Health Law PA News

Newsletter of the Pennsylvania Health Law Project

Harrisburg Philadelphia Pittsburgh

Statewide Help Line: 1-800-274-3258 On the Internet: www.phlp.org TTY: 1-866-236-6310

Volume 8, Number 5 September 2005

Dual Eligibles May Lose Doctors With "Passive Enrollment" Into Medicare HMOs

"Dual Eligibles" are Medicare beneficiaries who are also Medical Assistance recipients. As we have noted in previous Newsletters, dual eligibles will no longer be able to get prescriptions covered by Medical Assistance as of January 1, 2006. Instead, these persons will need to enroll into a Medicare Prescription Drug Plan and receive their prescription coverage through the Medicare Plan.

Many dual eligibles in Pennsylvania are required to get their Medical Assistance services through a Managed Care Plan (MCO). All of the Medical Assistance MCOs in Pennsylvania have, or are affiliated with, a Medicare HMO. Six of these Medicare HMOs have been told that they will be approved by the Center for Medicare and Medicaid Services (CMS) to be "Special Needs Plans". A Special Needs Plan is a Medicare HMO that is also a Prescription Drug Plan and that offers coverage only to certain special needs populations – for example, dual eligibles.

INSIDE THIS EDITION

New Medical Assistance Service Caps and Co-pays	3
Mandatory Medical Assistance MCO Lock-in	4
Update on the New Medicare Prescription Drug Benefit	5
Announcement of PHLP Presentations on Changes to MA	6
Medical Assistance Premiums	8
DPW proposes regulations for equal access in Nursing Homes	9
State to Implement Preferred Drug List	10
Telephone cost Savings	11

The "Passive Enrollment" Process

As we go to press, PHLP has learned that the federal government has given these six Special Needs Plans (hereinafter "Medicare HMO-SNP") at least preliminary approval to "passively enroll" dual eligibles from its Medical Assistance MCO into its Medicare HMO-SNP. Under the process established by CMS, the Medicare HMO-SNP will send a "passive enrollment" notice to the dual eligibles enrolled in the Plan's Medical Assistance MCO in early October. The notice will tell consumers that they will be automatically enrolled into the plan's Medicare HMO-SNP unless they "opt out"-that is, they specifically decline enrollment- by October 31, 2005.

? Consumers who "opt out" will then

(Continued on page 2)

have until December 31, 2005 to choose among any of the Medicare Prescription Drug Plans available and enroll into the Plan of their choice

- Consumers who do not opt out will be enrolled into the Medicare HMO and will then be required to get their prescription drugs, as well as all of their Medicare services, through the Medicare HMO beginning January 1, 2006.

Loss of Access to Health Care Providers

Being passively enrolled into a Medicare HMO-SNP will likely not be the best choice for many consumers. Most dual eligibles have been in "traditional Medicare" where they could be treated by any health care provider who participates in Medicare. Being passively enrolled into a Medicare HMO-SNP has the potential to cause these elderly and disabled individuals to lose the freedom to choose their doctors and other health care providers that they presently enjoy. Unless the Medicare HMO-SNP allows these dual eligibles the freedom to be treated by any Medicare provider, and then entices the provider to accept their payment (many doctors refuse to deal with HMOs), the consumer will be limited to the Medicare HMO-SNP's provider network. This could result in a major disruption in treatment.

A consumer should consider the following things before deciding whether or not to opt out:

- Will I be able to continue to see my primary care doctor and any other specialists or medical providers that are important to me? Most Medicare HMOs require their members to obtain treatment from doctors and other providers who belong to the Medicare HMO's network.
- Will I be able to continue to access all the drugs I now have available to me through my Medical Assistance MCO? Keep in mind that the rules for Medicare Prescription Drug Plans are different and do not require the Plans to offer the same broad drug formulary that Medical Assistance provides.
- Will I have extra costs if I join this Medicare HMO-SNP? Most Medicare HMOs charge an additional premium because they offer "extra benefits" beyond what traditional Medicare covers. Though these consumers will be eligible for a "full subsidy" to cover the standard $32 premium for a Prescription Drug Plan, if the Medicare HMO-SNP's premium exceeds that amount the consumer is responsible for the additional costs.
- Is the Medicare HMO-SNP the best choice among all the Prescription Drug Plan options available to me? Other Plans may have a broader drug formulary, a broader pharmacy network, and/or other benefits not offered by the Special Needs Plan.

