# Health Law PA News and Senior Health News

Newsletters of the Pennsylvania Health Law Project

Harrisburg Philadelphia Pittsburgh

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On the Internet: www.phlp.org

HLN
Volume 12, Number 4
June/July 2009

SHN
Volume 11, Issue 3
June/July 2009


***This newsletter is a combined issue of PHLP's two bi-monthly newsletters. We plan to return to our regular schedule of issuing monthly newsletters in August.***

## Stalemate Continues Over State Budget

As of the date of this Newsletter's publication, Pennsylvania has not passed a revenue and spending plan four weeks into the new fiscal year. The two chambers of Pennsylvania's General Assembly each passed different budget bills and now leaders from each chamber have appointed members to a conference committee to negotiate an agreement.

On July 17th, Pennsylvania's House of Representatives authorized a $29.1 billion budget similar to the budget the Governor originally proposed in that it provides funding to maintain the state's existing public health programs. However, the House Bill imposes $500 million in additional cuts including a $106 million reduction for the Department of Public Welfare. In addition, the House Bill does not contain a broad-based tax increase, such as the 16% increase to the personal income tax the Governor proposed.

The House Bill was rejected by the Senate which passed its own $27.1 billion budget bill on July 20th (H.B. 1416). Similar to Senate Bill 850 (see description from May 2009 Health Law PA News), the Senate sharply reduced the funding of many public health programs including Medical Assistance, CHIP and county-based mental health and drug & alcohol programs. Under the Senate's proposal, the state's Office of Long Term Living reports that its budget

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would be cut $578 million resulting in an $18 million cut to the Attendant Care Program and a $8.7 million cut to the state's CSPPPD waivers. Such a cut will create waiting lists for these waivers for the first time in recent memory. Also endangered is the Act 150 Program (that provides attendant care services to those not eligible for a waiver) which is totally state-funded. The Office of Mental Health and Substance Abuse Services (OMHSAS) reports that under the Senate's proposed budget there would be a $13.5 million decrease for Behavioral Health Services Initiative funds and a $10 million reduction to Community Mental Health services which combined would impact 13,000 consumers needing mental health and/or drug & alcohol services.

Given that these two competing budget bills are $2 billion apart, the conference committee members have their work cut out for them seeking common ground and compromise on a budget that both chambers and the Governor must approve. Once a state budget **is** passed, PHLP will provide detailed analysis in our next Newsletter about how the budget will impact consumers of Pennsylvania's public health programs.

# Pennsylvania Terminates Medical Assistance Coverage for Certain Legal Immigrants

Under a 1996 federal law that overhauled the nation's welfare system, states were no longer allowed to claim federal matching funds for providing Medicaid coverage to legal immigrants in their first 5 years in the United States. However, until recently, Pennsylvania provided full Medical Assistance coverage to these legal immigrants who are in special "qualified" statuses. That policy has ended. On June 30th, the Department of Public Welfare released a Medical Assistance Operations Memorandum announcing that the state will end health coverage for some qualified immigrants—including legal permanent residents during their first five years in qualified status. This means numerous current enrollees will receive termination notices in the coming two months and that new applications will be denied for individuals who have been in a qualified status for less than five years.

Anyone who works with immigrants affected by this policy change should be mindful of several points.

1. This rule does not affect U.S. citizens, regardless of when or how they got their citizenship.
2. This change has no effect on the Emergency Medical Assistance program for non-qualified immigrants.
3. Immigrants who are in a "qualified" status will be ineligible for Medical Assistance for their first five years in a qualified status **unless they fit into one of the following exceptions to the rule:**
   - pregnant women;
   - children (under age 21);
   - asylees, refugees, and certain other select qualified immigration statuses
4. This change does not affect individuals already enrolled in, or applying for, General Assistance (GA) related Medical Assistance categories (i.e., persons with temporary disabilities, persons who take health sustaining medications). This means that GA enrollees can remain in GA programs, and immigrants terminated from other categories should be considered for GA eligibility.
5. Individuals terminated from Medical Assistance who do not fit into any exception or qualify under a GA category of Medical Assistance may be able to at least get Emergency Medical Assistance if they have an emergency medical condition and meet other program qualifications.

