HIV *and* Insurance

Your Legal Rights

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This is one in a series of booklets published by the AIDS LEGAL COUNCIL OF CHICAGO. All are designed to help you understand YOUR LEGAL RIGHTS in Illinois. The booklets in this series are:

HIV and Confidentiality

HIV and Discrimination

HIV and Insurance

HIV and Public Benefits

HIV and Undocumented Immigrants

HIV in the Workplace

HIV: Issues for Families with Children

HIV: Issues for Youth and Young Adults

HIV: Returning to Work

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This guide is intended as an overview of HIV-related Illinois and federal law. As with any legal matter, it is always a good idea to consult an attorney concerning the particular circumstances of your case.

HIV and Insurance

INTRODUCTION

People may have told you that because you're HIV positive, you'll never get health insurance. The good news is that that's just not true anymore. You have the same right to get insurance as anyone else—and at the same rates. Health care reform (sometimes called "ObamaCare") has made a huge difference for people with HIV. This booklet will tell you more.

If you have more questions about insurance after you're done reading, you can call the AIDS LEGAL COUNCIL OF CHICAGO at **(312) 427.8990**. Someone there will be happy to speak with you.

Chapter One

APPLYING FOR INSURANCE

1) Is it better to get individual health insurance or group health insurance?

It doesn't make much difference, which is a good thing since you probably don't have much choice either way. Because of health care reform everyone is now required to have insurance. That can be through a public program like Medicare, Medicaid, or the VA. It can be through your employer. Or it can be an individual policy. But all insurance plans must meet the same standards and cover the same "essential benefits." That doesn't mean all plans are the same, of course. This booklet will help you know what to look for in choosing an insurance plan and some tips on using it once you have it.

2) Can I get insurance from my employer?

That depends. A company is not required to offer insurance to its employees. So if your company does not offer insurance to anyone, you cannot force it to do so. But if your employer does offer insurance to all employees, then you must be offered the insurance as well. See Chapter Two for more information on getting insurance from your employer.

3) Can I call an insurance company and buy an individual health insurance policy?

Yes, as long as you're in the "open enrollment period" for buying an individual plan. In 2014, the open enrollment period went from October 2013 through March 2014 because this was the first time people had a chance to buy individual policies that were covered by health care reform. But after the end of March 2014, the open enrollment period will be between November 15th and January 15th. There are special enrollment periods for people in certain circumstances,

but for most people it will be important to enroll or switch plans during the open enrollment period.

4) Is there any way I can get life insurance?

One of the most common ways people with HIV get life insurance is through work. If your employer offers life insurance as a benefit, then you should be able to get that policy like all the other employees.

Buying a private life insurance policy might be difficult. Almost all insurance companies refuse to sell life insurance to people with HIV. They ask your HIV status on their application forms (even the ones that advertise "just answer a few short health questions"), and if you lie and say you don't have HIV, they won't pay your beneficiary when you die. Many companies even now test people for HIV.

The other possibility is to buy one or more small "guaranteed issue" plans. These policies are available to anyone, but don't pay out anything if you die within the first two years after you buy the policy. **However, even if you can get a life insurance policy, it is important for you to read the policy carefully. Many policies refuse to pay death benefits if the cause of death is from a pre-existing condition.** In other words, if you die from something you have when you get the policy, the insurance company won't pay your beneficiary anything after you die. Check the policy carefully for a pre-existing condition clause before you buy.

Chapter Two
THE HEALTH INSURANCE MANDATE

1) Why is there a rule that everyone has to have health insurance?

Insurance only works if lots of people buy it. You buy auto insurance in case you have an accident. If you have a house you buy fire insurance in case you have a fire. Many people with insurance will never use it, or won't use it very much. But that means the money is there for the people who need to use it a lot. If a thousand people spend $500 a year on fire insurance, and only one of them has a fire, that means there will be enough money in the pool to cover that one person who has the fire. That's why you sometimes hear the term "insurance pool" because everyone is pooling their money together. So the requirement that everyone have health insurance keeps the premiums low enough for people to afford while still making sure there will be enough money in the pool to pay for people with expensive illnesses.

2) Are there any people who don't have to buy health insurance?

Yes. Anyone who already has health insurance doesn't have to buy more. This includes anyone on Medicaid, or Medicare, or insurance they get through work. You also don't have to buy health insurance if your income is so low you don't have to file a tax return, or if the cheapest insurance you can buy would still cost more than 8% of your income. There's also no penalty if you don't go more than three months without insurance, or if you're incarcerated, or if you're not legally in the U.S.

