S.O.S. NEWSLETTER

"SERVICE OFFICERS FOR SERVICE"

SERVICE OFFICER NEWSLETTER VOLUME 10-3 July 2010

EDITORS COMMENTS

The year is passing by fast and we have a number of concerns related to the new Health Reform Act as it affects our benefits, and the benefits of others. If you found the information in my April issue helpful, you should be able to keep up with the expected changes until 2018. Service Officers should try to keep up to date on the expected information on the many issues in future issues in the NARFE magazine.

The District training sessions I have attended to date are not well attended by Service Officers. This still gives me concern regarding their ability to keep up to date on the important issues. Of course the other issue is that some don't have a computer and don't access the internet on-line with NARFE and OPM. .

This Newsletter has grown in pages because of the number of changes to our benefits and new rules and regulations that affect both current employees and retirees. Again I suggest that Service Officers get the SOS Directory in their file to help in answering member questions.

(See CSFCNarfe.org – Publications – Service). Please make sure your Chapter members are kept informed by preparing articles for your Newsletter and periodic chapter meeting presentations. Also remember that if you don't have the answer, I do. Calls will be answered and I will provide references for the answer.

Mary Venerable
Chair, Service Committee

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NARFE SERVICE CENTERS IN
STATE OF CALIFORNIA

1 – NARFE Service Center, Residence - P.0. Box 69, Patton, CA. 92369, (909) 862-7685 – Vaudis Pennell - By Appointment, guovau@sbcglobal.net
4 – Vallejo, Ca. (707) 552-2546 Gordon Triemert, - By Phone – any time 946 Heartwood Ave., Vallejo, CA 94591 jay94591@yahoo.com
8 – NARFE Federal Retiree Service Center 5440 Dudley Blvd, McClellan, CA. 95652 (916)971-2888 Mgr. Robert Johnson (916) 635-4576. Mon. & Thurs. 9 a.m. to Noon. frjohnson4@aol.com

12 - Oceanside Senior Center, 455 Country Club Lane, Oceanside, CA.92054 Josephine M. Murphy – (760) 757-5559 - Wednesdays 12 Noon to 3pm. jomurphy@oco.net
#21 – Service by phone (619) 460-7992 – William Doll – after 9 a.m. imadoll@earthlink.net
35 – Residence of JoAnne Rowles 3916 Marilyn Place, Bakersfield, Ca. 93309-5924 (661) 833-1647– By Appt. jrowles@bak.rr.com
#42 – Residence of Vernon Rood, Service by Phone (707) 578-3180 –vrood@aol.com
#55 – NARFE Service Center, 1524 Jefferson St., Napa, CA 94558 – Oliver E. Sheridan – (707) 257-2228 Monday thru Saturday – By Appt.
#78 – Fresno Service by Phone Charles Hedrick, (559)299-4207.
#133 – Service by Phone, Jean Stone, – (530) 222-2321 – logeneaa@wmconnection. com
#145 – Naval Air Weapons Station, 1 Admin. Circle, Mail Stop 1323, China Lake, CA. – Donald W. Cooper, (760) 939-0978. Mon. – Friday from 9 to 11 a.m. & 1-3 p.m. dat.cooper@verizon.net
149 – Antelope Valley Senior Center, 777 W. Jackman Street, Lancaster, CA 93534 - Norma Keipe, (661) 726-4409. – Mondays 9 a.m. to Noon (except holidays)
171 – Service by phone - Gerald Sprouse, 1650 Christina Ct., Paso Robles, CA. 93446 (805) 237-0051 Jerrysprouse@charter.net.
183 – Service by phone - Bob Willis, Port Hueneme, Ca. (805) 486-1235
#202 – Norman P. Murray Com. & Senior Center, 24932 Veterans Way, Mission Viejo, CA. 92692, Bert Zucker, (949) 470-3063. 2nd & 4th Mondays 1 to 3 p.m.

Notice: For up-to-date information see the Federation's website. Please notify Jo Murphy of changes by FAX (760) 757-5559 or E-mail at JoMurphy@oco.net

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YOUR ATTENTION IS INVITED TO THE FOLLOWING WEBSITES OF INTEREST

NARFE National Office at http://www.narfe.org

Issues of all SOS Newsletters and a Directory of Topics are available on line on the NARFE California Federation's Website in Publications at:
http://www.csfcnarfe.org

Publications on FEGLI Life Insurance at:
http://www.opm.gov/insure/life Index.htm .
Or (800) 633-4542

OPM Retirement at: www.opm.gov.retire for inquiries and changes.