PHLP has already learned of many erroneous implementations of this new policy and we encourage advocates and clients to immediately appeal all such terminations and denials and contact PHLP's HELPLINE for assistance (1-800-274-3258). In addition, advocates can consider filing an Emergency Medical Assistance application for all terminated or denied clients.

# Update on the Autism Insurance Law- Act 62

Pennsylvania's Autism Insurance Law (Act 62), requiring employer-sponsored health plans to cover certain diagnostic and treatment services for children and young adults with autism spectrum disorders, became effective July 1st. Health insurance plans issued to Pennsylvania employers with 51 or more employees are subject to Act 62 starting on or after July 1st (the effective date depends on the policy's renewal date).

PHLP continues to receive numerous questions from families and advocates about the new law and its implementation. Here are some of the questions we have received from families, along with our answers.

**How do I know if Act 62 applies to my child?**
Act 62 applies if:

- your child is under 21 and has an autism spectrum disorder diagnosis (or an evaluation is recommended to determine whether he/she has an ASD diagnosis);
- your child is covered under your employer-sponsored group health insurance policy;
- your employer has at least 51 employees (full or part time);
- your employer, or the branch of your employer that holds the commercial health insurance policy, is located in PA; and
- your commercial health insurance policy is not "self funded" by the employer (ask the employer's HR person if you are not sure if the policy is "self funded").

**If Act 62 applies to my child, when does it go into effect?**
The Act goes into effect for your child on the date on or after July 1, 2009 that the employer's commercial health insurance policy renews (ask the employer's HR person if you do not know the renewal date).

**Can my child continue to use their current behavioral health provider?**
Yes, if the current provider is enrolled in the network of your child's commercial health insurance company.

**I've heard that my child's commercial health insurance company won't allow his/her provider to enroll in the insurance company's network. Will my child's Medical Assistance still cover his/her current provider?**
This is currently unresolved. Pennsylvania's Departments of Insurance and Public Welfare are working with commercial insurance companies to get them to enroll into their networks all autism service provider agencies that are enrolled in Medical Assistance and that want to be enrolled with that insurer. If the commercial insurance company still refuses to contract with the current provider, the child may have to switch to another provider in the insurance company's network that can provide a similar service. If there is no other provider enrolled in the insurance company's network that can provide a similar service, PHLP believes Medical Assistance will have to pay the child's current provider (assuming the services are determined by to be medically necessary by DPW or the Medical Assistance Behavioral Health Managed Care Organization (BH-MCO)).

**What if my child's provider decides they don't want to enroll in the network of my child's commercial health insurance company?**
Medical Assistance will not cover services delivered by that provider unless those services are not of a type required to be covered under your child's commercial health insurance policy by Act 62.

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**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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**My child has been authorized by our Medical Assistance BH-MCO for a Summer Therapeutic Activities Program ("STAP"). Does the STAP provider also have to enroll in the network of my child's commercial health insurance policy?**
No, STAP is not currently considered a service that commercial insurance companies will have to cover under Act 62.

**What if my child's commercial health insurance company denies or reduces services?**
You can appeal—first to the commercial insurance company and then to an independent psychologist or psychiatrist chosen by the Pennsylvania Insurance Department. During the appeal, the provider can also seek coverage from Medical Assistance. If Medical Assistance authorizes coverage, services would not be reduced or stopped despite the reduction or termination by the child's commercial insurance company.

