# Health Law PA News

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

## Health Insurance Marketplace is Up and Running

Pennsylvanians who are uninsured can now go to the Health Insurance Marketplace to purchase health insurance. In order to ensure that coverage begins on January 1, 2014, individuals must enroll in a health plan through the marketplace **and** make their first premium payment by December 15th. Anyone who enrolls or makes their first premium payment after December 15th will not have coverage until February 1, 2014 or later (depending on when enrollment occurs). For this inaugural year only, the open enrollment period is six months (from October 1, 2013 until March 31, 2014). Annual enrollment for the Marketplace for every year thereafter will be from October 15th through December 7th.

Pennsylvania's Marketplace is being operated by the federal government. The website for the Marketplace is www.healthcare.gov and the toll-free number is 1-800-318-2596 (TTY: 1-855-889-4325). The website is also available in Spanish at www.cuidadodesalud.gov. Navigators, funded by the federal government, and other "assisters" are available to help Pennsylvanians with the enrollment process. Individuals can find out where and how they can get help by calling the Marketplace or going to the Marketplace website. See page 4 to learn more about the Navigators in Pennsylvania.

### Marketplace Functions

The Marketplace has a number of functions including offering Qualified Health Plans, helping consumers understand and select a plan, and determining eligibility for premium tax credits and cost-sharing subsidies to help qualified individuals pay for insurance coverage through the Marketplace.

### Qualified Health Plans (QHPs)

The number of QHPs available through the Marketplace will vary depending on what part of the state someone lives in. For example, the Philadelphia metropolitan area has 42 plans available and the greater Pittsburgh area has 36 plans available. There are four levels of coverage based on how much of the cost for health care services is covered by the health insurance company. Plans are classified as metallic tiers—bronze, silver, gold or platinum.

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## INSIDE THIS EDITION

*(Continued from Page 1)* All plans, regardless of metallic tiers, will cover essential benefits like doctor visits, prescriptions drugs and hospital stays. The major difference will be in what you pay when you need these services and the monthly cost of the health plan. For example, a bronze plan has a lower monthly premium but a higher deductible and co-pays while a silver plan has higher monthly premiums but a lower deductible and co-pays. As a general rule, the bronze plan could be a good option for someone who does not need to use a lot of health care services; however, individuals who use health care services on a regular basis or who want to be protected from higher out of pocket costs when using health care services should consider joining a silver, gold, or platinum level plan.

Starting January 1, 2014, insurers can no longer charge higher premiums based on gender or pre-existing health conditions. However, premiums can vary based on geographic area, age, and family size. Also, insurers will be able to charge tobacco users up to 50 percent more in premiums.

## Essential Health Benefits

To be a QHP sold through the Marketplace in Pennsylvania, the plan must meet Pennsylvania state insurance rules and also provide coverage of Essential Health Benefits. Essential Health Benefits include items and services within the following ten categories:

- ambulatory patient services, like X-rays;
- emergency care;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services and chronic disease management; and
- pediatric services that include oral and vision care.

Prevention and wellness services must be covered without cost-sharing.

Each QHP must also have a summary of coverage available through the Marketplace that is uniform and easy to understand to help consumers when shopping for coverage.

## Financial Help with Marketplace Coverage

In Pennsylvania, when someone applies for coverage through the Marketplace, their application will first be screened for possible eligibility for Medicaid (which is called Medical Assistance (MA) in Pennsylvania) or the Children's Health Insurance Program (CHIP) for kids under age 19. If an adult or child appears eligible for MA or CHIP, the Marketplace will share the application information with these programs so they can make a formal determination of eligibility. For applicants whose information is not sent to MA or CHIP, the Marketplace will determine if they can get a tax credit for monthly premiums and if they qualify for a cost-sharing subsidy to help pay for coverage bought through the Marketplace.

**Monthly Premiums:** Individuals who buy insurance through the Marketplace and who have incomes between 100 percent and 400 percent of the Federal Poverty Level (FPL) can receive assistance paying for their monthly health insurance premiums. The assistance will be in the form of tax credits. The federal government will pay this amount directly to the health insurance

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*(Continued from Page 2)* company, which lowers the consumer's monthly premium costs. Individuals who get this help can join any level of Marketplace plan (i.e., bronze, silver, gold or platinum plans).

