Affordable Care Act Coverage and Benefits Guide for HIV Prevention CBOs

The **Affordable Care Act (ACA)** requires most U.S. citizens and residents to have health insurance. People living with HIV (PLWH) who were uninsured due to a pre-existing condition or for other reasons may now have access to expanded Medicaid options and low-cost insurance plans that can cover HIV and broader health care needs. HIV-negative individuals at higher risk of becoming infected may also benefit from expanded services required under the ACA. This guide is intended to help community-based organizations (CBOs) understand different coverage options, as well as address client questions and concerns about obtaining health coverage. The guide also includes links to additional resources that CBO staff may use to further assist their clients.

Health Care Coverage Options Available Under the ACA

MEDICAID EXPANSION

Currently, 27 states and the District of Columbia have decided to expand their Medicaid programs under the ACA.[1] Clients may qualify for Medicaid if they:

- Can verify U.S. citizenship or legal US residency
- Meet income thresholds based on size of household

Under the ACA, a client with an income at or below 138% of the federal poverty level (approximately $16,105) can qualify for Medicaid in states that have expanded their program. Qualified individuals can apply for and enroll in Medicaid programs at any point during the year. This change in Medicaid eligibility means that a number of clients who have received HIV care and treatment services through the Ryan White HIV/AIDS Program (RWHAP), may now qualify for health care coverage under Medicaid without having to have an AIDS diagnosis or be considered disabled.

In addition, some states are implementing Medicaid waivers to provide additional benefits to their enrollees.

[1] Information regarding state Medicaid expansions is current as of August 28, 2014. More information regarding status of state Medicaid expansions can be found at: http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

HELPFUL HINT

As a CBO working with clients, it is important to understand your state initiatives and any assistance that may be available, or know where to refer clients for additional support.

MARKETPLACES

Health Insurance Marketplaces in all states now enable eligible residents to purchase health insurance plans. Clients may enroll in these plans during federally-specified open enrollment periods. Marketplace plans have five categories or "metal levels" of coverage options. As the levels increase from bronze to platinum, the benefits (services) covered increase and thus deductibles and co-pays may decrease. However, premiums that clients must pay are also higher and so up-front out-of-pocket costs may be more significant. For someone with ongoing health needs, the long-term coverage may outweigh these upfront costs.

The five plan levels are:

- **Catastrophic** plans pay less than 60% of the total average cost of care
  These plans are available only to people who are under 30 years old or have been given a hardship exemption.
- **Bronze** plans pay ~ 60% of costs, individuals pay 40%
- **Silver** plans pay ~ 70% of costs, individuals pay 30%
- **Gold** plans pay ~ 80% of costs, individuals pay 20%
- **Platinum** plans pay ~ 90% of costs, individuals pay 10%

HELPFUL HINT

Plan selection may be of particular importance to PLWH clients, as their need for regular access to specialty providers and medications will likely justify the selection of plans in higher cost levels that will cover more expenses over time.

ESSENTIAL HEALTH BENEFITS

All plan levels must offer essential health benefits (EHBs), which are minimum requirements for all plans in the Marketplace. Some prescriptions (including antiretroviral therapy (ART) and other HIV-related medications) and lab services may be covered under EHBs. EHBs are also intended to increase access to preventive services, including HIV testing. Under the ACA, routine HIV testing is available to everyone between the ages of 15 to 65 (as well as people of other ages who have increased risk) with no additional out-of-pocket costs. Routine testing will increase the number of individuals who are aware of their HIV status and aid in linking those who are HIV-positive with essential treatment and care. Engagement in HIV care and treatment can lead to improved health outcomes and lower HIV viral load, thus helping prevent HIV transmission.

There are several resources available to help eligible clients meet their out-of-pocket insurance costs. For example, RWHAP and AIDS Drug Assistance Programs (ADAP) in many states provide assistance for insurance premiums and co-payment costs. To be eligible for this assistance, PLWH may have to, at minimum, select a plan at the Silver level. In addition to resources available through RWHAP/ADAP, PLWH will also have continued access to co-payment assistance programs (CAPs) operated by pharmaceutical companies to help insured PLWH with out-of-pocket medication costs.