There are some more exceptions for people in crisis situations like domestic violence, homelessness, or bankruptcy. The AIDS Legal Council strongly

believes that everyone with HIV should have health insurance, but if you missed the deadline and are worried about a penalty, feel free to call for advice about your individual situation.

3) What is the penalty for not buying health insurance?

For the first year, it's 1% of your income or $95, whichever is higher. So if your income is $20,000, your penalty would be $200. The penalties go up each year. In 2016 it will be $695 or 2.5% of your income, whichever is higher.

4) How is the penalty collected?

It's added on to the tax you owe when you file your income tax return at the end of the year.

Chapter Three

GETTING INSURANCE AT YOUR JOB

1) Does every employer offer insurance?

Some do and some don't. In 2015 companies with more than 100 employees have to offer health insurance to their full-time employees. In 2016 that rule will apply to companies with more than 50 employees. Companies with fewer than 50 full-time employees don't have to provide health insurance. A full-time employee is someone working 30 hours per week or more.

2) Can my company deny me coverage because I'm HIV positive?

No. If your company provides insurance to its employees, then every employee eligible for insurance must be accepted onto the policy. If you are eligible for insurance, then you cannot be denied coverage.

3) If I get insurance at a new job, will the policy pay for my HIV– related expenses?

Yes. Your policy has to cover your HIV-related expenses even if you already had HIV when you started working for the company.

4) I have to fill out an insurance form for my employer that asks me questions about my health. What do I say?

These questions should go away soon, since it doesn't make any difference whether or not you have HIV, but if you are asked one, here are your answers.

If you work for a smaller company, then your employer is probably giving you a standard form called the "Illinois Standard Health Employee Application for Small Employers." If you look at Section F of that form, it tells you to talk to your employer if you prefer to submit the application directly to the insurance company or insurance broker. You can just say "I'd rather submit this directly like it says in Section F. Can you tell me how to do that?"

If you work for a very large company (say over 1000 employees), you should be okay, because they probably have other employees with serious health problems and their Human Relations Department probably knows the rules about keeping medical information confidential. But if you have any doubts, or you work for a smaller company, here are three ways that you might handle this.

- Put a big circle around the whole section that lists all the health conditions and write "various pre-existing conditions – full details available from my doctor" and give the doctor's name and phone number. Sign a form at your doctor's office that it's okay to tell the insurance company about your HIV, but not your employer.
- Tell your employer "I know I'll be in trouble if I leave anything out on this form so I'm just going to take it to my doctor's office and have them fill it in. My doctor is a nut about privacy, though, and he'll want to fax it directly to the insurance company. Could you give me their fax number?" Then, whether or not you give it to your doctor, fax the completed form to the insurance company yourself with a note that they must not share the information with your employer (which they already should know).
- Call the insurance company yourself and tell them your situation. Tell them you are going to fill out two forms – one for them with all the truthful answers, and one for your employer that leaves out your HIV and anything else you might be worried about disclosing (for example, mental illness). Get their fax number. Then tell your employer you need an extra form because you messed up on the first one. Fax the form with the true information to the insurance company. Turn the other one in to your employer.

5) My employer offers several different plans. How do I chose between them?

This is an important decision. There are two things that are most important—the cost of the plan and the network of doctors who are in the plan. Your employer will tell you how much the plan will cost you from each paycheck, but that's not the only cost you need to figure out. Here are some other important terms you need to know to understand the cost of any plan.

- "Deductible." This is the amount you have to pay each year before your insurance starts covering your costs. Your deductible can be as low as $100, or as high as $6500.
- "Co-pay." This is a certain amount you pay for each doctor visit or prescription. For example a policy might say that the co-pay for a doctor's office visit is $20, but $75 for an emergency room visit.
- "Co-insurance." This is like a co-pay, but it's a percentage instead of a fixed amount. Your insurance might say that you pay 20% co-insurance for any hospital stay. That means the insurance will pay 80% of the bill, but you have to pay the other 20%.
- "Out-of-pocket Maximum." This is the most you have to pay in one year for your deductible, co-pays, and co-insurance combined. After you reach your out-of-pocket maximum, all your expenses are covered 100%

Here's an example of how this all works. Policy number one has a $500 deductible, a $20 co-pay for doctor's visits, and 80% co-insurance for hospital stays. The out-of-pocket maximum is $2000. In January you visit your doctor and she charges you $75. Because you haven't met your deductible, you pay the whole $75. Then at the end of the month you go to the hospital and the bill is $12000. You would have to pay the remaining $425 of your deductible, and 20% of the rest. But that would be a total of $2740, which would put you above your out-of-pocket maximum. So you'd really only have to pay $1925 for the hospital stay, since that plus the $75 you paid for your first doctor visit puts you at your $2000 annual out-of-pocket maximum. After that, all of your medical expenses for the rest of the year would be covered at 100%.

