Health Law PA News

Newsletter of the Pennsylvania Health Law Project

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Proposed Budget Presents Opportunities and Challenges

Before Governor Rendell unveiled his proposed 2009-10 Pennsylvania budget in early February, health advocates and providers braced for severe cutbacks to health service to vulnerable populations because the state faces a $2.3 billion deficit due to declining revenues and the end of certain funding sources. However, the proposed budget cuts were not as drastic as many feared because of the American Recovery and Reinvestment Act of 2009 ("Federal Stimulus"). That Act provides PA with approximately $4 billion in Federal Medicaid matching funds over a 27-month period (October 2008 through December 2010).

The highlights of the proposed budget impacting Medical Assistance recipients include:

- No major cuts in MA eligibility
- No major cuts in MA services
- Increases for Home and Community Based Services Waiver programs for older adults and persons with disabilities
- Cuts for mental health and drug and alcohol services (see page 3)
- Major expansion of the adultBasic program (see page 4)

Medical Assistance ("MA") funding

The Governor's proposed budget anticipated and counted on the receipt of Federal Stimulus monies. In addition, the proposed budget includes several cost-containment measures which, if implemented, will allow the state to avoid major cuts in MA services.

The Governor's proposed budget includes two major components—MCO Assessment and Smart Pharmacy—to increase MA revenues. If neither proposal goes forward, there will likely be cuts to MA services which will impact consumers and providers.

MCO Assessment: This proposal levies an assessment (tax) on all Managed Care Organizations ("MCOs") operating in the state. Currently, the state assesses only Medical Assistance MCOs at 5.5% of their

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revenues. The state uses this money to draw down additional federal matching funds and then pays the MCOs an enhanced MA reimbursement. However, starting October 2009, this type of assessment will no longer qualify for federal matching funds.

The only way Pennsylvania can continue receiving federal match on MCO assessments is to impose an assessment on all MCOs, including commercial MCOs that do not participate in the MA program. The Governor's proposed 2% assessment on all MCOs will replace the $200 million projected loss from the current MA-MCO assessments during the coming fiscal year and is projected to bring in $400 million in subsequent years, helping to fill the gap when the Federal Stimulus ends. The 2% assessment represents the current tax on health insurance premiums that some commercial insurers (but not the MA MCOs) currently pay. Imposing this assessment on all MCOs will likely require legislation which will be politically challenging as it would require non-MA MCOs to pay towards the cost of Medical Assistance.

Pharmacy Carve-Out: DPW has again proposed "carving out" pharmacy benefits from the Medical Assistance Physical Health MCOs to obtain substantial rebates from the pharmaceutical manufacturers that are currently available only to the states. Through this proposal, called **"Smart Pharmacy,"** DPW projects $54 million in additional revenue for the coming fiscal year and $146 million annually in additional revenues for subsequent years. Although DPW has been unsuccessful at securing a pharmacy carve-out in previous years, the current economic climate is far more dire and there are huge savings projected by adopting this measure. In the alternative, Congress may amend the pharmaceutical rebate provisions to require pharmaceutical manufacturers to pay enhanced rebates to MA MCOs as well. This would provide significant savings to Pennsylvania's MA program without the need to fight with the MCOs over a pharmacy carve out.

The budget proposal does not include new restrictions in MA eligibility as the Federal Stimulus package prohibits states receiving stimulus funds from imposing new restrictions on MA eligibility. However, the Federal Stimulus will only last until the end of 2010, so the political debate in the General Assembly will likely focus on whether to start finding other revenues to replace the eventual loss of Federal Stimulus (which the Governor proposed) or to cut MA spending now in anticipation of the eventual loss of the federal funds.

Currently, the state House and Senate are holding hearings about the budget proposals. A final package must be passed by July 1st, the start of the fiscal year, or the state loses its ability to spend money.

For more information about the proposed budget and the impact on the Medical Assistance program as well as other health care programs, please see our website (www.phlp.org) and the February edition of the *Senior Health News* (available on our website).

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Governor's Proposed Budget Decreases Funds for Behavioral Health Services

The proposed budget released by Governor Rendell in early February includes cuts in funding to some mental health and drug and alcohol services. Cuts to mental health include a 2% reduction ($3.055 million) to county "base funding". County mental health base funds are used to provide mental health services to low income individuals who do not qualify for Medical Assistance (MA) and do not have private health insurance. The funds also help those with private insurance that does not cover needed mental health services. The specific services provided by the base dollars vary from county to county. For example, some counties use base funding to provide pharmacy assistance for mental health medications while others do not. The state will give counties discretion over how to implement the 2% funding cut.

