



COMMONWEALTH of VIRGINIA
Department for the Aging

[Click here to go to the Virginia Department for the Aging Home Page](#)

TABLE OF CONTENTS
AAA TUESDAY E-MAILING
November 9, 2010

SUBJECT	VDA ID NUMBER
<u>Commonwealth Broadband & Health IT Survey</u> (Katie M. Roeper)	11-29
<u>Winter Preparedness Week</u> (Kathy Miller)	11-30
<u>Medicare Plan Finder</u> (Kathy Miller)	11-31
<u>Aging Best Practices</u> (Jim Rothrock)	11-32
<u>2011 Medicare Deductibles</u> (Tim Catherman)	11-33
<u>Preliminary Election Analysis from NASUAD</u> (Bill Peterson)	11-34

Note: The web addresses (links) in this document may change over time. The Department for the Aging does not attempt to refresh the links once the week has passed. However, this document is maintained on the web for a period of time as a reference. Some links may require registration.



11-29

COMMONWEALTH of VIRGINIA
Department for the Aging

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Katie M. Roeper, Assistant Commissioner

DATE: November 9, 2010

SUBJECT: Commonwealth Broadband & Health IT Survey

An online Broadband and Health IT survey of health care providers throughout the Commonwealth is currently being conducted on behalf of the Office of Telework Promotion and Broadband Assistance (www.virginia.wired.gov) and endorsed by the Office of the Secretary of Technology and the Office of the Secretary of Health and Human Resources.

The survey is funded by The Department of Commerce - National Telecommunications and Information Administration under the State Broadband Data & Development Program (<http://www2.ntia.doc.gov/SBDD>).

The purpose of the study is to enhance the state's broadband mapping efforts by providing a special focus on key health care anchor institutions. The survey is also intended to provide Dr. Hazel's Office with information related to HIT applications affected by broadband adoption (EHR Adoption, Telehealth Services and HIE Connectivity).

You can access the survey by clicking on this link (<http://research.zarca.com/k/SsXQURsQSsPsPsP>) or copying and pasting the URL into your web browser.

If there are health care providers in your area that you have a relationship with, please forward them this information and ask them to consider completing this survey. This will help to ensure that your region is well-represented. Many thanks for your assistance with this initiative.

Commonwealth Broadband & Health IT Survey
November 9, 2010
Page 2 of 2

For more information contact:
Kirby Farrell
Broad Axe Technology Partners
455 Second Street, Suite 100
Charlottesville, Va 22902
Tel 434.987.0092
kfarrell@broadaxepartners.com



11-30

COMMONWEALTH of VIRGINIA
Department for the Aging

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Kathy Miller, Director of Programs

DATE: November 9, 2010

SUBJECT: Winter Preparedness Week

Winter Preparedness Week is Dec. 5-11, 2010. This is an outreach effort of the Virginia Department of Emergency Management, Ready Virginia and the National Weather Service. The effort is supported by VDOT, VDH, VDFP and many other agencies. The Governor has issued a proclamation in support of the week, which will be posted on his website later this month.

I am attaching a short article from Ready Virginia about Winter Preparedness Week. Feel free to post, print, or edit in order to share this information with your communities to encourage citizen emergency preparedness.



Winter is Coming – Get Ready Now

Winter Preparedness Week is Dec. 5-11, 2010

Who can forget the winter of 2009-2010! Multiple record-breaking snowstorms and cold temperatures affected every part of Virginia.

Millions of us suffered through power outages. Snowplow drivers worked around the clock to get roads open. School systems shut down for days. Sadly, 14 Virginians lost their lives due to last winter's storms.

Many communities set records for the number of days with at least one inch of snow on the ground. And it could happen again this year.

Winter Preparedness Week – set for Dec. 5-11 – is the time to get ready for possible bad weather. All it takes is one heavy snow that sticks around for several days or an ice storm that knocks out power to remind us that being prepared ahead of time just makes sense.

- ***Make a plan.*** Decide on a meeting place outside of your neighborhood if your family is separated and cannot return home because of closed roads. Choose an out-of-town relative or friend to be your family's point of contact for emergency communications. With your family, write down your emergency plan – get a free worksheet at www.ReadyVirginia.gov.
- ***Get a kit.*** Here are basic supplies for winter weather: three days' food; three days' water (a gallon per person per day); a battery-powered and/or hand-crank radio with extra batteries; and your written family emergency plan. After you have these essential supplies, add a first aid kit, medications if needed, blankets and warm clothing, supplies for special member of your household, and pet items.
- ***Stay informed.*** Before, during and after a winter storm, you should listen to local media for information and instructions from emergency officials. Be aware of winter storm watches and warnings and road conditions. You can get road condition information 24/7 by calling 511 or checking www.511Virginia.org.

Go to www.ReadyVirginia.gov and print out an emergency supply checklist and a family emergency plan. It's time to get ready for winter weather now.

-end-



11-31

COMMONWEALTH of VIRGINIA
Department for the Aging

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Kathy Miller, Director of Programs

DATE: November 9, 2010

SUBJECT: Medicare Plan Finder

The Annual Election Period for Medicare Part D begins on November 15th. VDA has been made aware of the many issues that are occurring with the Plan Finder that impact the ability of VICAP Coordinators and Volunteers to assist Medicare beneficiaries with their plan choices. In response to these concerns, Commissioner Rothrock has written a letter to Dr. Donald Berwick, Administrator of the Centers for Medicare and Medicaid Services. A copy of the letter is attached.

VICAP Coordinators are asked to continue to communicate problems encountered with the Plan Finder directly to Liz Pierce, State VICAP Director. Liz is in daily communication with the CMS Regional Office in Philadelphia to address these issues.



COMMONWEALTH of VIRGINIA

Department for the Aging

James Rothrock, Interim Commissioner

November 8, 2010

Donald M. Berwick, MD, Administrator
Centers for Medicare & Medicaid Services
200 Independence Ave. S.W.
Washington, DC 20201

Dear Dr. Berwick:

As we approach critical dates in this program, it is clearly incumbent on us to share with you some grave concerns that impact our Commonwealth's capacity to provide the quality of services our consumers deserve and have become used to receiving.

The Virginia SHIP program, called the Virginia Insurance Counseling and Assistance Program (VICAP), assisted more than 34,000 beneficiaries last year. We have 22 local program coordinators and approximately 200 trained and certified volunteers providing Virginia's beneficiaries, or their caregivers, the information they need to make the best decisions possible regarding their health care coverage. The VICAP program utilizes various tools and its success positively correlates with strong partnerships such as the one we share with the Centers for Medicare & Medicaid Services (CMS).

As you know, CMS launched the new **Plan Finder** earlier this year in an effort to improve performance and assist beneficiaries in choosing appropriate Medicare prescription drug coverage. The **Plan Finder** is critical to all SHIPs nationwide because of the plethora of information it provides beneficiaries when deciding on a plan that best fits their needs.

