

# Pennsylvania

## Constitutional Provisions

There are no apparent constitutional provisions which would require either the state or its local governments to provide health care services to indigents, a proposition repeatedly enunciated by the courts.<sup>1</sup>

## Statutory Provisions

Even where there is no constitutional basis for arguing that society is obligated to afford basic health coverage to its poor, any person meeting the statutorily defined qualifications of a public assistance program should have a right to enforcement of that law, and should have standing to so argue.

## State Responsibility

Two programs, General Assistance (“GA”) and the Children’s Health Care Act, represent the state’s most concerted and systemic efforts to address the health care needs of low-income persons not otherwise qualifying for either Medicaid or Medicare. This report shall discuss the GA program and Children’s Health Care Act first, then will turn towards the smaller less systemic or comprehensive programs providing health care services to narrow categories of low-income populations.

### General Assistance<sup>2</sup>

General Assistance (“GA”) is a state funded program which provides “money, services and payment for medical coverage for needy persons who are residents of Pennsylvania, are in need of assistance and meet all conditions of eligibility.”<sup>3</sup>

The legislature declared that its intention was not to create an entitlement to cash or medical assistance unless a person is either “permanently disabled and unable to work[,] or is required to be in the home full time to care for a dependent adult or child who requires constant attention and there is no other adult in the household capable of providing such care.”<sup>4</sup>

Taking its words to heart, as of August 29, 1995, the transitionally needy GA program was terminated.<sup>5</sup> Now GA is only provided to persons who are chronically needy due to medical, social or

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<sup>1</sup>*Walker v. O’Bannon*, 487 F.Supp. 1151 (W.D. Pa. 1980), *affd.* 624 F.2d 1092; *Smith v. Reynolds*, 277 F.Supp. 65 (E.D. Pa. 1967), *affd.* 394 U.S. 618.

<sup>2</sup>62 P.S. §§ 401 *et seq.* [West 1996]; 55 Pa. Code Ch. 141 [Fry 1997].

<sup>3</sup>62 P.S. § 402 [West 1996].

<sup>4</sup>62 P.S. § 401(b) [West 1995].

<sup>5</sup>62 P.S. § 432(3)(G)(iv) [West 1996].

related circumstances.<sup>6,7</sup> However, as this report shall discuss, the definition of chronically needy can be, and is, defined relatively broadly. Chronically needy GA recipients are automatically enrolled under the Medically Needy Medicaid Program (NMP-MA). Further, those persons who would have qualified for cash assistance under transitional GA, but for the program's aforementioned termination, may nonetheless receive time limited Medically Needy Medicaid coverage.

### **Program Description Differences between the Legislature and the Department of Public Welfare**

There are some differences, perhaps significant ones, between the statutes and the administrative code in which categories of people are eligible for services under this program. Since the administrative code which outlines the public assistance programs<sup>8</sup> is quite detailed and reflects the policy of the agency in charge of implementing the legislature's public assistance programs, it is probably fair to say that it reflects how this program is actually being implemented. Thus, where the administrative code addresses a specific category of eligibility outlined by the legislature, but defines it more narrowly, the more narrow definition is probably what is being used. Where the legislature has defined a category which the administrative code does not address at all, it may be the case that the failure of the code to define the category means that the category described by the legislature is not receiving services. Where the administrative code defines a category more broadly than does the legislature, or defines a category upon which the legislature was silent, it is probably the case that the category as defined by the administrative code is in fact receiving services.

The Public Welfare Agency is provided considerable authority by the legislature to establish eligibility categories.<sup>9</sup> Whether the differences in the GA program exceed that authority, however, is a question whose resolution would depend on a number of factors, an analysis outside the scope of this report.

### **Benefits**

Persons eligible for general assistance will receive medically necessary services under a subsection of state's Medically Needy Medicaid program (NM-MA).<sup>10</sup> The MA program is presented in detail in Title 55, Part III, of the Administrative Code.

After GA recipients incur a certain level of medical costs in a given budget period they become eligible for the same scope and duration of medical services available to federally defined "categorically needy" MA recipients, with the following exceptions: (1) a maximum number of 18 medical office or clinic visits and 30 home health care visits per fiscal year; (2) no more than three prescriptions or refills per month, and under a more restrictive drug formulary than that provided for categorically needy MA

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<sup>6</sup>62 P.S. § 432(3)(i) [West 1996]; 55 Pa. Code § 141.61(1) [Fry 1997].

<sup>7</sup>As you can see, there some significant differences between what the statutes and the administrative codes provide. It is likely that the administrative code describes the program as it is being implemented.