In addition to household income, the amount of the premium credit that an individual or family receives will take into account family size, geographic area, and age. For example, older people will get larger premium credits than younger people. However, the premium credit will **not** cover the portion of the premium that is due to a tobacco surcharge. As noted previously, in Pennsylvania, tobacco users can be charged up to 50 percent more in premiums.

**Cost-Sharing:** Those with incomes below 250 percent of the Federal Poverty Level can also get assistance with the costs they pay when they receive care (i.e., deductibles, co-payments, and co-insurance). **However, the individual must be enrolled in a silver level plan through the Marketplace to get this cost-sharing help.**

| | 250% FPL Level in 2013 | | 400% FPL in 2013 | |
|---|---|---|---|---|
| **Household Size** | **Monthly** | **Yearly** | **Monthly** | **Yearly** |
| 1 | $2,394 | $28,728 | $3,830 | $45,960 |
| 2 | $3,232 | $38,784 | $5,170 | $62,040 |
| 3 | $4,070 | $48,840 | $6,510 | $78,120 |
| 4 | $4,907 | $58,884 | $7,850 | $94,200 |

Determining eligibility for premium tax credits and cost-sharing subsidies should happen quickly, so that the individual has this information when they shop for coverage and choose their plan. Before enrolling in a plan through the Marketplace, consumers should review a side-by-side comparison of different plan options with the varying premiums and other out-of-pocket costs to help them decide which plan to enroll in for coverage. Before making a choice, consumers will also want to find out about the networks of doctors and hospitals for the health plans they are considering. Future PHLP newsletters and publications will have more information about how to choose the best plan.

## Special Note: Hundreds of Thousands of Poor Left Uncovered

Pennsylvanians with incomes below 100 percent of Federal Poverty Level cannot get assistance with Marketplace premium costs. When the Affordable Care Act was passed, it required all states to expand Medicaid to cover individuals with income up to 133 percent FPL. However, the U.S. Supreme Court ruling overturned that part of the law and made Medicaid expansion optional for states.

Since Pennsylvania has not chosen to expand Medicaid at this time, individuals who cannot qualify for a subsidy because their income is too low, but who do not qualify for Medicaid, will likely continue to be uninsured. For more information about Pennsylvania's developments see the article on page 7 describing the Governor's "Healthy PA" proposal.

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## Who Should Shop on the Marketplace?

Individuals who currently do not have any insurance should visit the Marketplace. Also, anyone paying for private, commercial coverage (either an individual policies or a family policy) that is not offered through an employer should shop on the Marketplace.

Those who currently have coverage through their employer can contact the Marketplace; however, they will not be able to get any premium tax credits or cost-sharing subsides if they are considered to already have affordable coverage. Small businesses (those with fewer than 50 full time equivalent employees) can also shop on the Marketplace.

**Individuals who have already have coverage through Medicaid, CHIP, or Medicare should not go to the Marketplace.** They will not be able to get any tax credits or cost-sharing subsidies to help them pay for Marketplace coverage, nor do they need Marketplace coverage if they have coverage through these programs.

# Help Available to Those Shopping on the Marketplace

With the Marketplace up and running, a number of organizations are offering assistance to individual consumers as they shop for and enroll into health care coverage. In August, the U.S. Department of Health & Human Services (HHS) awarded federal funds to various organizations around the country to act as health care Navigators under the Affordable Care Act (ACA). Navigators must participate in a federal training program and then be certified as health care Navigators by HHS.

Under the ACA, the functions of the Navigator include:

- Maintaining expertise on the Health Care Marketplace and how to use it;
- Providing information to consumers in a fair, accurate, impartial, and culturally competent manner on the Marketplace, Qualified Health Plan options, Premium Tax Credits and cost-sharing subsidies, Medicaid and the Children's Health Insurance Program (CHIP);
- Assisting consumers with selecting and enrolling into a Qualified Health Plan; and
- Making referrals to other useful resources.

The following organizations were awarded grants to act as health care Navigators in Pennsylvania:

- **PA Association of Community Health Centers (PACHC)**– PACHC coordinates enrollment assistance efforts throughout Pennsylvania and represents and supports the state's largest network of primary care providers working with underserved populations. Individuals can contact 1-866-761-0626 or pachc@pachc.com. Individuals can also visit www.pachc.com.

