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In This Issue

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Get Ready for the Medicare Open Enrollment Period

Medicare's Annual Open Enrollment Period starts **October 15th** and runs until **December 7th.** During this period, all Medicare beneficiaries can make changes to their health or their drug plan coverage. Changes made during this period start January 1, 2019.

Beneficiaries already enrolled in a Medicare Prescription Drug Plan or Medicare Advantage Plan should have received information from their current plan about what the benefits will be in 2019. This information should detail any changes to the plan's coverage or costs for next year. Everyone is encouraged to review this information to decide whether they should stay with their current plan or join a new plan for next year.

If a Medicare plan will **not** continue in 2019, enrollees should receive notice in early October that their plan is ending December 31st. Beginning October 1, 2018 insurance companies are allowed to start marketing their 2019 plans and Medicare's website, www.medicare.gov will show 2019 plan information. Activities and materials by Medicare companies as well as agents or brokers who enroll people into Medicare plans are subject to communications and marketing guidelines which can be found here.

Information about 2019 Medicare Prescription Drug Plans and Medicare Advantage Plans is available on www.medicare.gov. Pennsylvanians continue to have many options for health and drug coverage in 2019. APPRISE staff and volunteers can help people across Pennsylvania review their 2019 Medicare coverage options. Medicare beneficiaries who need help reviewing their plan options for next year are encouraged to call APPRISE at 1-800-783-7067.

Please note: change to Special Enrollment Period for Dual Eligibles and those with Extra Help in 2019: Starting January 1, 2019, dual eligibles will no longer have a continuous monthly special enrollment period to change their Medicare Advantage/Part D plans throughout the year. As modified, dual eligibles and other individuals who are eligible for Extra Help with their Part D costs will only be able to request a plan change once a quarter during each of the first three quarters in a calendar year, in addition to the annual open enrollment period during the last calendar quarter. Stay tuned as we will discuss this change in more detail in our November newsletter and in our Medicare 2019 webinar on November 7th.

Stand-Alone Prescription Drug Plans: There are 30 stand-alone prescription drug plans available across Pennsylvania for enrollment in 2019. Premiums for these plans range from $14.50 to $156.00 per month. There are still nine plans to choose from that are "zero-premium" for individuals who qualify for the full Extra Help (click here for the 2019 list). However, there are two notable changes to this list between this year and next – the Symphonix Value Rx plan will no longer be offered in 2019 and AARP MedicareRx Saver Plus will be back as a zero-premium plan in 2019.

Medicare Advantage Plans: Residents in every county in Pennsylvania continue to have many Medicare Advantage plans to choose from. Lancaster County and Bucks County have the most Medicare Advantage plans (51 each) and Pike County has the fewest (17). These numbers do not include Medicare Special Needs Plans that limit their enrollment to certain groups of Medicare beneficiaries: dual eligibles, people in nursing homes, and people with certain chronic conditions.

Most, but not all, of the Medicare Advantage plans available include drug coverage. Individuals considering a Medicare Advantage plan for 2019 should check the plan's costs, benefits, provider network and pharmacy network, list of covered drugs, and any extra benefits offered, such as dental or vision care.

Special Needs Plans for Dual Eligibles (D-SNPs): These plans only enroll Medicare beneficiaries who also have Medicaid (dual eligibles). However, it is important to remember that the D-SNP only provides the member with their **Medicare** coverage and the person still has Medicaid as their second, separate insurance coverage. In 2019, all counties in Pennsylvania will have at least one D-SNP available except for Pike County which has no D-SNP plan. All current D-SNPs will continue to operate in 2019, although some plans are expanding to new counties while others are leaving counties where they had previously been offered. Click here for the listing of D-SNPs by county for 2019.

Medicare and Community HealthChoices: As a reminder, dual eligibles moving to Community HealthChoices (CHC) will continue to have Medicare as their primary coverage. Their move to CHC is only changing their secondary Medicaid coverage. Dual eligibles continue to have all the Medicare plan choices noted above. For those in Southeastern PA moving to Community HealthChoices January 1, 2019, each insurance company offering a CHC plan will also offer a Medicare D-SNP. **However, consumers are not required to enroll in the Medicare D-SNP that is offered by the same insurance company as their CHC plan.** If a dual eligible is happy with her current Medicare coverage,

she can keep the coverage she has, but she will still need to enroll in a CHC plan for her **Medicaid** coverage.

