Health Law PA News

Newsletter of the Pennsylvania Health Law Project

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The Medicare Act of 2003: Helps Some, Hurts Others

On December 8, 2003, President Bush signed into law H.R. 1, the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003". After years of discussion and months of Conference Committee negotiation on the differing pieces passed earlier this year by the House and Senate, here is what the Medicare Act of 2003 includes. While the most publicized piece of the Act is the Medicare Prescription Drug Plan, there are numerous other components of the Act. For more information, visit our website at www.phlp.org.

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University of Pennsylvania Health System Quits AmeriChoice

As of December 1, 2003, the University of Pennsylvania Health System quit AmeriChoice. This affected approximately 5,600 consumers whose primary care physicians were through the University of Pennsylvania Health System and approximately 1,800 consumers who received specialty care through the University of Pennsylvania Health System. AmeriChoice has a Medical Assistance plan, a Medicare + Choice plan and a CHIP plan. The hospitals affected were the Hospital of the University

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Report Cards Show Great Variation Among HealthChoices Plans

There is a big difference in the care being delivered by HealthChoices HMOs, according to the "report cards" DPW has just published. The so called "performance profiles" are based on data collected by the state for 2002. Although DPW has published report cards in previous years, this is the first time it has included specific data on each plan's performance. The profiles show big differences among the plans in several major areas.

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IMPORTANT ALERT: New Medicare law will mean major changes for persons on Medicaid

Persons who have full Medicaid will be significantly impacted by the new Medicare Law. It is unclear whether they can be or will be required to enroll in Medicare Part D, as the new prescription drug benefit is called. What is clear is that prescription drug coverage under Medicare Part D will be less than their coverage under Medicaid.

How will I enroll to get reduction in costs?

You will be able to enroll either through your local Social Security Office or through your local County Assistance Office. If you are denied, you will be able to appeal. However, the appeal process will differ whether you enroll through the SSA or through the CAO.

Will I still be able to get the drugs that are medically necessary for me?

Not necessarily. For those enrolled in the Medicare drug plan, you will be able to access only the drugs that the drug plan you choose to join covers.

If my Medicare drug plan doesn't cover what I need or denies coverage for me, will Medicaid cover it?

Not likely. The Medicare law prohibits Medicaid from wrapping around or filling the gaps in Medicare drug coverage. Thus if your Medicare drug plan does not cover a drug at all but covers something else in the same therapeutic class or if they cover it but don't think it is medically necessary for you to have, Medicaid would not be able to cover it for you. Medicaid will only be able to cover drugs in therapeutic classes that your Medicare plan does not cover. We do not foresee that there will be therapeutic classes that are wholly uncovered by the Medicare drug plans.

If I am denied a drug (that my plan covers), will I be able to appeal the denial?

Maybe. The appeals process will be through Medicare (not Medicaid) and the appeal rules for Medicare apply. Under Medicare law, there are rules governing whether an appeal can proceed that relate to how much money is in controversy. Thus, a person may not be able to appeal if they have been denied a prescription for a medication that costs $5 while they may be able to appeal if they have been denied a prescription for a medication that costs $100.

If I appeal a denial of a medication, will I be able to get a 72 hour supply while I try to document my need for the medication?

The Medicare bill does not provide for this.

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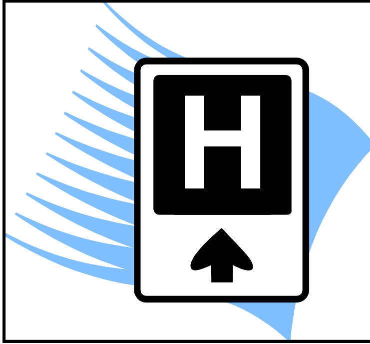

Pennsylvania, Presbyterian Medical Center, Phoenixville Hospital, and Pennsylvania Hospital. However, Children's Hospital of Philadelphia and its doctors were not affected by this change and are still part of AmeriChoice.

