Health & Retirement Services Of Illinois

May 2010 Newsletter

OUR NEWS LETTER

QUESTIONS ABOUT FINANCIAL RELATIONSHIP BETWEEN UNITED HEALTH GROUP AND AARP

By Patrick Yoest Of DOW JONES NEWSWIRES

WASHINGTON (Dow Jones)--Republican members of the House Ways and Means Committee on Monday sought more information about the financial relationship between UnitedHealth Group Inc. (UNH) and AARP, suggesting that the two entities were trying to hide information about their partnership from the panel.

UnitedHealth and the AARP market a number of Medicare-related plans to seniors, including private Medicare Advantage plans and supplemental insurance intended to cover ...

• April 19, 2010, 6:00 AM ET

Republicans Revive Fight With AARP Over Ties to Insurer

By Greg Hitt

The health care fight may be over on Capitol Hill, but congressional Republicans are continuing to spar with AARP, the influential seniors group that helped win passage of the sweeping bill.

Congressional Republicans had criticized AARP during the health-care fight for supporting the legislation, which made cuts in Medicare payments to health-care providers.

Now, Republicans on the House Ways and Means Committee are asking questions about AARP's financial relationship with UnitedHealth Group Inc., an insurer. AARP licenses its name to UnitedHealth, which offers seniors AARP-branded insurance products.

In a four-page letter to be sent Monday to UnitedHealth, Michigan Rep. Dave Camp, the top Republican on the House Ways and Means Committee, asks UnitedHealth for extensive information about the company's financial relationship with AARP.

Camp, along with three other committee Republicans, ask for the information to be turned over by April 26.

AARP was among several groups that supported the legislation. Groups representing hospitals, doctors and drug makers also backed the bill.

In Our Newsletter

HEALTH REFORM LAW & HOME HEALTHCARE INDUSTRY.

Health Reform Law Includes $40 Billion In Cuts To Home Healthcare Industry.

Forbes (3/24, Zendrian) reports, "The recent health reform changes will mean $40 billion in cuts toward home healthcare, according to a report issued by Oppenheimer & Co. on Monday morning. These cuts will spur consolidation in the fragmented industry that collectively took in between $70 billion and $80 billion in 2009." Data suggest that "as people are getting older, they often prefer to be taken care of at home."

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FACT CHECK ON CHILDREN WITH PREEXISTING CONDITIONS.

Obama Overstated Protections For Children With Preexisting Conditions.

The AP (3/24, Alonso-Zaldivar) reports the Administration is "scrambling to fix...a gap in coverage improvements for children in poor health. ... Under the new law, insurance companies still would be able to refuse new coverage to children because of a pre-existing medical problem, said Karen Lightfoot, spokeswoman for the House Energy and Commerce Committee." According to the AP, "In recent speeches, Obama has given the impression that the immediate benefit for kids is much more robust," but, according to Senate HELP Committee spokeswoman Kate Cyrul, "full protection for children would not come until 2014." The AP adds, "Obama's public statements conveyed the impression that the new protections for kids were sweeping and straightforward."

"Fact Check": Obama Statements On Lower Premiums May Be Inaccurate. In a "Fact Check" analysis piece, the AP (3/24, Alonso-Zaldivar) reports, "Obama says that once new competitive insurance markets open for business, in 2014, individuals buying coverage comparable to what they have today will pay 14-20 percent less. Family coverage costs about $13,400 a year, so that could be real money." However, "the president's assurance is based on a selective reading of a Congressional Budget Office report that found most individuals would probably buy better, more expensive coverage than what's available today."

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The Moral Dilemma of "Strategic Defaults"

BY DENNIS RODKIN

Last Wednesday on WGN Radio, John Williams and I were talking about "strategic defaults." That's the current term for the situation where people walk away from their mortgaged home, figuring that its value has dropped so far that they will never make anything on it. Williams and I both opposed the practice. Here is how some other people feel.