<sup>8</sup>Part II, Title 55, Pa. Code [Fry 1997].

<sup>9</sup>62 P.S. § 403 [West 1996].

<sup>10</sup>62 P.S. §§ 441.1(1), 442.1 [West 1996].

recipients, and; (3) no more than 30 days inpatient medical rehabilitation hospital care, and no more than 30 days of drug and alcohol hospital care per fiscal year.<sup>11</sup>

After incurring a certain level of medical costs those persons who would have been eligible for transitional GA benefits are also entitled to approximately the same scope and benefits as provided to chronically needy GA recipients.<sup>12</sup>

### **Transitional and Chronically Needy GA Eligibility**

Eligible applicants for GA are low-income state residents<sup>13</sup> who are neither eligible for Supplemental Security Income (SSI)<sup>14</sup> nor Aid to Families with Dependent Children (AFDC),<sup>15</sup> and who are either citizens or lawfully admitted aliens.<sup>16</sup>

### **Categorical Eligibility for Chronically Needy GA**

The categories of GA eligibility under the Chronically Needy GA program that have been constructed are quite broad. Special categories of eligibility have been created for women, children, caregivers of children in the household with severe illnesses or with disabilities, the working poor, persons with temporary or permanent disabling conditions, caregivers of household members with severe illnesses or with disabilities, and the “middle aged.”

#### **Women**

A woman with a verified pregnancy, or who is a victim of domestic violence and is receiving protective services is eligible—under this category—for up to nine months in a life-time. This category is not enumerated in the administrative code, however, so this category may not have been implemented.<sup>17</sup>

#### **Children**

Children and youth under the age of eighteen years, or eighteen through twenty years of age and attending secondary or an equivalent vocational or technical school full-time and expected to complete the program before reaching twenty-one years of age [administrative code says 19 years], are eligible for

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<sup>11</sup>55 Pa. Code § 1101.31(e)(1) [Fry 1997].

<sup>12</sup>55 Pa. Code § 1101.31(e)(2) [Fry 1997].

<sup>13</sup>62 P.S. § 432(5)(i) [West 1996]; 55 Pa. Code §§ 147.22 *et seq.* [Fry 1997].

<sup>14</sup>55 Pa. Code § 141.61(a)(1)(xi) [Fry 1997].

<sup>15</sup>55 Pa. Code § 141.61(a)(1)(xii) [Fry 1997].

<sup>16</sup>62 P.S. § 432(3) [West 1996]; 55 Pa. Code §§ 150.1 *et seq.* [Fry 1997].

<sup>17</sup>62 P.S. § 432(3) [West 1996].

benefits.<sup>18</sup>

### Caregivers of Children

Parents (in *two*-parent households) or non-parental caregivers, living in households having a child younger than 13 years of age or 13 years and older if the child has a verified disability, are eligible. The administrative code is more restrictive, limiting coverage to persons providing care to children under six, where the caregiver, but for brief and infrequent absences from the child, is required to be present in the household due to illness or incapacity of a household member.<sup>19</sup>

### The Working Poor

Persons employed 30 or more hours per week, whose earned income after allowable deductions provided under the GA program is less than the family size allowance for that budget group, are eligible. Further, those persons who are unemployed and no longer have unemployment compensation, and who have worked for four out of the last eight years are also covered.<sup>20</sup> Interestingly, these programs only appear in the administrative regulations.

### Persons with Temporary/Permanent Disabilities

Persons with professionally diagnosed and documented disabilities, whether of temporary or permanent nature, who because of the disability are unable to earn income which meets the minimum wage are eligible.<sup>21</sup> Persons who are currently undergoing active treatment for substance abuse in either state or federally approved drug or alcohol programs are eligible—under this category—for up to nine months of benefits in a life-time under this program.<sup>22</sup>

### Caregivers of Persons with Disabilities

Caregivers of persons (of any age) with disabilities are also covered. So too are non-parental caretakers of persons in their households who are either ill or disabled.<sup>23</sup>

### The Middle-Aged

Last but certainly not least, those persons age 45 years or older, are eligible for coverage (only the

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<sup>18</sup>62 P.S. § 432(3)(i)(A) [West 1996]; 55 Pa. Code § 141.61(d)(1)(i) [Fry 1997].

<sup>19</sup>62 P.S. §§ 432(3)(i)(B),(D) [West 1996]; 55 Pa. Code § 141.61(d)(1)(iv) [Fry 1997].

<sup>20</sup>55 Pa. Code §§ 141.61(d)(1)(vi), (viii) [Fry 1997].