Many AmeriChoice members received a notice from the University of Pennsylvania Health System informing them of the withdrawal and telling them that they could change health plans in order to keep their doctor. The other health plans in the five-county Philadelphia area are Health Partners and Keystone Mercy. Many AmeriChoice members also received a notice from AmeriChoice telling them that they will be receiving a new primary care physician. These conflicting messages may have left many consumers confused as to their rights. In this situation consumers have the following rights:

Ø **Medical Assistance consumers have the right to change health plans.** To do this, the member must call 800-440-3989. It can take 6 weeks for plan change to take effect. Members considering a plan change should ask:

- Does the new plan include my dentist, specialist or other health care providers?
- Are prescription drugs, medical equipment and other services that I need more readily available under Health Partners or Keystone Mercy?

Ø **Medical Assistance consumers have the right to change providers.** If the consumer wants to stay with AmeriChoice, he or she should call Member Services at 800-321-4462 and ask for a new primary care provider (PCP). If the

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PHLP submits LEP policy guidance comments on behalf of Philadelphia Welfare Rights Organization

In August 2003, the Department of Health and Human Services issued a new version of its policy guidance on the rights of Limited English Proficient (LEP) persons. The guidance is aimed at enforcing LEP rights from Title VI of the 1964 Civil Rights Act, and which prohibit discrimination on the basis of national origin in federally funded programs. The new HHS policy guidance is a serious step backwards from the previous HHS policy guidances (issued in 2000 and 2002), which offered much better protections for LEP persons. The weakened protection could affect LEP persons across PA by hurting their ability to enroll in and use publicly-funded programs such as Medical Assistance.

Among other things, the new guidance will harm LEP Pennsylvanians by:

- Weakening the definition of who is an LEP person
- Weakening the requirements for services to LEP persons
- Allowing doctors to refer LEP patients to avoid providing language services
- Weakening competency requirements for translators and interpreters
- Eliminating the requirement that providers develop language assistance plans

PHLP submitted comments on behalf of the Philadelphia Welfare Rights Organization, highlighting these and other major flaws in the new policy guidance, and suggested changes for the HHS policy guidance. PHLP's comments requested that HHS return to the language in its previous policy guidances, to strengthen rules protecting LEP individuals.

To obtain a copy of PHLP's full comments, or learn more about LEP rights, contact PHLP at 1-800-274-3258, or www.phlp.org.

Consumer and Advocate Education

Invite us to talk to your consumers or staff!

Here are just a few topics that PHLP is available to discuss:

- Accessing services under HealthChoices and Fee-for-Service Medical Assistance, including prescription medications, mental health and drug and alcohol treatment; durable medical equipment, and home health services.
- Patient's rights under managed care.
- The Medicaid HMO appeal process
- How to qualify for health coverage under Medicaid, CHIP, adultBasic and other programs for Pennsylvanians who are low-income, elderly or have a disability.
- New Medicaid Programs like **Medical Assistance for Workers with Disabilities (MAWD)** and the **Breast and Cervical Cancer Prevention Treatment Program**.
- How to get help with prescription drug costs.
- How to get Medicare premiums paid.

Call (800) 274-3258 to schedule.

Upcoming Trainings:

- "MA for children with disabilities"- Bucks Co. IU , Jan. 9, 11:30 a.m. the Maple Point Administration Building in the Neshaminy School District, 2250 Langhorne-Yardley Road, Langhorne, PA and again on Jan. 23, at 9:00 am at the 3rd floor conference room (Room A) of the Community Education Center of St.Luke's/Quakertown Hospital, 10th and Juniper Streets, Quakertown, PA.

Do you value this newsletter?
Do you find our other free resources helpful?

Now there are two ways you can show your support for PHLP!

