Health Law PA News

Newsletter of the Pennsylvania Health Law Project

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Pennsylvania House Votes to Help Uninsured Adults

AdultBasic Program to be Replaced by More Comprehensive "ABC" Program

On March 17, the Pennsylvania House of Representatives voted to expand subsidized health insurance to uninsured adults between the ages of 19 and 64 with household income up to 200% of the federal poverty level ($42,400 for a family of four) under a new program to be called **Pennsylvania Access to Basic Care** (**ABC**). The program would succeed the current adultBasic program, which began under the Ridge Administration. In addition to covering prescription drugs and behavioral health services, which are not paid for by adultBasic, the new program would provide sufficient funding to eliminate the adultBasic waiting list, which now exceeds 81,000 persons. Presently, adultBasic covers just over 53,000 Pennsylvanians. The vote on the measure was bi-partisan, with seventeen Republicans joining the House Democrats in support. The legislation, sponsored by Rep. Todd Eachus as an amendment to SB 1137, is expected to face significant opposition in the Pennsylvania Senate.

Cost to Purchase "ABC" Coverage

Under ABC there would be no health insurance premium for adults with household income below 150% of the federal poverty level ($31,800 for a family of four). ABC would charge a monthly premium of $40.00 for those with income between 150% and 175% of poverty, and $50.00 for those between 175% and 200%. As currently structured, persons with income between 200% and 300% of the poverty level could purchase the insurance at cost. Those with income above 300% of poverty ($63,600 for a family of four) could purchase it at cost but only upon demonstrating that other coverage is unaffordable or that they were refused other coverage due to a preexisting condition. There would be no preexisting condition exclusions under ABC.

Conditions of Eligibility

Only Pennsylvania residents (for at least 90 days) who are legally residing in the United States could qualify for ABC. An applicant would have to have been without health insurance for a period of six months, unless health insurance was lost due to unemployment, divorce, separation, death of a family member, or if the individual was transferring from another publicly financed health insurance

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INSIDE THIS EDITION

Proposed MA Budget Would Expand Prescription Coverage and Avoid Cuts to Eligibility and Services

Governor Rendell announced his proposed budget for 2008-09 to the Pennsylvania General Assembly on February 5th. The Medical Assistance portion of the budget, which accounts for 20% of state general fund expenditures, contains no proposed cuts, and would extend prescription drug coverage to 43,000 Pennsylvanians for the first time. These individuals, who already qualify for Medical Assistance under the Medically Needy Only (MNO) eligibility category, do not have prescription drug coverage in their benefit package at present. The cost for extending coverage to these Pennsylvanians is $11.3 million this year. The logic of providing a benefit package without prescription drugs has often been questioned, and this expansion would address that deficiency. It would also avoid the incongruous result, if Pennsylvania Access to Basic Care (ABC) were to be enacted (see page 1 and below), of having poorer Medicaid recipients qualify for a benefit package that is less generous than the package provided to ABC recipients with higher income.

The Medical Assistance budget was generally unchanged, reflective of an uncertain economy with a likely negative impact on state revenues. The Administration proposes modest increases

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program. Persons eligible for Medicare or Medical Assistance could not qualify for ABC.

Encouraging Employers to Offer Coverage

Small, low-wage employers with between 2 and 50 employees who pay an average annual wage below 300% of the poverty level ($31,200) and who have not offered health insurance for 6 months could buy into the ABC program for their employees by paying half the cost of coverage. These employers would have to offer their employees an option to pay their share of the premium in pre-tax dollars.

Unlike the Governor's "Cover All Pennsylvanians" plan, ABC would not penalize employers for not offering health insurance. Instead, in addition to offering premium subsidies to small, low-wage employers, SB 1137 would establish a pool of money to offset the cost of health care for employers who have offered health insurance to their employees for 12 months. This money would be distributed in the form of tax relief called "Continuing Access with Relief for Employers" (CARE) grants.

