PENNSYLVANIA Health Law PROJECT

Health Law PA News

A Publication of the Pennsylvania Health Law Project

Volume 17, Number 5
May 2014

Statewide Helpline: 800-274-3258
Website: www.phlp.org

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Marketplace Updates

Enrollment Numbers Released

Open enrollment to purchase a Qualified Health Plan from the Marketplace is officially closed. Government officials indicate over eight million people across the country selected and enrolled in a Qualified Health Plan during open enrollment. In Pennsylvania, over 318,000 people joined a health plan through the Marketplace with 81 percent of these individuals determined eligible to receive some financial assistance to help cover the cost of their coverage. The Marketplace determined another 42,335 Pennsylvanians eligible for CHIP or Medical Assistance.

The "Coverage Gap" & Shared Responsibility Tax Penalty

What you need to know about the "Coverage Gap"

Because Pennsylvania decided not to expand Medicaid, many low-income adults fall into what is referred to as the "coverage gap." The coverage gap applies to people who do not qualify for Medicaid under the existing rules but who at the same time make too little income (under 100 percent of the Federal Poverty Level) to qualify for premium tax credits through the Marketplace.

Do individuals in the coverage gap face a tax penalty?

Possibly, yes! Unless found exempt, individuals who do not have health insurance in 2014 will face a "shared responsibility" tax penalty. The amount of the tax penalty in 2014 is $95 or 1 percent of a person's income over the filing threshold-whichever is greater. Individuals in the coverage gap could face this tax penalty. Most will be exempt because they have income under the tax filing threshold, which is $10,150 in 2014 (if filing single). These individuals do not need to take any action.

For those with income above the tax filing threshold, a "hardship exemption" is available based on Pennsylvania's failure to expand Medicaid. However, obtaining this exemption requires a person to apply for and be denied Medicaid. These individuals need to take these two steps:

1. Apply for Medicaid through COMPASS or the local County Assistance Office and hold on to the denial notice;
2. Apply for a hardship exemption on HealthCare.gov, submitting the Medicaid denial notice.

Note: The federal government may modify these rules to make it easier for individuals in states like Pennsylvania that have not expanded Medicaid to qualify for a hardship exemption. Until then, those in the coverage gap with income above the tax filing threshold should follow the steps above to avoid the tax penalty.

Hardship Exemption Example: Mary and her two children applied for the Marketplace in January 2014. The children were found eligible for Medicaid. Because Mary's part-time job only paid her $1,600 per month, she was not eligible for premium tax credits because her projected income was under 100 percent of the Federal Poverty Level for a household of three. Given that Mary cannot afford to buy insurance at full price, she decides to apply for Medicaid but is found not eligible and she receives a denial notice. Mary then fills out a Hardship Exemption Application and attaches her Medicaid denial notice. The Marketplace reviews it and grants Mary the exemption from a tax penalty.

Highlighted Special Enrollment Periods

Since Marketplace Open Enrollment is over, people are not able to join a Marketplace plan for the remainder of the year unless they qualify for a Special Enrollment Period (SEP). Federal agencies administering the Affordable Care Act and overseeing the Marketplace continue to issue guidance clarifying, and in some cases modifying, these SEPs.

New SEP Allows People to Drop COBRA and Join a Marketplace Plan by July 1, 2014

Because of confusion among beneficiaries and advocates about the Marketplace and COBRA, the federal government recently announced a temporary SEP allowing people with COBRA coverage to voluntarily drop that coverage and join a Marketplace plan as long as they act before July 1st.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. Qualified individuals may be required to pay the entire premium for coverage.