NEW WEB SITE

OPM has posted a new Web Site:
www.opm.gov/insure/quickguide.asp
It is well organized and easy to navigate. It includes information on FEHBP, FEGLI, and civil service retirement. It also includes a section on retirement planning, tools to calculate federal income taxes, a menu of publications for downloading and printing, and links to other federal agencies as well as to NARFE Web Site,

OTHER IMPORTANT WEB SITES

Social Security and Survivor Benefit Plan for military: http://www.military.com/newcontent/0, 13190, Philpott 040105,00.html and http://www.military.com/

resources/resourcesContent/0,13964, 13964,31301,00. html
Military Surviving Benefits – Covers Survivor Family Benefits, e.g. Dependency and Indemnity Compensation (DIC), Death Gratuity Death Pension , Tricare, and other survivor related benefits. http://www.military.com/benefits/survivor-benefits-family-benefits

U.S. Coast Guard, Benefits Information and Financial Education Department – Military Officers Association of America at 800-234.6622, x-106 (703) 838-8106 and website at www.moaa.org

Medicare Part D Plan premiums
http://www.cms.hhs.gov/MedicareAdvtg

Free Cell phone number for 411. Information Calls
(800) Free 411 - (800) 373-3411 -- This also works on you home phone .

California Legislative Bills: Telephone number to make your voice heard. The number is (961)-445-2841.

White House Comment Line: (202) 456-1111 - E-mail – president@whitehouse.gov

NARFE Capitol Hill Toll Free No: **(866) 220-0044** Call this number, give the name of your Senator or Representative and you will be switched to their office.

NARFE Legislative Hotline by phone – (877-217-8234 (Toll-Free)

Links to Membership Renewal, Join GEMS, Update Your Record, etc., are located on the Members Home Page in the left panel under What You Can Do Online.

Links to Forms (including interactive), Publications and NARFE Online Reports are found on the Leadership Home Page in the left panel.

New Service Officer BLOG. The **S**ervice **O**fficers **B**ulletin **B**oard or **SOBB** can be accessed at www.narfe.org/sobb. What is a 'blog'? The word blog is a blend of the older term 'weblog' and is a website where you can enter comments that

are commonly displayed and read by other users who have access to the blog. With a blog, you can access the site anytime the system is available.

Current Service Officers can now create their own messages instead of commenting on existing ones found under the 4 different categories. When you log on just click on "Create New Entry" and a screen will come up that allows you to title and write your message. David Snell, Director, Retirement Benefits Service Department suggests that you should give it a try – your will like it.

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IRS PUBLICATION 721

This is the publication that retirees can refer to when matters/issues about annuity tax on retirement contributions. Persons interested can now go to the IRS.gov web site under Publications and view the new edition. The front cover under "What's New" describes the Government Retiree Tax Credit.

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Taxation of Federal Retirement Benefits

Because the federal government offers various types of retirement benefits, the question of how these benefits are taxed presents a great challenge when preparing income tax returns. To assist annuitants, survivor annuitants, and for some, their tax preparers, in the preparation of federal and state income tax returns, 1105 Media, Inc. announces the 2010 update to its popular annual publication, Taxation of Federal Retirement Benefits. Written by recognized federal employee benefits expert, accountant, federal annuitant and FEND "Informed Investor" columnist Edward Zurndorfer, the publication explains in simple, easy-to-understand terms how federal retirement benefits are taxed.

Taxation of Federal Retirement Benefits is not only for annuitants, survivor annuitants and their tax preparers. Current employees can avoid surprises later on by using the guide to find out exactly how their benefits will be taxed once they retire from federal service. And current federal employees can plan for their loved ones by understanding how survivor benefits are taxed in the event they die while still in federal service.
Get the complete guide on tax issues affecting your federal retirement benefits. Purchase and download your copy today, and you'll:

a. Learn important information survivor annuitants need to know to ensure they don't accidentally pay more taxes than they should
b.. Get an informative overview of the retirement systems (CSRS, FERS, CSRS Offset, FERS Transfer)
c.. Discover if your CSRS or FERS annuity is taxable
d.. Learn what circumstances will require you to file a federal income tax return
e.. Know the rules on how retirees can figure the tax-free portions of their annuities (Simplified Method, General Rule, and the Three-Year-Rule)
f.. Discover if you are eligible for the "alternative form of annuity" option
g.. Learn the important tax considerations regarding monies distributed and withdrawn from your Thrift Savings Plan account
h.. Find out the important - and often overlooked - rules regarding tax-free withdrawals (rollovers) from your TSP account, including the I instances when TSP owners cannot roll over their balances
i.. Find out if you will be eligible for Social Security benefits, and, if so, what portions of those benefits are taxable
j.. Get plain-English explanations of the tax rules affecting survivors of federal employees and retirees
k.. Learn the three options CSRS and CSRS Offset employees have in regard to accumulated monies in the Voluntary Contribution Program
l.. Get information on crucial tax issues — including gift taxes, estate taxes, state income taxes, and much more.

