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Medicare Open Enrollment Period Underway:

Time to Compare Plan Options & Make Changes

Medicare's Annual Open Enrollment Period has been underway since October 15th and will end December 7th. **All** Medicare beneficiaries can add (or drop) drug coverage during this period and change their Medicare Advantage plan or their Medicare prescription drug plan for 2015. After this period ends, individuals are generally only allowed to make changes to their health or drug plans during the year if they qualify for a Special Enrollment Period.

Dual eligibles (people that receive both Medicare and Medicaid) and people receiving the Part D Extra Help qualify for an ongoing Special Enrollment Period and can change their plans at **any** time during the year.

It is important that **all** Medicare beneficiaries review their current plan, as well as their 2015 plan options, to determine whether their best choice is to stay with the plan they have or to switch to a different plan. Pennsylvanians on Medicare continue to have many plan options available. As discussed in our September newsletter, next year there are 26 stand-alone prescription drug plans available for enrollment (8 of which are zero-premium for people with full Extra Help). Individuals can also choose between 11 and 33 Medicare Advantage plans depending on the county where they live. At least one Special Needs Plan for dual eligibles is available in every county except for Bradford and Franklin.

Here are some factors to consider when comparing plan options:

Costs: What does the plan charge for a premium? Is there a deductible? What are the co-pays for medications, for other services? How much will my drugs cost in the doughnut hole?

> Please note: if you qualify for Extra Help, you are **not** required to pay the plan's listed costs for prescription drugs. Instead, your Extra Help limits how much you pay for drugs under any plan you join. You can contact Medicare for more information about drug costs when you have Extra Help.

Coverage: Are the drugs I take covered on the plan's formulary? Does the plan have any special rules for coverage of my drugs such as requiring Prior Authorization, Step Therapy, or having Quantity Limits ?

Pharmacy network: Can I continue to go to my local pharmacy to get my medications? What are the plan's mail order options? Does the plan have "preferred" pharmacies? If so, how much will I pay at a preferred versus a non-preferred pharmacy?

Provider Network (if considering a Medicare Advantage Plan): Are all the health care providers I use in the plan's network? Does the plan have any rules for how I access care-i.e., do I need a referral to see a specialist?

Anyone who needs help comparing plans or learning about plan options for next year can call Medicare (1-800-633-4227), APPRISE (1-800-783-7067), or PHLP (if dual eligible) at 1-800-274-3258. Plan options can also be researched by going to www.medicare.gov.

Medicare 2015 Webinar on November 5th– Spaces Still Available!

PHLP is offering a free webinar training 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 webinar will be conducted **November 5th from 1:30pm-3:30pm**.

The 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 the webinar, please click here or visit our website at www.phlp.org. Please share this announcement with others who may be interested!

Medicare 2015 Costs Announced

Medicare recently updated the premiums, deductibles, and co-pay amounts for beneficiaries in 2015. Once again, there will be **no change** to the Medicare Part B monthly premium or annual deductible. The Centers for Medicare & Medicaid Services credit slower health care growth within the Medicare program since implementing various reforms required by the Affordable Care Act as the reason for the continued relative stability in Medicare costs next year. The following costs are effective January 1, 2015.

Medicare Part A

Part A is the hospital benefit of Medicare that covers inpatient hospital care, care in a skilled nursing facility (up to 100 days), some home health care, and hospice (care for the terminally ill) services. In 2015, the Part A hospital deductible will be $1,260. If someone is in the hospital longer than 60 days, their cost-sharing will be:

- $315/day for days 61-90
- $630/day for days 91-150

Beneficiaries in a skilled nursing facility that accepts Medicare will pay $157.50/day for days 21-100. There is no cost for Medicare-covered care for the first 20 days.

Medicare Part B

Part B is the medical benefit of Medicare that covers outpatient services such as doctor visits, outpatient hospital services, diagnostic tests and lab work, ambulance services, and durable medical equipment. The Part B monthly premium will continue to be $104.90 in 2015. As in previous years, beneficiaries with higher income (greater than $85,000 for a single person/$170,000 for a married couple) will pay a higher Part B monthly premium. Individuals with limited incomes and resources may be able to get help through the Medicare Savings Program to cover the cost of their Part B premium.

The Part B annual deductible will remain at $147 next year. Once the deductible is met, Medicare covers both physical health and mental health services at 80%.