Depending on their income, workers and their families who use this SEP may also qualify for a premium tax credit and cost-sharing reduction subsidies to help make Marketplace coverage more affordable. Anyone wishing to take advantage of this new SEP should contact the Marketplace by phone at 1-800-318-2596 to get approval. Once they have this approval, they can apply for and enroll in a Qualified Health Plan either over the phone or online at HealthCare.gov. **Individuals and their families using this SEP must enroll in a plan before July 1st.**

Under existing rules, individuals with COBRA coverage have the option to join Marketplace coverage and drop their COBRA during Open Enrollment. If they remain on COBRA outside of Open Enrollment, these individuals qualify for a SEP to join a marketplace plan **only** when their COBRA benefits are exhausted. After the end of Open Enrollment, individuals are not able to **voluntarily** drop COBRA and join a Marketplace plan. The new SEP changes that- but only until July 1st. After that, the existing rules remain in place and someone will only be able to join a Marketplace plan outside of an Open Enrollment period after their COBRA coverage runs out.

SEP for Those up for Renewal of Their Private Plans in the Individual Market

Federal guidance recently clarified that people who have individual (not group) coverage through the private market whose plan is up for renewal can choose Marketplace coverage instead of renewing their private individual policy. Under this SEP, these individuals have 120 days (beginning 60 days prior to their private plan expiring and extending 60 days after expiration) to select and enroll in a Marketplace plan if they choose not to renew their private coverage.

SEP for Those Determined Erroneously Eligible for Medicaid by the Marketplace

Some people applied to the Marketplace during Open Enrollment and were erroneously told they were eligible for Medicaid. In Pennsylvania, the Marketplace sent the person's information to the Department of Public Welfare who upon review of the information determined that the person was not, in fact, Medicaid eligible. Often, the local County Assistance Office sent a Medicaid denial notice weeks after the person initiated an application to the Marketplace. Anyone in this circumstance whose Marketplace application was started during Open Enrollment is entitled to a SEP and should call the Marketplace to obtain coverage. As a reminder, only those who have a household income above 100% of the Federal Poverty Level ($11,490 per year for a single person; $23,550 per year for a family of four) are eligible for premium tax credits.

Healthy PA Update: Pennsylvania Seeking Interested Insurers

In May, the Department of Public Welfare (DPW) announced it was seeking applications from commercial health insurance plans to provide physical and behavioral health services to approximately 500,000 low-income, uninsured Pennsylvanians, who are ages 21-64 and not medically frail. Readers may recall that Pennsylvania submitted its Healthy PA Waiver application to the federal government in April outlining its plan to expand Medicaid to adults with incomes less than 133 percent federal poverty level not through traditional Medicaid but instead through a Private Coverage Option. The Waiver application must first be approved by the federal government.

Pennsylvania and federal government officials are still negotiating the terms of the state's Waiver application. Nonetheless, Pennsylvania decided to proceed so that it would be ready to implement expanded coverage by January 2015 as proposed. Federal officials are aware that the state is moving forward with its procurement process.

Pennsylvania plans to utilize the same nine regions used by the Federally Facilitated Marketplace and to offer **at least** two insurers in each region. Any insurer wishing to operate in a given region must cover all counties within that region.

Region	Counties	Potential Enrollment (HMA Estimates)
Region 1	Clarion, Crawford, Erie, Forest, McKean, Mercer, Venango, Warren	30,700
Region 2	Cameron, Elk, Potter	2,400
Region 3	Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne, Wyoming	46,700
Region 4	Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Indiana, Lawrence, Washington, Westmoreland	90,300
Region 5	Bedford, Blair, Cambria, Clearfield, Huntingdon, Jefferson, Somerset	34,100
Region 6	Centre, Columbia, Lehigh, Mifflin, Montour, Northampton, Northumberland, Schuylkill, Snyder, Union	54,300
Region 7	Adams, Berks, Lancaster, York	57,600
Region 8	Bucks, Chester, Delaware, Montgomery, Philadelphia	153,900
Region 9	Cumberland, Dauphin, Franklin, Fulton, Juniata, Lebanon, Perry	29,800
Statewide		500,000

Source: HMA Weekly Roundup, May 14, 2014

DPW released a Request for Application to potential insurers and held a bidders conference with potential applicants in May. Representatives from 15 health plans attended the conference. The deadline for application submission is June 10th. Assuming the federal government approves Pennsylvania's Waiver application, the Departments of Public Welfare and Health will begin reviewing the provider networks of selected insurance plans in early August.