One of the troubling aspects of the "passive enrollment" process established by CMS is that consumers are given less than 30 days to decide if they want to "opt out" of the Medicare HMO-SNP. That may not give consumers sufficient time to gather information, educate themselves and compare the Medicare Prescription Drug Plans available to them.

Not all dual eligibles will face "passive enrollment". Specifically, dual eligibles cannot be passively enrolled if: they are in Medical Assistance Fee For Service; they enrolled into

(Continued on page 4)

New Medical Assistance Service Limits and Co-Pays!

Pennsylvania's 2005-2006 Budget made important changes to Medical Assistance. One such change was serious cuts to services and the expansion of co-pays. All of these changes became effective August 29, 2005.

Service limits are numerical caps on how many times consumers can get a service.

For Fee-For-Service/AccessPlus General Assistance (GA-related) consumers, the budget imposes a limit of 1 Inpatient Hospitalization Admission per year (the previous limit was 2 per year). In addition, for all non-pregnant adult consumers, the budget sets a limit of 1 Inpatient Rehabilitation Admission per year (previously unlimited). These Hospitalization limits do not apply to children under 21 or pregnant women.

In addition, the budget sets a limit of 18 Outpatient Health Visits per year for all Fee-For-Service/AccessPlus adults. (Previously, GA-related adults already had this limit). This limit will apply to all doctors and specialist visits. However, consumers will be allowed to exceed the limit to see their PCP or any specialist their PCP refers them to. These Outpatient Visit limits do not apply to children under 21 or pregnant women.

Individuals in a Medical Assistance Managed Care plan will be subject to Service Limits as determined by their health plan. Managed Care plans will be informing their members of their changes in the coming months. The Managed Care plans are allowed to implement less, but not more, than the FFS/AccessPlus Service Limits.

Mental health services will be reduced for Fee-For-Service/AccessPlus and Voluntary Managed Care consumers. Inpatient Psychiatric Hospitalizations are limited to 30 days per fiscal year (previously, the limit was 60 days per year). Psychiatric Outpatient Clinic Services are limited to 5 hours, or 10 30-minute sessions, per month (previously, the limit was 7 visits per month). Finally, Psychiatric Partial Hospitalizations are limited to 540 hours per fiscal year (previously, the limit was 720 hours per year). These Behavioral Health limits do not apply to children under 21 or pregnant women. In addition, these Behavioral Health limits do not apply to individuals in a Mandatory Managed Care plans.

There is an Exceptions Process for consumers who need more services after they have reached their services limit. Consumers will be getting instructions about how to request additional services, and their doctors can also make the request on their behalf. It is important that consumers learn about their right to get exceptions, so they don't go without needed medical care.

Co-payments are payments that consumers have to make every time they get a service. None of these co-payment rules apply to Children under age 18, pregnant women, or adults in Nursing Homes.

Consumers will have prescription co-payments of $1 for each generic prescription and $3 for each brand-name prescription the fill (previously, GA-related consumers had a $2 co-pay on all drugs, and non-GA adults had no co-pays). However, if co-pays exceed $90 in a 6-month period ($180 for a GA related recipient), the consumer will be reimbursed for the excess amount they paid.

In addition, DPW is still considering a possible $1 co-pay per one-way para-transit trip for Medical Assistance Transportation (MATP).

Consumers should contact the Helpline of the Pennsylvania Health Law Project if they have further questions or problems with the new Medical Assistance **service limits** and **co-payments**.

(Continued from page 2)
their Medical Assistance MCO after August 15, 2005; or if they are already enrolled in a Medicare HMO.

It is also important to remember that all dual eligibles have a special election period under the Medicare Prescription Drug Benefit and can change their Prescription Drug Plan at any time. Consumers who are passively enrolled into a Special Needs Plan can change their mind before or after January 1, 2006, disenroll from the Special Needs Plan and enroll into a different Prescription Drug Plan.

CMS Reasoning Doesn't Apply in Pennsylvania

Ironically, CMS' articulated reason for giving Special Needs Plans the authority to "passively enroll" consumers is that consumers would be better served by getting their Medical Assistance and Medicare services (including prescription drugs) through the same health plan. That reasoning does not apply in Pennsylvania, however, because DPW has announced it will be taking all dual eligibles out of managed care on January 1, 2006 and putting them into the MA Fee for Services (FFS) system. If CMS' plan goes forward, health plans will be enrolling consumers into their Medicare HMO-SNP the same day the consumers are disenrolled from their Medical Assistance MCO.