Funding for ABC

ABC would be paid for by rolling over the current funding for the adultBasic program; adding untapped reserves from the Medical Care Availability and Reduction of Error (MCARE) fund that provides malpractice insurance relief to physicians and hospitals; drawing down federal matching funds; and an as yet unnamed source, such as a tax on smokeless tobacco.

Prospects for Expanded Coverage

SB 1137 permits ABC subsidies to be expanded to help those with income up to 300% of the poverty level ($63,600 for a family of four), if the federal government is willing to provide matching funds. Last year, the federal government agreed to support Pennsylvania's Cover All Kids initiative under the CHIP program, which extended subsidized coverage to kids up to the 300% of poverty level. However, since that time, the Bush Administration has taken a much harder line on health insurance expansion, and it will likely take a change in Administration before Pennsylvania can extend coverage beyond the 200% level ($42,400 for a family of four).

DPW To Create New "HealthChoices Plus" Zone

Starting January 2009, Medical Assistance consumers in sixteen counties in central to northwestern Pennsylvania will have the option to join a managed care plan, instead of Access Plus, for their Medical Assistance physical health coverage. This new initiative will be called Health Choices Plus and would have the HealthChoices physical health HMOs compete directly with the state's Access Plus fee-for-service program.

The sixteen counties in the new HealthChoices Plus zone are: Erie, Crawford, Mercer, Warren, Forest, Venango, Clarion, McKean, Elk, Jefferson, Cameron, Clearfield, Cambria, Blair, Somerset and Bedford counties. Of these counties, Venango, McKean, Elk, and Cameron currently have no managed care option, while the other twelve counties do currently have at least one voluntary managed care plan. This initiative would presumably require health plans operating in the 12 counties to expand their networks and operate in all 16 counties. HMOs that operate in this new zone would have to offer coverage in all counties.

Consumers who have already chosen to be in Access Plus or in a managed care plan will not have their enrollment changed (unless they are enrolled in a managed care plan which is not approved by DPW for HealthChoices Plus). Consumers who are new to Medical Assistance, or who are in a managed care plan which is not approved for HealthChoices Plus, will be auto-assigned to either Access Plus or a HealthChoices Plus plan. Individuals will always have the option to switch between AccessPlus and a managed care plan, although the processing takes from 2 to 6 weeks.

DPW has indicated that it will challenge providers to develop strategies to support the Governor's Prescription For Pennsylvania health care reforms. Presumably, this means making primary care more available in order to reduce emergency room use and not paying for medical mistakes.

Consumers have raised some concerns about the minimum network requirements, since the proposed HealthChoices Plus zone is extremely large and runs the length of the state. This is problematic because, for certain types of providers, current HealthChoices rules only require a choice of two providers in the whole zone. DPW has said it will investigate this potential problem.

DPW has released the Request For Proposals (RFP) and expects to have responses by early April. To review the RFP, go to:http://www.dgsweb.state.pa.us/RTA/GeneralEdit.aspx?SID=DPW%20RFP%2034-08.

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for certain providers of services that consumers have problems accessing. They include skilled home nurses for children with severe disabilities (for whom $6 million would be allotted), dentists ($1.9 million), and primary care providers. Health centers and mobile clinics would receive $2.9 million.

For the third straight year, the Administration proposes to "carve out" responsibility for prescription drugs from the managed care plans that participate in Medical Assistance, and administer this benefit under the fee-for-service program. The stated rational is to take advantage of federal rebates that are otherwise unavailable. This change would occur starting in January 2009, and would be implemented first in the HealthChoices program in the Southeast and Lehigh/Capital zones, along with a new Northwest HealthChoices PLUS zone that is proposed. The last two years, the pharmacy carve out was rejected during budget negotiations.

Hospital "Accountability" Sought

Together with Community Legal Services, ACORN, and the Philadelphia Unemployment Project, PHLP is moving forward with a Hospital Accountability Project designed to help consumers who are underinsured or uninsured and are either being denied treatment or being excessively billed by Pennsylvania hospitals.