Additional cuts are being proposed to Behavioral Health Services Initiative (BHSI) funding. An allocation of $25.5 million for mental health services and $30.5 million for drug and alcohol services represents a total decrease of 2% or $1.145 million. BHSI funding is currently used to provide mental health and drug and alcohol services for individuals who have lost eligibility for MA due to welfare reform implemented in 1996.

The Governor proposes a one time additional savings to the state by reducing counties' risk and contingency funds for Behavioral HealthChoices. Currently, the Behavioral HealthChoices contract allows for counties at risk, or who subcontract for full risk with managed care plans, to reserve funds up to the amount needed to provide 90 days worth of services as "risk and contingency funds". The Governor proposes to reduce the funding reserve from 90 days to 30 days with an anticipated statewide savings of $23.7 million. This change would require an amendment to the HealthChoices contract as well as approval from the Centers for Medicare & Medicaid Services (CMS).

Additional savings to the state would result from the Governor's proposal to require counties to return uncommitted and unspent HealthChoices reinvestment funds. Reinvestment funds are monies counties may realize as "profit" from behavioral health managed care. The expected savings from uncommitted funds is $.343 million and the expected savings from the return of unspent reinvestment funds is $.379 million. The Governor is also proposing to cap reinvestment funds at 2% going forward for an anticipated annual savings to the state of $10 million. There is currently no cap on reinvestment dollars and the reinvestment average across the counties over the life of the Behavioral HealthChoices program is 3.5%.

Many consumers, families, advocates and providers are expressing concern over the Governor's proposed cuts to mental health and drug and alcohol services. Historically, in periods of recession, the demand for behavioral health services increases. If these cuts are approved by the legislature, it will add pressure to an already overwhelmed system and limit consumer access to these critical services.

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Governor Proposes Expansion of adultBasic Health Insurance Program

The Governor's 2009-2010 Budget proposes both to increase the number of uninsured adults who can obtain health insurance from the state's adultBasic Health Insurance Program as well as to expand the benefits provided by the program. adultBasic currently provides health insurance to approximately 62,000 Pennsylvanians whose household income is less than 200% of federal poverty guidelines (currently $21,660/year for a single person and $44,100/year for a family of four). adultBasic is administered by the Insurance Department and provides basic benefits to those enrolled (e.g., doctor's care, hospitalization, tests, lab work). The program does not cover dental, vision, mental health, drug and alcohol or prescription medication services.

The proposed budget calls for funding to allow 50,000 more uninsured adults into the adultBasic Program. This would increase enrollment to approximately 110,000 people. While this would be a significant expansion of the program, it would still leave a large number of people on the waiting list. As of the end of February 2009, there were over 200,000 adults on the adultBasic waiting list.

In addition to expanding enrollment, the Governor also proposes to expand coverage to include prescription drugs and mental health services. In order to fund the expansion, the Governor proposes to draw down federal Medicaid matching funds for the adultBasic Program by requesting a Medicaid waiver from the federal government. This expansion would also require a separate legislative amendment to the adultBasic statute.

The State projects this expansion will result in a decrease to the per person/per month cost of adultBasic from $260 to $116 because adding more people will expand the risk pool. If these changes are enacted, then the contracts for insurers who administer the coverage will be re-bid to ensure enrollees have a choice of insurers. Currently, those enrolled in adultBasic have only one managed care plan available based on the county in which they reside.

Under the Governor's proposal, the adultBasic program would sunset (end) on June 30, 2013 with the expectation that some form of national health care insurance will then be in place.

Additional Note: To help residents cope with the current economic crisis, the Governor recently allocated funds to increase enrollment in the adultBasic Program. On March 16, 2009 the Pennsylvania Insurance Department announced that 16,370 individuals on the waitlist were offered adultBasic coverage for a monthly premium of $35. This recent offering is separate from the Governor's proposal to add 50,000 individuals to the adultBasic Program in FY 2009-2010.

Update on Keystone Mercy Health Plan Contract Terminations

In our January edition of this newsletter, we informed readers of contract breakdowns between Keystone Mercy Health Plan (KMHP) and two major providers-Temple University Hospital and Crozer-Chester Hospital System. PHLP has learned from the Department of Public Welfare that:

- KMHP and Temple University Hospital have reached an agreement on a new contract that will be in effect through 12/31/2010.
- KMHP and Crozer-Chester Hospital System reached an agreement on a new contract that will be in effect until 12/31/2009.