- **PA Mental Health Consumers Association (PMHCA)**– PMHCA will work in a consortium with Mental Health Association in PA and Mental Health America Westmoreland County to provide enrollment assistance to people who use or need behavioral health services in their insurance plans, particularly those who experience serious mental illness or serious psychological distress. Individuals can contact 717-564-4930, 1-800-887-6422, or navigator@mhapa.org to be connected to a navigator. Individuals can also

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*(Continued from Page 4)* visit PMHCA's website for more information-www.pmhca.org.

- **Mental Health America**– The Mental Health America Navigator Initiative will target individuals with behavioral health disorders who are uninsured or underinsured. In Pennsylvania, the work will be done by the Mental Health Association of Southeastern Pennsylvania which serves Bucks, Chester, Delaware, Montgomery, and Philadelphia counties. Individuals can contact 1-800-969-6642 or health@mhasp.org for assistance. Individuals can also find more information here-www.mhasp.org.
- **Resources for Human Development (RHD)**– RHD provides health insurance navigator services in these Pennsylvania counties with the highest rates of uninsured people: Philadelphia, Montgomery, Bucks, Chester, Delaware, Allegheny, Lancaster, York, Berks and Lehigh. Individuals seeking assistance can call 1–855-668-9536 or e-mail healthinsurance@rhd.org. More information can be found here: www.rhd.org/navigator.

In addition to these Navigators, other organizations are available to provide application assistance. Some are Certified Application Counselors who do not receive any federal funding, but who must meet certain requirements and be approved by the federal government. Individuals can visit localhelp.healthcare.gov or contact the Marketplace at 1-800-318-2596 (TTY: 1-855-889-4325) to find local resources for application assistance. Unfortunately, when resources are listed on the Marketplace website, they are not identified as Navigators, Certified Application Counselors, or other designations.

# New Eligibility Rules for Medicaid Effective October 1

As of October 1st, there are new eligibility rules for children, pregnant women, and parents or caretaker relatives of minor children applying for Medical Assistance, also called Medicaid. Medicaid eligibility for these groups will still be based on fitting into a category (e.g., pregnant woman, child, parent) and then meeting the income limits for that category based on an individual's household size. However, Medicaid will now use Modified Adjusted Gross Income (MAGI) as the new standard for determining financial eligibility.

MAGI relies on Internal Revenue Service (IRS) rules for who counts in a household and what counts as income. Under the previous Medicaid rules, household size and whose income counted was based on who physically lived together and their relationship to each other. For example, step-parents and/or siblings were not always counted in a household (nor did their income count) for a child applying for Medicaid under the previous rules. Under the MAGI rules however, household size and whose income counts is instead based on whether and how someone files taxes.

The switch to MAGI rules is required by the Affordable Care Act and these rules will be used to determine eligibility for Medicaid (for the groups mentioned above) and the Children's Health Insurance

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(Continued from Page 5) Program (CHIP) (starting January 1, 2014). MAGI will also be the basis for determining premium tax credits and cost sharing subsidies available through the Marketplace. As a result of the change to MAGI rules, some individuals and families may qualify for Medicaid now that did not qualify before and others who currently have Medicaid may no longer qualify for this coverage under the new rules.

The MAGI rules do not change how individuals and families apply for Medicaid. Applications can still be submitted online through www.compass.state.pa.us or by using a paper form that is submitted to someone's local County Assistance Office. The Department of Public Welfare (DPW) is also working on developing a phone application process for Medicaid, and we will share details about that with our readers once they become available. Medicaid applications submitted on or after October 1st should be reviewed using these new MAGI rules. In addition, the new rules will be used for Medicaid redeterminations that are conducted on or after October 1st.

**Please note:** Medicaid eligibility rules are **not changing** for individuals who are over age 65 or individuals of any age who qualify for Medicaid coverage because of a disability or serious health condition. For example, there will be no change to Medicaid eligibility for children with disabilities who qualify for Medicaid under the PH-95 category. Also, there is no change to Medicaid eligibility for people who qualify under Healthy Horizons, Medical Assistance for Workers with Disabilities (MAWD), a Home and Community Based Services Waiver program, or women who qualify for the Breast and Cervical Cancer Prevention and Treatment (BCCPT) Program.

## Who Counts in Determining Household Size?

Under the MAGI rules, household size will be reviewed on an individual basis for each member of the household who is applying for Medicaid coverage. This means that members of the same physical household could be considered to have different household sizes under Medicaid depending on their tax filing status. Generally speaking, individuals who file taxes and their tax dependents will be included in the same household for Medicaid eligibility *unless* the tax dependent is: claimed by someone other than a spouse or parent, a child living with both parents who file taxes separately, or a child claimed by a non-custodial parent.