You can **mail** your tax-deductible donation - check or money order - to:
The Pennsylvania Health Law Project
924 Cherry Street, Suite 300
Philadelphia, PA 19107

You can also make donations to PHLP through The **United Way Donor's Choice Program.** If your employer participates in this program, please ask for an application form and enter the PHLP number, **10277**. The amount you choose to designate will be deducted from your paycheck. *Some employers provide matching gifts.*

If you are outside of the Southeast Pennsylvania Region, please check with your local United Way on how to donate to PHLP through Donor's Choice. To locate your local chapter of **The United Way**, and to find out more about this program, please visit the new donations page on our website at:

http://www.phlp.org/Donations.html.

If you would like a letter acknowledging your donation for tax purposes, we will be happy to furnish one upon your request.
The official registration and financial information of PHLP may be obtained from the Pennsylvania Department of State by calling toll free, within Pennsylvania, 1-800-732-0999. Registration does not imply endorsement.

(Medicare, Continued from page 1)

1. Spring 2004-December 2005

Discount drug cards that provide some discount on drugs purchased will be for sale for $30/year to beneficiaries with income over 135% of the federal poverty level. These will be free to beneficiaries under 135% FPL and will include a $600 credit to use towards the cost of drugs, although the consumer will have to pay 5-10% co-payment on each purchase.

Those enrolled in Medicaid and eligible for Medicaid drug coverage would not be eligible for the discount cards. Those enrolled in PACE or PACENET will be eligible for the discount cards. (The PACE program may be able to become a discount drug card provider under contract with Medicare so that it may provide both the Medicare benefit and the state benefit to those already enrolled in PACE).

Discount Drug Card companies will be able to change their benefits at any time. The enrollee will only be allowed to be enrolled in one of these and will only be able to switch plans once per year. The regulations for the discount cards were published in virtually final form on December 10th in the Federal Register. These discount cards are expected to be up and running before June 2004.

Beginning in January 2006

In January 2006, Part D of Medicare is scheduled to go into effect.

Here are the anticipated costs to beneficiaries over 150% of the federal poverty level:

a. Annual Premium – Estimated to be $420/year or $35/month. There is no fixed amount set in the law. Premiums are likely to vary by where you live.
b. Annual Deductible - $250

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Now Available on the PHLP Website

- Accessing Health Care for Adults Age 18-59
- Home and Community Based Services Waiver Programs Available in Pennsylvania
- How Going to Work Impacts SSI, SSDI, and Health Care Coverage for Adults with Disabilities
- A Summary of the New Medicare Prescription Drug Plan
- A Look at the Impact of the New Medicare Law on Persons on Medicaid
- Other Interesting Facts About the Medicare Act of 2003

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c. Annual Benefits –

i. Initial Coverage - Part D will pay 75% and you will pay 25% of your drug costs up until your total drug costs for the year reach $2,250

ii. Doughnut Hole of No Coverage - Once you reach $2,250 in drug expenses in a year, your coverage stops and you have to pay all of the next $2,850 in drug expenses you incur

iii. Catastrophic Coverage - Once your total drug expenses reach $5,100, you pay either a flat co-payment of $2/generic or $5/brand-name or 5% of each drug's cost – whichever is **greater** – with no limit on total expenditures

Are these costs fixed for good?

These are the projected costs at the outset of the program. As noted, premiums may be higher than estimated. And, the premiums, deductibles and doughnut hole amounts may change with time due to increases in drug spending and drug costs. And, the private plans offering the benefit have the freedom to raise co-payments as long as Medicare determines that the overall benefit remains equal to that described above.

Here are the anticipated costs to beneficiaries under 150% of the federal poverty level:

For Persons with Income Under 100% of the Federal Poverty Level (currently $8,980 per year for a single individual) and Enrolled in Medicaid:

a. Annual Premium – None

b. Annual Deductible – None

c. Asset Test – State Rules Apply (SSI limits are used in PA)

d. Annual Benefits –

- Initial coverage - Co-Payment - $1/generics, $3/brand-name
- "Doughnut hole" – None
- Catastrophic coverage – After total drug expenses reach $3,600, no co-payments.