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COBRA Subsidy Helps Individuals Who Lost Jobs Afford Healthcare Coverage

The American Recovery and Reinvestment Act of 2009 (Federal Stimulus), signed into law by President Obama on February 17, 2009, provides a 65% subsidy to COBRA premiums to many workers who lost their jobs and employer-sponsored health insurance. It also allows many recently unemployed workers a second opportunity to elect COBRA coverage.

COBRA is a federal law that gives workers who lose their jobs the right to purchase, under certain circumstances, the group health plan coverage provided by their former employer. To be eligible for COBRA continuation coverage, an individual must:

- have worked for an employer with 20 or more employees that continues to offer a group health plan;
- have been covered under the employer's group health plan as an employee or as the spouse or dependent of an employee; and
- have a "qualifying event," such as an involuntary termination or reduction in hours, that causes her to lose her group health plan.

COBRA generally provides up to eighteen months of guaranteed coverage, during which an individual is required to pay the full premium amount at the employer's group plan rate and a 2% administrative fee.

What is the subsidy and who qualifies?
The Federal Stimulus provides a 65% subsidy in COBRA premiums for up to nine months to "assistance eligible individuals." Assistance eligible individuals are responsible for paying 35% of their COBRA premium during the period of subsidy coverage, with the remaining 65% of the premium being reimbursed to the employer through a payroll tax credit. An "assistance eligible individual" is an employee (or member of her family) who:

- was involuntarily terminated between Sept. 1, 2008 and Dec. 31, 2009;
- is eligible for and elects COBRA continuation coverage at any time between Sept. 1, 2008 and Dec. 31, 2009; and
- is not eligible for Medicare or any other group health plan coverage.

Being laid off and told not to return to work until further notice is an involuntary termination of employment for purposes of COBRA and the premium subsidy. Termination for gross misconduct, however, will generally disqualify an individual for COBRA coverage. Individuals whose same year income exceeds $125,000 (or $250,000 for families) must pay back part or all of any subsidy received through 2009 income taxes.

What if someone previously declined COBRA?
The Federal Stimulus provides a second opportunity to elect COBRA to workers who (i) were involuntarily terminated between Sept. 1, 2008 and Feb. 16, 2009 and (ii) declined COBRA coverage (or elected coverage and have since dropped it) and (iii) qualify as an assistance eligible individual. This gives workers who initially declined COBRA coverage a chance to benefit from the premium subsidy. This special election period under the federal stimulus begins Feb. 17, 2009 and ends 60 days after the plan administrator provides notice of the new election opportunity.

How and when will workers be notified?
Employers are required to notify all workers who have a COBRA qualifying event between Sept. 1, 2008 and Dec. 31, 2009 of the premium subsidy and to provide these workers with the necessary application forms. For workers who had a qualifying event between Sept. 1, 2008 and Feb. 17, 2009, employers must provide the required notice by April 18, 2009. If a person has a qualifying event after February 17, 2009, then notice of COBRA election rights and the subsidy must be sent within 44 days. These individuals will only get one opportunity to enroll in COBRA.

For assistance eligible individuals who had a COBRA qualifying event prior to Feb. 17, 2009 and who are not enrolled in COBRA coverage, employers must also provide notice of the special election period by April 18, 2009.

How does someone apply for the subsidy?
Individuals can apply for the COBRA premium

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subsidy by either completing the forms provided by their former employer or by contacting the employer directly to request treatment as an assistance eligible individual. Individuals currently paying a full COBRA premium who qualify for the subsidy can immediately begin paying only 35% of their premium subsidy. Because the Federal Stimulus was only recently enacted, though, individuals are strongly encouraged to contact their previous employer to discuss the premium subsidy before sending in a reduced premium.

When does the subsidy start?
The COBRA premium subsidy begins with an individual's first period of COBRA coverage beginning on or after Feb. 17, 2009. This means the subsidy will be retroactive for most beneficiaries. If there are retroactive coverage periods on or after February 17, 2009 for which individuals have already paid their COBRA premium in full, the individual should contact their plan or their employer to discuss whether they will be credited for the unused subsidy or be reimbursed. Individuals electing COBRA coverage through the special election period created by the Federal Stimulus should contact their previous employer *as soon as possible* to discuss start dates for the coverage and to find out whether there will be any period of retroactive coverage (starting on or after February 1, 2009) for which they will owe 35% of the applicable premium payments.