Unfortunately, the new **Plan Finder** is more cumbersome and too often inaccurate, rendering the system unreliable and ineffective to the SHIPs and all individuals utilizing the new system. Below is a list of some of the issues **Plan Finder** users are experiencing and need to be addressed immediately:

- costs for medications differ between comparison pages and plan detail pages;
- there are inconsistencies in costs of co-payments relative to beneficiaries' full/partial dual status;

- "Timing Out" occurs while utilizing the **Plan Finder**. Sometimes saving mid-way through the process helps, but not always, and this slows down counselors;
- printing issues include the font being *too small* and too light in color;
- **Plan Finder** is "temperamental" at best when trying to print cost comparisons. Users are unable to print drug comparison sheets when comparing multiple plans and unable to print a full monthly cost comparison;
- CMS server problems prohibit users from accessing the **Plan Finder** at all or it slows the **Plan Finder** environment down dramatically;
- during the middle of the day, while doing **Plan Finder** comparisons, users have received the following message, "*We are performing routine maintenance...back shortly,*" halting further progress with beneficiaries; and
- personal beneficiary information is not always populating when the information has been entered into the system.

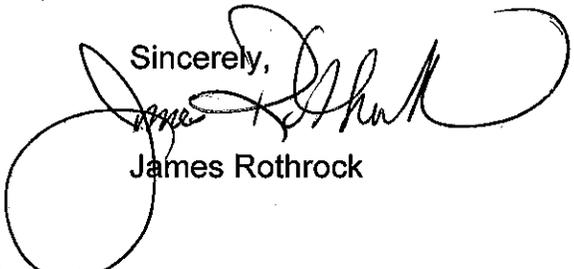
While this letter comes from a SHIP perspective, it is important to remember that SHIPs are not the only users of the **Plan Finder**. These struggles exacerbate an already complicated system for those navigating Medicare and their options independently. With the Annual Enrollment Period beginning in just over a week, we respectfully request that CMS work to **immediately remedy** the issues presented in this letter and other issues that have been presented through the SHIP mailbox, emails and direct phone calls.

You fully realize the importance of this effort and know that we at VDA are working to bring about a process that works for all, and **Plan Finder** is such a critical element of any success that can be attained. VDA stands ready to work with you to realize the requisite improvements our partners deserve to fully implement this system, but it is so frustrating to expend substantial resources and have the system fail and often requiring additional and duplicative resource expenditures.

Thank you in advance for your time and consideration of this situation which threatens the ability of older Virginians and Virginians with disabilities to acquire affordable and appropriate health care coverage. We look forward to seeing your affirmative response.

With high expectations, and best regards, I am

Sincerely,


James Rothrock

cc: Hon. William A. Hazel, Jr., MD
Secretary of Health & Human Resources
Alfonso Lopez, Director
Virginia Liaison Office



COMMONWEALTH of VIRGINIA
Department for the Aging

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging
FROM: Jim Rothrock, Interim Commissioner
DATE: November 9, 2010
SUBJECT: Aging Best Practices

I just left an energizing discussion regarding our emerging Options Counseling initiative and wanted to share some related information with you.

Earlier in the Fall, I asked you to submit some suggested best practices for collaboration among our AAAs and CILs. Below is a listing of the ones that were submitted which clearly demonstrate how we are working together on behalf of Virginians who have disabilities or Older Virginians.

Also, there are contact numbers given in hopes that you can see what you think is something you could replicate and you can make a call or shoot an email to learn about what you may consider in your own backyard.

Thanks to all who submitted items and thanks for all you do to improve our system of services.

Table with 3 columns: Submitted by, Best Practice, Contact. Row 1: JABA, JABA's Adult Care Centers (ACCs) in Charlottesville and Louisa, Cheryl Cooper, COO JABA 434-817-5227 ccooper@jabacares.org

	<p>Participants receive assistance with ADLs, medications and health monitoring. These intergenerational sites provide activities such as crafts, singing, arranging flowers, discussion groups and word games that keep older adults and individuals with physical and/or cognitive disabilities active in every way.</p>	
JABA	<p>Access Guide to Local Businesses and Services</p> <p>JABA and the local CIL conducted a study to gauge accessibility to local businesses and services in the Charlottesville area. Using wheelchairs, teams moved through the community to determine which businesses and agencies were accessible and which had limited and challenging accessibility. The agencies plan to update the study this year.</p>	<p>Cheryl Cooper, COO JABA 434-817-5227 ccooper@jabacares.org</p>
JABA	<p>Home Safety Assessments in Public Housing</p> <p>Using CDBG funds, JABA conducted home safety assessments in a public housing site in Charlottesville, allowing older adults and people with disabilities to remain living in the community. An OT and a CNA worked with residents. Home modifications and assistive devices were provided and residents were instructed in their use.</p>	<p>Cheryl Cooper, COO JABA 434-817-5227 ccooper@jabacares.org</p>
JABA	<p>Nursing Clinic in Public Housing Community</p> <p>JABA provides nursing services at a Charlottesville public housing community that is home to older adults and adults with disabilities. Nurses provide monitoring of chronic health conditions, medication management, first aid and collaboration with primary care physicians. These services help reduce ER visits and hospitalizations and allow aging in community.</p>	<p>Cheryl Cooper, COO JABA 434-817-5227 ccooper@jabacares.org</p>
Lake Country Area Agency on Aging	<p>AAA Office as Training Site for DRS Clients</p> <p>Lake Country Area Agency on Aging - PSA 13 is currently serving as a training site for a recent graduate of a PCA program who came</p>	<p>Gwen Hinzman, President/CEO LCAAA</p>

	<p>to us through DRS. His goal is to later enroll in a CNA program and perhaps move on to the nursing field. Our Hazelwood Adult Day Health Care Center serves as a wonderful site for him to gain one on one hands-on experience with older adults and individuals with disabilities as well as help us provide better services to our clients ages 49 - 92. Other aides and employees serve as mentors and role models for this young man.</p> <p>I would encourage other personal care providers to seek out their local DRS office and agree to be a training site if the need should arise. This is a win-win situation for both of us.</p>	
<p>Prince William Area Agency on Aging</p>	<p>AAA and CIL Collaborations in Transportation</p> <p>Independence Empowerment Center, Inc., (IEC) and the Prince William Area Agency on Aging (Agency) will provide transportation vouchers for persons who cannot drive. IEC will become a <i>No Wrong Door</i> partner. We will pass through New Freedom grant funds to IEC for transportation service vouchers, PeerPlace connection, computer equipment/service and some staff time. Customers will choose their transportation providers from a consortium of local transportation providers contracted for the grant.</p>	<p>Courtney Tierney</p>
<p>Fairfax Area Agency on Aging</p>	<p>Collaborative Organizational Structure</p> <p>The Disability Services Planning and Development unit and the Fairfax Area Agency on Aging are part of the Adult & Aging Services Division, which also includes Adult Services and Adult Protective Services, within the Fairfax County Department of Family Services.</p>	<p>Sharon K. Lynn Acting Director, Fairfax Area Agency on Aging 703-324-5425</p>
<p>Fairfax Area Agency on Aging</p>	<p>Combined Intake Service</p> <p>Adult & Aging Services has a combined Intake called the Aging, Disability and Caregiver Resource Line (ADCR). ADCR provides CRIA services for adults over age 18 and caregivers. Callers have to call only one number to be connected with Adult Protective Services, case management, in-home care, caregiver support,</p>	<p>Sharon K. Lynn Acting Director, Fairfax Area Agency on Aging 703-324-5425</p>