**Can I drop my child from my employer-sponsored coverage and just go with their Medical Assistance?**
We don't recommend it. If your child can be kept on the commercial coverage at no additional cost to you, then your child could lose Medical Assistance if you drop him/her. Even if you could drop your child from your commercial coverage without risking his/her Medical Assistance, there are other risks. One is that the child may need other providers that don't take Medical Assistance (or the child's Medical Assistance BH-MCO) but who would accept your commercial coverage. If that occurs, you may not be able to add the child back to your commercial coverage for several months until the next "open enrollment period." This would also be a problem if the child loses Medical Assistance for any reason and then can't get back on your commercial coverage right away.

Additional information about Act 62 implementation can be found at www.paautisminsurance.org. Families are urged to contact their child's service provider and their child's care manager at their Medical Assistance BH-MCO (CBH, CBHNP, CCBH, Magellan or Value) for assistance with the transition to commercial insurance coverage. Also, the Health Law Project is interested in hearing from families whose children are transitioning to commercial insurance coverage and are facing problems with that transition. Families can contact our HELPLINE at 1-800-274-3258.

# Update on Medical Assistance Contract Terminations in Southeastern PA

In our last newsletter, we reported on two possible 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), which includes Hahnemann University Hospital and St. Christopher's Hospital for Children, were scheduled to terminate their contract on July 31, 2009. This contract has now been extended to September 1, 2009.

The contract between HealthPartners and Abington Memorial Hospital (Abington) was previously set to terminate on September 4, 2009 but has been extended to October 4, 2009. Since the publication of our previous newsletter where we reported that Abington accepted KMHP (giving people in Health Partners the option of switching to KMHP in order to continue going to Abington if the Health Partners contract terminated), we learned that the contract between KMHP and Abington was also under discussion. PHLP has now been informed that KMHP and Abington have reached a tentative agreement to renew their contract. However, no formal contract has been signed as of the publication of this newsletter.

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**Options for Affected Members**
Remember that members impacted by contract terminations between their MA health plan and their providers may continue to see their providers by (1) switching to a different MA plan that has their provider in its network, or (2) staying in their current plan and continuing to see their provider at other locations that accept their MA plan (if the provider works at more than one location). Impacted members can also stay in their current plan and choose a new provider.

**Current Notice Requirements**
Consumers affected by provider contract terminations are entitled to 30-day advance notice of that termination. The advance notice informs the affected members of the termination and explains their options. The Consumer Subcommittee of the Medical Assistance Advisory Committee has recommended that DPW increase this advance notice requirement to 45 days prior to the termination date. This would give consumers more time to explore their options and make any necessary changes to their coverage and/or provider.

# New Grant to Bolster CHIP and Medicaid Advocacy

PHLP has received a grant from the Center on Budget and Policy Priorities to work on implementation of the enrollment and renewal simplifications and Medicaid bonus payment options available to states under the Children's Health Insurance Program Reauthorization Act (CHIPRA). Under this grant, PHLP will be working with Community Legal Services of Philadelphia and Public Citizens for Children and Youth (PCCY) to advance policy ideas and provide technical assistance to the Departments of Public Welfare and Insurance as the state decides what policy options to pursue and develops plans to implement the chosen options.

CHIPRA offers states multiple options to expand CHIP and Medicaid coverage for children including: extending eligibility to legal immigrant children and pregnant women who have been in the United States less than 5 years; encouraging states to work with the Social Security Administration to document citizenship; and providing opportunities to draw down bonus payments for increasing Medicaid enrollment. PHLP, Community Legal Services and PCCY will work together to advocate for potential improvements to the application and renewal process, to encourage the state to develop policies that maintain and grow Medicaid and CHIP enrollment, and to pursue opportunities to leverage federal outreach funding. For more information, contact Ann Bacharach, Special Projects Director at abacharach@phlp.org or 215-625-3596 (or through the toll-free HELPLINE at 1-800-274-3258)

**Do you currently get the Health Law PA News and/or Senior Health News through the mail? Would you like to get these newsletters by e-mail?**