Hospitals in Pennsylvania receive special funding from numerous sources to assist patients who are underinsured or uninsured by providing free or reduced cost care. The Hospital Accountability Project will be analyzing how much money different hospitals get and how they use that money to offer charity care to uninsured and underinsured consumers.

The Hospital Accountability Project will review the charity care policies of hospitals around the state and work to improve the numerous problems consumers face. These problems include:

- *Lack of clear, strong rules about hospitals' charity care policies and lack of consistency among hospital policies*: The lack of clear guidelines means that government funded benefits are distributed at the discretion of the hospitals.
- *Lack of awareness about availability of charity care:* Consumers may not find out about the hospital's charity care policy, or may find out too late, because no one told them about it or the description was so vague.
- *Burdensome application forms and processes:* A hospital charity care application may be so long or complicated that consumers cannot fill it out correctly, which means the application gets rejected.

The Hospital Accountability Project will also develop consumer education material. For example, it will create a brochure about consumers rights when dealing with hospitals. The Project will also compile hospital charity care policies throughout the state and make this information available to consumers. All of this information will be available on a web page which consumers and advocates can access to help consumers understand and navigate hospital charity care programs.

Finally, the Project will outreach to the community to inform consumers and those who work with them of their rights and will provide assistance to those whose rights have been violated. The Project is funded by Community Catalyst.

We will provide more information about this initiative in future issues of the newsletter.

What If I Can't Afford My MA Drug Co-Pays?

People who receive Medical Assistance cannot be denied medications at the pharmacy simply because they cannot afford the co-pays. If a consumer cannot afford the co-pay, he should tell this to the pharmacist. The consumer is still liable for the co-pay, but the medication cannot be denied if the consumer cannot afford the co-pay. If a consumer cannot afford prescription co-pays but his pharmacist refuses to give him medicine, he should call his MA managed care plan (if enrolled in a plan) or 1-866-542-3015 (if in ACCESS).

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How the Clinton and Obama Health Plans Address the Uninsured Problem

As Pennsylvanians prepare for the April 22nd primary, it is important to compare the health plans of the presidential candidates. This article highlights how each Democratic candidate's plan would address the problem of 47 million Americans lacking health insurance. The initiatives of John McCain, the Republican nominee, which emphasize tax credits and cost containment, are not considered here at this time, since his nomination is not contested.

Both Senator Clinton and Senator Obama would maintain the current private insurance markets, maintain current federal programs, and create a new, co-existing product to be offered by the government. Both would expand Medical Assistance and CHIP coverage. Both would eliminate the barrier to coverage created by pre-existing condition exclusions. Each plan would seek system-wide savings by improving quality, introducing technology-related improvements, allowing the government to use its purchase power to reduce the cost of drugs, and permitting the re-importation of drugs. Senator Clinton speaks of mental health parity.

The candidates differ on their approach to employers and individuals. Senator Obama would impose a payroll tax on employers who do not provide "meaningful" coverage or offer a "meaningful" contribution toward employee health care. He would offer to reimburse a percentage of catastrophic coverage costs of employers whose costs rise due to expensive employees. Senator Clinton would mandate coverage by large firms and offer incentives to small firms to provide coverage. Rather than reimburse employers for catastrophic coverage, she would focus on rate protections.

Senator Obama would mandate that all children have health insurance. Senator Clinton, embracing a philosophy more like that of the supporters of the Social Security System, would insist that all Americans have minimum health insurance. She would limit one's premium payment to a percentage of family income, through the use of tax credits. She would also tax the "high end" portion of expensive health plans for those making over $250,000.

For more details, you can view each candidate's health plan online. The Clinton Plan is available at: http://www.hillaryclinton.com/feature/healthcareplan/americanhealthchoicesplan.pdf. The Obama plan can be reviewed at: http://www.barackobama.com/issues/pdf/HealthCareFullPlan.pdf.