What if the subsidy is denied?
Individuals denied the COBRA premium subsidy can request an expedited review of the denial from the U. S. Dept. of Labor (or, in some circumstances, the U. S. Dept. of Health and Human Services). The Departments are required to decide an appeal within 15 business days of receiving a completed application for review. Appeals must be submitted on a particular form, which is being developed and will be available at www.dol.gov/COBRA.

Where can I find more information?
Please see PHLP's website (www.phlp.org) for a fact sheet about the subsidy. You can also contact the Department of Labor, Employee Benefits Section at (866) 444-3272 or visit their website: www.dol.gov/COBRA

Stimulus Payments

The American Recovery and Reinvestment Act of 2009 (Federal Stimulus) authorized one-time payments of $250 to consumers who receive:

- Social Security benefits*
- Supplemental Security Income (the stimulus payment will go to adults and children on SSI, but not to recipients who live in a nursing home or other facility where Medicaid pays for more than 50% of their care),
- Veterans Administration Benefits, or
- Railroad Retirement benefits*

** Children under 18, or those under 19 who are still in high school, who receive these benefits are not entitled to a stimulus Payment.*

Please note: There may be other reasons why a beneficiary may not receive this stimulus payment. To receive this one-time payment you must have been eligible for at least one of the benefits listed above in November 2008, December 2008, or January 2009.

If you receive more than one type of benefit listed above, you will only get one payment of $250. You do not need to apply for the payment nor do you need to file a tax return for this benefit. You should receive the stimulus payment by the end of May 2009.

You will either get this payment via mail or direct deposit depending on how you currently receive your monthly benefits. This payment is not counted as income for Medicaid eligibility or when determining eligibility for Extra Help with paying for Medicare Part D prescription drug costs.

If you live in a Personal Care Home, you will receive a letter from the home soon stating your rights to this payment.

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Keystone 65 Complete Disenrollments

Approximately 2100 individuals who had been enrolled in the Keystone 65 Complete Medicare Special Needs Plan (SNP) for dual eligibles (people with both Medicare and full Medical Assistance) were disenrolled effective March 1, 2009. Notices were sent out to affected members initially in December and final notices were sent mid-March.

Keystone 65 Complete is a Medicare SNP for dual eligibles-however it does not take all dual eligibles. According to their contract with CMS, to be eligible for Keystone 65 Complete someone must be a Qualified Medicare Beneficiary (QMB) which the federal government defines as a person having full Medical Assistance (MA) **and** having income under 100% FPL. Mostly, this includes people on MA because they get SSI benefits and those who qualify for full MA under the Healthy Horizons category. Individuals who get MAWD and/or individuals enrolled in Home and Community Based Service Waiver programs are not in QMB categories and are therefore being disenrolled from Keystone 65 Complete. Individuals are also being disenrolled if they either no longer qualify for MA at all or now only get help paying their Part B premium.

Because of complaints and concerns raised by PHLP regarding these current disenrollments, Keystone 65 Complete will retrain their customer service staff to provide accurate and useful information to disenrolled members. Also, Keystone began conducting phone outreach to affected members. This will continue during future disenrollments*. Finally, the plan will revise notices sent to disenrolled individuals to inform them of the back-up Wellpoint system to cover prescriptions for Low-Income Subsidy recipients who have no Medicare Part D coverage.

**Individuals may receive disenrollment notices going forward because the plan must review its membership every month to determine whether individuals continue to qualify. If someone is identified as no longer being a QMB, the plan will take action to disenroll them within 90 days and send notice.*

Individuals disenrolled from Keystone 65 Complete on March 1st who still have full MA benefits are now being auto-enrolled by Medicare into Part D plans with coverage retroactive to 3/1/09.

Please call our HELPLINE (1-800-274-3258) if you need assistance accessing your prescriptions or health care coverage as a result of being disenrolled from Keystone 65 Complete.

PACE-like Benefit Available for Adults on SSDI in Medicare Waiting Period

As a result of a recent lawsuit settlement between two pharmacy benefit management companies (Caremark and Express Scripts) and the PA Attorney General's office, more than $1.6 million are now available to provide free prescription drug coverage for individuals who receive Social Security Disability Income (SSDI) but who are not yet eligible for Medicare coverage. Generally, individuals who qualify for SSDI are not eligible for Medicare coverage until they've received the SSDI cash benefits for 24 months (2 years).

The settlement funds, which will provide eligible individuals with free drug benefits for one year, is being administered by the state's PACE prescription assistance program. Although there is no income limit for this program, it will be especially valuable to adults on SSDI with limited incomes who do not yet qualify for Medicare and who are not eligible for Medicaid because of income and/or resources. These individuals often find themselves without health insurance or affordable access to prescription drugs. Now, thanks to the $1.6 million settlement funds, Pennsylvanians on SSDI in the two-year waiting period for Medicare can get free drug coverage for one year.