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consumer has a particular doctor or nurse practitioner in mind, he or she should ask for that PCP. Members considering staying in AmeriChoice, should ask:

- Do I need to change my hospital, specialist, dentist or other health care providers?

AmeriChoice has said that it will continue to pay University of Pennsylvania Health System providers during a transition period if they treat current AmeriChoice patients. However, providers are not required to accept the payment or treat AmeriChoice members after December 1, 2003.

If the consumer changes plans, items that have been prior authorized must be continued for the amount and duration specified by the prior authorization. The new plan may not change, reduce, or terminate

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Ask PHLP

Dear PHLP:

I have several complicated medical conditions and can only work part-time. I earn $850 a month and my total resources are $4000. I learned about the Medical Assistance for Workers with Disabilities (MAWD) program when I called the PHLP Helpline. But when I applied at the County Assistance Office (CAO) the intake worker told me I had to apply for Social Security Disability before I could be determined eligible for MAWD. Is that correct? I am willing to challenge the CAO if you think I should.

- I.M. Brave, Greene County

Dear Brave:

The CAO intake worker is **not** correct! The Medical Assistance Eligibility Handbook clearly states in section 316.21, "Individuals applying for MAWD are not required to apply for SSI or SSDI as a condition of eligibility". If an individual, such as yourself, is not on SSI or SSDI you need to provide the CAO with thorough medical records documenting your medical conditions. The CAO worker is then responsible for submitting those records to the Medical Review Team (MRT) within the Department. A doctor on the MRT uses the Social Security definition of "disabled" to determine if your medical conditions make you disabled or not. If the MRT determines you are disabled, then the CAO worker can process your application. If you meet the other criteria for MAWD (i.e. age 16-64, working, countable income less than 250% of FPG & resources under $10,000) then you qualify for Medical Assistance.

Be brave! Go back to the CAO and ask to speak with the MAWD contact person in that office. And remember, you can always call our Helpline again at 1-800-274-3258 if you need our assistance.

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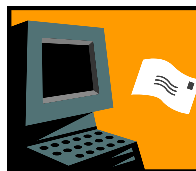
the services during the prior authorization period, unless it conducts a concurrent review of the need for the prior authorized services, at the consumer's option. If the new plan authorizes a change or termination in the prior authorized services, the consumer has appeal rights and may receive benefits pending an appeal if an appeal is filed within 10 days of the notice.

If consumers have problems, they should contact the PHLP at 1-800-274-3258.



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Income Under 135% FPL or those enrolled in Full Medicaid (in PA includes people on MAWD, or Home and Community Based Services Waivers, etc.):

a. Annual Premium – None
b. Annual Deductible – None
c. Asset Test – State Rules Apply
d. Annual Benefits –
- Initial coverage - Co-Payment - $2/generics, $5/brand-name
- "Doughnut hole" – None
- Catastrophic coverage – After total drug expenses reach $3,600, no co-payments.

Income Under 135% FPL and NOT Enrolled in Medicaid:

a. Annual Premium – None
b. Annual Deductible – None
c. Asset Test – $6,000/individual, $9,000/married couple
d. Annual Benefits –
- Initial coverage - Co-Payment - $2/generics, $5/brand-name
- "Doughnut hole" – None
- Catastrophic coverage – After total drug expenses reach $3,600, no co-payments.

Income Under 150% FPL and NOT Eligible under other categories:

a. Annual Premium – Amount based on income – sliding scale up to $35/mo
b. Annual Deductible – $50
c. Asset Test – $10,000/individual, $20,000/married couple
d. Annual Benefits –
- Initial coverage - Co-Payment – 15% of the cost of drug costs
- "Doughnut hole" – None
- Catastrophic coverage – After total drug expenses reach $3,600, co-payments go down to $2/ generic, $5/brand-name

How will I enroll in Part D?

This benefit will only be available through **private prescription drug plans or through managed care plans** under contract with Medicare unless there are fewer than two plans willing to serve an area. In that case, the government will provide a "fall-back" plan that will offer all the same benefits. To receive the benefit, you will have to sign up with a plan offering it in your area.