SUBJECT:Aging Best Practices

	Medicaid pre-admission screenings, home delivered meals, volunteer services, and comprehensive consultation on disability rights laws.	
Fairfax Area Agency on Aging	<p>Cluster Care Services</p> <p>Cluster care services, which integrates Department of Social Services' companion services and Adult Services with AAA's cost sharing program, respite services, care coordination, home delivered meals, and volunteer services, serves over 3,500 older adults and adults with disabilities per year.</p>	Sharon K. Lynn Acting Director, Fairfax Area Agency on Aging 703-324-5425
Fairfax Area Agency on Aging	<p>Collaborations toward Universal Design</p> <p>Disability Services and AAA staff participate on the county's Building for All Committee that developed a Universal Design website, established a Universal Design Ombudsman position for Fairfax County and held a number of public and private trainings and outreach events promoting the benefits of universal design.</p>	Sharon K. Lynn Acting Director, Fairfax Area Agency on Aging 703-324-5425
Fairfax Area Agency on Aging	<p>Emergency Preparedness</p> <p>An emergency medical shelter plan with a training component was developed. Disability Services and AAA staff also worked with Fairfax County's Department of Emergency Management to develop an emergency medical registry.</p>	Sharon K. Lynn Acting Director, Fairfax Area Agency on Aging 703-324-5425
Fairfax Area Agency on Aging	<p>SeniorNavigator and disAbility Navigator</p> <p>Disability Services staff along with other county staff worked with SeniorNavigator to develop disAbility Navigator.</p>	Sharon K. Lynn Acting Director, Fairfax Area Agency on Aging 703-324-5425

COMMONWEALTH of VIRGINIA
Department for the Aging

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Tim Catherman
Director of Administrative Services

DATE: November 9, 2010

SUBJECT: 2011 Medicare Deductibles

Medicare Part A, which pays for inpatient hospital, skilled nursing facility, and some home health care, the hospital inpatient deductible will be \$1,132 in 2011, an increase of \$32 from this year's \$1,100 deductible. For skilled nursing facilities, the daily co-insurance for days 21 through 100 in a benefit period will be \$141.50 in 2011, compared to \$137.50 in 2010.

The monthly premium paid by beneficiaries enrolled in **Medicare Part B** covers a portion of the cost of physicians' services, outpatient hospital services, certain home health services, durable medical equipment, and other items. The standard Medicare Part B monthly premium will be \$115.40 in 2011, a \$4.90 increase (or 4.4 percent) over the 2010 premium.

Attached is the CMS announcement.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
Room 303-D
200 Independence Avenue, SW
Washington, DC 20201



Media Affairs Office

MEDICARE FACT SHEET

For Immediate release
November 4, 2010

Contact: CMS Office of Media Relations
(202) 690-6145

MEDICARE PREMIUMS, DEDUCTIBLES FOR 2011

The Centers for Medicare and Medicaid Services (CMS) has set the Medicare premiums, deductibles and coinsurance amounts to be paid by Medicare beneficiaries in 2011.

For Medicare Part A, which pays for inpatient hospital, skilled nursing facility, and some home health care, the deductible paid by the beneficiary when admitted as a hospital inpatient will be \$1,132 in 2011, an increase of \$32 from this year's \$1,100 deductible. The Part A deductible is the beneficiary's cost for up to 60 days of Medicare-covered inpatient hospital care in a benefit period. Beneficiaries must pay an additional \$283 per day for days 61 through 90 in 2011, and \$566 per day for hospital stays beyond the 90th day in a benefit period. For 2010, the per-day payment for days 61 through 90 was \$275, and \$550 for beyond 90 days. For beneficiaries in skilled nursing facilities, the daily co-insurance for days 21 through 100 in a benefit period will be \$141.50 in 2011, compared to \$137.50 in 2010. Those who enroll in Medicare Advantage plans may have different cost-sharing arrangements. All of these Part A program payment changes are determined in accordance with a statutory formula.

About 99 percent of Medicare beneficiaries do not pay a premium for Medicare Part A services since they have at least 40 quarters of Medicare-covered employment. However, some enrollees age 65 and over and certain persons with disabilities who have fewer than 30 quarters of coverage obtain Part A coverage by paying a monthly premium established according to a statutory formula. This premium will be \$450 for 2011, a decrease of \$11 from 2010. Individuals who have between 30 and 39 "quarters of coverage" may buy into Part A at a reduced monthly premium rate of \$248 in 2011.

The monthly premium paid by beneficiaries enrolled in Medicare Part B covers a portion of the cost of physicians' services, outpatient hospital services, certain home health services, durable medical equipment, and other items. The standard Medicare Part B monthly premium will be \$115.40 in 2011, a \$4.90 increase (or 4.4-percent) over the 2010 premium. However, the majority of Medicare beneficiaries will continue to pay the same \$96.40 premium amount they have paid since 2008.

Part A premiums are decreasing because spending in 2010 was lower than expected and the Affordable Care Act implemented policies that lower Part A spending due to payment efficiencies and efforts related to waste, fraud and abuse. Part B premiums are increasing because of growth in the use of services like outpatient hospital care, home health and physician-administered drugs. In addition, the premium accounts for a likely Congressional action to avert a precipitous decrease in physician

- More -

payments, which the Administration supports, and has occurred every year since 2003. The Administration is committed to permanent reform of the physician payment formula.

By law, the standard premium is set to cover one-fourth of the average cost of Part B services incurred by beneficiaries aged 65 and over, plus a contingency margin. The contingency margin is an amount appropriate to (i) cover incurred-but-unpaid claims costs, (ii) provide for possible variation between actual and projected costs, and (iii) amortize any surplus assets or unfunded liabilities. The remaining Part B costs are financed by Federal general revenues. (In 2011, \$2.5 billion in Part B expenditures will be financed by the new fees on manufacturers and importers of brand-name prescription drugs under the Affordable Care Act. The revenue from these fees reduces the standard Part B premium by \$0.90.)

Based on current estimates, Part B assets are not sufficient to cover the amount of incurred-but-unpaid expenses and to provide for a significant degree of variation between actual and projected costs. Thus, a large positive contingency margin is needed to increase assets to a more appropriate level.

The size of the contingency margin for 2011 is affected by two additional factors. First, the current law formula for physician fees will result in a payment reduction of 23 percent in December 2010 and, in this analysis, is projected to cause an additional reduction of about 6.5 percent starting January 2011. (The actual reduction in physician fees under current law for January 2011 is now known to be 2.5 percent. As is typical, the final adjustment was not available in time to include in the premium determination.) There is a strong likelihood that these reductions will be overridden by legislation enacted after Part B premiums are established for 2011. For each year from 2003 through November 2010, Congress has acted to prevent smaller physician fee reductions from occurring.

In recognition of this strong possibility of higher Part B expenditures resulting from similar legislation to override the decreases in physician fees in December 2010 and January 2011, it is appropriate to maintain a significantly larger Part B contingency reserve than would otherwise be necessary. The asset level projected for the end of 2010 would otherwise not be adequate to accommodate this contingency.

