

THOMSON, RHODES & COWIE, P.C.

MANAGED CARE LAW UPDATE

Volume III, Issue 7

August 2000

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PENNSYLVANIA FEDERAL COURTS

Court rules DPW failed to provide adequate behavioral health rehabilitative services to children. On June 27, 2000, the U.S. District Court for the Eastern District of Pennsylvania granted partial summary judgment against DPW on two counts of a class action complaint addressing the provision of behavioral health rehabilitative services (“BHR Services”) to children in the state Medicaid program. The court found that DPW violated federal Medicaid laws by failing to develop adequate time lines to measure promptness of the initiation of BHR Services. In awarding summary judgment, the court ruled, in effect, that the undisputed evidence established that certain BHR Services were not provided promptly in HealthChoices counties. The court also ruled that DPW had violated its HCFA waiver by failing to ensure that behavioral health managed care contractors had adequate networks of BHR Service providers. The court denied summary judgment with respect to plaintiff’s claim that the wait times for BHR Services in the fee-for-service counties were even longer than in HealthChoices counties. The court found that the evidence on the “comparability of service” issue, while supportive of plaintiff’s case, was insufficient to support an award of summary judgment. *Kirk v. Houston, No. 99-3253, (E.D. PA June 27, 2000)*

PENNSYLVANIA LEGISLATURE

Pennsylvania enacts risk-based capital requirements for plans. On June 22, 2000, Governor Ridge signed Act 62 of 2000 instituting risk-based capital requirements (RBC) for Pennsylvania managed care plans. Insurance Commissioner Diane Koken asserts that the new law will assist regulators in evaluating the financial standing of the 350 domestic insurance companies in the state. The RBC requirements utilize a standardized method to consider the size, structure and risk profile of a managed-care insurer to determine the minimum amount of capital needed to support business operations. If the insurer’s RBC results indicate a deteriorating or weak financial condition, the new law allows the Commissioner to take regulatory action to avoid or minimize the impact of an insolvency. The new law applies to all types of managed care insurers licensed to do business in Pennsylvania.

PENNSYLVANIA AGENCIES

CHIP program tops 100,000 enrollees. On July 18, 2000, Insurance Department issued a press release announcing that more than 100,000 Pennsylvania children now receive free or low cost health care through the Children’s Health Insurance Program (CHIP). Under CHIP, families earning up to 200% of the federal income poverty guidelines (or \$34,100 gross income for a family of four) may be eligible for free health insurance. Low cost insurance is available for children of families earning up to 235% of the federal income poverty guidelines (or \$40,068 gross income for a family of four). In April of 1999, the CHIP program was expanded to provide health care to 24,000 more Pennsylvania children and new benefits were added. The expansion was due to the adoption of a “net income” test to determine eligibility, rather than the previous “gross income” test. The new formula discounts certain work and day care deductions. For more information, see the Insurance Department’s website, <http://www.insurance.state.pa.us>.

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FEDERAL AGENCIES

Humana settles with DOJ for \$14.5 million re: reporting of dual eligibles. On June 6th, 2000, the Department of Justice announced that Humana agreed to pay \$14.5 million to settle allegations that the company provided inaccurate information to the Medicare program. This settlement is believed to be the first between the Agency and a plan related to Medicare managed care payments. The alleged inaccuracies resulted from the characterization of certain enrollees as dual eligibles, i.e. eligible for both Medicare and Medicaid, and inflation of Medicare managed care payments to the Humana. The settlement included a 5-year corporate integrity agreement with the HHS office of the Office of Inspector General.

HCFA: Over 900,000 enrollees impacted by M+C withdrawals, PA second highest state. On July 24, 2000, the Health Care Financing Administration (HCFA) announced that approximately 934,000 Medicare beneficiaries will be affected by the recent decisions of managed care plans to withdraw from the Medicare managed care program known as Medicare+Choice. In a state by state analysis, Pennsylvania (89,641) is second only to Texas (180,749) in terms of residents impacted by the withdrawals. Aetna U.S. Healthcare's and Cigna HealthCare Inc.'s decision to withdraw from many of the M+C markets contributed to the high number of affected beneficiaries. HCFA claims that the majority of beneficiaries affected will be able to join other MCOs operating in their area. For more information on the state by state analysis, see HCFA's web site at <http://www.hcfa.gov/medicare/nrwebdat.htm>.

STUDIES

Kaiser report: Good grades for managed care. A recent survey conducted by the Kaiser Family Foundation found that 83% of the persons interviewed who had contact with their plans during the last year reported that their experiences have been positive. The survey was based on a national representative random sample of 2,500 adults between the ages of 18 and 64 who have health care coverage other than Medicare. Even among persons who reported problems with their plans, 71% report their recent experiences as positive. The study also found that 51% of the interviewees reported some problem during the last year. Most problems related to delays or denials in coverage. Consumer groups expressed dismay with the study's determination that 40% of enrollees did not know whether they had a right to appeal a health care decision to a state or independent expert. Copies of the survey and related information are available online at <http://www.kff.org>.

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