Medicare Part D

Medicare beneficiaries who **do not** qualify for any level of Extra Help from Medicare will pay the following costs for a **standard** Part D Plan in 2015:

- The plan's monthly premium (national average premium for a basic Medicare drug plan is $32);
- An annual deductible of **$320;**
- During the initial coverage period, a 25 percent co-pay for each prescription until the consumer's total drug costs reach **$2,960;**
- During the coverage gap (also referred to as the "doughnut hole") a percentage of the costs of their drugs (**45 percent** of the cost of brand-name drugs and **65 percent** of the cost of generics plus a small dispensing fee) until the consumer's total out-of-pocket expenses reach **$4,700;** and
- During the catastrophic coverage period, a co-pay of **$2.65**/generics and **$6.60**/brand name drugs, or a 5 percent co-pay, **whichever is greater,** for the rest of the year.

Part D Costs for Those Receiving Extra Help from Medicare

Any beneficiary 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 2015:

- $0 premium (as long as they are enrolled in a Part D plan that provides standard benefits and charges a premium below the Extra Help Benchmark amount of $33.91)

  See www.phlp.org for a list of the 2015 "Zero-Premium" stand alone prescription drug plans

- Small co-pays for their prescription medications:
  - ◊ **$1.20**/generics and **$3.60**/brand names (if income is less than 100 percent FPL) **or**
  - ◊ **$2.65**/generics and **$6.60**/brand names (if income over 100 percent 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 who qualify for **partial** extra help in 2015 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 **$66;**
- 15 percent co-pays on all of their medications until they reach total out-of-pocket expenses of **$4,700**;
- During the catastrophic coverage period, co-pays of **$2.65**/generics and **$6.60/**name brands for the rest of the year

Note: Beneficiaries who receive any amount of Extra Help from Medicare have no coverage gap (doughnut hole) no matter what Part D plan they join.

Healthy PA Private Coverage Option Expected to Begin January 1, 2015

Department of Public Welfare (DPW) officials recently reported that they have already received signed contracts from six Private Coverage Option insurance plans and expect to receive contracts from two more plans. State officials continue to move forward with the January 1st launch date for the new Private Coverage Option.

The Private Coverage Option (PCO) is a new Medicaid managed care delivery system that will provide health coverage to most adults who qualify under the new Medicaid expansion group that will begin January 1st. All adults who gain coverage through the expansion (estimated at 600,000 statewide) will be enrolled in a PCO plan unless they are found "medically frail." The PCO managed care program will operate

separately from Pennsylvania's existing Medicaid managed care program, called HealthChoices. See the September Health Law News for more details about the PCO and Healthy PA approval and implementation.

At the September meeting of the Consumer Subcommittee of the Medical Assistance Advisory Committee, DPW officials provided the following operational timeline for the Private Coverage Option:

Private Coverage Option Event	Date Occurred or Anticipated
Request For Application Released	May 8, 2014
Healthy PA Demonstration Approved	August 28, 2014
Signed PCO Agreements (Contracts) Due to DPW	October 17, 2014
DOH Operating Authority Received	October 17, 2014
PCO Agreements Fully Executed	November 15, 2014
PCO Enrollment Begins	December 1, 2014
Readiness Review Completed	December 5, 2014
PCO Coverage Begins	January 1, 2015

As of late October, DPW officials stated that eight PCO plans sought operating authority from the Department of Health; however, before this authority can be issued, the Department of Health must confirm that a plan has enough hospitals, primary care providers, and specialists in its network (and in each county where the plan intends to operate) to comply with the access requirements in state law. DPW acknowledged that the plans' establishment of adequate provider networks has taken longer than had been anticipated. We will continue to update our readers about the PCO implementation in future newsletters.

Healthy PA Benefit Package Won't Impact Behavioral Health Services for Those in HealthChoices

DPW continues to move forward with implementing the changes required under Governor Corbett's Healthy PA Initiative. State Plan Amendments have been submitted to the federal government seeking approval to enroll adults receiving Medicaid coverage into one of two benefit packages based on medical need: **Healthy** ("low risk") or **Healthy Plus** ("high risk").

Each benefit package places limits on certain physical health and behavioral health services for adults. For example, the Healthy (low risk) benefit package submitted to the federal government (**but not yet approved**) limits radiology services to six tests per year and inpatient psychiatric services to 30 days per year. Several other services such as durable medical equipment, supplies, and outpatient drug and alcohol treatment will also have limits.