<sup>21</sup>62 P.A. § 432(3) [West 1996]; 55 Pa. Code § 141.61(d)(1)(iii) [Fry 1997].

<sup>22</sup>62 P.S. § 432(3)(i)(E) [West 1996]; 55 Pa. Code § 141.61(d)(1)(v) [Fry 1997].

<sup>23</sup>62 P.S. § 432(3)(i)(D) [West 1996]; 55 Pa. Code § 141.61(d)(1)(iv) [Fry 1997].

administrative code designates this category).<sup>24</sup>

### **Transitional GA Eligibility**

A person who would be eligible for GA but for the fact that she or he does not fit into any one of the categories described above is eligible for up to 90 days in any 12-month period for NM-MA.<sup>25</sup>

### **Financial Eligibility for Transitional and Chronically Needy GA: Income & Resource Limits**

#### **The Support Law: The Concept of Legally Responsible Relatives (LRR)**

In 1937 the Legislature enacted “The Support Law,”<sup>26</sup> whereby “[t]he husband, wife, child, [] father and mother of every indigent person, whether a public charge or not, shall, if of sufficient financial ability, care for and maintain, or financially assist, such indigent person at such rate as the court of the county, where such indigent person resides shall order or direct. . . .”<sup>27</sup> The legislature has given the Department of Public Welfare leave to deem the income of legally responsible relatives (LRRs) available to applicants, notwithstanding whether the LRRs resources or income are in fact available to the applicant.<sup>28</sup>

The Department of Public Welfare cites 62 PS. §§ 101-1503 as requiring the Department to grant assistance only to those persons who are without sufficient resources to maintain themselves. The Department argues that given that the Support Law provides authority to the courts to order or direct support to needy persons from legally responsible relatives upon petition from the needy person or the Department, it is required to explore and develop the resource than an LRR may provide to a client.<sup>29</sup>

With respect to the GA program, the Department has restricted the definition of LRR to natural or adoptive parents of unemancipated minors less than 21 years of age, and spouses.<sup>30</sup> To the extent that the LRR’s income and resources are not exempt from these provisions, they shall be deemed available to the applicant for public assistance, and shall be factored into the determination of the applicant’s eligibility for assistance.<sup>31</sup> In the following discussion of income and resource rules applicable to the program, one should remember to factor in these deeming requirements.

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<sup>24</sup>55 Pa. Code § 141.61(d)(1)(ii) [Fry 1997].

<sup>25</sup>55 Pa. Code § 141.61(d)(2) [Fry 1997].

<sup>26</sup>1937, June 24, P.L. 2045, as amended 1945, May 23, P.L. 865, § 1; 1951, Sept. 26, P.L. 1455, § 1.

<sup>27</sup>62 P.S. § 1973 [West 1996].

<sup>28</sup>62 P.S. § 432.12 [West 1996].

<sup>29</sup>55 Pa. Code § 187.21 [Fry 1997].

<sup>30</sup>55 Pa. Code §§ 177.2, 181.2, 187.22 [Fry 1997].

<sup>31</sup>55 Pa. Code §§ 187.24, 187.81, 177.1, 177.11, 177.21, 177.22, 177.23, 181.251, 181.285.

## Earned and Unearned Income

The applicant or recipient for GA is not eligible unless his or her total gross earned and unearned monthly income after exemptions<sup>32</sup> is less than the AFDC/GA income eligibility limits established for various sized families (specifically, persons designated as being part of the same family unit for the purpose of calculating the budget).<sup>33</sup> The limits vary by county, but are on average, \$530 for a family budget unit of one, \$829 for a unit of two, \$1,064 for a unit of three, and \$1,310 for a unit of four.<sup>34</sup> Although, these limits are fairly low, for some persons the specific income exemption provisions<sup>35</sup> provided under the code may make be singularly helpful in being able to come below these limits.

## Resources

### Limits

Only non-exempt resources which are legally (even if not actually) available to the applicant or those individuals within his or her budget unit are applied toward the resource limitation.<sup>36</sup> The resource limit is \$250.00 for a GA single person budget unit, and \$1,000.00 for GA budget groups of two or more persons.<sup>37</sup> Only if the total equity value of nonexempt personal property and nonresident real property is equal to or is less than the resource limit is the budget group is eligible.<sup>38</sup>

### Exemptions

Basic items essential to day-to-day living, such as household furnishings and appliances, family heirlooms, personal effects of limited value, and farm animals and equipment, are exempt from inclusion in the calculation of what resources are available to the applicant.<sup>39</sup> One automobile whose equity value does not exceed \$1,500.00 and certain types of public assistance, including food stamps are also exempt from consideration.<sup>40</sup>

Residential property, such as a house or mobile home, within which the applicant or the person

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<sup>32</sup>55 Pa. Code §§ 183.71(d), 183.95 [Fry 1997].

