Health & Retirement Services Of Illinois

June 2012 Newsletter

OUR NEWS LETTER HRSI

Physicians fight "unworkable" Medicare overpayment rule

More than 100 physician organizations adamantly oppose a requirement that practices keep 10 years of records to identify possible excess pay.

By CHARLES FIEGL, amednews staff. ***Posted April 30, 2012.***

Washington Organized medicine is pushing back against a Medicare proposal to recoup overpayments quickly from physicians, who would be required to go back through up to 10 years of medical records when determining if they received excess pay.

The American Medical Association and state and specialty medical organizations have called on the Centers for Medicare & Medicaid Services to clarify — or in some cases abandon — new requirements that practices must return overpayments within 60 days. About 110 groups, led by the AMA, sent an April 16 letter to CMS acting Administrator Marilyn Tavenner calling on the agency to make necessary changes before the proposal is finalized.

The AMA specifically requested several revisions to the overpayment proposal that would reduce administrative burdens for physicians significantly, said AMA Chair-elect Steven J. Stack, MD. "Current CMS initiatives, like the Medicare recovery audit program, are already in place, and conflicting requirements will make it difficult for physicians to know which guidelines to follow."

CMS has proposed that physicians be able to review their previous 10 years of claims to identify any overpayments that might be suspected during that time frame. The 10-year look-back is inappropriate, wrote Paul A. Hamlin, MD, president of the Medical Society of the State of New York, in a March 27 letter. The medical society would support the retrospective period only if its intent was "to put the fear of the federal government into those who knowingly and willfully with malice of intent act to defraud" the Medicare program. But the consequences of innocent mistakes by physicians and practice administrators must not also be swept up by rules aimed at those knowingly committing fraud and abuse, he said.

"To subject individuals to persecution because of impossible, unworkable, and unattainable rules and regulations is unfair and might even constitute entrapment," Dr. Hamlin wrote. "Often, many Medicare program rules are impossible to keep current or are difficult to follow, let alone comply with, without confusion, error or mistakes. Lumping billing errors and typographical errors into the mix of fraud and abuse is preposterous."

In Our Newsletter

The AMA letter also adamantly opposes the 10-year look-back window. Combing through up to a decade's worth of records would be an "insurmountable burden" for physicians. The proposal conflicts with claims reopening and audit standards established by other Medicare statutes. In general, physicians are bound to retain records for about six years, the letter said.

For instance, Medicare's reopening regulation allows claims to be reconsidered within one year for any reason, within four years with good cause and further back any time when there is clear evidence of fraud. The False Claims Act allows for a six-year look-back. The Health Insurance Portability and Accountability Act requires record retention for six years. However, the Medicare recovery audit contractor program, which is similar to the overpayment recovery initiative, allows for only a three-year look-back.

"We recommend [that the look-back period] be shortened to three years to remain consistent with other initiatives," Dr. Stack said. In addition, physicians who are required to return an overpayment but disagree with that determination should be given the chance to appeal, he added.

Physicians demand clarifications

The AMA also sought clarification of what it meant for a physician to identify an overpayment. CMS had stated that the rule created an "incentive to exercise reasonable diligence to determine whether an overpayment exists." But the rule should not imply that doctors must actively search for overpayments from a decade's worth of claims without some piece of information that would signal that an excess payment might have been received, the Association said.

The proposed rule essentially would create an unfunded mandate that forces medical practices to conduct self audits and apply compliance plans, wrote American Academy of Family Physicians Board Chair Roland A. Goertz, MD, in an April 11 letter.

"Though often recommended business practices, they are time-consuming, expensive and never before required by Medicare," he said. "Further troubling is that this considerable burden is not even addressed in the regulatory impact section" of the proposed rule.

The health system reform law specified that the 60-day period to return an overpayment begins when a physician practice identifies it. However, the proposed rule lacked clarity on when the two-month countdown begins in cases where several overpayments stemming from a systemic problem may exist. The Association recommended that CMS say the 60-day period begins on the day an "error-specific overpayment inquiry has concluded."

The AMA letter also calls for adding an appeals process to the rule, because medical billing is complex, and Medicare rules can be difficult to interpret across the health care industry. The agency also has allowed for an appeals process in the recovery audit contractor program.

