Health Law PA News

Newsletter of the Pennsylvania Health Law Project

Harrisburg Philadelphia Pittsburgh

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Volume 12, Number 3 May 2009

Proposed Senate Budget Slashes Health Care Funding

In the face of a significant drop in projected revenue, Governor Rendell proposed a budget that made some significant cuts to health care funding in order to balance fiscal responsibility with the intent to maintain health care coverage for thousands of vulnerable Pennsylvanians. In May, the Pennsylvania Senate responded to the Governor's proposed budget and passed Senate Bill 850 ("SB850"), which slashes health care funding across the board. SB850 also makes wide cuts to other areas such as education and public safety. Past newsletters have analyzed the Governor's proposed budget; this issue examines SB 850's impact on public health programs.

SB850 rejects almost all key funding mechanisms proposed by the Governor and slashes funding for health care programs. For example, SB850 rejects the proposal for a tax on smokeless tobacco continuing Pennsylvania's reputation as the only state in the country that refuses to tax smokeless tobacco products. SB850 also does not include the Governor's Smart Pharmacy initiative which would give the Commonwealth control of the pharmacy benefit for all Medicaid recipients resulting in simplification for consumers and providers and cost-savings to the state. The cost-savings, estimated at $146 million annually, would be achieved through pharmacy rebates to the Commonwealth that are not currently available to the Medicaid managed care plans that now administer the pharmacy benefit for their consumers . (For more information about this initiative and other aspects of the Governor's proposed budget, see our March *Health Law PA News* or our website, www.phlp.org.).

SB850 will have serious consequences for Pennsylvania's vulnerable populations which depend upon public health care funding. SB850 eliminates the Governor's proposed expansions to home and community based waiver programs that keep older adults and persons with disabilities out of nursing homes and other institutions by providing care in their home and communities. In addition to eliminating funding for expansion of these programs, the cuts to funding for waiver programs under SB850 mean current waiver recipients will lose services. SB850 reduces the level of funding for waivers by over 4,000 waiver slots from the

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Governor's proposal. This creates a perverse financial incentive: consumers (and their family members) who prefer to remain in the community and receive care in a community setting will be more likely to be (or remain) in institutional care, even though institutional care is more expensive for the state.

In addition to the reduction in funding mentioned so far, SB850 will also have a drastic impact on PA's health care system as a whole. Specifically, SB850:

- reduces funding for a range of health programs and services such as:
  - the Children's Health Insurance Program (CHIP),
  - Breast and Cervical Cancer Screening,
  - Chronic Renal Disease Program,
  - State Health Care Centers,
  - STD Screening and Treatment,
  - Maternal and Child Health Programs,
  - AIDS Programs,
  - "Prescription for Pennsylvania" initiatives,
  - Outpatient, inpatient, obstetric and neonatal hospital services,
  - Hospital community access funds,
  - Hospital based burn centers,
  - Health related transportation, and
  - Nursing homes.

- eliminates:
  - specific programs dealing with chronic health conditions such as diabetes, arthritis outreach and education, lupus, epilepsy support services, Tourette syndrome, osteoporosis prevention and education, and organ donation.
  - support payments to numerous specific health care providers.
  - the Governor's Office for Health Care Reform, which has led state-wide health reform efforts
  - state funding for legal assistance programs that help low-income consumers obtain and maintain health care coverage as well as provide legal help with other public benefits and civil legal matters (such as housing, family law, and domestic violence).

Individuals or organizations are encouraged to contact their local State Senators and Representatives to express opposition or support for the health care cuts in Senate Bill 850. This month the Senate Republican Leadership, the House Democratic Leadership and the Governor's office will negotiate a final budget. The state's fiscal year ends June 30, 2009 and the state cannot spend additional money without a new budget. In recent years, the final budget has not been passed by the end of the fiscal year.

Important Post Publication Alert: As this newsletter was being produced, the Pennsylvania House Appropriations Committee defeated SB 850 and its proposal to strip millions of dollars from programs without raising taxes. The Committee voted 20-14 along party lines to kill the Senate's $27.3 billion budget counterproposal offered by Senate Republicans. Pennsylvania now has competing budget proposals: one by the Governor and another by the Senate. Neither has been enacted. As noted above, June remains a critical time for the General Assembly and the Governor to agree on a fully funded, balanced budget.