Second, for most Part B beneficiaries a “hold-harmless” provision prevents their net Social Security benefit from decreasing as a result of an increase in the Part B premium. There was no increase in Social Security benefits for 2010, and, as a result of slow growth in the CPI, this result will occur again for 2011. Consequently, the increase in the Part B premium for 2011 will be paid by only a small percentage of Part B enrollees. Approximately 27 percent of beneficiaries are not protected by the hold-harmless provision because they are subject to the income-related additional premium amount (5 percent), they are new enrollees during the year (3 percent), or they do not have their Part B premiums withheld from Social Security benefit payments (19 percent, 17 percentage points of whom qualify for both Medicare and Medicaid and have their Part B premiums paid by Medicaid).

Although Part B premiums will remain flat in 2011 for the great majority of beneficiaries, program costs will still increase significantly. In order for Part B to be adequately funded in 2011, the 2011 contingency margin has been increased to account for this situation. However, this adjustment results in a larger-than-usual premium paid by or on behalf of a minority of Part B enrollees. No other means is available under current law to prevent a substantial decrease in account assets, which would jeopardize the ability to pay Part B benefits.

As required in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, beginning in 2007 the Part B premium a beneficiary pays each month is based on his or her annual income. Specifically, if a beneficiary's "modified adjusted gross income" is greater than the legislated threshold amounts (\$85,000 in 2011 for a beneficiary filing an individual income tax return or married and filing a separate return, and \$170,000 for a beneficiary filing a joint tax return) the beneficiary is responsible for a larger portion of the estimated total cost of Part B benefit coverage. In addition to the standard 25 percent premium, affected beneficiaries must pay an income-related monthly adjustment amount. About 5 percent of current Part B enrollees are expected to be subject to the higher premium amounts.

The 2011 Part B monthly premium rates to be paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year), or who file a joint tax return are shown in the following table:

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Part B income-related monthly adjustment amount	Total monthly Part B premium amount
Less than or equal to \$85,000	Less than or equal to \$170,000	\$0.00	\$115.40
Greater than \$85,000 and less than or equal to \$107,000	Greater than \$170,000 and less than or equal to \$214,000	\$46.10	\$161.50
Greater than \$107,000 and less than or equal to \$160,000	Greater than \$214,000 and less than or equal to \$320,000	\$115.30	\$230.70
Greater than \$160,000 and less than or equal to \$214,000	Greater than \$320,000 and less than or equal to \$428,000	\$184.50	\$299.90
Greater than \$214,000	Greater than \$428,000	\$253.70	\$369.10

In addition, the monthly premium rates to be paid by beneficiaries who are married, but file a separate return from their spouse and lived with their spouse at any time during the taxable year are as follows:

Beneficiaries who are married but file a separate tax return from their spouse:	Part B income-related monthly adjustment amount	Total monthly Part B premium amount
Less than or equal to \$85,000	\$0.00	\$115.40
Greater than \$85,000 and less than or equal to \$129,000	\$184.50	\$299.90
Greater than \$129,000	\$253.70	\$369.10

As a result of the Medicare Modernization Act, the Part B deductible was increased to \$110 in 2005 and is indexed by the annual percentage increase in the Part B actuarial rate for aged beneficiaries. In 2011, the Part B deductible will be \$162. (The actuarial rate is set by law at one-half of the total estimated per-enrollee cost of Part B benefits and administrative expenses, adjusted as necessary to maintain an adequate contingency reserve.)

Enrollees in Medicare Part D prescription drug plans pay premiums that vary from plan to plan depending on each plan's efficiency and scope of benefits. Beginning in 2011, the Affordable Care Act requires Part D enrollees whose incomes exceed the same thresholds that apply to higher income Part B enrollees to pay a monthly adjustment amount. These enrollees will pay the regular plan premium to their Part D plan and will pay the income-related adjustment to Medicare. The 2011 Part D income-related monthly adjustment amounts to be paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year), or who file a joint tax return are shown in the following table:

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount
Less than or equal to \$85,000	Less than or equal to \$170,000	\$0.00
Greater than \$85,000 and less than or equal to \$107,000	Greater than \$170,000 and less than or equal to \$214,000	\$12.00
Greater than \$107,000 and less than or equal to \$160,000	Greater than \$214,000 and less than or equal to \$320,000	\$31.10
Greater than \$160,000 and less than or equal to \$214,000	Greater than \$320,000 and less than or equal to \$428,000	\$50.10
Greater than \$214,000	Greater than \$428,000	\$69.10

In addition, the income-related monthly adjustment amounts to be paid by Part D beneficiaries who are married, but file a separate return from their spouse and lived with their spouse at any time during the taxable year are as follows:

Beneficiaries who are married and lived with their spouse at any time during the year, but file a separate tax return from their spouse:	Income-related monthly adjustment amount
Less than or equal to \$85,000	\$0.00
Greater than \$85,000 and less than or equal to \$129,000	\$50.10
Greater than \$129,000	\$69.10

As noted above, states have programs that pay some or all of beneficiaries' Part A and Part B premiums and coinsurance for certain people who have Medicare and a limited income. Similarly, Part D beneficiaries with limited income and assets are eligible for Federal subsidies to reduce their premiums and coinsurance. Information is available at 1-800-MEDICARE (1-800-633-4227) and, for hearing and speech impaired, at TTY/TDD: 1-877-486-2048.



11-34

COMMONWEALTH of VIRGINIA
Department for the Aging

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Bill Peterson

DATE: November 9, 2010

SUBJECT: Preliminary Election Analysis from NASUAD

FYI: Attached is a preliminary analysis of the November 2, 2010 election results from the National Association of States United for Aging and Disabilities (NASUAD).

Attachment



MEMORANDUM

DATE: November 4, 2010

TO: NASUAD Members

FROM: NASUAD Staff

SUBJECT: Preliminary Election Analysis

The purpose of this memorandum is to provide National Association of States United for Aging and Disabilities (NASUAD) members with a preliminary analysis of the November 2 midterm election results. Below, the Association staff provide a preliminary overview and analysis of the following:

- ***Congressional Implications*** – In this section, NASUAD staff discuss implications for Committee Chairpersonship positions and major legislation (e.g., Affordable Care Act (ACA), the reauthorization of the Older Americans Act (OAA), Appropriation measures, and the reauthorization of the Workforce Investment Act (WIA)).
- ***State-Federal Representation*** – Also discussed, below, are possible changes in the composition of key state government associations including the National Governors Association (NGA), the National Conference of State Legislatures (NCSL), and the Council of State Governments (CSG).
- ***Ballot Initiatives*** – Finally, the memo offers an overview of key state ballot initiatives. The initiatives have been grouped into the following categories: a) budget and financing; b) health; and c) aging and disability.

Still outstanding are two U.S. Senate seats, a handful of U.S. House of Representative seats and one Governor – West Virginia. As these seats are filled and more information becomes available about possible policy agenda shifts and priorities for the new Congress, NASUAD will provide regular updates.

If you have questions or suggestions for tracking and reporting, please feel free to contact either Martha Roherty at mroherty@nasuad.org or Mike Cheek at mcheek@nasuad.org.

