SENIOR HEALTH NEWS

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Independence Blue Cross Drops Medicare Plans for Low-Income Beneficiaries

The Philadelphia region's largest health insurer, Independence Blue Cross (IBC), announced plans to drop three health plans for older adults and people with disabilities that make up its Keystone 65 Medicare Advantage Plans. Almost 40,000 Medicare beneficiaries currently enrolled in these plans will lose their coverage on December 31,2009 and will need to make new choices about how to receive their Medicare benefits in 2010.

Medicare Advantage plans provide, through managed care networks, services covered by Medicare Parts A, B (and often Part D) and may offer some additional benefits such as dental care, fitness reimbursement, preventive care and wellness programs. The three IBC plans being terminated (Keystone 65 Complete, Keystone 65 Value Medical Only, and Keystone 65 Value Rx) principally affect low-income Medicare beneficiaries. IBC says it can no longer afford the programs citing "unprecedented" funding cutbacks regionally and nationally for Medicare Advantage plans and increased medical costs.

Keystone 65 Complete is a Medicare Special Needs Plan with no monthly premium that only enrolls low-income consumers who have both Medicare and full Medical Assistance (known as “dual eligibles”). *Keystone 65 Value Medical Only* is a zero premium Medicare Advantage plan that covers medical services but does not provide prescription drug (Medicare Part D) coverage. *Keystone 65 Value Rx* covers medical services and provides Medicare Part D prescription coverage. Enrollees in Keystone 65 Value Rx currently pay a monthly premium of $23.90; however, individuals in this plan who qualify for the full low-income subsidy have no premium as the subsidy covers the premium in full. There are 19,870 members in Keystone 65 Complete and 18,800 members in the Value Medical Only and the Value Rx plans combined.

IBC already sent cancellation notices to members enrolled in these three plans. A final notification letter will then be sent in October explaining in more detail the Medicare coverage options available. Plan changes will need to be made by the end of the year to ensure coverage is in place on January 1, 2010.

The dual eligibles, those having both Medicare and Medical Assistance coverage, enrolled in the Keystone 65 Complete plan, must decide whether to join another Medicare Advantage Special

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Needs Plan available in their area or go back to original Medicare (using their red, white and blue Medicare card) and enroll in one of the zero premium, stand-alone prescription drug plans.

Those enrolled in one of the two Keystone 65 Value plans have the following choices:

- enroll into another Medicare Advantage plan with or without Medicare Part D coverage (note that individuals who do not have other creditable prescription coverage such as PACE/ PACENET should enroll in a plan with drug coverage);
- go back to original Medicare (using their red, white and blue Medicare card), buy a Medigap (Medicare Supplement) policy, and enroll into a stand-alone prescription drug plan (PDP); or
- go back to original Medicare and just enroll into a stand-alone prescription drug plan (PDP). Please note that those who choose this option who do not have secondary insurance (i.e., Medical Assistance) will then only have basic Medicare Part A and B coverage for their medical services and will have to pay significant deductibles and co-pays for their Medicare-covered services.

Before making any enrollment decisions for 2010, all affected Keystone 65 members should wait until they receive a "Medicare & You 2010" Handbook in the fall to learn about their plan choices (both Medicare Advantage plans as well as stand-alone Part D plans). The Handbook will also have information about each plan's premiums, deductibles and co-pays in 2010. **Those enrolled in one of the 3 plans being terminated by IBC need to choose coverage they can afford and that will best meet their needs. New enrollments must be done by December 31st to ensure continuing coverage in January 2010.**

Persons enrolled in one of the 3 affected plans who are dual eligible or have the Medicare Low Income Subsidy (LIS) and who fail to act by the end of the year will be automatically changed to original Medicare and randomly assigned to a stand-alone, zero premium Part D plan. Persons who are <u>not</u> dual eligibles, do <u>not</u> have LIS**,** and who fail to act by the end of the year will also be changed to original Medicare but they <u>will not</u> be assigned to a Part D plan and will find themselves without Medicare prescription coverage. Approximately two-thirds of the members in the Keystone 65 Value plans do not have the LIS and will need to take action before the end of the year to make sure they continue to have drug coverage next year.