The guide also includes several real-life examples, worksheets and sample forms -- plus a helpful index to IRS resources. If interested you can order today. Promo code: X0CDTX Get fast, Internet delivery for just $14.95 for PDF download or order the print version for $15.95 (plus shipping/handling)

HOW EXCESS RETIREMENT CONTRIBUTIONS WORKS

If a CSRS-covered employee works beyond 41 years and 11 months, then the employee will continue to contribute 7 percent of the employee's paycheck to the CSRS Retirement and Disability Fund. Upon retiring, the employee will receive within 30 days of retirement a letter from OPM's retirement. The letter will ask the retired employee what the employee wants to do with the "excess" CSRS retirement contributions (those in excess of 41 years and 11 months of service). Here are the choices: (1) receive a lump sum payment of the contributions together with 3 percent interest; or (2) receive another CSRS annuity; this annuity is computed based on the same rules that are used to compute a CSRS annuity under the CSRS Voluntary Contribution Program (VCP).

QUESTION RE: TRUST FOR THRIFT SAVINGS PLAN FUNDS.

I would like to set up a Trust and move my TSP into it. The trust would be used to help finance college for any of my Grandkids who would like to attend college. Can this be done, and if so what would be the best way to go about it. I must act quickly or the money will be squandered.

ANSWER:

You need to discuss your question with an attorney who specializes in trusts. But chances are that your TSP account could not be moved to a trust. Most likely, you would have to start taking monthly distributions (and pay tax) from your TSP account and have the distributions paid into the trust. Once the after-taxed TSP distributions are in the trust, the trust monies could be directed to a college savings vehicle (such as a 529 plan or a Coverdell Educational Savings Account).

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DUES WITHHOLDING

For the annuitant and spouse on dues withholding - When the annuitant dies, the survivor is taken off of dues withholding by OPM.? NARFE? automatically places the survivor, upon notification of the annuitant's death, on an annual renewing membership until the original deceased anniversary date, up to one year. At that time the member is asked if they wish to be placed on DW as before, using their new CSF number, and they reapply through NARFE to OPM.? If they choose not to go on DW, they can just pay annual dues.

For the life member who dies, the spouse is automatically placed on the membership roster as an annual member until the original anniversary date of the deceased life member. At that time they are sent a renewal notice.

AGE CHANGE EFFECTIVE DATE FOR DEPENDENT CHILD

On May 12, 2010, Margaret L. Baptiste, president of the National Active and Retired Federal Employees Association (NARFE), praised Sen. Benjamin L. Cardin, D-MD, for introducing legislation (S. 3341) in the Senate that would allow dependent children of federal workers and annuitants to remain on their parents' federal health insurance plan to age 26. The bill is a companion to a bill introduced in the House of Representatives on May 4 by Rep. Chris Van Hollen,D-MD and would resolve the inequity by amending the FEHBP law so that coverage may be extended to young adults during the current contract year..

Baptiste also thanked other Democratic Senators for also sponsoring the "Federal Employees Health Benefits Program (FEHBP) Dependent Coverage Extension Act."
The comprehensive health care legislation includes a requirement that, by September 2010, group health plans cover dependent children on their parents' health insurance up to age 26. While many insurers have decided to extend dependent coverage even before the September deadline, the law authorizing the FEHBP prevents the Office of Personnel Management from allowing federal workers and annuitants to extend coverage for their dependent children until January 2011.

"Today, dependent children of federal workers and annuitants lose their health coverage when they turn 22 years old, just when they graduate and begin looking for employment with health benefits in the current tough job market," Baptiste said. "FEHBP should start covering our kids now, just as other insurers have started doing in the private-sector. That's why NARFE, as a matter of equity, endorses Senator Cardin's and Congressman Van Hollen's 'Federal Employees Health Benefits Program Dependent Coverage Extension Act.'

TREASURY MOVES TO MAKE ALL BENEFIT PAYMENTS PAPERLESS

As part of the government's push for efficiency—and to save a few trees—the Treasury Department will require that everyone receiving Social Security, Supplemental Security Income, Veterans, Railroad Retirement and Office of Personnel Management benefits get their payments electronically by 2013.

Individuals will be able to receive benefits either through direct deposit into a bank account or though Treasury's Direct Express debit card, the department said in an April 19 statement. The requirement will apply to new enrollees beginning on March 1, 2011, and to existing check recipients beginning on March 1, 2013. Moving all recipients of these benefits to electronic payments is expected to save upwards of $300 million in the first five years, the department said.
The paperless benefits initiative is part of the department's effort to be more environmentally conscious and to save about $400 million.