Consultant Gerald Rogan, MD, proposed other changes to the CMS rule that would educate doctors about potential liabilities and how overpayment situations can occur. Dr. Rogan, of Sacramento, Calif., is a former CMS medical director for a Medicare insurance carrier.

Common mistakes can create significant liabilities for doctors. For instance, a physician may mistakenly report an excess number of anesthesia units or improperly use a coding modifier when billing services, he said.

"I recommend CMS post a list of common reporting errors and supply the information as part of the provider enrollment process," Dr. Rogan wrote. "This information will allow new Medicare providers some means to verify the practice he/she is joining is compliant with Medicare billing rules."

U.S. health care spending 'dwarfs' that of other countries

The study concluded that the high price tag isn't because of more doctor visits. | AP Photo

By KATHRYN SMITH | 5/3/12

The United States spends more on health care than 12 other industrialized countries, a new Commonwealth Fund study finds – but that doesn't mean this country's care is any better.

The U.S. spent nearly $8,000 per person for health care services in 2009, the study found, confirming that "health care spending in the U.S. dwarfs that found in any other industrialized country."

David Squires, senior research associate at The Commonwealth Fund and the primary author of the study, found Norway and Switzerland were a distant second and third, respectively, on medical spending, at a little more than $5,000 per person.

The study is an update of past analyses by The Commonwealth Fund that compare U.S. health spending with trends in other countries.

The Commonwealth Fund concluded that this country's high price tag for health care isn't because of more doctor visits — the U.S., with an average of about four visits per person in 2009, ranked at the bottom for the number of doctor consultations. And it isn't because of lengthy hospital treatments — the study found the U.S. had shorter hospital stays, as well as a smaller number of hospital beds and discharges.

"It is a common assumption that Americans get more health care services than people in other countries, but in fact, we do not go to the doctor or the hospital as often," Squires said in a statement accompanying the study.

So what's causing the U.S.'s cost problem? The Commonwealth Fund points to high prices for medication and medical services, as well as a good deal of use of expensive technology, such as MRIs and CT scans. And at least a third of the American population is obese, a condition that drives up health spending.

The high rate of spending in the U.S. doesn't necessarily make for a high standard of care, however.

"The findings make clear that despite high costs, quality in the U.S. health care system is variable and not notably superior to the far less expensive systems in the other study countries," Squires wrote.

Data showed the U.S. had the highest survival rate among the countries for breast and colorectal cancer — but fared poorly when it comes to deaths from asthma and amputations due to diabetes. The U.S. suffers from "a failure to effectively manage these chronic conditions that make up an increasing share of the disease burden," Squires said.

Japan, which had the lowest medical spending of the 13 countries, uses strong price regulation to keep costs down. The study found that heath spending in Japan increased by just 2 percentage points in two decades — whereas it rose by 8 percentage points in the U.S. during that time.

The Commonwealth Fund study drew its findings from data from the Organization for Economic Cooperation and Development. It compared the U.S. with Australia, Canada, Denmark, France, Germany, Japan, the Netherlands, New Zealand, Norway, Sweden, Switzerland and the United Kingdom.

WARNING SIGNS OF ARTHRITIS

7 Warning Signs of Arthritis

Paula Spencer Scott Monday, April 30, 2012

1. 

7 Early Warning Signs of Arthritis

2. 

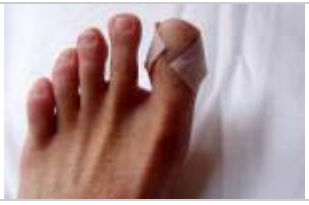
Morning stiffness

3. 

Pain when climbing stairs

4. 

Fatigue, flu-like symptoms

5. 

Sudden, excruciating pain in a big toe

6. 

Odd-looking bumps on fingers

7. 

Pain that interferes with sleep

8. 

Achy, hard-to-use hands

Think arthritis is just for the old? Half of those who get it are under age 65. One in five adults -- 50 million Americans-- has been diagnosed with arthritis. Most wait to see a doctor until pain interferes with daily life -- but pain isn't the only sign of trouble.