President
Irene B. Collins
Alabama

Vice President
James Toews
Oregon

Treasurer
Charles D. Johnson
Illinois

Secretary
Carol Sala
Nevada

Immediate Past President
Patricia A. Polansky
New Jersey

Past President
Kathy Leitch
Washington

Background

On November 2, 37 gubernatorial elections were held in addition to the midterm Congressional elections. Incoming elected officials will face a myriad of issues including directly several that will directly impact NASUAD members and their service systems:

1. *A Continuing Economic Crisis.* Most states are facing declining or flat revenues levels while, at the same time, they are facing an increasing demand for publicly-financed heating bills and providing home delivered meals, as well as all types of long-term services and supports (LTSS). Due to these issues, state directors continue to grapple with difficult budget and service reductions decisions. According to the most recent NASUAD Economic Survey nearly 80 percent of the states reported that they made cuts both FY 2009 and FY 2010. Most states have indicated that FY 2011 and FY 2012 also will prove challenging. Discussed in more detail below, the economic crisis also has forced many states to make administrative cuts, including in personnel, and struggle with unforeseen increases in service demands while resources dwindle.
2. *State Workforce Reductions.* In a 2009 NASUAD survey, 32 percent of the states reported that more than 25 percent of their department employees were eligible for retirement. Nearly one million state workers have vacated their positions in state service since the start of the recession through early retirement and increased furlough days resulting in a reduction of nearly one fifth of the overall state government workforce. This reduction has placed a strain on exiting staffs to maintain current government operations but in many cases without the institutional knowledge required to administer complex supports and services programs. Additionally, many states have implemented hiring freezes, resulting unfilled positions, furlough days, and lay-offs.
3. *A Growing Population of Baby Boomers and Increasing Demand for Services and Supports.* The first baby boomer turned 60 years old in 2006, heralding an era of increasing demand for services financed by the Older Americans Act, Medicare, Medicaid, as well as Social Security income supports and retirement benefits. Already, over 52 million Americans are over age 60. By 2020, almost one in six individuals will be age 65 and older. Exacerbating the demographic shift impacts, the economic crisis has resulted in unforeseen demand increases for NASUAD member services (i.e., meals, transportation, foreclosure assistance, information and referral, requests for assistance with benefits applications, such as Medicaid, and Medicaid-financed but NASUAD member operated services).
4. *A Complex New Health Care System.* The passage of the Affordable Care Act (ACA) signaled a sea change in the way that most state aging and LTSS programs are administered. In addition to the relatively minor ACA opportunities that will

be overseen by the Administration on Aging (AoA), state agencies are struggling to keep track of the numerous Medicare program and the Medicaid program changes. ACA also includes an array of options tended to help build stronger home and community based systems but such options differ from traditional mechanisms.

5. *Fragmented LTSS Systems.* In a global economy, adult children are geographically dispersed because of professional opportunities, but remain involved in their parents' health care and social needs. Frequently, adult children are unable to access timely and accurate information on long-term services and supports for their loved ones due to lack of a basic understanding of what services and supports are available and whom to call for help. Further complicating the matter are information technology databases that are unable to interface with other health and human services system. Such a fragmented MIS/IT infrastructure calls for a more coordinated effort between SUAs, AAAs, ADRCs, and Centers for Independent Living (CILs) that are able to deliver information in a reliable and timely manner. Cash strapped state agencies likely are not in a position to make significant changes in IT architecture without federal program assistance (i.e., Advanced Planning Documents, Cost Allocation Plans, etc.).

Preliminary Analysis

Below, NASUAD provides an overview of Congressional changes and potential implications, State-Federal representation and implications for liaison, and state ballot initiatives.

Congressional Changes and Potential Implications. Republicans have secured control of the U.S. House of Representatives and made significant gains in the U.S. Senate. Taking advantage of an anti-incumbent mood grounded largely on a weak economy and 9.6 percent unemployment rate, Republicans recaptured 61 seats in the House bringing their total number of representatives to 240, with 10 seats undecided. In the Senate, Republicans have *officially* (see discussion below) picked up six seats held by Democrats, bringing their total to 46, leaving Democrats with a razor-thin majority. Moving forward, Democrats will need to rely on the continued support of Independents Senators Lieberman (I-CT) and Sanders (I-VT) who currently caucus with the Democrats.

Two Senate seats remain too close to call, Murray (D-WA) and Murkowski (R-AK). Murkowski is battling against Republican tea-party backed Joe Miller; thus, regardless of the Alaska outcome, Republicans are guaranteed the seat in Alaska, bringing their total to **47**. In Washington State, there is a two percent spread between candidates meaning that the final results could take days or weeks to determine. Notably, Senator Harry Reid won his reelection bid against Sharron Angle, and he is expected to remain the Senate Majority Leader. However, Senator Lincoln (D-AR), staunch supporter of Older

Americans Act services and a member of the U.S. Senate Committee on Finance and its Subcommittee on Health Care with jurisdiction over Medicare and Medicaid programs, lost her bid for a third term.

Senate Democrats plan to hold elections for committee leadership on November 16. It has not yet been announced when Republican committee leadership elections will be held, but it is widely speculated that Alabama's Senator Sessions (R-AL) will move to the Budget Committee, opening the Judiciary leadership slot for Grassley of Iowa, who is term-limited as ranking member of the Finance Committee which has jurisdiction over Medicare and Medicaid. Taking over the GOP team on Finance will be Hatch of Utah. Control of the Senate Committee on Health Education Labor and Pensions (HELP), which has jurisdiction over the services provided under the Older Americans Act, is likely to remain the same.

Moving forward, Republicans will take over as the Chairs of key House Committees, including the Committee on Energy and Commerce which has jurisdiction over Medicaid, the Committee on Ways and Means which has jurisdiction over Social Security and Medicare, and the Committee on Education and Labor with jurisdiction all matters dealing with programs and services for the elderly, including nutrition programs and the Older Americans Act and other key programs such as the Social Services Block Grant program and the Low-Income Home Energy Assistance Program (LIHEAP).

State-Federal Representation and Liaison. Many of NASUAD's national partners are membership organizations, such as the National Governors Association, the National Conference on State Legislatures, and the Council of State Governments. Accordingly, their policy priorities and legislative agendas depend heavily on the composition of their membership. With the 2010 midterm elections ushering in dramatic partisan changes at the state and national levels, these organizations will necessarily be impacted with the influx of newly elected officials who are their members. As the new class of state and federal officials takes office, NASUAD will continue to work with our partners to monitor how the changes at the national and state levels will affect states in the coming years. See Table 1, below for an overview. The Governors and the Legislatures are discussed separately, below.