RECOMMENDED RESOURCE

The NASTAD Treatment Factsheet: Pharmaceutical Company Co-payment Assistance Programs provides information about CAPs and a list pharmaceutical companies providing assistance with medication costs. See *Resources* section.

DEFINITIONS

Co-pay: A co-payment is a fixed amount a client pays for some health care services. A co-pay is usually paid when a client receives the service. The amount may change for different types of care. For example, a client might pay $15 when they go in for a doctor's visit and $30 when they go to the emergency room.

Deductible: People with health insurance may have to pay for a portion of their health care services. The deductible is the amount that a client may have to pay for health care services before the health insurance plan begins to pay. For example, if a client's deductible is $500, their plan won't pay anything until they have paid $500 for health care services covered by their health plan. After that, their health insurance plan will pay for services and they will pay a co-pay for each visit.

Essential Health Benefits are the 10 types of health services that must be covered by health insurance plans starting in 2014, including:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care.

Out-of-Pocket Costs (OOP): Clients with health insurance may have to pay for part of their health care services. They must pay for health care costs that aren't paid by the insurance plan "out of their own pocket." Out-of-pocket costs include:

- Deductibles
- Coinsurance
- Co-payments for covered services
- All other costs for any services the insurance plan doesn't cover

Premium: The amount a client pays for a health insurance plan. A premium may be paid every month, every three months, or every year. Part or all of a client's premium may be paid by their employer, ADAP, or someone else.

Subsidy: Money that is paid usually by government to keep the price of a product or service low or to help a business or organization to continue to function.

Source: ACE TA Center Plain Language Glossary – See Resources section.

CAPs have also been established to assist high-risk HIV-negative clients with costs associated with pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) medications. These CDC-supported services are shown to be successful in helping prevent someone who may be or has been exposed to HIV from becoming infected. Additional federal subsidies may also be available for state Marketplace plans. These subsidies are generally offered to people with incomes between 100% and 400% of the federal poverty level.

RECOMMENDED RESOURCE

The following ACE TA Center resources can assist CBOs with enrolling PLWH clients in health coverage:

- Health Care Plan Selection Worksheet
- Plain Language Quick Reference Giude for Health Care Enrollment
- Eligibility Decision Tree

See *Resources* section.

OTHER COVERAGE OPTIONS

Employer Coverage – Some employers may now be providing insurance to employees for the first time under new ACA requirements. By 2015, all employers with over 100 full-time or full-time equivalent employees must provide affordable health insurance to those employees and their dependents. Those that choose not to provide coverage will have to pay a penalty. All clients should be encouraged to identify coverage options that are or will be available as part of their employment, as should their spouses/domestic partners.

Parental Coverage – In some instances, individuals under the age of 26 may qualify to be added to or kept on their parent's insurance. Those under 26 can be enrolled in available plans during open enrollment periods. Parental coverage ends for individuals once they reach the age of 26. At that point, they may be eligible for coverage under Medicaid or one of the Marketplace plans. Launched in 2014, "Born in '88" (see Resources section) is a federally-funded campaign to promote coverage options for those no longer eligible to be covered under parental insurance.

Client Concerns

Continuity of Care – When enrolling in Medicaid or selecting insurance plans in the Marketplace, clients are likely to prefer plans that include their existing health care providers and pharmacies. While maintaining access to a client's existing providers and facilities may be an option, clients should be informed that some providers may not be in all plan networks, or they may be in networks that will come with greater costs than a client is willing or able to meet.

If a client chooses a plan that will require him/her to select a new health care provider and to seek care at unfamiliar facilities, organizations should help the client identify key considerations for selecting a new provider. For PLWH and high-risk HIV negative clients, this may include expertise in HIV and related care, treatment, and prevention services; experience serving diverse populations; and the cultural expertise and competency to address population-specific needs and issues.

Disclosure of status/Denial of coverage –PLWH may be concerned that by discussing Medicaid or insurance, they will have to disclose their HIV status. They may be hesitant to engage in discussions based on prior negative experiences of being denied or losing coverage. Under ACA, no person can be denied or dropped from insurance coverage because of a pre-existing condition, including HIV. Staff should ensure that measures are in place to protect a client's confidentiality and privacy during insurance discussions.