Although the state is still waiting for federal approval of each benefit package, officials from DPW's Office of Mental Health and Substance Abuse Services have said that any behavioral health service limits approved will **not** apply to those who receive their Medicaid coverage through the Behavioral Health HealthChoices program. This means HealthChoices Behavioral Health Managed Care Organizations (BH-MCOs) will **not** limit services for mental health and substance abuse services regardless of whether someone is in the Healthy or Healthy Plus benefit package. Access to mental health and drug and alcohol treatment services under HealthChoices will continue to be based on medical need. The behavioral health limits **will apply,** however, to those who receive their behavioral health services through the Medicaid fee-for-service system (the ACCESS card).

As a reminder, Medicaid recipients in HealthChoices do not get to select their behavioral health managed care plan; the plan is determined by the county in which the consumer resides. The various BH-MCOs across the state include Community Behavioral Health, Community Care Behavioral Health Organization, Magellan Behavioral Health, Perform Care, and Value Behavioral Health.

Adults Currently Enrolled in Medicaid to Receive Letters About Benefit Package Changes

In early November, DPW will mail letters to approximately 800,000 households with an existing Medicaid recipient over the age of 21 to tell these individuals which benefit package they will likely receive starting January 1, 2015: **Healthy** (previously referred to as "low risk"), **Healthy Plus** (previously referred to as "high risk"), or **Healthy PA Private Coverage Option**. Although DPW is still waiting for official approval of the benefit package changes from the federal government, it plans to send these November notices to alert people of the anticipated changes.

DPW will assign individuals to a benefit package using their current Medicaid category and a review of their claims data to determine medical needs. Those placed in the Healthy package or the Healthy PA Private Coverage Option who wish to be considered for the Healthy Plus package **must** complete a health screening. The screening will be available via COMPASS or by calling the PA Consumer Service Center at 1-866-550-4355. Individuals using COMPASS will need to create a My COMPASS Account if they do not have one. Screenings **cannot** be done at the local County Assistance Offices. The letter people will receive provides further details about how and when to complete the health screening.

Adult Medicaid recipients will then receive a notice in December confirming their benefit package assignment for coverage starting January 1st. Persons can appeal this decision if they do not agree with the assignment.

Act 150 Waiting List Update: Action May Be Needed

Pennsylvania recently increased funding for the Act 150 Program to serve nearly 300 adults on the program's waiting list who were determined to need a nursing home level of care. These individuals, many of whom have been on the waiting list for several years, need attendant care services to help them with activities such as bathing and dressing so they can remain in the community; however, they do not qualify for a Home and Community Based Service (HCBS) Waiver program-usually due to excess income or resources.

In August, the Office of Long Term Living (which administers the Act 150 program), sent letters to those on the Act 150 waiting list who were determined to need a nursing home level of care, urging them to call the Independent Enrollment Broker at 1-877-550-4227 as soon as possible if they still needed attendant care services. We have been told that the Office of Long Term Living has tried to follow up with anyone who was sent a letter but who did not respond. Unfortunately, the state has been unable to locate 75 individuals.

PHLP urges anyone who knows an adult with a physical disability who is not currently enrolled in an HCBS Waiver program to find out whether that individual has applied for attendant care services through the Independent Enrollment Broker. If they have, that person should immediately contact the Independent Enrollment Broker again at 1-877-550-4227 to find out if they are among the individuals now eligible for attendant care services under Act 150.

Anyone on the Act 150 waiting list who was determined to not need a nursing home level of care is urged to reapply if their functional limitations have increased since their last assessment. Contact the Independent Enrollment Broker at 1-877-550-4227 to reapply. Those on the Act 150 waiting list who experience problems enrolling in the program should call PHLP's Helpline at 1-800-274-3258.

PA Senate Approves Bill to Regulate Navigators

Earlier this month, the Pennsylvania Senate passed a bill (SB 1268) to regulate Health Insurance Navigators who are certified under the Affordable Care Act to assist consumers in accessing coverage through the Health Insurance Marketplace. The bill requires Navigators to register with the Pennsylvania Department of Insurance, pay a registration fee, and pass a criminal background check. The bill also lists activities that Navigators are prohibited from engaging in including responding to consumers' questions about policy provisions or coverage (an essential part of counseling people about plan options through the Marketplace). Violations of the prohibitions can result in fines up to $5,000.