In another change, feds will no longer be able to purchase paper savings bonds through payroll deductions after Sept. 30. The policy covers only paper savings bonds purchased through payroll sales; individuals will still be able to purchase paper savings bonds at financial institutions. And they can still purchase electronic savings bonds through Treasury Direct. The move is expected to save nearly $50 million in the first five years. To see more, go to: www.treas.gov/press/releases/tg644.htm

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IT'S OFFICIAL! - TRICARE Enrollees Satisfy New Health Coverage Mandates

President Obama on April 26 signed into law the TRICARE Affirmation Act, which changes the IRS tax code to state that those covered under TRICARE and related health plans meet the minimum health insurance coverage required under the new health reform standards.

The bill, H.R. 4887, was necessary to clear up any potential confusion over whether enrollees in TRICARE and related plans met the minimum coverage requirements mandated by the massive health reform package Obama signed in March. Beneficiaries of TRICARE for Life and military veterans' health care programs also satisfy requirements under the law. To see more, go to: **http://tinyurl.com/2bvawtd**.

In October 2009, President Obama Signed into Law into law the Fiscal Year 2010 Defense Authorization bill, which includes several civil service improvements (Re-Employed Annuitant and FERS Sick Leave Bills) long sought by NARFE.

(NARFE) President Margaret L. Baptiste commended President Obama for signing, "Enactment of this legislation to eliminate inequities, increase productivity and address the skills shortage in the civil service is a great victory for active and retired federal employees."We are happy the president has signed this important bill into law, and we are grateful to our friends in Congress who moved heaven and earth to include the civil service improvements in the final legislation."

The new law allows federal agencies to re-employ federal retirees on a limited, part-time basis without offset of annuity; permits Federal Employees Retirement System (FERS) workers to initially credit half, and in 2014 all, of their unused sick leave toward retirement; provides for retirement equity for federal employees in Hawaii, Alaska and the U.S. Territories; ends the Department of Defense's pay-for-performance personnel system, the National Security Personnel System or NSPS, restoring employees to the Federal General Schedule pay system; and includes other civil service provisions.

Baptiste was particularly pleased that a compromise was reached on the FERS sick leave legislation by phasing in the allowance. "We recognize that the inequity in the treatment of accrued sick leave between FERS and CSRS has hurt productivity and increased agency costs," Baptiste said. "For that reason, we have strongly supported the concept that all federal civilian retirement programs credit unused sick leave toward retirement." The NARFE president specifically lauded Moran for being a long-time champion of this issue.

HEALTH INSURANCE COVERAGE

Several months ago I received a copy of correspondence sent by a gentleman currently on workers compensation. He expressed difficulty in deciding on a health plan in a new area he was relocating to. He also questioned a decision regarding his having to sign up for Medicare Part B coverage.

I believe the response from David Snell, NARFE Retirement Benefit Services Director is important for Service Officers to be aware of because it involves issues raised by many members.

Dear Sir:

I'm sorry you are having a difficult time sorting out your health insurance coverage. You still have health insurance coverage under the Federal Employees Health Benefits Program, you just need to change health insurance plans to one that will cover you in your new address area. One of the events that allows you to change your FEHBP enrollment outside of the annual Open Season is when you move out of the service area of your plan. You may change to another HMO plan that covers your new residence area or change to a Fee for Service plan such as Blue Cross, GEHA, Mail Handlers, which will cover you no matter where you live. To make a change you need to contact your OWCP office because that is the agency that is paying you benefits and withholding monthly health insurance premiums. Inform them you have moved out of your current plan's area of coverage and need to change to another plan. Ask them to send you an enrollment guide, 70-6 Guide to Federal Benefits for Individuals Receiving Compensation from the Office of Workers Compensation Programs so that you can read about the plans available to you. OR go to OPM's website at www.opm.gov/insure and view the plans available to you in the State/area that you live.

You do not have to enroll in Medicare Part B and because of the penalty for late enrollment, that you would be subject to, the Medicare coverage would very likely not be worth the additional premiums. Despite what the Department of Labor may have told you, you are subject to the additional 10% premium surcharge for every year after you retired from employment that you were not enrolled in Medicare and were eligible to enroll.

If we can be of any further assistance, feel free to contact us.

David B. Snell, Director
Retirement Benefit Services
National Active and Retired Federal Employees Association
571-483-1269

A word about Medicaid

You may think that Medicaid and Medicare are the same. Actually, they are two different programs. Medicaid is a state-run program that provides hospital and medical coverage for people with low income and little or no resources. Each state has its own rules about who is eligible and what is covered under Medicaid. Some people qualify for both Medicare and Medicaid. For more information about the Medicaid program, contact your local medical assistance agency, social services or welfare office.

MEDICARE INFORMATION

Medicare has four parts

Hospital insurance (Part A) that helps pay for inpatient care in a hospital or skilled nursing facility (following a hospital stay), some home health care and hospice care.