<sup>33</sup>55 Pa. Code §§ 141.61(c), 183.71 [Fry 1997].

<sup>34</sup>55 Pa. Code Ch. 183, Appx. B, Table 2 [Fry 1997].

<sup>35</sup>55 Pa. Code §§ 183.71(d), 183.95 [Fry 1997].

<sup>36</sup>62 P.S. § 432.5 [West 1996]; 55 Pa. Code § 177.22 [Fry 1997].

<sup>37</sup>62 P.S. § 432.5(c) [West 1996]; 55 Pa. Code § 177.31 [Fry 1997].

<sup>38</sup>*Id.*

<sup>39</sup>55 Pa. Code § 177.21(a) [Fry 1997].

<sup>40</sup>*Id.*

included within the GA budget unit lives is exempt.<sup>41</sup> There may be limits on how much land, or on how much equity is exempt, but the regulations do not specify them. When an applicant or a person whose resources are deemed available to applicant's family budget unit, owns residential property, however, she or he is required to allow the Department of Social Welfare to place a lien against the property for the value of benefits which the applicant actually receives.<sup>42</sup> The lien would not go into effect until such time as the property was not used as a home by the applicant or his spouse or minor or incompetent children.

### Spend-down Schedule

A GA recipient must follow the spend down provisions of the Medically Needy Medicaid Program (NMP-MA) before she or he may receive medical benefits.<sup>43</sup> Thus, in a given time period, GA recipients must either pay for or incur an obligation to pay for medical expenses equal to the amount their incomes exceed the monetary cut-off level set by the state.<sup>44</sup> The monetary level varies by county, but on average is \$203.00 for a one-person family unit, \$308.00 for a two-person family unit, and \$396 for a three-person family unit.<sup>45</sup>

Here is an example. A one-person family unit would qualify for GA if his or her gross income after deductions is less than \$530.00 (see above discussion on financial eligibility). Let us say that the applicant in this example has countable gross income of \$529.00 per month. That applicant would have to incur medical expenses equal to the difference between his or her \$529.00 monthly income and the set monetary level set by the state, which is stated above as being on average \$203.00. Thus, before this GA recipient would be able to receive NM-MA benefits, she or he would have to incur medical expenses equal to \$326.00. It should be emphasized that the would be NM-MA recipient need only have incurred the legal *obligation* to pay for medical expenses. His or her actual payment may be made at some other time.

### Children's Health Care Act<sup>46</sup>

The Children's Health Care Act ("program") is a state administered program which provides grants from a limited fund to approved health insuring organizations that agree to provide an approved package of medical benefits to as many eligible children as its grant can afford.

### Program Funding

#### General Funds

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<sup>41</sup>55 Pa. Code § 177.22(a) [Fry 1997].

<sup>42</sup>*Id.*

<sup>43</sup>55 Pa. Code §§ 178.11, 181.13 [Fry 1997].

<sup>44</sup>55 Pa. Code §§ 181.13(d)(3), (4) [Fry 1997].

<sup>45</sup>55 Pa. Code § 181.13(d)(4), and Ch. 181, Appx. 3 [Fry 1997].

<sup>46</sup>62 P.S. §§ 5001.101 *et seq.* [West 1996], enacted 1992, Dec. 2, P.L. 741, No. 113.

The costs of administering this program at the state level are to be paid for by the state's general fund, upon submission and approval of a budget by the administration.<sup>47</sup>

### **Children's Health Fund**

The legislature has not provided, nor has it committed itself to so provide, any appropriations from general funds for this program's operations. Rather, this program must budget for and pay all of its expenses out of an account known as the Children's Health Fund.<sup>48</sup> The Children's Health Fund receives two thirty-firsts (approximately 6%) of the state's cigarette tax revenue.<sup>49</sup> The cigarette excise tax rate is one and fifty-five hundredths of a cent (.01/155) per cigarette.<sup>50</sup> In 1996, the Children's Health Fund received a one-time lump payment of five million dollars (\$5,000,000), which the legislature ordered transferred from the State Stores Fund, a fund derived from liquor sales regulation.<sup>51</sup>

### **Children's Health Fund Spending Limitations**

The program's management team (consisting of the Secretaries of the Budget and Health, and the Insurance Commissioner) is required to spend 70 percent of the fund on providing subsidies to children eligible for "free care" until such time as it determines that all eligible children have been enrolled. Most of the remainder may be used to subsidize health insurance premiums for children above 100 percent of the Federal poverty level, but below \*\*\*\*\*

### **Provider Plans (Grantees or Contractors)**

State certified Health Maintenance Organizations (HMOs),<sup>52</sup> health insurance companies,<sup>53</sup> hospital plan corporations,<sup>54</sup> and professional health services plan corporations<sup>55</sup> may apply to the

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<sup>47</sup>62 P.S. § 5001.701(b)(4) [West 1996].