DPW hopes to receive official approval of its application soon. At the May meeting of Medical Assistance Advisory Committee, DPW reported state and federal officials are meeting weekly about the terms of the Waiver application. More information about Healthy PA can be found here.

PA Lawmakers Consider Expanding Medicaid Immediately to Ease $1.2 Billion Deficit

As June, the final month of the state's fiscal year, gets underway, Governor Corbett and the legislature face an end of the month deadline to approve a state budget. Unfortunately, monthly revenue has been below projections. The Commonwealth is facing a $1.2 billion budget deficit for the next fiscal year, and state lawmakers do not want to use new taxes to reduce the deficit. The state's deep budget hole and limited interest in sending popular programs to the chopping block in an election year have left lawmakers and the Governor scrambling to find new revenue sources.

One of the solutions being proposed to address Pennsylvania's budget woes is House Bill 1492, and a related amendment, which would "expand Medicaid in Pennsylvania **immediately**" through the current HealthChoices program and help with the state's budget shortfall.

House Bill 1492, sponsored by Representative Gene DiGirolamo (R-Bucks), authorizes Pennsylvania to expand Medicaid now. The bill is a temporary measure: allowing the state to expand Medicaid to uninsured adults age 21-64 with incomes less than 133 percent of the federal poverty level (approximately $15,500 for a single person and $31,700 for a family of four) while awaiting federal approval of the state's Healthy Pennsylvania plan to use federal expansion funds to pay for private coverage for these uninsured adults. If the Healthy Pennsylvania plan is approved, these individuals would then be shifted to the private coverage as proposed.

Proponents say immediately expanding Medicaid would allow Pennsylvania to achieve more than $600 million in savings and new revenue for the 2014-15 Fiscal Year – enough to compensate for Healthy Pennsylvania's uncertain future and much of the growing tax revenue shortfall. The House Human Services Committee, chaired by Representative DiGirolamo, will consider House Bill 1492 in early June. If approved by the committee, the bill would need approval from the full House and then from the Senate to move forward. Readers who support House Bill 1492 should contact their lawmakers.

PHLP Works with Coalition Urging DPW to Cover ABA Therapy for Children with Autism

To help ensure that Pennsylvania is appropriately meeting the needs of children with autism, PHLP attorneys helped organize a coalition of individuals interesting in having Applied Behavior Analysis (ABA) therapy covered as a distinct service under Pennsylvania's Medicaid program. Along with PHLP, the coalition includes the Disability Rights Network of Pennsylvania, clinicians, behavioral health providers, and parents of children with autism. In April, this coalition met with DPW officials, including staff from DPW's Office of Mental Health and Substance Abuse Services, Bureau of Autism Services, and Office of Legal Counsel, to ask that ABA be recognized as a service distinct from any current Behavioral Health Rehabilitative Services (BHRS) service-with its own authorization criteria, provider enrollment requirements, and rates. The coalition also urged DPW to develop its ABA criteria and procedures with the coalition's input as well as the input of the Bureau of Autism Services so that the criteria and procedures are generally consistent with accepted medical standards.

Currently, Pennsylvania's Medicaid program does **not** cover ABA as a distinct service. ABA is an evidence-based, intensive, behavioral intervention program for children and adults with autism spectrum disorders. Recognized as the "gold standard" in autism treatment, ABA therapy has been shown to produce socially-significant improvements in human behavior—including communication, social relationships, play, school, employment, and adaptive living skills. Adaptive living skills include gross and fine motor skills, eating and food preparation, toileting, dressing, personal self-care, domestic skills, time and punctuality, money and value, home and community orientation, and work skills.