- Kathy is a Chicagoan who moved to Florida a few years ago when she married a man who had a two-bedroom condo there that cost him $190,000. Based on the sale prices of condos in their development, Kathy estimates the home is now worth only $45,000. "We stopped paying in February, after 18 months of agonizing about this," she says. Now they are looking at handing the condo back to the bank and renting a four-bedroom house—about twice the square footage of the condo—for approximately the same amount of money as the condo's $1,700 monthly payment (including taxes and assessments).

  John [Williams] is saying we have a moral obligation," Kathy says. "No, we don't. We have a legal obligation, and if we don't meet that obligation, the bank will take back the house. We're

saying, 'OK, we'll take that option. You can have the house.'"

- Bob is a mail carrier who lives in a three-bedroom ranch house in Ingleside that he bought in 1992. His mortgages, taken when the house was valued at $167,000, total $140,000, but the house's value is now at or below $130,000. Rate hikes on Bob's adjustable-rate mortgage have pushed his monthly payment from $1,223 a month to $1,506, half his monthly take-home pay. "
- Several [mortgage brokers] told me to stop paying and just pile up that money," he says. "They said it will take [the bank] at least a year to evict me, and if I've been saving up the money I can rent even with bad credit, because I'll have six months or a year of rent to put down in advance." Bob would also be in a position to pay off his credit cards and some other debts. But Bob has no plans to walk away. "I still feel the moral obligation," he says. "I've lived in this house a long time, and I would like someday to die in it. But given my current situation, it will probably be from starvation."
- Phyllais and her husband live in Batavia. In 2007 they bought a house in Phoenix for about $200,000; their daughter and son-in-law live in it and pay a portion of the mortgage. The house is now worth less than half its purchase price. "We'll never break even on it," Phyllis says. They remain current on the payments, but Phyllis says that this is for two reasons only: they don't have another home lined up for their daughter's young family, and Phyllis's husband is opposed to walking away for moral reasons. (He's also worried about the hit to their credit rating.) "If this works out financially better for my family," Phyllis says, "then we should do it. A bank or [corporation] would do the same thing."

As she contemplates her next step, Phyllis, like Kathy and Bob, feels the moral sting diminish a little every time she reads about another bank or financial firm handing out big bonuses or living it up after being bailed out by the federal government. "Sometimes," she says, "you just get tired of being screwed all the time."

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On the Horizon: Study anticipates stable housing recovery for Chicago in 2011

BY DENNIS RODKIN

After enduring a multiyear decline, the values of most homes in the Chicago area may finally increase slightly by the middle of 2011. Or so says a detailed national forecast issued this past fall by Fiserv, a Wisconsin-based financial services company. According to the report, home prices in the metropolitan region defined as Chicago-Naperville-Joliet will increase by 0.7 percent in the year ending June 30, 2011. Elsewhere, in the area that encompasses Lake County, Illinois, and Kenosha County, Wisconsin, prices will decline by 0.4 percent in that same period—an improvement over the 2.2 percent decline anticipated there for the year ending June 30, 2010. Though relatively flat, both numbers indicate that a stable housing recovery is on the horizon locally, says David Stiff, Fiserv's chief economist. "Chicago is heading toward a period of flat prices more quickly than other parts of the United States because it didn't participate in the [real-estate] bubble as much."

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Single Seniors on the Go

Ed Perkins Tribune Media Services
March 19, 2010

Don't let being single stop you from sailing the seven seas.

The tour and cruise businesses are built around the model of serving people in couples. Unfortunately, the travel industry, in general, has been slow to catch up with the country's increasing single-adult demographic. And it's still behind the times: The traditional "single supplement" can increase the singles' price by as much as 100 percent, and often by 50 percent or more. Although lots of cruise lines and tour operators target singles, their solution is almost always to pair you up with another single. If you really want to travel solo, you continue to face some serious cost hurdles.

