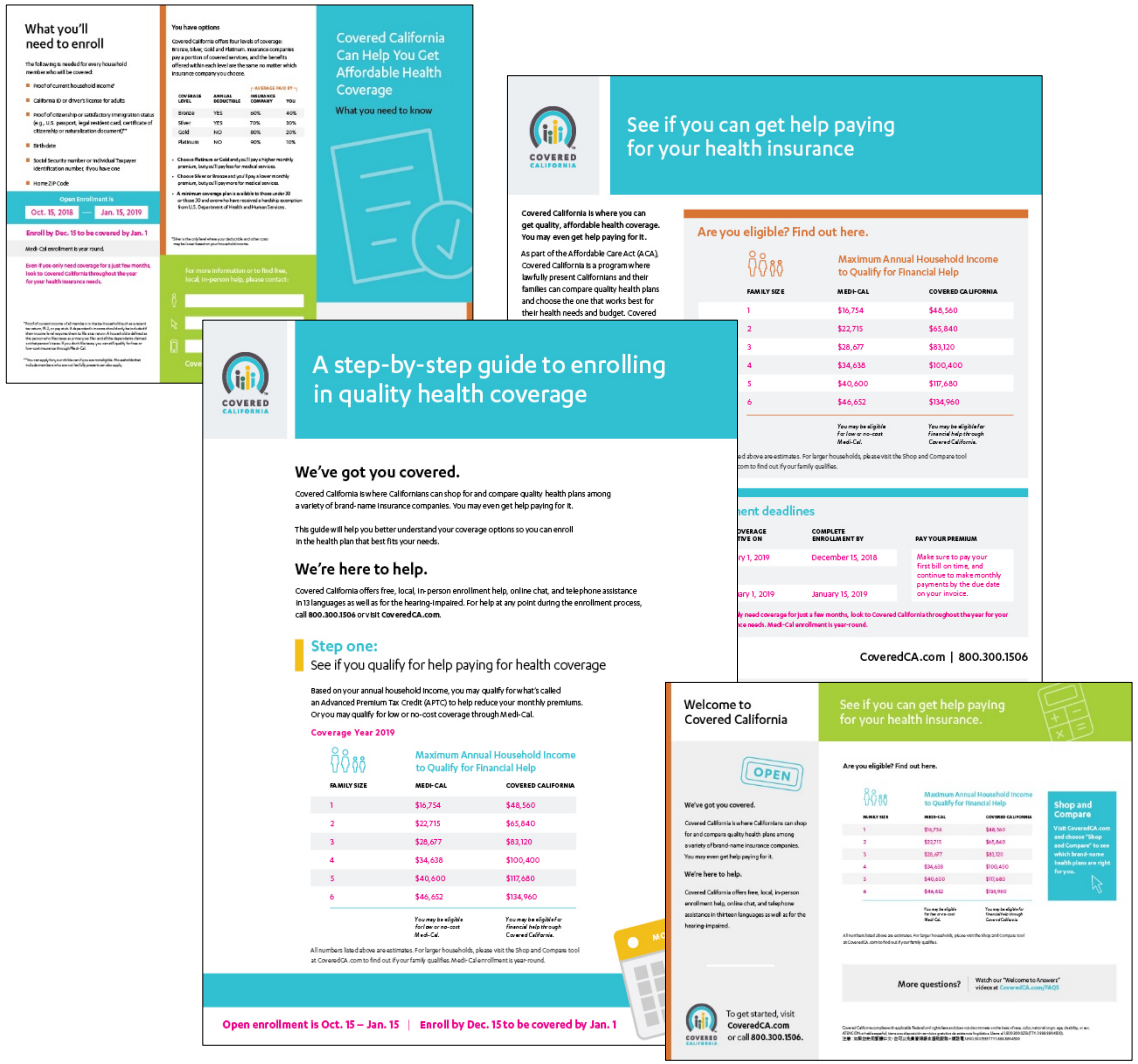
ine Store | www.coveredCA.com

34

sk Support
CCULearning@covered.ca.gov.

CONSUMER COLLATERAL MATERIALS

- Reflect sign up dates for the 2019 plan year
- Remove references to individual mandate penalty
- CoveredCA.com printable materials: http://hbex.coveredca.com/toolkit/collateral.shtml
- KP Print Store: https://360.kpcorp.com/coveredca/Login.aspx



SALES SERVICE CENTER

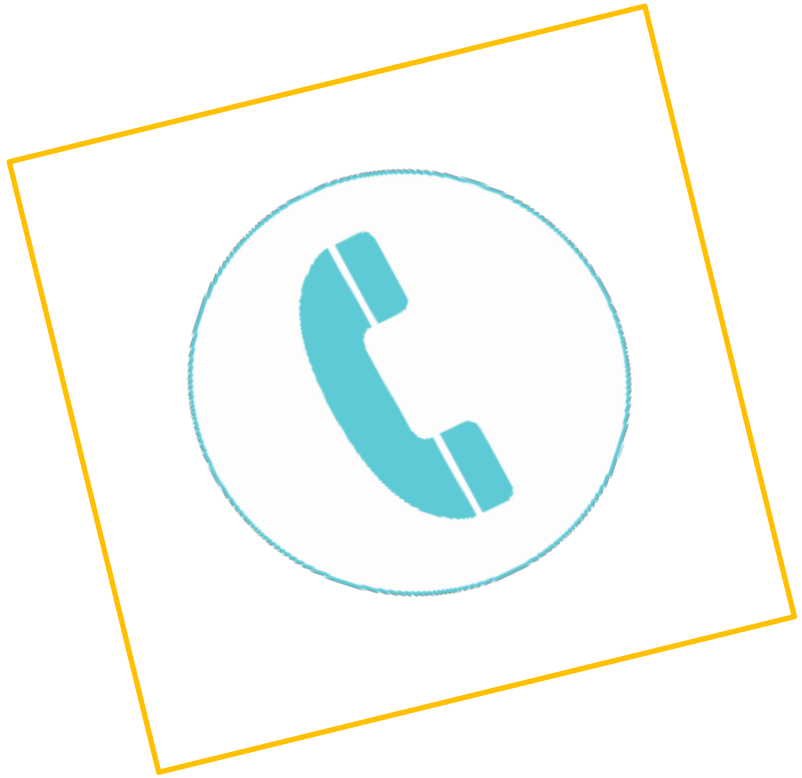
Agent Service Center Phone:
(877) 453-9198, agents@covered.ca.gov

CEC/PBE Help Line Phone:
(855) 324-3147

CCSB Service Center Phone:
(855) 777-6782, shop@covered.ca.gov

Hours of Operation:
Monday thru Friday
8:00 a.m. to 6:00 p.m.
Saturdays and Sundays, Closed

Service Center Hours of Operation>>



Helping Consumers Find Local Help

Free Confidential Help In Your Area

Enrollment Centers

Find a Covered California Storefront near you for free in-person assistance

Help On-Demand

Have a Certified Enroller call you

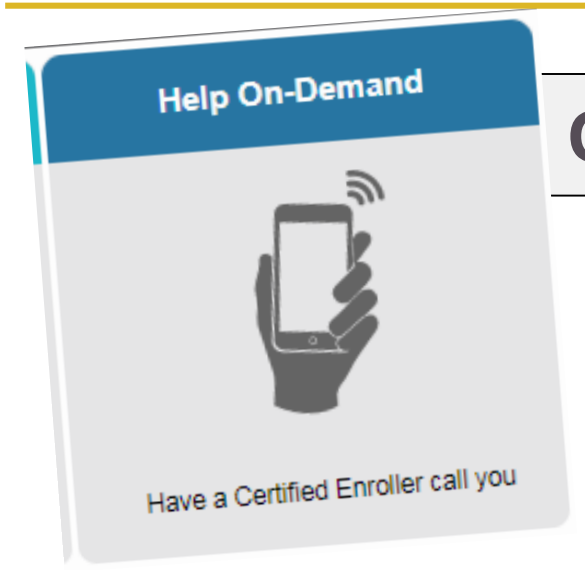
Find a Certified Enroller Near You

Events Near You

Find a County Services Agency

Find Local Help: www.coveredca.com/get-help/local

Help On-Demand Tool for New Consumers

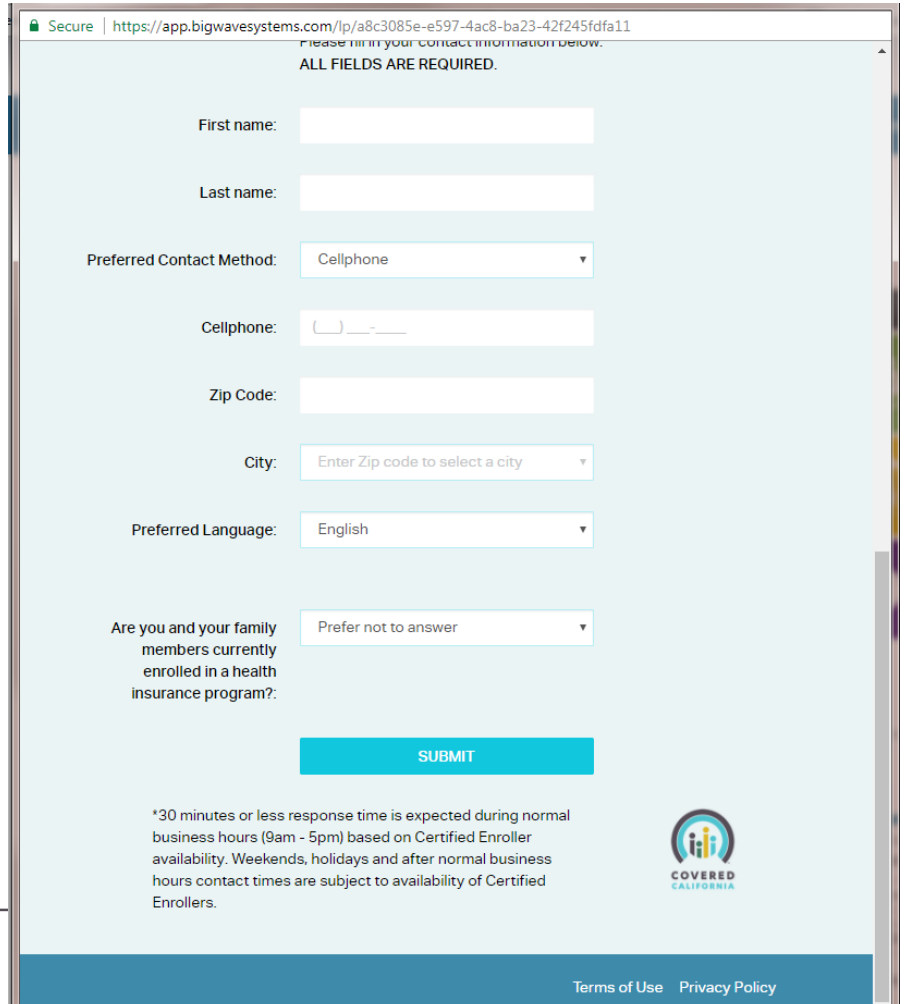


Get help when you need it most...right now!

- Web-based assistance tool
- Consumer Oriented

Benefits:

- **Immediate enrollment support** for new consumers
- **Consumer convenience**
- **High conversion rate**
- **Reduces** Service Center **call volumes**
- **Bi-lingual assistance** – 17 language options



COVERED CALIFORNIA

http://www.coveredca.com/get-help/local/

OFFICE OF THE OMBUDSMAN

Who: *A team of state employees working at the Covered California.*

Role: *To help Covered California consumers with unresolved complaints and issues.*

- **What <u>can</u> an Ombudsman do?**
  - Informally investigate complaints.
  - Look for fair resolutions and make recommendations to resolve issues of unfairness and improve practices.
  - Discuss concerns, clarify issues, and offer informal advice.
  - Provide information and a referral when they can't help directly.

OFFICE OF THE OMBUDSMAN

- **What an Ombudsman <u>cannot</u> do:**
  - Conduct formal investigations.
  - Conduct appeal hearings.
  - Provide legal advice.
  - Accept payments on behalf of the insurance provider.
  - Make recommendations to the court or change court decisions.
  - Change laws and regulations set forth by government agencies.

OFFICE OF THE OMBUDSMAN

Key Notes:

- Call toll free at (888) 726-0840 from 8 a.m. to 5 p.m., Monday through Friday (excluding state-observed holidays). Assistance is available in multiple languages.
- Fax: (888) 726-0841
- Mail:

  Covered California
  Attn: Ombuds Office
  1601 Exposition Blvd. Sacramento, CA 95815
- Need guidance for using our independent contractor, Health Consumer Alliance (HCA), which provides free legal advice and representation, including assistance filing a complaint or grievance and arranging a hearing.
  - For more information on the services HCA provides, please see the Helpful Resources section below. Or, call HCA at (888) 804-3536.
- **General questions,** contact: Office of the Ombudsman by email at: ombuds@covered.ca.gov

Thank you.

Any questions?

Marc Ross

Marc.Ross@covered.ca.gov

916-539-5524

HIV Program Policy Updates

Courtney Mulhern-Pearson, MPH
Senior Director of Policy and Strategy
October 5, 2018

AGENDA

- PrEP Assistance Program (PrEP-AP)
- Medicare Part D Premium Payment Program Enhanced with Medigap Premium Payment and Medical Out-of-Pocket Assistance (MDPP)
- Employer Based Health Insurance Premium Payment Program (EB-HIPP)

PrEP Assistance Program

Overview of PrEP-AP

- In 2016, the California HIV Alliance proposed the creation of a statewide PrEP Assistance Program (PrEP-AP)
- In 2018, the PrEP-AP was implemented in two phases, with Phase 1 prioritizing the uninsured population and Phase 2 expanding to cover insured individuals
- Phase 1 launched on April 9, 2018
- Phase 2 launched on June 14, 2018

PrEP-AP for uninsured clients

- For uninsured clients, the PrEP-AP will only provide assistance with PrEP-related medical costs, as PrEP medication is provided free by Gilead's PAP
  - An uninsured client is any individual who does not have health coverage
- PrEP-AP is the payer of last resort, so program funds may not be used when the costs can be paid through other sources (Medi-Cal, Family PACT, etc)
- Uninsured clients who are not eligible for Medi-Cal and are eligible for health insurance should obtain comprehensive health insurance, but not required
- Medi-Cal clients with a Share of Cost (SOC) are eligible for PrEP-AP medication benefits up to their SOC obligation

Eligibility and covered services

- Residents of California (including undocumented)
- HIV-negative (result dated within 6 months of application)
- At least 18 years old
- At or below 500% FPL MAGI (modified adjusted gross income), based on family size and household income - $60,700
- Not fully covered by Medi-Cal or other third party payers
- Enrolled in the Gilead PAP

- Medical visit
- HIV and STI testing
- Pregnancy testing
- Kidney function testing
- Screening for hepatitis A, B and/or C
- Medications on the PrEP-AP formulary for treating STIs
- Medications on the PrEP-AP formulary for PEP
- Immunizations

How to enroll

- Uninsured individuals must visit a local ADAP enrollment site to enroll

- To begin the enrollment process, clients must provide (and reenroll every 6 months):
  - Proof of residency
  - Identification
  - Income

- Enrollment workers will refer the client to a clinical provider within the PrEP-AP network

- Other documentation must also be provided:
  - PrEP-AP Provider Network Referral Form signed by a PrEP-AP provider
  - Gilead PAP application signed by a PrEP-AP provider
  - Proof of HIV-negative status

