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Feds Approve Gov. Corbett's Healthy PA Expansion: Understanding the New Landscape Ahead

On August 28th the Centers for Medicare & Medicaid Services (CMS) approved Governor Corbett's Healthy PA demonstration, making Pennsylvania the 27th state to expand Medicaid under the Affordable Care Act. The terms and conditions governing Pennsylvania's approach are detailed in a 40-page [document](#).

As summarized in the table below, many of the most controversial Medicaid "waivers" Governor Corbett requested were **not** approved by the federal government. New eligibles refers to individuals who are newly eligible under the expansion group.

PA Request	Status Following Waiver Approval
Impose premiums	Approved in part. Monthly premiums of up to 2 percent of income are allowed beginning in 2016 for certain recipients.
Recipient Lock out for nonpayment of premiums	Denied. Recipients may have their coverage terminated for nonpayment of premiums after a 90 days grace period, but must be allowed to reapply immediately.
Impose work search requirements/ incentives for new and existing recipients	Denied. Medicaid funds cannot be used to incentivize work. DPW will set up a state-funded "Encouraging Employment" program in 2016 to allow participants to reduce their Medicaid cost sharing through certain work activities.
Eliminate MAWD	Retracted. DPW announced in July 2014 that it will preserve the Medical Assistance for Workers with Disabilities (MAWD) program.

Pennsylvania Request	Status Following Waiver Approval
No retroactive coverage for new eligibles	Denied. New eligibles can receive up to three months of retroactive coverage to pay recently incurred medical bills.
Delay coverage for new eligibles	Denied. New eligibles will enroll as of the date of application.
No medical transportation for new eligibles	Approved in part. Non-emergency medical transportation is waived in 2015, but must be provided to new eligibles beginning in 2016.
No Medicaid appeal rights for new eligibles	Denied. New eligibles will be entitled to participate in DPW’s hearings and appeals process for eligibility or service denial disputes.
Restrict choice of family planning provider	Denied.
Reduce benefits for current adult recipients	Pending. DPW and CMS are negotiating State Plan Amendments to alter the benefit packages for current adult Medicaid recipients.

Who will be newly eligible in January 2015?

Low-income adults will be newly eligible for Medicaid coverage through a Private Coverage Option beginning in January 2015. This new category of Medicaid applies to adults with income under 138 percent of the Federal Poverty Level, which is about \$16,000 per year for a single person and \$32,000 per year for a household of four.

The coverage expansion applies to adults ages 19 through 64. It has no asset limits, unlike most Medicaid categories for adults. It does **not** apply to individuals who qualify for Medicare. Under the Affordable Care Act, the Medicaid expansion was intended to close a gap in Medicaid coverage, which traditionally covered only children, very low-income parents, adults with disabilities, and people age 65 and older.

Newly-eligible individuals who are 19 or 20 years old, as well as those who are found to be “medically frail”, will be enrolled in the existing Medicaid managed care system (HealthChoices) rather than in the Private Coverage Option.

What is the Private Coverage Option?

The Private Coverage Option (PCO) is a new Medicaid managed care delivery system that will provide both physical and behavioral health coverage to most adults in the Medicaid expansion group. The Department of Public Welfare (DPW) will administer the PCO through contracts with managed care organizations, operating in [nine regions](#) across Pennsylvania. PCOs will operate separately from Pennsylvania’s existing Medicaid managed care program, called HealthChoices.

PCO enrollees will have the same essential health benefits as adult enrollees in Qualified Health Plans offered by the Health Insurance Marketplace: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, and chronic disease management. Unlike HealthChoices, which has separate insurance plans responsible for

physical and behavioral health coverage, the consumer's PCO will provide **both** physical **and** behavioral health coverage.

In addition, PCO enrollees are entitled to federal Medicaid managed care protections. That means a PCO enrollee denied a medical item or service can request an internal appeal with their plan or the standard DPW Fair Hearing process to challenge the PCO insurer's denial.

When will PCO enrollment begin?

Enrollment in PCOs will begin December 1st with coverage starting January 1, 2015. There is no deadline to apply for coverage. This can be done through COMPASS, by submitting a [paper application](#) to a local County Assistance Office, or by phone through the DPW Consumer Service Center at 866-550-4355.