<sup>48</sup>62 P.S. §§ 5001.701(a), 5001.103, 5001.3101 [West 1996].

<sup>49</sup>72 P.S. § 8296 [West 1997 Supp].

<sup>50</sup>72 P.S. § 8206 [West 1997 Supp].

<sup>51</sup>47 P.S. § 8-802(g) [West 1997].

<sup>52</sup>40 P.S. §§ 1551 *et seq.* [West 1992].

<sup>53</sup>40 P.S. § 363 [West 1992].

<sup>54</sup>Defined as a not-for-profit corporation incorporated for the purpose of establish, maintaining and operating a nonprofit hospital plan. 40 Pa.C.S.A. § 6101 [West 1992].

<sup>55</sup>Defined as a not-for-profit corporation engaged in the business of maintaining and operating a nonprofit professional health service plan. 40 Pa.C.S.A. § 6302 [West 1992].

Department of Insurance for grants to enroll children into their benefit plans.<sup>56</sup> At the time of the Act's inception, the legislature required that within 90 days of the effective date of the Act, health service and hospital plan corporations apply for grants under this program.<sup>57</sup>

The use of the term "grant" could be confusing. Actually, each plan submits a type of bid, a proposed premium rate, of which no more than 7.5 percent may go toward overhead costs. Those organizations contracting with this program to provide services are responsible for enrolling eligible state residents.<sup>58</sup>

### Benefit Package

Each contractor must generally<sup>59</sup> provide: (1) well child exams per the guidelines of the American Academy of Pediatrics;<sup>60</sup> (2) ambulatory diagnostic and treatment services; (3) outpatient surgery, including anesthesia; (4) emergency services, including anesthesia if necessary; (5) prescription drugs with a co-payment of five dollars per prescription; (6) injections and medications incidental to out-patient services; (7) emergency, prophylactic and routine dental and vision care, with some limitations and exclusions; (8) inpatient hospitalization of up to 90 days per year for eligible children who cannot qualify for Medicaid through share-of-cost send down provisions, and; (9) if inpatient care is warranted and the child would be Medicaid eligible but for income in excess of the Medicaid program's income limits, such payments which under the share of cost program would allow the patient to become Medicaid eligible (see below).<sup>61</sup>

### Share-of-Cost Medicaid

If a child might be eligible for share-of-cost Medicaid coverage and is currently in need of hospitalization, an application for share-of-cost Medicaid must be submitted to the Medical Assistance program through the combined efforts of the plan, the hospital and the enrollee.<sup>62</sup> Share-of-cost Medicaid is a program for persons who, apart from having income somewhat in excess of the program's threshold standard, are Medicaid eligible.<sup>63</sup> A spend-down program will provide coverage to a person whose medical expenses in a given period of time equals the amount that person's non-exempt income

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<sup>56</sup>62 P.S. §§ 5001.103, 5001.701 [West 1996].

<sup>57</sup>62 P.S. § 5001.701(k) [West 1996].

<sup>58</sup>62 P.S. § 5001.701(c) [West 1996].

<sup>59</sup>See discussion below on waiver of these requirements.

<sup>60</sup>Providers under this program are encouraged but not required to be qualified EPSDT providers. 62. P.S. § 5001.701(l)(5) [West 1996].

<sup>61</sup>62 P.S. § 5001.701(l)(7) [West 1996].

<sup>62</sup> 62 P.S. § 5001.701(b)(5) [West 1996].

<sup>63</sup>See NATIONAL HEALTH LAW PROGRAM, ADVOCATES GUIDE TO THE MEDICAID PROGRAM

exceeds a particular threshold.

