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Department of Public Welfare Now Called Department of Human Services

Effective November 24, 2014, the Pennsylvania Department of Public Welfare began using its new name: **the Department of Human Services**. Starting with this newsletter, we will refer to the Department using its new name. Please note the Department's new website: www.dhs.state.pa.us. Anyone who visits the previous website will be directed to the new one. As a reminder, although the Department of Human Services name is now in use, references to the previous name will continue to be seen. The transition to full use of the new name is slated to happen over time as signs, forms, and other items are replaced when needed.

Immigrants Losing Medicaid Need to Act to Keep Coverage!

Adult immigrants who currently have Medicaid coverage under a General Assistance category, but who cannot qualify under the new adult category, will need to take quick action to avoid a gap in health care coverage after the end of the year. Affected individuals were sent letters in November telling them that the General Assistance related Medical Assistance program (GA-MA) is ending December 31st. The Department of Human Services (DHS) intends to send formal termination notices in early December.

Please note: Pennsylvania calls its Medicaid program "Medical Assistance." We use the general term Medicaid throughout the newsletter.

As a part of the Healthy Pennsylvania plan, Pennsylvania is eliminating all GA-related categories of Medicaid. Unlike other Medicaid programs, GA-MA is solely state funded. Because of this, it was able to provide coverage to groups that are not typically eligible for Medicaid including very low-income individuals who: have temporary disabilities, need health sustaining medications, are domestic violence victims, or are older adults whose immigration status prevents them from qualifying for federally-funded Medicaid coverage.

Who qualifies for the new adult Medicaid category?

Most current GA-MA recipients will qualify for Medicaid under the new adult category that starts January 1, 2015 because the GA-MA income limits are well under the income limits for the new adult Medicaid category (138 percent of Federal Poverty Level). However, because the new adult category of Medicaid is federally funded, only immigrants with a qualified immigration status are eligible.

Which immigrants are not eligible for the new adult Medicaid category?

Immigrants are generally required to be in a qualified immigration status for five years before they can qualify for Medicaid. This is referred to as "the five year bar." Individuals currently receiving GA-MA coverage who do not meet this requirement will not be eligible for Medicaid after December 31st unless they fit into one of the exceptions listed in the next section.

Note: Emergency Medical Assistance is **not** affected by the elimination of the GA-MA categories and remains an option for people whose immigration status prevents them from qualifying for Medicaid but who have an emergency medical condition that, if left untreated, would result in serious impairment of bodily functions or of a body part or organ, or in death.

Which immigrants still qualify for Medicaid?

Adults (persons older than age 21) who have been Legal Permanent Residents in the United States for five years or more, as well as those who entered the United States as humanitarian immigrants such as asylees and refugees, can qualify for the new adult Medicaid category.

Children under age 21 and pregnant women who are "lawfully present" can qualify for Medicaid regardless of how long they have been lawfully present in the United States. Lawfully present individuals include those who are here legally with permission to remain permanently in the country as well as those who are allowed to be here for a specified time in order to live, work, or go to school.

What should immigrants losing Medicaid do?

Immigrants losing their GA-MA should receive a formal termination notice from DHS in early December. Immigrants who will not remain on Medicaid under a different category or qualify for the new adult category can appeal this decision if they believe that their immigration status may still qualify them for continued Medicaid coverage.

Immigrants who will not qualify for Medicaid should contact the Federal Marketplace **as soon as possible** to purchase a Marketplace plan. They will be eligible for help to pay for insurance purchased through HealthCare.gov. Typically, people need to have income above 100 percent of the federal poverty level ($11,670/year for a single person and $23,850/year for a family of four) to qualify for Marketplace premium tax credits or cost-sharing subsidies; however, immigrants can qualify for this help even if their income is

less than 100 percent FPL **if**: 1) they are not eligible for Medicaid **and** 2) the immigrant, or the person who claims them as a dependent, files taxes for 2015. Open enrollment on HealthCare.gov has already started and ends February 15, 2015. Individuals should apply for coverage by **December 15, 2014** to ensure that the coverage will start January 1st. Application help is available-visit localhelp.healthcare.gov.

Those who have questions about whether their immigration status allows them to qualify for Medicaid and anyone needing further advice about coverage options can contact PHLP's Helpline at 1-800-274-3258.