RECOMMENDED RESOURCE

The ACE Discussion Guide can prepare CBO staff for their conversations with clients about enrolling in health insurance. See *Resources section*.

Legal status – Enrollment in either Medicaid or a Marketplace insurance plan is limited to U.S. citizens or individuals with legal U.S. residence. Information about mixed-status families (i.e., some members are citizens or legal residents and others are undocumented) cannot be used to deny coverage to qualified applicants. Enrollment information about mixed-status families cannot be used for deportation or shared with the U.S. Immigration and Customs Enforcement, and can only be referred to in special circumstances when individuals are in the process of applying for legal residence.

Resources

The following resources contain guidelines, information, and tools that can be used to help clients at your organization navigate the insurance enrollment process. While many of these resources are specific to general patient navigation and enrollment, some address issues specifically for PLWH, high-risk HIV-negative clients, and other groups with whom your organization may work.

ACE TA Center – The ACE TA Center helps Ryan White HIV/AIDs Program grantees and providers enroll diverse clients, especially people of color, in health insurance and build providers' cultural competence. Many of the tools referenced in this factsheet and additional resource can be found on the ACE TA Center website: targethiv.org/ace.

- **ACE Discussion Guide:** to prepare CBO staff for their conversations with clients about enrolling in health insurance: careacttarget.org/library/common-questions-and-suggested-responses-engaging-clients-health-coverage
- **ACE Plain Language Quick Reference Guide for Health Care Enrollment:** to support conversations with clients: careacttarget.org/library/plain-language-quick-reference-guide-health-care-enrollment
- **ACE Health Care Plan Selection Worksheet:** a tool for listing a client's health and medication needs, health care providers, and plan options to help choose a plan: careacttarget.org/library/health-care-plan-selection-worksheet
- **ACE Eligibility Decision Tree:** tool tol help decide if a client should enroll in the Marketplace, with Medicaid, or neither and see how ADAP fits with other coverage: careacttarget.org/library/eligibility-decision-tree

AIDS.gov – Federally sponsored resource site that provides information on how ACA is intended to benefit PLWH: aids.gov/federal-resources/policies/health-care-reform/

Born in '88 – A federally-funded campaign to promote coverage options for those no longer eligible to be covered under parental insurance and includes resources on how to go about getting insurance: www.getcoveredamerica.org/born-88/

HealthCare.gov – This federal website is the primary hub of information for individuals, families, and small businesses about insurance marketplace enrollment. Information about ACA rights and protections, EHBs, and official responses to immigration concerns can be found on this site. Clients ready for Marketplace enrollment will need to create an account and can begin enrollment procedures during the open enrollment period.

Kaiser Family Foundation Subsidy Calculator – This tool can be used to help clients estimate the amount in tax credits that could be used to help with payment of selected marketplace plans. The calculator allows clients to enter information about their state and zip code, and find out if they may be eligible for Medicaid. www.kff.org/interactive/subsidy-calculator/

NASTAD Treatment Fact Sheet: Pharmaceutical Company Co-payment Assistance Programs – Basic information about CAPs and pharmaceutical companies providing assistance, along with their contact information and specific medications supported. nastad.org

NASTAD Fact Sheet: Pharmaceutical Company Patient Assistance Programs and Co-payment Assistance Programs for Pre-exposure Prophylaxis (PrEP) and Post-exposure Prophylaxis (PEP) – Information regarding PrEP and PEP, along with information for pharmaceutical companies that support these programs. nastad.org

Strong Families Movement – This guide provides information and a list of questions that may be important for lesbian, gay, bisexual, and transgender individuals and their families to consider when selecting a plan for enrollment. www.strongfamiliesmovement.org/assets/docs/where-to-start-what-to-ask.pdf

WE>AIDS: Find Your State – Greater than AIDS, a resource site for PLWH, provides information related to the ACA and the convergence of Medicaid, Marketplaces, and private insurance specific to each state, the District of Columbia, and Puerto Rico. www.greaterthan.org/campaign/obamacare/#find-your-state

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CBA@JSI offers assistance to community-based organizations that provide HIV prevention services in the U.S. and its territories to navigate ACA enrollment, and establish billing systems. Learn more about how JSI can help your organization at www.cba.jsi.com.