Under this Children's Health Care program, the plan in which the child is enrolled will spend down on the child's behalf.<sup>64</sup> This might seem to contradict the requirement that a medically needy Medicaid recipient actually incur a legal obligation to pay for a given value of medical services before being deemed to have met his or her share of cost obligation. However, federal law provides that even where the medical costs are reimbursed under some other state program, they shall count toward meeting the individual's spend-down obligation.<sup>65</sup>

This manner of financing and delivering hospital services is the only way children who are eligible for share-of-cost Medicaid may obtain inpatient services under this program. If the child's responsible relative or guardian refuses to cooperate with the plan in the Medicaid application process, the child becomes ineligible to receive ANY services under the program.<sup>66</sup>

### **Waiver of Minimum Benefit Package Requirements**

Without much explanation, this Act allows deviations from the benefit package outlined above if a contractor demonstrates to the satisfaction of the department that the benefit package it is offering meets the "purposes and intent" of the section of the Act concerning benefits.<sup>67</sup> This is especially troubling given that other than the quality of care standards are poorly defined (see below under Quality Assurance).

### **Eligibility and Degree of Subsidization**

No applicant may be denied on the basis of a preexisting condition; nor may a diagnosis or treatment for the condition be excluded based on the condition's preexistence.<sup>68</sup> Eligible applicants are low-income state residents<sup>69</sup> under the age of eighteen years<sup>70</sup> who neither have health insurance, nor are eligible for non-share-of Medicaid.<sup>71</sup>

A person meeting the aforementioned requirements shall be eligible for "free" insurance coverage if she or he is either under the age of six years and in a family whose income does not exceed 185 percent of the Federal poverty line, or is six through seventeen years of age and in a family whose income does

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<sup>64</sup>62 P.S. § 5001.701(b)(5) [West 1996].

<sup>65</sup>42 U.S.C. § § 1396a(a)(17)(D) [Lawyers Coop. 1993].

<sup>66</sup>62 P.S. § 5001.701(c)(1)(iv) [West 1996].

<sup>67</sup>62 P.S. § 5001.701(m) [West 1996].

<sup>68</sup>62 P.S. § 5001.701(c)(2) [West 1996].

<sup>69</sup> Except for newborns, an eligible applicant must have been a state resident for at least thirty days prior to enrollment. 62 P.S. § 5001.701(c) [West 1996].

<sup>70</sup>62 P.S. § 5001.701(d) [West 1996].

<sup>71</sup>62 P.S. § 5001.701(c) [West 1996].

not exceed 100 percent of the federal poverty line.<sup>72</sup> A premium subsidy of up to 50 percent may be given to a person under the age of six years who meets the aforementioned requirements, and whose family income is between 185 and 235 percent of the Federal poverty level.<sup>73</sup>

Not only must a child be eligible for program benefits, but there must be sufficient funds remaining in the Children's Health Fund to pay for the cost of providing coverage to the applicant. If an eligible applicant is eligible, but may not be enrolled because the program's financial capacity has been met, the program must nonetheless offer enrollment to the child at cost.<sup>74</sup>

### Public Assistance Eligibility Determination Rules

Public Assistance is defined by statute as "money, services and payment for medical coverage for needy persons who are residents of Pennsylvania, are in need of assistance and meet all conditions of eligibility."<sup>75</sup> Since the Children's Health Care Act is a program whereby children in families with incomes below set levels are provided with a health insurance premium subsidy, it would seem that it is a form of public assistance. Whether public assistance rules regarding the calculation of available income and resources, including the rules regarding what constitutes the family unit and whose income and resources shall be deemed to whom, is unclear.

From what one can gather from reading the Act itself, which might be a very different impression from what the administrative regulations might say if and when they are published, the insurance plans establish applicants' eligibility. The insurance plans are given very little guidance by statute, except with respect to the percentages of the federal poverty level which are relevant. It seems unlikely that the insurance plan would engage in the type of complex eligibility determinations one might expect the Department of Public Welfare to use.

### Program Oversight and Quality Assurance

There are three groups which exercise some degree of oversight over the program's operations: (1) the "Management Team," which is composed of the Secretary of the Budget, Secretary of Health, and the Insurance Commissioner;<sup>76</sup> (2) the Department of Insurance,<sup>77</sup> and; (3) the Department of Health.<sup>78</sup>

The Management Team oversees the program's budget, executes contracts with provider plans, and promulgates such regulations as may be appropriate under the program. The Insurance Department is responsible for approving the premium rates proposed by the individual provider plans, for reviewing and approving proposed provider plan contracts, and for monitoring the plans and exercising some type

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<sup>72</sup>62 P.S. § 5001.701(d) [West 1996].

<sup>73</sup>62 P.S. § 5001.701(e) [West 1996].

<sup>74</sup>62 P.S. § 5001.701(e)(3) [West 1996].

<sup>75</sup>62 P.S. § 402 [West 1996].

<sup>76</sup>62 P.S. § 5001.701(f) [West 1996].

<sup>77</sup>62 P.S. § 5001.701(g) [West 1996].