"Early is better with arthritis diagnosis," says Arthritis Foundation Vice President Patience White, a professor of medicine and pediatrics at the George Washington University School of Medicine and Health Sciences in Washington, D.C. Treating the autoimmune disease rheumatoid arthritis (RA) within the first months of onset, for example, can minimize joint deformities and even put the disease into remission, thanks to the latest treatments. With osteoarthritis (OA), a degenerative joint disease that's the most common kind of arthritis, the sooner you start behavioral changes, the better you may be able to manage pain and preserve mobility, White says.

Health care costs worry workers nearing retirement

By Christine Dugas, USA TODAY

Health care costs are a top retirement fear, and that's even though many older workers vastly underestimate how much they'll have to pay.

- 

Joe Brier, for USA TODAY

Karl Keul visits with audiologist Dr. Ken Henry to have his hearing checked in Falls Church, Va.

"Americans — even those who have diligently saved for their golden years — are not prepared for the reality of health care costs in retirement and don't really understand how Medicare works," says John Carter, president of Nationwide Financial Distributors.

Nearly half of affluent Americans, who have at least $250,000 in household assets, say they are scared that rising health care costs will deplete their retirement savings, according to a Harris Poll released today by Nationwide Financial.

And 43% of the affluent older workers don't know how much they will spend for health care in retirement, the survey says.

The pre-retirees who expect health care to be their biggest retirement expense estimated that their average annual health care cost will total $5,621. But that is a drastic underestimate. Citing a 2011 Fidelity study, Nationwide says out-of-pocket health care expenses will average as much as $10,750 a year.

One big reason is that pre-retirees often wrongly assume that Medicare covers the cost of long-term care, Carter says. That is a wake-up call that Americans need good financial advice to prepare for their future health care costs, he says.

"There are a lot of things that are not covered" by Medicare such as most eye care, dental and hearing, says Henry "Bud" Hebeler, a former Boeing executive who developed the retirement planning website analyzenow.com. "I've had to have two pairs of hearing aids so far and they cost me over $5,000 each time, says Hebeler, 78.

People also don't realize that Medicare will be financed partly by premiums deducted from Social Security checks, Hebeler says. "Depending on a retired couple's income, their annual Medicare cost could be over $9,000 a year," he says.

Last month, a government trustee report said that Medicare will be exhausted by 2024 and Social Security by 2033. That reality is forcing many workers to plan to work longer. This year, 57% of workers who have $50,000 to $250,000 in household assets plan to push back their retirement, citing health care costs as their top financial concern, up from 36% in 2011, says Bank of America's Merrill Edge report.

"Nobody gives workers a clue" about the rising cost of health care, Hebeler says. "It's incredible how many have no idea what's coming at them."

Top 6 Workout Recovery Foods

Wednesday, May 2, 2012 by: Dual Fit

Lifting is great and some people enjoy the soreness they feel the next day after an intense workout while others really can't stand it -- especially if they did a crazy leg workout. But you know the phrase: You can feel sore or you can feel sorry. Feeling sore can offer a sense of achievement. Still, it's important to recover from many long training sessions, so try incorporating the foods below to recuperate more quickly.

Why Do I Feel Sore? Many people feel the soreness but aren't sure where the pain comes from. The question that I get most often is, "How come I feel sore the day after, but not that same day?" The answer is Delayed Onset Muscle Soreness (DOMS). So what causes this? When you work out, you are creating tiny tears in your muscles. This is normally a result of high intensity exercises such as heavy lifting or sprinting. Your muscles then want to recover, so they begin to heal themselves. Consuming an adequate amount of protein and nutrients, while giving your body enough time to rest helps accomplish this; and your muscles are built during this phase. That's why recovery days are very important.

1) Whole Grain Cereal: You may have heard that you should eat carbs *before* a workout, which is true, but you should also consume them after as well. Carbohydrates can help your body fight the fatigue that it feels after a workout by restoring your glycogen stores. When you exercise, you are using up all of your glycogen stores (or energy stores.) It's really important to replenish them after a workout so that you do not experience that sleepy feeling. Any carbohydrate snack will do but whole grains are always the best choice.

2) Cherries: Cherries are kind of like a magical fruit. They have many anti-inflammatory properties, which are really important for relieving muscle soreness. The antioxidant that gives cherries this healing ability is called anthocyanins. Many athletes consume tart cherry juice prior to workouts for this reason. Instead of popping that ibuprofen or Advil, reach for some nice, fresh cherries or cherry juice instead.