This report was triggered by a release from the USTOA (United States Tour Operators Association), the trade association for the country's largest and most substantial operators. According to USTOA's data,

more than 40 percent of American adults are single and single travelers account for 20 percent to 40 percent of most individual tour departures. And if you're in that very large population segment, your choice often is either travel single or stay home. Seniors, especially can feel the pinch: A long-term spouse or companion may be unable to travel, or may no longer be around at all. But the problem faces travelers of just about any age.

With many singles, the main challenge is economic, not social. If you're willing to have a cruise line or tour operator find you a cabin- or roommate, you can easily get around the single supplement. That way you pay the usual "per person, double occupancy" rate, just as couples do. USTOA says that more than 60 percent of its members offer "single shares," and many other tour operators and cruise lines do the same. Some even "guarantee" a share: If they can't find you a companion of the same sex, you can travel alone at the per-person rate.

Although I've never done it, I can see some advantages to traveling with a stranger. You're together strictly to share a room or cabin for sleeping; the rest of the time, you're free to do whatever you want, whenever you want. Even if you're more social, on a tour you can hang with anyone you want in the tour group - including the roommate, if you get along well.

However, if you're wary of spending a week or more in close quarters with a stranger, you have the option of finding your own companion. Often, you can locate a traveling companion from among your usual circles - friends, relatives, co-workers, or members of your church, club, professional association or your other organizations. You can ask around or even post a notice in a newsletter, bulletin, on a board, or such.

If that doesn't work, you can still explore potential companions before you start your trip. Several membership organizations match potential travelers, including Connecting Solo Travel Network, Travel Acquaintance and Travel Chums. You enroll (usually with modest "dues") and submit a personal profile with a list of places you want to visit. The organization then sends you a list of potential matches, and, depending on your reaction, you can start contacting or even meeting with any that seem of interest. Depending on your interests beyond just travel, these organizations arrange either same- or opposite-sex matches.

If you really want to travel solo, you have a tougher problem avoiding single supplements. However, a few online agencies specialize in tours and cruises either with low single supplements or none. Among them is O Solo Mio Tours; although it, too, pushes shares, it tries to find at least a few one-person accommodations on its tours.

OTHER OPTIONS: Tour operators and cruise lines sometimes reduce or waive single supplements as a promotional gimmick, especially on last-minute deals. And some big cruise ships have a few cabins designed - and priced - strictly for solo travelers.

Of course, if nothing else works, you can shun organized tours and arrange your travel independently. You will, however, pay as much or almost as much for solo occupancy of a hotel room as double. Still, if you really want privacy, you can find it at reasonable rates.

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High-Risk Health Pool Faces Start-Up Hurdles.

By ANNA WILDE MATHEWS

The health-care overhaul enacted this past week sets a 90-day deadline for setting up a high-risk insurance pool for uninsured people with health problems, but the complexity of that task presents challenges for regulators.

Existing state insurance pools, which often contract with insurers to administer benefits, might provide a platform. The Department of Health and Human Services will start by evaluating the existing resources, an Obama administration official said.

"To the extent there are programs that work, we would like to build on them," the official said. But the administration will also consider starting a new plan or plans, the official said.

The department is "working hard to implement this bill responsibly and we are confident we will be able to meet this deadline," a spokesman said.

The law sets aside $5 billion for the new federal program, and lays out broad guidelines for eligibility and structure. People with pre-existing health conditions and without insurance for six months qualify. The

premiums are supposed to be similar to those paid in a typical "standard population" for insurance. The high-risk pool will end in 2014, when other provisions of the legislation are supposed to ensure that people with pre-existing health conditions can obtain coverage.

The new plan must cover at least 65% of the costs of participants' care on average, and it caps out-of-pocket charges at $5,950 a year for an individual or $11,900 for a family. Also, it can't exclude coverage of participants' pre-existing conditions.
That is appealing to people like Theresa Hoss, 57 years old, of Bedford, Texas. Ms. Hoss said she and her husband haven't been insured since the company that employed him shut down last year. Their application to buy individual insurance was rejected because of their pre-existing health conditions.