<sup>78</sup>62 P.S. § 5001.701(h) [West 1996].

of oversight. The Health Department is responsible for coordinating and evaluating the program's efforts to enroll the maximum number of eligible children. A Health Council, consisting of the Secretary of Health, the Secretary of Welfare, the Insurance Commissioner, elected officials, and professional and community representatives, advises the Health Department.<sup>79</sup> Given that the Council is required to meet only once per year, however, it is questionable whether its function constitutes "oversight."

This Act has not established many objectives by which these three departments should exercise oversight. The objective most clearly and repeatedly articulated is that the maximum number of children eligible for this program's coverage should be enrolled.<sup>80</sup> "Cost-effectiveness" is the coin of this program's realm with respect to achieving its goal of enrolling the maximum number of children. Contracts and grants are to be awarded only to the most cost-effective provider plans. In other words, the paramount objective is to contract with provider plans who ostensibly are able to offer the minimum benefit plan to the maximum number of people.<sup>81</sup> Oversight is focused on ensuring that plans are making good faith efforts to enroll as many children as possible, and that the plans are specifically targeting traditionally underserved communities.<sup>82</sup>

This structure creates a potential problem. If a program, or provider group provides any service not actually required by the program, it might be underbid by those plans or providers who, because they only provide the minimum, have lower costs. Thus, competition has a tendency to cause a "rush to the bottom."

Although the program's basic benefit package seems to be fairly broad,<sup>83</sup> and requires plans to abide by the American Academy of Pediatric's guidelines for well-child screens,<sup>84</sup> that alone does not ensure adequate access. The proof of a plan's quality may rest more with whether a child in need actually receives services in a timely and appropriate manner than simply with whether the services are theoretically available. The quality of care may have as much to do with physician to patient ratios, hours of operation, physician credentials, phone access standards, specialist referral policies, and so on, than the laundry list of benefits potentially available.

Although the Act does not contain explicit medical quality standards, nor language from which principles concerning standards may reasonably be inferred, it does state that "[t]he Management Team shall use its best efforts to provide grants that ensure that eligible children . . . have access to health care services to be provided under this act."<sup>85</sup> This statement, together with the regulatory authority delegated to the Management Team,<sup>86</sup> would allow the Team to develop access criteria. For example, patient to physician ratios, phone line access, appointment scheduling rules regarding waits, systems of referrals,

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<sup>79</sup>62 P.S. § 5001.701(i) [West 1996].

<sup>80</sup>62 P.S. §§ 5001.701(f), (g), (h), (j), (l) [West 1996].

<sup>81</sup>62 P.S. § 5001.701(j)(1) [West 1996].

<sup>82</sup>62 P.S. §§ 5001.701(j)(1), 5001.702(a) [West 1996].

<sup>83</sup>62 P.S. § 5001.701(l)(7) [West 1996].

<sup>84</sup>62 P.S. § 5001.701(l)(7)(i) [West 1996].

<sup>85</sup>62 P.S. § 5001.701(b)(1) [West 1996].

<sup>86</sup>62 P.S. § 5001.701(f)(3) [West 1996].

grievance mechanisms, and so on. Those criteria could form the base of any contracts signed with plans. Key language could be inserted into the contracts which establish that the plans would be held in breach of contract and subject to predetermined penalties if certain conditions are not upheld.

### **Due Process Provisions**

This is a state program which uses private plans to meet the state's objective of providing a basic medical insurance package to children. The grantees, or contractors are state actors in the context of this program and thus afford certain procedural rights.

When a person is denied entry into the program, is denied a benefit, or suffers a reduction in benefits, or is an enrollee and is dissatisfied in some other way with the plan, certain procedural rights come into play.

The program's ability to dole out grants is limited to the money in its fund. Would be applicants probably cannot challenge the program for not spending more money than it has. An applicant probably does not have a right to membership under this program if the program's funds are exhausted, although at a minimum the program must at least offer coverage at cost.

Once a contract has been awarded, however, and the plan (grantee) is accepting applications, the applicants have a right to a substantially fair process. And those persons who are enrolled within the program have a right to continued receipt of benefits, benefits which may only be withdraw or reduced under due process of law. Strikingly, there is no language in the Act about procedural protections.

### **County/Municipal Responsibility For Indigent Health Care**

Although the legislature conferred the power and responsibility upon counties to care for indigents, it is unclear what that amounts to, and especially whether any medical care for indigents comes out of that mandate. Counties may establish public hospitals which could be significant for poor persons' health, and county health departments may play some medical role for indigents to the extent they dole out free immunizations or test for and treat sexually transmitted diseases. But on the whole, the state Department of Welfare is the primary agency with the responsibility for the medical care of Pennsylvania's paupers.