3) Nuts: Walnuts, almonds, brazil nuts -- whatever kind of nuts you want. All kinds of nuts are very high in Vitamin E. This vitamin has muscle strengthening powers which will ultimately help to fight muscle soreness. Once you begin to get stronger, you will notice that you are not as sore as you were when you first began training. When you have been training for a while, your muscles are stronger and you don’t tear the muscle as much as you did in the beginning. Less tears equals less soreness. Vitamin E also helps repair the damage that

was done to the muscle tissue. Eat foods high in Vitamin E, like nuts, to help build that muscle strength…and keep training.

4) Berries: Berries such as strawberries, blueberries, blackberries and raspberries all contain antioxidants called polyphenols. These antioxidants are what protect your cells against damage. Aside from their ability to reduce muscle pain, they also help protect against all the other damages that can be done to our cells that can cause cancer. Generally, the darker the berry, the more antioxidants it contains so try to eat dark berries such as blackberries and blueberries. They are a healthy and delicious snack. You can even throw them into your protein shake for an added bonus.

5) Salmon: Fish in general is loaded with protein and a ton of essential fatty acids. Fatty acids help to reduce inflammation which in turn fights muscle soreness. Not a fan of fish? Take a fish oil supplement.

6) Eggs: Particularly egg yolks. Ignore the cholesterol factor. Eggs are high in protein and Vitamin D. Both of these two things help fight muscle soreness and aid in muscle growth. Vitamin D has become one of the biggest deficiencies in the American diet. It is really important to consume foods high in this vitamin, especially to help reduce muscle pain. Many people tend to get rid of the yolk of the egg because of the added cholesterol and calories but those calories in the yolk are all really good calories. They provide vitamin D and protein. Eat the whole egg. If you do have high cholesterol, try to limit yourself to a couple whole eggs a week and consume Vitamin D fortified low fat milk.

Overview: All of these foods are high in many nutrients and vitamins that your body needs on a daily basis in order to sustain life. They all have the ability to reduce muscle soreness and inflammation so it's important to include them in your diet. Now, they aren't really "super" foods. If you have sore muscles and eat some eggs, you aren't going to automatically feel better but they will aid in the healing process. Aside from getting the right nutrients, it's important to allow yourself some rest. Taking one to two days a week off heavy training will be very beneficial for body. If you are an exercise freak and *need* to get to the gym, take it easy. Do some light cardio or lift lighter. You really only experience soreness when you push yourself to your limits.

MAYO CLINIC ON ASPIRIN

Subject: Mayo Clinic on Aspirin

Mayo Clinic Aspirin
Dr. VirendSomers, is a Cardiologist from the Mayo Clinic, who is lead author of the report in the July 29, 2008 issue of the Journal of the American College of Cardiology.

Most heart attacks occur in the day, generally between 6 A.M. and noon. Having one during the night, when the heart should be most at rest, means that something unusual happened. Somers and his colleagues have been working for a decade to show that sleep apnea is to blame.

1. If you take an aspirin or a baby aspirin once a day, take it at night.
The reason: Aspirin has a 24-hour "half-life"; therefore, if most heart attacks happen in the wee hours of the morning, the Aspirin would be strongest in your system.

2. FYI,

Aspirin lasts a really long time in your medicine chest for years, (when it gets old, it smells like vinegar).

Please read on.

Something that we can do to help ourselves - nice to know.
Bayer is making crystal aspirin to dissolve instantly on the tongue. They work much faster than the tablets.

Why keep Aspirin by your bedside? It's about Heart Attacks -

There are other symptoms of a heart attack, besides the pain on the left arm. One must also be aware of an intense pain on the chin, as well as nausea and lots of sweating; however, these symptoms may also occur less frequently.

Note: There may be NO pain in the chest during a heart attack.

The majority of people (about 60%) who had

a heart attack during their sleep did not wake up.
However, if it occurs, the chest pain may wake you up from your deep sleep.

If that happens, immediately dissolve two aspirins in your mouth and swallow them with a bit of water.