Update on Mental Health Parity Legislation

As promised in our November 2007 newsletter, we continue to update our readers on federal mental health parity legislation. In early March, the House of Representatives overwhelmingly (268-148) passed H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007, sponsored by Rep. Patrick Kennedy (D-RI) and Rep. Jim Ramstad (R-MN). The bill would require that coverage of mental health benefits be equal to medical and surgical benefits. The legislation bars health insurance plans from imposing different day and visit limits or applying different deductibles, co-payments, out-of-network charges and other financial requirements for mental health or addiction treatment than for medical or surgical procedures. H.R. 1424 will now be reconciled with the Senate's Mental Health Parity Act of 2007 (S. 558). We will continue to keep you updated about developments in future newsletters.

Can MAWD/HCBS Waiver Recipients Get Payment for Medicare Part B Premiums, Too?

PHLP and other legal services programs across the state have received calls from consumers with Medicare and Medicaid who are forced to make a difficult choice. If their income is above a certain level, they must choose between participation in the State's Medicare Savings Program (under which Medical Assistance pays for their Medicare Part B premium, but doesn't pay for health care) and participation in the Medical Assistance for Workers with Disabilities (MAWD) program or in Home and Community Based (HCBS) Waiver programs (without receiving coverage of Part B premiums).

Current DPW policy only allows the payment of Part B premiums for MAWD/HCBS recipients with income below certain limits. Specifically, DPW policy allows for the following:

- **If an individual's income is below 120% of the poverty level** ($1,060/month for 2008) and she is in MAWD or receiving HCBS services through a Waiver, DPW will also pay her Medicare Part B premium.
- **If an individual's income is between 120% and 135%** ($1,060-$1,190/month), she can only get payment of the Part B premium through the Medical Savings Program **or** receive health care benefits through MAWD/HCBS. DPW's policy does not allow for individuals at this income level to qualify for both programs at the same time. In situations where someone has been getting payment of the Part B premium prior to enrolling in MAWD or HCBS Waiver, she has to "choose" between continuing to receive payment of the Part B premium or enrolling into MAWD or HCBS Waiver. Similarly, if someone has been receiving MAWD or HCBS Waiver benefits and then becomes eligible for Medicare, she must "choose" between continuing to get the MAWD or HCBS Waiver coverage or getting payment of the Part B premium.
- **If an individual's income is above 135%** ($1,190/mo for 2008) and she is a MAWD or HCBS Waiver consumer, her Medicare Part B premium is not covered under current DPW policy. This is because the income limit to qualify for payment of the Part B premium benefit under the Medicare Savings Program is 135% or less.

PHLP's position is that DPW is misinterpreting federal law, and that all MAWD and HCBS Waiver recipients should have their Part B premiums covered. Our position is that a Medicare recipient who receives Medical Assistance benefits through MAWD or HCBS Waiver is entitled to full Medicare cost-sharing, including Payment of the Part B premium, as part of the MA benefit package under these categories. We believe that DPW is superimposing requirements of the Medicare Savings Program onto MAWD/HCBS Waiver recipients without any regulatory support. We are interested in hearing your experience with this issue and encourage people to call our Helpline at 1-800-274-3258 (voice) or 1-866-236-6310 (TTY) to discuss this further.

Some Medicare Consumers Losing Part D LIS on April 1st

Earlier this month, the Social Security Administration (SSA) sent notice to approximately 3,300 individuals in PA (approximately 76,000 nationwide) who will lose their Part D low-income subsidy (LIS) effective April 1, 2008. The notices were sent to individuals who were previously found eligible for the LIS by SSA, who were selected for redetermination in fall 2007, and who failed to provide the requested redetermination paperwork to SSA or respond to subsequent follow-up attempts*. As we detailed in our September 2007 Newsletter, SSA's redetermination process for the LIS changed in 2007 and required that all LIS recipients selected for redetermination return paperwork even if their situation had not changed.