Consumers are urged to register for this free benefit as enrollment is limited to approximately 500 individuals. Any interested individuals should contact the Pennsylvania Pharmaceutical Assistance Clearinghouse at 1-800-955-0989 to initiate the application process.

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Over 1 Million Pennsylvanians Are Uninsured

In February 2009, the Pennsylvania Department of Insurance released the results of its new research report on health insurance in Pennsylvania, showing that over one million Pennsylvanians are without health insurance including 140,000 children. The report was based on a telephone survey conducted from September 2007 to May 2008 across all counties in PA. Results of the survey were compared to a similar study completed in 2004.

According to the Department of Insurance Report:

1) The number of Pennsylvanians without health insurance increased from the 2004 survey.
2) 60% of uninsured Pennsylvanians work full time and 20% work for large employers with over 1000 employees.
3) 24% of uninsured adults are eligible for Medicaid.
4) More than one in five Pennsylvania residents, insured and uninsured, had difficulty paying a medical bill in the last 12 months.

The number of Pennsylvanians with private health insurance is down, and the number of Pennsylvanians with public health insurance has increased. One out of three children under age 18 across the state are covered by Medicaid. For adults between 19 and 64, the same percentage is covered by Medicaid as those who are uninsured (11%).

The largest numbers of employed, uninsured Pennsylvanians work in construction, food preparation, and sales. Almost one out of four uninsured individuals have been with their current employer more than five years. The majority of the uninsured surveyed work in small companies with fewer than 99 employees, however, even employees of large companies reported themselves without health insurance.

Although all income groups are represented among the uninsured, lower income persons are more likely to be without health insurance. One-third of the uninsured have a family income under $22,050/year for a family of four (100% FPL). Almost another third are between 100% and 199% FPL ($22,050-$44,100/year for a family of four). Another 10% are between 200% and 250% FPL ($44,100-$55,125/year for a family of four).

The report notes that 24% of the uninsured surveyed are eligible for Medicaid programs but are not covered because of lack of knowledge of the program or perceived barriers to applying. Another 42% of uninsured persons are eligible for adultBasic, but only 7% of them were on the adultBasic waiting list at the time of the survey. The report projected, that at the current growth rate, the adultBasic waiting list in June 2009 will be 282,000, more than double its size at the end of the previous fiscal year. According to the Insurance Department's website, there are currently 205,977 individuals on the adultBasic waiting list.

Minority groups tend to be uninsured at a higher rate than white Pennsylvanians. Approximately 10% of African-Americans and almost 17% of Hispanics in PA are uninsured compared to 9% of the white population.

The report also notes that more than half of persons with health insurance saw an increase in the out-of-pocket expenses for health care, and almost one out of ten had a medical bill of more than $500 at some time during the past year. Numerous national studies have shown that persons without insurance are much more likely to go without needed health care. However, the report found that almost 10% of those with state sponsored insurance (Medicaid, CHIP, or adultBasic) could not find a health care provider who would accept their insurance.

The full PA Department of Insurance report (500 pages) has additional details on the uninsured as well as the characteristics of Pennsylvanians covered by Medicare and state sponsored insurance programs. The report is available on the Department of Insurance website: http://www.ins.state.pa.us/ins/lib/ins/whats_new/2008_survey_report_web.pdf.

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Families USA Report on the Uninsured

In March 2009, Families USA commissioned the Lewin Group, a national health care consulting organization, to analyze data from three United States government data sources to find out how many people are affected by being uninsured. Because many people are uninsured for part of a year, annual Census data or telephone surveys such as the Pennsylvania survey (described on the previous page) that measure only one point in time may underestimate the number of persons who are actually affected by being uninsured. The Families USA survey reports the following numbers on Pennsylvania:

- 27.3% of Pennsylvanians under age 65 went without health insurance for all or part of 2007-2008 – 2.8 million persons, or almost 3 times the number reported in the Pennsylvania Department of Insurance survey.
- Two-thirds of the uninsured were uninsured for more than six months.
- Hispanics and African-Americans are much more likely to be uninsured, with 46.5% of Hispanics uninsured during this time, and 37.7% of African-Americans uninsured during this time. Twenty-four percent of white Pennsylvanians were uninsured, although their numbers represent three-quarters of all the uninsured across the state.
- Over 75% of uninsured Pennsylvanians are members of working families.
- Almost half (48.3%) of the uninsured were below 200% FPL ($21,660 for a single person and $44,100 for a family of four).