If an individual applies for coverage through the Health Insurance Marketplace at www.healthcare.gov, but appears to qualify for Medicaid, their application information will be sent to DPW for a determination of Medicaid eligibility.

Persons determined eligible for PCO coverage should be able to choose from at least two PCO insurers. An independent enrollment broker will help consumers choose a PCO. PCOs are not permitted to perform direct marketing. Consumers who do not choose a PCO insurer will be automatically assigned one.

Who will be required to pay a monthly premium?

Under Healthy PA, monthly premiums of two percent of income will be imposed beginning in 2016 on certain adult recipients with household income over 100 percent of the Federal Poverty Level, which is about \$12,000 per year for a single person. Among Medicaid recipients over the Federal Poverty Level, premiums will apply to (1) newly eligible adults in the expansion group, (2) Transitional Medical Assistance recipients, and (3) Home and Community Based Services (HCBS) Waiver recipients who are not otherwise exempt. Any HCBS Waiver recipient who is age 65 or older, or dually-eligible for Medicare and Medicaid, will be exempt from premiums.

Recipients subject to the two percent premium will **not** be charged co-payments except for an \$8 co-pay anytime they use an emergency department for a "non-emergency use". This has not yet been defined.

Individuals who engage in "healthy behaviors," defined as completing a wellness exam and making timely co-payments in 2015, will have their premiums reduced in 2016. Premiums can also be reduced through participation in the state-funded "Encouraging Employment" program which will start in year two.

How will Medicaid benefits change for existing recipients?

Pennsylvania and CMS are still negotiating the benefit changes for existing adult Medicaid recipients. The state proposed reducing the Medicaid benefit packages for adults from fourteen to two: a "low risk" and a "high risk" benefits package. Medicaid law offers Pennsylvania significant flexibility to reduce benefits for adults, and it appears likely that CMS will approve the state's proposed changes.

The state intends its new “high risk” benefits package to be for adults currently on Medicaid who:

- are pregnant;
- are in a Supplemental Security Income (SSI)-related eligibility category;
- are institutionalized;
- receive Home and Community Based Services through a Waiver program; or
- are dually eligible for Medicare and Medicaid.

In addition, current Medicaid recipients who do not fit into one of the above groups, but, who are determined “medically frail” through a health screening (described later), will receive the “high risk” benefits package.

Exactly what benefits will be in the “high risk” and the “low risk” packages is not yet clear. PHLP will provide more details about the benefit changes once they become known.

Are children currently enrolled in Medicaid affected by Healthy PA?

No. The one million children under age 21 who are now on Medicaid are not affected by Healthy PA or by any of the other changes discussed previously.

What about those on General Assistance Medicaid and those in Select Plan for Women?

The 80,000 current recipients in General Assistance (GA)-related categories for Medicaid and the nearly 90,000 women in Select Plan for Women will be affected by Healthy PA because both of these programs will be ending. Those in the GA-related categories, unless found to be medically frail, will be enrolled in the Private Coverage Option beginning January 2015.

Select Plan for Women recipients will have their coverage discontinued on December 31, 2014. DPW officials state that these women will be encouraged to apply for coverage through Medicaid (including the newly eligible group) or the Health Insurance Marketplace (www.healthcare.gov).

What do people need to know about the new health screens?

Beginning in January 2015 (or sooner for adults currently on Medicaid and adults applying for the newly eligible group before the end of the year), individuals age 21 and older may be asked to complete a health screen. For the newly eligible individuals in the expansion group, this will determine whether they will receive coverage through HealthChoices or the Private Coverage Option. It will also determine whether they will receive the “high risk” benefit package (in HealthChoices) or “essential health benefits” (in the PCO). For current recipients, the health screen will determine whether they will receive the “high risk” or “low risk” benefit package. DPW designed a [14-question survey](#) that asks an individual to describe their health, including hospitalizations, doctor visits and previous conditions. The survey is intended to be filled out by the individual applying for or receiving Medicaid, and does not require a health care professional to complete. It can be completed either over the phone or on [COMPASS](#).