What if I delay enrollment in Part D?

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If I appeal a termination of a medication, will I be able to get continuing benefits pending the outcome of the appeal?

The Medicare bill does not expressly call for this. However, the Supreme Court has previously held that this is required.

My prescriptions have been free under Medicaid, will I now have to pay co-payments?

Yes. Under the Medicare law, you will be required to pay the $1/generic and $3/brand-name co-payments that are imposed under the Medicare bill. And, that co-pay is expected to rise as drug costs go up. States cannot use Medicaid to pay these co-payments for consumer.

Information compiled from resources at: Families USA – www.familiesusa.org; Center for Medicare Advocacy – www.medicareadvocacy.org; and Kaiser Family Foundation – www.kff.org .

PHLP is Enhancing its Website!

Over the past several months, **www.phlp.org**, PHLP's website, has undergone a facelift. The site will continue to provide you with the same up-to-date and useful information, in a new and easier to navigate, searchable format. We will make changes to the content and features on our site continuously so be sure to visit often!

One of the most exciting, new features of the PHLP website is the **Provider Page,** developed by a physician and attorneys at PHLP to help providers better advocate for their patients. From our Provider Page, providers will find links to useful **information** to help them better understand their patients' health care rights. Providers will also find many useful **tools** to help them carry out some important advocacy tasks, such as:

- Writing an effective **letter of medical necessity**
- Completing **Employability Assessment Forms**
- Obtaining **Emergency Medical Assistance** for immigrants

Also available on the **Provider Site** are resources on other important topics, including:

- Screening patients for Medical Assistance Eligibility
- Advocating for patients in Department of Public Welfare fair hearings, and Health Choices grievances and appeals
- How to receive further training from PHLP for you, your staff and your patients.

Suggestions for changes to any part of the PHLP website should be made by email to:
Josh Kershenbaum at **jkershenbaum@phlp.org.**

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If an eligible person on Medicare does not enroll in the Medicare Part D benefit within the first quarter of 2006, there will be penalties including higher premiums and co-payments. (This is likely to be similar to the penalty imposed on persons who delay enrollment in Medicare Part B).

If my income is under 150% of the Federal Poverty Level, how will I enroll to get reduction in costs?

You will be able to enroll either through your local Social Security Administration (SSA) Office or through your local CAO. If you are denied, you will be able to appeal. The appeal process will differ whether you enroll through the SSA or through the CAO.

Will my drugs be covered?

It will depend on the plan you choose. While Medicare is required to contract with at least 2 plans in every area or provide "fall back" coverage on its own, there is no requirement to cover all available prescription drugs. Plans will be required to cover at least one drug in each "therapeutic class" but are not required to cover all drugs. And, we do not understand there to be any exception process through which you could get an off-formulary drug. Medicare will not define what is a "therapeutic class." That will be left to the Drug Plan provider. Consumers should check the drugs that a plan covers before enrolling.

For those who also have full Medicaid coverage, the drug coverage will be significantly less than what they have under full Medicaid. See our piece on the "Impact of the New Medicare Law on Lower-Income Pennsylvanians" available at www.phlp.org.

Can I have other drug coverage?

Yes and no. You may have other private coverage but, it will not be counted towards your out-of-pocket costs. You must pay out-of-pocket for all the co-payments, premiums, and deductibles for which you are responsible and the full cost of drugs (in the doughnut whole) or your catastrophic coverage will not kick in. You may not have other Medicare coverage –meaning you cannot be in two Part D plans at once.

Must out-of-pocket costs be incurred on particular drugs?

Yes. Out-of-pocket costs will have to be spent on prescription drugs that are available through your drug plan. You cannot incur costs on uncovered drugs and use these costs to reach your deductible or catastrophic cost level.

Information compiled from resources at:

- **Families USA – www.familiesusa.org**
- **Center for Medicare Advocacy – www.medicareadvocacy.org**

Kaiser Family Foundation – www.kff.org .