Act 62 Requires Many Commercial Insurers to Cover Services for Children and Young Adults with Autism Spectrum Disorders

In the past, commercial insurers typically did not provide any coverage for diagnosing and treating autism spectrum disorders. Act 62, the Autism Insurance Act, changes this practice in Pennsylvania by requiring some insurers to cover certain diagnostic assessments of and treatments for autism spectrum disorders.

Who is affected?

Children and young adults under the age of 21, who are covered under an employer group health insurance policy (including HMOs and PPOs) may be affected. The employer must have a minimum of 51 employees, counting both full time and part time employees; however, there does not have to be 51 employees enrolled in the employer group health plan. Act 62 does not apply to "self-insured" or "self-funded" policies. Employees should check with their employer's human resource department to determine if their plan is of this type as this is not something that can be determined by looking at the insurance card. The law becomes effective on the date the policy covering the child is renewed on or after July 1, 2009.

What is covered?

If the group health insurance policy **is** subject to Act 62 as described above, diagnostic assessments and certain treatments for autism spectrum disorders must be covered. These include prescription medications, blood level tests, psychiatric services, psychological services, applied behavioral analysis ("ABA"), rehabilitative care, and speech, occupational and physical therapies. Insurers may impose co-pays and deductibles; but, if the medical provider participates in the commercial insurance plan and Medical Assistance (assuming the child/young adult qualifies for Medical Assistance), the provider cannot charge the family any co-pays or deductibles. Under Act 62, there is a cap on commercial coverage of $36,000 per year per child. Once the cap is reached, if the child has Medical Assistance, it can cover additional services.

To be covered under Act 62, treatments must be:

- for an autism spectrum disorder,
- medically necessary,
- indentified in a treatment plan, and
- ordered by a physician, physician assistant, psychologist, licensed clinical social worker or certified registered nurse.

Additionally, the services must be provided by an "autism service provider" who participates in the child's insurance plan in order to be covered. Families should check with their insurers to locate a participating provider. **Please note that Medical Assistance will not cover autism services for children who have commercial insurance coverage under Act 62 before the $36,000 cap is reached if the family chooses to use a provider that does not participate in the child's commercial insurance plan**. However, a provider that participates in both the child's commercial insurance plan and Medical Assistance may still be able to bill Medical Assistance if services are first denied by the child's commercial insurance plan.

What are the transition issues?

PHLP is concerned about children and adolescents with autism spectrum disorders receiving wraparound services who will be transitioning from using Medical Assistance coverage as the sole payer of these services to having their commercial insurance become primary coverage and Medical Assistance become secondary coverage for these services. Many providers are not yet enrolled with the various commercial insurance companies that cover the children they serve. Furthermore, insurance companies may require

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new psychiatric evaluations be done and revised treatment plans be created. In addition, Act 62 does not specify how long an insurance company can take to decide whether to authorize services. Families are urged to contact their child's autism service provider(s) and their child's care manager at their Medical Assistance Behavioral Health Managed Care Organization (CBH, CBHNP, CCBH, Magellan or Value) for assistance with the transition to commercial insurance coverage. PHLP is also interested in hearing from families whose children are transitioning to commercial insurance coverage starting in July and who face problems with that transition. Families can contact our HELPLINE at 1-800-274-3258.

Need More Information?

The website, www.paautismsinsurance.org, features detailed, current information especially for families and providers. Additional questions can be submitted to ra-in-autism@state.pa.us.

New Possible Medical Assistance Contract Terminations in Southeastern PA

PHLP has learned of two potential contract terminations between Medical Assistance (MA) managed care plans and hospital systems in Southeastern PA.

Keystone Mercy Health Plan (KMHP) and Tenet Health System (Tenet)

Keystone Mercy Health Plan (KMHP) and Tenet Health System (Tenet), which includes Hahnemann University Hospital and St. Christopher's Hospital for Children, have a scheduled contract termination on July 31, 2009. This contract was supposed to run through December 2010. Tenet and KMHP are currently negotiating to avoid the termination.