The survey is **not** a requirement for eligibility. All information received from the tool is confidential, and protected by the Health Insurance Portability and Accountability Act (HIPAA). Responses to the health

screen will be analyzed by DPW against its definition of medical frailty. Current Medicaid recipients who complete the health screen and who highlight a significant need for health care services should be assigned to the “high risk” benefit package. Those who do not complete the health screen will likely be assigned to the “low risk” benefit package.

Most newly eligible Pennsylvanians in the expansion group will be assigned to PCO coverage except for those ages 19 and 20 or those who are determined by the health screen to be medical frail; these individuals will go to HealthChoices. At a recent meeting, a DPW official predicted 42 percent of the General Assistance-related population would be deemed medically frail and assigned to HealthChoices, while the remaining 58 percent will move to the PCO.

Beginning in January 2015, it appears an individual can only complete the health screen when applying for Medicaid or at their annual renewal. PHLP and other advocates have requested the screening process be changed so that a consumer diagnosed with cancer, for example, can “raise her hand” and be screened for medical frailty at any time - not just at application or renewal. It is not clear whether, or how, a healthy individual who later develops a significant health condition will be able to identify themselves to state officials so they can be transferred from the “low risk” to the “high risk” benefit package. Stay tuned to future newsletters for updates about Healthy PA’s implementation and Medicaid changes for adults.

Healthy PA Outreach to Current Medicaid Consumers

The Department of Public Welfare (DPW) released details on how current **adult** Medicaid recipients will be informed about the changes described in the previous article: two new benefit packages in HealthChoices, the creation of a health screen to determine assignment to those new benefits packages, the creation of a Private Coverage Option, and the discontinuance of General Assistance (GA)-related Medicaid and Select Plan for Women.

In November, the approximately 800,000 households with an existing adult Medicaid recipient will receive a letter from DPW describing these changes and the date they will become effective: January 1, 2015. These letters will inform adult Medicaid recipients of which benefit package—either “low risk” or “high risk”—that DPW believes their medical needs warrant. This will be based on their Medicaid category and a review of claims data. Consumers placed in the “low risk” benefit package who want to be considered for the “high risk” package will be encouraged to complete a health screen which can be done either over the phone by calling DPW’s Consumer Service Center **or** on [COMPASS](#).

In December, all current adult Medicaid recipients will receive a notice from DPW about their assignment to a new benefit package (either “high risk” or “low risk”) that will begin January 1, 2015. Individuals can appeal this determination through the DPW Fair Hearing process. This notice will also inform Medicaid recipients in the GA-related category who were not found to be medically frail that they are being transferred to the Private Coverage Option on January 1, 2015. Anyone who believes they were mistakenly assigned to the wrong benefit package can contact PHLP for assistance.

Reminder: Coventry Cares is No Longer a Medicaid Managed Care Plan as of October 1st

Coventry Cares has merged with Aetna Health Plan. As a result, former members of Coventry Cares who have **not** joined a different plan will be covered by Aetna Better Health beginning October 1st. These individuals should have received member identification cards and plan information from Aetna and will generally need to seek health care services from a provider in the Aetna Better Health Network.

Medicaid has continuity of care rules that apply when people change their Medicaid health plan. Under those rules, individuals who are in a course of treatment, or who are currently receiving services that were prior authorized by Coventry Cares, should be allowed to receive that care from their provider for some period of time even if that provider is not part of Aetna Better Health's provider network. Anyone in this situation should have their provider contact Aetna Better Health to notify the new plan about the treatment they are receiving and to get the approvals needed so that the provider will get paid by Aetna.

Members of Aetna Better Health who are having problems receiving their continued treatment, or who are otherwise having problems accessing care, are encouraged to call PHLP's Helpline at 1-800-274-3258. Remember, people enrolled in a HealthChoices Medicaid managed care plan can change plans at any time by contacting PA Enrollment Services at 1-800-440-3989 or visiting www.enrollnow.net.

Consumers in HealthChoices Physical Health Plans Have a Right to an In-Person Grievance or Complaint In Their Zone

It has been over a year since the Department of Public Welfare (DPW) issued an Operations Memorandum to Medicaid physical health managed care plans requiring that they offer members the opportunity to have an in-person grievance meeting within their Zone. However, PHLP continues to hear from consumers who are not given this option.

