Health Law PA News

Newsletter of the Pennsylvania Health Law Project

Harrisburg Philadelphia Pittsburgh

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

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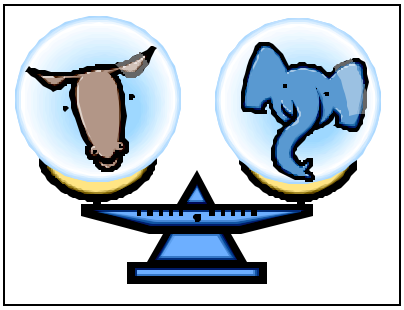
Presidential Candidates' Healthcare Proposals A Side-By-Side Comparison

In the race leading to the upcoming presidential election, one of the most hotly debated issues between John Kerry and George W. Bush is how each candidate plans to address the healthcare needs of the country. Both candidates tout plans that they claim will provide or increase healthcare coverage for many of those who are uninsured or underinsured. Pages 2, 3 and 4 of this edition of the newsletter include a brief comparison of the substance of the candidates' plans.



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PHLP Files Comments on Blue Cross Surplus Issue

Last month PHLP, Community Legal Services and the Community Justice Project submitted comments on the issue of the Blue Cross surplus to the Pennsylvania Insurance Department on behalf of 13 non-profit organizations from across the Commonwealth. The comments argued that the Blue Plans have amassed unjustified surpluses while evading their statutory charitable obligation.

The comments were a response to filings prepared by the four Blue Plans in compliance with a notice issued by the Insurance Commissioner. The notice required the Blues to submit information about their surplus and to explain what they are doing to fulfill their charitable obligation.

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	Bush-Cheney	Kerry-Edwards	Analysis
General	Bush signed legislation making Health Savings Accounts (HSA's) available for people who buy into low-cost, high-deductible health-care plans. He hopes to expand the use of these tax-deductible personal accounts set up to pay for medical expenses. Bush would also offer a tax credit to low-income workers who buy their own insurance. In addition, he has a five-year plan to fund 1,200 new or expanded Community Health Centers.	Kerry's plan aims to cut the average family's insurance premium by $1,000. His plan expands existing public programs (such as Medicaid and CHIP) to cover many more children under age 18 and low-income adults. It also creates a new national purchasing plan, modeled after the federal employees' health plan, to provide more affordable coverage to small businesses, the self-employed, and individuals.	HSA's may be practical for some consumers, but a major complaint about them is that they force people into insurance plans with very high deductibles. The main criticism of Kerry's plan comes from worries about the cost of the program for taxpayers, and the increased governmental regulation of healthcare.
Children	Bush will launch a nationwide, billion dollar Cover the Kids campaign to sign up more children for health care coverage. The Cover the Kids campaign will combine the resources of the federal government, states, and community organizations, including faith-based organizations, with the goal of covering all SCHIP-eligible children within the next two years.	Under Kerry's plan, the Federal government would pick up the cost of the nearly 20 million kids enrolled in Medicaid in exchange for states covering kids in the Children's Health Insurance Program. In order to participate in this swap, states must agree to expand eligibility for children to 300 percent of poverty.	Kerry's campaign claims that Bush would cut approximately $16 billion from Medicaid, including kicking off 500,000 children from Medicaid and SCHIP.* A concern raised by opponents of Kerry's plan is that it would free states from any incentive to control costs by altering the federal-state partnership in Medicaid.**
Adults Currently Uninsured	Bush supports a tax credit for low-income workers who buy their own insurance.	Parents with incomes under 200% FPL and adults with income under 100% FPL will get coverage through the expansion of CHIP.	