Individuals in Southeast PA who need more help understanding how CHC will work with their Medicare coverage next year are encouraged to contact PHLP's Helpline at 1-800-274-3258.

Medicare Part D Costs for 2019

A Medicare beneficiary who **does not** qualify for any level of Extra Help from Medicare will pay the following costs for a standard Part D Plan in 2019:

- The plan's monthly premium (the national average premium for a basic drug plan will be $33.19);
- An annual deductible of **$415;**
- During the initial coverage period, a **25%** co-pay for each covered prescription until the person's total drug costs reach **$3820**;
- During the coverage gap (often referred to as the "donut hole"), a person will pay **25%** of the cost of brand-name drugs and **37%** of the cost of generics (plus a small dispensing fee) until the consumer's total out-of-pocket expenses reach **$5100**; and
- During the catastrophic coverage period, a co-pay of **$3.40** for generics and **$8.50** for brand name drugs, or a 5% co-pay, **whichever is greater**, for the rest of the year.

Part D Cost for Those Receiving Extra Help from Medicare: Anyone who qualifies for the **full Extra Help** from Medicare (this includes all dual eligibles who have Medicare and who receive **any** benefit from Medicaid), will have the following costs in 2019:

- $0 premium (as long as she enrolls in a Part D plan that provides standard benefits and charges a premium below the 2019 Extra Help Benchmark amount of $37.03)
- Small co-pays for their prescription medications:
  - ◊ $1.25/generics and $3.80/ brand names (if income is less than 100% FPL) **or**
  - ◊ $3.40/generics and $8.50/ brand names (if income is above 100% FPL) **or**
  - ◊ $0 if someone is on Medicare **and receiving Medicaid long term care services** in a nursing home **or** through a Home and Community-Based Services Waiver program

Those beneficiaries who qualify for **partial Extra Help** in 2019 will pay the following costs:

- A portion of their Part D plan monthly premium depending on the amount of their Extra

Help;

- A deductible no higher than **$85;**
- 15% co-pays on all of their medications until they reach total out-of-pocket expenses of **$5,100;**
- During the catastrophic coverage period, co-pays of **$3.40**/generics and **$8.50** /name brands for the rest of the year

Remember! A Medicare beneficiary who receives <u>any</u> amount of Extra Help from Medicare has no coverage gap (donut hole) no matter what Part D plan she joins!

Update on Medicare Summary Notices to Qualified Medicare Beneficiaries

Qualified Medicare Beneficiaries (hereinafter QMBs) are individuals on Medicare who are low income and who have limited assets. These individuals qualify for Medicaid to pay their Medicare Part B monthly premium and to cover their Medicare Part A and Part B deductibles, co-insurance and co-pays. In Pennsylvania, the QMB program is also called "Healthy Horizons". Under longstanding Medicare law, Medicare providers and suppliers are prohibited from billing QMBs for any Medicare cost-sharing for services covered under Medicare Part A or Part B and face sanctions if they do. Despite these protections, QMBs have continued to receive bills for Medicare deductibles and coinsurance.

Qualified Medicare Beneficiaries (QMBs) have income below 100% of the federal poverty level. The figures for 2018 are:

- ◊ $12,140/year for a single person
- ◊ $16,460/year for a married couple

Those on Original Medicare (using their red, white and blue Medicare card) get a Medicare Summary Notice in the mail every three months that lists all the services billed to Medicare. It shows what Medicare paid to the service provider and what the consumer <u>may</u> owe the provider after Medicare pays.

In October 2017, Medicare added important information to the Medicare Summary Notices for

QMBs to show their QMB status and what that means in terms of their billing protections. This change was suspended on December 8, 2017 because it caused problems within the Medicare billing system. We are happy to report that the identification of QMB status on Medicare Summary Notices has now been reinstated.