Other Interesting Facts About the Medicare Act of 2003

1. **QI-1 Benefit Reauthorized until September 2004.** Reauthorization of this program was widely supported. It is surprising to see that it was only reauthorized for 6 additional months (as a Continuing Resolution already authorized it until March 2004).

2. **Few Preventive Benefits Added.** Although called a modernization law, very few preventive benefits were added. A physical exam, which could have been added as an annual benefit, was added only as an initial benefit which can be obtained by a new enrollee to Medicare Part B within 6 months of their enrollment. Other preventive benefits include cardiovascular disease screening blood tests and diabetes screening for at-risk individuals.

3. **Prohibitions on States Being More Generous.** In the past, states have chosen to adopt more liberal asset tests than are provided under federal programs. This law prohibits states from doing this for any of these programs.

4. **Applications for Lower-Income benefit**

- **Social Security Administration.** SSA is required to conduct outreach to publicize these programs. Will also be required to take application for the lower-income subsidy.
- **DPW to do eligibility determinations.** DPW will be required to make eligibility determinations for the low-income components of the Medicare Rx program. It is anticipated that there will be a uniform application for the lower-income subsidy. The application process will include self-declaration of assets (under penalty of perjury).
- **All applicants must be screened for eligibility in Medicare Savings Programs (QMB, SLMB, and QI-1).**

5. **PA will have to pay Medicare for "savings" on dual eligibles.** State must pay back to feds the amount they will "save" each year by not having to pay Rx costs for persons on Medicare.

6. **No medigap policies including Rx drugs can be sold after 1/1/06.**

7. **Part B deductible and premium changes:**

- **Deductible amount to rise annually.** Starting in 2005, the Part B deductible will go up to $110 and is expected to increase annually by the same percentage that the Part B premium increases.
- **Starting in 2007, Part B premium will cost more for persons with higher incomes.** Currently, Part B premiums are 75% subsidized by the federal government. In essence, what this means is that the Part B premium, which will cost $66.60 in 2004 really costs $266.40 but that Medicare pays $199.80 of it. Starting in 2007, the part that Medicare pays will be decreased based on income, for persons with incomes at or above $80,000/year.

Information compiled from resources at: Families USA – www.familiesusa.org; Center for Medicare Advocacy – www.medicareadvocacy.org; and Kaiser Family Foundation – www.kff.org.

(Report Cards, Continued from page 1)

For example, 85.2% of pregnant women received regular prenatal care from Three Rivers/MedPLUS+, but only 64% of AmeriChoice pregnant women got such care. When it came to providing vaccines to children, 66.7% of Gateway members had their recommended immunizations at age 2, compared to only 46.2% of AmeriHealth Mercy children of the same age. AmeriHealth Mercy performed far below the national average for Medicaid plans (53.8%) for this measure. Only 49.4% of women between the aged 21-64 in AmeriChoice had a PAP test in the two years prior to 2002, whereas 71% of UPMC For YOU members had the test.

All of the HMOs performed poorly when it came to providing regular dental care for children aged 3-20. The highest performing plan, UPMC For YOU, provided dental care to only 36% of its members. AmeriHealth Mercy, the lowest performing plan, gave dental care to only 20.4% of its members.

In all, there are 27 different measures on the report card. AmeriHealth Mercy ranked lowest in 12, and Americhoice was lowest in 10. UPMC For YOU was highest in 7 categories, and Three rivers/Med Plus+ was highest in 6. The consumer subcommittee of the state's Medical Assistance Advisory Committee has been asked to recommend other measures that may be helpful to consumers so that next year's report can even better meet their needs.

The report card is online in English or Spanish. The English version is at: www.state.pa.us/OMAP/hcmc/OMAP2003profileeng.pdf. Spanish is …profilespn.pdf. Hardcopies are due for release by DPW in early 2004. The Consumer Subcommittee has urged the state to send copies to all HealthChoices members,

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