SSA mailed the termination notices to affected individuals at the beginning of March. Individuals who received the notice and who do nothing will lose their LIS on April 1, 2008. Individuals who received the notice and who appealed within 10 days should continue to receive the LIS during the appeal process. Individuals who have not yet filed an appeal may want to do so; however, they will not get continued benefits pending appeal unless they can show good cause for not filing an appeal within 10 days. Appeals can be filed by calling SSA at 1-800-772-1213.

Affected individuals should decide whether to stay in their current plan or change to a different plan. Individuals whose LIS will end as of April 1st should receive information from their current Part D plan telling them how much their premium will be, starting April 1, 2008, without the LIS. Individuals who wish to change plans as a result of losing the LIS will have a 3-month Special Enrollment Period (starting April 1, 2008) to enroll in a different plan.

Individuals who lose their LIS on April 1st can always reapply for the LIS again after April 1st. As a reminder, the current LIS guidelines are:

Full Subsidy

- ***Individual***: Income less than $1,170/month ($14,040/year); Resources less than $7,790.
- ***Married Couple***: Income less than $1,575/month ($18,900/year); Resources less than $12,440.

Partial Subsidy

- ***Individual***: Income less than $1,300/month ($15,600/year); Resources less than $11,990.
- ***Married Couple***: Income less than $1,750/month ($21,000/year); Resources less than $23,970.

Call PHLP's Helpline if you received this notice and have questions or need assistance (1-800-274-3258 (voice) or 1-866-236-6310 (TTY)).

***NOTE:** Individuals with both Medicare and Medical Assistance should not receive these notices as they are "deemed" eligible for the LIS for entire year by Medicare (not SSA).

PHLP staff are available in Southeastern PA to conduct trainings on Part D to help social service agencies and their clients navigate the Part D system. Trainings focus on the rights that dual eligibles have under Part D and the appeals and grievance processes that are available to all Part D enrollees.

To learn how to help get your clients' needs met through Medicare Part D, contact the PHLP HELPLINE to schedule a training (1-800-274-3258 voice or 1-866-236-6310/TTY). Please let us know if you require any special accommodations for persons with hearing and/or vision needs.

State Improves Access to Buprenorphine

Recent state guidance is intended to make it easier for individuals who struggle with opiate addiction to obtain buprenorphine. In January 2008, the PA Department of Health's Division of Drug & Alcohol Program Licensure issued Licensing Alert 01-08. This Alert identifies the process by which licensed drug and alcohol outpatient programs can request an exception to the Narcotic Treatment Program regulations. This Licensing Alert is in response to Secretary of Health Dr. Calvin Johnson's recent approval of the PA Community Providers Association's Buprenorphine Workgroup's recommendation to improve access to buprenorphine.

Buprenorphine is an FDA approved prescription medication used to treat opiate addictions. Buprenorphine can be most effective for people who have used opiates for only a short period of time or who have used smaller amounts of opiates when they did use. Federal regulations require that only physicians who have completed a specialized training and receive a special DEA number are permitted to prescribe buprenorphine. Additionally, the State requires that drug and alcohol providers obtain approval as a Narcotic Treatment Program in order to prescribe buprenorphine. Effective January 2008, as outlined in Licensing Alert 01-08, non-residential drug and alcohol providers may submit an exception request to this state requirement.

The Licensing Alert defines the process outpatient drug and alcohol providers are to follow to request an exception to the regulations at 28 PA Code Chapter 715 requiring a provider which uses agents for maintenance or detoxification to comply with Chapter 715 and to obtain the approval of the Department of Health to operate as a Narcotic Treatment Program. Once an exception is granted to an outpatient provider it can prescribe and treat people with buprenorphine without being approved to operate a Narcotic Treatment Program.