Afterwards:
- Call 911.
- Phone a neighbor or a family member who lives very close by.
- Say "heart attack!"
- Say that you have taken 2 Aspirins.
- Take a seat on a chair or sofa
near the front door, and wait for their arrival and

...DO NOT LIE DOWN!

Choosing the Best Sunscreens - and Avoiding the Worst

By Sarah B. Weir, Yahoo! blogger | Healthy Living

Is your sunscreen safe? It's sunscreen shopping season and the just-released 2012 Sunscreen Guide published by the Environmental Working Group (EWG) helps steer consumers toward healthy, affordable choices. This year's guide rates over 1,800 sunscreens (for both adults and kids), lip balms, and moisturizers and cosmetics with SPF. The leading cause of skin cancer is exposure to ultraviolet (UV) radiation from the sun and, according to the National Cancer Institute, over one million people are diagnosed a year.

Often people grab whatever sunscreen is labeled with the highest SPF and assume it's the best. The EWG guide warns shoppers that choosing a safe product isn't just about the numbers. Their research spotlights potential health hazards:

Dangerous ingredients. Retinylpalmitate (Vitamin A) may cause tumors and lesions to develop more quickly when skin is exposed to the sun. NnekaLeiba, Senior Research Analyst and the guide's lead author, tells Shine, "The FDA and National Toxicology both say it may heighten risk of skin damage and cancer." Oxybenzone is linked to hormone disruption and can cause allergic reactions. EWG recommends choosing products with one of these ingredients instead: zinc, titanium dioxide, avobenzone, or Mexoryl S.

Sprays or powders. These formulations can fill the air with tiny particles that EWG says are dangerous to inhale. They can cause lung inflammation and may be carcinogenic.

SPF values above 50+. The FDA says these labels are misleading and may encourage people to stay out in the sun for too long. Since SPF is based only on UVB protection (which prevents sunburn but does not guard against premature aging and deeper tissue damage), users of super high SPF products often have a false sense of security.

The guide comes on the heels of a recent announcement by the Food and Drug Administration (FDA) that they will give sunscreen manufacturers an additional six months to comply with guidelines that were that were outlined in June, 2011 and were aimed to ending confusion about sunscreen labeling. The FDA guidelines, which were to go into effect June 18, encouraged companies to use ingredients that protect against both UVB and UVA rays, required warning labels on products with lower than an SPF 14 rating, and banned manufacturers from using unsubstantiated terms such as "waterproof," "sunblock," and claims of "all-day protection."

Since the FDA guidelines now won't go into effect until long past beach season, the EWG Sunscreen Guide is your best bet for finding effective products.

EWG's list of worst sunscreens

The EWG recommends avoiding these sunscreens because they are spays or powders, have SPF values above 50+, and contain retinylpalmitate and/or oxybenzone.

Neutrogena Fresh Cooling Body Mist Sunblock, SPF 70

Banana Boat Sport Performance Active MAX Protect Continuous Spray Sunscreen, SPF 110

Aveeno Continuous Protection Sunblock Spray Active, SPF 70

Wegmans Sheer Sunscreen Body Mist, SPF 55

Rite Aid Extreme Sport Continuous Spray, SPF 70+

CVS Sheer Mist Sunscreen, SPF 70

Walgreens Sheer Body Mist Sunscreen Spray, SPF 70

Coppertone Sport Clear Continuous Spray Sunscreen, SPF 90

Best affordable sunscreens

- Based on its analysis of over 800 beach and sport sunscreens, the EWG provided Yahoo! Shine with its 15 most affordable, recommended products:
- Coppertone Kids Pure & Simple Sunscreen Lotion, SPF 50
- BabyGanics Cover Up Baby Sunscreen for Face & Body, Fragrance Free, SPF 50+
- Sunbow Dora the Explorer Sunscreen, Pink, SPF 30
- Purple Prairie Botanicals SunStuff Mineral Lotion, SPF 30
- Nature's Gate Aqua Block Sunscreen Lotion, SPF 50
- Solbar Shield Sunscreen, SPF 40
- Caribbean Solutions Sol Kid Kare Biodegradable Sunscreen, SPF 25
- Tropical Sands Broad Spectrum Sunscreen, SPF 30
- KidsUV Natural Sunscreen, Blue, SPF 30
- Color Me Pink Baby UV/ Kids UV 100% Natural Sunscreen, SPF 30
- Alba Botanica Natural Very Emollient Sunblock, Kids Mineral Protection, SPF 30
- Blue Lizard Australian Sunscreen, Face, SPF 30+
- Healing-Scents Live Long Mineral-Based Sunscreen, SPF 25
- Hara Body Care Hara Sport Sunscreen, SPF 30
- Vanicream Sport Sunscreen Lotion, SPF 35