The contract termination affects only the contract with the hospitals and not with physician groups working in those hospitals (as long as the physician also has an affiliation with another hospital in KMHP's network). Thus, a KMHP member whose doctor is employed by Hahnemann or St. Christopher's, or whose only hospital affiliation is a Tenet hospital, would need to make a choice between changing her health plan or changing her primary care physician. As of May 2009, 5,213 KMHP members were assigned to primary care physicians whose only hospital affiliation is a Tenet hospital.

KMHP members who have a PCP affiliated with Hahnemann or St. Christopher's, *but also affiliated with another non-Tenet hospital in KMHP's network*, could stay with that PCP. However, as a practical matter, consumers often choose a PCP who is affiliated with a familiar hospital and one that is convenient for them. If the Tenet contract with KMHP is broken, a member in this situation who stayed with her PCP would not be able to use the facilities of Hahnemann and St. Christopher's for any services including a hospitalization, lab work or x-rays/other diagnostic tests.

Both Hahnemann University Hospital and St. Christopher's Hospital currently accept the two other Medicaid managed care plans in Southeastern PA, Health Partners and AmeriChoice Health Plan.

Should KMHP's contract with Tenet terminate at the end of July, impacted members will have the following options:

- They can stay with their current provider and KMHP if the provider has admitting privileges outside of the Tenet system with another hospital/health system in KMHP's network;
- They can switch to a different MA plan that has their current provider in its network; or
- They can stay in KMHP and choose a new provider.

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Health Partners and Abington Memorial Hospital

The contract between Health Partners and Abington Memorial Hospital (Abington) is set to terminate on September 4, 2009. Negotiations to reach a new contract agreement are currently taking place.

Abington currently accepts KMHP, but does not accept AmeriChoice. Should Health Partners' contract with Abington terminate at the beginning of August, impacted members will have the following options:

- They can stay in Health Partners and continue to see their providers at other locations if the providers have privileges at other hospitals in Health Partner's network;
- They can continue to see their provider at Abington and switch to KMHP (if their provider is in the KMHP network); or
- They can stay in Health Partners and choose a new provider.

Notice Requirements for Plans When Contracts Are Terminated

Members of a Medical Assistance managed care plan that would be affected by a contract termination must be provided thirty-day advance notice of that termination. This means that affected KMHP and Health Partners members must be sent a letter informing them of the terminations and explaining their options at least 30 days prior to the termination dates. The notice will explain, in more detail, what options consumers will have. The Consumer Subcommittee of the Medical Assistance Advisory Committee recently made recommendation to improve the notice that is sent to consumers impacted by contract terminations due to the unusual number of contractual disputes in recent months as we have reported in previous newsletters. DPW accepted the Subcommittee's recommendations and revised the notice so that affected consumers receive clearer information to help them better understand their options when their health plan terminates a contract with a network provider.

An update about the status of these contract negotiations will be in our next newsletter,

"Mini-COBRA" Legislation Approved

On June 10th, Governor Rendell signed "mini-COBRA" legislation that allows employees of small businesses (those with 2-19 employees) who lose their employer-based health insurance to have the option of continuing that coverage for up to nine months. Now known as Act 2 of 2009, the law takes effect July 10th (30 days after enactment).

The "mini-COBRA" legislation extends the continuation of coverage rights granted to employees of larger businesses (those with 20 or more employees) under federal COBRA laws to small business employees and their dependents. To be eligible for COBRA continuation coverage, an employee or dependent must have a "COBRA qualifying event," such as an involuntarily job termination. Employees electing COBRA coverage have to pay a monthly premium based on their employer's group plan rate. Because this premium includes both the employee portion **and** the employer portion of the group plan rate, plus an administration fee (of up to 5% under the "mini-COBRA" legislation), COBRA is difficult to afford for many individuals.

Just like federal COBRA, the "mini-COBRA" law results in no cost to the state or to employers, as employees electing continuation coverage are responsible for paying the full monthly premium for the coverage. Once the state's "mini-COBRA" legislation goes into effect in July, Pennsylvania employees of small companies who have insurance through their employer but who involuntarily lose their jobs will be able to take advantage of the COBRA premium subsidy provided by the federal government to help cover the cost. Please see our March newsletter or our website, www.phlp.org, for more information about this subsidy.

The Governor's office reports that 25 percent of Pennsylvanians working in the private sector are

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employed by companies with two to nineteen employees. It is these employees of small companies and their dependents who could potentially benefit from this legislation. Pennsylvania now joins forty other states who have passed "mini-COBRA" legislation.