For individuals who do not file taxes and who are not claimed as dependents by someone else who files taxes **and** for those tax dependents who meet one of the exceptions noted above, household size will be determined as follows:

- **Adults:** the individual adult plus any spouse and children who live with the individual.
- **Children:** the child plus any parents (including step-parents) and any siblings who live with the child. Siblings include biological, adopted, half and step-siblings.

## What Counts as Income?

MAGI uses Adjusted Gross Income as defined by the IRS and calculated on someone's tax return. Adjusted gross income includes wages and tips, pensions, annuities, self-employment, unemployment, alimony received, rental payments, and more. For MAGI, foreign income, tax-exempt dividends and

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(Continued from Page 6) interest income, and non-taxable Social Security income (except for SSI) get added to someone's adjusted gross income.

The change to using MAGI for Medicaid means that certain income that previously counted will no longer count. The biggest changes for Medicaid eligibility under the MAGI rules include child support received, workers' compensation, and veterans' benefits. These are sources of revenue that will no longer be considered income for Medicaid when MAGI rules are used.

### Whose Income Counts?

After Medicaid determines household size for each individual applicant and what counts as income, they must then decide whether all household members' income counts. Under the MAGI rules, if a married couple lives together, then the income of each spouse counts. Dependents' income counts only **if** the individual is required to file taxes. Individuals can find more information about tax filing requirements at www.irs.gov or by talking to a tax professional.

Using MAGI rules for determining Medicaid eligibility for certain Medicaid categories is clearly complicated and is a major change to how children, pregnant women and parent/caretaker relatives of minor children qualify for Medicaid . PHLP staff, like the DPW caseworkers who determine eligibility and other advocates and professionals across Pennsylvania and the country, are working hard to learn this new way of determining eligibility. Things will hopefully become clearer and less complicated over time. Individuals who are denied Medicaid or whose Medicaid benefits are terminated can continue to call PHLP's Helpline for assistance at 1-800-274-3258.

## Governor Corbett Announces Medicaid Expansion & Program Reform Proposal

As part of a broader plan called *Healthy PA*, Governor Tom Corbett announced a proposal in mid-September to both expand and reform the Medicaid program. The Governor conditioned his embrace of Medicaid expansion to: (1) the federal government agreeing to substantial changes to PA's existing Medicaid program; and (2) being allowed to place the estimated 520,000 "newly eligible" individuals who are included in the expansion into private coverage through the federal health insurance Marketplace.

### Private Option

An estimated half-million adults in Pennsylvania who have income less than 133 percent of the federal poverty level (currently $15,228/year for a single adult) are expected to benefit from Medicaid expansion. Rather than enroll the newly eligible individuals into the existing Medicaid program, Healthy PA proposes to use federal funding to buy this population private health insurance through the new insurance Marketplace. If Pennsylvania were to expand Medicaid, a person could

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*(Continued from Page 8)* qualify solely on the basis of being low-income and no longer need to also meet category requirements (such as being a pregnant woman, being a child, having a disability, or being over age 65).

Eligibility for this expanded population would be determined using the MAGI rules described earlier. Resources are not a consideration under MAGI and therefore, there would be no resource determination for this expanded population. Newly eligible individuals found to be "medically frail" and who would qualify under the traditional Medicaid rules would have the option of enrolling into the traditional Medicaid program.

The Corbett administration contends this "private option" would require less bureaucracy, expand provider choices for consumers, and work better in conjunction with the private insurance market compared to traditional Medicaid. Not specified in the proposal is whether or how state Medicaid officials would exercise oversight over the private marketplace insurers to ensure Medicaid affordability, access, and due process protections as required under Medicaid law.

## Program Reforms: Premiums, Benefit Redesign, and Work Search Requirement

Consistent with his earlier comments, Governor Corbett contends that major reforms are needed to the existing Medicaid program in order to make it a fiscally sustainable safety net and to broaden access to affordable, quality health care. One such reform would simplify the existing 14 benefit packages into two commercial-like benefit packages based on the federally-mandated "essential health benefits." Without changing benefits for children under 21, Healthy PA would give adults either a low-risk or a high-risk benefit package, depending on a person's of level of care needs. How level of need would be determined has not been specified.