SelectPlan Extended, But Women Need to Act to Get Broader Health Coverage

Women who currently receive the SelectPlan for Women program should take action in early December to either apply for coverage under the new adult Medicaid category **or** apply for Marketplace coverage through HealthCare.gov to be sure they have comprehensive health care coverage starting January 1, 2015. The SelectPlan for Women program provides very limited health care services for almost 80,000 women who are uninsured or underinsured and who do not otherwise qualify for Medicaid; specifically, it covers family planning, breast exams and Pap smears. This program was slated to end December 31st, but advocates were successful in urging the Department to extend it until June 30, 2015 to allow time for women to transition to more comprehensive coverage.

Women with incomes below 138 percent FPL should apply for Medicaid via Compass starting December 1st. Paper applications can also be submitted to a woman's local County Assistance Office. If a woman meets this income requirement, then she should qualify for the new adult Medicaid category for coverage beginning January 1st. Her SelectPlan coverage will likely end when the new Medicaid coverage begins.

If a woman's income is higher than this limit, then she should apply for coverage through HealthCare.gov, also known as the Marketplace. Tax credits and subsidies are available to make this coverage more affordable. **For Marketplace coverage to start January 1st, women must apply by December 15th**.

Although advocates continue to urge the Department of Human Services (DHS) to use the information available in their system to either automatically approve Select Plan participants for the new adult Medicaid category or share the information with the Marketplace, no decision has been made by DHS on this matter. As a result, affected women are encouraged to be proactive and explore the options described above so that they can have broad health care coverage as soon as possible.

Household size	Monthly Income Limit (138% FPL)
1	$1,342
2	$1,809
3	$2,276
4	$2,743

Notices will be sent in December to SelectPlan participants telling them about the program's extension and their options for more extensive health care coverage. Women can call PHLP's Helpline at 1-800-274-3258 for advice and help.

Details of Adult Medicaid Benefit Package Changes Released

The Department of Human Services (DHS) recently released a draft benefit plan comparison chart that summarizes the three benefit packages created as part of the Healthy PA initiative. The full comparison chart is available under the "Consumer Resources" section of www.healthypa.com.

Despite the election of Governor-Elect Tom Wolf, who publicly opposed Governor Corbett's Healthy PA initiative, DHS continues to move forward implementing the initiative's significant benefit changes. On January 1, 2015, DHS intends to change the benefit packages for current adult Medicaid recipients and start a benefit package for the new adults who qualify for the Medicaid expansion and are enrolled in the Private Coverage Option. Governor-Elect Wolf will be inaugurated on January 20, 2015.

What is covered by the new benefit packages?

The following chart condenses the DHS comparison chart to highlight differences in benefit limits and caps. It also compares the new benefit packages to the current benefit package for most adult Medicaid recipients. As the chart makes clear, recipients assigned to the "Healthy" (low-risk) benefit package will face a significant reduction in benefits.

This information is based on DHS's benefit plan comparison chart, which summarizes Medicaid state plan amendments that have been submitted to, but have not yet been approved by, the federal government. DHS plans to implement these benefit packages prior to receiving federal approval.

Service	Current Medicaid Limits for Adults	"Healthy Plus" High-Risk Plan	"Healthy" Low-Risk Plan	"Healthy PA PCO Benefits"
Specialist/ Doctor Visits	18 per year unless referred by PCP	No limit	4 per year	No limit
Optometrist Services	Included in 18 per year limit	1 visit per year	1 visit per year	1 visit per 2 years
Dental	Covered with limits	Covered with limits	Covered with limits	Not covered
Pharmacy	6 per month	No limit	6 per month	No limit
Radiology	No limit	No limit	6 tests per year	No limit
Lab Work	No limit	No limit	$350 per year	No limit

Service	Current Medicaid Limits for Adults	"Healthy Plus" High-Risk Plan	"Healthy" Low-Risk Plan	"Healthy PA PCO Benefits"
Inpatient Acute Hospital	No limit	No limit	2 admits per year (non-emergency)	No limit
Durable Medical Equipment	No limit (except orthotics)	No limit	$1,000 per year	No limit
Medical Supplies	No limit	$2,500 per year (except for diabetic supplies)	$1,000 per year	Not covered (except for diabetic supplies)
Inpatient Drug & Alcohol Hospital	No limit	No limit	30 days per year	No limit
Outpatient Drug & Alcohol Treatment	Opiate detox: 42 visits per year. Chemo/drug-free visits: 3 visits per 30 days	No limit	Opiate detox: 42 visits per year. Chemo/drug-free visits: 3 visits per 30 days	No limit
Outpatient Mental Health Treatment	60 visits per year	No limit	30 visits per year	No limit
Therapies (Physical, Occupational, Speech)	Only through hosp., outpatient clinic, or home health agency	30 visits per year (PT and OT); 30 visits per year (ST)	Only through hosp., outpatient clinic, or home health agency	30 visits per year (PT and OT); 30 visits per year (ST)
Medical Transporta-tion	Covered	Covered	Covered	Not covered until 2016

Note: This chart was developed in coordination with Community Legal Services of Philadelphia.

