Article

Article Title:	Pre Existing Condition Insurance Plans (PCIP)		
Domain	General Information	Subject:	Covered California Essentials
Topic:	Affordable Care Act	Subtopic:	Market Reform

Introduction *1 or 2 paragraphs that can be used to set context or be used as talking points*

If you have a chronic condition, such as diabetes or heart disease, or are currently undergoing treatment for a serious illness such as cancer, you should choose a health plan very carefully to make sure you understand if your plan options will let you keep the same doctors and medications.. Consumers with current and ongoing care needs will need help determining:

1) What their potential out of pocket costs might be under each of the plan options available including the various metal tiers, benefit designs, and cost of out of network or second tier hospital providers;
2) Whether their current doctors, hospitals or other facilities are "in-network" for the different plan options; and
3) Whether their current medications are covered by the plan or whether they would need special authorization to continue with their current medications. If you have a chronic condition, you may be able to continue with your current medication if it is the only one you can tolerate and thus, is medically necessary for you.

Many consumers in this category will favor a plan that allows them to continue with their current doctors, current medications, and will allow them to predict and minimize their likely out-of-pocket costs. Choosing the right plan requires deciding whether an HMO, PPO or EPO type of plan will work best for them and their family. The choice between HMO , PPO or EPO plan types should account for different cost-sharing designs, different doctor and hospital networks, including hospital tiers, and different access requirements. For example, HMOs typically require approval by your primary care doctor before you can see a specialist. Keep in mind that all l Covered California health plans are required to cover the Essential Health Benefits, provide quality care and meet applicable regulatory standards for network adequacy.

Key Points *3-5 bullet points*

- Look at all available health plans in your zip code. **HMO** plans require that you sign up with a specific primary care doctor who is coordinates your care, including finding specialists when you need one. **PPO** plans tend to have higher premiums but offer larger networks with more doctors and potentially more choice. PPOs include coverage of out of network benefits although it can be very limited and may have higher out of pocket costs. **EPO** plans are like PPOs but do not cover out of network benefits and may have more limited networks**. HMO** plans do not cover out of network services that are not emergencies. Some **PPO** plans tier hospital networks and higher tier hospitals generally have higher out of pocket costs.
- Find out which plan networks have your preferred doctors and hospitals. If no plan has your preferred doctor, you may need help changing doctors and your current doctor might be able to help you choose a plan with specialists you need. Not every plan has all doctors. If staying with a specific doctor or hospital is important to you, make sure you know what plan includes that doctor or hospital.

Article

Key Points *3-5 bullet points*

- Consider what metal tier plan would work best for you. Bronze and catastrophic plans have lower monthly premiums but higher out of pocket costs which may mean consumers who use more medical care may pay more in the end. Catastrophic plans are generally only available to people under age 30(with some exceptions). If you expect to see the doctor often, expect to use a hospital or surgery center or take multiple medications, you might be better off with a higher metal tier plan -- such as silver or gold, or even platinum. Premiums are higher in gold or platinum plans, but out of pocket costs for higher users of medical care are lower so that the total amount you pay may be less. For each of the plans you are considering, review the premium cost and use the *Covered California Use of Services estimator* to see what your total cost of care would be. This estimator includes premium and out of pocket costs you may pay when you visit the doctor or use a facility for care. There is an annual maximum out of pocket you will be required to pay before your health plan will pick up 100% of your additional medical costs. This maximum varies by metal tier (bronze, silver, gold or platinum) and health plan, but is limited to $6350 per individual for 2014.
- Consumers with lower incomes may be able to enroll in "enhanced silver "plans. These plans have both lower premiums and much lower out of pocket costs, deductibles and out of pocket maximums. The enhanced silver plans will always be better plans for consumers who qualify to enroll in them.

Consumers with chronic conditions or complex conditions often take several medications. Many will prefer to keep taking the same medications. Check the list of medications that the plan covers- called the drug formulary- to see if the medications you are taking now are covered by plans you are looking at. Even if one or more of the medications is not on a plan's formulary, if there is not another medication that works for you, the plan must cover an alternative if it's medically necessary. However, every plan has its own process for deciding this.

Details *Elaborate key points*

While the law requires every plan to cover the same Essential Health Benefits and provide all medically necessary care including specialty care as well as provide care for consumers regardless of their current health condition or illness, plans do vary quite a bit in how they arrange for care. Plans have different networks of doctors and hospitals (though there is overlap among networks too) , differences in medications on a plan formularies and even some differences in the prior authorization and referral requirements for seeing a specialist. These factors should be evaluated by a consumer as they choose a plan. There may be trade-offs that need to be made between these and other factors. For example, if a consumer wants to continue to see a particular doctor or got to a particular hospital, it will be important to check the plan's network. Or, if a consumer is taking a medication that's not on the plan's formulary, find out the plan requirements to approve an exception for medical necessity for a non-formulary drug. Some consumers may need to select a new doctor in order to choose a plan with lower premium and out of pocket costs. In some cases the consumer's current doctor will assist their patient to find a new doctor who can meet their care needs.