Given that Medicaid is the single largest funder of medical care for children with autism in Pennsylvania, coverage of effective autism treatment by the state is critically important. Children with autism currently receive Behavioral Health Rehabilitation Services (also referred to as BHRS or "wraparound") through Medicaid. BHRS includes Mobile Therapy, Behavior Specialist Consultant, and Therapeutic Staff Support. However, BHRS was never designed to treat developmental disorders such as autism and advocates argue that its limitations mean it cannot provide a true ABA program. The Bureau of Autism Services itself has recognized that BHRS is not a "good fit" for children with autism. The coalition argues that by continuing to offer BHRS as the **only** Medicaid-funded treatment for children with autism, Pennsylvania's children are being deprived of the opportunity to benefit from the treatment model that research has shown to be the most effective for autism. Instead, Pennsylvania's Medicaid program continues funding expensive BHRS services that are often ineffective for these children.

The coalition is awaiting a formal response from DPW to the issues raised and requests made during last month's meeting. Coalition members hope DPW will consider the concerns raised and recognize the importance and the legal significance of providing appropriate treatment for children with autism in Pennsylvania's Medicaid program.

CMS Issues Sanctions Against Capital Blue Cross Prohibiting Enrollment and Marketing in Their Medicare Plans

Effective May 28, 2014, Capital Blue Cross is prohibited from enrolling Medicare beneficiaries into its Senior Blue Option PPOs, Senior Blue Option HMOs, and Secure Rx Option Prescription Drug Plans or from marketing these plans. The plans no longer appear on the Plan Finder at Medicare.gov and will remain absent until the sanctions are lifted.

Capital Blue's Senior Blue Option PPO (two plans) and HMO plans (three plans) are Medicare Advantage Plans available in certain counties in central and eastern Pennsylvania. The following counties offer at least one of these Capital Blue plans to residents with Medicare: Adams, Berks, Centre, Columbia, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lancaster, Lebanon, Lehigh. Mifflin, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Union, and York. The Secure Rx Option Prescription Drug Plans (two plans) operate throughout the state of Pennsylvania (neither is a zero-premium plan for dual eligibles or other individuals receiving the full amount of Part D Extra Help).

These actions are the result of intermediate sanctions imposed by the Centers for Medicare & Medicaid Services (CMS) against Capital Blue for failing to follow specific Medicare requirements with respect to the services and benefits provided to its members. CMS determined that Capital Blue's failure to comply with these rules posed a serious threat to the health and safety of their members who experienced delays in receiving medications (or denials of medications) and increased out of pocket costs for medical services and prescriptions. An audit conducted by CMS prior to the sanctions being issued found widespread and

systemic problems as Capital Blue failed to follow Medicare requirements regarding appeals and grievances, drug formularies and benefit administration.

The sanctions will remain in effect until Capital Blue demonstrates that the problems identified have been fixed and CMS is satisfied that the corrections made will prevent recurrence. More information can be found here.

Current members of a Capital Blue Medicare plan wishing to change to a different plan can contact Medicare (1-800-633-4227) or APPRISE (1-800-783-7067) to see if they qualify for a Special Enrollment Period or another exception that allows them to make a change to their Medicare coverage at this time.

SilverScript Drug Plans Report Problems with Collection of Late Enrollment Penalties

SilverScript, a sponsor of three Medicare Prescription Drug Plans in Pennsylvania, recently began notifying members about problems involving its assessment of late enrollment penalties. Medicare beneficiaries who have gone without Part D drug coverage for longer than 63 days (and who do not have other creditable prescription coverage) are required to pay a Part D late enrollment penalty once they do join a Part D plan. One exception is for those receiving any level of "Extra Help" from Medicare, who are not assessed the penalty once they start receiving this extra help. The SilverScript members receiving these notices are individuals who had a break in creditable prescription drug coverage longer than 63 days and who therefore should have been assessed a penalty by the plan for the time they were without Part D.