It appears that CMS did not know about Pennsylvania's plan for dual eligibles. PHLP has been in discussion with CMS about the ramifications of their plan and whether "passive enrollment" should go forward in Pennsylvania. PHLP will report any new developments on the Medicare Prescription Drug Benefit Page of our website, www.phlp.org.

New Medical Assistance Mandatory Managed Care 'Lock-In'!

Pennsylvania's 2005-2006 Budget made important changes to Medical Assistance. One such change was a '**lock-in**' rule which will lock consumers into their Mandatory Managed Care plan for a full year once they enroll. This will not apply to Voluntary Managed Care consumers. This 'lock-in' does not have a certain implementation date yet, but it is expected to be implemented around March 1, 2006.

Starting around March 1 of next years, when consumers enroll in their Mandatory Managed Care plan (and each time thereafter that they enroll into a new plan), they will be 'locked-in' to that plan for a period of one year, meaning they won't be allowed to switch to another health plan until the year has passed. This may affect consumers in many ways; for example, a consumer's most trusted doctor may switch to a different HMO network while the consumer is locked-in, leaving the consumer with no way to see that doctor.

Advocates, including MAAC Consumer Subcommittee, and PHLP on behalf of the Consumer Subcommittee, are working with DPW to develop broad exceptions so consumers can switch plans if the medical needs depend upon it.

Consumers should contact the Helpline of the Pennsylvania Health Law Project if they have further questions or problems with the new Medical Assistance **lock-in**.

Update on the Medicare Prescription Drug Benefit

The Centers for Medicare & Medicaid Services (CMS) is still in the process of approving organizations to offer Medicare prescription drug coverage under the new benefit. They will officially announce the approved organizations later this month. However, on August 29, 2005, CMS announced that they expect 23 organizations to offer stand-alone Prescription Drug Plans in PA. Some of these organizations will offer more than one Plan. According to CMS' information:

- Plans will charge premiums ranging from less than $20 to $35 per month.
- Many Plans will have no deductible or have a deductible less than the $250 for a Standard Plan.
- Some "Enhanced" Plans will continue to cover generic drugs while a person is in the "doughnut hole". Under a Standard Plan, consumers do not get any coverage from the Plan during the "doughnut hole".
- Almost all of the stand-alone Plans will offer a mail-order option in addition to their network of retail pharmacies.

Impact on Dual Eligibles (consumers that have both Medicare and Medical Assistance)

Of the 23 organizations expected to offer stand-alone Plans, 13 will offer Plans with a premium less than the premium subsidy amount of $32.59 that all full benefit dual eligibles will automatically receive. Full benefit dual eligibles are Medicare beneficiaries who currently receive prescription drug coverage through Medical Assistance. These consumers not currently in a Medical Assistance HMO will be auto-enrolled into one of these "zero-premium" Medicare Prescription Drug Plans. Please see the article on page 1 to find out about how full benefit dual eligibles currently in a Medical Assistance HMO will be enrolled into a Medicare Plan.

CMS also announced last month that they revised the Special Election Period for dual eligibles who do not get their prescription drugs through Medical Assistance but who get other benefits through the Medical Assistance program (i.e., help paying their Medicare costs). Instead of only being able to change Plans once, and only in the first year, these consumers will get an ongoing Special Election Period and will be able to change Plans at any time. This change now means that all dual eligibles can change Plans at any time.

Final Marketing Guidelines Released

Approved Medicare Prescription Drug Plans are allowed to start marketing their benefits on October 1, 2005. Plans must follow certain rules when they mail information about their benefits to consumers, advertise their benefits on television or radio, or call consumers on the phone to describe their benefits and encourage them to enroll. Medicare has a process in place to review and approve the marketing materials that Medicare Prescription Drug Plans will use.

(Continued on page 7)

Please feel free to copy and post or distribute this announcement.

The Pennsylvania Health Law Project presents:

BIG Changes to the Medical Assistance Program

The Pennsylvania Health Law Project will be conducting presentations to discuss the details of the changes to Medical Assistance

Attend one of our trainings to learn more about the service caps, co-pays, premiums and more.

Locations, Dates and Times

Pittsburgh

Friday, September 16, 2005
10am—12pm
Carnegie Library of Pittsburgh-Downtown
First Floor Meeting Room
612 Smithfield Street
Pittsburgh, PA 15222

Harrisburg

Co-sponsored with Pennsylvania Protection and Advocacy
Friday, September 23, 2005
10am—12pm
1414 N. Cameron St
2nd flr conference room
Harrisburg, PA 17103

Philadelphia

Tuesday, September 27, 2005
9am—11am
Philadelphia Bar Association
1101 Market St, 11th flr
Philadelphia, PA

The Briefing is FREE!