Policy number two has a $2000 deductible plus the same co-pays and co-insurance but with an out-of-pocket maximum of $3000. You have the same $75 doctor visit, but a shorter hospital stay that only costs $6000. You would pay the remaining $425 of your deductible, plus 20% of the rest. That comes to a total of $1115 plus the $425. You'd have to pay all of that--$1540--because you haven't reached your out-of-pocket maximum yet. But you have met your deductible, so the next time you go to the doctor you'll only pay the $20 co-pay. When your share of expenses adds up to $3000, then your expenses for the rest of the year will be covered 100%.

6) My employer offers an HMO that is much cheaper than the other alternatives. Should I sign up for it?

This is where that other important issue, the network, comes into play. If you chose an HMO, you will only be able to go to doctors and hospitals that are in the network of that HMO. If you see a doctor or go to a hospital outside the network you will have to pay all of the cost yourself. So the first thing you'll have to check is whether your regular doctors are in the HMO network. If they are, then check to see if the hospital you prefer to go to is also in the HMO. If it is, then maybe the HMO is a good choice for you. But there is one other thing to consider, and that is that usually an HMO won't let you see a specialist unless you get a referral from your primary care doctor. That may be what you do now, anyway. But if you're in the habit of choosing your own dermatologist, or foot doctor, then you might not be comfortable with having to first have a referral for every specialist visit.

Checking out the network isn't important just for HMO plans, though. Usually the alternative to an HMO is a PPO—Preferred Provider Organization. With a PPO you can see a provider who is not in the network, but it will usually be more expensive. For example, there might be 20% co-insurance if you use a hospital in the PPO network, but 30% co-insurance if you use one that's not in the network. You won't need a referral to see a specialist, but you'll pay more if you choose one not in the network. So you still need to check to see if your preferred doctors, specialists, and hospitals are in the network before you chose that plan.

7) I'm most worried about the cost of my HIV drugs in the insurance plans my employer offers. How do I deal with that?

The first thing is to check the maximum co-pays or co-insurance for medications. There's a good chance that's how much you will have to pay for your HIV medications. If one plan has a maximum medication co-pay of $50 per prescription, and another has a 20% co-insurance charge and you know your HIV medications cost $2000 a month (which would mean that your share of the cost would be $400 a month), then you probably want to pick the first plan instead of the second.

Another thing to check is whether you can fill your prescriptions at the ADAP pharmacy. If you can, and your income is under 500% of the federal poverty level (about $4,800 per month), then you don't have to worry about the co-pays or co-insurance because ADAP will pay those for you. Many insurance plans let you use the ADAP pharmacy, but some plans use a pharmacy benefit manager called Medco, and often those plans won't let you use the ADAP pharmacy. If you want to figure out if your plan will let you use the ADAP pharmacy, you'll have to start by calling ADAP at 1 800 and then follow their instructions. You may have to call the plan itself, but ADAP will tell you the right questions to ask.

Chapter Four

BUYING AN INDIVIDUAL INSURANCE PLAN

1) I've seen a lot of ads for the health insurance marketplace — can anyone go on there and buy insurance?

No. Although many people with HIV will go to the new on-line health insurance marketplace — called healthcare.gov or getcoveredillinois.gov — to get their insurance, it is only for people who don't have other health insurance. So you can't use it if you already have Medicare, Medicaid, or affordable insurance from your employer. You also can't buy insurance on the health insurance marketplace if you are undocumented.

2) Does that mean if my employer's insurance is too expensive I can forget it and buy on the marketplace instead?

The insurance from your employer is considered "affordable" if it costs less than 9.5% of your pay. So if you make $2000 per month, you have to stick with the insurance from your employer unless your share of the premium is more than $190 a month.

3) I've seen a lot in the news about how hard it is to use the websites, and I'm not comfortable with computers anyway. Is there any other way I can apply?

Yes. You can call and get help applying The Illinois number is 1- 866 311-1119. You will be connected with someone in your area who can help you apply. Any insurance broker can also help you. Alternatively, you can call the federal number, 1-800-318-2596, and complete your application over the phone.

4) How much does an individual policy cost?

There are four different levels of policies—bronze, silver, gold, and platinum—running from least to most expensive. The costs will vary depending on where you live, how old you are, and whether or not you smoke. But they will not be any higher because you have HIV or any other health conditions. More importantly, there are three programs that will help with the costs associated with individual plans and should make them affordable for you. Here are the three programs:

- **Federal subsidies**

  These are actually tax credits that help pay the cost of your insurance premium. They can be paid directly to the insurance company each month to lower the amount you have to pay. The amount of the subsidy varies with your income, but as long as your income is less than 400% of the federal poverty level ($46,680 in 2014) you will get some subsidy. You can use your subsidy to buy any plan on the marketplace.