PrEP-AP for insured clients

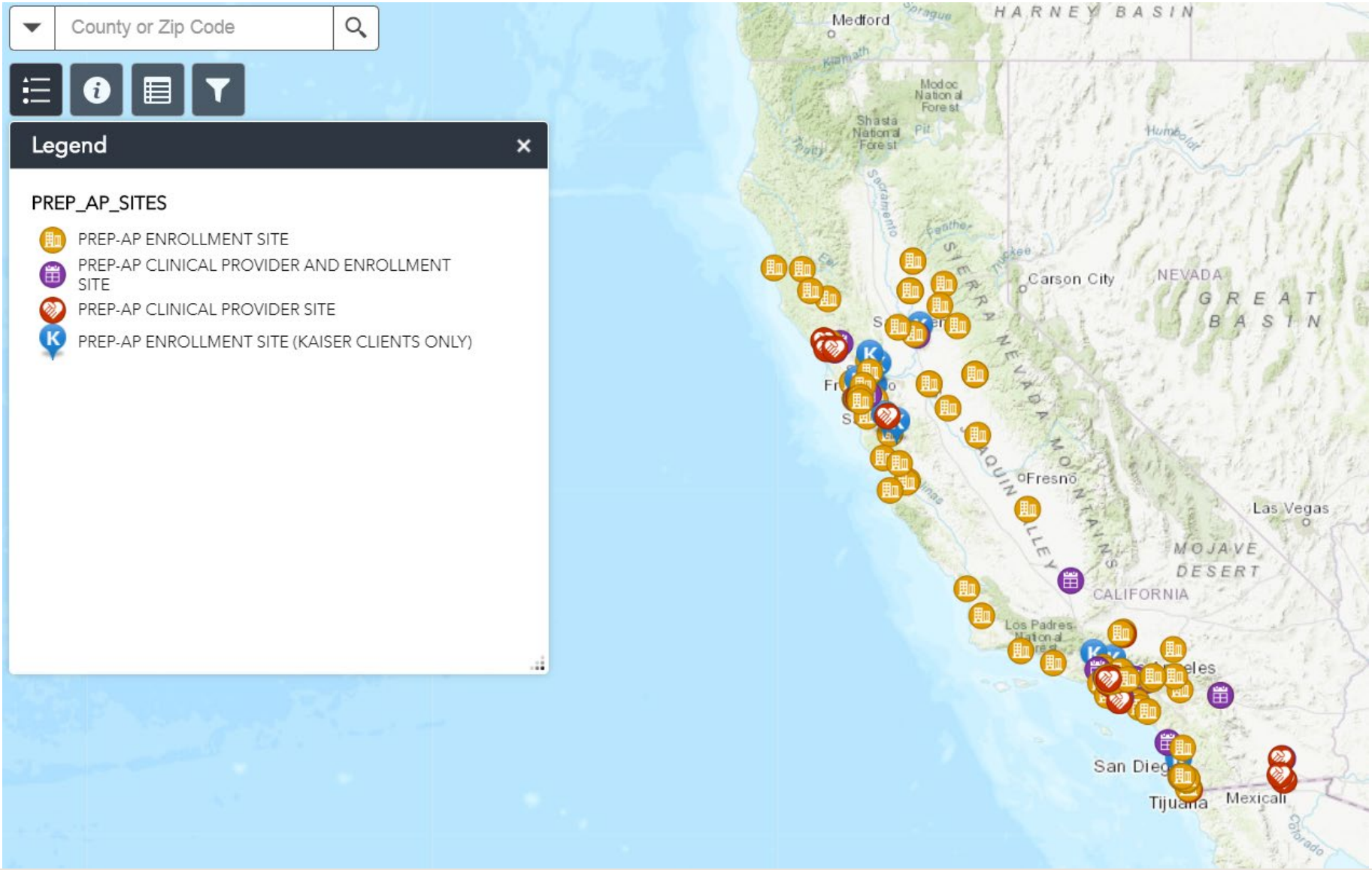
- For clients with private insurance, the program will also cover drug costs not covered by the individual's health insurance plan or Gilead's copay assistance program

- Medicare clients with prescription drug coverage will receive copayment assistance for all medication on the PrEP-AP formulary

- Medicare clients without prescription drug coverage can enroll in the Gilead PAP, and the PrEP-AP will cover all other medications on the PrEP-AP formulary

- For clients with private insurance and Medicare, the program will cover PrEP-related medical out-of-pocket costs

Enrollment sites and providers



PrEP-AP resources

- Program Overview
  - https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAadap.aspx
- Resources Page
  - Client FAQ, client brochure, acceptable enrollment documents, provider locator
  - https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_adap_resources_prepAP.aspx

Next steps for PrEP-AP

- Expanding eligibility to individuals at least 12 years old
- Covering full cost of medication for individuals ineligible for Gilead's PAP
- Not requiring use of Gilead's PAP if not accepted by health plan or pharmacy
- Allowing individuals on parent's or partner's health plan to be considered uninsured
- Covering starter packs for PrEP and PEP

Medicare Part D Premium Payment Program Enhanced with Medigap Premium Payment and Medical Out-of-Pocket Assistance (MDPP)

MDPP overview

- MDPP pays the client's portion of their Medicare Part D insurance premiums for persons living with HIV/AIDS
- Premium assistance is offered only to qualified clients who are enrolled in both a Medicare Part D prescription drug plan and the AIDS Drug Assistance Program (ADAP)
- As of June 2018, MDPP clients will also be able to submit outpatient Medical Out-of-Pocket (MOOP) claims for reimbursement
- Clients are now also able to request Medigap Plan premium payment assistance through their Enrollment Worker, if enrolled in a Medigap plan
- MDPP does not pay Part B or Part C premiums

MDPP Eligibility Requirements

- Be actively enrolled in ADAP
- Have an active Medicare Part D plan with a discernible Part D monthly premium
- Not be deemed 100% Low Income Subsidy (LIS) or Extra Help
- Not be full-scope Medi-Cal

New Medigap and MOOP benefit

- New and existing MDPP clients will now be eligible to receive assistance with their portion of their Medigap insurance premiums
- CDPH will also assist with eligible MDPP MOOP expenses
- Reimbursements will be made to the medical provider
- Clients will access the MOOP benefit by presenting their PAI-CDPH ID card to their medical provider at time of service
- To confirm client's program eligibility, the provider's office may contact CDPH
- The provider's office may call PAI to establish an electronic claims submission process for reimbursement.

Requirements to file a MOOP claim

- An outpatient service on or after June 1, 2018
- The date of service must have been within a period of time you were actively enrolled in the MDPP program
- CDPH must not have been the primary payer, Medicare must have been billed first
- The service must count towards your out-of-pocket maximum.

MDPP resources

- Program overview: https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_adap_medpartd.aspx

Employer Based Health Insurance Premium Payment Program (EB-HIPP)

EB-HIPP Overview

- A new program available to AIDS Drug Assistance Program (ADAP) clients that will cover their portion of their employer-based insurance premiums

- CDPH will pay medical and dental premiums for standalone medical and dental plans but not stand alone vision plans.

Eligibility and benefits

Eligibility requirements:

- Be enrolled in ADAP
- Employer that offers comprehensive health care coverage
- Enrolled in an employer based insurance policy
- Employer signs an EB-HIPP Participation Agreement form
- EB-HIPP must pay the client's portion of their premium in order for the client to receive MOOP benefits

Benefits:

- Covers up to $1,938 per month
- The clients portion of the insurance premium payments are sent directly to the employer on a monthly basis
- Covers medical and dental premiums and vision if it is included in the medical or dental premium
- MOOP costs that count towards the medical insurance plan's annual out-of-pocket maximum.

Maintaining eligibility

- Clients are required to re-enroll into ADAP and EB-HIPP simultaneously in order to extend EB-HIPP eligibility before their birthday month every year by submitting all of the required documents

- Documentation requirements for re-enrolling into EB-HIPP:
  - Paystub dated with the last 3 months
  - Client Attestation

EB-HIPP resources

- Program overview: https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_ADAP_EB-HIPP_Assistance.aspx

- EB-HIPP client checklist: https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/EB-HIPP%20Client%20Checklist.pdf

Questions

Cpearson@sfaf.org

415-487-8008

sfaf.org

1035 Market Street, Suite 400 | San Francisco, CA 94103

SF HIV Systems of Care

SF HIV Frontline Workers
FOG Bootcamp IV
October 5, 2018

WHO IS HERE?

- Name
- Agency
- # of years working in HIV in SF
- When I think about HIV benefits and insurance, I feel…

LEARNING OBJECTIVES

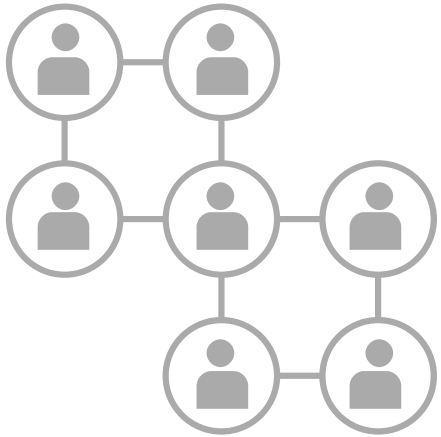
- Describe how benefits eligiblity affects primary care provider and medical home options
- Demonstrate how to use the SF HIV Care Options tip sheet to navigate a client into care

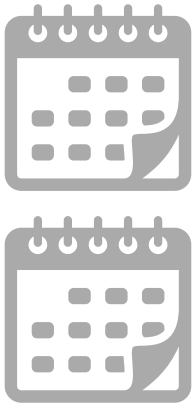
MEDI-CAL MANAGED CARE

Most people in Medi-Cal must enroll in a managed care plan after enrolling in either Traditional or Medi-Cal Expansion.

SAN FRANCISCO HEALTH PLAN

Anthem BlueCross





60 days to choose a plan

Changes: Call Health Care Options to switch plans, or to make changes

SF HIV CARE OPTIONS

A guide to clinics, providers, and the healthcare coverage they accept.

HIVReConnect
Increasing retention and re-engagement

Clinic-Based Care Options

HIV Clinics often offer "wrap around" care with Primary Care Physicians, RNs, Social Workers, Benefits Coordinators and other services

CLINIC NAME	BENEFITS INFO
Positive Health Program at Ward 86 SF General Hospital, 995 Potrero Ave., Bldg. 80, Fl 6 (415) 206-2400, option 3 (new patient appointments)	• Medi-Cal: SF Health Plan (23421) • Medicare • Healthy San Francisco; uninsured on sliding scale
Sister Mary Philippa Health Center Saint Mary's Hospital, 2235 Hayes Street, Fl 5 Leah Kramer, LCSW (415) 750-5923	• Covered CA: Blue Shield of CA; HealthNet • Medi-Cal: Anthem Blue Cross (H2P367) • Medicare & some private insurance plans • Healthy San Francisco
Clinica Esperanza Mission Neighborhood Health Ctr, 240 Shotwell St. *Se habla español* Roberto Maldonado (415) 552-1013, x2319	• Covered CA: Blue Shield of CA • Medi-Cal: SF Health Plan (21047) Anthem Blue Cross (XKI000) • Medicare & some private insurance plans • Healthy San Francisco; uninsured on sliding scale
While the clinic specializes in services for the Spanish-speaking, Latino community and all communities are welcomed. Evening Hours: Tu, Wed, Th, noon-9:00pm; Daytime: Mo and Fri, 9:00-6:00pm	
HealthRight 360 **Integrated Care Ctr:** 1563 Mission St. (415) 746-1940 **Haight Ashbury:** 558 Clayton St. (415) 746-1950 **Tenderloin Health:** 330 Ellis St. (415) 674-6140	• Medi-Cal: SF Health Plan (Mission 22677; Clayton 22652; Ellis 25203; Market 21844) Anthem Blue Cross (Mission XX4; Clayton XXU; Ellis XXA; Market XXM)

EXERCISES

SF HIV NAVIGATION OPTIONS

HIVReConnect
Increasing retention and re-engagement

Side A navigation services help connect people to **ANY** clinic or provider in San Francisco.

NAVIGATION PROGRAM	HIV+ CLIENT FOCUS	HEALTHCARE ACCEPTED	NOTES
LINCS Navigation City Clinic, 356 7th St. Drop in or call Mark O'Neil (415) 487-5520	All HIV+ people, especially: • Gay & Bi Men • Transgender & Gender non-conforming • Women • Clients w/complex needs	• No insurance restrictions • Can help establish health care coverage	• Se habla Español • HIV Care Navigation and linkage to PrEP & PEP prescription and navigation services at SF City Clinic are also available
SF AIDS Foundation 1035 Market St. 470 Castro St. (@ 18th) assist4hiv@sfaf.org (415) 602-9676 or (415) 487-3000 ask for the HIV Navigator	All HIV+ people, especially: • Gay & Bi Men • Drug Users • Transgender & Gender non-conforming • HIV & Hep C co-infected • Undocumented	• No insurance restrictions • Can help establish health care coverage	• Se habla Español • Short- & long-term case management available • PrEP & PEP prescription and navigation available
Glide 330 Ellis St. (@ Jones) Amber Taylor (415) 674-6168	All HIV+ people, especially: • Drug Users • HIV & Hep C co-infected • Transgender & Gender non-conforming	• No insurance restrictions • Can help establish health care coverage • Glide/HealthRight 360 insurance: Medi-Cal, Medicare, Healthy SF	• Can link HIV- partners to PrEP • Direct connection with Glide/HealthRight 360 Clinic and can link clients to other clinics as well

Andy Scheer, LCSW

SFDPH, SF City Clinic

Andy.Scheer@sfdph.org

ACCESS TO HEALTH CARE FOR IMMIGRANTS IN CALIFORNIA

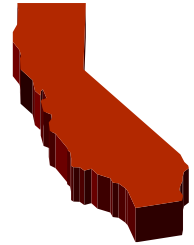
Positive Resource Center
October 2018

Tanya Broder
National Immigration Law Center

Issues Affecting Access to Benefits

- **Immigrant eligibility rules**
- **State residency** and other eligibility rules
- Privacy, Confidentiality and Verification
- Concerns about "Public charge"
- Concerns about Sponsors
- Linguistic and Cultural Competence
- Logistical Barriers
- The "Climate"

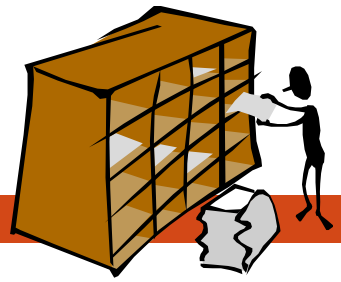
State Residency: Medi-Cal



- **Live in CA with intent to reside here, or**
- Live in CA and entered State with job commitment or to seek employment, whether or not currently employed.

Children generally assume the residence of their parents, with an opportunity to establish state residence independently.

Immigrant Benefit Classifications



- **U.S. Citizens**
- "**Qualified**" immigrants
  - Entering the U.S. before 8/22/96
  - Entering the U.S. on or after 8/22/96
- **"Not Qualified" immigrants**
  - **PRUCOL** (Permanently Residing Under Color of Law)
  - Other lawfully present non-citizens
  - **Undocumented immigrants**

Qualified Immigrants

- **Lawful Permanent Residents (LPR)**
- **Refugees, Granted Asylum, Withholding of Deportation/Removal, or Conditional Entrant status**
- **Paroled into U.S. for at least 1 Year**
- **Cuban and Haitian Entrants**
- **Certain Battered Spouses and Children**
- **Certain Survivors of Trafficking**

Qualified Battered Immigrants

Must have *prima facie case* or approved:

- **Visa petition** filed by U.S. citizen or LPR spouse/parent
- **Self-petition under VAWA**, or
- Application for cancellation of removal/suspension of deportation under VAWA

Parent of battered child and **child** of battered spouse also considered "qualified"

Survivors of Severe Form of Trafficking

- If 18 or over, must be certified by HHS
- Children under 18 may get HHS "eligibility letter"
- **Eligible for federal benefits to the same extent as refugees**.
- Derivative beneficiaries of "T" visas also eligible for federal benefits.