Medical insurance (Part B) that helps pay for doctors' services and many other medical services and supplies that are not covered by hospital insurance.

Medicare Advantage (Part C) plans are available in many areas. People with Medicare Parts A and B can choose to receive all of their health care services through one of these provider organizations under Part C.

Medicare Prescription drug coverage (Part D) offers prescription drug coverage to everyone with Medicare. There are two ways to get Medicare Prescription drug coverage:

1. Medicare Prescription Drug Plans – These plans (sometimes called "PDPs") add drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service (PFFS) plans, and Medicare Medical Savings Account (MSA) Plans.
2. Medicare Advantage Plans (like HMO or PPO) or other Medicare health plans that offer Medicare prescription drug coverage. You get all of your Part A and Part B coverage, and prescription drug coverage (Part D), through these plans. Medicare Advantage Plans with prescription drug coverage are sometimes called "MA-PDs"

You can receive a publication, "*Medicare & You*" (Publication No. CMS-10050) that describes your Medicare benefits and Medicare plan choices.

Hospital Insurance (Part A)

Most people age 65 or older who are citizens or - permanent residents of the United States are eligible for free Medicare hospital insurance (Part A). You are eligible at age 65 if:

- You receive or are eligible to receive Social Security benefits; or
- You receive or are eligible to receive railroad retirement benefits; or
- You or your spouse (living or deceased, including divorced spouses) worked long enough in a government job where Medicare taxes were paid; or
- You are the dependent parent of a fully insured deceased child.

Medical Insurance (Part B)

Anyone who is eligible for free Medicare hospital insurance (Part A) can enroll in Medicare medical insurance (Part B) by paying a monthly premium. Some beneficiaries with higher incomes will pay a higher monthly Part B premium.

Medicare hospital insurance is free for almost everyone, but you do pay a monthly premium for medical insurance. (**2009/2010 is and will be $96.40 per month**) If you already have other health insurance when you become eligible for Medicare, is it worth the monthly premium cost to sign up for Medicare medical insurance?

For more information, ask for *Medicare Part B Premiums: New Rules For Beneficiaries With Higher Incomes* (Publication No. 05-10161) or visit ***www.socialsecurity.gov/mediinfo.htm***.

If you are not eligible for free hospital insurance, you can buy medical insurance, without having to buy hospital insurance,
if you are age 65 or older and you are —

- A U.S. citizen; or
- A lawfully admitted noncitizen who has lived in the United States for at least five years.

Medicare Advantage plans (Part C)

If you have Medicare Parts A and B, you can join a Medicare Advantage plan. With one of these plans, you do not need a Medigap policy, because Medicare Advantage plans generally cover many of the same benefits that a Medigap policy would cover, such as extra days in the hospital after you have used the number of days that Medicare covers.

- Medicare Advantage plans include:
- Medicare managed care plans;
- Medicare preferred provider organization (PPO) plans;
- Medicare private fee-for-service plans; and
- Medicare specialty plans.

If you decide to join a Medicare Advantage plan, you use the health card that you get from your Medicare Advantage plan provider for your health care. Also, you might have to pay a monthly premium for your Medicare Advantage plan because of the extra benefits it offers.

Medicare prescription drug plans (Part D)

Anyone who has Medicare hospital insurance (Part A), medical insurance (Part B) or a Medicare Advantage plan (Part C) is **eligible** for prescription drug coverage (Part D). Joining a Medicare prescription drug plan is voluntary, and you may pay an additional monthly premium for the coverage.

You can get more detailed information about what Medicare covers from *Medicare & You* (Publication No. CMS-10050). To get a copy, call the Medicare toll-free number, **1-800-MEDICARE** (**1-800-633-4227**), or go to *www.medicare.gov*. If you are deaf or hard of hearing, you may call TTY **1-877-486-2048**.

HEALTH CARE REFORM ACT (FEHBP)

We are now in the implementation phase of the Health Care Reform Act. Many have asked about the effects of the Act on our Federal Employees Health Benefit Plans (FEHBP). There is also much confusion about what is in the new law, much less what it means. Health insurance, the largest online health insurance broker, has been inundated with calls to NARFE. Many are calling to find out where they sign up for their free health care insurance. Not only is the insurance not free, most of the insurance reforms and benefits do not start until 2014. Other important provisions, many of them tax related, may start very soon, while others will be delayed until 2018. Furthermore, the mandates on states to provide health care have not entwined the Medicare and Medicaid programs together in ways still to be reveals.

The following information is offered to help you understand the changes that will occur over the next few years.