	Bush-Cheney	Kerry-Edwards	Analysis
Unemployed Individuals	Bush's trade bill provides a tax credit to help workers who lose their jobs due to international trade obtain health insurance coverage.	Kerry proposes giving laid-off workers would receive a 75% tax credit so that they can keep their health insurance while they are between jobs.	
Prescription Drugs	Bush's site emphasizes the prescription benefit added to Medicare and the discount cards. He says the Medicare Modernization Act authorizes drug reimportation from other countries (like Canada) when they are shown to be safe and effective, but that the FDA has not been able to certify the safety of those imported drugs. He also says that he is leading the fight to bring generics to market quicker.	Kerry's plan would require transparency rules for pharmaceutical benefit managers that do business with the federal government to clearly show what savings they receive from the industry and from bulk purchasing, encouraging them to pass these savings along to consumers. Kerry says he would allow drug reimportation of safe, FDA-approved drugs. He would also give incentives to states to implement more efficient contracting to obtain better rates for prescription drugs. He would seek to end loopholes in patent law that keep cheaper alternatives off the market.	Kerry's campaign claims that Bush opposes allowing the HHS Secretary to negotiate for lower drug prices in the Medicare program, and that he opposes drug reimportation. ***
Medical Liability Reform	Bush would seek to adopt proven minimum standards in order to avoid the costs of frivolous lawsuits. He also seeks a cap of $250,000 on pain and suffering damages.	Kerry opposes capping damages in medical malpractice suits, but would support mandatory sanctions for frivolous lawsuits. He would also require states to make available non-binding mediation in all cases before permitting a plaintiff to go to trial on a medical malpractice claim. He opposes the award of punitive damages in medical liability cases except upon proof of intentional misconduct, gross negligence, or reckless indifference to life.	Bush says that medical liability reform could save Americans between $60 and $108 billion annually, but the CBO and GAO have both criticized the 1996 Stanford University study on which that figure is based. ****

	Bush-Cheney	Kerry-Edwards	Analysis
Number of Newly Insured	Bush campaign aides say the plan could cover up to 10 million people who currently lack insurance.	According to the Emory University analysis, his plan would cover 26.7 million people who currently do not have health insurance.	Projections by the Congressional Budget Office, the Treasury Department, academics suggest that, under the best circumstances, Bush's plans for health care would extend coverage to no more than 6 million people over the next decade and possibly as few as 2 million.*****
Cost of Implementation	The Bush campaign estimates his plan will cost $102 billion over the next 10 years.	Kerry's campaign estimates that his plan will cost $653 billion over the next decade.	According to independent analysis by Emory University professor Ken Thorpe, the Kerry plan would cost $895 billion over 10 years. Several news organizations have said that Kerry has underestimated the costs of his healthcare plan.******

*www.johnkerry.com
**www.georgewbush.com
***www.johnkerry.com
****"President Uses Dubious Statistics on Costs of Malpractice Lawsuits," www.factcheck.org, January 29, 2004
*****Connolly, Ceci. "Bush Health Care Plan Seems to Fall Short Gap Grows Between Hard Data, Projections for Covering 10 Million Uninsured," The Washington Post, August 22, 2004, A04.
******VandeHei, Jim and Faler, Brian. "Kerry's Spending, Tax Plans Fall Short; Review of Proposals Shows Expenditures Exceeding Savings by $165 Billion," The Washington Post, Feb 29, 2004, A.05.

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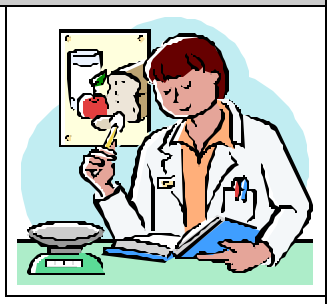
DPW Allows Nurse Practitioners To Make Disability Assessments



Individuals who do not have a formal disability diagnosis and receive Social Security Disability benefits, are required by DPW to have a medical provider certify their disability to receive Medical Assistance benefits. In the past, DPW limited certification to only permit certification by physicians and psychologists. DPW has now announced that they will accept certification of disability from certified registered nurse practitioners (CRNP), registered nurses, and physician's assistants. This will help many individuals who have been prevented from enrolling in Medical Assistance, for example, because their regular care is provided by a CRNP instead of a physician.

