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Marketplace Updates

The Open Enrollment Period to purchase insurance though the Federally Facilitated Marketplace is now officially closed. For the remainder of the year, people will be unable to purchase insurance through the Marketplace unless they qualify for a "Special Enrollment Period."

The federal government recently announced that individuals enrolled in the federal Pre-existing Condition Insurance Program (PCIP) that ends April 30th, formerly known as PA Fair Care for Pennsylvania residents, qualify for a Special Enrollment Period to enroll in a Qualified Health Plan through the Marketplace.

Individuals who have been covered by the PCIP may contact the Marketplace Call Center (1-800-318-2596) to begin the enrollment process. If they are otherwise eligible for a marketplace plan, they will then have until June 30, 2014 to select a plan. Coverage will be effective back to May 1st under this particular Special Enrollment Period for former PCIP members.

Individuals who do not qualify for a Special Enrollment through the Marketplace will have to wait until the next open enrollment period, which will begin November 2014, for coverage starting 2015. See Healthcare.gov or the *March Health Law News* for more information about Marketplace Special Enrollment Periods.

Please note that even though the Marketplace is closed, **individuals can continue to apply and enroll in Medicaid and the Children's Health Insurance Program (CHIP). There are no enrollment deadlines for these two programs.**

Applications for these programs can be made through the Compass website at www.compass.state.pa.us.

Individuals can also apply for Medical Assistance* by phone through the PA Consumer Service Center at 1-866-550-4355. CHIP applications can also be made to the CHIP Insurance Company of the family's choice—see www.chipcoverspakids.com for available CHIP plans.

> In Pennsylvania, our Medicaid program is called Medical Assistance (MA). Throughout the newsletter, we use the general term Medicaid. When referring specifically to Pennsylvania, Medicaid will mean Medical Assistance.

Update to the Shared Responsibility Tax Penalty

Individuals who do not have adequate health care coverage for a period greater than three months in 2014 may face a shared responsibility tax penalty next year if they are required to file a tax return. New federal policy clarifies that anyone who applied for and received coverage through the Federally Facilitated Marketplace, Medicaid, or CHIP, during the open enrollment time period, will not be subject to a penalty for not having insurance in the months prior to their enrollment. Instead, these individuals will receive an automatic exemption.

Victims of Domestic Abuse Now Have New Opportunity to Get Coverage

A recent policy clarification from the Internal Revenue Service (IRS) allows some victims of domestic abuse access to affordable coverage through the Marketplace even when filing taxes separately from their abusive spouse. Generally, to qualify for a premium tax credit, federal law requires married couples to either file their taxes jointly or for one spouse to file as head of household. However, for some victims of domestic abuse, filing taxes jointly with their estranged spouse is not a safe, viable option and they may not meet the criteria to file as head of household.

IRS guidance, released on March 26, 2014, allows married individuals, who would generally have to file jointly to qualify for the premium tax credit, the option to file federal taxes separately from their abusive spouse. Because the IRS guidance was issued so close to the end of the Marketplace Open Enrollment Period, enrollment for domestic violence victims has been extended until May 31, 2014. To qualify under the extended enrollment period, a person must live apart from their abusive spouse at the time she/he files her tax return and be unable to file a joint return because she/he is a victim of domestic abuse, both of which must be confirmed on the tax return. Victims of spousal abuse seeking premium tax credits and enrollment into a Marketplace plan under this policy change should contact the Marketplace Call Center directly at 1-800-318-2596. Local sources of help with Marketplace coverage can be found here.

LTC Commission Announces Schedule for Public Input Meetings

The Secretaries of the Department of Aging and the Department of Public Welfare have announced the remaining Long Term Care Commission public input meetings to be held throughout the Commonwealth. The locations, dates, and times are:

May 8, 2014 from 9 a.m. to noon Mercer County Career Center 776 Greenville Road Mercer, PA 16137 **May 9, 2014 from 1 p.m. to 4 p.m.** A.W. Beattie Career Center 9600 Babcock Blvd. Allison Park, PA 15101 **May 30, 2014 from 9 a.m. to noon** Pennsylvania College of Technology 1 College Ave Williamsport, PA 17701	**June 6, 2014 from 1 p.m. to 4 p.m.** Montgomery County Community College Central Blue Bell Campus 340 Dekalb Pike Blue Bell, PA 19422 **June 20, 2014 from 9 a.m. to noon** Pike County Training Center 135 Pike County Blvd. Lords Valley, PA 18428

In our March newsletter, we reported that the Governor's Long Term Care Commission had begun to solicit public input on how the long term care system operates in Pennsylvania and how it can be improved. The first public input meeting took place in Harrisburg on April 11, 2014. Nine individuals-including consumers, family members and advocates- offered testimony before the Commission that day.