As a reminder, Medicaid Managed Care (called HealthChoices) exists in every county in Pennsylvania. The state has divided up counties into five HealthChoices "Zones": Southeast, Southwest, Lehigh/Capital, New West, and New East. Medicaid consumers generally must enroll into one of the physical health managed care plans available in their Zone and use this plan to access their physical health services. Individuals get behavioral health coverage through a separate managed care plan that operates in their county.

If a consumer is unhappy with a health plan decision or with how they are treated as a plan member, the individual has a right to file a grievance or a complaint with the plan. The plan has two levels of review and individuals have the right to participate in both the first and second level grievance and complaint meeting in person or by phone.

Last year, PHLP and the Consumer Subcommittee of the Medical Assistance Advisory Committee met with DPW to raise problems consumers were experiencing with where, and how, their HealthChoices physical health plan was conducting in-person grievances and complaints. In response to the issues raised, DPW issued an Operations Memorandum to the HealthChoices physical health plans that requires:

- Each plan must have at least one location within each Zone in which they operate where they will conduct in-person grievances and complaints.
- All review panel members should be physically present for the proceeding but, at minimum, at least one panel member must be face-to-face with the consumer.
 - ◊ If any members of the review panel will not be physically present, the plan must notify the consumer in advance (in writing, or by phone if written notice is not possible) which panel members will not be physically present at the proceeding but who will instead be attending by phone.
 - ◊ The plan must also tell the consumer how to submit any evidence they have prior to the review so that it will be received by all the panel members.
- Each plan is to develop protocols and procedures for conducting in-person grievances at each Zone location that must be submitted for DPW approval.

DPW has since approved the plans' protocols and procedures, as well as the locations chosen for in-person proceedings within each Zone. All physical health plans should follow these procedures when a member requests an in-person grievance or complaint. Individuals seeking an in-person grievance or complaint meeting and who are having problems obtaining this are encouraged to call PHLP's Helpline at 1-800-274-3258.

PHLP encourages consumers to participate in their grievance or complaint proceeding whether in person or by phone. Consumers **must** tell the plan in advance that they want to participate in the proceeding. The decision letter and/or the acknowledgement letter from the plan will include instructions for how to make this request.

Governor Signs Bill to Change the Name of the Department of Public Welfare

By the end of November, the Pennsylvania Department of Public Welfare will have a new name- **The Department of Human Services**. On September 24th, Governor Corbett signed [Act 132 of Session 2013-2014](#) that changes the name of DPW within 60 days of its passage. Advocates of the name change pursued this issue for more than a year, citing Pennsylvania as one of only two states that continued to use the term "welfare" in the name of their human services agency.

Because of cost concerns, the legislation allows for additional time to fully transition to the new name. Under the law, the new name is not required to be put on signs, forms, or other items until these items need to be replaced. As a result, it is likely that people will continue to see the name "Department of Public Welfare" for some time after the law goes into effect.

Further Guidance Issued About Continued Medicaid for Former Foster Care Youth in Philadelphia

The Affordable Care Act requires that individuals in foster care and on Medicaid when they turn 18 continue to get Medicaid coverage until age 26 regardless of their income. In past months, the Department of Public Welfare issued policy guidance to the County Assistance Offices (CAOs) about continued Medicaid for these individuals ([Operations Memorandum 131203](#)). As of January 1, 2014, the CY60 discharge form, used when youth leave the foster care system, also acts as the application for Medicaid under the new former foster youth category (known as PC40).

Philadelphia's Department of Human Services, which serves as the county's children and youth agency, does not use the CY60 form; instead, it communicates discharge and other information electronically to DPW. Because of this, DPW provided further guidance through an [Information Memorandum](#) in early August addressing youth in Philadelphia.

The recent guidance states that, in Philadelphia, the electronic transmission about discharge from foster care to the County Assistance Office will serve as the application for Medicaid. The transmission must include the following information in the comments section:

1. Give "aging out" as the reason for discharge from foster care;
2. The date of discharge;
3. Any personal income (although this will not count when determining eligibility for Medicaid as a former foster youth, it will be used to screen the individual for other possible categories of eligibility if the youth is now a parent or is currently pregnant);
4. Place of residence; and
5. Other available information such as pregnancy.