A form request for exception to 28 PA Code Chapter 715 is attached to the Licensing Alert and is also available from the Division of Drug and Alcohol Program Licensure. The Alert and the Exception Request form can be found at http://www.dsf.health.state.pa.us/health/cwp/view.asp?a=189&q=238248.

Requests may be submitted electronically to the Division at dapl@state.pa.us. The form is just two pages and the Department of Health has set a goal of a 24-hour turnaround time for approvals of exception requests. Questions about the Licensing Alert may be directed to the Division at 717-783-8675.

New Medicaid Tamper Resistant Prescription Rules In Effect April 1st

Starting April 1, 2008, all written prescriptions for Medicaid recipients in the Fee-for-Service (FFS) system (i.e., who use the ACCESS card) must be written on "tamper proof" prescription pads. This is required by federal law. Originally, the new rules were to go into effect October 1, 2007, but implementation was delayed six months at the request of many stakeholders including consumer groups, pharmacists, physicians, and state Medicaid directors.

The new rules will apply to all out-patient prescriptions covered by Medicaid, including over-the-counter drugs when those drugs are covered by Medicaid with a prescription. The provisions apply whether Medicaid is a primary or secondary payer for the prescription. This includes prescriptions written for consumers who are in behavioral health managed care but whose prescriptions are paid for by the Fee-for-Service system. It also includes prescriptions that are excluded under Medicare D and paid for by Medicaid (such as Ativan or Phenobarbital). It **DOES NOT** apply to prescriptions that are covered through a Medicaid managed care plan. There are several other exceptions:

- The provision does not apply to prescriptions written in nursing facilities, or intermediate care facilities for the mentally retarded or "other specified institutional settings."
- It does not apply to refills of prescriptions when the original prescription was written before October 1, 2007.
- **It does not apply to prescriptions transmitted to a pharmacy by telephone, fax, or electronic transmission.** However, electronically printed prescriptions must be printed on tamper proof paper.

Pharmacies will be permitted to dispense an emergency supply of a medication, consistent with Medicaid law, as long as a verbal, faxed, electronic, or tamper-proof prescription is provided to the pharmacy within 72 hours. This applies to all MA covered prescriptions except controlled substances (Schedule II narcotics) for which Pennsylvania law requires a written prescription at the time of dispensing. If a person fills a prescription when she is not on Medicaid, and subsequently becomes Medicaid eligible, the prescription must be re-written on tamper proof paper in order to allow refills to be covered by MA.

If consumers present a prescription at a pharmacy and the pharmacist is unable to accept the prescription because it is not tamper proof, the pharmacist should call the prescribing physician and accept a telephone prescription. If consumers find that a pharmacist cannot fill a prescription because it is not on tamper proof paper and the pharmacist cannot reach a physician or declines to dispense an emergency supply, consumers may call the PHLP helpline at 1-800-274-3258 (voice) or 1-866-236-6310 (TTY) during weekday business hours.

A more extensive discussion of the provisions of the law is available in the September 2007 Health Law News available at www.phlp.org. The original Medical Assistance Bulletin is available at http://www.dpw.state.pa.us/PubsFormsReports/NewslettersBulletins/003673169.aspx?BulletinId=4095. The updated bulletin announcing implementation is available at http://www.dpw.state.pa.us/PubsFormsReports/NewslettersBulletins/003673169.aspx?BulletinId=4135.

Respite Funding Must Be Spent

This alert is a follow up to our January Newsletter article, *"Respite Funding Available for Families with Children with Behavioral Health Needs".* Of the $500,000 allocated to the County Mental Health Offices across the state only $62,000 was spent as of December 31, 2007. Even though additional funds have likely been used since January it is also likely that every county still has respite funds remaining that must be spent by June 30, 2008. If you or a family you know can benefit from respite care for their children with behavioral health issues please contact the County Mental Health Office immediately to inquire how to access these services. If you need assistance in getting this information from your county please contact the PHLP Helpline at 1-800-274-3258.

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