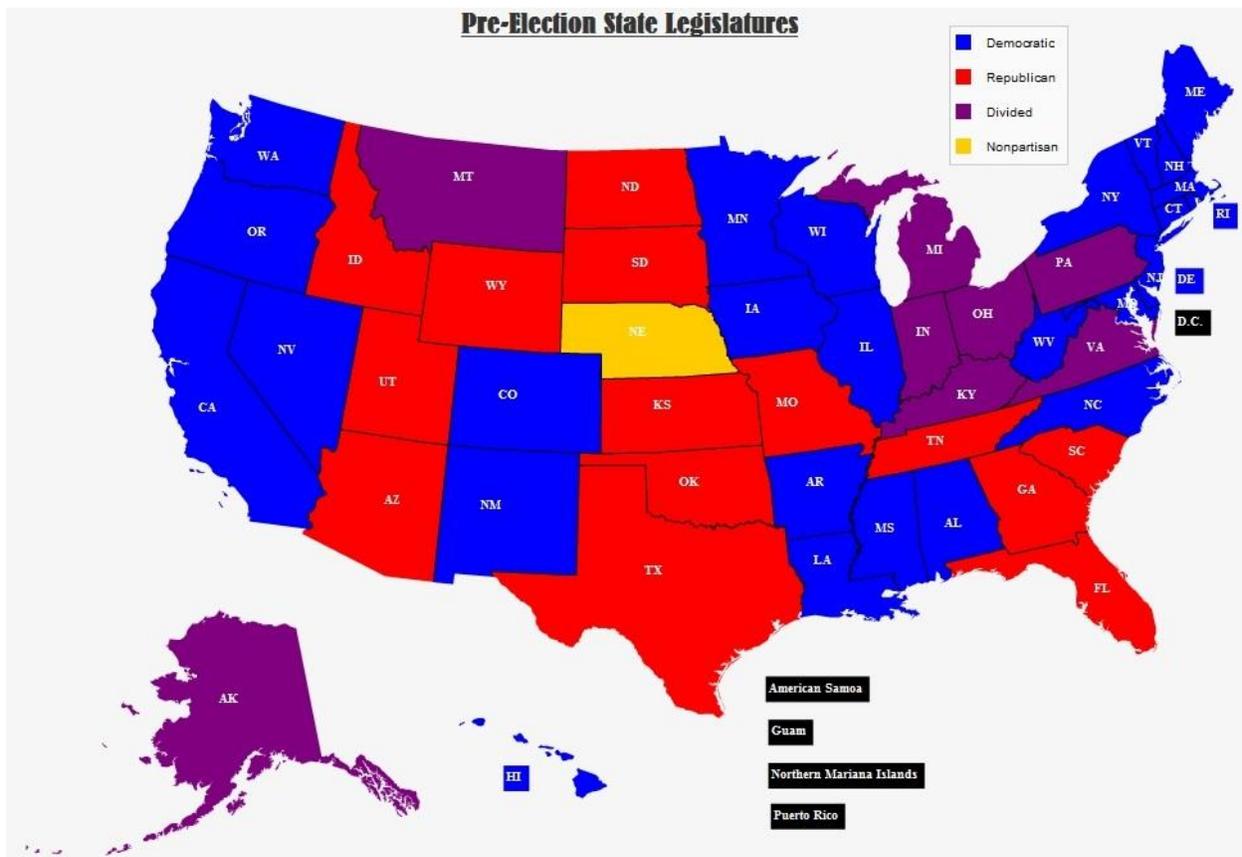
Table 1.

2010 STATE AND LEGISLATIVE PARTISAN COMPOSITION PRE AND POST MIDTERM ELECTIONS						
	Legislative Control		Governor's Party		State Control (Gov. and Leg.)	
	Pre- Election	Post-election	Pre-election	Post-election	Pre-election	Post-election
Democrat	27		26	16	16	
Republican	14		23	29	9	
Independent			1	1		
Divided	8				24	
Undecided				4		

Table 3.

STATE LEGISLATURE PARTY CHANGES		
	Pre-election	Post-election
Democrat	27	N/A
Republican	14	N/A
Independent		
Divided	8	N/A
Undecided Races		

Figure 3.



Ballot Initiatives. A number of states also included ballot initiatives. **Attachment A** provides an overview of these efforts categorized as follows: a) state budget and finance initiatives; b) health-focused initiatives; and c) aging and disability-focused initiatives.

Implications

Regarding Congress, in their new positions, House Republican leaders have vowed to deliver on their "golden opportunity" to roll back the size of government and President Barack Obama's signature health care law. Repealing the health care law, with its mandates and subsidies to extend health insurance to nearly all Americans, has been a Republican rallying cry for months but Obama, with his veto power, and the Democrats still in control of the Senate stand in the way. "I think it is important for us to lay the groundwork before we begin to repeal this monstrosity," Boehner said. Senate Majority Leader Harry Reid, said "I'm ready for some tweaking" on the health care law but would fight its repeal. Other Democrats in both Houses of Congress also have expressed an appetite for ACA changes.

Thus, with prospects of repealing the law increasingly unlikely, GOP lawmakers have begun to look for other ways to promote their "repeal and replace" health care agenda, such as interfering with the law's implementation through blocking ACA funding, targeting the repeal of unpopular provisions of the bill, and filling the calendars of key Administration officials with Congressional hearings.

A successful Republican strategy of blocking funds needed to implement the law would require the unlikely approval of both Senate Democrats and President Obama. Thus, House appropriators will have to compromise on spending bills, or be willing to risk a government shutdown if funding is not approved through the appropriations process. To avoid such a scenario, the GOP may elect to target funding for the more unpopular provisions of the law, such as the Independent Payment Advisory Board created to limit Medicare spending growth, instead of electing to stall all implementation funding. Similarly, the House majority may work to garner bipartisan support for eliminating certain pieces of the legislation, such as the ACA's tax-reporting requirement for small businesses, a provision which both parties have introduced legislation to repeal.

While Republican lawmakers could potentially disrupt the implementation process by holding numerous hearings to question top administration officials, such as HHS Secretary Sebelius and CMS Administrator Berwick, these efforts would serve more as a temporary political maneuver than as a long-term legislative strategy. Therefore, as a result of Republicans gaining control of the House, it is likely that their agenda will include initiatives designed to impede the implementation of the ACA, rather than immediate, successful efforts to repeal the law in its entirety. While any legislation

would require approval of Senate Democrats and a Democratic President, there remain procedural and legislative tactics that the GOP may employ in the 112th Congress.

Additionally, it is likely that the FY 2011 budget process will not proceed; instead a Continuing Resolution with level funding will ensue until the new Congress is sworn in 2011. Therefore, the proposed increased funding for the Older Americans Act programs for FY 2011 is in question. In addition, given the ambitious legislative agenda of the Republican Party (i.e., extending the Bush Tax cuts, reducing government spending, repealing and replacing the Affordable Care Act, government reform, and national security), it will prove difficult to reauthorize in the 112th Congress the Older Americans Act and other important legislation, such as the Workforce Investment Act.

At the state level, currently, 20 Republican state attorneys general and governors have filed a challenge to the ACA and its implementation in Florida Federal District Court, alleging in part, that the new law's individual mandate is unconstitutional, and that the ACA's requirement that states expand their Medicaid programs violates state sovereignty by unlawfully commandeering state resources. The federal judge in the case ruled in October that the challenges in the suit may proceed, and the case is pending.

Recently, a federal judge in Michigan upheld the ACA's insurance coverage mandate as constitutional, ruling that the mandate was well within Congress's power to regulate interstate commerce, thereby dismissing the plaintiff's motion to enjoin the enforcement of the ACA. Elsewhere, a federal court in Virginia denied the Obama Administration's motion to dismiss a similar lawsuit challenging the ACA's constitutionality, thus allowing the case to proceed. With conflicting judicial opinions being issued, it is likely that the question of the ACA's constitutionality will eventually be resolved by the Supreme Court. With a net gain of seven Republican governors (as of 11/3), it is possible that additional states will file lawsuits challenging the ACA, or will join existing suits. NASUAD will continue to monitor the progress of these judicial challenges.