For more information on this new law, go to www.legis.state.pa.us and search by keyword or HB 1089.

HealthChoices Consumers in Central and Southeastern PA May Have More Managed Care Plan Options in Future

The current HealthChoices Physical Health Managed Care Organization (PH-MCO) contracts for the Southeast and Lehigh/Capital Zones are set to expire at the end of this year. Earlier this year, DPW issued a new Request for Proposals (RFP) seeking MCOs who wish to bid for a multi-year contract to serve the Medical Assistance (MA) recipients who live in each zone. As a result, five bidders submitted proposals in response to the RFP for the HealthChoices-Southeast Zone and six MCOs submitted proposals in response to the RFP for the HealthChoices-Lehigh/Capital Zone.

All eleven proposals met the requirements set forth in the RFP. This means all of the MCO bidders will proceed to the next round which includes readiness reviews and contract negotiations that will determine whether each will be awarded a state contract to serve the Medical Assistance population in the Zone beginning on January 1, 2010.

The five bidders for the Southeast Zone are:

- Aetna Better Health
- AmeriChoice of Pennsylvania, Inc.*
- HealthAmerica/Coventry Health Care
- Health Partners, Inc.*
- Keystone Mercy Health Plan*

In the Lehigh/Capital Zone, the six bidders are:

- Aetna Better Health
- AmeriHealth Mercy Health Plan*
- Gateway Health Plan*
- HealthAmerica/Coventry Health Care
- Unison Health Plan*
- UPMC for You**

* These plans currently have contracts with the state and provide Medical Assistance coverage to recipients in the Zone.

** UPMC for You currently has a contract with the state to provide Medical Assistance in the HealthChoices-Southwest Zone but not the Lehigh/Capital Zone.

DPW will contract with any or all of the MCOs that meet its requirements to serve MA recipients set out in the HealthChoices-RFP. The contracts become effective January 1, 2010.

However, there are still a number of steps an MCO must take before beginning operations on January 1, 2010. For example, bidders must pass a readiness review conducted by DPW staff which is now underway and which should be completed by September. Readiness review will ensure the MCO is ready and able to meet all the terms of the contract (such as network adequacy requirements) and begin serving MA consumers.

Next, the bidders enter into contract negotiations with DPW during which they will need to assess the adequacy of the HealthChoices payment rates for their company operations in the Zone. Finally, bidders must obtain authority from the Department of Health to operate in all the counties in the Zone. DPW hopes to have contracts in place by October.

We will keep you posted about developments with the PH-MCOs in the Southeast and Lehigh Capital HealthChoices zones in future newsletters.

Input Sought from Youth and Parents of Children With Special Health Care Needs

PHLP is looking for parents of children with special health care needs as well as youth with special health care needs to participate in six regional forums.

As part of a State Implementation Grant (SIG) for Integrated Community Systems for Children with Special Health Care Needs, the Pennsylvania Department of Health, the Pennsylvania Chapter of the American Academy of Pediatrics, the PEAL Center, the Pennsylvania Health Law Project, and other key partners have joined forces to create the Pennsylvania Consortium for Children & Youth with Special Health Care Needs. The goal of the SIG grant is to create sustainable improvements in systems serving children and youth with special health care needs in Pennsylvania through family-professional partnerships with youth leaders, parents, community groups, health care professionals and government agencies that embody family-centered care and culturally competent principles.

PHLP's role within this project is: to convene and facilitate six regional Parent/Youth/Professional forums; to identify the strengths and gaps for children and youth with special health care needs in each region; to develop policy recommendations at the local, regional and state levels to address the gaps; and to advocate for a more seamless, family-centered service system.

Two forums are already scheduled: The **Northwest region** will meet **Monday, June 15** at Midwestern Intermediate Unit IV, 453 Maple Street in Grove City. There will be casual networking from 9 am to 10 am followed by the meeting from 10 am to 12 pm.

The **Southwest region** will meet on **Tuesday, June 16** at the Westmoreland County Intermediate Unit, 102 Equity Drive in Greensburg. This forum will also begin with casual networking from 9 am to 10 am and the meeting will take place from 10 am to 12 pm.

