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Community HealthChoices Updates

[December 21– The Real Deadline to Choose a CHC Plan in Southeast PA](#)

As of the end of November, most (61%) of the 130,000 plus people in Southeast Pennsylvania who will move to Community HealthChoices (CHC) did not choose a managed care plan and were auto assigned, by the state, to one of three CHC plans—Keystone First, PA Health and Wellness, and UPMC Community HealthChoices. These plans will begin providing Medicaid coverage of physical health and long-term services and supports on January 1, 2019.

However, it is not too late for people to choose a different CHC plan for January 1st. Consumers have until December 21, 2019 to do so and that plan selection will prevail. This option to switch plans before the January 1st CHC start is available to everyone going into CHC in Southeast PA, whether they are among the 61% of people who were auto-assigned to a plan, or a person who already made an affirmative plan selection, but has since had a change of mind.

To minimize the risk of disruptions in healthcare services, it is advisable for those who were auto-assigned to a CHC plan to take time between now and mid-December to choose a plan that includes their critical healthcare providers. This is particularly true of the thousands who were auto-assigned to a CHC Plan and whose *only insurance is Medicaid*.

People with Medicaid-only insurance are most at risk of disruption in their healthcare services when CHC starts. This is because they must see providers who are in their CHC plan’s network. In contrast, people who have both Medicare and Medicaid can continue to see their Medicare providers and the CHC plan must pay the Medi-

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caid portion of their medical bills even if the provider is not in the CHC plan's network.

While there is a brief period—60-days—during which CHC plans must pay out-of-network medical providers for ongoing treatment or prior authorized services, this “continuity of care” period does not apply in all situations and can be challenging to obtain even when required. Therefore, relying solely on continuity of care to be able to access medical providers is a risk that should be avoided. (The 60-day continuity of care period applies to regular physical health services and medication. A longer and more tightly monitored 180-day continuity of care period applies to waiver services such as personal assistance services.)

To determine in which plans specific providers are participating, individuals may call the CHC Enrollment Broker at 1-844-824-3655 or use its [provider search tool](#). The provider search tool indicates it can only be used to search for specific primary care providers or practices, but PHLP has tested it and individual specialists can be searched as well.

Once CHC begins, participants can switch plans at any time. There is no lock-in. However, depending on when a plan change is made, it could take from two weeks to a month and a half for the change to go through, so choosing the right CHC plan now will save time and potential problems accessing care.

[**Problems Obtaining CHC Enrollment Packets**](#)

PHLP and other advocacy groups have fielded a number of complaints from people moving to CHC who did not receive the CHC enrollment packet. The packet contains several items, including a plan comparison and individualized paper enrollment form. Those who still need the packet should promptly request one from the CHC Enrollment Broker reachable at 1-844-824-3655. The contents of the packet, other than the enrollment form, is also available on the state's CHC website under [Pre-Enrollment Packet](#).

[**Southwest PA Update**](#)

At the November meeting of the Managed Long Term Services and Supports (MLTSS) Subcommittee, the state announced that only one CHC managed care plan, UPMC Community HealthChoices, currently is permitted to issue notices denying or reducing long term services and supports to the older adults and individuals with disabilities who are members of its plan. State officials confirmed the other two CHC plans—AmeriHealth Caritas and PA Health and Wellness—are still required to have their denial notices reviewed by the state and are not yet approved to issue any denials. As reported in prior newsletters, all three plans remain under corrective action regarding their person-centered service plans.

Consumers whose long term services or supports are denied or reduced by any of the CHC plans should immediately contact PHLP's Helpline at 800-274-3258 or Staff@PHLP.org.

PHLP Offers FREE Help with CHC

Did Your CHC Plan:

- ◇ Cut Your Personal Care Hours?
- ◇ Refuse Your Request to Make Your Bathroom Accessible?
- ◇ Tell You Must Get Home Delivered Meals Instead of Assistance with Meal Preparation?
- ◇ Deny, Change or Reduce Your Community Long Term Services and Supports in Any Way?

We want to help. Contact the PHLP Helpline at 1-800-274-3258 or Staff@PHLP.org. Our legal services are free and confidential.

Important Changes to Medicare Enrollment Periods in 2019

The Medicare Annual Open Enrollment Period for health and drug plans ends December 7th. Before this deadline, everyone on Medicare can make changes to their Medicare Advantage plan or Medicare Prescription coverage for 2019. Enrollments made during this period take effect on January 1st. This enrollment period also allows people on Medicare who have not yet enrolled in Medicare Part D (prescription drug coverage) to do this.