**If so, contact staff@phlp.org to change the way you get your PHLP newsletters!**

# State, Looking for Input on Integrated Care Initiative, Holding Statewide Listening Sessions in August

Pennsylvania's Office of Long Term Living (an Office within both the Department of Aging and the Department of Public Welfare) will be holding listening sessions across the state in August 2009 on the proposed Integrated Care Initiative (ICI). This initiative, scheduled to begin July 2010, will allow individuals 60 and older who have both Medicare and Medical Assistance (MA) to join Medicare Advantage integrated care plans. By enrolling in one of these plans, the consumer will receive both their Medicare and MA benefits through **one** plan, rather than have two separate coverages as they do now. Individuals under age 60 will be included in the future.

Individuals with Medicare and Medical Assistance, as well as their family members, friends, and advocates, are encouraged to attend a listening session in their area to learn more about the Integrated Care Initiative. Those who attend will be given an opportunity to ask questions and give feedback/input to the state as it continues to develop the details of this initiative. **It is important that the state hears from consumers about this initiative!** Please note that if you cannot attend the session near you, there is a toll-free Conference Call scheduled for August 31st at 9 a.m. Anyone from across the state can dial in and participate, ask questions, and offer comments or suggestions.

The state is especially looking for feedback to the following questions:

- Have you been having trouble getting your health care or helping someone else get their health care from Medicare and Medicaid?
- After learning about this new program, what would be the best way to provide you with more information—U.S. Mail, e-mail, phone call, or more meetings?
- Should Pennsylvania hire people to explain the advantages and disadvantages of this new program as compared to current options?
- Should Pennsylvania also hire people to help people who have problems getting services from this new program?
- What services are important to you?
- Should people already in a Medicare Advantage plan be automatically enrolled in this new program or should they have to tell us first that they want to enroll? (They can always opt out.)

**Each listening session begins at 9 am and will end by noon**. Registration is required (see below). Refreshments will be served.

Friday, August 7, 2009
(Philadelphia County)
Philadelphia Senior Center
509 South Broad Street
Philadelphia, PA 19147

Monday, August 10, 2009
(Beaver County)
Circle of Friends – Baden
The corners of Linmore and Wayne Streets
Baden, PA 15005

Tuesday, August 11, 2009
(Allegheny County)
Vintage Senior Center
401 North Highland Avenue
Pittsburgh, PA 15206

Friday, August 14, 2009
(Lancaster County)
Lancaster Farm & Home Care Center
1383 Arcadia Road
Lancaster, PA 17601

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Monday, August 17, 2009
(Westmoreland County)
Westmoreland Community College
Science Hall
145 Pavilion Lane
Youngwood, PA 15697

Wednesday, August 26, 2009
(Philadelphia County)
JCC's Kline Branch Center & Russian Satellite
10100 Jamison Avenue
Philadelphia, PA 19116

Friday, August 28, 2009
(Northampton County)
Hispanic Senior Center
520 East Fourth Street
Bethlehem, PA 18015-1804

Monday, August 31, 2009
(Conference Call)
Dial-In: 1-800-706-7745
Passcode: 341-064-31
TTY Users: 1-800-654-5984

**Individuals interested in attending must contact the state 2 days before the session to register**. Registration can be done by:

- Phone: Call 1-877-591-6826 (TTY Users: 1-800-654-5984)
- E-mail: RA-IntegratedCareComments@state.pa.us
- Mail: Office of Long-Term Living
  Attention: Listening Sessions
  P.O. Box 2675, Harrisburg, PA 17105.

The state needs the following information to register someone:
1) Name
2) Session location
3) Whether or not someone plans on commenting

More information about the Integrated Care Initiative is available online at: http://www.dpw.state.pa.us/about/oltl/snp or by calling the Office of Long Term Living at 1-877-591-6826.