Plans have different types of cost-sharing. Some plans emphasize co-payments which are a fixed dollar amount and others have co-insurance, which is a percent of the plan's negotiated rate. Higher metal tier plans charge more premium but have lower overall out of pocket costs. Lower metal tier plans have lower premiums but higher out of pocket costs depending on how much medical care you end up actually using.

Article

Scenarios *2-5 scenarios*

Scenario 1: *Steve is a 35 year old male with stable HIV disease. He is currently seen by a physician who has taken care of him for five years and is taking three medications regularly to keep his disease in check. Steve is a free-lance writer and is hoping to get more affordable coverage through Covered California , but is worried he will not be able to keep his physician or may not have all his medications covered.*

Steve begins the enrollment process about 4 weeks ahead of when he wants to switch coverage. He finds his doctor is available in one of the health plans available in his area but the premium is about 10% higher than the least expensive plan. Further, the simulation tool suggests a silver plan is best based on his anticipated use of care, which will mean that he can anticipate paying some out of pocket costs. He isn't sure if the medicines he is on will be available. Fortunately he has some time to figure this out.

What Steve should do next:

1. Steve should contact the plan customer service representative and ask if the plan covers his medications for the exact Covered California plan that includes his doctor. If his medications aren't available, ask them to identify specifically the alternative medications that are available and what his out of pocket cost would be.
   Steve finds that two of his three medications are available, but the third medication is only available through an approval process. An alternative medication is suggested.

2. Next, Steve should contact his doctor and explain he wants to stay with him and that the option available to do that is through the specific plan identified. Also, Steve should explain that two of his three current medications are available, but the third is not. He should ask his doctor whether the alternative medication suggested is a reasonable substitute in this specific situation and if not, whether his doctor would be willing to seek approval on an exception basis for his current medication.

   Steve's physician is glad he can continue to provide care and says he will provide the information to the plan supporting the need for Steve to stay on all his current medications. His physician will stress that Steve had a serious side effect when he previously took the alternative medication suggested the plan.

Finally, Steve should determine the total estimated cost of selecting that plan and compare it to what he is currently spending. Steve should call his current insurance carrier to see if his current plan will continue to be offered in the marketplace or not and if so, at what price. This will enable Steve to compare his current coverage and benefits with the new Covered California plan. If Steve is satisfied with his current carrier, he should confirm that he can enroll in a Covered California plan offered by his carrier. He should consider both the monthly premium less any subsidy he is eligible for on the Exchange and the estimated out of pocket cost using the cost estimator, up to the plan's maximum out of pocket requirement. If the Covered California plan costs less than what Steve would pay to continue his current coverage, there is better value in selecting a plan offered by Covered California.

Scenario 2: *Kathy is a 48 year old with rheumatoid arthritis who now requires a biologic therapy be*

Scenarios *2-5 scenarios*

added to her regular medications to prevent further destruction of her joints. She has been seeing the same rheumatologist for 15 years and previously had coverage through her ex-husband's insurance. Now she is living alone, works at local floral shop and needs to get her own insurance. She does not qualify for Medi-Cal based on her income, but has learned she is eligible for a premium subsidy if she purchases coverage in Covered California.

Unfortunately her rheumatologist is not available through any of the plans s currently offered. She does determine that given the high frequency of her medical visits and her chronic medications, it would be best to enroll in a gold plan despite the higher premiums.

1. Kathy will need to consider whether or not to switch physicians, despite her long standing relationship. It may be best for her to continue with her current physician despite the potential added expense of purchasing coverage outside the Exchange where no subsidy is available. Kathy could also see if she could stay with her current doctor under the law's continuity of care requirements. This requires calling the Covered California plan and inquiring about their requirements for obtaining approval of use of the continuity of care provision to stay with her current doctor.
2. Kathy should next discuss her situation with her current physician and seek his/her input. If it is agreed that she needs to transition to a new physician, she should ask her physician to help select and inform her new care team. It is also critical that a formal transition plan be implemented that includes input from her current physician and specifically addresses her need for the biologic therapy.
3. Before switching, Kathy should ask her physician for recommendations of physicians in order to see if they might be available in a plan offered through Covered California and then review the provider directory offered by Covered California
4. Kathy then needs to assess which health plans include one or more of the new physicians of interest. She also needs to contact each plan customer service representative and ask about the availability of her medication for the prospective Covered California plans which includes the potential new physician and which she is considering. She needs to make sure that her potential new physician can accept her into his or her practice.

FAQs *Frequently asked Questions and Answers. This will be used for a variety of different uses including Certification Exam Questions, Marketing/Communications, etc.*

Supporting Materials *Please include the title and all relevant links to Scripting; step action table; charts/visuals; helpful hints; flowcharts; publications or materials. (The majority of Covered California developed materials should be stored in SharePoint)*

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Helping the Consumer Choose the Right Plan (powerpoint)

Bibliography/Reference Material *(Links and citations to law/regs; advocates' material; CovCA formal background)*
Federal Register/ Vol. 78, No. 37 / Monday, February 25, 2013 / Rules and Regulations State Essential Health Benefit laws and regulations

Key Words (*Top Search words to find article)*