CRNPs, registered nurses, and physician's assistants will be allowed to complete the following essential disability forms:

- Employability Assessment Form (PA 1663)
- Health Sustaining Medication Assessment Form (PA 1671)
- Temporary Disability Reassessment Form (1664)

It should be noted that the Medical Assistance Eligibility Handbook used by County Assistance Offices for assessing eligibility for Medical Assistance was amended to include this new rule. Unfortunately, the MAEH amendment contains errors, so PHLP will be working with DPW to ensure the new policy is correctly stated.

Any questions about this new policy or the MAEH amendment should be directed to the Pennsylvania Health Law

Community Choice Roll-out Continues

On September 30, 2004, Community Choice expanded to Chester and Delaware counties. Community Choice is already in effect in Philadelphia, Fayette, Greene, and Washington counties.

Community Choice is the expedited process of enrolling consumers in home and community based services (also known as Waivers), so that consumers receive services quicker to be able to live or remain in a home setting. This process is gradually being implemented in all counties in Pennsylvania.

In Delaware County, consumers can call the County Office of Services for the Aging (COSA) at (610) 490-1300. Consumers should ask for the In-Home Care Department. In Chester County, consumers should call the Department of Aging Services at 1-800-692-1100 ext. 6350. Consumers should ask for the In-Home Care Department. Consumers in either Chester or Delaware counties can call Liberty Resources at 1-888-634-2155 ext. 411 for Community Choice. The phones are staffed 24 hours a day, 7 days a week.

Note: To apply for services in Philadelphia county, call 1-888-482-9060. To apply for services in Fayette, Greene, and Washington counties, call 1-800-734-9603.

(Continued from page 1)

PHLP's comments addressed the amount of the surplus, the inability of the Blue Plans to sufficiently justify the amount of the surplus and the Blue Plans' failure to fulfill their charitable obligation. Major points from the comments are:

* The Blue Plans severely understated the amount of their surplus by failing to report the reserve and surplus levels of the consolidated company. Instead of reporting the assets of the parent company and all of its subsidiaries, the plans reported only the reserves and surplus of the parent company. In so doing, the Blue Plans reported a combined surplus of just under $4 billion. If they had reported the surplus of the consolidated company, as required by the Insurance Department, the surplus amount would be even higher.

* The Blue Plans failed to adequately justify the need for the current level of surplus. The Blue Plans each provided the Insurance Department with recommended minimum and maximum surplus levels. However, they did not make enough information available to the public to justify these recommendations.

* The Blue Plans charitable expenditure claims are inconsistent and inadequate. Each Plan claimed different types and amounts of contributions and many of the claimed contributions were hardly charitable. For examplem included as claimed charitable expenditures were:
    * Loses on products that all Pennsylvania insurers in are statutorily required to offer.
    * The payment of taxes.
    * Tax-deductible donations to organizations, like the orchestra, that have no connection to providing health insurance to those in need.
    * Un-audited administrative support to government funded programs.
    * Investment in infrastructure and capital improvements.

The comments also included a number of procedural objections and requested that a contested, public hearing - with the public interest represented by a state appointed Public Advocate - be held to determine whether or not the Blue Plans have excess surplus.

To view the entirety of the comments, visit PHLP's website at www.phlp.org.

PHLP and MAAC Consumer Subcommittee Working On HealthChoices Language Access Initiative

Title VI of the 1964 Civil Rights Act prohibits discrimination on the basis of national origin for federally funded programs, and therefore requires Medical Assistance to provide language assistance to individuals who are Limited English Proficient ("LEP"). Although DPW has developed policies regarding the language services which HealthChoices plans must provide, it has not yet formalized these policies into any clear, written form. PHLP and the Consumer Subcommittee of the Medical Assistance Advisory Committee (MAAC) are working to have DPW include clear language services requirements in its new contracts with Health Choices plans.