# Update On Federal Health Care Reform

President Obama has stated that he remains committed to passing health care reform legislation this year and, in line with that goal, Congress is currently working on various proposals for comprehensive health care reform. Three major health care reform proposals have now been introduced that would require all Americans to have health insurance. These proposals are: the Senate Finance Committee's Policy Options; the Senate Health, Education, Labor and Pensions (HELP) Committee's Affordable Health Choices Act; and the Tri-Committee proposal of the House Ways and Means Committee, Energy and Commerce Committee, and Education and Labor Committee called HR 3200, America's Affordable Health Choices Act of 2009. For more information on these proposals, see http://finance.senate.gov/sitepages/baucus.htm, http://help.senate.gov, and http://edworkforce.house.gov. These three proposals contain common elements such as:

- People won't be denied health insurance if they have a pre-existing condition.
- People won't lose their health insurance if they change jobs or lose their job.
- People won't lose their health insurance if they get sick.
- People can pick the health plan they want.
- If someone likes their current health plan, they can keep it.
- The creation of a public insurance option.

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- Money will be spent on prevention and wellness.
- There will be limits on out-of-pocket expenses to prevent bankruptcy that can result from the high costs of health care.

Now that the contents of the health care reform proposals have been developed and made public, the major concern and topic of debate has turned to how to fund these proposals. Hospitals have already agreed to cut $155 billion in Medicare and Medicaid spending over ten years so these savings can be used to help pay for the costs of healthcare reform. Some additional proposals for paying for health-care reform include:

- Charging pharmaceutical companies fees
- Taxing sugary beverages
- Imposing a surtax on people who make over $350,000 per year
- Making businesses pay a tax if they don't offer a health insurance plan for their employees

**Health Care Reform Efforts Targeting Older Adults**

Older adults face particular difficulties managing health care costs because the cost of their health care generally rises as they get older yet they usually live on a fixed income. Here are some provisions included in the current health care reform proposals that would benefit older adults:

- **Reduced costs during the Part D donut hole**: The pharmaceutical companies have agreed to a 50 percent discount on the cost of brand-name prescription drugs during the Medicare Part D "doughnut hole." The "doughnut hole" is a gap in prescription drug coverage that occurs after a person with a Medicare Part D plan has spent $2,700 (in 2009) on prescription drugs but before they reach $6,100 (in 2009) in total out of pocket drug costs. Currently, while in the "doughnut hole," a person must pay 100 percent of the costs of their prescription drugs, creating a huge financial burden on most seniors who do not qualify for the Medicare low-income subsidy. No additional paperwork would be needed to get the discount because the discount would be received at the pharmacy. Also, 100 percent of the cost of the drugs would count toward reaching the out-of-pocket limit that allows a person to get out of the "doughnut hole" and obtain catastrophic coverage, even though the beneficiaries would only be paying half the cost of the drugs.

- **Increasing the asset limit for the low-income subsidy and for the Medicare Savings Program (also called the Medicare Buy-In)** to $17,000 for a single person and $34,000 for a married couple. The limits would then be increased annually. Currently, the asset limits for the low-income subsidy are $11,010 for a single person and $22,010 for a married couple (not counting the $1500 per person disregard given if assets will be used to pay for burial). Note: Under a law passed last summer, the resource limits for the Medicare Savings Program will increase to match those of the LIS program starting January 2010.

- **Eliminating the Part D co-pay for people in a Home and Community Based Waiver Program.** Currently, individuals with both Medicare and Medical Assistance who are residing in a nursing home do not have any co-pays for their Medicare Part D covered prescription drugs. Under this proposal, individuals with both Medicare and Medical Assistance who live in the community and who are receiving services under a Home and Community Based Service Waiver program (an alternative to nursing home care) would also no longer have Part D prescription co-pays.

- **Providing Medicare coverage for preventive services** and waiving all Medicare cost sharing (both co-pays and deductibles) for preventive services.