This raises a disturbing question as to where persons who are not quite poor enough to qualify for GA or the Children's Health Program receive their care. It may be that counties are meeting their needs, but there is no statutory or regulatory structure which seems to assure it.

The county commissioners of counties with populations of less than 225,000 [4th through 8th classes<sup>87</sup>] have the power and duty to appropriate county funds and to provide or arrange for the

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<sup>87</sup>Classes are based on population size: Class 1: population 1,500,000; Class II: between 799,000 and 1,500,000; Class IIA: between 499,000 and 800,000; Class III: between 224,999 and 500,000; Class IV: between 149,999 and 225,000; Class V: between 94,999 and 150,000; Class VI: between 44,999 and 95,000; Class VII: population between 19,999 and 45,000, and; Class VIII: population less than 20,000. 16 P.S. § 210 [West 1997 Supp].

provision of care to “dependents”<sup>88</sup> who have settled<sup>89</sup> in the county and are not otherwise being provided for.<sup>90</sup> The county commissioners are required to follow the regulations established by the Welfare Department with respect to establishing eligibility and providing benefits,<sup>91</sup> and may collect fees to the extent of the patient’s ability to pay.<sup>92</sup>

Given that the counties are required to follow the Department of Welfare’s rules, however, it is difficult to see how this will help those individuals who are not quite poor enough to qualify under the Department’s guidelines. It is also not clear what medical services, if any, are required under this provision.

### Hospitals

The county board of commissioners of any county may acquire, hold, construct, improve, maintain and operate, own and lease, either in the capacity of lessor or lessee, general hospitals within the county for the use, benefit, health, comfort, safety and general welfare of the people of the Commonwealth and appropriate moneys from the county treasury for such purposes, or may create a municipal authority and appropriate moneys to such authority for any of such purposes.<sup>93</sup>

The residents of a county in which such a hospital is situated shall be entitled to receive care at a hospital so constructed, but the county may collect fees from the patient and/or the legally responsible relative.<sup>94</sup> It may be that these two provisions, read together, really say that any county resident is entitled to care, but that the county may collect fees from either the patient or his/her legally responsible relative to the extent it is able to do so.

### Tuberculosis (“TB”) Hospitals

Not that it is very important to the large number of low-income persons in need of basic health care, the counties may establish TB hospitals. If one hundred or more citizen county residents petition the county commissioners for the establishment of a county TB hospital, the decision as to whether to establish one shall be presented to the voters in a duly held election.<sup>95</sup>

If the county establishes a county TB, county residents shall be entitled to its services, although subject to fees imposed on them and their legally responsible relatives. Unlike the provision for county

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<sup>88</sup>A dependent means an indigent person requiring public care, including maintenance, medical care, clothing and incidentals, because of physical or mental infirmity. 16 PS 2160 [West 1996 Supp].

<sup>89</sup>Settlement, or residency rules are found at 16 P.S. §2175 [West 1997 Supp].

<sup>90</sup>16 P.S. § 2164 [West 1997 Supp].

<sup>91</sup>*Id.*

<sup>92</sup>16 P.S. § 2164(7) [West 1997 Supp].

<sup>93</sup>16 P.S. § 2199.5 [West 1997 Supp].

<sup>94</sup>16 P.S. § 2199.8 [West 1997 Supp].

<sup>95</sup>16 P.S. § 5315 [West 1956].

hospitals above, however, the statutes do provide a specific caveat that the county may not impose charges on such persons who are, after reasonable investigation, found unable to pay.<sup>96</sup>

### **Funding**

For the purposes of establishing a TB hospital, the county commissioners may issue bonds and levy an annual tax in an amount sufficient to pay the interest and sinking fund charges upon such bonds.<sup>97</sup> The funds appropriated annually to TB hospitals for operating expenses shall be obtained through levying a special tax sufficient.<sup>98</sup>

### **Local Boards of Health**

Each county of the third class may, by ordinance, create a board of health.<sup>99</sup> Such boards of health may, in addition to other standard public health services, provide gratuitous vaccinations and any other medical relief which, in its opinion, would benefit the public's health.<sup>100</sup>

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<sup>96</sup>16 P.S. §§ 5315, 5322 [West 1956].

<sup>97</sup>16 P.S. § 5325 [West 1956].

<sup>98</sup>16 P.S. § 5324 [West 1956].

<sup>99</sup>16 P.S. § 2185 [West 1997 Supp].

<sup>100</sup>16 P.S. § 2192(7 ) [West 1997 Supp].