The Pennsylvania Insurance Department opposed the legislation, stating that in the first year of open enrollment for the Health Insurance Marketplace, there have been no complaints of inappropriate actions by Navigators. The bill now heads to the Insurance Committee of the PA House of Representatives for consideration. If passed and approved by the Governor, the bill would go into effect in February 2015, or at the end of the 2015 open enrollment period, whichever is later. Individuals who wish to voice their support or opposition to this bill should contact their local representatives.

Federal Government Notifying Current Marketplace Enrollees About Renewing Coverage

In past weeks, the federal government began sending notices to Pennsylvanians who currently have coverage through the Health Insurance Marketplace about how to renew their coverage for the 2015 calendar year. These notices instruct individuals to contact the Health Insurance Marketplace (www.healthcare.gov or 1-800-318-2596) starting November 15th, update their application information, and compare their plan options to enroll in a plan that will best meet their needs in 2015.

Each year, Health Insurance Marketplace plans change their costs and benefits. That means enrollees need to review their current plan to determine if it will continue to meet their medical needs and their financial situation. Also, new plans might be available in 2015 for people to explore.

Enrollees are encouraged to contact the Health Insurance Marketplace between November 15th and December 15th to update their information, compare plan options, and find out if any financial help (e.g., premium tax credits and cost-sharing subsidies) they receive to pay for coverage will change so coverage can continue smoothly on January 1st. If someone with Marketplace coverage does not contact the Marketplace to update their information, their enrollment in the same plan will renew (if the plan is still available in 2015), and the financial help they received in 2014 will be renewed for 2015. Since Open Enrollment ends February 15th, individuals have until then to change their plans and update their financial information.

Visit www.healthcare.gov for additional information about Marketplace Open Enrollment and to view the Marketplace's 5 Steps to Staying Covered.

Anyone without "minimum essential coverage" (i.e., health insurance that covers basic health care needs) will be able to enroll in Marketplace coverage and apply for premium tax credits and cost-sharing subsidies during the Health Insurance Marketplace Open Enrollment Period which starts November 15, 2014 and ends February 15, 2015. Help is available for people who need more individualized assistance applying for help with Marketplace coverage costs and selecting a plan. **Remember: for coverage to start January 1st, plan enrollment must be completed by December 15th.**

PHLP Expanding Its Helpline Until the End of 2014!

Starting November 3rd, PHLP's Helpline will be open Monday through Friday from 8 am to 8 pm until the end of the year to handle the expected increase in call volume related to the Healthy PA expansion of Medicaid through the Private Coverage Option and other Medicaid changes for adults. As a reminder, individual consumers, family members, and advocates across the State can call our Helpline for advice and assistance. Our Helpline is not answered live. People must call and leave a message and a staff person will call them back as soon as possible to discuss their situation to determine how PHLP can help. Individuals can reach our Helpline by calling 1-800-274-3258 or by e-mailing staff@phlp.org.

Guidance Sought on Marketplace to Medicaid/PCO Transition For Those Who Earn Less than 138 Percent FPL

Pennsylvania's decision to expand Medicaid through the Healthy PA Private Coverage Option (PCO) starting January 1, 2015 creates a potential problem for adults with incomes between 100 percent and 138 percent of the Federal Poverty Level (FPL) who are currently covered by the Health Insurance Marketplace. These individuals were able to qualify for premium tax credits and cost-sharing subsidies in 2014 to help make the Marketplace coverage more affordable to them. Given the fact that these adults can now qualify for coverage beginning in January 2015 through the Healthy PA PCO or Medicaid (if medically frail), state officials are awaiting further information and guidance from the federal government about whether these individuals will be able to stay with their Marketplace coverage for a transition period or whether they will need to move to the Healthy PCO or Medicaid right away.

The Affordable Care Act does not allow individuals who qualify for Medicaid to receive premium tax credits through the Health Insurance Marketplace. Since adults earning less than 138 percent FPL will qualify for the Healthy PA coverage in 2015, one area of concern is how these people will be notified of this new option and whether they'll be instructed to apply for Medicaid/PCO coverage immediately or be allowed to remain in the Marketplace with a premium tax credit for some transitional period. Another concern is whether these individuals would face tax consequences if they stay in a Marketplace plan in 2015 and receive premium tax credits even though they qualify under the Healthy PA Private Coverage Option or Medicaid.

We will keep readers updated any decisions about this or guidance issued in future newsletters and through PHLP's special e-alerts.

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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