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As of the date of this newsletter, America's Affordable Health Choices Act of 2009 (HR 3200), has passed the Education and Labor Committee and Ways and Means Committee, but not the Energy and Commerce Committee. HR 3200 does include options for financing the reform efforts, including raising taxes. A group of fiscally conservative Democrats, called the Blue Dogs, are opposed to the financing mechanisms included in HR 3200. The House leadership hoped that HR 3200 would pass all three committees and go to the floor for a vote before the August recess. The latest reports are that it is unlikely that the full House will vote on the bill before the August recess (starts August 3rd) and that it will wait until House members return in September.

The Senate bills have not passed out of committee at this time. Therefore, it is not likely that these proposals would go to a floor vote before the Senate leaves for August recess on August 10th.

Readers concerned about the outcome of federal health care reform efforts are encouraged to take advantage of the August recess to contact their U.S. Senators and/or Representatives and voice their opinion on this important matter.

# PA House of Representatives Passes Insurance Rate Protection Bill for Small Businesses

Legislation that would reform the small group health insurance market has been approved by the Pennsylvania House of Representatives and is currently pending before the Senate Banking & Insurance Committee. The legislation (H.B. 746) would apply rate protections to insurers with at least a one percent share in the small group market, defined as policies covering 2 to 50 employees.

In addition to prohibiting rate increases of more than ten percent annually, H.B. 746 would require insurance companies to set their rates based on the aggregate claims histories of all small groups within a geographical region. Currently, insurers are allowed to set rates according to a risk assessment of each individual small group, which typically just includes the employees of one company. This means that if a small company has one employee who becomes pregnant or falls ill and requires expensive treatment, there is currently no limit on how much an insurer can raise that company's insurance rates. Under the proposed legislation, variation in rates among small groups would still be permitted, but could no longer be based on medical underwriting or on the mix of males and females within the group. Variation could be based only on age and wellness incentives. Additionally, variations in rates among small groups would be limited by "rate bands" that could not exceed a 2:1 ratio. That means the highest premium charged by an insurer within a small group geographic region could not be more than double the lowest premium charged by that insurer within the region. Finally, the legislation would require insurers to pay out at least 85% of their premium revenues in medical benefits, meaning no more than 15% could be retained for administrative costs and profit.

Pennsylvania is one of only two states that currently does not provide some form of rate protection for small employers. Before H.B.746 passes the Senate and is signed into law by the Governor, there could be changes to what was described above. For more information or to check the status of the legislation, go to www.legis.state.pa.us/.

# OLTL Issues Interim Draft Assisted Living Regulations

On June 24th, Pennsylvania's Office of Long Term Living released interim draft Assisted Living Regulations to stakeholders and interested persons. The draft regulations are available on the IRRC website (http://www.irrc.state.pa.us). Because this is an interim draft, the state provided 30 days for those interested to make "last chance" comments on revisions the state should make prior to publishing final proposed regulations.

The Pennsylvania Assisted Living Consumer Alliance (PALCA), lead by PHLP and consisting of 31 organizations across the state representing older adults and persons with disabilities, reviewed the interim draft along side an earlier draft of the regulations. **There are many good changes.** They include first aid and CPR training for all direct care staff, a core benefit package that all facilities must offer, and the requirement that in most cases a resident's assessment and support plan are to be completed prior to admission. PALCA believes the state is now on the right track. However, there are still some major **outstanding issues that need to be resolved** so that consumers can be well-served in Pennsylvania's assisted living facilities. Issues that remain to be addressed include: requiring all facilities to be fully accessible to wheel chair users; allowing residents the right to appeal adverse decisions made by their facility (including eviction decisions); articulating a full array of residents' rights; setting appropriate staffing levels; and establishing sufficient hours of staff and administrator training. To review a list of the good aspects as well as the problem areas in the interim draft regulations, along with PALCA's comments and line-by-line edits, see the PALCA website at www.paassistedlivingconsumeralliance.org.

We will let you know when the final proposed regulations are published. For more information or to share your story, visit the PALCA website noted above.

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