Stay tuned to future editions of the *Senior Health News* for more information as we follow this issue. If you have questions about IBC's plan terminations or need help understanding the process for enrolling into a new plan by 12/31/2009, please call APPRISE at 1-800-783-7067, PHLP's Helpline at 1-800-274-3258 (1-866-236-6310/TTY), or Medicare at 1-800-633-4227 (1-877-486-2048/TTY).

Help PHLP Reduce Reliance on Institutional Care: Send Us Your Stories About Consumer Struggles to Become Financially Eligible for Home & Community Based Waiver Services

Individuals at risk of being placed in long-term care institutions such as nursing facilities or intermediate care facilities would prefer receiving services that allow them to live in their homes and communities. Home and Community Based Services (HCBS) Waiver programs (such as the Aging Waiver, Attendant Care Waiver, AIDS Waiver, and Consolidated Waiver) provide alternatives to institutional care. The HCBS waiver programs in Pennsylvania recognize that many individuals at risk of being placed in institutions can be cared for in their homes and communities, preserving their independence and ties to family and friends, at a lower cost to the state than institutional care. However, many people who need the long term living services that HCBS Waiver programs offer and who prefer in-home services do not qualify because their income is over the state's income limit for these programs.

To be financially eligible for a HCBS Waiver program, one's monthly income has to be below $2,022 (for 2009). Just like in other Medical Assistance (Medicaid) programs, individuals whose monthly income are above the waiver limit can use medical bills and medical expenses to spend-down their excess income in order to qualify for the program. However, instead of spending excess income down to the waiver program income limit of $2,022 each month, a consumer seeking entry in an HCBS waiver program has to spend-down their countable income to $701 each month. Faced with the prospect of diverting so much of their income to meet this monthly spend-down, consumers rarely qualify for a waiver using a spend-down because they cannot meet their normal living expenses. Too many Medicaid-eligible people, consequently, have no option but to leave their communities to receive long term care services in a more expensive and less preferred institutional setting.

To reduce the long-term care system's reliance on institutional care, PHLP, along with other advocates, is trying to change this policy. Individuals whose incomes are too high to qualify for waiver services should be able to spend-down their excess income to the waiver program income limit of $2,022 a month rather than the current $701 spend-down limit noted above. PHLP is interested in hearing from consumers (as well as family members and professionals who work with consumers) who would benefit from such a change in policy. Individuals are encouraged to contact PHLP's HELPLINE at 1-800-274-3258 to discuss this further.

Integrated Care Initiative: Consumer Feedback Still Encouraged

Throughout August, the Office of Long Term Living (OLTL) has held listening sessions across the state to hear from consumers about various aspects of its Integrated Care Initiative (ICI) set to start July 1, 2010 for individuals age 60 and older who have both Medicare and Medical Assistance. To date, hundreds of consumers have attended the sessions to give their input, ask questions, and raise concerns. Several common themes have emerged:

- Consumers are against passive enrollment into Integrated Care Plans and prefer to choose enrollment rather than have the choice made for them;
- Consumers are interested in care coordination and want to know more. They also raised concerns about turnover of care coordinators and caseload size;
- Consumers are concerned about their out-of-pocket costs under this program; and
- Consumers think an Independent Enrollment Broker, that is responsible for enrollment activities, would be helpful.

The last scheduled listening session is a call-in session and will be held Monday, August 31, 2009 from 9 am to noon. People can dial in by calling 1-800-706-7745 and using Passcode: 341-064-31.

Consumers unable to attend any of the listening sessions can still submit their comments, questions, and concerns by e-mailing: RA-IntegratedCareComments@state.pa.us or calling 1-877-591-6826. OLTL hasn't given a deadline for comments, but they have scheduled meetings in mid-September to review consumer input so it would be best to submit comments before then.