Please Call the Pennsylvania Health Law Project to RSVP so that we know how many people to expect:
1-800-274-3258

Visit us online at
www.phlp.org

(Continued from page 5)

The following rules apply to all Medicare Prescription Drug Plans when they market their benefits:

- Plans cannot identify themselves as "Medicare-approved", or discuss their specific plan or enrollment, until October 1, 2005.
- Plans cannot use misleading or confusing terms within their marketing materials, or misrepresent their Medicare prescription drug benefits and services.
- Plans must include information in all written materials to let consumers know that they can get the information in alternate formats such as Braille, foreign languages, audio tapes, and large print.
- Plans cannot call anyone who is on the National Do-Not-Call List.
- If a Plan representative calls a consumer and the consumer asks them to not call again, the Plan must honor that request.
- Plans cannot sign anyone up over the phone.
- Plans cannot ask for personal identification such as Social Security Number, bank account numbers, or credit card numbers over the phone.
- Plans that violate the rules will be subject to penalties and/or fines.

How to Sign-Up for the Do-Not-Call Registry

PHLP encourages anyone who does not want to receive calls from Medicare Prescription Drug Plans to sign up for the Pennsylvania "Do Not Call" List. Individuals who sign up for this list will also be placed on the National Do-Not-Call Registry. People can sign up for the PA "Do Not Call" list by calling the PA Office of Attorney General's hotline at 1-888-777-3406 or by visiting the website www.nocallsplease.com. The number registered on the "Do-Not-Call List" will remain on the List for 5 years unless the person wishes to remove it. If someone is not sure whether their phone number is registered on the list, they can call the toll-free number listed previously to find out.

People can sign up for the National Do-Not-Call registry by calling 1-888-382-1222 or 1-866-290-4236 (for TTY users). Individuals must call from the phone number they wish to register on the National Do-Not-Call List. People can also sign up for the National Do-Not-Call registry at www.donotcall.gov.

Reports of Medicare Prescription Drug Benefit Scams

There have been reports of scams where Medicare consumers are being told that, for a certain fee, the caller will sign them up for a Medicare Prescription Drug Plan or help them with choosing a Plan. Remember, no one can sign up for this benefit until November 15, 2005. Also, Plans are not allowed to sign people up over the phone or ask for any personal identification. If a consumer thinks they may be a victim of fraud or abuse, they should report it immediately to 1-800-MEDICARE (1-800-633-4227) or 1-877-486-2048 for TTY users, the HHS Office of Inspector General Fraud and Abuse Hotline at 1-800-447-8477, or the PA Attorney General's Consumer Protection Hotline at 1-800-441-2555.

Please call the PA Health Law Project Helpline at 1-800-274-3258 (voice) or 1-866-236-6310 (TTY) with any questions about these updates.

New Medical Assistance Premiums!

Pennsylvania's 2005-2006 Budget made important changes to Medical Assistance. One such change was a monthly **premium** for non-poor Families with a Child with a Severe Disability. This monthly premium does not have a certain implementation date yet, but it is expected to be implemented around November 1, 2005.

The premiums will be implemented starting with families with income at or above of 200% of the Federal Poverty Level (FPL). The premium amount will be determined on a sliding scale, based on family income and size of family.

PHLP has obtained a proposed premiums chart, and DPW issued a Public Notice regarding the premiums with a 30-day comment period was published in the PA Bulletin on August 13, 2005. DPW must get approval from the federal government (CMS) before this can be implemented. Some examples from the proposed premiums chart:

- Family of 4 earning $40,000-$50,000 = $27/mo.
- Family of 4 earning $100,000-$110,000 = $135/mo.
- Family of 4 earning $200,000-$550,000 = $903/mo.

Local County Assistance Offices will contacting the parents of severely disabled children to request parental income information, if they do not already have information. However, these contacts from the CAOs should only be asking the parents for the information, not seeking verification. Verification will occur at the official and regular redetermination time for all such MA families. In addition, it is expected that an individualized notice will go out to these parents in the next 2 months, telling the parents what DPW has on record with respect to their income and household size, and giving them an opportunity to correct this info

Consumers should contact the Helpline of the Pennsylvania Health Law Project if they have further questions or problems with the new Medical Assistance **premiums**, or would like a copy of the proposed premium payment chart.