All of the above meet the following criteria:

- Good, stable sun protection
- Fewest ingredients with toxicity concerns. Do not contain the worst offenders: retinylpalmitate and oxybenzone.
- No sprays or powders
- No SPF values above 50+

Applying sunscreen correctly

It is important to be aware that sunscreen isn't going provide you with proper protection if you don't apply it correctly, and only about one in five people actually do so on a daily basis.

"Adults need to apply a palmful [an ounce] of sunscreen every two hours," Leiba tells Shine. "Don't slather it on once and stay out all day." Leiba also recommends that you avoid the sun completely from 10AM to 2PM and use a hat, clothing, and sunglasses as your primary protection.

Opinion: Tax hikes will exact steep price

By Judd Gregg - 05/14/12

> If current law goes into effect, consider the changes that 2013 will bring:
>
> Payroll taxes will increase by $120 billion; bonus depreciation will end, adding $64 billion in taxes; the Affordable Care Act, also known as ObamaCare, will kick in, adding $46 billion in taxes; the tax cuts will end for upper-income Americans, increasing taxes by $83 billion; the tax cuts will end for middle-income Americans, increasing taxes by $198 billion.

The likely consequences are obvious. Such a massive increase in taxes will lead to a significant slowdown in the economy as investment and disposable income both drop dramatically. People and businesses will have to retrench in order to deal with these higher taxes.

This will result in less economic activity and potentially less revenue for the federal government. The opportunity to partly address deficit problems through economic growth will be lessened, and this will ensure that our deficits and debt situation will continue to grow and become even more of a drag on our prosperity and national culture.

Yet along with these evident effects of the tax increase gluttony, there will also be a number of very significant occurrences that have, so far, gone unnoticed or at least not discussed — especially by this administration, which is so enamored of taxing more people at higher rates to support its massive expansion in the size of the federal government.

First, under the Obama plan, the tax on dividend income will jump to a record high. It will go from 15 percent to a new top rate of 43.4 percent. This will create numerous unintended consequences that will pervert investment decisions and drive down economic activity.

For people who are retired and living on a fixed income, it will mean a massive adjustment. This is especially pernicious as we head into a time when the largest generation in American history, comprised of the so-called baby boomers, is moving into retirement. This is the first generation in history to retire depending primarily not on defined benefit plans but rather on contribution plans that are disproportionately comprised of dividend income.

Thus this generation, aging out of alternative ways to generate income, will find itself being socked with a tax increase promoted by the left as a prerequisite for “fairness.” It will be a bitter pill to swallow for a lot of people whose only pathway to adjusting to their reduced income will be through a commensurate reduction in their standard of living — and all this to feed the left’s insatiable appetite for a large and more costly government.

In addition, the tax on capital gains will go from 15 percent to 23.8 percent. It is also fairly certain that the new 3.8 percent tax on passive income will take effect. Both of these changes will further retard any possibility of economic expansion.

We must also consider the effect that these tax increases on capital gains and especially dividends will have on stocks. Companies that pay dividends have seen their stock price surge amid the extremely low interest rates of the last few years, for the simple reason that people have sought a better return through dividends.

These companies are going to see their stock prices come under pressure. The attractiveness of investing in dividend-paying stocks will be significantly muted when the tax rate on those dividends jumps from 15 percent to as high as 43.4 percent.

Thus the baby boom generation takes a double hit. First, income is impacted by the higher tax on their dividends; second, the value of their portfolio is reduced due to the fall in the value of dividend-paying stocks.
All this will lead to a further contraction in economic activity by a generation that has lost considerable spending and savings power through the simple act of getting old. This cannot be good for the nation or the economy as a whole.
When the tax man cometh, he brings with him a whole array of unintended consequences.
Judd Gregg is a former governor and three-term senator from New Hampshire who served as chairman and ranking member of the Senate Budget Committee and as ranking member of the Senate Appropriations subcommittee on Foreign Operations. He also is an international adviser to Goldman Sachs.