PHLP will announce future regional forums in upcoming editions of our newsletter and on our website, www.phlp.org.

If you are interested in participating in a regional forum, please contact Ann Bacharach directly by email at abacharach@phlp.org or by phone at 215-625-3596, or leave a message on our Helpline-1-800-274-3258.

Pennsylvania Consortium for CYSHCN
Children & Youth with Special Health Care Needs

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Stories of the Uninsured

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

Charles' Story

If you met Charles on the street in February 2009, he might catch your eye for several reasons. Sticking out from the right side of his woolen winter cap are several stick-like objects. He walks with some difficulty, his right lower leg and foot wrapped up in a special brace. He occasionally winces in pain, but if you spoke to him, he would tell you the pain now is a lot better than it was right after the accident.

Charles is a 54-year-old self-employed carpenter. He's been a carpenter for the last 25 years. He would still be doing it if it weren't for a co-worker who neglected to properly hold a ladder. In mid-November 2008, Charles fell two stories, shattering his foot and ankle. Since he had no health insurance he considered going home to see if the swelling would go down. A friend looked at his foot and immediately took him to a hospital where he was admitted. The foot was too swollen to operate, so he was sent home to wait for the swelling to go down. However, he became nervous when the scrapes in the skin began to look infected. He returned to the hospital and he was admitted again. They found a blood clot and a skin infection. While in the hospital, he fell and broke a bone in his hand. He was discharged again, this time with prescriptions for blood thinners, antibiotics, and a small amount of pain medication. But still he had no health insurance. Social workers and billing staff in the hospital began the process to apply for Medical Assistance.

While the Medical Assistance application was being processed, Charles tried to make an appointment with the foot and ankle orthopedic specialist as he had been instructed at discharge. He was told the office did not see people without insurance, and that even if he got Medical Assistance, they did not take that form of insurance. Charles knew that he was on a blood thinner and that he needed to get special blood tests to adjust the dose. He was in terrible pain and needed more medication. He checked his discharge instructions and saw that he was also supposed to see a primary care doctor. Fortunately, the nurse at the primary care clinic realized the urgency of the situation. He was seen that day. Doctors, nurses and a social worker went the extra mile, helping him find sources for less expensive medication and completing a form certifying his disability to help him qualify for Medical Assistance.

Charles called the Pennsylvania Health Law Project, who contacted the County Assistance Office and asked that he be approved rapidly under a new expedited process for persons with immediate medical needs. His Medical Assistance card arrived about the same time as a $34,000 bill from the hospital – a bill he is hoping Medical Assistance will cover, but he is confused about how to find this out and what procedures he needs to follow.

Getting back to seeing Charles on the street in February 2009, several months after his accident, those stick-like objects poking out from under his cap are pencils. "I'm a carpenter; I'm always drawing things and I need to have them." Working as a carpenter is an essential part of his identity, and his livelihood. Yet he doesn't know if he will be able to work again.

Charles is like many working people. He has a skill, and made enough money to support himself – but not enough to buy health insurance. Six years ago, he had a crew working with him and he offered group insurance if the employees paid for it. He himself was paying $5000 per year for insurance. But then, rates went up and he could no longer afford it. He considered himself lucky – he was healthy. He had no idea if he had high blood pressure, or high cholesterol, because he had never been checked. Now, because he is disabled and has Medical Assistance, he can be checked. It took a catastrophic accident to give him access to the preventive health care he previously lacked.

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Charles wonders whether he was treated differently because he had no insurance. Although numerous physicians and clerical personnel in the hospital asked him about insurance status and learned that he had none, he was discharged with prescriptions for costly medications he could not afford, and instructions to make appointments with physicians whom he could not see. He is concerned whether the several week delay in seeing an orthopedist has affected the healing in his foot. And he still has months of medical needs and healing ahead of him. Would things have been different if he had insurance? No one can say for sure—the doctors can only speak to his medical condition now. But he would not have had to worry about huge medical bills, about whether he could afford medication, and about whether he should go to a hospital at all, even when the bones in his foot and ankle were in more than a few pieces.