The Pennsylvania Families USA report is available by going to the full report at http://www.familiesusa.org/resources/publications/reports/americans-at-risk-findings.html and clicking on state level reports.

DPW Contracts With New Enrollment Broker

As of April 1, 2009, Maximus is operating the Enrollment Assistance Program in Pennsylvania for DPW. The Enrollment Assistance Program (EAP) is responsible for:

- helping MA consumers in HealthChoices counties choose a Physical Health Plan;
- helping MA consumers who live in ACCESS Plus counties choose between enrolling in ACCESS Plus or enrolling in a Voluntary Managed Care Plan (if available);
- assisting MA consumers enrolled in HealthChoices or Voluntary Managed Care choose their initial PCP (later PCP changes are handled by the person's Health Plan); and
- assisting consumers in ACCESS Plus select an initial PCP and make subsequent changes to their PCP.

We previously reported in our November Newsletter that DPW broke its EAP contract with ACS because the Center for Medicare & Medicaid Services determined ACS had a conflict of interest. DPW used an expedited bidding process to award a new contract to Maximus in December. From mid-December until March 31, 2009, Maximus worked with DPW to start up and put systems in place to assure a smooth transition from ACS that causes no disruption in service for consumers.

The EAP phone line and website will remain unchanged. Calls will be answered from 8 am to 6 pm Monday through Friday and from 8 am to noon on Saturdays. To contact the Enrollment Assistance Program consumers can call 1-800-440-3989 or go to www.enrollnow.net.

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SCHIP Reauthorization: How It Impacts CHIP and Medicaid

On February 4, 2009, President Obama signed into law the Children's Health Insurance Program Reauthorization Act of 2009 or CHIPRA. Most provisions take effect April 1, 2009 with some exceptions as noted below.

CHIPRA is designed to finance the program for the next 4.5 years through September 31, 2013. Building on the existing CHIP program, CHIPRA extends coverage to additional children, creates more stable and predictable financing, adds benefits, improves data collection, and launches a new quality initiative for children's health care. Most notably, CHIPRA drops the "S" and renames the program simply "CHIP".

CHIPRA addresses a broad range of funding issues, benefit re-design, and outreach and enrollment supports for CHIP and makes some additional changes in Medicaid rules. Provisions relevant to Pennsylvania's Cover All Kids Program (as CHIP is known in PA) and Medicaid Program are:

- Significant new CHIP funding that increases Pennsylvania's allotment, revises the formula for dividing unspent funds and establishes a mechanism for "re-basing" state allotments every two years. Essentially, these changes make financing stable and predictable for state budgets. Pennsylvania's allocation for federal fiscal year 2009 will be $312.5 million.

- The citizenship and identity verification rules required through the Deficit Reduction Act (DRA) for Medicaid will extend to CHIP beginning January 1, 2010. As of that date, CHIPRA also provides for an electronic option for states to verify citizenship through data matches with the Social Security Administration. This will ease the burden on families applying for CHIP and Medicaid and will give states a new way to comply with the citizenship documentation requirement. CHIPRA provides some **immediate changes** to the DRA requirements in Medicaid and will apply those same changes to CHIP in January:
    - States must provide health care benefits to individuals who otherwise meet the eligibility requirements for Medicaid while they are proving their citizenship.
    - Newborns are automatically enrolled in Medicaid for one year if they are born to mothers on Medicaid. These infants will no longer have to prove their citizenship at the end of the automatic one-year enrollment period.

- CHIPRA establishes a new, explicit statutory option to cover pregnant women with CHIP funds. This can be done through a state plan amendment rather than a more cumbersome waiver. Pennsylvania's Cover all Kids program covers pregnant teens through age 18 whose income is above the Medicaid limit of 185%. Currently, pregnant women over 18 years of age are not covered. PA will have to decide whether to adopt this provision and cover pregnant women above the age of 18.

- New provisions for providing subsidies for employer-based coverage are included in the reauthorization. CHIPRA clarifies the cost-effectiveness calculations and the benefits package and cost-sharing standards that must be met or supplemented through CHIP. Pennsylvania's Cover All Kids program has statutory authority for a premium assistance option that has not yet been implemented. PA will have to decide whether to offer premium assistance through CHIP.