Consumer Input Needed for Waiver Renewal

DPW's Office of Social Progams-Bureau of Home and Community Based Services (BHCBS) will be hosting several "Information Gathering Sessions" across Pennsylvania to get feedback from consumers on the Independence or OBRA waivers about their experiences with the services provided and how services can be improved. This information will assist BHCBS as they prepare to submit the renewal applications for both waivers in early next year. Family members, advocates, and workers are invited to attend as well. There are currently three scheduled sessions:

Harrisburg, Pennsylvania – September 16, 2005 from 3:30 to 5:00

Whitehall, Pennsylvania – September 21, 2005 from 10:30 to 12:00

Wilkes-Barre, Pennsylvania – September 21, 2005 from 2:00 to 3:30

If you are interested in participating in any of these sessions, please contact Amy Townson at c-atownson@state.pa.us or at (717) 346-9782 for more details.

DPW Proposes Regulations to Facilitate Equal Access to Nursing Homes

On July 30, 2005, DPW published proposed regulations to require nursing homes participating in the Medical Assistance Program to keep written records of who applied for admission, along with demographic information, for a period of four years. Civil rights inspectors presently have no ability to determine whether nursing facilities are discriminating against applicants on the basis of race, disability, or other grounds. Instead, they are limited to determining if room placement, dining room seating assignments and the like occur in a discriminatory manner. This regulation would change the status quo to enable regulators to investigate discrimination on admissions.

Consumers and advocates, such as the Health Law Project, have long argued that the state needs to determine if discrimination is taking place on admission. Citing examples of facilities with an all white resident population, located in the midst of African-American neighborhoods, advocates have argued that Pennsylvania should follow the lead of other states and enforce first-come, first-served admissions practices, or at least give civil rights enforcement staff the tools to do their job. Advocates have pointed to published studies such as those of Temple University Professor David Barton Smith, in support of their position. See, e.g. Smith, D.B. 1993. The Racial Integration of Health Facilities. Journal of Health Politics, Policy and Law.

Governor Announces Medical Assistance "Listening Tour"

Governor Ed Rendell has announced that he is convening a series of panel discussions throughout Pennsylvania on the state's Medical Assistance Program. Noting national and state budgetary concerns, as well as the growing demand for Medical Assistance services, the Administration is soliciting new ideas and solutions for containing costs in the program while still providing quality healthcare. These are the cities and dates where the panel discussions will occur:

Sept. 23 Pittsburgh
Sept. 29 Allentown
Sept. 30 Scranton
Oct. 6 State College
Oct. 7 Somerset
Oct 14 Erie
Oct 21 Harrisburg
Oct 28 Philadelphia

Consumers, providers, community members, elected officials and other stakeholders are invited to submit written testimony that offers their ideas and solutions to help address the state's health care crisis. The testimony must be submitted 1 week before the panel discussion the submitter plans to attend. DPW will then notify individuals directly who will be invited to give their testimony orally to the panel. Written testimony can be sent to DPW via email at cfruhwirth@state.pa.us , or by U.S. Mail to : Welfare Communications Office, P.O. Box 2675, Harrisburg, PA 17105, or by fax to: (717) 787-1229 Attn: MA Panels.

State to Implement Preferred Drug List in October, Recipient 10-Day Appeal Right Is Important

One of the cost cutting measures proposed by the Department of Public Welfare in order to balance the 2005-'06 budget was the implementation of a "Preferred Drug List" (PDL). Under this initiative, which has been imposed by other states, a Medical Assistance (MA) recipient could get drugs on the preferred list simply by presenting a prescription at the pharmacy. However, drugs not on the list would have to go through a prior authorization process. For example, a recipient might have to demonstrate that he or she has not been helped by using one or more drug on the PDL before being allowed access to a drug that is not preferred. This is mechanism employed by all of the MA managed care plans in Pennsylvania through the use of restrictive drug formularies and prior authorization. A statewide PDL allows DPW to get discounts from drug manufacturers that want their drugs on the list. The state has announced that it will put the best drug in any class on its list, and will only use cost as a factor if all drugs in a class are equally effective, using an "evidence based" standard.

Recognizing that most MA recipients are already subjected to preferred drug lists, and that if properly developed and implemented, a single preferred drug list might be easier for prescribers and consumers to use, the Consumer Subcommittee of the Medical Assistance Advisory Committee (MAAC) did not oppose a statewide preferred drug list, so long as certain conditions were met. Consumers insisted that the list be developed through a public process, using unbiased clinical experts, and containing a consumer-friendly exception process.