Laura's Story

What do you do if you are 27 years old, you were born with a serious heart condition, and you suddenly lose your health insurance because you lost your job? Worry, look for another job, worry some more…and call for help. Laura called PHLP for help, and she learned what too many people in this economy are learning – her unemployment compensation benefits place her over the income limit for Medical Assistance but do not give her enough money to purchase health insurance. For her, the situation is overwhelming.

Laura was born with an illness that affects the electrical system of her heart. Many people think of a pacemaker as a medical device that is only needed by older persons, but Laura, at age 27, is on her third pacemaker. As the technology has gotten better, pacemakers last a little longer; but, like any other mechanical device, batteries wear out. Replacing batteries requires surgery – they can't be bought at the corner store and popped in and out. Laura's last pacemaker was inserted in 2008, but she noted recently that she was getting frequent "shocks" from the device. She was on a trip to New York when these became so frequent that she became frightened and went to an emergency room. She left with a diagnosis of a faulty wire and a bill for $2400.

Laura has no health insurance. She went to school for graphic arts, but she soon realized that steady jobs with insurance were a scarcity in the art world. She became interested in health education and obtained a full time job at a medical school in Philadelphia. "For me," she said, "job equals health insurance." She was able to see her cardiologist regularly; her insurance also covered medical equipment that allowed her to monitor and test her pacemaker once a month at home and send the information electronically to her physician's office. The monitoring ended in late summer 2008 when she was laid off and her insurance stopped.

Although she was eligible for COBRA (continued health insurance coverage through her former employer), the benefits counselor at the medical school advised her that she would be unlikely to afford the insurance. Former employees who elect COBRA must pay both the employer and the employee's share of the health insurance costs as well as a 2% administrative fee. The benefits counselor was correct that her unemployment benefits would not allow her to pay rent and utilities, buy food, and purchase health insurance. Unfortunately, Laura did not qualify for the subsidy offered under the economic stimulus package to cover 65% of her COBRA premium because she lost her job six days before the subsidy took effect in September 2008.

Like many other persons, Laura thought public insurance was a safety net to which she could turn if she had exhausted other options. She quickly learned that was not the case. Her unemployment benefits gave her an income too high for Medical Assistance so she did not qualify. Even if Laura had the money to buy insurance now, it is unlikely that any commercial insurance would cover her pacemaker. In her search for help, she discovered programs for children born with heart disease but those programs end at age 22. She was frustrated and angry. "My cardiac monitoring and care began prenatally. Don't I

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have a congenital condition and have I not suffered with such a condition longer than a person of 22 years?"

For now, Laura spends every day looking for work. She is on the waiting list for Pennsylvania adult-Basic insurance which is currently a two year wait. That is too long for Laura. She wants to be a health educator and wants to return to school full time – as long as the school offers health insurance. At her apartment, she has all the equipment she needs to transmit information about her pacemaker to her doctor – but she can't use it because she can't pay the bill. She is facing probable surgery to fix the broken pacemaker. The likely cost of this surgery, including the equipment and the physician, and hospital fees, is at least $10,000. For her, this can be a life and death matter, but she has yet to figure out how to cover the costs of the surgery. "I've learned that the way this country works, health care is a benefit and not a right."

Parents Will Soon Have the Option of Keeping Their Adult Children on Their Health Insurance Policies

Governor Rendell has signed legislation into law that allows adult children to remain on their parents' health insurance policies through age 29. This bill (SB 189) was signed by the Governor on June 10, 2009 and is now known as Act 4 of 2009. The legislation requires insurance companies to provide an option for extending coverage under group health plans (including HMOs) for adult children of enrollees.

To be eligible, the adult child must be:

- 29 years of age or younger,
- unmarried,
- without dependents,
- a Pennsylvania resident or enrolled as a full-time student at an institution of higher education, and
- have no other health insurance (including Medical Assistance and AdultBasic).

Parents who elect to keep adult children on their policy will be responsible for paying all additional premiums that apply for the continued coverage as employers are not required to contribute to any premium increase. The extension of coverage legislation does not apply to the following types of insurance coverage:

- individual health plans;
- self-insured or self-funded health plans (individuals should ask their Human Resource representative if their plan is self-insured or self funded);
- hospital indemnity, accident; specified disease, disability, dental or vision insurance;
- insurance provided by the U.S. military;
- Medicare supplemental insurance;
- long-term care policies; and
- other limited benefit plans.