Ms. Hoss has diabetes, high cholesterol and high blood pressure, among other health issues, and her husband is a colon-cancer survivor who also had polio as a child. They haven't completed the process of applying for the Texas high-risk pool because they plan to move to a different state.

Ms. Hoss said they have dipped into retirement savings to pay for treatment, and she is closely watching the details of the new federal plan. "We are very hopeful," she said. "It would be absolutely a relief."

The 35 state pools often have high premiums and sometimes don't cover existing health problems for an initial period. Many existing state risk pools "have struggled" largely because of limited funds, said Deborah Chollet, a senior fellow at Mathematica Policy Research. The Florida pool has been closed to new enrollees since 1991.

The National Association of State Comprehensive Health Insurance Plans, a trade group, is pushing for the new federal program to work through the state entities, its members. "We're here, we're shovel-ready, we know the population," said Vernita Bridges-McMurtrey, chairwoman of the organization.

Legislative action is typically needed to start a new pool. Even some existing pools might need actions by state legislatures to handle the federal program, though the health bill includes language aimed at avoiding such situations. The alternative of setting up either a new national pool or separate new pools in the states without them might be daunting as well.

"Creating a new not-for-profit insurance entity is a very formidable undertaking, and you don't do it in 90 days," says Stephen Finan, senior director of policy for the American Cancer Society's Cancer Action Network.

The federal risk pool—which isn't allowed to contract with for-profit companies—may also risk running into a funding shortfall at some point, experts say. The current high-risk pools insure around 200,000 people and spent roughly $2 billion in 2008. The Government Accountability Office estimated in a report last July that roughly four million more people might be eligible in states with pools.

It is premature to say whether the funding may fall short, the administration official said, but the amount was derived from projections by the Congressional Budget Office and the GAO number likely overshoots the eligible population.

The administration official said the federal implementers "don't have time to wait for a state to start something that will take a year to get up and running." The person said there are other possibilities, such as working through insurance plans that cover states' own employees

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HEALTH REFORM LAW INCLUDES CHANGES

The changes to the health reform law contained in H.R.4872 include:

• A new 3.8 percent tax on high income taxpayers' unearned income, including annuity withdrawals. The tax will take effect in 2013. Thus, for taxpayers with modified adjusted gross income in excess of $200,000 (individual) or $250,000 (married filing jointly), annuity distributions received in 2013 and later will be subject to the 3.8% tax. Other unearned income subject to the 3.8% tax includes interest, dividends, rents, and royalties.

• An increase in the threshold at which the high value health insurance tax is triggered, and a change in the tax's effective date. The tax takes effect in 2018. It is a 40% tax, payable by "the insurer" (the insurance company or the employer or plan administrator in the case of self insurance or other non-insurance company coverage, like flexible spending accounts), if the aggregate value of the employer-

offered insurance exceeds $27,500 for dependent coverage or $10,200 for individual coverage. Stand alone dental and vision coverage is exempt from the aggregation rules. The employer is responsible for doing the aggregation calculations.

• Starting in six months, insurance policies will be required to allow coverage for adult (unmarried) children up to age 26 under their parents' policies.

• Starting in six months, insurance can no longer base coverage (availability or price) on preexisting conditions for children. Adult coverage cannot be denied based on preexisting conditions as of 2014.

• The fine for failure to comply with the individual mandate was modified. The new law will fine those who fail to carry health insurance coverage, and whose income exceeds the amount needed to be required to file federal income tax returns, as follows:

o In 2015, the fine will be the greater of $325 or two percent of income.

o In 2016 it will be the greater of $695 or 2.5 percent of income.