→ Survivors with approved/*prima facie* case for T visa are "qualified" - but other trafficking victims also are eligible for benefits.

Not Qualified Immigrants

- *ALL* Other Non-citizens

… even if have work authorization and are lawfully present in U.S.

PRUCOL

Permanently Residing Under Color of Law - not an immigration status, but a benefit eligibility category (see MC 13 Form – Statement of Citizenship, Alienage, and Immigration Status). May include persons:

- with approved immediate relative visa petition
- who filed application for adjustment to LPR status
- granted deferred action (**including DACA**)
- granted Family Unity status
- granted a stay of deportation
- who have lived in the US continuously since before Jan. 1, 1972
- who are survivors of domestic violence (certain immigrants)
- **Other persons in the US with the knowledge of DHS whose departure that agency does not contemplate enforcing.**

Not Qualified Immigrants: Programs Barred

- **Federal**

  "Public Benefits" barred

- **State or Local**

  "Public Benefits" barred

  unless state passes new law

Not Qualified Immigrants: Federal Program Bar

Bar on Federal "Public Benefits"

"Public Benefits" defined by federal agencies

→ Executive Order asked them to look again

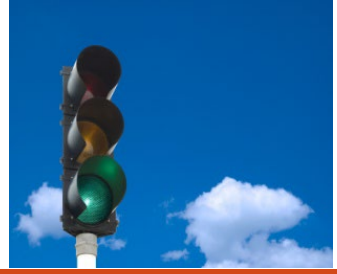
Examples of "public benefit" in law

- Grants, Contracts, Loans, Professional or Commercial Licenses provided by government
- Retirement, Welfare, Health & Disability, Housing, Post-Secondary Education, Food Assistance, Unemployment Benefit, FEMA, or any "similar benefit," AND
- Assistance **provided to individual, household, or family unit**, by an agency/funds of federal government

Examples of HHS Federal Public Benefits

- Adoption Assistance
- Child Care and Development Fund
- Foster Care
- Independent Living
- Low Income Home Energy Assistance Program (LIHEAP)(weatherization of single unit buildings)
- Medicare
- Medicaid (except emergency medical)
- Mental Health Clinical Training Grants
- Refugee benefits (Cash, Medical, Social Services)
- Social Services Block Grant (SSBG)
- Children's Health Insurance Program (CHIP)
- Temporary Assistance for Needy Families

Programs Exempt from Federal Bar



- **Emergency Medicaid** and other emergency medical services
- Immunizations, testing and treatment for symptoms of communicable diseases (outside of Medicaid)
- Short-term non-cash disaster relief
- Certain housing assistance if receiving on 8/22/96
- School Lunch and School Breakfast
- State option to provide WIC

AND programs

1. delivered at the community level, that...
2. do not condition assistance on income or resources
3. are necessary to protect life or safety

AG's List of Programs "Necessary to Protect Life or Safety"

- Child protection & adult protective services
- Violence and abuse prevention, including domestic violence
- Mental illness or substance abuse treatment
- Short-term shelter or housing assistance
- Programs during adverse weather conditions
- Soup kitchens, food banks, senior nutrition programs

- Medical & public health services & mental health, disability,
- Substance abuse services necessary to protect life or safety
- Programs to protect life & safety of workers, children & youth, or community residents
- Other services necessary for the protection of life or safety

Non-Profit Agencies

Non-profit charitable organizations are not required to determine, verify or otherwise ask for proof of an immigrant's status

- applies to immigrant restrictions in the 1996 welfare and immigration laws

- Non-profits can create a safe environment for immigrants and their family members who are seeking services

CA Programs Available Regardless of Status

- **Medi-Cal for children**
- **Emergency Medi-Cal**
- **Prenatal care** (Medi-Cal)
- Medi-Cal Access Program (MCAP, formerly AIM)
- Long-term care
- Early Breast Cancer Detection and Breast and Cervical Cancer Treatment
- IMPACT (prostate cancer)
- California Children's Services (CCS)
- Healthy Kids (Children's Health Initiatives)
- Health Programs in some counties (Healthy SF)
- **Community clinics**
- Family PACT
- Minor consent services
- Mental health services
- **ADAP & OA-HIPP**
- Regional Center Services
- Women Infants and Children (WIC)
- School lunch and breakfast

Angie and Nadia

Angie works in a health clinic, a non-profit organization that receives federal funds. Patients can be treated at the clinic, regardless of their income.
Nadia, an undocumented woman with HIV, seeks treatment at the clinic.

1. Is Nadia eligible for treatment?
2. Is Angie required to verify Nadia's immigration status?
3. Is Angie required to report Nadia to the Department of Homeland Security?

Immigrant Eligibility for Major California Programs

Full-Scope Medi-Cal
Adults: Qualified immigrants & PRUCOL;
Children & Pregnant women: regardless of status

CalWORKs
Qualified immigrants
& PRUCOL. Deeming rules apply

CalFresh/California Food Assistance Program (CFAP)
Qualified immigrants (plus) Deeming rules apply.

SSI/Cash Assistance Program for Immigrants (CAPI) and IHSS
Qualified Immigrants and PRUCOL. Deeming rules apply.

NOTE: Trafficking survivors and U visa applicants/holders are eligible for all state & local programs

Andrea

Andrea applied to become an LPR based on her marriage to a U.S. citizen, but does not have her green card. She has a disability.

Which services can she receive?

What if her husband is abusive?

Kim and her Family

- Kim is a 28-year-old mom with one child, age 6. Both are LPRs who entered the U.S. in 2015. Kim lost her job. Are mom and child eligible for nutrition assistance or health coverage?
- Kim's mother travels to U.S. from Japan to visit. When her visa expires, she overstays. Grandma slips, breaks her arm, and is taken to the emergency room. Is she eligible for Medi-Cal?

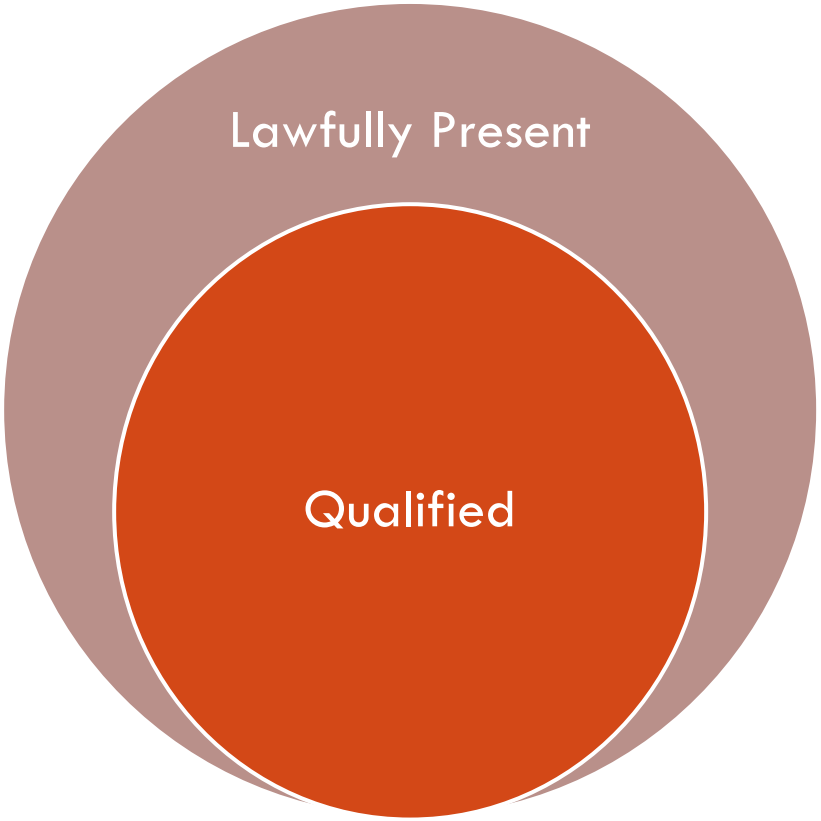
Survivors of Trafficking and other Serious Crimes in CA:

- **Trafficking Survivors** can get state and local benefits before certified for federal benefits
- 12 months, extended if T visa application or Continued Presence request filed
- **U visa applicants/ holders** get state and local benefits
- Continues unless U status finally denied
- **State RCA and RSS** available for trafficking survivors & U visa applicants/holders

Clare, Mike and Tyler

- Clare and her boyfriend Tom are undocumented. Tom is in jail due to domestic violence. Clare has two children, Mike, an undocumented teenager, and Tyler, a six-year old, born in the U.S. Clare is pregnant. Which benefits can they receive?

Eligibility for Covered California



lawfully present
immigrants are eligible to purchase health coverage through state health care marketplaces

- No waiting period

exception:

People who received deferred action through DACA are specifically excluded

Lawfully Present Noncitizens

- **All "qualified" immigrants**
- **Others authorized to live and/or work in the U.S., e.g.**
  - temporary protected status (TPS)
  - most with deferred action
- **Applicants for:** adjustment to LPR, asylum, and certain other statuses
- **Individuals with valid nonimmigrant status**

Complete list:
https://www.healthcare.gov/immigration-status-and-the-marketplace/

Public Charge: Background

- Public Charge is a ground of inadmissibility that applies when a person seeks:
  - Admission to the US
  - Lawful permanent residence (LPR, a green card)

- Refugees, survivors of domestic violence, crime, or trafficking, special immigrant juveniles, other "humanitarian" immigrants - and LPRs applying for citizenship are **not** subject to public charge.

Public Charge

- Public charge test is based on **all facts** relevant to individuals' ability to support themselves, including at a minimum, their:
  - Age
  - Health
  - Financial resources
  - Family status
  - Education and skills
- Other relevant factors, like an affidavit of support, may be considered

Public Charge

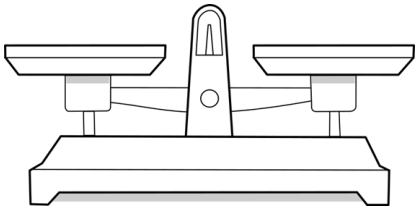
- Other potentially relevant factors include the person's use of public benefits. Under current rules, only two types of benefits can be considered:
  - **Cash assistance** for income maintenance
  - Institutionalization for **long-term care** at government expense
- USCIS expected to propose new regulations that would expand factors considered in the public charge test dramatically, including the benefits that can be considered
- Instructions for consular officers abroad were revised (less dramatically) in January, and may be revised again to conform with any new rules for decisions made in the US.

Proposed Rules: Not Retroactive

- Under leaked drafts of the proposal, benefits:
  - received before the final date of any new regulations
  - that are currently excluded from the public charge assessment

- **Will not** be considered in the Public Charge determination

Messages for Consumers



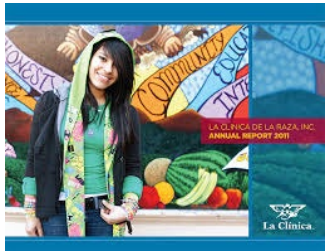
- **Some immigrants are NOT subject to public charge**
- **Positive factors are balanced against negative factors**. A person with a negative factor may be able to overcome it by showing positive factors.
- **Forward Looking**. If proposal becomes final, non-cash benefits used before that time will not be counted. Using benefits now can help you or your family members become healthier, stronger and more employable in the future.
- **Each situation is different**. People with questions should consult an immigration attorney about their individual case.
- **Fight back!** Let the government know that this proposed rule would harm you, your family, community and the country. Organize with others to weigh in.

Key Issues for Mixed-Status Families

- Undocumented individuals may apply for coverage on behalf of their dependent family members
  - Applications should distinguish between *applicants* (e.g., U.S. citizen child) & *non-applicants* (e.g., undocumented parent)
  - Non-applicants are not required to provide their immigration status
  - Non-applicants without SSNs cannot be required to provide one
    - Never provide an SSN unless officially issued by the Social Security Administration
    - Individual Taxpayer Identification Numbers (ITINs) should not be used
- Information provided on an application may be used ONLY to determine eligibility for health insurance.

Health Care Providers Can:

- **Document harm of restrictive policies and benefits of improving access**
- **Monitor policies to ensure they are implemented properly**
- Educate families about available services
- Help ensure that immigration and health policies are responsive to families and public health needs
- **Address the barriers that prevent eligible families from securing care**



Resources

- Major Benefit Programs for Immigrants in California
- **Public Charge Information (NILC)**
- Sponsored Immigrants and Benefits in California

Protecting Immigrant Families Campaign Resources

- Fact sheet on proposed changes to public charge
- Fact sheet on changes to the Foreign Affairs Manual (FAM)
- "Things to Keep in Mind When Talking with Immigrant Families"
- Proposed Changes to Public Charge Policies for Immigrants: Implications for Access to Health Care (Kaiser Family Foundation)
- **National Immigration Law Center:** www.nilc.org

More Resources

- Privacy Protections in Selected Federal Benefits Programs
- Health care Providers and Immigration Enforcement: Know Your Rights, Know Your Patients' Rights
- Everyone has Certain Basic Rights, No Matter Who is President (Arabic, Chinese, English, Korean, cards also in Farsi and Somali)
- Know Your Rights Cards from the Immigrant Legal Resource Center (Arabic, Chinese, English, Hmong, Korean, Spanish & Vietnamese)
- Family Preparedness Plans from the Immigrant Legal Resource Center

BAY AREA LEGAL AID
HEALTH CONSUMER CENTER

MEDI-CAL 101

TIFFANY HUYENH-CHO
HEALTH CONSUMER CENTER
BAY AREA LEGAL AID

October 5, 2018

HEALTH CONSUMER CENTER

- Statewide legal hotline providing free assistance on health care coverage and health access issues
- The Health Consumer Center (HCC) also provides legal advice, brief services, and extended representation, including representation at State Fair Hearings.
- Spanish, Mandarin, Cantonese, Korean, and Hindi speaking attorneys. All other languages accessed via a telephone interpreter service.
- Areas of health law include Medi-Cal, Covered CA, Medicare, and private insurance.
- All services are free and we welcome all income levels.
- **Hotline: 1 (855) 693 - 7285. Open M-F, 9-5pm.**

MEDI-CAL: WHAT IS IT?

- **Federally & state funded health insurance program for low-income persons**
- **Administered by California's Department of Health Care Services (DHCS)**
  - http://www.dhcs.ca.gov/services/medi-cal
- **Eligibility is determined at the county level**

ELIGIBILITY: WHO GETS MEDI-CAL?

- ✓ Programmatically-linked: *i.e.*, SSI, CalWORKs,
- ✓ Seniors
- ✓ "Expansion/Childless" adults 19-64
- ✓ Foster care, adoption assistance
- ✓ Parent/Caretaker Relatives
- ✓ Infants and children up to age 19
- ✓ Pregnant women
- ✓ Persons with disabilities
- ✓ Former foster youth to age 26
- ✓ Long term care

TYPES OF MEDI-CAL COVERAGE

- **<u>Free, Full-Scope Medi-Cal:</u> no cost-sharing, responsibility to pay for services**
  - Pays for medically necessary health care & treatment when using a Medi-Cal provider. $0 out of pocket responsibility
  - Expansion Medi-Cal (138% FPL, Parent/Caretaker etc), 250% Working Disabled, Aged & Disabled Medi-Cal
- **<u>Share of Cost (SOC):</u> income too high for free, full-scope Medi-Cal programs**
  - Beneficiary is expected to contribute financially to the cost of their medical care
  - A SOC is assigned when a household's countable income <u>*exceeds*</u> the maximum income limit for the free, full scope Medi-Cal programs.
  - SOC applies to beneficiaries that are ineligible for expansion Medi-Cal

MEDI-CAL EXPANSION: WHAT IS MAGI?