The law will be effective for new health insurance policies on December 7, 2009 (180 days from the date it was signed by the Governor). For existing policies, the law will be effective upon the next contract renewal date occurring on or after December 7, 2009. You can read the law by going to the PA General Assembly website at www.legis.state.pa.us.

House Bill Introduced to Create Set-Aside Accounts to Support Mental Health & Mental Retardation Services

Representative Dan Frankel introduced legislation (HB 1190) in April that would direct the net proceeds from the sale or lease of state-owned mental health and mental retardation facilities to be set aside and used only to support community services and programs for consumers with mental health or mental retardation conditions. This Act would amend the Mental Health or Mental Retardation Facility Closure Act of April 28, 1999.

It has been the practice of the State to deposit any proceeds from the sale of state-owned property into the General Fund where it can be used to meet any of the state's expenses or obligations. House Bill 1190 requires the proceeds from the sale or lease of state-owned mental health facilities to be deposited into a Mental Health Community Services Account. Likewise, the proceeds from the sale of state-owned mental retardation facilities are to be deposited into a Mental Retardation Community Services Account. The funds in these accounts are not intended to replace existing funding for existing community mental health or mental retardation programs. Rather, the funds in the Mental Health Account are to be used to support "one-time costs for a full range of housing options that support independent living for individuals with serious mental illness." The funds in the Mental Retardation Account are to be used for "one-time costs associated with the community mental retardation system". Both funds are to be used in accordance with "consumer-centered planning"- meaning consumers and family members of consumers who use these community services must have input into how the funds are spent.

There has been strong support for this legislation in the mental health community, most notably in Southwestern PA by the Consumer Health Coalition's Health Care for People with Disabilities Committee. This Committee has been present and vocal at the public meetings of the Mayview Land Reuse Task Force, sporting t-shirts proclaiming, "The Time is Always Right, to do the Right Thing." Mayview State Hospital closed on December 29, 2008 and the Task Force has been charged with making recommendations about how the Mayview buildings and land should be used. The Disabilities Committee, together with many consumers, family members and advocates, voiced strong support for the Mayview property to be sold at fair market value and the proceeds of the sale directed to housing supports for those with mental illness. Thousands of postcards were sent to State Senator Pippy and State Representative Kotik who co-chaired the Task Force. The postcards urged the Task Force to have the property fairly assessed, to sell the property at fair market value, and to place the proceeds into a community mental health savings account.

Representative Frankel's introduction of House Bill 1190, co-sponsored by Representative Kotik, supports the position that proceeds from the sale of state-owned mental health and mental retardation facilities should be earmarked to fund community supports for the populations who had been served by those facilities. The bill also requires that if the property is resold by the purchaser within 10 years of the original sale by the Commonwealth, one-half of the purchaser's profit from the sale must be deposited into the respective mental health or mental retardation account. House Bill 1190 was referred to the Health & Human Services Committee on April 3, 2009. To view the bill go to the Pennsylvania General Assembly's website at www.legis.state.pa.us and enter "H.B. 1190" in the "Find Legislation By" box at the top of the screen.

Federal Health Care Reform Update

National health care reform efforts to provide affordable coverage to the 46 million uninsured individuals in the U.S. are moving at a rapid pace. President Obama has stated that he is "absolutely committed" to overhauling the health care system, and he has tasked Congress with passing health care reform legislation this year.

President Obama announced eight principles for health care reform:

1. **Guarantee Choice** so there is a choice of health plans and doctors.
2. **Make Health Coverage Affordable** by reducing costs and eliminating unnecessary services.
3. **Protect Families' Financial Health** by reducing the growing costs for health care and protecting Americans from bankruptcy resulting from illness.
4. **Invest in Prevention and Wellness** that reduce the amount of illnesses and long-term health care costs.
5. **Provide Portability of Coverage** so that health insurance is available to those without jobs or with preexisting conditions.
6. **Aim for Universality** so that health insurance is available to all Americans.
7. **Improve Patient Safety and Quality Care** including computerizing health records.
8. **Maintain Long-Term Fiscal Sustainability** by reducing costs and providing money for health care.