Finally, with a large number of new Federal and State Legislators as well as Governors, it will be critical for NASUAD members to be prepared to secure lines of communication with new federal and state legislators as well as in-coming Governors' transition teams to education them about key issues such as:

1. *Impacts of the Continuing Economic Crisis on Elders, Persons with Disabilities and the Systems that Support them.* First, Legislators and new Executives must understand the new demand-side landscape. The first baby boomer turned 60 years old in 2006, heralding an era of increasing demand for services financed by the Older Americans Act, Medicare, Medicaid, as well as Social Security income supports and retirement benefits. Already, over 52 million Americans are over

- age 60. By 2020, almost one in six individuals will be age 65 and older. Exacerbating the demographic shift impacts the economic crisis has resulted in unforeseen demand increases for NASUAD member services (i.e., meals, transportation, foreclosure assistance, information and referral, request for assistance with benefits application, such as Medicaid, and Medicaid-financed but NASUAD member operated services).
2. *Dwindling State Resources and Complex New Systems.* Many states have or currently are experiencing a significant number of early retirements. Additionally, many states have implemented hiring freezes, resulting unfilled positions, furlough days, and lay-offs. The culminating impact in most states is a much smaller workforce. Concurrently, states have an array of mandatory efforts that must be implemented. First, the passage of the Affordable Care Act (ACA) signaled a sea change in health care coverage. State Medicaid agencies are struggling to keep pace with ACA ***mandatory*** provisions as well as implement ***critical*** budget saving efforts. At the same time, ACA also includes an array of ***optional*** changes to how aging and long-term supports and services (LTSS) programs may be administered. Second, states continue to struggle to develop efficient strategies to deliver LTSS with fewer staff in fragmented arrangements. NASUAD officials may struggle to position LTSS system priorities in the broader context of tight resources and mandatory efforts (i.e., ACA-required provisions and budget efforts) unless such efforts can be attached to a budget savings effort or piggyback on an ACA provision.

In the coming months, NASUAD will be producing resources and tools for the membership to aid with these messaging and educational efforts.

Conclusion

As more detail become available, NASUAD to provide members with additional information. If you have questions, suggestions or concerns, please feel free to contact Martha Roherty at mroherty@nasuad.org or Mike Cheek at mcheek@nasuad.org.

STATE BALLOT MEASURES: STATE FINANCE AND BUDGET INITIATIVES

Summaries and highlights of state finance and budget ballot initiatives being considered in the 2010 midterm elections

STATE	BALLOT MEASURE	TYPE*	TOPIC AREAS	PROPOSAL SUMMARY	IMPACT	PASS/FAIL			
California	Proposition 19	I	<table border="1"> <tr><td>Tax & Revenue</td></tr> <tr><td>Drug Policy</td></tr> <tr><td>Criminal Justice</td></tr> </table>	Tax & Revenue	Drug Policy	Criminal Justice	Legalizes the possession and personal use of marijuana to anyone over the age of 21, and permits state and local governments to regulate and tax the sale of marijuana.	California initiatives tend to spread eastward, impacting future initiatives in other states, as it did with the passage of medical marijuana in 1996. This marks the first time a state has voted on legalizing and taxing the sale of marijuana.	FAIL
Tax & Revenue									
Drug Policy									
Criminal Justice									
California	Proposition 23	I	<table border="1"> <tr><td>Environment</td></tr> <tr><td>Energy & Utilities</td></tr> </table>	Environment	Energy & Utilities	Suspends compliance with the Global Warming Solutions Act of 2006 (The Act) until the state's unemployment rate drops to 5.5% for 4 consecutive quarters. The Act requires CA to reduce its greenhouse gas emissions to 1990 levels by 2020, and imposes fines on industries in 2012 if they do not reduce their carbon emissions.	California's global warming debate is symbolic of the debate at the national level; and election results on Prop. 23 could sway federal and state policy makers. It is also an example of the impact of corporate interests in state ballot measure campaigns, with the oil industry being the primary funding source for the "yes" side, and environmental groups funding the "no" side.	FAIL	
Environment									
Energy & Utilities									
Colorado	Amendment 60	I	<table border="1"> <tr><td>Tax & Revenue</td></tr> <tr><td>State Government</td></tr> <tr><td>Education</td></tr> </table>	Tax & Revenue	State Government	Education	Cuts local property tax rates in half, and requires Colorado to replace the reduction in local property tax revenue with state funding.	Colorado will have to decrease spending and services in other areas, such as programs that help older Americans and individuals with disabilities.	FAIL
Tax & Revenue									
State Government									
Education									

STATE	BALLOT MEASURE	TYPE*	TOPIC AREAS	PROPOSAL SUMMARY	IMPACT	PASS/FAIL				
Colorado	<u>Amendment 61</u>	I	<table border="1"> <tr><td>State Budgets</td></tr> <tr><td>State Government</td></tr> <tr><td>Local Government</td></tr> <tr><td>Elections</td></tr> </table>	State Budgets	State Government	Local Government	Elections	Prohibits all state borrowing after 2010, require voter approval for local government borrowing, requires that local government bonds be repaid within 10 years, and that tax rates be cut once outstanding bonds are repaid.	If approved, Amdt. 61 would make CO the only state prohibited from issuing bonds to fund infrastructure projects.	FAIL
State Budgets										
State Government										
Local Government										
Elections										
Colorado	<u>Proposition 101</u>	I	<table border="1"> <tr><td>Tax & Revenue</td></tr> <tr><td>State Budget</td></tr> <tr><td>Telecom</td></tr> <tr><td>Transportation</td></tr> </table>	Tax & Revenue	State Budget	Telecom	Transportation	Implements a phased-in approach to cutting the state income tax rate from 4.63% to 3.5%, and reduces or eliminates most taxes and fees on transportation and telecommunication.	As a result of the decrease in tax and fee collections, the state and local governments will have to decrease spending and services, increase fees to pay for services, or some combination of both.	FAIL
Tax & Revenue										
State Budget										
Telecom										
Transportation										
New Jersey	<u>Constitutional Amendment</u>	L	<table border="1"> <tr><td>State Budget</td></tr> <tr><td>State Government</td></tr> <tr><td>Labor & Employment</td></tr> </table>	State Budget	State Government	Labor & Employment	The Amendment prohibits state collection of assessments based solely on employee wages and salaries for any purpose other than providing employee benefits.	If approved, NJ would be prohibited from using surpluses in state worker benefit funds to fund other programs or help balance the state budget.	PASS	
State Budget										
State Government										
Labor & Employment										
Oklahoma	<u>Question 744</u>	I	<table border="1"> <tr><td>State Budget</td></tr> <tr><td>Education</td></tr> </table>	State Budget	Education	Changes the way the state is required to fund public schools by establishing a formula to determine the average amount spent by surrounding states, and require the legislature to meet or exceed that amount.	This would increase state spending on K-12 education, though it is unclear by how much, and it would also place restrictions on spending decisions made by the legislature.	FAIL		
State Budget										
Education										