- New methodology for determining eligibility for Medi-Cal, based on Modified Gross Adjusted Income (MAGI). MAGI is based on Adjusted Gross Income under the U.S. Tax Code PLUS any foreign income, tax-exempt interest, and Social Security Benefits.
  - Includes an across-the-board 5% disregard for all programs
  - Exempts resources (like money in savings accounts or personal property) as an eligibility factor.
  - Calculation: **Adjusted Gross Income + Non-taxable Social Security Benefits** (ex, Social Security Disability, Social Security Retirement),Tax-exempt interest, Foreign earned income & housing expenses
    - Adjusted Gross Income: Income Line 37 on IRS Form 1040, Line 4 on Form 1040EZ, Line 21 on Form 1040A
    - Common tax deductions will affect the AGI, such as student loan interest deductions, and educator expenses etc
    - Common Income Exceptions: Example, State Disability Insurance is exempt, financial assistance used to pay for tuition.

MAGI MEDI-CAL CONTINUED

Eligibility is determined by whether the applicant(s) income falls beneath the income limit for that household size.

- **Household Size: HH size is based on tax household size.**
  - Ex: Generally, tax household is the tax filer, spouse, and any dependents.
- **Self-Employment Income**
  - Counted as reportable income but only the taxpayer's net business profit (or loss), as shown on the Schedule C.
- **IHSS Income Special Rules**
  - Under MAGI based programs, IHSS wages received by IHSS providers who live in the same home with the recipient of those services are **excluded** from gross **income**

TRADITIONAL MEDI-CAL

- Traditional Medi-Cal programs have both income and asset requirements unlike Expansion Medi-Cal, like the 138% FPL, which does not have asset tests.
  - 250% Working Disabled, Aged, Blind, & Disabled, Medically Needy Share of Cost, & long term care.
  - Countable Income under traditional Medi-Cal is not the same as expansion MAGI. Countable income is income after all applicable deductions are made for the particular Medi-Cal program. Deductions can vary from one program to another.
- **Asset Limit**
  - Single: $2,000/mo
  - Couple: $3,000/mo
- **Aged, Blind, and Disabled:** full-scope Medi-Cal program for those over 65, or under 65 and have Medicare, and below the income/asset limits for the household size.
- **Medically Needy Share of Cost:** for households whose income is above the income limit threshold, they are expected to contribute financially to their medical expenses.

DETERMINING INCOME

MAGI VS. NON-MAGI

TRADITIONAL MEDI-CAL CATEGORIES

- Aged, Blind, Disabled
- Medically Needy
- Long Term Care (skilled nursing facility)

MODIFIED ADJUSTED GROSS INCOME (MAGI) COUNTING RULES

- Expansion Childless adults 19-64
- Pregnant women
- Children up to age 19
- Parent/Caretaker Relative

MEDI-CAL INCOME LIMITS

Coverage Group	Income FPL	2018 Monthly Income (1 person)	2018 Annual Income (1 person)
Expansion adult, 19-64	138%	$1,397	$16,754
Parent/Caretaker Relative	109%	$1,103	$13,233
Aged, Blind, or Disabled*	100% + $230	$1,242	$14,820
Working Disabled*	250%	$2,530	$30,350

*Non-MAGI

COUNTABLE INCOME UNDER MAGI & NON-MAGI

	MAGI Programs	Traditional non-MAGI Medi-Cal
Counted as Income?		
Social Security Disability	Y	Y
State Disability Income	N*	Y
IHSS Wages	N (wages received as a live-in provider)	N (only for IHSS wages earned on behalf of minor child and/or spouse)
Workers Compensation	N	Y
Gifts, Inheritances	N	Y
SSI	N	N

MEDI-CAL ASSET & RESOURCE RULES

Traditional Medi-Cal categories have an asset/resource limit

- Asset Limit
  - Single: $2,000/mo
  - Couple: $3,000/mo
- A house is exempt (if you live in the home) and 1 car (2 cars for a couple).
- IRAs, KEOGHs, and other work-related pension plans: exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal and payments of principal and interest are being received, the balance is considered unavailable and it is not counted
- Life insurance policies: Exempt if the face value is $1,500 or less

COUNTABLE INCOME FOR TRADITIONAL MEDI-CAL

- Countable Income for Medi-Cal purposes is calculated by taking monthly income minus some common deductions:
  - **Medical insurance premiums**
  - **Automatic $20 deduction**
  - **Any Employment Income Deductions (aka earned income)**
    - Deduct $65 Employment Income
    - Minus any Impairment-related expenses you pay to become/remain employable (if you are disabled)
    - Minus any Income-related work expenses, i.e. transportation, uniforms, etc. (if you are blind)
    - 50% of the balance of employment income after the above deductions
    - = countable *earned* income.
    - Ex: Joe earns $3,000 in employment a month. 3,000-65/2 = $1467.5 countable income.
    - *These rules apply to spousal employment as well.

MEDI-CAL MEDICALLY NEEDY PROGRAMS AND SHARE OF COST

A SHARE OF COST (SOC) is assigned when the applicant's *countable income* is over the maximum income limit for the applicable Medi-Cal programs.

What is a Share of Cost?

- It is not a monthly premium
- It functions more like a monthly deductible, or a monthly cap on the amount you have to pay for health services. Therefore,
  - If you do not use health services in the month, you do not pay the SOC.
  - If you do use health services in a month, you are responsible to pay out of pocket for your health services up to the SOC amt. After meeting the entire SOC in one month, MC will cover any expenses above your SOC in that same month.
  - SOC restarts every month

CALCULATING THE SHARE OF COST

Share of Cost is Calculated by the County Office

- Share of Cost = Countable Income minus the Maintenance Need Level for the household
- Maintenance Need Level is set by the govt and the amt of income the govt allows a beneficiary to retain for rent, food, utilities. It is a standard level and does not take into account cost of living.
- Maintenance Need Level:
  - Single person $600
  - Couple $934

EXAMPLE #1

Joseph is 67, a single person, and receives $1,600 in Social Security Retirement each month. His insurance is Medicare and he pays $134/mo in Part B Premiums and $60 in vision insurance. Does he qualify for free, fullscope Medi-Cal?

- No. Joseph has a SOC bc his monthly income exceeds the $1,235/mo limit.
  - His SOC = $846
  - Calculation:

    $1600
    - $20 (automatic deduction)
    - $134 (part B premium) & $60 (vision)

    = $1,386 in countable income.'
- His SOC = $786 ($1,386 - $600 Maintenance Need Level)

MEETING THE SHARE OF COST

- A beneficiary is deemed to have "met" their share of cost when they have paid out of pocket for their medical expenses, up to the SOC cap.
- Example:
  - John has a $150 share of cost for the month of June. In June, John had multiple medical appointments and prescriptions he needed. John paid $150 out of pocket for his appointment co-pays, co-insurance, and prescriptions. John has met his SOC for March. Any medical expenses in excess of the $150, Medi-Cal will pay for.
- Medical bills paid on behalf of other family members also count towards meeting the SOC.

SHARE OF COST STRATEGIES

COMMON STRATEGIES

- Using unpaid bills
- Medical expenses paid on behalf of another family member
- 250% Working Disabled Program
- Supplemental medical insurance

SUPPLEMENTAL MEDICAL INSURANCE

- Medical Insurance premiums are a common way to reduce someone's countable income to at or below the free Aged & Disabled limit ($1,242 for single person in 2018). Paid monthly premiums for supplemental insurance (vision, dental, medigap) can be deducted from the household's countable income.
- Premiums paid on behalf of other immediate family members count too (spouse, children etc).

EXAMPLE #4: MEDICAL INS PREMIUMS

- John and Jane are married and live together. John and Jane are both 65 years old. John receives $900 in SSA and Jane gets $1,000 in SSA. John and Jane pay $268 combined in Medicare Part C premiums. Are John and Jane eligible for free, full scope A&D Medi-Cal? The maximum income limit for a household of 2 is $1,664/mo.

Answer: Yes.

- $900 + $1,000= $1,900
- $1900 minus
  - - $20 deduction
  - - $268 medical insurance premiums
- = $1,612 in countable income
- $1,612> $1,664 max. income for a couple

250% WORKING DISABLED PROGRAM

Alternatives to SOC:

- 250% Working Disabled Medi-Cal Program provides full-scope Medi-Cal with a monthly premium to working disabled individuals with countable income below 250% of the federal poverty level.
- Criteria:
  - 1) Disabled – either SSA or Medi-Cal must have given a determination of disability
  - 2) Minimal employment - beneficiary must engage in some sort of minimal employment. Medi-Cal has not set out minimum hours, wages etc to qualify. Common jobs have been babysitting grandchildren, filling our forms, gardening etc.
- Under 250% WDP, all disability income is exempt. The monthly premium is on a sliding scale and determined by the non-exempt income. The lowest monthly premium is $20.
- 250% WDP also allows the beneficiary to save employment income, in a separate bank account, in excess of the regular Medi-Cal $2,000 asset limit.

STRATEGIES

- Group health services into as few months as possible so that you only have to pay out-of-pocket for health services during as few months as possible. Medi-Cal will pick up any health service expenses that exceed the SOC in those months.
- Use unpaid medical bills to meet the SOC. The bills can be for the individual themselves or their family members. You can combine unpaid bills into one month. Contact the county MC worker to apply this strategy.
- Ex: Joseph has a $500 Share of Cost. In February, Joseph got a $600 hospital bill he did not pay. Joseph showed the unpaid bill to his county Medi-Cal worker for the month of March. The bill, bc it is over Joseph's SOC, will cover his March SOC and $100 of it will go towards a future month – April. Joseph doesn't have to prove that he has paid on the bill, only that he is obligated to pay. Joseph must keep in mind that the bill itself still needs to be reckoned with the provider.

STATE FAIR HEARINGS

APPEAL RIGHTS

If you disagree with a county's action (example, termination or share of cost), you have rights:

- Request a State Fair Hearing and appeal the county action
  - Beneficiary has 90 days from date of the Notice of Action to appeal a county action
    - If you are appealing a managed care plan decision (denial of medical treatment, diff appeal deadlines apply).
- Aid Paid Pending: if an appeal is submitted *before* the county action goes into effect, Medi-Cal benefits will continue as is until you receive a final State Fair Hearing decision.
  - Example: John receives a Notice of Action dated August 5, 2018 that his Medi-Cal benefits will terminate on August 31, 2018. John appeals the county's proposed termination on August 12, 2018. Because John appealed before the termination occurred, he will receive Aid Paid Pending and his Medi-Cal will not terminate pending the appeal outcome.

State Fair Hearings

- State Fair Hearings ("SFH") are before by an Administrative Law Judge who makes a judgment based on testimony, facts, and the applicable Medi-Cal regulations.
- SFHs are usually informal. An attorney is not required and beneficaries can represent themselves at a SFH.
- The beneficariary has the right to present their case, provide oral testimony, and to submit relevant documents to support their case.
- The county also has the opportunity to attend and provide a statement of their case.
- After the SFH decision is released, 30 day deadline to request a rehearing if the beneficiary disagrees with the SFH decision.

WHERE TO APPLY?

ONLINE

- https://www.coveredca.com/apply/ - Download application or fill out online
- https://www.mybenefitscalwin.org/

IN PERSON

- 1440 Harrison or 1235 Mission Street, San Francisco (M-F, 8am - 5pm)

BY MAIL or FAX

- Human Services Agency
  PO BOX 7988
  San Francisco, CA 94120
- Fax: (415) 355-2432

HELP!

Health Consumer Center Hotline: 1 (855) 693-7285

- Monday – Fridays, open from 9am to 5pm

U = U

The Evidence for U=U

MATT SPINELLI, MD

INFECTIOUS DISEASE FELLOW

DIVISION OF HIV, ID, AND GLOBAL MEDICINE ZSFG/UCSF

Undetectable=Untransmittable Outline

U = U

- Review of the Science
  - What are the origins of U=U?
  - Prior to antiretroviral therapy (ART), how did we learn lower viral load = lower risk?
  - What supports starting ART to lower transmission risk?
  - What supports U=U in the real world?
  - What supports U=U in MSM?
- Frequently Asked Questions

What Are the Origins of U=U?

U = U

1998:
Studies of HIV transmission from mother to baby: 0 transmissions when on ART

Beckman et al (Int Conf AIDS 1998)

1998:
U.S. guidelines include "possibly decreasing transmission" as rationale for starting ART

DHHS guidelines 1998

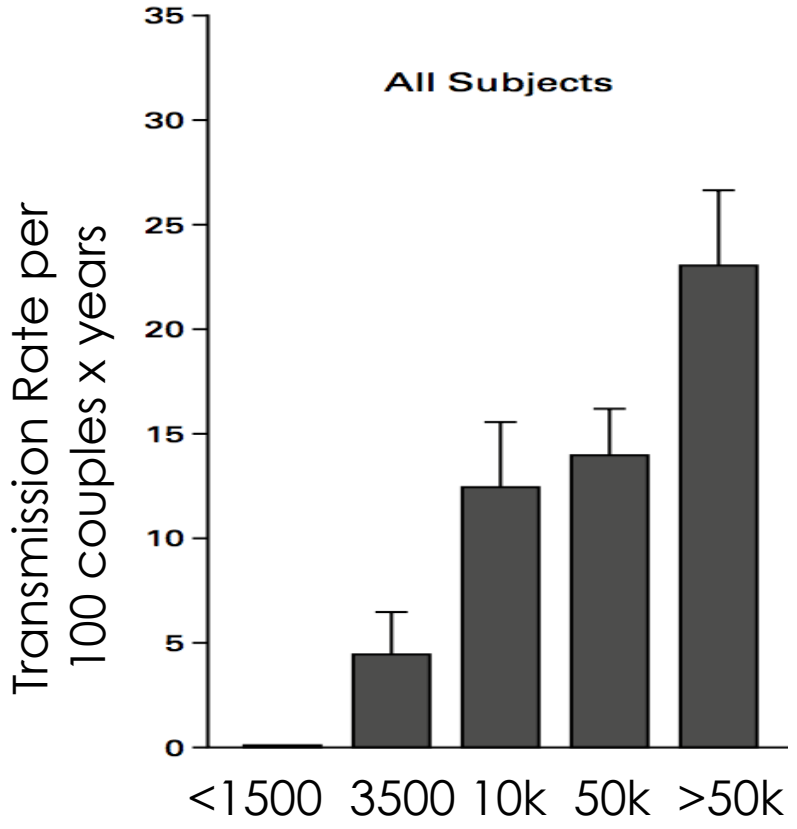
2000:
Study of HIV transmission in sero-different partners in Uganda

Quinn et al 2000

2000: Without Antiretroviral therapy No Transmissions When Viral Load <1500

U = U

- 415 couples in Uganda studied for up to 30 months
- Lower viral load, lower risk
- No transmissions when viral load was <1500



Quinn NEJM 2000

What Supports Starting Antiretroviral Therapy to Lower Risk?