- **Federal cost-sharing**

  This helps with co-pays and deductibles that you would otherwise have to pay in an individual plan. You are eligible for help with cost-sharing if your income is less than 250% of the federal poverty level ($29,175 in 2014). To get this subsidy you must chose a Silver level plan.

- **ADAP/CHIC**

  People with HIV with incomes up to 500% of the federal poverty level ($58,350 in 2014) can get two kinds of help from the Illinois Department of Public Health. The CHIC program will pay the entire premium for almost any plan and the ADAP program will pay all the cost-sharing for HIV and related prescriptions. To get this help, though, you must buy a plan that coordinates with ADAP. You can find information about what plans coordinate with ADAP on the HIV Care Connect website, http://www.hivcareconnect.com/ .

5) I'm confused about HMOs and PPOs and I don't understand all this business about deductibles and co-pays.

All of the information in the previous question about choosing an employer-sponsored plan applies to choosing an individual plan as well. You need to be sure your providers are in the plan's network and you have to figure out what the true costs are—not just the cost of the premium. For example, the premium for a bronze plan will always be cheaper than the premium for a silver or gold plan. But the silver and gold plans will cover more and if you have HIV you probably will end up saving money by buying the higher level plan. That's one reason that the ADAP and CHIC programs require you to buy a silver level plan or above.

There's another important thing to know if you are going to be getting help from ADAP and CHIC. The amount that ADAP and CHIC pay for your medications will help cover your deductible and help move you quickly to your out-of-pocket maximum. So you might not have to worry too much about how to meet your deductible or pay the co-insurance for your HIV medications.

Chapter Five

MAINTAINING INSURANCE

1) I have great insurance at work, but I don't like my job very much. I would love to look for a new job, but I'm afraid I'll never be able to get insurance again. Am I stuck in this job forever?

No. Remember two things:

1. Insurance companies and employers aren't allowed to discriminate against people with HIV. They can't refuse to sell insurance, or charge more, because of your HIV status.
2. If you lose your job and don't have money to buy insurance, you may be able to qualify for Medicaid, which will be free.

Even though normally you can only buy insurance on the new marketplace during the open enrollment people, there are special enrollment periods for people who have lost their other insurance or had big changes in their income. In addition, you can sign up for Medicaid at any time. So if you switch jobs, or lose your job, it shouldn't mean that won't have health insurance.

2) I have insurance through work. If I'm fired or if I quit, is there any way I can keep that insurance policy instead of buying a new one?

Yes. A federal law called **COBRA** allows most employees to continue their health insurance after they leave their job. **COBRA only applies to companies with 20 or more employees. It does not apply to religious organizations or the federal government.**

So if you work for a company that has 20 or more employees and you leave your job, you have a right to continue your health insurance. COBRA covers you whether you leave your job voluntarily, you are laid off, or you are fired. The only time COBRA doesn't cover you is if you are fired for gross misconduct.

3) What are my rights under COBRA?

COBRA says that you can continue your health insurance for at least 18 months after you leave your job. In most cases, you will have to pay the full premium.

If you are disabled according to Social Security when you elect COBRA, or if you become disabled within 60 days of electing COBRA, then you can get an 11-month extension of COBRA, so you can continue your insurance for 29 months. If you are found eligible for Social Security while you are on COBRA, you must tell your former employer immediately so that you can get the extra months of COBRA coverage. If your spouse or children are eligible for COBRA, they can continue the insurance for 36 months.

The coverage that you get must be *identical* to the coverage you had while working. COBRA gives you the right to continue your health insurance but *not* life insurance or disability insurance.

4) How do I sign up for COBRA?

If you are eligible for COBRA, your employer is required by law to offer it to you. If your employer forgets to give you a COBRA application, you could bring a lawsuit against him. However, that lawsuit might takes years to get through the courts, and you wouldn't have any insurance during that time. Therefore, it is always a good idea to request a COBRA application when you're leaving your job.

5) How expensive is COBRA?

COBRA can be very expensive, because instead of just paying your part of the premium, when you're on COBRA you pay the entire cost. So if the insurance company charged your employer $500 a month, but you only paid $100 a month, you'll have to start paying the entire $500 per month. But the good news is that in most cases, the ADAP/CHIC program will pay the premium for you. So if you'd rather keep that insurance, it's worth finding out if ADAP/CHIC will pay it.