- Through bonus payments in Medicaid, CHIPRA focuses on enrolling the lowest income children. States can draw down 15% of the average state cost per child if they exceed a baseline enrollment threshold by 4% and implement 5 of 8 enrollment or renewal

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simplifications in both Medicaid and CHIP. If enrollment grows by more than 10%, states can draw down 62.5% of the state cost for every additional child. PA will have to decide whether to implement enrollment and renewal simplification strategies to draw down bonus payments in Medicaid.

- CHIPRA adds dental coverage as a required benefit in CHIP (must be in place by October 1, 2009) and gives states the option to offer stand alone dental coverage to children who have private insurance. Pennsylvania's Cover All Kids program currently includes dental coverage. The state will have to decide if it wants to offer stand-alone dental coverage through Cover All Kids for children with private health insurance.

- CHIPRA will create new child health quality measures for all children, including those covered through private insurance. It will also create a new model for children's electronic medical records and demonstration projects on quality improvement.

The Pennsylvania Department of Insurance has an array of decisions to make as described above. In addition, further guidance about implementation of these provisions is expected in upcoming months. Stay tuned to future newsletters for updates about any changes to the CHIP program as a result of the CHIPRA legislation.

2009 CHIP Contractors Include 2 New Plans

In early February, the Department of Insurance announced the award of contracts for the CHIP program to insurers effective February 1, 2009. Eight of those who received contracts currently provide CHIP coverage and will continue to operate in their current counties. These are: AmeriChoice of Pennsylvania; Aetna Health Inc.; BlueCross of Northeastern Pennsylvania; Capital BlueCross; Highmark Inc.; Keystone Health Plan East/Independence Blue Cross & Highmark Blue Shield Caring Foundation; Unison Family Health Plan of Pennsylvania; and UPMC Health Plan)

Two of the insurers awarded a contract are new to CHIP: Geisinger Health Plan and Health Partners. These new CHIP plans will undergo a readiness review process to assure that they can meet the standards set by the Department of Insurance. Once the readiness review is completed and standards met, the Department will determine what counties the new plans will operate in and allow enrolment into these plans, possibly by Fall 2009.

For more information about CHIP benefits, how to apply and what contractors are available in your county, visit www.chipcoverspakids.com or call 1-800-986-KIDS (5437).

PHLP staff are available in Southeastern PA to conduct trainings on Medicare 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 Medicare 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 PHLP 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 hearing and/or visual impairments.

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Stories of the Uninsured

This is a regular feature of our newsletter highlighting stories of the uninsured in Pennsylvania.

Beth's Story

Beth has been a mental health therapist for 17 years. She works full time counseling Philadelphia residents who struggle with mental health and substance abuse problems and are on public assistance. Yet, she herself has no health coverage - leaving her frustrated, angry, and worried.

While pregnant with her second child, Beth and her daughter were both covered under her husband's health insurance. However, when Beth and her husband separated, he dropped the coverage, leaving her and her daughter without insurance. Beth earned too much to qualify for Medicaid and could not obtain any other health insurance, because of her pre-existing condition—pregnancy! Beth worked as much as she could but unfortunately lost the baby. While grieving the loss, she had to find the money to pay for the medical costs associated with miscarriage.

Beth later became pregnant again and was paying out of pocket for two separate health coverage policies for her and her daughter. Throughout her pregnancy, she worked full time to pay for her family's health insurance policies (often falling behind due to other financial obligations). She felt underinsured, because the plan she could afford had high co-pays for doctor's visits and cost her hundreds of dollars. Once she gave birth to her son, she could not afford to add him to her policy nor could she afford to purchase a separate policy for him. Eventually, Beth lost even the health insurance she had for herself and her daughter. As a single parent trying to pay for childcare, housing, and daily life needs to raise her two children, Beth was forced to let some things go.

In her continued search for insurance, Beth went online and researched numerous health insurance options, but she found most of it confusing since she'd always either had employer based insurance or managed care of her own. "I didn't know what '80/20', 'out-of-pocket', or '$2500 deductible' meant. I didn't understand that the deductible meant that I had to pay up to that amount first before the insurance company would start covering us." Desperate for insurance to cover herself and her children, she purchased insurance online that she felt she could afford. Later, the $2200 emergency room bill Beth received after her daughter was assaulted at an after care program provided a quick lesson in the meaning of "deductible" when she discovered that she was responsible for the bill.