None of the pending measures open the FEHBP Program to non-federal civilians, nor would FEHBP become part of the public health care plan. It is also important to keep in mind that any comprehensive plan that changes insurance law, provider financing, taxation policy and health infrastructure, will have some ramifications on how FEHBP operates in the larger health system. Member of Congress and some congressional staff will have to enroll in the state-based exchanges instead of FEHBP starting in 2014.

Like other employer-sponsored health insurance plans, pending health reform measures propose no direct changes to FEHBP until 2018. That's when FEHBP would be required under the House bill to have an "essential benefits package," offer preventive services and treatments with no additional co-payments or co-insurance, and comply with a federally-mandated coverage appeals process.

Under the House bill, the Department of Health and Human Services' (HHS) Health Benefits Advisory Committee, a group of up to 27, more than half of whom would be appointed by the President and led by the Surgeon General, will recommend what coverage should be provided in the essential benefits package and which preventive services and treatments enrollees would be offered without paying co-payments or co-insurance. They would also establish a uniform coverage appeals process. In consultation with the Advisory Committee's recommendations, the HHS Secretary would make the final decisions on standard benefits and the appeals process.

The essential benefits package would only affect FEHBP if it includes coverage not currently offered by the federal employees program. That is unlikely to happen since most FEHBP plans offer comprehensive benefits. Like the law which authorizes the FEHBP, the House bill requires that the essential benefits package contain broad categories of benefits, including hospitalization, outpatient care, prescription drugs, rehabilitative services, mental health and substance use services, maternity and well baby care. If the essential benefits package were to exceed current FEHBP coverage, insurance carriers could raise premiums and/or increase enrollee cost sharing.

Likewise, preventive services coverage without cost sharing could result in a premium increase. Some health care policy experts argue that preventive coverage would eventually save money because such services could prevent illness or catch diseases earlier when they may be treatable. Whether or not preventive coverage saves or costs money, many observers believe it could improve the quality of life of patients who use such coverage and comply with lifestyle changes suggested by a physician in response to diagnosis and testing.

Since 1977, FEHBP has had a disputed claims process which ensures an independent review of disputes between participating insurance carriers and enrollees. A federally mandated process would only affect FEHBP if its consumer protections were greater or less than those practiced by the federal employee program. NARFE would prefer retaining the existing appeals process or enhancing it.

The Senate HELP Committee bill would require all individual and group market health insurance plans, including FEHBP, to offer dependent coverage for children up to age 26. Currently, most child dependents loose their FEHBP coverage by at the age of 22. The NARFE Legislative Program "supports legislation to provide that children of Federal civilian and military employees and retirees be permitted to remain under government-sponsored medical insurance plans until age 25 or the age generally allowed by larger medical insurers."

Employer Mandate

With the exception of small businesses, employers are required by the House bill -- and the Senate Health, Education, Labor and Pensions (HELP) Committee bill – to either provide their workers with health insurance or contribute to a fund that would help finance coverage for the uninsured through the "Health Insurance Exchange" system (described below). The effect of this requirement on the federal government should be minimal since nearly all federal employees, retirees and survivors are eligible to enroll in FEHBP. However, some temporary and seasonal federal workers are not currently eligible, and as a result, their agency may either be forced to insure them or pay into the Health Insurance Exchange Fund. The Senate Finance Committee proposal did not include an employer mandate.

Individual Mandate

All individuals are required to have "acceptable health coverage" or pay a penalty, under the three major bills. Exceptions would be granted for dependents, religious objections and financial hardships. Federal workers or retirees who choose not to enroll in FEHBP, a spouse's employer-sponsored plan, Medicare, TRICARE, Veterans health care or some other form of coverage would pay a penalty.

Workers and retirees sometimes decline FEHBP enrollment because they cannot afford to pay their share of premiums. Exemptions will be granted for financial hardship and for those whom the lowest cost health plan options exceed 8 percent of an individual's income and those with incomes below the federal tax filing threshold. In addition, exemptions will be provided for religious objections, American Indians, those without coverage for less than three months, undocumented immigrants and incarcerated individuals.

Beginning in 2014, U.S. citizens and legal residence are required to have qualified health coverage. FEHBP is considered qualified coverage. 88 percent of federal workers and 72 percent of federal annuitants are enrolled in FEHBP. The House legislation addresses this problem by allowing individuals who pay 10 percent or more of their income on employer-sponsored health premiums to enter the Health Insurance Exchange program. In addition, they would be eligible to obtain income-based "affordability credit" to help pay for premiums for plans offered by the exchange.