Effective July 1, 2018, the Medicare Summary Notice sent to QMBs includes information showing their QMB status, their billing protections, and, most importantly, that their Medicare cost-sharing is $0 for the service provided. Consumer advocates are hopeful that this new information will remind QMBs that they are not responsible for Medicare cost-sharing and help stop Medicare providers from wrongly billing QMBs for these costs. QMBs who believe they have been improperly billed are encouraged to contact PHLP's Helpline at 1-800-274-3258.

PHLP Offers Medicare 2019 Webinar

PHLP is offering a free webinar to educate advocates, providers, and professionals who work with dual eligibles and other low-income Medicare beneficiaries about Medicare in 2019. Dual eligibles are people who get coverage through both Medicare and Medicaid.

The webinar will be held on **Wednesday, November 7, 2018 from 10 a.m. to noon.** It will cover the following topics:

- Medicare Part D plans and costs in 2019
- Programs that help Medicare beneficiaries with their costs
- Community HealthChoices – impact on dual eligibles
- What's ahead for Medicare (changes to Medicare enrollment periods and more!)

To register for the webinar, please click here. Space is limited, so register today! We ask individuals who are registering from the same organization to gather around one computer when possible. This will help to ensure that space is available for all those who are interested in participating.

Please share this announcement with others who may be interested in the webinar!

Federal Funding for Marketplace Navigators Reduced

Since taking office, the Trump administration has dramatically reduced funding for federal marketplace navigators. The Affordable Care Act (ACA) created navigator programs to provide outreach, education, and enrollment assistance to consumers eligible for marketplace or Medicaid coverage. Since 2015, the Centers for Medicare and Medicaid Services (CMS) has funded navigator programs in the 34 states, including Pennsylvania, that use the federal marketplace. In 2017, CMS reduced navigator funding by 43%--from $63 million in 2016 to $36.1 million for 2017. In September 2018, CMS announced navigator awards totaling only $10 million for the coming year. Three states (Iowa, Montana, and New Hampshire) will receive no navigator funding.

The Pennsylvania Association of Community Health Centers is the sole grantee for Pennsylvania and will receive $400,000 for 2018-19 enrollment activities. This compares to the $3 million in funding it received in 2016 and $1,9 million for 2017.

The Navigator program provides in-person assistance, education and outreach events as well as informational materials, and answers to individual inquiries. Navigators serve the hardest-to-reach individuals and communities who struggle to understand the health insurance options offered on or off the Marketplace (also known as Healthcare.gov).

Reduced funding is the latest in a series of constrictions on outreach and enrollment efforts that include shorter open enrollment periods, reductions in advertising for the Marketplace, and limited promotional materials.

Tips for Marketplace Open Enrollment

The Marketplace helps people shop for and enroll in affordable health insurance. The federal government operates the Marketplace, available at HealthCare.gov, for most states (including Pennsylvania). Here's what consumers need to know for the open enrollment period for 2019 Marketplace Health Insurance Plans:

1. Open Enrollment Deadlines Have Changed

The 2019 Marketplace Open Enrollment period starts **November 1, 2018** and continues through **December 15, 2018** for coverage starting January 1, 2019. Those applying to the Marketplace who are told they qualify for Medicaid or the Children's Health Insurance Program (CHIP) can enroll in those programs at any time of the year. These are state-federal programs for people with limited incomes or disabilities.

2. What Consumers Can Do During Marketplace Open Enrollment

- Renew their current individual/family health insurance plan
- Choose a new health insurance plan through the marketplace or through private insurance

If someone is currently enrolled in a marketplace health insurance plan, it will automatically renew. However, the plan may make changes to its provider network, copays, co-insurance and drug coverage. The plan must send its members a notice of any changes it will make for 2019.

It is important that consumers take the time to read the notice to see what it means for them. They should make certain their doctors and preferred hospital are still in the network. Be aware that a consumer may be able to use out-of-network doctors and hospitals, if they are willing to pay more. In some cases, however, the person might not be covered at all if they go to a provider out of network.