U = U

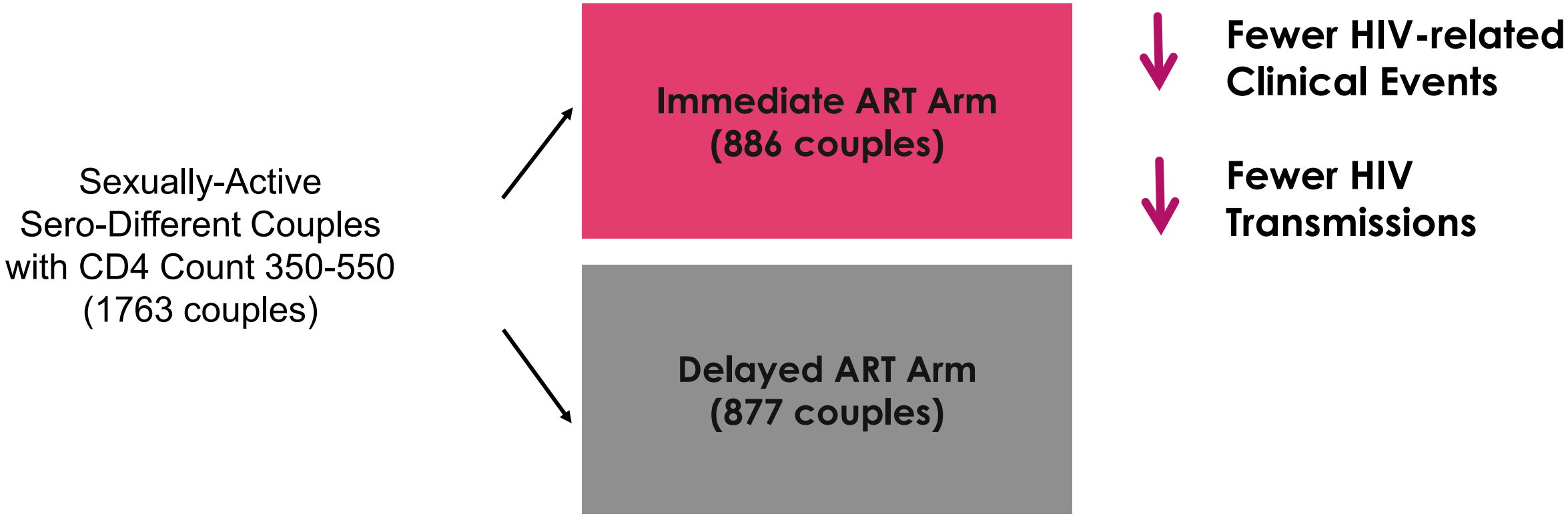
2001- 2008: Swiss Commission Statement summarizing observational trials: "Suppressed does not transmit" (with caveats)
Vernazza et al 2008

2011: Large Randomized Trial: Starting Antiretroviral Therapy to Decrease HIV Infection (HPTN 052)
Cohen et al. NEJM 2011

2015: Final Analysis Of Same Trial (HPTN 052)
Cohen et al. IAS 2015
Cohen et al. NEJM 2016

2011: Antiretroviral Therapy Decreases HIV Transmission in a Randomized Trial (HPTN 052)

U = U

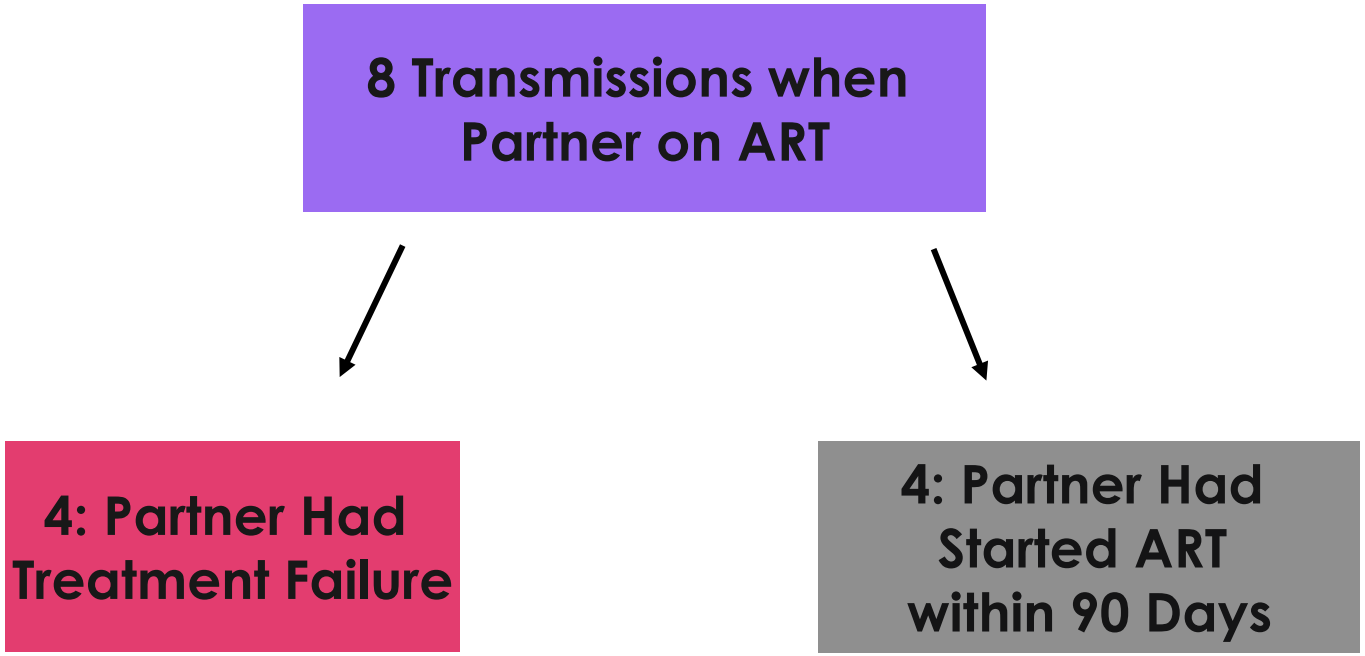


Cohen MS, et al. NEJM 2011; 365:493-505.

2015: Final Analysis of HPTN 052-- No Transmissions If Undetectable

U = U

- 36% of transmissions occurred outside of partnership ("unlinked")
- No "linked" transmissions when partner on ART 3 months and virally suppressed
- Caveats: ~0 MSM, High Condom Use



Cohen MS, et al. IAS 2015
Cohen MS, et al. N Engl J Med. 2016;375:830-839.

U = U

What supports U=U in the real world?

Study	Population	Condomless Sex Acts	Transmissions within Partnership
PARTNER	888 couples, 38% MSM	58,000	**0**
Opposites Attract	343 couples, 100% MSM	17,000	**0**
PARTNER2	783 couples 100% MSM	77,000	**0**

Rodgers et al. JAMA 2016; 316: 171-81
Bavinton et al, Lancet HIV 2018; 5e 438-47

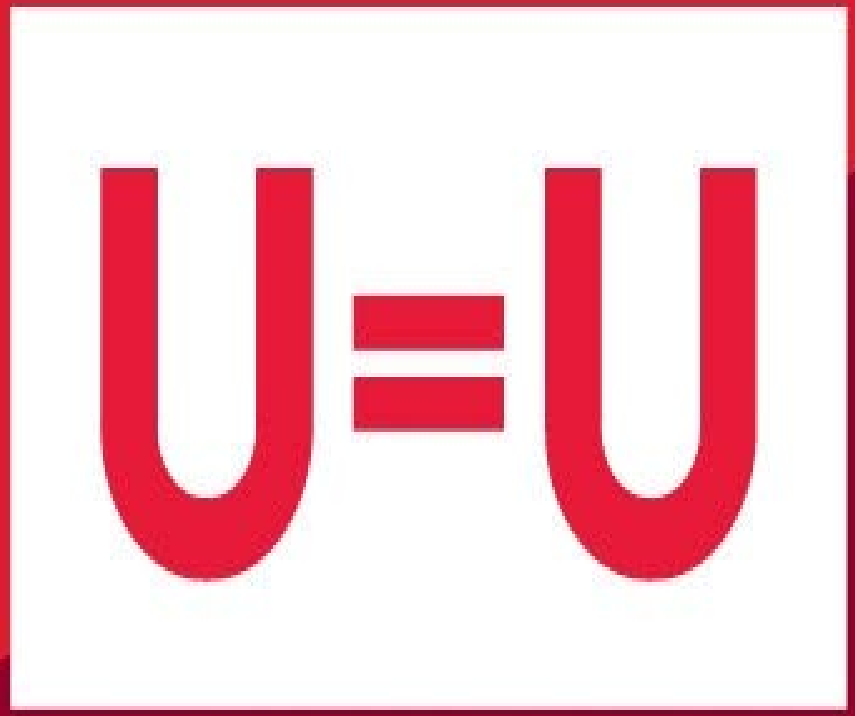
#UequalsU

U = U

- "**The science really does verify and validate U=U**." Anthony S. Fauci, M.D., Director, NIAID, NIH Speech at United States Conference on AIDS (September, 2017)

- **"People who take ART daily as prescribed and achieve and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV-negative partner."** CDC (September, 2017)

- **"It is time, to end the fears!" "I really think these community members who were active on U=U did a great job."** Pietro Vernazza, author of Swiss Commission Statement (November, 2017)



UNDETECTABLE = UNTRANSMITTABLE

FAQ: U=U

U = U

- How long after starting antiretroviral therapy does U=U?
- What if you or a partner misses doses or stops therapy?
- What about sexually transmitted infections (STIs)?
- What about people with injection drug use?

How Long After Starting ART Is Safe?: No Infections After 6 Months in Partners-PrEP

U = U

- Randomized, placebo-controlled trial in sero-different heterosexual partners with partner starting ART
  - 3 infections in first six months vs. 0 after six months
- 6 Months May Be Conservative
  - Older HIV Regimens

Mujugira, JAIDS 2016;72:579-84

What If I/My Partner Misses Doses Or Stops Antiretroviral Therapy (ART)?

U = U

- When do people become detectable off ART?
  - Risk increases significantly after one week (2x odds).
  - Can be as soon as 48hrs (Genberg et al. AIDS 2012)
    - Risk of transmission is still very low if only missing several days

- If you/partner stops for longer than several days:
  - Other prevention strategies remain available: PrEP, condoms
    - Continue until undetectable

What Do We Know about Sexually Transmitted Infections? Injection Drug Use ?

U = U

- Sexually Transmitted Infections:
  - No transmissions if undetectable (6-17% with STIs in PARTNER)

    (Rodgers et al. JAMA 2016; 316: 171-81)

- Injection Drug Use:
  - Limited data (only 2% with injection drug use in PARTNER)
  - PrEP is effective for prevention (Choopanya K. et al. Lancet 2013)

Stigma and shame

Changing our world

U = U

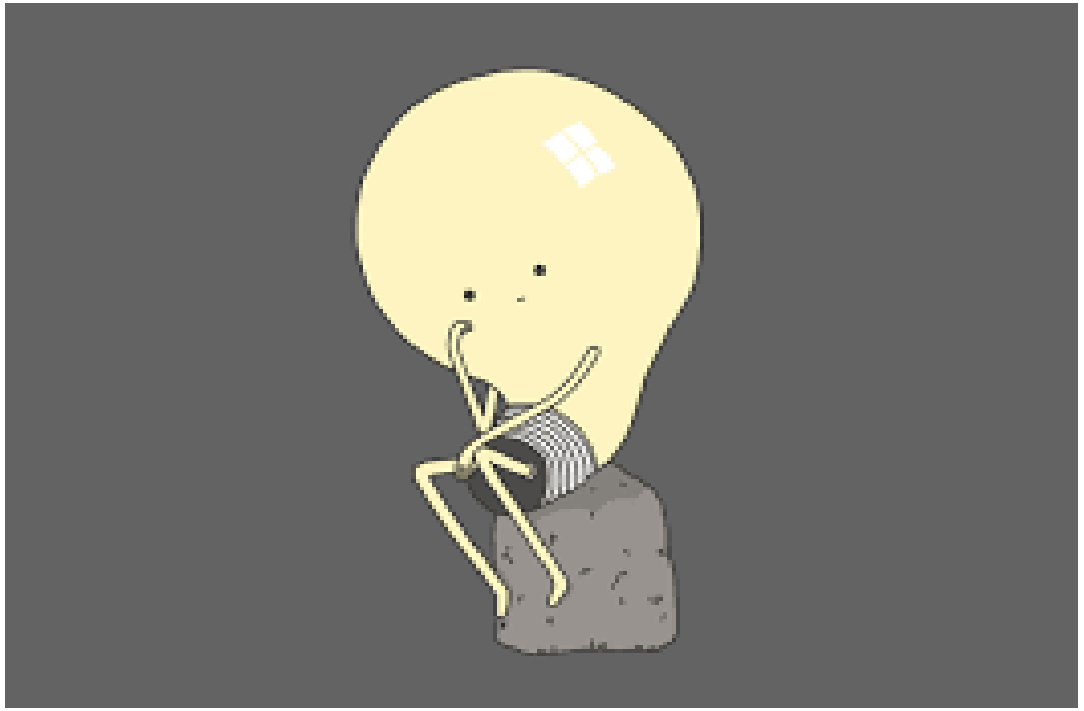
Implicit bias refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner.

U = U

Let's talk about sex

CIRCLES OF SEXUALITY

Self-reflection



Health Insurance and Counseling and Advocacy Program (HICAP) *Presents*

A,B,C of MEDICARE

Presented by Miguel Martinez

HICAP Manager

What is a HICAP??

- Health Insurance Counseling and Advocacy Program
- We help people with Medicare and their family and caregivers understand their health insurance benefits, options, and rights.
- We offer **free**, **unbiased**, one-on-one assistance from health insurance counselors registered by the California Department of Aging.

Who Uses HICAP?

- People who have Medicare
- People soon to become eligible for Medicare
- Family members, caregivers, and advocates of people with Medicare

What Is Medicare?

- Health insurance for three groups of people
  - 65 and older
  - Under 65 with certain disabilities
  - Any age with End-Stage Renal Disease
- Administered by
  - Centers for Medicare & Medicaid Services

The Four Parts of Medicare

Part A Hospital Insurance

Part B Medical Insurance

Part C Medicare Advantage Plans (like HMOs and PPOs) This includes Part A, Part B , & sometimes Part D

Part D Medicare Prescription Drug Coverage

Automatic Enrollment—Parts A and B

- Automatic for those receiving
  - Social Security benefits
  - Railroad Retirement Board benefits
- Initial Enrollment Period package
  - Mailed 3 months before
    - Age 65
    - 25th month of disability benefits
- Others must enroll themselves

Part A and Part B Benefits and Costs

- Medicare Part A (Hospital Insurance)
  - What's covered
  - Part A costs
- Medicare Part B (Medical Insurance)
  - What's covered
  - Part B costs

Medicare Part A–Covered Services

Inpatient Hospital Stays	Semi-private room, meals, general nursing, and other hospital services and supplies. Includes care in critical access hospitals and inpatient rehabilitation facilities. Inpatient mental health care in psychiatric hospital (lifetime 190-day limit). Generally covers all drugs provided during an inpatient stay received as part of your treatment.
Skilled Nursing Facility Care	Semi-private room, meals, skilled nursing and rehabilitation services, and other services and supplies.
Home Health Services	Part-time or intermittent skilled nursing care, and/or physical therapy, speech-language pathology services, and/or services for people with a continuing need for occupational therapy, some home health aide services, medical social services, and medical supplies for use at home.
Hospice Care	For terminally ill and includes drugs for pain relief and symptom management, medical care, and support services from a Medicare-approved hospice.
Blood	In most cases, if you need blood as an inpatient, you won't have to pay for it or replace it.