After December 7th, people can only enroll in Part D or make changes to their Medicare health or drug coverage if they qualify for another enrollment period that allows them to make a change or other enrollment decision after January 1, 2019. This article describes important changes to some of the enrollment periods in 2019.

As a reminder, APPRISE staff and volunteers can help people across Pennsylvania review their 2019 Medicare coverage options or determine if they can make plan changes after January 1, 2019. Medicare beneficiaries who need help reviewing their plan options for next year are encouraged to call APPRISE at 1-800-783-7067.

[New Medicare Advantage Open Enrollment Period](#)

The Medicare Advantage Open Enrollment period will run from January 1st through March 31st. This new enrollment period allows people who are enrolled in a Medicare Advantage plan on January 1st

to switch to another Medicare Advantage plan (with or without drug coverage) or disenroll from their Medicare Advantage plan and return to Original Medicare. Anyone choosing to return to Original Medicare during this period will be able to join a stand-alone prescription drug plan for Part D coverage. **Only one change may be made during this period.** Any change made during this period will become effective the first day of the next month. For example, if someone disenrolls from their Medicare Advantage plan and enrolls in a prescription drug plan on February 16th, they will have Original Medicare and that prescription drug plan coverage starting on March 1st.

[Special Enrollment Period For Dual Eligibles And People With Extra Help Is More Limited!](#)

Starting January 1, 2019, dual eligibles (those eligible for both Medicare and Medicaid) will no longer have a continuous monthly special enrollment period to change their Medicare Advantage/Part D plans throughout the year. Next year, dual eligibles and other individuals who are eligible for Extra Help with their Part D costs will only be able to change their Medicare health or drug plan **once a quarter during each of the first three quarters in a calendar year.** Changes made during this period will start the first of the next month. During the last quarter, they will use the annual enrollment period to make changes and the new plan will start January 1st.

Please note: As this change does not go into effect until January 1st, dual eligibles and those with Extra Help have until the end of December to make a 2019 plan choice.

Here are some examples of how the changes to this Special Enrollment Period in 2019 could affect dual eligibles:

Example 1: If a dual eligible decides to change their Medicare drug plan on January 20th, the new plan will start February 1, 2019. They will not be able to make another change to their drug coverage until April 1st.

Example 2: If a dual eligible decides to change their Medicare drug plan in July, the new plan will start August 1st. They will not be able to make another change to their drug plan in 2019. They can make a change during the Open Enrollment Period (October 15th-December 7th) but the new plan will not start until January 1, 2020.

Example 3: If a dual eligible decides to change their Medicare Special Needs Plan in February 2019, the new plan will start March 1st. After joining the new Plan, they realize that the new plan is not meeting their needs. They have to wait until April to change plans and the new plan will start May 1st. They may be able to change their plan sooner if they can qualify for another Special Enrollment Period.

[Other Special Enrollment Period Changes](#)

Aside from the Special Enrollment Period discussed above, there are a number of other SEPs that ex-

ist for various circumstances. People can use different Special Enrollment Periods to make changes during the year. Even if they are a dual and have the limited opportunity to change plans as described above, they could make additional changes if they qualify for another Special Enrollment Period. Common ones include when people move, when people enter or leave a nursing home, or when people lose other prescription coverage and need to enroll in Part D.

Another change we wanted to highlight for readers in 2019 is for individuals who lose eligibility for Medicaid or Extra Help. Next year, these individuals will have three full months to be able to make one change to their Medicare health or drug coverage. The three months starts from either the date they are no longer eligible or the date they are notified they are no longer eligible, whichever is later. During this special enrollment period, individuals who are losing eligibility for Medicaid or Extra Help can join a Medicare Advantage or Part D prescription drug plan, switch from their current plan to another Medicare Advantage or Part D prescription drug plan, drop their Medicare Advantage plan and return to Original Medicare, or drop their Medicare prescription drug coverage.

For more information about Medicare enrollment periods and other special enrollment periods that may be available, see Medicare's publication on this topic [here](#).

December 15th Deadline to Purchase Health Insurance through the Marketplace

December 15th is the last day for 2019 Marketplace Open Enrollment. Individuals wanting to purchase health insurance through the Marketplace (HealthCare.gov) for 2019 must do so by that date for coverage to be effective January 1, 2019. And unless someone qualifies for a special enrollment period Marketplace coverage cannot be purchased after December 15.