PHLP and the Consumer Subcommittee of the MAAC are suggesting a comprehensive language access policy, that includes identification of language needs, tracking of language assistance clients, translation of written documents from health plans, interpretation services from health plans, interpretation services at doctor's offices, and other issues. For further information about PHLP's language access work, call PHLP at 1-800-274-3258.

DPW POLICY UPDATES:

New Income Verification Policy; New MAWD Presumptive Disability Policy

Income Verification Changes. In accordance with the Department of Public Welfare's (DPW) efforts to ease the barrier of income verification for consumers, a **single pay stub policy** has been implemented! As of June 1, 2004 individuals can provide a single pay stub (weekly, bi-weekly or monthly) that is representative of income received. This will be used to determine eligibility (either at application or at renewal). In addition, the pay stub submitted can be dated up to ***60 days prior*** to the application or renewal date instead of the 30 day period that was previously required. As a result, pay stubs for a full month's income are no longer required and individuals can submit an older pay stub if they can't find a current one. Some CAOs may still not be familiar with this policy, so refer your caseworker to "Ops Memo 04-05-07." As always, keep in mind that the CAO has a duty to assist the consumer with obtaining verification and a consumer cannot be denied Medical Assistance for lack of verification if they have cooperated in efforts to obtain it. (MEAH 350.11)

MAWD Presumptive Disability. Medical Assistance for Worker's with Disabilities, better known as MAWD, is a program which provides full Medical Assistance to individuals who are disabled and working, provided they meet certain citizenship, residency, and income and resource requirements. In an effort to remove barriers and streamline the MAWD application process, DPW has implemented a presumptive disability policy for individuals applying for MAWD.

Under the new policy (Ops Memo: OPS040908), an individual who applies for MAWD and provides some type of information on disability will be presumed disabled and, provided they meet all other eligibility requirements, will be found eligible for the program. The presumed disabled period will be set for three months and can be extended for an additional three months if more time is needed for the applicant to gather documentation of the disability. In order to receive benefits during this period, the applicant must pay the MAWD premium.

During the presumed disabled period the applicant will be able to submit documentation of their disability to the Medical Review Team. The MRT will then make a final disability determination. If the MRT finds the applicant disabled, they will remain enrolled in the program. If the MRT finds that the applicant is not disabled, the individual will be determined ineligible for MAWD and will be evaluated for eligibility in other Medical Assistance categories. If the person is not ultimately found eligible for MAWD, there is no overpayment.

For more information about either of these new policies, call the PHLP helpline at 1-800-274-3258.

Remember to Vote!

Tuesday

November 2, 2004

Polls Open at 7:00 AM

Polls Close at 8:00 PM

PHLP Files Comments on Proposed Medicare Part D Regulations

On October 1, 2004, PHLP submitted comments on the Proposed Medicare Part D Regulations to the Center for Medicare and Medicaid Services. PHLP took a nationally significant role in responding to the proposed regulations, by circulating drafts of the PHLP Comments and conducting open trainings across the state, to help explain the content and effects of the proposed regulations. PHLP's final submitted comments contained over 70 pages of analysis and suggested changes, to help improve the future Part D benefit for Pennsylvanians.

PHLP's comments focused on numerous issues important to Medicare and dual-eligible (Medicare and Medicaid) consumers. For example, PHLP suggested numerous changes to facilitate the enrollment process, and even create auto-enrollment when it would favor consumers. At the same time, PHLP suggested many more safeguards for consumers in the disenrollment process to ensure that consumers aren't disenrolled unfairly or arbitrarily.

PHLP also made recommendations to protect consumers from arbitrary drug denials, to allow consumers fair appeal procedures when drugs are denied, to require drug plans to provide consumers notice about their benefits and rights, and in many other areas where consumers may be disadvantaged by the proposed regulations. PHLP hopes the comments will help improve the very problematic Medicare Part D Prescription Drug Benefit. You can view the comments on our website at: www.phlp.org. Further information is also available by calling PHLP at 1-800-274-3258.

Pennsylvania Health Law Project
924 Cherry Street, Suite 300
Philadelphia, PA 19107