Paying for Medicare Part A

- Most people receive Part A premium free
  - If you paid Federal Insurance Contributions Act (FICA) taxes at least 10 years
- If you paid FICA less than 10 years
  - Can pay a premium to get Part A
  - May have a penalty
    - If not bought when first eligible

Benefit Periods

- Measures use of inpatient hospital and skilled nursing facility (SNF) services
- Begins the day you first receive inpatient care
  - In hospital or SNF
- Ends when not in hospital/SNF 60 days in a row
- Pay Part A deductible for each benefit period
  - $1,340 in 2018
- No limit to number of benefit periods you can have

Paying for Inpatient Hospital Stays

For Each Benefit Period in 2018	You Pay
Days 1-60	$1,340 deductible
Days 61-90	$335 per day
Days 91-150	$670 per day (60 lifetime reserve days)
All days after 150	All Costs

Paying for Skilled Nursing Facility Care

For Each Benefit Period in 2018	You Pay
Days 1-20	$0
Days 21-100	$167.50 per day
All days after 100	All Costs

Paying for Home Health Care

- Fully covered by Medicare
- Plan of care reviewed every 60 days
  - Called episode of care
- In Original Medicare you pay
  - Nothing for covered home health care services
  - 20 percent of Medicare-approved amount
    - For durable medical equipment
      - Covered by Part B

Paying for Hospice Care

- In Original Medicare you pay
  - Nothing for hospice care
  - Up to $5 per Rx to manage pain and symptoms
    - While at home
  - 5 percent for inpatient respite care
- Room and board may be covered
  - Short-term respite care or for pain/symptom management
  - If you have Medicaid and live in a nursing facility

Blood (Inpatient)

- If hospital gets blood free from a blood bank
  - You won't have to pay for it or replace it
- If hospital has to buy blood for you
  - You pay for first three units per a calendar year, or
  - You or someone else donates to replace blood

What Are Medicare Part B–Covered Services?

Doctors' Services	Services that are medically-necessary (includes outpatient and some doctor services you get when you're a hospital inpatient) or covered preventive services. You pay 20 percent of the Medicare-approved amount (if the doctor accepts assignment) and the Part B deductible applies.
Outpatient Medical and Surgical Services and Supplies	For approved procedures, like X-rays, casts, or stitches. You pay the doctor 20 percent of the Medicare-approved amount for the doctor's services if the doctor accepts assignment. You also pay the hospital a copayment for each service. The Part B deductible applies.

What Are Medicare Part B–Covered Services (continued)

Durable Medical Equipment	Items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds for use in the home. Some items must be rented. Medicare is phasing in a program called "**competitive bidding**," which means that in some areas, if you need certain items, you must use specific suppliers, or Medicare won't pay for the item and you'll likely pay full price. Visit medicare.gov/supplier to find Medicare-approved suppliers in your area. You pay 20 percent of the Medicare-approved amount, and the Part B deductible applies.

More Medicare Part B–Covered Services

Home Health Services	Medically-necessary part-time or intermittent skilled nursing care, and/or physical therapy, speech-language pathology services, and/or services for people with a continuing need for occupational therapy, some home health aide services, medical social services, and medical supplies. You pay nothing for covered services.
Other Services (including but not limited to)	Medically-necessary medical services and supplies, such as clinical laboratory services, diabetes supplies, kidney dialysis services and supplies, mental health care, limited outpatient prescription drugs, diagnostic X-rays, MRIs, CT scans, and EKGs, transplants and other services. Costs vary.

Part B–Covered Preventive Services

- "Welcome to Medicare" preventive visit
- Annual "Wellness" visit
- Abdominal aortic aneurysm screening
- Alcohol misuse screening and counseling
- Behavioral therapy for cardiovascular disease
- Bone mass measurement
- Cardiovascular disease screenings
- Colorectal cancer screenings
- Depression screening
- Diabetes screenings
- Diabetes self-management training
- Flu shots
- Glaucoma tests
- Hepatitis B shots
- HIV screening
- Mammograms (screening)
- Obesity screening and counseling
- Pap test, pelvic exam, and clinical breast exam
- Pneumococcal pneumonia shot
- Prostate cancer screening
- Sexually transmitted infection (STIs) screening and high-intensity behavioral counseling to prevent STIs
- Smoking cessation

NOT Covered by Part A and Part B

- Long-term care
- Routine dental care
- Dentures
- Cosmetic surgery
- Acupuncture
- Hearing aids and exams for fitting hearing aids
- Other–check on medicare.gov

Paying for Part B Services

- In Original Medicare you pay
  - Yearly deductible of $183 in 2018
  - 20 percent coinsurance for most services
- Some programs may help pay these costs

Monthly Part B Premium

If Your Yearly Income in 2016 was		In 2018 You Pay*
File Individual Tax Return	File Joint Tax Return	
$85,000 or less	$170,000 or less	$134
$85,000.01-$107,000	$170,000.01-$214,000	$187.50
$107,000.01-$160,000	$214,000.01-$320,000	$267.90
$160,000.01-$214,000	$320,000.01-$428,000	$348.30
Above $214,000	Above $428,000	$428.60
*per month		

Note: Premiums are usually deducted from your Social Security benefit payment

Paying the Part B Premium

- Deducted monthly from
  - Social Security (SSA) benefit payments
  - Railroad retirement benefit payments
  - Federal retirement benefit payments
- If not deducted
  - Billed every 3 months
  - Medicare Easy Pay to deduct from bank account
- Contact SSA, the Railroad Retirement Board, or Office of Personnel Management about premiums

What Is Original Medicare?

- Health care option run by the federal government
- Provides your Part A and/or Part B coverage
- See any doctor or hospital that accepts Medicare
- You pay
  - Part B premium (Part A is usually premium free)
  - Deductibles, coinsurance, or copayments
- Get Medicare Summary Notice
- Can join a Part D plan to add drug coverage

Medigap (Medicare Supplement Insurance) Policies

- Private health insurance for individuals
- Sold by private insurance companies
- Supplement Original Medicare coverage
- Follow federal/state laws that protect you
- Medigap Open Enrollment Period
  - Starts when you're both 65 and signed up for Part B
  - Once started, it can't be delayed or repeated

Medigap Policies

- You pay a monthly premium
- Costs vary by plan, company, and location
- Medigap insurance companies can only sell a standardized Medigap policy
  - Identified in most states by letters
- Doesn’t work with Medicare Advantage
- No networks except with a Medicare SELECT policy

Medigap Plan Types

	Medicare Supplement Insurance (Medigap) Plans									
Benefits	**A**	**B**	**C**	**D**	**F***	**G**	**K****	**L****	**M**	**N**
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medicare Part B coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100% ***
Blood (first 3 pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A hospice care coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Skilled nursing facility care coinsurance			100%	100%	100%	100%	50%	75%	100%	100%
Medicare Part A deductible		100%	100%	100%	100%	100%	50%	75%	50%	100%
Medicare Part B deductible			100%		100%					
Medicare Part B excess charges					100%	100%				
Foreign travel emergency (up to plan limits)			100%	100%	100%	100%			100%	100%
							Out-of-pocket limit in 2018			
							$5,240	$2,620		

* Plan F also offers a high-deductible plan in some states. If you choose this option, this means you must pay for Medicare-covered costs (coinsurance, copayments, deductibles) up to the deductible amount of $2,240 in 2018 before your policy pays anything.

**For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible ($183 in 2018), the Medigap plan pays 100% of covered services for the rest of the calendar year.

*** Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don't result in an inpatient admission.

Medicare Advantage (MA) Plans (Part C)

- What is Part C?
- How the plans work
- MA Plan costs
- Who can join?
- When to join and switch plans
- Other Medicare health plans

Medicare Advantage Plans

- Health plan options approved by Medicare
  - Another way to get Medicare coverage
  - Still part of the Medicare program
  - Run by private companies
- Also called Part C
- Medicare pays amount for each member's care
- May have to use network doctors or hospitals
- Types of plans available may vary

How Medicare Advantage Plans Work

- Still in Medicare with all rights and protections
- Still get Part A and Part B services
- May include prescription drug coverage (Part D)
- May include extra benefits
  - Like vision or dental
- Benefits and cost-sharing may be different

Types of Medicare Advantage (MA) Plans

- Health Maintenance Organization (HMO)
- HMO Point-of-Service
- Preferred Provider Organization
- Special Needs Plan

Medicare Advantage Plan Costs

- Must still pay Part B premium
  - Some plans may pay all or part for you
  - Some people may be eligible for state assistance
- You may also pay monthly premium to plan
- You pay deductibles/coinsurance/copayments
  - Different from Original Medicare
  - Varies from plan to plan
  - Costs may be higher if out of network

Medicare Prescription Drug Coverage

- What is Part D?
- Part D benefits and costs
- Who can join?
- When to join and switch plans
- Part D–covered drugs
  - Drugs not covered
- Access to covered drugs

Medicare Prescription Drug Coverage (continued)

- Also called Medicare Part D
- Prescription drug plans approved by Medicare
- Run by private companies
- Available to everyone with Medicare
- Must be enrolled in a plan to get coverage
- Two sources of coverage
  - Medicare Prescription Drug Plans
  - Medicare Advantage Plans with Rx coverage
    - And other Medicare health plans with Rx coverage

Medicare Drug Plan Costs

- Costs vary by plan
- In 2018, most people pay
  - A monthly premium
  - A yearly deductible
  - Copayments or coinsurance
  - 35 percent for covered brand-name drugs in coverage gap
  - 44 percent for covered generic drugs in coverage gap
  - Very little after spending $5,000 out of pocket

Standard Structure in 2018

Example: Ms. Smith joins the ABC Prescription Drug Plan. Her coverage was on January 1, 2018. She doesn't get Extra Help and uses her Medicare drug plan membership card when she buys prescriptions.

Monthly Premium–Ms. Smith pays a monthly premium throughout the year.

1. Yearly deductible	2. Copayment or coinsurance (what you pay at the pharmacy)	3. Coverage gap	4. Catastrophic coverage
Ms. Smith pays the first $405 of her drug costs before her plan starts to pay its share.	Ms. Smith pays a copayment, and her plan pays its share for each covered drug until their **combined** amount (plus the deductible) reaches $3,345.	Once Ms. Smith and her plan have spent $3,345 for covered drugs, she's in the coverage gap. In 2018, she pays 35 percent of the plan's cost for her covered brand-name prescription drugs and 44 percent of the plan's cost for covered generic drugs. What she pays (and the discount paid by the drug company) counts as out-of-pocket spending, and helps her get out of the coverage gap.	Once Ms. Smith has spent $5,000 out of pocket for the year, her coverage gap ends. Now she only pays a small coinsurance or copayment for each covered drug until the end of the year.

Part D Eligibility Requirements

- To be eligible to join a Prescription Drug Plan
  - You must have Medicare Part A and/or Part B
- To be eligible to join a Medicare Advantage Plan with drug coverage
  - You must have Part A and Part B
- You must live in plan's service area
  - You can't be incarcerated
  - You can't live outside the United States
- You must be enrolled in a plan to get drug coverage

Part D–Covered Drugs

- Prescription brand-name and generic drugs
  - Approved by the Food and Drug Administration
  - Used and sold in United States
  - Used for medically-accepted indications
- Includes drugs, biological products, and insulin
  - Supplies associated with injection of insulin
- Plans must cover range of drugs in each category
- Coverage and rules vary by plan

Understanding Medicare Resource Guide

Resources

Centers for Medicare & Medicaid Services (CMS)
1-800-MEDICARE
(1-800-633-4227)
1-877-486-2048 for TTY users
medicare.gov

cms.gov

Social Security
1-800-772-1213
1-800-325-0778 for TTY users
socialsecurity.gov/

Railroad Retirement Board
1-877-772-5772
1-312-751-4700 for TTY users
rrb.gov/

State Health Insurance Assistance Programs (SHIPs)
For telephone numbers call CMS
1-800-MEDICARE (1-800-633-4227)
1-877-486-2048 for TTY users

medicare.gov/caregivers/

healthcare.gov

benefits.gov

insurekidsnow.gov

Affordable Care Act
healthcare.gov/law/full/index.html

Medicare Products

"Medicare & You Handbook"
CMS Product No. 10050

"Your Medicare Benefits"
CMS Product No. 10116

"Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare"
CMS Product No. 02110

To access these products

View and order single copies at medicare.gov

Order multiple copies (partners only) at productordering.cms.hhs.gov. You must register your organization.

HIV 101

HIV Treatment as Prevention

Fall/Winter 2018

1) PrEP Assistance Program (PrEP-AP)
2) The Evidence for U=U

PrEP Assistance Program (PrEP-AP)

From SF HIV FOG Open Enrollment Boot Camp IV October 5, 2018

Courtney Mulhern-Person, MPH
Senior Director of Policy and Strategy SFAF

Pre-exposure prophylaxis (PrEP) Assistance Program (AP)

Pre-exposure prophylaxis (or PrEP) is when people at very high risk for HIV take HIV medicines daily to lower their chances of getting infected. PrEP can stop HIV from taking hold and spreading throughout the body.

It is highly effective for preventing HIV if used as prescribed, but it is much less effective when not taken consistently.

Daily PrEP reduces the risk of getting HIV from sex by more than 90%.
Among people who inject drugs, it reduces the risk by more than 70%.
Risk of getting HIV from sex can be even lower if PrEP is combined with condoms and other prevention methods.

Centers for Disease Control and Prevention
https://www.cdc.gov/hiv/basics/prep.html

Overview of PrEP- AP

- In 2016, the California HIV Alliance proposed the creation of a statewide PrEP Assistance Program (PrEP-AP)
- In 2018, the PrEP-AP was implemented in two phases, with Phase 1 prioritizing the uninsured population and Phase 2 expanding to cover insured individuals
- Phase 1 launched on April 9, 2018
- Phase 2 launched on June 14, 2018

PrEP-AP for Uninsured Clients

- For uninsured clients, the PrEP-AP will only provide assistance with PrEP-related medical costs, as PrEP medication is provided free by Gilead's PAP
  - An uninsured client is any individual who does not have health coverage
- PrEP-AP is the payer of last resort, so program funds may not be used when the costs can be paid through other sources (Medi-Cal, Family PACT, etc)
- Uninsured clients who are not eligible for Medi-Cal and are eligible for health insurance should obtain comprehensive health insurance, but not required
- Medi-Cal clients with a Share of Cost (SOC) are eligible for PrEP-AP medication benefits up to their SOC obligation

Eligibility and Covers Service

- Residents of California (including undocumented)
- HIV-negative (result dated within 6 months of application)
- At least 18 years old
- At or below 500% FPL MAGI (modified adjusted gross income), based on family size and household income - $60,700
- Not fully covered by Medi-Cal or other third party payers

- Enrolled in the Gilead PAP
- Medical visit
- HIV and STI testing
- Pregnancy testing
- Kidney function testing
- Screening for hepatitis A, B and/or C
- Medications on the PrEP-AP formulary for treating STIs
- Medications on the PrEP-AP formulary for PEP
- Immunizations