Youth who aged out of foster care before January 1, 2014, and who have not yet turned 26, **must** apply for Medicaid to get this coverage. Individuals can apply in person at their local CAO, by mail using the [PA 600 HC](#) paper application, over the phone at 866-550-4355, or through the [COMPASS](#) website. Applicants should be sure to answer the foster care question on the application.

Former foster youth having problems getting this Medicaid coverage are urged to call the PHLP Helpline at 1-800-274-3258.

PA's Long Term Care Commission Meeting to Finalize Recommendations

After conducting seven public hearings throughout the state between April and July, [Pennsylvania's Long-Term Care Commission](#) has begun developing recommendations to better coordinate the state's long-term care programs and services and ensure quality health care for older Pennsylvanians and adults with disabilities. Secretary of Public Welfare Beverly Mackereth and Secretary of Aging Brian Duke co-chair the Commission.

The twenty-four members of the Commission have been assigned to one of several workgroups that met throughout August and September to review the public comments and to draft recommendations to propose to the full Commission for consideration. All recommendations as well as a White Paper must be finalized before the Commission's charge expires at the end of 2014. The remaining meetings of the full Commission are October 10th, November 14th, and December 5th. All the meetings will be in Harrisburg and are open to the public.

Medicare Annual Open Enrollment Starts Oct. 15th!

The time of year when all Medicare beneficiaries can make changes to their drug or their health plan coverage starts October 15th. This period, known as Open Enrollment, runs until December 7th. Any changes made by a beneficiary during this period go into effect on January 1, 2015.

Beneficiaries already enrolled in a Medicare Prescription Drug Plan or Medicare Advantage plan should have received information from their current plan about the benefits in 2015. This information from the plan details changes to the plan's coverage or costs for next year. If the plan will not continue in 2015, enrollees will receive notice in early October that their plan is ending on December 31, 2014.

Starting October 1st, plans are allowed to market their 2015 plans and Medicare's website (www.medicare.gov) will be updated with 2015 plan information. Pennsylvanians continue to have many choices for their Medicare health and drug coverage in 2015:

Stand-Alone Prescription Drug Plans: Although there will be fewer stand-alone prescription drug plans offered in 2015, Pennsylvanians will still have a choice of 29 plans. Of these 29 plans, 26 are available for enrollment during the upcoming Open Enrollment Period. The other three plans (Avalon Insurance Company's Secure Rx-Option 1 and Secure Rx-Option 3, and Express Scripts Medicare-SmartD Rx Saver) are currently under sanction by the federal government and banned from all marketing activities and from enrolling new members. Premiums for available prescription drug plans range from \$15.70 to \$151.80 per month.

In 2015, there are fewer "zero-premium" plans available for individuals who qualify for full Extra Help with their Part D costs — there will be 8 "zero-premium" plans next year compared to the 12 currently available. The United American Select plan will no longer be a zero-premium plan next year. In addition, the Cigna-

HealthSpring Rx-Reg 6, HealthMarkets Value Rx, and SecureAdvantage Rx-Option 1 plans are ending December 31, 2014. PHLP will post the listing of 2015 “Zero-Premium Plans” to our website in the near future.

Medicare Advantage Plans: Each county in Pennsylvania has a choice of at least 11 Medicare Advantage plans available to residents on Medicare. Bradford County has the fewest Medicare Advantage Plans (11) and Lancaster County has the most (33).

There are five Medicare Advantage Plans currently under federal sanction who are prohibited from marketing activities and from enrolling new members for 2015: Capitol Advantage Insurance Company’s Senior Blue Option 1 and Option 2 PPO plans and Keystone Health Plan Central’s Senior Blue Option 1, Option 2, and Option 3 HMO plans. These plans operate in certain counties in Central Pennsylvania.