The person's prescription drug coverage also could change. The plan may no longer cover the drugs the consumer takes to manage their chronic conditions. It's important to check the plan's drug benefits for 2019 before the consumer allows it to renew. The consumer may need to find a different plan to meet their needs and now is the time to do it.

Health plans must provide an online link to the list of drugs they will cover, known as formularies.

3. These Rules Are For <u>Marketplace Open Enrollment Only</u>

Consumer who qualify for employer-sponsored health insurance will not be affected by Marketplace Open Enrollment. And, as described elsewhere in this newsletter, those enrolled in Medicare have a different open enrollment period that runs from October 15th through December 7th each year.

4. Federal Penalties For Not Having Health Insurance - Done Away With For 2019

For the 2018 tax year, the penalty for going without insurance will remain at 2.5 percent of the person's income or a flat amount (whichever is more). The 2018 flat and maximum amounts have not been published yet as the government will adjust for inflation. In 2017, the flat amounts were $695 per adult and $347.50 per child with the maximum penalty set at $2,085.

If someone owes a penalty, it will be taken from their 2018 tax refund. Unlike nonpayment of child support or other activities, the federal law prohibits the government from garnishing wages or filing liens to collect an insurance penalty.

Starting in 2019, however, the individual mandate penalty for not having health insurance has been eliminated. Pennsylvania, unlike Massachusetts or New Jersey, does not have a state-based mandate for individuals to have health insurance.

State Cancels Procurement for Independent Enrollment Broker for Long-Term Support Services

In late August, the Department of Human Services (DHS) announced the cancellation of a procurement that began in April 2017 for an Independent Enrollment Broker (IEB) to provide enrollment assistance to those applying for Medicaid funded long term services and supports and for those enrolling in Community HealthChoices (CHC).

Consumers have reported many problems and frustrations in their dealings with the current IEB, Maximus. For those applying for long term services and supports the process has been laborious, lengthy and confusing. Readers may recall that in April 2016, Maximus became responsible for application and enrollment process into the Aging waiver, which had previously been done by the Area Agencies on Aging. However, Maximus was not able to provide applicants enough enrollment assistance- especially with tasks such as obtaining physician certifications and identifying and obtaining documents needed for the financial eligibility process. Consequently, many applicants were denied because they did (or could) not complete an application. With the implementation of CHC, the enrollment broker system has become more stressed system because Maximus took on the additional responsibility of enrolling people into CHC plans.

DHS stated it is canceling the IEB procurement to reconsider the scope of the procurement and services a vendor would provide going forward. The Department plans to utilize recent experiences with the implementation of CHC and says it will solicit information and input on the structure and requirements prior to issuing a future independent enrollment Request for Proposals. Advocates are hopeful that along with a new IEB, a more accessible, efficient and streamlined process applying for long term services and supports will be developed.

The state anticipates issuing a new procurement in the coming months with the transition of services to the selected vendor starting on January 1, 2020. After the transition is completed, the selected vendor will begin providing services on July 1, 2020. We will keep readers updated with additional information on the new procurement as it becomes available. In the meantime, DHS will continue to contract with Maximus to provide independent enrollment broker services.

State Delays FED Implementation

In our May newsletter we announced the state's intent to implement a new assessment tool called the Functional Eligibility Determination (FED) when assessing the clinical need for Medicaid-funded long term services and supports (LTSS) of older adults and people with physical disabilities. Implementation of the FED was initially slated to begin in July 2018 and then it was pushed back to August. The state has now announced it is delaying implementation of the FED until the spring of 2019 to train persons who will be administering the tool. Advocates, including PHLP, have raised questions and concerns about the validity of the new instrument compared to the current assessment tool.

For individuals to receive Medicaid-covered LTSS covered by the Office of Long Term Living, they must meet state defined functional eligibility criteria which are based on physical abilities. To determine whether an individual meets the functional eligibility criteria, states use functional assessment tools—sets of questions that collect information on an applicant's health conditions and functional needs. The federal government does not require state Medicaid programs to use any specific assessment tool to determine eligibility for Medicaid-covered LTSS. In fact, a recent analysis of states' functional assessment tools shows that there are at least 124 tools currently in use for eligibility determination and care planning.