Generally, individuals with expected 2019 household incomes between 138% and 400% of the federal poverty level will qualify for Premium Tax Credits. (Individuals with incomes below 138% of the federal poverty level likely qualify for Medicaid.) For example, a single person with a projected 2019 annual income between \$16,764 (138% FPL) and \$48,576 (400% FPL) could receive a tax credit to offset the cost of their monthly insurance premium on coverage purchased through the Marketplace. A household of four people can also receive a tax credit if their projected 2019 annual income is between \$34,644 and \$100,416. The lower the household income, the more help received in Premium Tax Credits.

There are four different types of plans available: Bronze, Silver, Gold and Platinum. The Bronze plans generally have a lower monthly premium but higher deductibles and co-pays. Platinum plans have a higher monthly premium but lower deductibles and co-pays. Individuals and families eligible for the Premium Tax Credits can purchase any of the four types of plans.

Individuals and families with annual incomes between 138% and 250% of the federal poverty level are eligible for cost-sharing reductions, in addition to the Premium Tax Credits. The cost-sharing reductions reduce co-pays and deductibles. To get both the Premium Tax Credits and the cost-sharing reductions, individuals **must** purchase a Silver Plan.

Individuals with Medicare or Medicaid are not eligible for Premium Tax Credits or cost-sharing reductions. However, uninsured individuals who expect to become eligible for Medicare sometime in 2019, can apply for insurance through the Marketplace and receive Premium Tax Credits until the month their Medicare begins.

Individuals can use the [Kaiser Family Foundation calculator](#) to get an estimate of their premium tax credits and potential Marketplace plan costs or visit [Consumers Checkbook](#) to use its plan comparison tool. Even though federal funding for organizations who help people enroll in Marketplace coverage or apply for premium tax credits has been drastically reduced, help is still available. People can

Update on Restoration of General Assistance

On November 19th the first round of General Assistance (GA) payments were authorized by the Department of Human Services. All applicants approved in this initial round should receive a notice and their first payment by November 30th. Several thousand more applications are still pending. Applicants are reminded to check their mail for notices from their local County Assistance Office.

In previous newsletters, we reported on the important victory of our colleagues at Community Legal Services (CLS) and Disability Rights Pennsylvania in *Washington, et al v. The Department of Public Welfare*. In that decision, issued July 18, 2018, the Pennsylvania Supreme Court voted unanimously to repeal Act 80 of 2012, which ended the General Assistance (GA) program that year.

Following the decision, Pennsylvania reinstated its GA program that provides a small monthly cash benefit to those who qualify. People can apply for GA benefits online at www.compass.state.pa.us, by mail, and in person at local [County Assistance Offices \(CAOs\)](#). CAOs have been accepting applications, interviewing applicants, and requesting verifications from applicants in anticipation of beginning to issue benefits this month.

For continuing updates and helpful information about applying for GA, visit www.clsphila.org/GA. Remember, anyone turned down for General Assistance can appeal. To seek free legal help with an appeal, go to www.palegalaid.net and click “Find Legal Help.”

Gov. Wolf Again Vetoes Medicaid Work Requirement Bill

On October 19, 2018, two weeks before Pennsylvania's gubernatorial election, Governor Wolf vetoed a bill passed by the General Assembly two days earlier that sought to impose Medicaid work requirements. [House Bill 2138](#) would have amended the Human Services Code to require the Department of Human Services (DHS) to seek a waiver from the federal government to impose employment and job search requirements as a condition of Medicaid eligibility for non-elderly, non-disabled adults.

As he did in vetoing the Medicaid work requirements bill passed by the legislature last fall, Governor Wolf in his [letter of veto](#) touted the benefits of Medicaid expansion and the value of Medicaid in responding to the substance use disorder epidemic. He noted, further:

This legislation does not promote health coverage, access and treatment. Instead, this legislation increases costs, creates unnecessary delays and confusion, penalizes individuals who need healthcare, and terminates health coverage for those who need it most.

The Trump administration has been encouraging work requirements for a variety of federal support programs, from food stamps to housing subsidies, and because Congress has balked, administration officials have turned to state governments to push ahead. Arkansas, Indiana, Kentucky and New Hampshire have received approval from the Trump administration to impose work requirements for Medicaid. Eight other states — Arizona, Kansas, Maine, Mississippi, Ohio, South Dakota, Utah and Wisconsin — have formally applied for similar waivers.

PHLP applauds Governor Wolf for vetoing this bill. It would have increased red tape, cut needed benefits, and created unnecessary barriers to Medicaid coverage. Most non-elderly, non-disabled Medicaid recipients are [already working](#), many in low-wage occupations that do not offer health insurance, and those who aren't working are typically in school or caring for a child or older family member. Work requirements would only serve to depress enrollment, reduce access to preventive care, and impede the ability of Pennsylvania's low-income residents to become and stay healthy.