• Increases the "employer shared responsibility" assessment in two ways:

o The assessment goes from $750 per full-time employee to $2,000 per full-time employee, if the employer does not offer health insurance and also employs at least one person who qualifies to buy his/her own health insurance with federal subsidies. The employer's first 30 employees are not counted in calculating the assessment. Employees in the waiting period between date of hire and eligibility for the employer's health plan are not counted. Only full-time employees are counted for purposes of calculating the assessment, although "full-time equivalents" are used to determine whether the employer is subject to the rule. (Only employers with 50 or more full-time (including full-time equivalents) are subject to the rule.) Full-time equivalents are determined by counting all part-time hours worked in a month, and then dividing by 120, to reach the number of "full-time equivalent" employees the employer has. The employer responsibility rules take effect in 2014.

o The assessment on employers whose insurance is not "affordable" goes from $2,000 per affected full-time worker to $3,000 per affected full-time worker. This means that if a full-time worker has to pay more than a specified percentage of his/her salary (a sliding scale that tops out at 9.5%) for the employer's health insurance, the employer's insurance is not "affordable." If that full-time worker uses a federal subsidy to buy his/her own insurance, then the employer must pay an assessment of $3000 to help defray the cost of the subsidy for that worker buying his/her own insurance. This rule also takes effect in 2014.

• A delay of the Flexible Spending Account (FSA) cap ($2,500, indexed) effective date to 2013.

• Closes the Medicare Part D prescription drug benefit "donut hole" over 10 years—i.e., provides for coverage under Medicare Part D for the cost of all prescription drugs, not just costs below $2,830 and above $4,550.

• Modifies Medicare Advantage (MA) plan rules as follows:

o Freezes MA payments in 2011. Beginning in 2012, MA benchmarks are reduced to from 95% of Medicare spending in high cost areas to 115% of Medicare spending in low-cost areas. The benchmark reductions will be phased in over three, five or seven years, depending on the extent of the resulting payment reductions.

o Authorizes the Centers for Medicare and Medicaid Services to adjust MA risk scores for observed differences in coding patterns relative to fee-for-service.

o Requires MA plans spend at least 85% of their revenue on medical costs on activities that improve quality of care.

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FTC's Free Credit Report Rule takes effect April 2

NEW ORLEANS

A quick Google search of "free credit report" will result in a whole host of Web sites that claim to offer free credit reports, but the Federal Trade Commission is warning consumers that just because a site says it's free, doesn't mean it is.

The Problem Solvers first informed consumers about the FTC's new Free Credit Reports Rule in February, but that rule is going to officially take effect this Friday. Starting April 2, if a Web site offers a free credit report, it must, by law, include

going to officially take effect this Friday. Starting April 2, if a Web site offers a free credit report, it must, by law, include the following disclosure (with functioning, clickable links) at the top of each page that mentions free credit reports:

THIS NOTICE IS REQUIRED BY LAW. Read more at FTC.GOV.
You have the right to a free credit report from AnnualCreditReport.com
or 877-322-8228, the ONLY authorized source under federal law.

One Web site, FreeCreditReport.com, is already presenting a version of this message on the top of its site, but under federal law, it will have to present the full message after April 1. See a screen shot of the top of its Web site as of March 30 here:

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www.healthcareil.com

Nursing home industry, advocates for elderly wrangle over change.

Both sides agree overhaul needed, but not on the extent.

By Gary Marx and David Jackson, Tribune reporters 6:31 p.m. CDT, March 30, 2010

Though nursing home operators and advocates for seniors have expressed support for an overhaul of Illinois' troubled long-term care system, sharp differences are emerging in Springfield over how much change is needed.

The nursing home industry is balking at three key proposals of Gov. Pat Quinn's Nursing Home Safety Task Force, whose February report served as a starting point for legislative action. Operators are objecting to raising minimum staffing levels across the board, increasing fines and penalties for unsafe and poorly run facilities, and raising fees to help pay for new safety enforcement.

Meanwhile, some nonprofit groups advocating for the elderly and mentally ill are trying to advance various additional reforms they have championed for years.

Some senior advocates oppose the task force recommendation to license separate wings or facilities for violent patients so they will not endanger vulnerable nursing home residents. Such segregated units, they argue, would present little improvement over state-funded institutions that have offered the mentally ill inadequate therapy and support.