This problem affects approximately 1,000 Pennsylvania Medicare beneficiaries enrolled with Silver Script. These individuals should have received written letters from SilverScript notifying them about how the late enrollment penalties owed will be collected. SilverScript is also reaching out to affected members through phone calls and additional mailings to those it cannot reach by phone. Plan members who receive a letter or phone call from SilverScript about this matter and who need assistance can contact Medicare (1-800-633-4227) or APPRISE (1-800-783-7067). Anyone who is receiving the Part D Extra Help but is being told they have to pay a late enrollment penalty is encouraged to call PHLP at 1-800-274-3258.

Health Partners Adopting & AmeriHealth Dropping the "Six-Drug-Limit"

Three Medicaid managed care organizations are changing their policy towards the pharmacy benefit limit of six prescriptions per month. Health Partners is adopting the six-drug-limit for its adult members effective July 1, 2014. By contrast, both AmeriHealth Caritas and AmeriHealth Northeast, who previously implemented the pharmacy limit, have decided to eliminate the six-drug-limit effective June 1, 2014.

Since the Corbett Administration reduced the pharmacy benefit for adults in fee-for-service Medicaid in January 2012, half of the Medicaid managed care organizations adopted the limit (see the chart on the next page). The AmeriHealth plans are the first to adopt and then rescind the monthly limit.

As a reminder, all medications count toward the six-drug-limit. However, many drugs are "automatically exempted" from the six-drug-limit, meaning they will be covered even after the monthly limit is reached. To obtain any medication not automatically exempted after the limit is reached, a consumer's prescriber can request a "benefit limit exception" from the managed care plan.

For more information on which types of medication are automatically covered after the monthly drug limit is reached, see the PHLP Factsheet: Medical Assistance Prescription Coverage Limit. Consumers denied a medication at the pharmacy because of the six-drug-limit, or because the medication requires prior authorization, should ask their pharmacist for a five day emergency supply. Individuals seeking help with a medication denial can call PHLP's Helpline at 1-800-274-3258.

Medicaid Managed Care Plan	*Pharmacy Cap (6 Rx/month)*
Aetna	No
AmeriHealth Caritas	**No**
AmeriHealth Northeast	**No**
Coventry	No
Gateway	Yes-as of May 2012
Geisinger	No
Health Partners	**Yes- as of July 2014**
Keystone First	Yes- as of July 2012
United	Yes-as of March 2012
UPMC	Yes-as of May 2012

OLTL Seeking Comments on Draft Transition Plan for Aging, Attendant Care, and Independent Waivers

The Office of Long-Term Living (OLTL) has released a draft transition plan for bringing the Aging, Attendant Care, and Independence Waivers into compliance with new federal regulations issued earlier this year. Readers may recall that these home and community-based services regulations include requirements for person-centered planning processes and for ensuring that services are provided in settings that focus on consumer choice and promote meaningful access to the community and community activities.

OLTL is seeking public input on this transition plan--interested individuals are encouraged to submit comments! **The deadline for submitting comments is June 13, 2014.** Comments can be submitted via e-mail to RA-waiverstandard@pa.gov or by regular mail to: Department of Public Welfare, Office of Long-Term Living, Bureau of Policy and Regulatory Management, Attention: John Esposito, P.O. Box 8025, Harrisburg, PA 17105-8025.

Following the comment period, OLTL will submit the transition plan to CMS for approval. Transition plans are still being developed for the other Medicaid waivers that also need to meet these new requirements: AIDS, Autism, COMMCARE, Consolidated, OBRA, and Person/Family Directed Support.

Reminder-Deadline to Submit Comments to the LTC Commission is June 27, 2014!

As discussed in previous newsletters, the Long-Term Care Commission seeks public input about how long-term care services and supports are delivered in Pennsylvania. Click here for more information.

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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