Who will get which benefit package?

The **"Healthy Plus"** benefit package is assigned to current adult Medicaid recipients who are any of the following:

- pregnant;
- over age 65;

- on Medicare;
- in a nursing facility or Intermediate Care Facility for people with Intellectual Disabilities;
- in an SSI-related category (this includes MAWD, Healthy Horizons, and the Home and Community Based Service Waiver programs); or
- Determined to be "medically frail".

The **"Healthy"** benefit package is assigned to very low-income parents and relative caretakers, and former foster youth age 21 or older, who are not been found to be "medically frail." Last month, we reported that the behavioral health managed care plans do not intend to limit services for mental health and substance abuse services as allowed under the Healthy benefit package; coverage for these services will continue to be based on medical need. The limits on all services listed in the chart **will** apply to individuals who receive their coverage through the fee-for-service system (ACCESS card).

The **"Healthy PA PCO"** benefit package is assigned to individuals who qualify under the new adult Medicaid category, including current adult Medicaid recipients in a General Assistance-related category, who are not been found to be "medically frail."

The benefit package is **not** changing for children under age 21 receiving Medicaid.

For more information on recent DHS mailings and the screening process, see this PHLP special alert. Additional Consumer Resources are also available on www.healthypa.com.

Notices Confirming 2015 Benefit Package Assignment

Adult Medicaid enrollees should receive notices in early December confirming which benefit package they will receive starting January 1, 2015. These notices can be appealed if individuals do not agree with the benefit package to which they are assigned.

As discussed in last month's newsletter, the Department of Human Services (DHS) mailed letters in November to all adults on Medicaid to tell them which benefit package they would likely have in 2015. Individuals with ongoing health issues who were assigned to the "Healthy" or "Healthy PA Private Coverage Option (PCO)" benefit package were instructed to complete a health screening to determine if they were "medically frail". If so, they would receive the Medicaid Healthy Plus benefit package.

Those who receive a December notice assigning them to the "Healthy" or "Healthy PA PCO" benefit package can appeal this decision if think their assigned benefit package will not meet their needs. **Individuals who appeal within ten days of the notice mail date can keep their benefits during the appeal**. Individuals can appeal even if they were unable to complete the Health Screening that was to be done by November 26, 2014. As a reminder, appeals must be made in writing by completing the form that is included with the notice, and individuals should mail their appeal request in some way that provides proof of mailing and delivery.

The appeal process can take as long as 90 days to have a hearing and a decision issued. In addition to filing an appeal, those who wish to contest their assigned benefit package are encouraged to ask their doctor to complete an Employability Assessment Form. This form can then be submitted to the local County Assistance Office with a note asking that the individual's eligibility be re-reviewed. Depending on how the form is completed, it may help someone qualify for a category of Medicaid that automatically gives them the more comprehensive Healthy Plus benefit package. If the individual does not qualify for a disability-related category, his or her Employability Assessment Form will be forwarded for a medical frailty review.

Accessing Behavioral Health Services for Those in the Private Coverage Option (PCO)

The Private Coverage Option (PCO) is the new managed care delivery system that will provide coverage to most adults who qualify under the new adult Medicaid category that begins January 1, 2015. All adults who gain coverage through this new expansion category, including those losing the General Assistance related Medicaid discussed previously, will be enrolled in a PCO plan unless they are found to be "medically frail".

Accessing behavioral health services in the PCO plans will **not** work the same as it does for Medicaid recipients in HealthChoices. The Department of Human Services will not "carve out" behavioral health services into separate health plans as is currently done in HealthChoices. For example, a current HealthChoices Medicaid recipient living in Allegheny County has a choice of four physical health plans to enroll in and is automatically enrolled in Community Care Behavioral Health for mental health and drug and alcohol coverage.