The legislative maneuvering follows months of stated support from industry and advocates for broad changes in Illinois' nursing homes. Quinn's panel was formed in response to Tribune reports documenting cases where elderly and disabled residents were assaulted, raped and even murdered by their housemates.

The tough and sometimes tense negotiations have been playing out in twice-weekly meetings co-chaired by task force chairman Michael Gelder and David Ellis, chief legal counsel for Illinois House Speaker Michael Madigan (D-Chicago).

State officials, elder advocates and industry representatives are now meeting in roughly two dozen smaller "working groups" in an effort to hammer out a consensus on the most difficult issues before proposed legislation moves forward in the next week or so. The General Assembly is scheduled to adjourn May 7.

It is unclear whether Madigan will use his considerable power to ensure that the bill emerging from Ellis and Gelder's committee reflects the recommendations of the task force report — and whether Madigan will then push that bill through the House. Ellis declined to comment.

"Dozens of interested stakeholders have been putting in scores of hours of effort to try and make this a legislative reality," Gelder said. "I am approaching the moment of decision where we have to decide what we will actually

accomplish in this bill. No group is likely to get everything it wants."

Illinois relies more heavily than other states on nursing homes to house younger psychiatric patients — including thousands with felony records — and understaffed facilities have failed to treat and monitor violent residents who cycle in from jails, psychiatric wards and homeless shelters, government records show.

The task force's 52-page report attempts to address problems in the system through 38 specific recommendations along with an ambitious plan to move thousands of mentally disabled people from nursing homes into smaller residential programs that provide intensive therapy and supervision for those who require it, but greater independence for those who don't.

The report was widely praised by industry and advocates for the elderly and mentally ill, but in recent weeks the two sides have laid down markers of their own.

Wendy Meltzer, executive director of the nonprofit Illinois Citizens for Better Care, said the outcome of the negotiations is uncertain given that the nursing home industry is "minimizing the need for changes."

"We just don't know ultimately where this is going," said Meltzer. "We don't know what the bill will look like."

But Terry Sullivan, regulatory director of the Health Care Council of Illinois, the state's largest nursing home trade association, said the advocates are introducing "extraneous issues that have nothing to do with nursing home safety."

"An awful lot of legislative proposals in the past six weeks go far beyond the governor's nursing home task force and the main issues raised by the Tribune series," he said.

Sullivan argues that the industry's problems center on the subset of nursing homes that mix younger mentally ill patients with the elderly and disabled. He said legislative solutions should be focused on resolving that issue.

But David Vinker, AARP's associate state director, said many Illinois nursing homes fail to reach even minimum standards for quality of care and safety.

The two sides have introduced very different legislative proposals as part of the negotiating process, and Republican and Democratic lawmakers have entered the fray, sponsoring bills and occasionally participating in roundtable negotiations led by Gelder and Ellis.

State Rep. Lou Lang, D-Chicago, has emerged as the most prominent lawmaker pushing the industry-backed proposals. On the advocate side are Democratic legislators Heather Steans, Jacqueline Collins, Mary Flowers and Julie Hamos.

The nursing home industry has long been an influential voice in Springfield, in part because local nursing facilities are among the most important employers in many Downstate communities. The industry also has donated generously to the campaigns of prominent politicians and enlisted politically connected lobbyists, according to interviews and records.

"The nursing home lobby has traditionally been very strong," said Steans, a state senator whose Uptown/Edgewater district includes several troubled facilities. "But I remain cautiously optimistic."

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www.healthcareil.com

Seniors Wary Of Healthcare Overhaul.