Health Insurance Exchange System

The House legislation created "Health Insurance Exchanges" to provide private health insurance or coverage through a public option in which individuals and employers could purchase health benefits. In 2014 and thereafter, only those workers or retirees who spend 10 percent or more of their income on health plan premiums would be eligible to participate in the exchange program (described above in the "Individual Mandate" section). Starting in 2018, all workers and retirees could decline their employer-sponsored health plan and instead enter the exchange. The legislation does not require employers to pay for all or part of an exchange plan premium. However, persons with income at or below 400 percent of the federal poverty level ($73,240 for a family of three in 2009) would be eligible for an income-based sliding scale affordability credit which would pay part of the premium for a basic private or public health plan offered by the exchange.

The effect that such access would have on FEHBP would depend on how many federal workers and retirees eligible for the affordability credit leave FEHBP for the Health Exchange program.

The Senate Finance Committee appears to be embracing state nonprofit insurance cooperatives, based on a model used in Minnesota, owned and run by consumers, as an alternative to the health insurance exchanges proposed by the House or the related "American Health Benefit Gateways" in the Senate Health, Education, Labor and Pensions (HELP) Committee bill.

Taxing Health Benefits

The bipartisan group of members of the Senate Finance Committee has discussed taxing employees and retirees for part of the value of their employer-provided health insurance. Here is how the tax will work in 2018. Insurance carriers would pay an excise tax if the aggregate values of their enrollees' spending on health premiums and other related costs exceed $10,200 for individual coverage and $27,500 for family coverage per year, indexed for inflation.

Supporters of this proposal believed that excluding generous health plans provided by employers from personal income taxes insulates workers and retirees from the true cost of health care. In other words, in plans where enrollees pay little or nothing out-of-pocket, there is no incentive for enrollees to select plans, that are more efficient and are better at containing costs, like Health Maintenance Organization options or High Deductible Health Plans.

In sum, supporters of ending or reducing the tax exemption of employer-sponsored health insurance hope to end the tax code's subsidization of so-called "gold-plated" coverage and make enrollees more cost-conscious of their health care choices. As a result, overall health care spending could be contained – a proposition supported by the Congressional Budget Office. What's more, there are few other ways to raise the amount of revenue necessary to pay for health care reform.

While highly-compensated executives and professionals in the private sector are sometimes provided such "Cadillac" coverage, many average "Ford" and "Chevy"

level health plans can be just as expensive when they have a high proportion of workers and retirees which generate costly medical bills. In other words, premium amounts are not necessarily an accurate measure of a health plan's generosity, particularly when, as in the FEHBP, plans are experience-rated.

NARFE still opposes taxing employees and retirees for part of the value of their employer-provided health plans. There is one bit of good news for federal annuitants, however, if lawmakers opt to tax employees and retirees for their employer-sponsored health benefits. In discussions with the Senate Finance Committee, staff indicates that under options they have explored, federal annuitants would be less likely to be affected. That is because annuitants pay for their health insurance premiums with after-tax dollars, and therefore the amount they pay would not be counted as part of their income. However, federal annuitants would lose this advantage if premium conversion legislation, which would allow them to pay for their share of health insurance with pre-tax dollars, were to become law.

While none of the current health reform plans actually contains a provision taxing benefits -- and the possibility of such a proposal seems to be dimming -- final health reform policy, particularly in the Senate, has not been finalized. Indeed, as an alternative, there appears to be growing interest in taxing insurers or employers who offer insurance with premiums above a certain level. Insurers and employers would likely respond to such a tax by not providing coverage with premiums above the benchmark set in the legislation. For example, if the premium benchmark was $21,000 a year, then insurance carriers and employers would be less likely to offer plans with premiums above that amount since they would be obligated to pay a 35 percent surcharge tax on any plan with premiums above the cap level. That would force them to design benefits that would cost less than the benchmark. As a result, individuals could be prevented from buying more generous coverage.

Long Term Effects of Reform

The combination of the public plan option, taxation of health insurance and mandated benefit packages could affect the ability of employers and carriers to ensure competition and offer the same health plan choices in group health plans like the FEHBP.

However, concerns about the public plan may have been mollified by a deal struck between the moderate and conservative "Blue Dog" Democrats, Energy, and Commerce Committee Chairman Henry Waxman. Instead of tying public plan payments to Medicare's rates of reimbursement to health care providers, as originally proposed, the compromise brokered in late July calls for the HHS Secretary to negotiate public plan rates with hospitals and doctors, just as private insurance companies do.

If carriers and the government, as an employer, can no longer offer plan competition and choice in FEHBP, the policymakers might question why the government is running a separate health care program for its employees and annuitants. As an alternative, they might suggest that federal workers and retirees be enrolled in the Health Insurance Exchange in lieu of FEHBP. For that to happen, however, the law authorizing the FEHBP would have to be amended, which the current health care reform legislation does not propose.