Special Needs Plans for Dual Eligibles (D-SNPs): These plans only enroll individuals that have both Medicare and Medicaid (“dual eligibles”). All counties except for Bradford and Franklin will offer at least one -SNP next year. All of the current D-SNPs will continue to operate in the counties they do now. The Gateway Medicare Assured Diamond and Ruby plans will be offered in more counties next year, so dual eligible individuals in the following counties will have additional D-SNP plan options: Bedford, Clarion, Crawford, Forest, Greene, and Huntingdon.

Everyone on Medicare should review their current coverage to see if it will continue to meet their needs in 2015. Those needing help during the Open Enrollment Period can contact APPRISE (Pennsylvania’s State Health Insurance Program) at 1-800-783-7067. Stay tuned to future newsletters for additional information about Medicare in 2015.

PHLP Offers Medicare 2015 Webinars

PHLP is offering free webinar trainings to educate providers, advocates and other professionals who work with dual eligibles (people who have both Medicare and Medicaid) and other low-income Medicare beneficiaries about upcoming changes to Medicare and other programs in 2015. The webinars will be conducted **October 28th from 9:30am-11:30am** and **November 5th from 1:30pm-3:30pm**.

Each webinar will cover the following topics:

- Medicare Part D plans and costs in 2015
- Programs that help Medicare beneficiaries with their costs
- Helping Medicare beneficiaries in times of transition, including becoming a dual eligible or losing their dual eligible status
- Medicare and the Health Care Marketplace

To register for one of the webinars, please click [here](#) or visit our website at www.phlp.org. Space is limited- register today! Please share this announcement with others who may be interested in the webinars.

APPRISE Program Helps Anyone on Medicare

APPRISE is the name of Pennsylvania's State Health Insurance Program that offers one-on-one counseling and assistance to people on Medicare and their families. Staff and volunteers are available in every county to offer free trainings and insurance counseling to residents of any age on Medicare. APPRISE educates new beneficiaries on how Medicare works, and assists those already on Medicare who want to enroll into, or switch, Medicare Advantage Plans, Medicare Supplement Plans (known as "Medigaps") and Medicare Part D prescription drug plans.

APPRISE staff and volunteers are also very knowledgeable about programs that help low-income Medicare beneficiaries pay for their Medicare costs. They work with individuals to determine if they qualify for PACE/PACENET, the Medicare Part D Extra Help Program, and the Medicare Savings Program, and can help people complete an application as well as trouble-shoot any problems that may arise.

To contact APPRISE, Medicare consumers can call their county's Area Agency on Aging or the APPRISE Hotline at 1-800-783-7067.

Review of Mailings to Medicare Beneficiaries in September and October

With Medicare Open Enrollment starting soon, Medicare beneficiaries are receiving mailings about their current plan's benefits in 2015 and about their plan choices for next year. Beneficiaries with limited income and resources who receive "Extra Help" to pay for their Medicare Part D coverage will receive notices if there will be changes to the Extra Help they get in 2015. Below is a list of common consumer mailings Medicare beneficiaries may receive in September and October. For a full list of Medicare consumer mailings, see [here](#).

- **Medicare & You 2015 Handbook:** Every Medicare beneficiary receives this book by the start of the Medicare Open Enrollment Period (October 15th). The book includes general information about Medicare benefits and consumer rights and protections. It also includes a listing of the 2015 Medicare plans.
- **Plan Annual Notice of Change and Evidence of Coverage:** Individuals currently enrolled in a Medicare Prescription Drug Plan or Medicare Advantage Plan should receive this information detailing their plan's benefits for 2015. This notice should be received by the end of September.
- **Plan LIS Rider:** Individuals with Medicare drug coverage who currently receive Extra Help should receive this document by the end of September from their plan detailing what their prescription drug costs will be in 2015.
- **Plan Non-Renewal Notice:** Individuals currently in a Medicare plan that will end in 2014 will receive this notice by October 2nd.

- **Extra Help Notices:** Individuals currently receiving Extra Help who will be losing this help or whose co-pay levels will change in 2015 will receive these notices:
 - ◇ **Grey Notice/Loss of Deemed Status Notice** is sent in September to individuals who automatically received the Extra Help in 2014 but who no longer automatically qualify in 2015 because they lost Medicaid coverage before July 2014. These individuals may still qualify for the Extra Help but will need to apply for it by filling out the application that is included with the notice.
 - ◇ **Orange Notice/Change in Extra Help Copayment Notice** is sent in October to individuals who automatically qualified for the Extra Help in 2014, and will still automatically qualify in 2015, but who will pay different co-pays for their prescriptions in 2015.