Anyone wishing to provide public comment at one of the sessions listed above must register prior to the meeting date by calling 717-425-5719 (TDD users should call 1-800-654-5984) or by registering online here. The Commission will also accept written comments and feedback through June 27, 2014. Written comments can be sent by email to ra-LTCCommission@pa.gov or by U.S. mail to: Attn: OLTL Policy, PA Department of Public Welfare, P.O. Box 8025, Harrisburg, PA 17105-8025.

As a reminder, the Commission is especially interested in receiving input about the following areas: prevention and caregiver support, accessibility, provision of service, and quality outcomes and measurement. More information can be found in the Notice of Public Input Meetings that was published in the Pennsylvania Bulletin on April 19th.

Medicaid Managed Care Plans and the Dental Benefit Limits

In April, the Department of Public Welfare released data showing dental "benefit limit exception" (BLE) activity for the Medicaid managed care plans. As a reminder, the state reduced dental benefits for adults receiving fee-for-service Medicaid in October 2011, and gave Medicaid managed care plans the option of continuing to provide full dental benefits or implementing DPW's reduced dental benefit. Most of the plans adopted the dental benefit limits within the first year. As of April 2014, all of the Medicaid managed care plans have adopted the dental benefit limits.

Under the dental benefit limits for adults aged 21 and older initiated in 2011, coverage for oral exams and cleanings increased to once every six months for those who have dental coverage (whether or not someone has dental coverage under Medicaid depends on their category of eligibility). Coverage for services such as fillings and extractions did not change. Other dental coverage for adults was limited as follows:

- Denture coverage was reduced to one upper and one lower denture per lifetime.
- Crowns, root canals, and periodontal services are no longer covered **except** through a benefit limit exception.

Consumers who need a dental service beyond the limits, such as a second set of dentures, should ask their dentist to file a benefit limit exception. Only a treating dental provider can file the BLE request. For consumers in Medicaid managed care, the exception request has to be filed with their managed care plan.

The BLE request should describe, **in as much detail as possible**, how the consumer's condition meets at least one of the following exception standards:

- The recipient has a serious chronic systemic illness or other serious health condition and denial of the exception will **jeopardize the life of** *or* **result in the serious deterioration of the health** of the recipient;
- Granting the exception is a cost-effective alternative for the Medicaid Program; or
- Granting the exception is necessary in order to comply with federal law.

Consumers are encouraged to obtain a letter from their primary health care provider or a specialist explaining how going without the dental service would result in "serious deterioration" of their health. For example, a consumer in a high-risk pregnancy should get a letter from her OB/Gyn explaining the necessity of a root canal or periodontal services to maintain her health through the pregnancy. A patient in dialysis should get a letter from his primary care provider or nephrologist detailing the importance of periodontal care for him while he is undergoing dialysis. This type of letter can be submitted as part of the BLE request from the dentist or separately.

According to the dental BLE data reported for the second half of 2013, there was tremendous variation in approval rates among the managed care plans. Between July and December 2013, five of the nine managed care plans approved 10 percent or fewer of their dental BLE requests. Health Partners, operating in the HealthChoices Southeast region, had by far the highest rate of approval at 47 percent.

Consumers denied a dental BLE have a right to written explanation of that denial and can appeal the decision through an internal grievance with the plan or by requesting a fair hearing. Consumers can call the PHLP Helpline at 1-800-274-3258 or contact their local legal aid program (www.palegalaid.net) for assistance with an appeal.

Medicare Can Now Recognize Same-Sex Marriages When Determining Eligibility

Earlier this month, the federal government announced that Medicare will recognize same-sex marriages for Medicare Parts A and B eligibility and enrollment as well as for late enrollment penalty reductions. This action is a result of the Supreme Court ruling last June in *U.S. v. Windsor*, which struck down section 3 of the Defense of Marriage Act (DOMA) as unconstitutional.