The AP (4/1, Alonso-Zaldivar) reports, "Seniors aren't celebrating President Barack Obama's healthcare overhaul," and Democrats "fear that seniors won't see it that way for this fall's elections." An Associated Press-GfK survey in March "found that 54 percent of seniors opposed the legislation that was then taking final shape in Congress," and last week a USA Today/Gallup Poll "found that a majority of seniors said passing the bill was a bad thing." Undoubtedly, "the broad cuts in projected Medicare payments to insurance plans, hospitals, nursing homes and other service providers will sting," but "the new law also improves the lot of many Medicare beneficiaries." AARP and "other major organizations representing seniors supported the law, despite the polls," and "now they're planning a sustained outreach campaign to call attention to the legislation's benefits. It might not be an easy sale."

http://www.washingtonpost.com/wp-dyn/content/article/2010/03/31/AR2010033102331.html

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Baffled by Health Plan? So Are Some Lawmakers.

By ROBERT PEAR Published: April 12, 2010

WASHINGTON — It is often said that the new health care law will affect almost every American in some way. And, perhaps fittingly if unintentionally, no one may be more affected than members of Congress themselves.

In a new report, the Congressional Research Service says the law may have significant unintended consequences for the "personal health insurance coverage" of senators, representatives and their staff members.

For example, it says, the law may "remove members of Congress and Congressional staff" from their current coverage, in the Federal Employees Health Benefits Program, before any alternatives are available.

The confusion raises the inevitable question: If they did not know exactly what they were doing to themselves, did lawmakers who wrote and passed the bill fully grasp the details of how it would influence the lives of other Americans?

The law promises that people can keep coverage they like, largely unchanged. For members of Congress and their aides, the federal employees health program offers much to like. But, the report says, the men and women who wrote the law may find that the guarantee of stability does not apply to them.

"It is unclear whether members of Congress and Congressional staff who are currently participating in F.E.H.B.P. may be able to retain this coverage," the research service said in an 8,100-word memorandum.

And even if current members of Congress can stay in the popular program for federal employees, that option will probably not be available to newly elected lawmakers, the report says.

Moreover, it says, the strictures of the new law will apply to staff members who work in the personal office of a member of Congress. But they may or may not apply to people who work on the staff of Congressional committees and in "leadership offices" like those of the House speaker and the Democratic and Republican leaders and whips in the two chambers.

These seemingly technical questions will affect 535 members of Congress and thousands of Congressional employees. But the issue also has immense symbolic and political importance. Lawmakers of both parties have repeatedly said their goal is to provide all Americans with access to health insurance as good as what Congress has.

Congress must now decide what steps, if any, it can take to deal with the problem. It could try for a legislative fix, or it could adopt internal policies to minimize any disruptions.

In its painstaking analysis of the new law, the research service says the impact on Congress itself and the intent of Congress are difficult to ascertain.

The law apparently bars members of Congress from the federal employees health program, on the assumption that lawmakers should join many of their constituents in getting coverage through new state-based markets known as insurance exchanges.

But the research service found that this provision was written in an imprecise, confusing way, so it is not clear when it takes effect.

The new exchanges do not have to be in operation until 2014. But because of a possible "drafting error," the report says, Congress did not specify an effective date for the section excluding lawmakers from the existing program.

Under well-established canons of statutory interpretation, the report said, "a law takes effect on the date of its enactment" unless Congress clearly specifies otherwise. And Congress did not specify any other effective date for this part of the health care law. The law was enacted when President Obama signed it three weeks ago.

In addition, the report says, Congress did not designate anyone to resolve these "ambiguities" or to help arrange health insurance for members of Congress in the future.

"This omission, whether intentional or inadvertent, raises questions regarding interpretation and implementation that cannot be definitively resolved by the Congressional Research Service," the report says. "The statute does not appear to be self-executing, but rather seems to require an administrating or implementing authority that is not specifically provided for by the statutory text."

The White House said last month that Mr. Obama would voluntarily participate in the health insurance exchange, though the law does not require him or other administration officials to do so. His participation as president may depend on his getting re-elected in 2012.

Representative Jason Chaffetz, Republican of Utah, said lawmakers were in the same boat as many Americans, trying to figure out what the new law meant for them.