How to Enroll for PrEP-AP

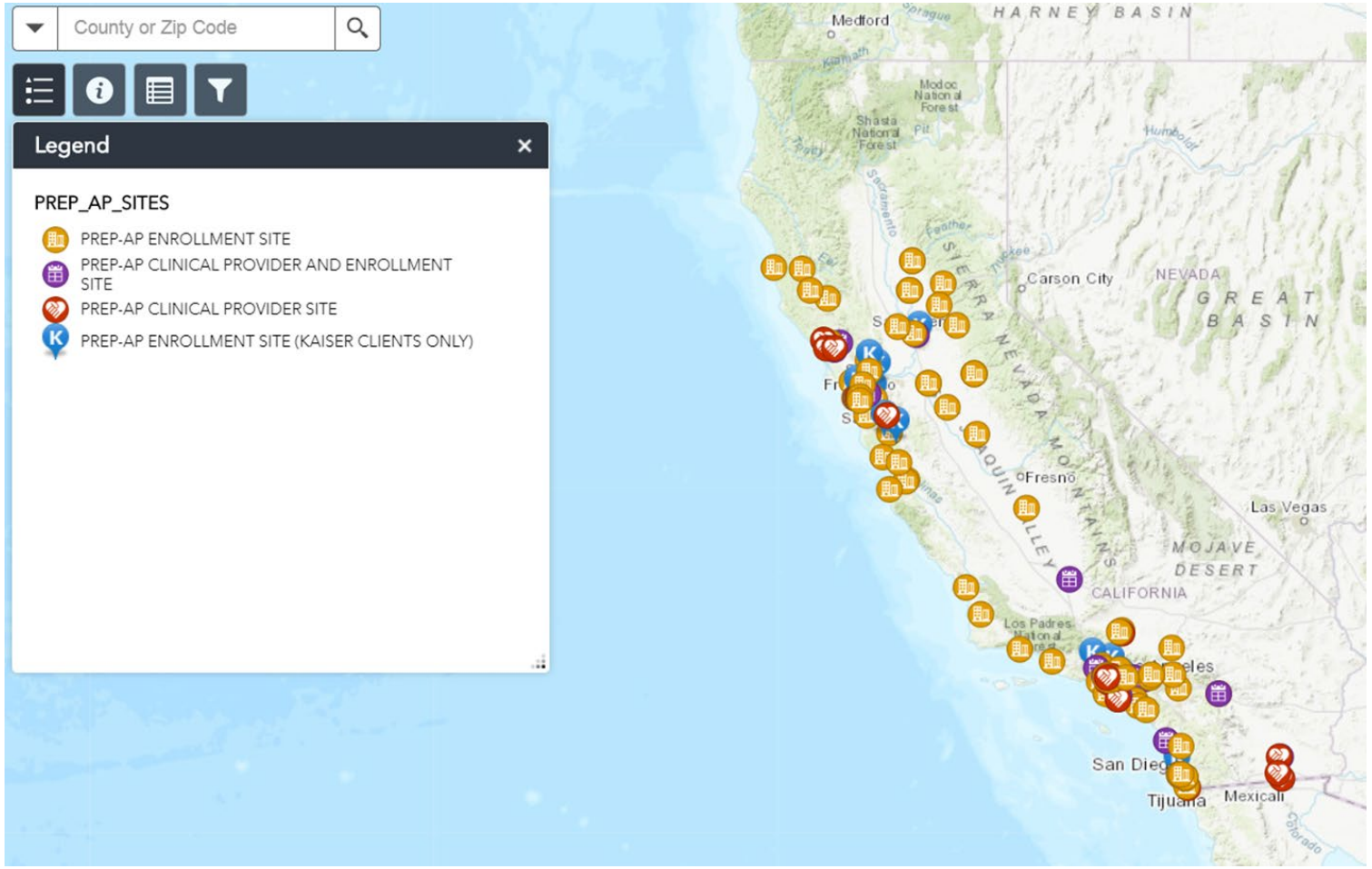
- Uninsured individuals must visit a local ADAP enrollment site to enroll

- To begin the enrollment process, clients must provide (and reenroll every 6 months):
  - Proof of residency
  - Identification
  - Income
- Enrollment workers will refer the client to a clinical provider within the PrEP-AP network
- Other documentation must also be provided:
  - PrEP-AP Provider Network Referral Form signed by a PrEP-AP provider
  - Gilead PAP application signed by a PrEP-AP provider
  - Proof of HIV-negative status

PrEP- AP for Insured Clients

- For clients with private insurance, the program will also cover drug costs not covered by the individual's health insurance plan or Gilead's copay assistance program
- Medicare clients with prescription drug coverage will receive copayment assistance for all medication on the PrEP-AP formulary
- Medicare clients without prescription drug coverage can enroll in the Gilead PAP, and the PrEP-AP will cover all other medications on the PrEP-AP formulary
- For clients with private insurance and Medicare, the program will cover PrEP-related medical out-of-pocket costs

PrEP-AP Enrollment Sites and Providers In San Francisco



PrEP-AP Resources

- Program Overview
  - https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAadap.aspx

- Resources Page
  - Client FAQ, client brochure, acceptable enrollment documents, provider locator
  - https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_adap_resources_prepAP.aspx

Next Steps for PrEP- AP

- Expanding eligibility to individuals at least 12 years old
- Covering full cost of medication for individuals ineligible for Gilead's PAP
- Not requiring use of Gilead's PAP if not accepted by health plan or pharmacy
- Allowing individuals on parent's or partner's health plan to be considered uninsured
- Covering starter packs for PrEP and PEP

The Evidence for U=U

From SF HIV FOG Open Enrollment Boot Camp IV October 5, 2018
Starting the Conversation on U=U

Matt Spinelli, MD Infectious Disease Fellow
Division of HIV, ID, and Global Medicine ZSFG/UCSF

Undetectable Equals Untransmittable Outline

- Review of the Science
  - What are the origins of U=U?
  - Prior to antiretroviral therapy (ART), how did we learn lower viral load = lower risk?
  - What supports starting ART to lower transmission risk?
  - What supports U=U in the real world?
  - What supports U=U in MSM?

- Frequently Asked Questions

What are the Origins of U=U?

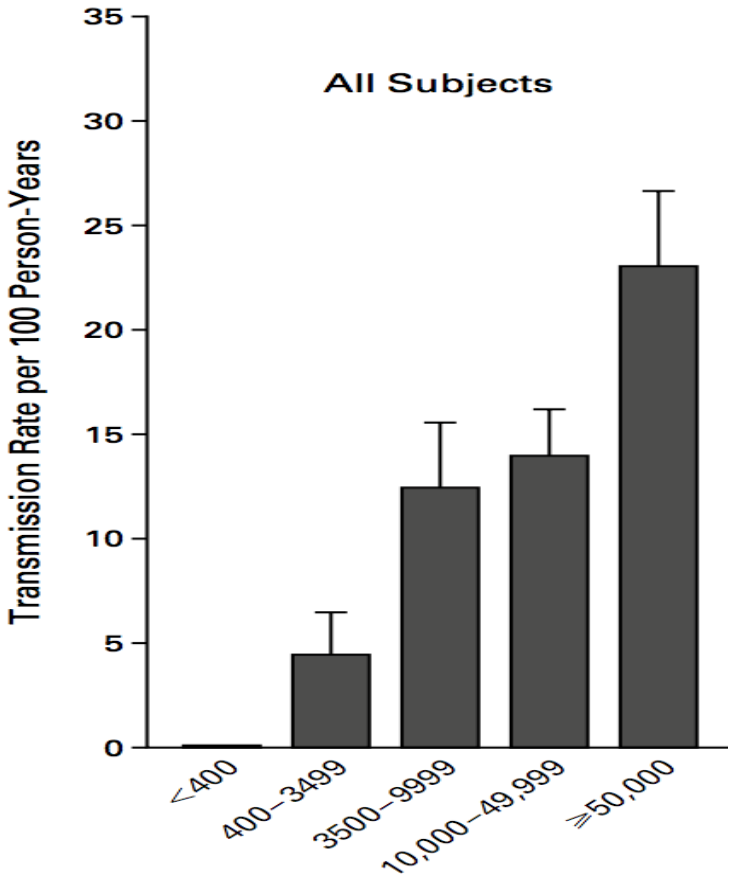
1998:
Studies of HIV transmission from mother to baby: 0 transmissions when on ART
Beckman et al (Int Conf AIDS 1998)

1998:
U.S. guidelines include "possibly decreasing transmission" as rationale for starting ART
DHHS guidelines 1998

2000:
Study of HIV transmission in sero-different partners in Uganda
Quinn et al 2000

2000: Without Antiretroviral Therapy No Transmissions When Viral Load <1500

- 415 couples in Uganda studied for up to 30 months
- Lower viral load, lower risk
- No transmissions when viral load was <1500



What Supports Starting Antiretroviral Therapy to Lower Risk?

2001- 2008: Swiss Commission Statement summarizing observational trials: "Suppressed does not transmit" (with caveats)

Vernazza et al 2008

2011: Large Randomized Trial: Starting Antiretroviral Therapy to Decrease HIV Infection (HPTN 052)

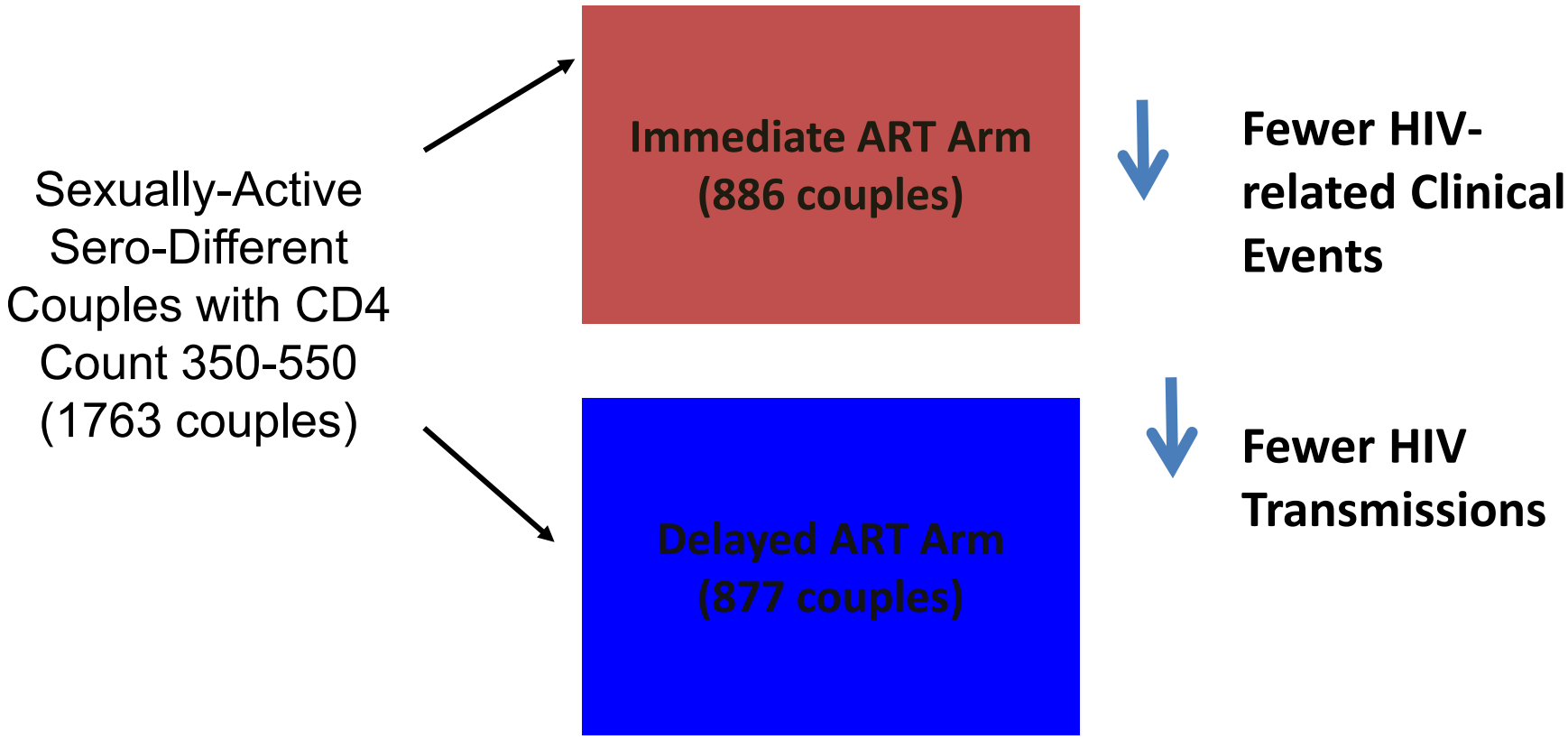
Cohen et al. NEJM 2011

2015: Final Analysis Of Same Trial (HPTN 052)

Cohen et al. IAS 2015

Cohen et al. NEJM 2016

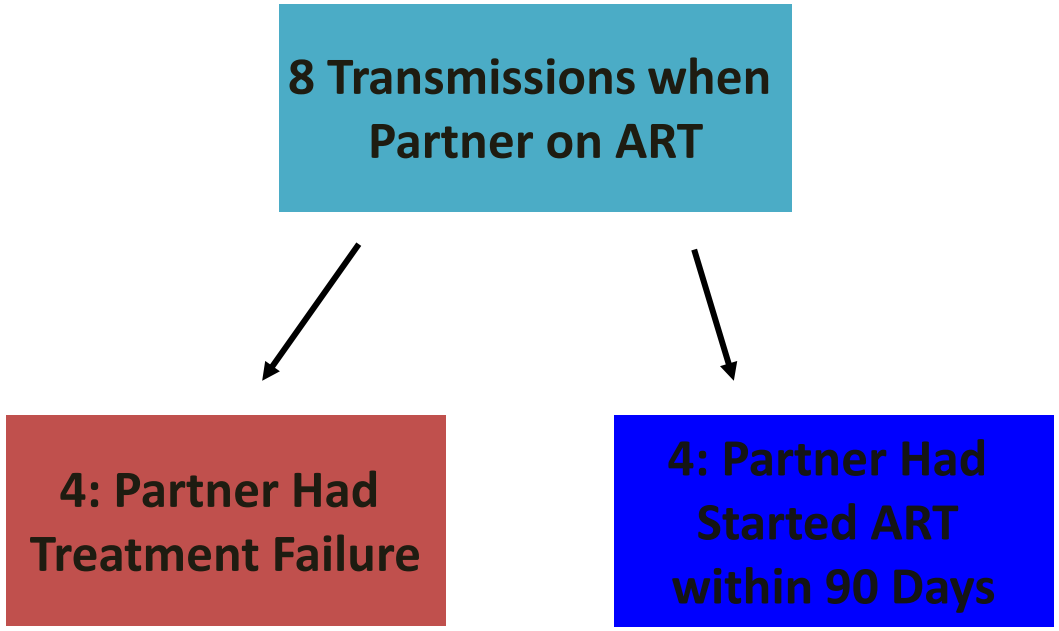
2011: Antiretroviral Therapy Decreases HIV Transmission in a Randomized Trial (HPTN 052)



Cohen MS, et al. NEJM 2011; 365:493-505.

2015: Final Analysis of HPTN 052-- No Transmissions If Undetectable

- 36% of transmissions occurred outside of partnership ("unlinked")
- No "linked" transmissions when partner on ART 3 months and virally suppressed
- Caveats: ~0 MSM, High Condom Use



Cohen MS, et al. IAS 2015
Cohen MS, et al. N Engl J Med. 2016;375:830-839.

What supports U=U in the real world?

Study	Population	Condomless Sex Acts	Transmissions within Partnership
PARTNER	888 couples, 38% MSM	58,000	**0**
Opposites Attract	343 couples, 100% MSM	17,000	**0**
PARTNER2	783 couples 100% MSM	77,000	**0**

Rodgers et al. JAMA 2016; 316: 171-81
Bavinton et al, Lancet HIV 2018; 5e 438-47

#UequalsU

- "**The science really does verify and validate U=U**."
  Anthony S. Fauci, M.D., Director, NIAID, NIH
  Speech at United States Conference on AIDS (September, 2017)

- **"People who take ART daily as prescribed and achieve and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV-negative partner."**
  CDC (September, 2017)

- **"It is time, to end the fears!" "I really think these community members who were active on U=U did a great job."**
  Pietro Vernazza, author of Swiss Commission Statement (November, 2017)

Anthony Fauci in 2008 said "there is no such thing as zero risk"
– TIME magazine

FAQ: U=U

- How long after starting antiretroviral therapy does U=U?
- What if you or a partner misses doses or stops therapy?
- What about sexually transmitted infections (STIs)?
- What about people with injection drug use?