The Social Security Administration (SSA), the agency that determines Medicare eligibility and handles Medicare enrollments, is now processing enrollments for same-sex spouses. Even though Pennsylvania does not currently recognize same-sex marriages, individuals living in Pennsylvania who were legally married in another state and who are otherwise eligible for Medicare may be impacted. These individuals are encouraged to apply for Medicare, request a Special Enrollment Period, or seek a reduction in late-enrollment penalties.

SSA, the U.S. Department of Health and Human Services, and the Department of Justice are currently working toward developing policies and instructions on this issue. More information about Medicare for individuals in same-sex marriages can be found here.

Certain Blues Plans Drop Limit on Autism Services

Capital Blue Cross (Capital) and Highmark Blue Cross Blue Shield (Highmark) both recently eliminated the dollar limit on coverage of autism diagnostic and treatment services in their group health policies subject to the Autism Insurance Law known as Act 62. When Act 62 of 2008 was passed, it required certain insurers to cover autism diagnostic and treatment services up to a specific dollar limit (currently $37,710 per year). This spending limit was a political compromise necessary to secure passage of the law.

In 2013, PHLP brought a lawsuit on behalf of a young man living with autism against Capital alleging that the Act 62 spending limit violates the federal Mental Health Parity and Addiction Equity Act. As a result of this lawsuit, Capital eliminated the dollar limit on coverage of autism services starting with their group policies renewing on or after January 1, 2014.

PHLP represented another young man living with autism in an appeal before the PA Insurance Department against Highmark regarding the limit on autism services. Highmark also eliminated the dollar limit on coverage of autism diagnostic and treatment services in their group health insurance policies subject to Act 62. Highmark stated in a letter to Benefits Administrators that the elimination of the dollar limit will have no effect on premiums for 2014.

These changes should save the state money as Medicaid will no longer be billed for services for children and youth in Capitol or Highmark when their autism services exceed $37,710 in a year. It should also assist children and youth in these plans without Medicaid to get the full amount of autism treatment services they need.

Resolution Introduced to Study Implementation of Autism Insurance Law

In testimony at a hearing held by the PA House of Representatives' Human Services Committee, PHLP and former Speaker of the House, Councilman Dennis O'Brien, recommended that the House authorize a study of the Autism Insurance Law to determine how well the law is being implemented. Shortly after that testimony, Rep. Murt (R. Montgomery) introduced a resolution to have the PA Legislative Budget and Finance Committee (the state version of the Government Accountability Office) study the law's implementation. That Resolution, HR 631, has 38 co-sponsors. It is currently in the House Insurance Committee which is chaired by Rep. Tina Pickett (R. Sullivan and parts of Bradford and Susquehanna Counties).

Healthy PA Update

On April 11th, the federal government's public comment period ended and negotiations between the federal government and the Corbett Administration have begun on Pennsylvania's request for waivers of federal rules to change Pennsylvania's current Medicaid program. The outcome is anything but certain.

Pennsylvania's application (called *Healthy Pennsylvania*) breaks new ground on Medicaid policy, and it is not clear whether federal officials are ready to allow that. There is no deadline by which the federal government must act to approve or deny Pennsylvania's application.

Pennsylvania wants to use the federal money earmarked for expansion of Medicaid to instead subsidize private insurance policies for the working poor while also implementing significant changes to Pennsylvania's current Medicaid program. Other elements that push the boundaries of Medicaid law — and thus would draw a hard look from the federal government — include premiums for some enrollees and terminating coverage if those enrollees fail to pay their premiums in a timely manner.

Pennsylvania also wants to waive the normal Medicaid appeals processes (which include certain protections and guaranteed benefits for enrollees while they fight to keep eligibility or a service that is being denied) for individuals covered under the private coverage option in favor of the private insurers' appeals processes.

Stay tuned to future newsletters and www.phlp.org for updates about developments regarding the Healthy Pennsylvania Waiver application.

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.

Support Our Work

Please support PHLP by making a donation on our website at phlp.org. You can also donate through the United Way.

For Southeast PA, go to uwsepa.org and select donor choice number 10277.

For the Capital Region, go to uwcr.org and pledge a donation to PHLP.

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

PHLP: Helping People in Need Get the Health Care They Deserve