"If members of Congress cannot explain how it's going to work for them and their staff, how will they explain it to the rest of America?" Mr. Chaffetz asked in an interview.

The provision governing members of Congress can be traced to the Senate Finance Committee. When the panel was working on the legislation last September, Senator Charles E. Grassley, Republican of Iowa, proposed an amendment to require that elected federal officials and all federal employees buy coverage through an exchange, "rather than using the traditional Federal Employees Health Benefits Program."

A scaled-back version of the amendment, applying to members of Congress and their aides, was accepted in the committee without objection.

The federal employees program, created in 1959, now provides coverage to eight million people and, according to the Congressional Research Service, is the largest employer-sponsored health insurance program in the country.

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TIMELINE CHART FOR HEALTH CARE REFORM LEGISLATION.

National Association of Health Underwriters
How the Health Care Reform Legislation Will Impact
Your Individual and Employer Clients
March 29, 2010

http://www.healthcareil.com/newsletter_files/HCreformtimeline.pdf

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5 PROVISIONS EFFECTIVE IN 2010.

There are five provisions effective this year that will be of great interest to you.

1. **Dependent Coverage Extended to Age 26 (beginning with plan years on or after September 23, 2010)**
    1. Dependent children must be covered until the child reaches age 26. This includes married dependent children, but does not include the spouse or grandchildren
    2. Grandfathered plan may exclude such dependent children if they are eligible for coverage under another employer-sponsored plan
    3. Dependent age extension applies only to medical plans
2. **No Lifetime Limits (beginning with plan years on or after September 23, 2010)**
    1. No lifetime dollar limits on the value of "essential benefits"
    2. Lifetime limit prohibition does NOT apply to non-essential benefits
    3. Grandfathered plans may not receive this benefit change until their next scheduled renewal date
    4. Prohibition on lifetime limits applies only to medical plans
3. **No Pre-existing Condition Exclusions for Dependent Children (beginning with plan**

years on or after September 23, 2010)

1. Prohibits pre-existing condition exclusions on children under the age of 19
2. Prohibition of pre-existing condition exclusions for adults takes effect in 2014
3. Prohibition on pre-ex applies only to medical plans

4. **Retiree Reinsurance Program (Beginning June 23, 2010)**
    1. New program to encourage employers to maintain benefits to retirees over 55 and not eligible for Medicare
    2. The program will reimburse employer-provided health plans for 80 percent of certain costs of providing health insurance to early retirees
    3. Reimbursement applies only to claims that exceed $15,000 but are no greater than $90,000
5. **Small Business Tax Credit (Effective Now)**
    1. Must cover at least 50 percent of the cost for workers, pay average annual wages below $50,000, and have less than the equivalent of 25 full-time workers (i.e. a firm with fewer than 50 half-time workers would be eligible)
    2. Tax credit worth up to 35 percent of the premiums (25 percent for nonprofits)
    3. Full credit is available to firms with average wages below $25,000 and less than 10 full-time equivalent workers.
    4. Phases out gradually for firms with average wages between $25,000 and $50,000 and equivalent of between 10 and 25 full-time workers

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national women's health week
May 9-15, 2010

Woman's Health Week.

National Women's Health Week is a weeklong health observance coordinated by the U.S. Department of Health and Human Services' Office on Women's Health (OWH). National Women's Health Week empowers women to make their health a top priority. With the theme "It's Your Time," the nationwide initiative encourages women to take simple steps for a longer, healthier, and happier life. Important steps include:

• Getting at least 2 hours and 30 minutes of moderate physical activity, 1 hour and 15 minutes of vigorous physical activity, or a combination of both each week

• Eating a nutritious diet

• Visiting a health care professional to receive regular checkups and preventive screenings

• Avoiding risky behaviors, such as smoking and not wearing a seatbelt

• Paying attention to mental health, including getting enough sleep and managing stress

Learn more about National Women's Health Week.
http://www.womenshealth.gov/whw/about/

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To contact us: go to www.healthcareil.com or
Call (800) 739-4700