The PCO plans will not work the same way. Even though most PCO plans will subcontract the delivery of behavioral health services, the PCO plans are responsible for covering both physical health **and** behavioral health benefits. When choosing a PCO plan, Medicaid recipients should consider their current physical health as well as mental health and drug and alcohol providers and enroll in a plan that covers **all** their health care needs.

PCO plan options vary by county. Visit www.healthypa.com and select Consumer Resources to find what PCO plans below are available.

- Aetna Better Health 1-855-346-5635 or TTY 7-1-1
- Capital Blue Cross SecureChoice 1-800-210-5600 or TTY 7-1-1
- Gateway Healthy Plus 1-855-401-8242 or TTY 7-1-1
- Geisinger Healthy Connect 1-844-866-8532 or TTY 7-1-1
- Health Partners Essential 1-855-215-7077 or TTY 7-1-1
- United Healthcare Community Plan for Adults 1-800-414-9025 or TTY 7-1-1
- UPMC for Best Health 1-855-398-8762 or TTY 7-1-1
- Amerihealth Connect 1-855-332-0729 or TTY 1-855-707-5815
- Keystone Connect 1-855-332-0434 or TTY 1-855-707-5815

Current Medicaid recipients being moved to a PCO plan have until **December 11th** to choose a PCO plan that will start January 1, 2015.

Individuals can contact PA Enrollment Services at 1-844-465-8137 or visit www.enrollnow.net to choose a plan.

Individuals who do not choose or miss the deadline will be assigned a PCO plan. Individuals are encouraged to join a plan by the deadline to help ensure they are in a plan that will meet their needs as soon as possible! Even though a plan change can be made, there will be a delay before the new plan starts.

Protections for Medicaid Recipients with Limited English Proficiency

Title VI of the Civil Rights Act of 1964 prevents programs receiving federal funding (like Pennsylvania's Medicaid program) from discriminating on the basis of race, color, or national origin. Under this law, national origin discrimination includes discrimination based on a person's ability to speak or understand English. Failure by Medicaid programs to ensure that individuals with Limited English Proficiency (LEP) have access to Medicaid services amounts to discrimination. An individual is considered to have LEP if she does not speak English as her primary language, or if she has a limited ability to speak, read, write, or understand English. This includes persons with sensory impairments (e.g. those with vision impairments or those who are deaf or hard of hearing.)

The mandate of Title VI applies to all Medicaid programs and offices, including but not limited to caseworkers at County Assistance Offices, doctors or other providers who accept Medicaid, and Medicaid Managed Care Organizations (MCOs).

A Managed Care Operations Memorandum from 2011 sets forth the requirement that all MCOs provide language services to allow LEP members to access Medicaid services. This memo is still in effect today and it directs MCOs to do all of the following:

- Provide in-person or telephonic interpretation services to members upon request;
- Disseminate written materials in five prevalent languages (Spanish, Russian, Vietnamese, Cambodian and Chinese) and make written materials accessible to members with visual impairments (i.e., Braille, large print, audiotape or CD) available upon request;
- Provide instructions in all written materials about how to access the material in other formats or languages; and
- Ensure that all MCO staff and providers understand the requirements of Title VI and can effectively access interpretation and translation services for members.

The HealthChoices Agreement between DHS and the Medicaid MCOs mandates that MCOs provide members with language services even more comprehensive than those outlined in the memo, including:

- Providing free oral interpretation services in **every language** and sign language interpreter services upon the member's request;
- Disseminating **vital documents** in alternative languages upon the member's request (Note: a "vital document" includes anything related to the access to programs and services. A prime example of a vital document is a written MCO denial of a requested service.); and
- Listing instructions on all materials (including the MCO's website) about how to access interpreter services and desired member materials in alternate languages.

MCO members should call their plan's Special Needs Unit for help accessing language services - both in interactions with the plan as well as with Medicaid providers. Direct phone numbers for each Special Needs Unit can be found in the statewide MCO directory. Members can also call their plan's Member Services line to ask for help accessing language services. The Member Services employee should facilitate access to any needed language services immediately upon recognizing the caller's need.

Anyone who receives their Medicaid coverage through the fee-for-service system (the ACCESS card) may request language services by calling the Bureau of Fee-for-Service Programs at 1-866-287-8969. When calling, choose Option #1 for English, Option #2 for Spanish, Option #3 for Vietnamese, Option #4 for Cambodian, Option #5 for Russian, Option #6 for Mandarin Chinese, or Option #7 for a sign language interpreter.