Immigration status is a health policy challenge

Medicaid may become more accessible for legal immigrants who have been here five years. | AP Photo

By KYLE CHENEY | 5/16/12

The Obama administration's drive to cut down on America's uninsured is about to get multilingual.

Come 2014, when core provisions of the Affordable Care Act kick in, millions of legal immigrants will have new options for gaining health coverage. And like U.S. citizens, most will be subject to the individual mandate, under which they will be required to get coverage to avoid a penalty.

The national health law explicitly excludes illegal immigrants — a politically explosive topic — and bans them from the new state insurance exchanges, even if they use their own money. They will make up a big chunk of the remaining uninsured population. But advocates say states have good reasons to reach out and get uninsured legal residents covered — especially as the federal government picks up most of the tab.

"States with high immigrant populations are definitely looking forward to seeing how the Affordable Care Act is going to be able to provide the state more options for those immigrants," said SonalAmbegaokar, a health policy attorney at the National Immigration Law Center. According to the Henry J. Kaiser Family Foundation, noncitizens — legal and illegal — are three times as likely as native-born citizens to be uninsured.

In 2014 — assuming the health law survives the Supreme Court and hasn't been undone by a new administration — legal immigrants will be able to shop for health coverage through the new state insurance exchanges. They can get the same income-linked subsidies as citizens.

Legal immigrants' five-year federal waiting period for Medicaid, approved in 1996, won't change. But for legal immigrants who have been here five years, Medicaid may be more accessible because it's being expanded and the eligibility rules are being broadened. Traditionally, the states and Washington have split the costs of covering this low-income population, but Washington will pay more for the newly eligible.

States have the option of waiving the five-year rule for legal immigrants, but they must use their own funds, and only about 15 have done so, according to Kaiser. More have lifted the rules for children and pregnant women in the Children's Health Insurance Program, Kaiser found.

Health policy experts say states have reasons to encourage legal immigrants to enroll in their exchanges. Most eligible immigrants are relatively young and healthy — part of a population states want to have in an insurance pool to spread the risk and make the market work.

“The overall benefit of having the legal resident population in is it tends to be younger, and therefore, it can be healthier,” said Ruselle Robinson, a Boston-based health care attorney. “That is the group that the individual mandate is trying to bring in.”

“It’s to a state’s advantage to really outreach and make sure all those immigrants who are eligible get enrolled,” agreed Ambegaokar.

One policy challenge has to do with “mixed-status” families. Those are families in which the children are legal, but one or both parents are not. About 6 million kids were in such families in 2010, the Urban Institute estimated. According to Kaiser report, those children are “are at increased risk of being uninsured.” The reason, Ambegaokar said, is many families with mixed status are hesitant to access the health care system, and others aren’t clear that some of their relatives may be eligible for coverage.

Even if states have energetic outreach efforts and boost enrollment among legal immigrants, they will face the daunting problem of care for undocumented immigrants — about 10 million in 2010, according to the Pew Hispanic Center. Payments to hospitals that treat disproportionate numbers of poor and uninsured patients will be cut under the health law because there will be fewer without coverage. But hospitals must provide emergency care to everyone. Any solutions will unfold in the charged environment that immigration policy engenders.

Even health care for legal residents can create political storms. Massachusetts state lawmakers tussled with Gov. Deval Patrick in 2009 when they attempted to strip subsidized health insurance from tens of thousands of lawful immigrants to help balance the budget. At Patrick’s insistence, those immigrants were instead placed in a program with reduced benefits. This year, the Massachusetts high court ruled the less-generous program is discriminatory and ordered state officials to return the immigrants to the state’s insurance exchange.

Will Adult Children Have to Pay Mom's Nursing Home Costs?

A Pennsylvania state appeals court has ruled that the adult son of a nursing home resident is responsible for her unpaid $93,000 bill. And the decision has some elder care lawyers wondering if this is just the beginning of a trend.