Medicaid Favored by Voters in the Midterm Elections

While not typically an election issue, Medicaid — particularly the Medicaid expansion created under the Affordable Care Act (ACA) — was an important issue in the 2018 midterm elections in a number of campaigns throughout the country. Medicaid expansion efforts were largely successful. Three states voted on Medicaid expansion through ballot initiatives. Voters in Idaho, Utah, and Nebraska decided to make more low-income people eligible for Medicaid through ballot initiatives. As a result, an [estimated](#) 363,000 more people will be able to gain access to the health program in 2019.

An additional four states—Kansas, Maine, Wisconsin, and Montana—elected governors who support implementation of Medicaid expansion. This comes after legislators in Kansas and voters in Maine had previously voted to expand the program only to be blocked by their respective governors.

Reminder: States may implement the Medicaid expansion at any time—Pennsylvania, for example, expanded in 2015—and while they can no longer receive 100% federal financing for three years, they remain eligible for enhanced federal financing of 93% in 2019 and 90% in 2020 and beyond.

The November elections may also change how expansion is implemented. Newly elected governors in New Hampshire and Michigan may reconsider their controversial positions to impose employment and job search requirements as a condition of Medicaid eligibility (see previous article about Medicaid work requirements in this newsletter). In Montana, a ballot issue to permanently fund Medicaid Expansion failed to pass, leaving coverage past 2019 uncertain.

Finally, the election results, specifically the Democratic takeover of the House of Representatives, will likely to put an end, at least for the next two years, to Republican congressional efforts to undo the ACA and reduce Medicaid spending.

Income Limits Increase for PACENET Prescription Assistance Program

A bill introduced by Pennsylvania state representatives Steve Samuelson and Frank Farry, which passed the House and Senate unanimously and was signed by Governor Wolf, has increased income limits in the PACENET Program. This is the first increase to the income limits in 15 years.

PACENET (and PACE) are state lottery-funded programs that assist low- and moderate-income Pennsylvania seniors (age 65 and older) with the costs of prescription drugs. PACE assists seniors who are single and have incomes of \$14,500 a year or less and married couples whose joint income is \$17,700 a year or less.

The increased income limits for PACENET, effective immediately, rose from \$23,500 to \$27,500 for seniors who are single and from \$31,500 to \$35,500 for married couples. Income limits are determined by using the prior year's tax returns. PACENET enrollees have a monthly premium (for 2019 it will be \$37.03). **However**, if PACENET enrollees are also enrolled in a Medicare Part D plan, the monthly PACENET premium is waived.

Seniors must be Pennsylvania residents for at least 90 days and not enrolled in PA Medicaid to be eligible for PACENET and PACE.

Seniors who think they may be eligible for PACENET (or PACE) can call 1-800-955-0989 or apply [online](#).

Comments Needed Before Dec. 10th on the Proposed Public Charge Rules For Immigrants

The Trump Administration [proposed a rule](#) in October defining when lawfully present immigrants should be considered a “public charge.” Monday, December 10th is the deadline to submit comments to tell the federal government why this proposal is a bad idea that will hurt many immigrants with disabilities and their families by submitting comments through an official “notice-and-comment” period.

As reported in previous PHLP newsletters, the administration has proposed changing the public charge determination test by broadening the public benefits considered in the test to include most forms of Medicaid, Medicare Part D premium and cost-sharing assistance, SNAP and housing assis-

tance. The proposed rule also asks for public comment regarding whether the Children’s Health Insurance Program (CHIP) should be added to the list of public benefits considered in the public charge determination test.

Input on the proposed public charge rule is important. These changes would worsen the chilling effect already seen across the country in immigrant communities, where families are disenrolling from health programs or forgoing medical care for fear of retaliation, like having their immigration status denied. The Kaiser Family Foundation’s (KFF) [analysis](#) of the proposed rule change concluded many more immigrants, including many who are not actually subject to the public charge requirement because they have an exempt status, are likely to avoid coverage due to fear of negative immigration consequences.

Below is information to assist organizations and individuals that wish to oppose the proposed changes to the public charge rule. **Comments may be submitted to the federal register [here](#) by 11:59 pm on December 10, 2018.** Click on “comment now” and either enter your comment in the text box (must be fewer than 5000 characters) or upload your comments as a pdf.

Additional information on the commenting process and answers to some FAQs are available [this document](#) from Protecting Immigrant Families.

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.

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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.