Currently, the House bill mandates studies in 2015 and 2019 to determine if there are significant groups (employer or employee) which would benefit from accessing the exchange. Such a study might consider that adding eight million enrollees from FEHBP, who have received comprehensive health care, could benefit the Health Insurance

Exchange's "risk pool" and economy of scale because the health care needs of feds may have been better managed under FEHBP and, therefore, their cost to the exchange could be lower than other participants. Again, NARFE would oppose such a move.

Medicare and Medicaid

About half the cost of health care reform is paid for by reducing payments to providers in Medicare and Medicaid. Under the legislation, provider payments are not cut, but the rate at which they increase every year would be reduced. The bill achieves $384 Billion over ten years in Medicare cost savings by slowing growth in – and reforming the way – Medicare pays health care providers and by reducing fraud, waste and abuse in the program. Most doctors and hospitals will be compelled to accept Medicare and Medicaid reimbursement because the programs control a huge share of all health care spending.

Even when providers do not accept Medicare, the program, when combined with FEHBP coverage, will reimburse enrollees for physician and hospital costs. Starting in 2011, primary care practitioners (physicians in family medicine, internal medicine, geriatrics and

pediatrics) will receive a ten percent bonus and an additional ten percent if they practice in an underserved area. Despite several procedural roadblocks and setbacks, the Senate is likely to approve pending legislation that would prevent a 21 percent cut in Medicare physician pay from taking effect.

The new law includes a new payment system that rewards providers who supply care that meets certain quality standards and ensures that services are paid on the basis of value and not volume. This includes a pilot program offering incentives for "bundled" services. Providers will receive a flat fee for certain procedures and treatment of chronic diseases. Medicare hospital payments will be lowered for institutions with an exception of preventable hospital readmissions and hospital-acquired conditions. Federal payments to states for Medicaid services related to hospital acquired conditions are prohibited.

NARFE supported the provision in the House bill which would end the "donut hole" in Medicare Part D prescription drug coverage, beginning with a $250 reduction in 2010, and eliminating the Medicare Part D coverage gap by phasing down the coinsurance to the standard 25 percent by 2020. Most federal annuitants do not participate in Part D since their FEHBP plan includes a prescription drug benefit.

In 2009, once Part D beneficiaries pay more than $2,700 in total annual drug costs, they are in the "donut hole" (a gap in coverage) and must pay 100 percent out-of-pocket for the cost of prescription drugs until their total out-of-pocket costs reach $4,350.

Under FEHBP coverage, federal annuitants simply pay co-payments and/or coinsurance for prescription drug coverage which is more generous than Part D

The House and Senate bills would expand eligibility in Medicaid to cover millions of low-income people who do not qualify under current law and either does not have access to private insurance or cannot afford it. Medicaid is funded by the federal and state governments, which pay for medical and long-term care for low-income individuals and families. The House and Senate bills makes families or individuals eligible for Medicaid if they earn up to 133 to 150 percent of the federal poverty level, or between $29,300 and $33,075 in 2009.

It is not clear if the bills would allow more childless adults to qualify for the program and whether long-term care benefits would be offered to newly eligible beneficiaries.

Absent additional federal funding, cash-strapped states would be hard pressed to pay for the expansion.

Long-Term Care

The House bill and Senate HELP Committee legislation includes the "Community Living Assistance Services and Supports" (CLASS) Act which would establish a national insurance program to be financed by voluntary payroll deductions to provide benefits to adults who become severely functionally impaired. To qualify for benefits, individuals must be 18 years old and have contributed to the program at least 5 years. While the CLASS Act would help Americans pay for long-term care, it has been criticized for providing a meager benefit of $50 to $75 a day and it would depend on overburdened state government Disability Determination Services examiners to evaluate and process benefit claims.

NARFE supports financing a more generous long-term care benefit and establishing a more robust disability evaluation and benefit claims process than proposed in the CLASS Act.

The NARFE Legislative Program "supports proposals that would help individuals who cannot afford long-term care insurance or have an immediate or likely need for long-term care to receive such services without impoverishing themselves."

Consultation and Information Regarding End-Of-Life Planning

Much inaccurate and false information has been circulated about a provision in the House bill which would provide insurance coverage for consultation with medical practitioners about a patient's wishes with respect to life sustaining treatment. The provision covers what already has become commonplace when anyone of any age is admitted to a hospital and is asked to consider completing an "advance directive" form or a living will. None of the language in the bill mandates the rationing of end-of-life care to Medicare beneficiaries.

Stay Up-To-Date on Health Care Reform Legislation

The NARFE Legislation Department will continue to closely examining any and all comprehensive health care proposals as the legislative process continues. NARFE Members will continue to be updated in future *NARFE* Magazine, the Legislative Hotline and Action Requests. We encourage members with e-mail access to join the Rapid Response team. If you have further questions regarding comprehensive health care reform or the process, please contact the Legislation Department at 703-838-7760 or leg@narfe.org.