Pennsylvania is one of 30 states that have filial responsibility statutes—laws that impose a duty on adult children to care for their indigent parents. About two-thirds of those states, including Pennsylvania, allow long-term care providers to sue family members to recover unpaid costs. The rest, including states such as Massachusetts, have no recovery provisions. However, failing to care for a parent is a criminal offense. In the Bay State, the penalty is a $200 fine or up to one year in jail.

The rules vary widely from state to state. But most take into consideration the adult child's ability to pay. For example, a daughter would be protected if she also has extensive bills for her own child's college education. In some states, such as Maryland, only the nursing home resident is responsible for a bill, although family members can voluntarily agree to help pay.

 **Howard Gleckman**Contributor

A Startling Reality: Your Aging Parent Runs Out of Money  **Carolyn Rosenblatt**Contributor

How Much Should You Help Your Aging Parents Financially?

Make Long-Term Care Insurance Part Of Health Care  **Howard Gleckman**Contributor

And federal law prohibits states from going after families after someone is already eligible for Medicaid long-term care benefits or from including an adult child's income and assets when determining whether a parent is eligible for Medicaid. As a result, these laws apply only before people enroll in Medicaid.

The Pennsylvania case involved a woman who spent six months in a nursing facility recovering from an auto accident. She had monthly Social Security and pension income of only $1,000, far less than the cost of her care. While she applied for Medicaid, that process can take many months and, in this case, the woman left the facility while her application was pending.

As a result, the nursing facility sued her son for her unpaid bill. He argued that she was not indigent since she had some income and that, even if she was, other family members also had an obligation to help and all the burden should not be placed on him.

The appeals court disagreed. It said that in Pennsylvania someone does not have to be destitute to be indigent. Family members are responsible even if she has income but has insufficient means to pay for her own care.

The court also ruled that the facility could arbitrarily go after any family member it wanted, as long as it could prove that relative had the resources to pay. For more details about the case, take a look at the Elder Law Answers Website, which brought the case to my attention.

These filial repsonsibility laws are not new. In fact, they can be traced back 400 years to Poor Relief laws in England. In the U.S. many states have had them on the books for decades, but they have been rarely enforced.

That may be changing. With the costs of long-term care rising (an average nursing home stay now exceeds $200/day), and with increasingly strict Medicaid rules making it tougher for people to receive government assistance, senior services providers may find themselves with more unpaid bills. These suits may generate bad publicity but may also be a facility's only recourse.

While these laws don't directly apply to Medicaid recipients, they may force children to pick up their parents' long-term care costs long before mom is ever eligible for Medicaid. Such a step could still shift significant costs from states to families.

IRS expects more small businesses to claim healthcare tax credit

By Sam Baker - 05/22/12

The IRS expects more small businesses to begin taking advantage of a new healthcare tax credit that has been criticized as too small to make a difference.

A Treasury Department spokeswoman said the IRS is taking several steps to boost awareness of the credits created under the Affordable Care Act (ACA). The law provides tax credits designed to make healthcare more affordable for small businesses, but the actual claims have been far lower than originally expected.

The Government Accountability Office (GAO) **reported Monday** that only 170,000 businesses claimed the credit in tax year 2010. Estimates of the number of eligible employers range from 1.4 million to 4 million.

But the IRS expects takeup to increase. The Treasury spokeswoman said takeup for 2010 would be low simply because of the timing. The healthcare law passed in March 2010, so most employers had already made their coverage decisions for the year.

As the spokeswoman noted, participation more than doubled in the first year alone. The White expects about 360,000 employers to claim the credit in tax year 2011.

That's still much lower than the number of potentially eligible businesses, but the IRS is taking additional steps to boost awareness of the tax credit.

The IRS is working with the companies that make tax software to build in new alerts for businesses that might be eligible, the spokeswoman said. The agency is also reaching out to tax preparers and insurance agents. And it's planning more Web presentations for small-business owners, following up on a webinar that brought in roughly 7,500 viewers.

According to GAO, the tax credit might be too small to be attractive to small businesses. More than 80 percent of the companies that would be eligible for the maximum credit don't offer health insurance, the GAO said, and those employers say the tax credit isn't big enough to get them to start providing coverage.

The credit is available to companies with fewer than 25 employees who make an average salary of less than $50,000 per year. Companies must provide healthcare benefits and pay for at least half of their workers' coverage.

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