PA Suicide Prevention Conference To Address Issues Related to the Older Adult Population

Pennsylvania's Office of Mental Health and Substance Abuses Services, Department of Health and Office of Long Term Living are co-sponsoring the third annual Suicide Prevention Conference. The two-day conference titled, "Suicide Prevention: Creating Healthy Communities" is scheduled for September 15th & 16th at the Ramada Conference Center in State College, PA. The target audience for the conference includes social workers, behavioral health providers, nurses, advocates, law enforcement, faith based community leaders, older adult care staff, survivors of suicide and their family members, as well as the general population.

Conference workshops will address issues specific to the older adult population. On September 15th, an afternoon workshop includes, "Assessment of Bipolar Disorder in Older Adults". On September 16th, workshops include, "Whole Population Approaches to Suicide Prevention in Older Adults: Focus on Health Promotion and Risk Reduction" in the morning and "Promoting Suicide Prevention in Older Adults" in the afternoon.

For more information on the conference and to register contact Debra Thompson at Debra.Thompson@Drexelmed.edu at Drexel University or call 215-831-6946.

Update on Efforts to Establish a New State Department of Aging and Long Term Living

In the April Senior Health News, we reported on legislation introduced in the Pennsylvania House of Representatives (House Bill 1152) to establish a new state agency, the Department of Aging and Long Term Living (ALTL). This new agency would merge the Department of Aging and the Office of Long Term Living (currently a dual deputate sitting under both the Department of Aging and the Department of Public Welfare) to create a single department responsible for the administration and oversight of long-term care programs available to older adults and persons with disabilities. The programs that would come under ALTL's jurisdiction include Medicaid coverage of nursing home care as well as many of the Medicaid Home and Community Based Services Waiver programs. (See our February 2009 SHN and April 2009 SHN for basic information about the proposed merger).

As of the publication of this newsletter, HB 1152 passed the House and has been referred to the Senate's Committee on Aging and Youth. Another proposal to establish the Department of Aging and Long Term Living (Senate Bill 927) was introduced and referred to the Senate Committee on Aging and Youth at the beginning of June but no further Senate action has been taken. Among the concerns raised to date about the proposed legislation are the allocation of resources to the Area Agencies on Aging and how lottery funds will be used.

If a law is passed, then a Memorandum of Understanding (MOU) between the new ALTL and the Department of Public Welfare will be developed and shared for comments. This MOU will outline how the administration and oversight of Medicaid programs will be handled between the two agencies since DPW will remain the single Medicaid state agency and continue to be ultimately responsible for how all Medicaid programs operate. State officials expect the MOU would take 3-6 months to develop (once legislation has passed). Given that budgetary issues must be resolved, legislation authorizing the creation of the new Department must pass, and an MOU needs to be developed, shared for comments, and then finalized, the creation of ALTL is not expected to happen before the middle of 2010.

We'll continue to keep you posted about developments in future newsletters. To view HB 1152 and SB 927, go to www.legis.state.pa.us.

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Legislation Proposed to Expand Medicaid Estate Recovery

House Bill 1351 was introduced in recent months by State Representative Dwight Evans and remains in the House Health and Human Services Committee. This proposed legislation expands the state's Medicaid estate recovery program-specifically, expanding the types of Medicaid services for which the state can seek recovery from a recipient's estate, as well as expanding the types of assets from which the state can seek recovery of Medicaid costs. See the Department of Public Welfare's website (www.dpw.state.pa.us) and our December 2008 Senior Health News for basic information about the estate recovery program.

Currently, the estate recovery program only allows the state to recover Medicaid funds spent on recipients age 55 and older receiving Medicaid covered nursing home care or home and community based waiver services. Under the proposed legislation, however, the state could attempt to recover funds spent for all Medicaid services provided to a recipient age 55 and older. The current estate recovery program also only permits the state to recover funds from the person's probate estate (if any). The proposed legislation, however, allows the state to recover funds from non-probate assets. This means that certain real and personal property that is not part of someone's estate and that is now excluded from the state's recovery efforts can be pursued.

For example, if a Medicaid recipient owns a house in joint tenancy with another individual and the Medicaid recipient dies, the other individual is then considered the sole owner and the house is not part of the deceased recipient's estate. Under the current law, the state cannot seek to recover funds against the house as it is not part of the deceased recipient's estate. Under the proposed legislation, however, the state would be permitted to recover against the house as the law allows the state to recover against probate **and non-probate** assets.