Beth now works full time with a counseling agency that contracts with Community Behavioral Health (CBH), the behavioral health managed care organization for Philadelphia residents who have Medicaid insurance. Because she is hired as an independent contractor, however, her full time job has no health benefits, and is not a reliable source of income. If a client does not keep an appointment then she does not get paid for that time. The only people paid a salary are the administrative staff, the owner, and clinical director. "On a typical day I might have 10 clients scheduled but only 4 will show. Sometimes I only get paid for 20 hours per week." On her current income, her son qualifies for Medicaid and her daughter qualifies for CHIP-and she is tremendously relieved about that. "My children have coverage, which is all that I care about."

But, of course, that isn't really true. Beth herself has been on the Adult Basic waiting list since August of 2008. She is one of approximately 29,000 Philadelphians, and almost 206,000 Pennsylvanians state-wide, who are waiting for the chance to get subsidized health insurance. Right now, she cannot afford to pay the full rate that would allow her to bypass the list. She recently developed chest pains that radiated down one arm, and she felt as if a ton of bricks were sitting on her chest. She also injured her ring finger on her right hand, but

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she has learned to deal with the pain due to not having any health insurance. With the vision of the last emergency room bill fresh in her mind, Beth's afraid to go to the ER.

Beth hopes to remain healthy and to find a job with health benefits or much better pay, despite the uncertain economy. She continues to spend her working days counseling troubled clients, and being paid by Medicaid dollars, while she herself has no insurance and could not afford counseling if she wanted or needed it.

Patricia's Story

Patricia, from Lackawanna County, spoke to PHLP about an increasingly common situation: being intermittently insured and uninsured. People like Patricia and her family often fall below the radar of surveys and statistics on the uninsured, but the uncertainty and financial difficulties they face are important to remember.

For some people, working "on again, off again" is just a fact of life. But when not having a job means not having health insurance, being periodically uninsured becomes a way of life.

That's a way of life Patricia and her family have known for too long. "We've really struggled over the years," said Patricia, a mother of three. "There were a lot of points in our lives when we had no medical insurance."

Because she had a young child, Patricia could work only part time, leaving her husband to be the major breadwinner. Beginning in 1999, however, he began suffering from a variety of medical problems. Then came a series of operations: open heart surgery in 2001, stents implanted in 2004, and a kidney removed last year.

In the middle of all that, Patricia's husband was laid off from his manufacturing job of 26 years because, the bosses told him, he was taking too much time off for his health troubles. He got another factory job, but was laid off after four months – again, because he needed too much time off.

"It's been the worst for my husband, with all of his problems," Patricia said. "We just took it day by day, but it was always a worry what we were going to do, because we weren't covered."

Then Patricia found herself hospitalized for kidney stones just last year. Because she had no health insurance at the time, the hospital had to fund her stay under a charity-care program.

She now works part time at a day-care center, and has health insurance – that covers her only. "And it's not really that affordable, considering (the insurance) is just for me," she added. Having to pay $184 a month "is definitely a financial strain on us."

An older son is insured through his college, though the coverage isn't all that good, Patricia said. Her 19-year-old daughter has been on CHIP, the state children's health insurance program, but will lose that coverage soon because of her age.

Patricia's husband is working again, and is on Medical Assistance for Workers with Disabilities, known by its acronym, MAWD. He may be kicked off that program, however, because despite all his health problems he's working full time again. If that happens, he will have no coverage for the eight different medications he takes.

The days when she worried about health insurance aren't all that far away – and still aren't over. "We were very stressed, and the children knew it," Patricia said. "Some days I would go home and cry. What else can you do?"

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PHLP Welcomes New Board Member

PHLP welcomes Mark Anderson as our newest board member! Mark is an associate professor at Temple University Beasley School of Law teaching courses in health, bioethics and environmental law.

Mark brings to PHLP his experience as a parent advocate for his oldest son, Michael, who has cerebral palsy. Since his birth, Mark and his wife Susan Tachau, Executive Director of the Pennsylvania Assistive Technology Foundation (www.patf.us), have advocated to ensure Michael and others with disabilities access devices and supportive services they need for health and independence.

Mark and Susan's advocacy created many firsts: Michael was mainstreamed throughout his public school education; he earned an Associates Degree at Edinboro University of Pennsylvania, the only college in the country that offers personal care attendant services to students with disabilities in its dorms; and, more recently, Michael and two housemates share attendant care services in a house that they own together.

Mark says he is honored to join PHLP's Board : "I look forward to supporting PHLP in its mission to help people obtain quality healthcare for Pennsylvanians. It's an invaluable resource for those navigating the complexities of the public health insurance system."

Please support PHLP by making a donation through the United Way of Southeastern PA. Go to www.uwsepa.org and select donor Choice number 10277.

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