As we reported in May, Pennsylvania officials tested the FED over the past year. The testing compared results from the FED and the current assessment instrument called the Level of Care Assessment (LOCA). Assessors administered both the LOCA and the FED to 160 applicants to compare results. The results of that testing raised concerns about the proposed use of the FED. We will continue to keep readers updated about new developments on this issue in future newsletters.

CHC Enrollment Underway in Southeast PA

Nearly 130,000 people in Southeastern PA are being moved to Community Health Choices (CHC) on January 1, 2019. This includes: people with Medicare and Medicaid (dual eligibles); people in the Aging, Attendant Care and Independence Waivers, most people in the OBRA Waiver, and people in nursing homes being paid for by Medicaid.

All of those being moved to CHC should have received a notice telling them about CHC and providing them with information about how to enroll in a CHC plan. The notices are being mailed in batches through October 12. If these individuals do not make a plan choice by November 14th, the state will assign them to a plan. However, individuals can still make a plan choice after that date and as long as they enroll in a plan by December 21st, their plan choice will prevail, and they should be enrolled in that plan on January 1st.

Later in November, letters will be sent to those individuals moving to CHC either confirming their plan choice or telling them about the plan they were assigned to by the state. As of October 3rd, the state reported that 4,600 people had already enrolled into a CHC plan, most of them by calling the CHC Enrollment Broker directly.

As a reminder, the three CHC plans in the Southeast are: Keystone First, PA Health and Wellness, and UPMC Community HealthChoices. The enrollment packet sent to those moving to CHC included comparison information about these three plans. To determine in which plans specific providers are participating, individuals may call the CHC Enrollment Broker at 1-844-824-3655 or use the provider search tools on the plans' websites. The ability to search by individual provider on the CHC Enrollment Broker's provider search tool is expected to be functioning by October 18th. Anyone who does not receive an enrollment packet by October 19 or who would like the information sent again can contact the CHC Enrollment Broker. Copies of each notice and most of the information contained in the enrollment packet can also be found here.

Update on CHC Implementation in Southwest PA

State officials announced that they are now permitting at least one CHC plan in the Southwest to resume issuing decisions denying or reducing long term services and supports to the older adults and individuals with disabilities who are members of their plan

As reported in our June newsletter, the state had placed AmeriHealth Caritas, PA Health & Wellness and UPMC Community HealthChoices in corrective action after PHLP provided examples of problems with service plans and denial notices that had been sent to consumers All three CHC plans had been sending denial notices to participants that did not include any explanation or reasoning for why services were being reduced or why requests for new or increased services were not approved. The state agreed that justifications like "you have been assessed as not needing these services" or "the services are not medically necessary" without any further explanation are insufficient. The state reacted swiftly and prohibited all three CHC plans from issuing denial or reduction notices until the state was convinced the CHC plans knew how to do things correctly going forward and lifted the sanction.

Over the last few months the state has required the plans to retrain their staff and review the service plans being developed for members getting LTSS. In addition, the state has been reviewing all denial decisions the plans are intending to issue to make sure the decisions are clearly written and adequately explain the reasons for the decision

In early September, the state gave the go-ahead to one CHC plan-UPMC Community HealthChoices-to again issue decisions denying or reducing services to its members. UPMC officials said they have notified at least 43 participants of denial or reduction of services — usually in the hours or the type of assistance a care attendant provides in their homes.

The notices tell the consumers they have the right to appeal the decision and how to proceed with an appeal. The two other CHC plans, AmeriHealth Caritas and PA Health and Wellness have not yet been given the go-ahead by the state to resume issuing decisions denying or reducing services. Consumers who receive a CHC plan decision reducing or ending services they are currently receiving should file a grievance quickly. If they request a grievance within 10 days of the date of the decision, they will continue to get the services they have in place until the grievance is decided.