How Long After Starting ART Is Safe?

No Infections After 6 Months in Partners-PrEP

Randomized, placebo-controlled trial in sero-different heterosexual partners with partner starting ART

- 3 infections in first six months vs. 0 after six months

6 Months May Be Conservative

- Older HIV Regimens

Mujugira, JAIDS 2016;72:579-84

What If I/My Partner Misses Doses Or Stops Antiretroviral Therapy (ART)?

- When do people become detectable off ART?
  - Risk increases significantly after one week (2x odds).
  - Can be as soon as 48hrs (Genberg et al. AIDS 2012)
    - Risk of transmission is still very low if only missing several days

- If you/partner stops for longer than several days:
  - Other prevention strategies remain available: PrEP, condoms
    - Continue until undetectable

What Do We Know about Sexually Transmitted Infections? Injection Drug Use ?

- Sexually Transmitted Infections:
  - No transmissions if undetectable (6-17% with STIs in PARTNER)

    (Rodgers et al. JAMA 2016; 316: 171-81)

- Injection Drug Use:
  - Limited data (only 2% with injection drug use in PARTNER)
  - PrEP is effective for prevention (Choopanya K. et al. Lancet 2013)

Health Insurance 101

Coverage for HIV Care & Treatment

Andy Scheer, LCSW

SFDPH / San Francisco City Clinic

Learning Objectives

I. Describe two ways that people obtain health insurance

II. Describe two cost-savings programs available to People Living with HIV (PLWH)

III. Explain how to triage common benefits problems to resolution

Health care coverage can be confusing!

Health care coverage can be *frustrating!*

Frontline Worker Role in HIV Health Benefits Continuity

What we do…

- **Educate clients & colleagues** about benefits options
- **Spot transition points** d/t changes in age, immigration status, income, household size, etc.
- **Spot benefits interruptions**
- **Triage benefits problems** to resolution
- **Stick with the patient**, managing anxieties and frustrations

How we do it…

- **Learn how the pieces fit** together & what programs are available
- **Understand how to get to the root** of the problem
- **Know who to call & what to ask** to resolve the problem
- **Explain the problem clearly** so it can be solved

HIV & the Affordable Care Act

Key Provisions of ACA Impacting PLWH

- No coverage denial for pre-existing conditions (e.g. HIV)
- Insurance Marketplace established (Covered CA)
- Medicaid Expansion established (Medi-Cal)
- Most “Lawfully Present” in the US required to have health insurance

Pre-ACA HIV Care+Tx Options

- Traditional Medi-Cal
- Medicare *(disabled and/or 65+)*
- Private insurance via employer
- Ryan White + ADAP safety net

Post-ACA HIV Care+Tx Options

- Traditional Medi-Cal
- Medicare *(disabled and/or 65+)*
- Private Insurance via employer
- Ryan White + ADAP safety net
- Medi-Cal Expansion
- Covered CA Marketplace
- OA-HIPP

Public Health Insurance

Medi-Cal

Full-scope, public health insurance covering medically necessary care.

- In-patient & out-patient care
- Mental health care
- Substance use treatment
- Prescription drugs
- Some vision & dental services
- Long-term care
  (*not included in Medi-Cal Expansion)*

This is not an exhaustive list of Medi-Cal benefits and programs

Medi-Cal Eligibility

Traditional Medi-Cal

- CA Resident
- Lawfully Present in US*
- Eligibility *usually* based on enrollment in another public assistance program *(e.g. CalWORKS, SSI, and many others)*
- Tip: Enrollees subject to "asset test" *($2k for single household)*

Medi-Cal Expansion

- CA Resident
- Lawfully Present in US*
- Age 19-64 years
- MAGI FPL138% or less, based on family size
- Tip: No "asset test" for MCE!

**Immigrants without "lawfully present" status qualify for limited scope Medi-Cal (in-patient hospitalization; aka "emergency Medi-Cal")*

Medi-Cal Expansion

aka “MAGI Medi-Cal”

Modified **A**djusted **G**ross **I**ncome

Tip: Google “UC Berkeley Labor Center MAGI”

Household Size	Annual 138% MAGI FPL	Monthly 138% MAGI FPL
1	$16,754	$1,397
2	$22,715	$1,893
3	$28,677	$2,390
4	$34,638	$2,887
5	$40,600	$3,384

Medi-Cal Managed Care

- **Required of all Medi-Cal only enrollees**
  Traditional or MCE; those without Medicare
- **Pts are defaulted into a Managed Care Plan if they don't pick one w/i 60 days of enrollment in Medi-Cal**
- **To enroll and/or make changes**
  Health Care Options (800) 430-4263
- **To change to another in-network provider**,
  call the managed care plan directly
  →SF Health Plan (415) 547-7818
  →Anthem BC (800) 407-4627

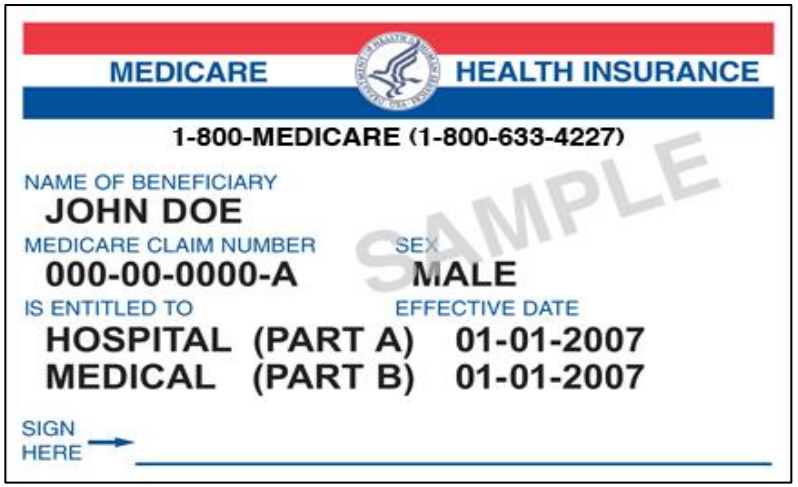
Medi-Cal, common issues

- Clients don't complete **annual re-enrollment**
- Clients don't **understand managed care plan** concept
- **Not enrolled in the right managed care plan** for their preferred clinic
- Auto-enrolled in the **wrong clinic/managed care plan**
- **Churning** in and out of eligibility (and clinics/providers)
- **Inter-county transfers**
  ex: from LA to San Francisco county

Medicare

Federal health insurance program

- In-patient/out-patient care
- Prescription coverage
- Mental health, substance use, and vision - limited



Eligibility

- 65 years and older
- If under 65 → deemed disabled or with certain other medical conditions
- 40 quarters work history (generally)

- Medicare.gov (Medicare Plan Finder)
- 1-800-Medicare
- Call Part D plan directly

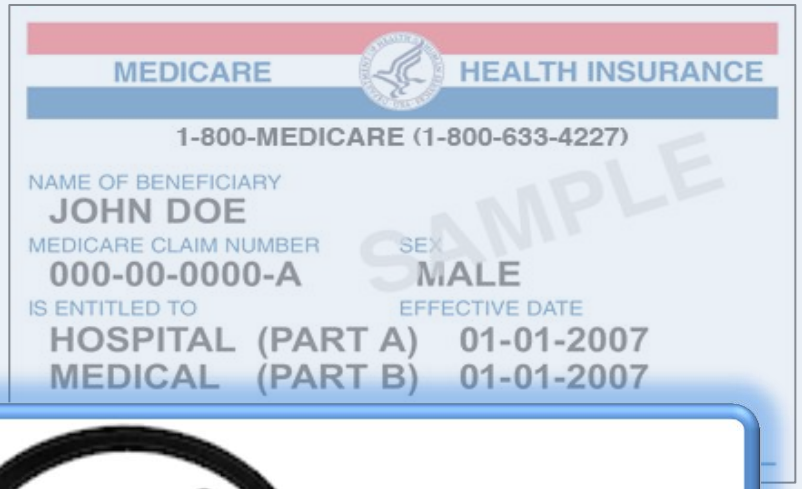
Coverage

80% of doctor's visits

Prescription costs change as you incur more drug costs.

Part A: hospitalization	→	no premium (usually)
Part B: ambulatory/outpatient, labs, ambulance, etc.	→	$109 or $134/monthly premium
Part C: Advantage plan / bundled services	→	premium depends on the plan
Part D: prescription drugs	→	premium depends on the plan

Medicare



Federal health insurance program

- In-patient/out-patient care
- Prescription coverage
- Mental health & substance use -
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80%

Pre as you incur more drug costs.

Part A: hospitalization → usually free

Part B: ambulatory/outpatient, labs, ambulance, etc. → usually $109 or $134/month

Part C: Advantage plan / bundled services → depends on the plan

Part D: prescription drugs → depends on the plan

Private Health Insurance

Private health insurance

Covers **all or part of the medical costs** for illnesses, injuries, and chronic medical conditions

- **Essential health benefits*** critical to
  - maintaining health
  - treating illness & accidents
- Protects from unexpected, high medical costs
- Pay less to see doctors within the insurance network
- Free or low cost preventive care
  e.g. vaccines, screenings, and some check-ups

**10, defined by the Affordable Care Act, if plan is compliant*

Private health insurance pays…

- How much, depends on the type of plan
- **Out-of-pocket costs** should be expected

Out of Pocket Costs can include

- **Premiums**: Monthly “membership” fee
- **Co-pays**: Usage fee each time service used (fixed $ amount)
- **Co-insurance**: Percentage of service fee (percentage; variable cost)
- **Deductibles**: Amount paid by the insured individual before the insurance plan starts to pay

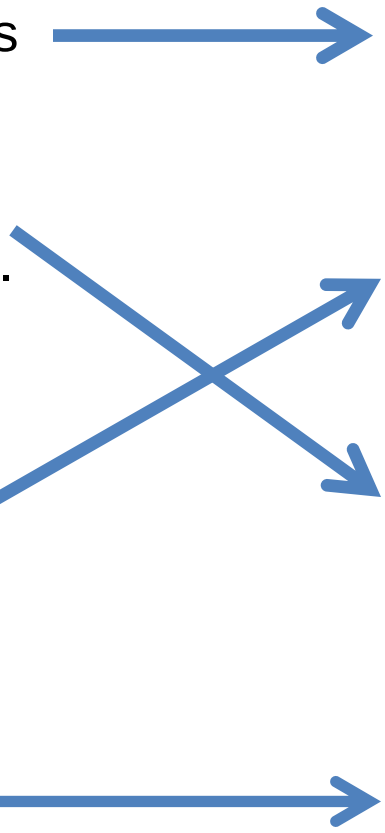
Insurance terms quiz!

Marla pays $20 each time she gets her labs done.

Joe underwent knee replacement surgery. The surgery cost $17,000. Joe paid $3,400 (20%) and his insurance paid the rest.

Stacey writes a check for $450 every month to her insurance company.

Marla used to pay $10 for primary care visits, but after her surgery, she didn't have to pay anything.



Co-pay

Premium

Co-Insurance

Deductible

How do people get coverage?

Created by Llisole
from Noun Project

UHC
UnitedHealthcare

COVERED CALIFORNIA

Buy directly from insurance company →

blue of california

Health Net®

KAISER PERMANENTE®

Covered California

CA marketplace for private health insurance

Where to Apply

- CoveredCA.com
- (800) 300-1506
- Certified Covered CA Enrollment Worker

Eligibility

- U.S. citizens
- Legal permanent residents & lawfully present individuals
- Households w/o Medicare or employer-sponsored health insurance (exceptions apply)

10 Essential Health Benefits

Ambulatory care; emergency care; in-patient; maternity & newborn; MH & SU; Rx; labs rehabilitative and habilitative services+devices; preventive & wellness services; pediatric services, including oral and vision care

Covered California plans in SF

blue california

KAISER PERMANENTE®

Health Net®

華人健保計劃 Chinese Community Health Plan CCHP

Covered CA financial assistance

Household Size	Up to 400% MAGI FPL	Over 400% MAGI FPL
1	$48,240	No APTC for people with income over 400% MAGI FPL
2	$64,690	
3	$81,680	
4	$98,400	
5	$115,120	

CA Office of AIDS

Cost savings programs for PLWH

ADAP

- **A**IDS **D**rug **A**ssistance **P**rogram
- **Managed by CA State Office of AIDS (OA)**
- **Administered by a Pharmacy Benefits Manager (PBM)**
  Magellan Rx, subcontracted by OA
- **Complements private insurance**
  pays ADAP formulary medication co-pays
- **Pays for full cost of drugs for uninsured**
  not enrolled in private insurance; undocumented clients
- **Ryan White-funded / payer-of-last-resort**

ADAP

General Eligibility Criteria

- **CA resident**
  immigration status not a bar
- **HIV+ w/ CD4 & VL results w/i last year**
- **18+ years of age**
- **MAGI FPL equal to or under 500%**
  based on household size
- **Rx from CA physician**
- **Do not qualify for insurance that pays 100% of medication costs**
  Med-Cal (Traditional or MCE); private

ADAP, common issues

- **Missed Re-certification**
  45-days before birthday
- **Missed completion of Self-Verification Form**
  6-months after birthday
- **Private Insurance or Medicare not aligned w/ ADAP**
  not in ADAP system
- **Client did not apply for Medi-Cal**
  before 30-day Temporary Access Period expires
- **Incomplete documentation**
  proof of income, Dx, residency
- **Can’t find an ADAP/HIPP EW**

OA-HIPP

- **O**ffice of **A**IDS **H**ealth **I**nsurance **P**remium **P**ayment
- Pays monthly health, dental, and vision insurance **premiums** and **out-of-pocket costs** for eligible clients, up to $1,938 monthly!
- Covered CA, COBRA, and other private insurance plans
- Covered CA enrollees must take 100% of APTC
  Ryan White-funded / payer-of-last-resort
- New program: EB-HIPP available to clients with employer-based insurance

OA-HIPP

General Eligibility Criteria

- **Enrolled in ADAP**
  all eligibility criteria met
- **Not enrolled in Medicare or Medi-Cal with no share of cost**
- **Enrolled in private health insurance with Rx drug coverage**

OA-HIPP, common issues

- **Missed Re-certification**
  45-days before birthday
- **Missed completion of Self-Verification Form**
  6-months after birthday
- **Did not do taxes**
  required w/ re-certs for most enrollees
- **Client unable to pay “binder payment”**,
  first month’s premium before HIPP starts making payments
- **Incomplete application documentation**
- **Client can’t find an ADAP/HIPP EW**

Common Profiles

Medicare

- **“Medi / Medi”**
  Traditional Medi-Cal + Medicare
  Client is disabled, income is SSI + SSDI
- **Medicare alone**
  Pt A, B & C
  Pt A, B and D
- **Working While Disabled (“250”)**
  Medi-Cal or Medi/Medi
  income under 250 FPL ($2,328 monthly)
  helps with access to IHSS

Common Profiles

Traditional Medi-Cal

- **SSI benefits alone**
  Ct is disabled with less than 40 quarters of work hx
- **SSI + SSDI but no Medicare**
  Ct is not yet eligible for Medicare; , e.g. in first two years of disability, not yet 65 year of age

Medi-Cal Expansion

- **Unemployment Insurance** is less than or equal to $1,367/month
- **Employment Income** less than or equal to $1,354/month
- **General Assistance + CalFresh + Medi-Cal Expansion**

Common Profiles

ADAP

- **Private Insurance + ADAP**
  COBRA, Employer-sponsored
- **No Insurance – Straight ADAP + RW Clinic**
  a bit more rare these days; not comprehensive health coverage
- **Healthy SF + ADAP**
  HSF is not insurance; only works in SF
- **Medicare + ADAP**
  + Pt D Premium Payment Program