The Consumer Subcommittee of Pennsylvania's Medical Assistance Advisory Committee opposes the proposed expansion of estate recovery rules for at least two reasons. First, estate recovery already scares consumers and prevents them from applying for the help they need. A more aggressive program will make the problem worse. At a time when the state is trying to rebalance its long-term care system by encouraging the elderly and persons with disabilities to use home and community based services, creating a more aggressive estate recovery program will drive people away from Medicaid until they have to rely on more expensive nursing home care. Moreover, the savings resulting from the expansion of estate recovery is relatively small ($2 million) compared to the administrative burden it presents the state.

We will keep you posted about this issue in future newsletters. To view HB 1351, go to www.legis.state.pa.us.

Third Circuit Allows Civil Rights Lawsuit Against County Nursing Home

The Third Circuit U.S. Court of Appeals recently paved new ground in allowing the daughter of a nursing home resident who died because of neglect and malnourishment to bring a civil rights lawsuit against an Allegheny County-run nursing home under the Federal Nursing Home Reform Amendments to the Medicaid Act.

The central question before the Court in *Grammar v. John J. Kane Regional Centers* was whether the Nursing Home Reform Amendments give Medicaid recipients federal rights that can be enforced by individual lawsuits under 42 U.S.C. § 1983. (Section 1983 is a federal statute that allows a cause of action to enforce federal rights against state actors.) In a split decision, the Court in *Grammar* held that, in passing the Amendments, "Congress did use rights-creating language sufficient to unambiguously confer individually enforceable rights."

Among the "clearly delineated" and "mandatory" rights created by the Nursing Home Reform Amendments and conferred to Medicaid recipients in nursing homes include "the right to choose their personal attending physicians, to be fully informed about and to participate in care and treatment, to be free from physical or mental abuse, to voice grievances and to enjoy privacy and confidentiality." Nursing homes are also required, under the law, to "care for residents in a manner promoting quality of life, provide services and activities to maintain the highest practicable physical, mental and psychosocial well-being of residents, and conduct comprehensive assessments of their functional abilities."

The Reform Amendments created standards of care and resident rights that apply to all nursing homes participating in Medicaid and Medicare. However, nursing home residents can only use Section 1983 to sue to enforce those rights if they are residing in a nursing home acting "under color of state law," such as the county-operated facility in *Grammar*. Residents of private nursing homes cannot use Section 1983 and must instead depend on the certification and compliance measures taken by the federal Department of Health and Human Services or their state Medicaid agency to remedy violations of the Nursing Home Reform Amendments.

Please support PHLP by making a donation through the United Way of Southeastern PA. Go to www.uwsepa.org and select Donor Choice number 10277.

Proposed Legislation Threatens Safety of PCH Residents Receiving Hospice Services

House Bill 1893, recently introduced and referred to the House Aging and Older Adult Services Committee, would allow personal care homes not to evacuate their residents who receive hospice services during required monthly fire drills. Currently, personal care home regulations require facilities to conduct unannounced monthly fire drills and to evacuate all residents to a safe place. Fire drills are necessary to prevent loss of life by having both residents and staff practice the procedures to follow in the event of a real fire.

The Coalition for Personal Care Home Reform, a group of advocates (including PHLP) who work on behalf of personal care home residents, recently sent a letter voicing opposition to HB 1893 to Representative Phyllis Mundy who chairs the House Aging and Older Adult Services Committee. Almost 3,000 personal care home residents receive hospice services. Unlike nursing homes and hospitals, personal care homes do not have a certification that allows residents to remain safely in their rooms in the event of a fire.

Since fire drills prepare staff and residents for what to do in the event of a real fire, failing to practice with these most medically fragile residents makes it unimaginable that staff could actually safely evacuate residents receiving hospice care should a fire occur. Between January and June of this year, there were 19 fires in Personal Care Homes across the state. Anyone interested in reading HB 1893 can go to www.legis.state.pa.us.

Pennsylvania Health Law Project
The Corn Exchange
123 Chestnut St., Suite 400
Philadelphia, PA 19106