The availability of meaningful language services has been problematic and PHLP continues to monitor these issues. Individuals and advocates working with LEP populations should call PHLP's Helpline if unable to obtain interpreter services or written information in the appropriate language or format through a Medicaid MCO.

Additionally, individuals who feel discriminated by the Medicaid program on the basis of their ability to speak or understand English may file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights (OCR). More information about OCR complaints is available online.

PA Supreme Court Preserves Family's Challenge to Insurer's Coverage of Autism Services in School

In an appeal brought by PHLP, the Pennsylvania Supreme Court ruled that Pennsylvania families have a right to fight in court over whether a private insurance company must cover in-school autism care.

Burke v. Independence Blue Cross is a case about whether a private insurance company's refusal to pay for in-school autism services violated Pennsylvania's Autism Insurance Law (also called Act 62). This Law requires certain Pennsylvania group health insurance plans to pay for diagnoses and treatment of autism for children and adolescents. Independence Blue Cross (IBC) argued that it was exempt from covering autism treatment in schools under a specific exception in the law because their policies had general exclusions of coverage of any services provided in a school setting. A state trial court decided against IBC and ruled that the exception relied upon by IBC did not allow them to exclude coverage of autism treatment services in school.

IBC appealed to the Pennsylvania Superior Court. Although IBC agreed that the Court had jurisdiction to hear the Burke's case and the Superior Court never questioned jurisdiction during oral arguments, the Court later held that the appeal language in the Law failed to give families a right to a court appeal. As a result, the Superior Court threw the case out without addressing the question of IBC's obligation to cover in-school autism services. PHLP, on behalf of the Burkes, appealed this decision to the PA Supreme Court which agreed to hear the case.

Writing for a unanimous Supreme Court, Justice Thomas Saylor held the Superior Court should not have dismissed the Burke's case. This is a matter of "public importance," wrote Justice Saylor, affecting "potentially thousands of individuals across the commonwealth diagnosed with autism spectrum disorders." Justice Saylor noted that denying families like the Burkes access to a court to contest denials of coverage for autism treatments was "constitutionally problematic." The case has now been returned to the PA Superior Court to decide whether the trial court was correct in finding that IBC was obligated to cover autism treatment services provided in school.

Senior PHLP Attorney David Gates was pleased with the Supreme Court's decision. "The Court has enabled the Burkes to pursue their legal claim against Independence Blue Cross so we can get to a final decision on whether Blue Cross is required under state law to cover their son's autism treatment in school."

Advocates note that having the insurer pay for services at home **and school** allows services to be provided by the same agency and staff in both settings to ensure consistency of treatment interventions and to build trust between the child and his treatment staff. It will also save the Commonwealth money insofar as many of these services are currently paid for with public dollars under Medicaid.

Individuals interested in learning more can contact David Gates at dgates@phlp.org. As noted in a previous newsletter, families, clinicians and PHLP have formed an Applied Behavioral Analysis [ABA] in PA Coalition to advance full coverage of autism treatment, especially ABA. The coalition's work can be followed on Twitter (@ABAinPA). A class action lawsuit has also been filed by the Disability Rights Network to obtain full coverage of ABA under Pennsylvania's Medicaid program.

Marketplace Updates

Marketplace Open Enrollment is now underway and will end February 15, 2015. During this time, individuals, can sign up for Marketplace coverage or change their Marketplace coverage through HealthCare.gov or 1-800-318-2596. Consumers can also apply for financial help (premium tax credits and cost-sharing subsidies) to pay for Marketplace coverage or provide updated financial information to have the amount of help they currently receive adjusted for 2015. The rest of this article provides important information for various groups of people seeking Marketplace coverage or who already have this coverage. Regardless of which group someone falls into, help is available-local help can be found at localhelp.healthcare.gov.

- **Individuals Covered by the Marketplace with Incomes <138% FPL**: Those with income below this limit (see page 3 for figures) should receive a notice by mid-December to let them know that Pennsylvania is expanding Medicaid starting January 1, 2015. These individuals will be encouraged to apply for Medicaid coverage as soon as possible.