Late this summer, DPW contracted with Provider Synergies to facilitate the development of the PDL. Provider Synergies must recommend classes of drugs, and prior authorization criteria for drugs that are not on the list. The department also appointed a Pharmacy and Therapeutics (P&T) Committee to make recommendations as to which drugs should be on the list. At the insistence of the Consumer Subcommittee, DPW required appointees to the P&T Committee to disclose any conflicts of interest, including ties to any drug companies. For information on the composition, meeting schedule and agenda of the P&T CommitteeDPW website at: http://www.dpw.state.pa.us/omap/geninf/PTC/omapPTCmain.asp.

DPW will be implementing the PDL in phases, beginning in October in the fee-for-service program. The PDL will be expanded to include recipients in the managed care plans in the near future. Fee-for-service recipients who have gotten a non-preferred drug during the 90-day period prior to implementation will get a notice telling them of the implementation of the program, and its implications for them. This notice will not include appeal rights.

(Continued on page 12)

Telephone Cost-Savings: Keeping You Connected

There are several programs available to Pennsylvania consumers with incomes of up to 150% FPL that offer cost savings with monthly phone service fees (the Lifeline programs) and with phone hook-up (the Link-Up program).

Lifeline: Consumers can save $11.59/month and not pay any line connection charge (through automatic eligibility for Link-Up). You are eligible for Lifeline if:

1. Your household income is at or below 100%, **or**
2. No one claims you as a dependent on their Federal Income Tax, unless you are over 60 and you are in one of these programs: General Assistance (GA), Supplementary Security Income (SSI), or Temporary Assistance for Needy Families (TANF)

Lifeline 150: Consumers can save $7.84/ month and 50% off any line connection charge (through automatic eligibility for Link-Up). You are eligible for Lifeline 150 if:

1. Your household income is at or below 150%, **and**
2. No one claims you as a dependent on their Federal Income Tax, unless you are over 60 and you are in one of these programs: Medicaid, Food Stamps, LIHEAP, GA, SSI, TANF, State Blind Pension, Federal Public Housing Assistance

Link-Up: Under this program, if you qualify for Lifeline, you will not have to pay any line connection charges and if you qualify for Lifeline 150, you will receive 50% off your line connection charge.

For an application and further details, contact the Verizon Pennsylvania Business Office at 1-800-640-4155.

Legislative Budget and Finance Committee Releases Report on Blues Surplus: Consumers Not Invited to Participate in Study

In June, the Legislative Budget and Finance Committee released a report on the Blue Cross surplus. This report was prepared as required by House Resolution 865 of 2004; a resolution which directed the Committee to conduct a study "with respect to the regulation and disposition of the reserves and surpluses of health insurers."

Unfortunately the firm that conducted the study did not include any consumers or advocates of the uninsured in their research. However, they did include the Blues. The lack of public or consumer input was also evident at an August hearing held jointly by the Health and Human Services Committee and the Insurance Committee.

The report essentially agrees with the Insurance Department Secretary's decision that the Blue surpluses are not "excessive." The report appears to support the new Community Health Reinvestment Agreement that the Blues entered into with Governor to provide funding for adultBasic and other health care related initiatives. The report does recommend that the Agreement provide more direction to the Blues on what types of non-adultBasic expenditures will qualify as charitable under the agreement.

PHLP Philadelphia has Moved!

As of **August 1, 2005** our new address is:

The Pennsylvania Health Law Project
The Lafayette Building, Suite 900
437 Chestnut St.
Philadelphia, PA 19106

All phone numbers and email remain the same.

(Continued from page 10)
Consumers whose prescriber believes that they are best served by using a non-preferred drug must first seek prior authorization. If prior authorization of the non-preferred drug is denied, a notice will be sent to the recipient and the prescriber. It is this notice that can be appealed. If the recipient files the appeal within ten days, he or she can continue to get an ongoing medication pending the outcome of the appeal. Call PHLP at 1-800-274-3258 with questions or for assistance.

Changes at PHLP

PHLP wishes a fond farewell to staff attorney, Kevin Prindiville, who recently moved to Germany for a year with his new wife, fellow public interest attorney Alison Pennington. We at PHLP will miss Kevin and all of his hard work and we know that everyone who worked with Kevin will miss him greatly as well. Best of luck, Kevin!

Pennsylvania Health Law Project
Lafayette Building, Suite 900
437 Chestnut St.
Philadelphia, PA 19106