Earlier this year, Congress agreed to pass legislation that guarantees health care for all Americans especially women, the underinsured, and the uninsured by the end of 2010. Five Congressional Committees are working on draft health care legislation. These Committees are the:

- House Energy and Commerce Committee;
- House Ways and Means Committee;
- House Education and Labor Committee;
- Senate Finance Committee; and
- Senate Health, Education, Labor and Pensions Committee.

These Committees have all held numerous hearings on this subject already and will continue to do so throughout the remainder of the year.

Thousands of individuals and groups have made recommendations to the Obama Administration about health care reform. The Administration has also met with various stakeholders including pharmaceutical companies, physician associations, doctors, insurance companies, and employers. Administration officials heard from individual consumers and others at five regional forums held around the country.

The main areas of contention in developing health care reform proposals include: costs and funding; the scope of coverage; and the structure-that is, how people will obtain the coverage (through private insurers, through the government or through a mixture of the two systems). There have been many proposals drafted thus far addressing these different components (see the table on the next page).

The Senate Finance Committee recently released its policy options for financing health care reform. Some of the proposed funding options are: taxes on sugary and alcoholic beverages; limits on the tax-exempt status of employer-provided health insurance; decreasing Medicare spending on home care, durable medical equipment, medical imaging and prescription drugs; addressing regional disparities in health care costs; charging higher-income seniors higher premiums for the Medicare prescription drug benefit; introducing new standards for not-for-profit hospitals to provide more no-cost care and to serve more low-income patients in order to keep their tax-exempt status; cutting special Medicare payments to teaching hospitals; and requiring pharmaceutical companies to give larger discounts to state Medicaid programs.

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The table below outlines the recent health care reform proposals introduced and under consideration by the 111th Congress.

BILL NUMBERS	TITLE	DATE INTRODUCED	COMMITTEE REFERRAL	SUMMARY
S. 441	Quality Reform Expansion and Savings Act of 2009	2/13/2009	Senate Committee on Health, Education, Labor and Pensions	Coordinated quality reform to improve delivery of health care and reduce the cost of health care
S. 486 & H.R. 1296	Access for All America Act	2/26/2009 & 3/4/2009 Respectively	House Committee on Energy and Commerce & Senate Committee on Health, Education, Labor and Pensions	Provides access to primary health care services for all Americans and expands the Community Health Center and National Health Service Corps programs
H.R. 1495	Comprehensive Health Care Reform Act of 2009	3/12/2009	House Committee on Ways and Means	Amendment to Internal Revenue Code of 1986 to provide more access to affordable health care
H.RES. 271	N/A	3/19/2009	House Committees on Energy and Commerce; Financial Services; Ways and Means; Education and Labor	Sets out the need for long-term care strategy in comprehensive health care reform
S. 698	State-Based Health Care Reform Act	3/25/2009	Senate Committee on Health, Education, Labor and Pensions	Provides health care for uninsured through State health care coverage pilot projects
H.CON.RES. 78 & H.CON.RES. 100	N/A	3/24/2009 & 4/21/2009 Respectively	House Committee on Energy and Commerce	Expresses Congress' view that State innovation is needed in national health care reform
S. 1099 & H.R. 2520	Patients' Choice Act	5/20/2009	House Committees on Energy and Commerce; Ways and Means	Creates state-based health insurance exchanges and tax credits to subsidize coverage premiums
S.RES. 156	N/A	5/21/2009	Senate Committee on Health, Education, Labor and Pensions	States that health care reform should include federally-backed insurance pool

More information about federal health care reform can be found at www.healthcarereform.gov. To read the text of any of these bills or resolutions, go to www.thomas.gov. We will continue to keep readers updated on federal health care reform efforts in future editions of the newsletter.

Extra $25/week Unemployment Benefit NOT Counted for Medical Assistance or CHIP Eligibility

Individuals and families receiving unemployment compensation should not lose Medical Assistance (MA) or CHIP (Children's Health Insurance Program) coverage because of the additional $25/week unemployment compensation payment they are entitled to receive under the American Recovery and Reinvestment Act (ARRA). While these programs do count income received from unemployment compensation, they will not count the additional stimulus payment of $25/week received by individuals getting state or federal unemployment benefits under the ARRA.

Please contact PHLP's HELPLINE (1-800-274-3258) if you or someone you are working with has been told that Medicaid or CHIP benefits are ending due to the increase in their unemployment benefits.

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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