Imposing premiums on adult Medicaid consumers is a second program reform proposed by Governor Corbett. Adults with income between 50 and 133 percent FPL would have a sliding scale premium up to a $25 per month maximum for a single person, or $35 maximum for a married couple. Under Healthy PA, this premium structure would replace the Medicaid's current co-pay structure. Only a $10 co-pay for inappropriate use of Emergency Department services would remain. With the intent of promoting healthy outcomes and personal responsibility, the administration would allow individuals to reduce their monthly premiums by participating in wellness or job search and training programs. Additional details regarding how these incentives would work have not been shared at this time.

A new work search requirement is the third major Medicaid reform outlined in Healthy PA. All unemployed, working age Medicaid consumers would be required to undertake "work search and job training" modeled on the requirements of unemployment compensation. The administration contends that individuals who are gainfully employed are healthier and that this requirement will help Medicaid consumers achieve independence.

The administration's two concept papers outlining Healthy PA are available here. Most of the Medicaid reforms contained in the proposal are unprecedented and would require special approval by the federal government. State officials have announced no timeline for the submission of a formal "waiver" request to the federal Department of Health and Human Services, and the earliest Healthy PA Medicaid expansion could take place is likely 2015.

# Medicare Annual Open Enrollment Starts October 15th!

The time of year when all Medicare beneficiaries can make changes to their drug and/or their health plan coverage starts October 15th. This period, known as Open Enrollment, runs until December 7th. Any changes made by a beneficiary during this period go into effect on January 1, 2014.

Medicare beneficiaries should have already received information from their current plan about 2014 benefits that details any changes to the plan's coverage or costs for next year. Individuals currently enrolled in plans that will not continue in 2014 have already been notified that their plan is ending on December 31, 2013. Plans are now allowed to market their 2014 plans and Medicare's website (www.medicare.gov) has been updated with 2014 plan information (although drug pricing information may not be accurate because of the federal government shutdown).

In 2014, Pennsylvanians continue to have many choices for their Medicare health and drug coverage:

- **Stand-alone Prescription Drug Plans**: Pennsylvania continues to have the highest number of stand-alone drug plan options of anywhere in the country. This year, there are 39 plans total; however, only 34 of these plans are available for enrollment (5 plans-3 offered by CVS Caremark-Silver Script and 2 by Smart D Rx-are currently under sanctions from the federal government and are banned from all marketing activities or new enrollments). Premiums for available plans range from $12.60 to $169 per month. There are 11 "zero-premium" plans for individuals who qualify for the full low-income subsidy that are available for enrollment in 2014. First Health will no longer have a zero-premium plan next year.

- **Medicare Advantage Plans**: Each county has a choice of at least 14 Medicare Advantage plans .

- **Special Needs Plans for Dual Eligibles (D-SNPs):** these plans only enroll individuals that have both Medicare and Medicaid. All counties except for Bradford and Franklin offer at least one D-SNP next year. The following D-SNP plans will end as of December 31st and current members will need to join a new plan for coverage starting January 1st—United Healthcare Dual Complete, Security Blue Care and Bravo Health Spring-Silver. The D-SNP Bravo-HealthSpring Select will be going by a new name-Cigna-HealthSpring Total Care; and, it will no longer be offered in Allegheny, Washington, and Westmoreland counties. Health Partners Medicare Special is a new D-SNP in 2014 but is only offered in Philadelphia County.

Everyone on Medicare should review their current coverage to see if it will continue to meet their needs in 2014. Those needing help during the Open Enrollment Period can contact APPRISE (Pennsylvania's State Health Insurance Program) at 1-800-783-7067.

# Medicare 2014 Webinar Offered by PHLP

PHLP is conducting free webinar trainings to educate advocates, providers, and other professionals who work with dual eligibles and other low-income Medicare beneficiaries about upcoming changes to Medicare in 2014.

Participate in a training to learn more about:

- 2014 Part D Plans and Costs;
- What Medicare beneficiaries need to know about the Marketplace/Exchange;
- Programs to help Medicare beneficiaries with costs (i.e., Low-Income Subsidy and Medicare Savings Programs); and
- Other updates to Medicare for 2014.

To register for the webinar from **10am - 11:30am** on **November 6, 2013**, please click here.

Space is limited - register today!

**Please share this announcement with others who may be interested in attending the webinar training.**

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