New Marketplace Navigators Available to Help Pennsylvanians with Marketplace 2015 Applications and Enrollments

Earlier this month, the federal government announced the organizations who will receive funding to help individuals access health care coverage through the Health Insurance Marketplace for 2015. Pennsylvanians use the federally-facilitated Marketplace (www.healthcare.gov). Navigators provide unbiased information and assistance to help individuals choose and select a Marketplace health plan that will meet their needs and be affordable for them. Navigators also help consumers determine if there are state administered health insurance programs, such as Medicaid or the Children’s Health Insurance Program (CHIP), that individuals might qualify for instead of buying coverage through the Marketplace.

Navigators must meet certain standards to receive the federal funding including receiving certification and training in various areas related to Marketplace coverage, having a physical presence in their service area in order to provide face-to-face help, complying with strict security and privacy standards, and submitting regular reporting data to the federal government to track their progress and work.

Entities who were interested in providing Navigator services for the second year of the Marketplace applied to the federal government. The federal government chose the following organizations to serve as Navigators in Pennsylvania to help people with Marketplace coverage for 2015:

- Penn Asian Senior Services
- Young Women’s Christian Association of Pittsburgh
- Consumer Health Coalition*
- National Healthy Start Association
- Pennsylvania Mental Health Consumer’s Association*
- Pennsylvania Association of Community Health Centers*

*Already providing
Navigator services
in 2014

Individuals can find navigators and other sources of local help with the Health Insurance Marketplace, by visiting localhelp.healthcare.gov.

The 2015 Marketplace Open Enrollment Period will run from November 15, 2014 until February 15, 2015. During this time, anyone without Minimum Essential Health coverage or affordable health insurance can enroll in a Marketplace plan and obtain premium tax credits and cost-sharing subsidies, if eligible. Individuals can also change their Marketplace coverage for next year during this time. Visit www.healthcare.gov for more information.

Health Care Marketplace Town Hall Meetings

The Pennsylvania Mental Health Consumers' Association (PMHCA) and the Pennsylvania Recovery Organizations Alliance (PRO-A) are holding Town Halls to encourage persons in mental health or drug and alcohol recovery to share their experiences with the Marketplace enrollment process verbally and by way of a survey. PMHCA and PRO-A will compile the survey results and feedback provided at the meetings and share them with policy makers at the local, state and federal levels to make the next enrollment period even more successful for all users of the Marketplace.

The remaining Town Halls meetings are scheduled for:

- October 10, 2014, 10:30am – 11:30am. Tanglewood Senior Center, 10 Austin Avenue, Lyndora PA
- November 3, 2014, 3:00pm - 4:00pm. Hopeworx, 1210 Stanbridge Street, Suite 600, Norristown PA

Those interested in sharing their experience with the Marketplace who are unable to attend the Town Halls can take the [online survey](#).

Questions about the meetings or the survey can be directed to Lynn Keltz, Pat Madigan or Ellen Schellenberger at 1-800-887-6422.

Our Mission

Founded in the mid-1980s and incorporated in 1993, PHLP protects and advances the health rights of low-income and underserved individuals. Our talented staff is passionate about eliminating barriers to health care that stand in the way of those most in need.

We seek policies and practices that maximize health coverage and access to care, hold insurers and providers accountable to consumers, and achieve better outcomes and reduce health disparities.

PHLP advances its mission through individual representation, systemic litigation, education, training, and collaboration.

You can help

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Support Our Work

Please support PHLP by making a donation on our website at phlp.org. You can also donate through the United Way.

For Southeast PA, go to uwsepa.org and select donor choice number 10277.

For the Capital Region, go to uwcr.org and pledge a donation to PHLP.

For the Pittsburgh Region, go to unitedwaypittsburgh.org and select agency code number 11089521.

PHLP: Helping People in Need Get the Health Care They Deserve