General Assistance Is Back: What Advocates and Consumers Need to Know

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

Following the court's decision, Pennsylvania has now reinstated its GA program that provides a monthly cash benefit to those who qualify. Individuals can qualify for General Assistance (GA) if they:

- Have a temporary or permanent disability; or
- Are a child under 18 who is not living with a relative; or
- Are between the ages of 18 and 21 and in high school; or
- Are caring for an unrelated child under the age of 13 or are caring for someone who is ill or disabled; or
- Are a victim of domestic violence (benefits will be limited to 9 months in a lifetime); or
- Are in a drug or alcohol treatment program that prevents them from working (benefits will be limited to 9 months in a lifetime)

The maximum GA cash grant for individuals in most Pennsylvania counties who have no other income is $205 per month or $316 per month for a married couple.

Applications Are Now Being Taken For GA!

Those wishing to apply for GA may do so in person at their local County Assistance Office or online at www.compass.state.pa.us. A face-to-face interview is required as part of the application process. Those who qualify can start receiving benefits as early as this fall, with benefits to be paid retroactively back to the date of eligibility. In general, that means the date all required application verification documents are submitted and an interview is completed.

CLS created a web page explaining more about who is eligible for GA, how medical providers can

help their patients applying for GA, and what documents individuals will need to provide when they apply. Visit www.clsphila.org/GA for more information. Anyone turned down for GA can appeal that decision. To get free legal help with your appeal, go to www.palegalaid.net and click "Find Legal Help."

The Health Impact Of The Proposed Public Charge Rules For Immigrants

On October 10th the Trump Administration published a proposed rule in the Federal Register defining when lawfully present immigrants should be considered a "public charge." The draft rule, posted by the U.S. Department of Homeland Security (DHS), begins a 60-day comment period for members of the public to provide input on DHS' proposal. After the public comment period ends on December 10th, DHS will consider the comments submitted and eventually publish a final rule. Advocates, including PHLP, believe DHS' proposed rule would have a dramatic and negative impact on public health and the health care system.

For over a century, the Immigration and Nationalization Act has required most immigrants (not including refugees, asylees and certain other exempt groups) who seek to enter the United States, and most non-citizens within the United States who want to obtain permanent residency status, to show that they are "not likely to become a public charge." The Act does not define "public charge," but under 1999 guidance from the federal government, the term has only been applied to non-citizens who rely on cash benefits for most of their income, or to those who require public assistance for long-term care or institutionalization. The receipt of non-cash benefits, including publicly-funded health insurance, does not make one a public charge.

The Administration's proposed regulations would end those exemptions and redefine "public charge" as including non-citizens who receive certain monetizable benefits that can be quantified, including Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP) and federal housing support. In addition, except in limited circumstances, a non-citizen could be considered a public charge for receiving **Medicaid or premium and cost-sharing subsidies under Medicare Part D for 12 out of 36 months**. Immigrants who use these benefits for fewer months could also be found to be a public charge if they also receive monetizable benefits. The proposal posted by DHS also seeks comments as to whether participation in the Children's Health Insurance Program (CHIP) could also cause a non-citizen to be found to be a "public charge."

DHS' changes would create a significant disincentive for immigrants to enroll in publicly-funded

health insurance programs. In its comments, DHS estimates that 2.5% of the eligible population of immigrants and their family members who are otherwise eligible for Medicaid or Medicare Part D subsidies will either dis-enroll or forego participation in the programs. 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.

"Despite efforts to assure families that Medicaid and CHIP could not be used in public charge determinations under previous policy, many eligible immigrants did not enroll themselves or their children because they feared that it could negatively affect their status. The proposed rule would amplify these fears, which would likely lead to broad falloffs in participation in Medicaid and other programs among a broader group of individuals that those directly impacted by the [proposed] policy change," KFF's report states.

Similarly, the National Health Law Program's issue brief on DHS' proposed rule notes that if the rule becomes reality, it "will likely have a chilling effect such that many immigrants and their family members abstain from securing health care programs or services."
Again, the public has 60 days to comment. During this period, health care providers, health policy experts, and the public health community will have an opportunity to weigh in. PHLP plans to submit comments. Check our future newsletters and our website for our draft comments.

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

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