  Anyone in this group who fails to apply for Medicaid may have to pay back some or all of the tax credits and subsidies they receive in 2015 when they pay their 2015 taxes. This is because these individuals could qualify for Medicaid, which is considered Minimum Essential Coverage. Under the law, individuals who are eligible for Minimum Essential Coverage cannot qualify for premium tax credits and subsidies through the Marketplace.

- **Individuals Currently Covered by the Marketplace with Incomes > 138% FPL**: These individuals should be reviewing their current coverage to see if it will continue to meet their needs and be affordable to them in 2015. If not, they should act by December 15th to ensure that they are in a plan that will meet their needs starting January 1, 2015. Even though people in this situation have until February 15, 2015 to change their plan for 2015, acting **after** December 15th means they will remain with their current coverage that may not meet their needs or that may no longer be affordable for some period of time in 2015. Coverage will automatically renew in the same plan, or in a similar plan if the current plan is unavailable in 2015, unless someone takes action to change their coverage.

  Those receiving tax credits and subsidies to help pay for Marketplace coverage should update their financial information with the Marketplace to make sure their financial help reflects their current situation. Again, taking action by December 15th helps ensure that individuals receive the correct amount of financial help starting January 1, 2015 and reduces the possibility that they will have to repay any tax credits or subsidies they get when they file their 2015 taxes. Otherwise, the financial assistance people receive will automatically continue at the current level in 2015, which may or may not be appropriate to someone's financial situation. Consumers need to take action and update their financial information with the Marketplace in order to have their tax credits and subsidies recalculated.

- **Individuals Without Minimum Essential Coverage Seeking Marketplace Coverage for the First Time in 2015:** Those without Minimum Essential Coverage should be researching their coverage options and applying for financial assistance to help pay for Marketplace coverage by visiting HealthCare.gov or calling 1-800-318-2596. **Applying for coverage before December 15, 2014 means coverage can start January 1, 2015.** If a person enrolls after this date, the start date of their coverage will depend on when the enrollment is completed. All enrollments for 2015 coverage must be completed by February 15th, which is the end of the Marketplace Open Enrollment Period.

U.S. Supreme Court to Rule on Health Care Tax Credits and Subsidies

Earlier this month, the U.S. Supreme Court announced it would hear a case, King v. Burwell, that challenges the legality of financial assistance (i.e., premium tax credits and cost-sharing subsidies) provided to help people buy insurance under the Affordable Care Act through the Federally Facilitated Marketplace (FFM). The suit asserts that financial assistance is only legal in the states that run their own Health Insurance Marketplace (i.e., exchanges). Since Pennsylvania is among the 36 states that declined to operate their own exchange and instead defaulted to the FFM (HealthCare.gov), the case impacts hundreds of thousands of Pennsylvanians.

Those who brought the lawsuit argue that the text of the Patient Protection and Affordable Care Act (ACA) only allows for financial assistance in the form of tax credits and subsidies through **state-run exchanges.** They assert that the regulations issued and implemented by the Internal Revenue Service (IRS) should be declared invalid because they go beyond the language of the Act and allow subsidies to be provided through the FFM as well as state-run exchanges. In other words, they claim that the IRS exceeded the authority Congress granted to it under the Act.

If the plaintiffs' challenge is successful, individuals who obtained coverage through the federally-facilitated Marketplace would lose their tax credits and, in many cases, their health insurance coverage since it may be unaffordable without the financial help.

Only 14 states have set up their own exchanges and they received millions of dollars from the federal government for the first year of operation. The federal government's official deadline for states to apply and receive federal funding to build a state-run exchange ended this month, but that deadline might be extended given that a Supreme Court decision could leave many people across the nation, including hundreds of thousands of Pennsylvanians, vulnerable.

Oral arguments in the U.S. Supreme Court are expected to be held in March and a decision issued by late June or early July 2015.

Attention Medicare Beneficiaries!

The Medicare Annual Open Enrollment Period ends December 7th. After that date, individuals will only be able to change their Medicare health and/or drug plan for 2015 if they qualify for a Special Enrollment Period. Beneficiaries are encouraged to review their current plan and available options for 2015 and act by this date if they need to change their plan. APPRISE (1-800-783-7067) is available to help people compare Medicare plan options and enroll in coverage.

Dual eligibles (those with Medicare and Medicaid) as well as individuals receiving the Medicare Part D Extra Help have an ongoing Special Enrollment Period and can change their plan at any time. So, these individuals who wish to change their Medicare plan for 2015 are still able to do so after December 7, 2014.

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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