STATE	BALLOT MEASURE	TYPE*	TOPIC AREAS	PROPOSAL SUMMARY	IMPACT	PASS/FAIL			
Oklahoma	<u>Question 754</u>	L	<table border="1"> <tr><td>State Budget</td></tr> <tr><td>State Legislature</td></tr> </table>	State Budget	State Legislature	Prohibits any initiative from requiring the legislature to spend a particular amount on any particular government service or program, and prohibits requiring the legislature to base spending decisions on how other states spend.	Question 754 was placed on the ballot by the Oklahoma state legislature in response to the citizen initiative Question 744. It is unclear what would happen if these two conflicting measures were to pass.	FAIL	
State Budget									
State Legislature									
Oregon	<u>Measure 72</u>	L	<table border="1"> <tr><td>State Government</td></tr> <tr><td>Tax & Revenue</td></tr> </table>	State Government	Tax & Revenue	The measure asks voters to authorize a new exception to Oregon's \$50,000 borrowing limit to allow the state to issue general obligation bonds.	The measure would add a new exception to allow the state to issue general obligation bonds. No specific bonds are authorized, and it will be up to the Legislative Assembly to enact implementing legislation.	PASS	
State Government									
Tax & Revenue									
Virginia	<u>Ballot Question 3</u>	L	<table border="1"> <tr><td>State Budget</td></tr> <tr><td>Tax & Revenue</td></tr> </table>	State Budget	Tax & Revenue	Amends the Constitution of Virginia to increase the permissible size of the Revenue Stabilization Fund.	Currently, the General Assembly is constitutionally forbidden to set aside more than 10% of the state's average annual sales and income tax revenue from the preceding 3 budget years. This amendment raises that figure to 15%.	PASS	
State Budget									
Tax & Revenue									
Washington	<u>Initiative 1053</u>	I	<table border="1"> <tr><td>Tax & Revenue</td></tr> <tr><td>State Legislature</td></tr> <tr><td>State Budget</td></tr> </table>	Tax & Revenue	State Legislature	State Budget	Re-imposes the two-thirds vote requirement for passing tax increases in the WA legislature. One deficit solution discussed in the 2010 session was a hazardous substances tax, which is expected to come up again in 2011.	The supermajority vote requirement will make it more difficult for WA to balance its budget by passing the hazardous substances tax, which would heavily impact the oil industry, one of 1053's chief financial backers of Initiative 1053.	PASS
Tax & Revenue									
State Legislature									
State Budget									

STATE	BALLOT MEASURE	TYPE*	TOPIC AREAS	PROPOSAL SUMMARY	IMPACT	PASS/FAIL				
Washington	<u>Initiative 1107</u>	I	<table border="1"> <tr><td>State Legislature</td></tr> <tr><td>Tax & Revenue</td></tr> </table>	State Legislature	Tax & Revenue	Repeals tax increases passed in 2010 by the legislature, including a temporary extension of the sales tax to include bottled water, a permanent extension of the sales tax and include most candy and gum, and a temporary excise tax on carbonated drinks.	With these tax increases in place, WA is on track to set a new state record for fundraising in initiative campaigns this year. If repealed, estimates are that state revenue would be reduced by \$352 million over the next five years, and local government revenue by \$83 million over the same time period.	PASS		
State Legislature										
Tax & Revenue										
Washington	<u>Initiative 1098</u>	I	<table border="1"> <tr><td>Tax & Revenue</td></tr> <tr><td>Health</td></tr> <tr><td>Education</td></tr> <tr><td>Human Services</td></tr> </table>	Tax & Revenue	Health	Education	Human Services	Imposes a new 5% tax on incomes of more than \$200,000 for individual filers and \$400,000 for joint filers. The revenue gained from the new income tax would offset cuts in the state property tax and business occupation tax, and any additional revenue would be directed to health and education programs.	The official fiscal impact statement for this initiative estimates that passage of the measure would bring in \$11.16 billion over the next five years. \$240 million of that would offset the loss created by an increase in the business and occupation tax credit, \$383 million would offset a cut in the property tax, and the remainder would fund health and education programs.	FAIL
Tax & Revenue										
Health										
Education										
Human Services										

Composed in part with materials provided by the National Conference on State Legislatures, www.ncsl.org

*L = Legislative Referendum I = Citizen-Initiated

STATE BALLOT MEASURES: HUMAN SERVICES AND PROGRAMMATIC INITIATIVES

Summaries and highlights of state human services and programmatic initiatives being considered in the 2010 midterm elections

STATE	BALLOT MEASURE	TYPE*	TOPIC AREAS	PROPOSAL SUMMARY	IMPACT	PASS/FAIL			
HEALTH-FOCUSED INITIATIVES									
Arizona	<u>Proposition 106</u>	L	<table border="1"> <tr><td>Health</td></tr> <tr><td>Federal Government</td></tr> <tr><td>Insurance</td></tr> </table>	Health	Federal Government	Insurance	Amends the Arizona Constitution by barring any rules or regulations that would force state residents to participate in a health care system.	As state law conflicting with federal law has no effect, Prop. 106 is largely seen as a referendum on federal health reform and as a mechanism to give the state standing to challenge the ACA in federal court.	PASS
Health									
Federal Government									
Insurance									
Arizona	<u>Proposition 203</u>	I	<table border="1"> <tr><td>Criminal Justice</td></tr> <tr><td>Drug Policy</td></tr> <tr><td>Health</td></tr> </table>	Criminal Justice	Drug Policy	Health	Avoids the drafting flaws of Prop. 200, passed in 1996, and allows qualifying patients with certain medical conditions to obtain an allowable amount of marijuana for medical use.	Omits the provision in Prop. 200 that requires a physician to write a prescription in order for a patient to legally obtain medical marijuana.	
Criminal Justice									
Drug Policy									
Health									
Colorado	<u>Amendment 63</u>	I	<table border="1"> <tr><td>Health</td></tr> <tr><td>Federal Government</td></tr> <tr><td>Insurance</td></tr> </table>	Health	Federal Government	Insurance	The Amendment would prevent the state from requiring a person to obtain health care coverage, from regulating direct payments, or from penalizing a person for participating or not participating in a particular plan.	The amendment applies only to state efforts to require participation in a health plan, and clarifies that Coloradans are still required to have acceptable coverage under federal law beginning in 2014. The language of the bill could interfere with the state's auto-enrollment of Medicaid and Child Health Plan Plus beneficiaries.	FAIL
Health									
Federal Government									
Insurance									

STATE	BALLOT MEASURE	TYPE*	TOPIC AREAS	PROPOSAL SUMMARY	IMPACT	PASS/FAIL
Idaho	<u>HJR 4</u>	L	Local Government Tax & Revenue Health	HJR 4 would allow public hospitals to invest in equipment, technology and real property, paid for solely from revenue earned from the existing or financed facilities.	The measure allows public medical facilities, including hospitals, to enter into debt in order to upgrade facilities.	PASS
Kansas	<u>Constitutional Amendment 2</u>	L	Health Elections	Repeal the authority of the legislature to exclude people with mental illness from voting	If passed, the Amendment will protect the voting rights of Kansans with mental health issues, estimated to be around 25% of the state's residents.	PASS
Maine	<u>Question 2</u>	L	Health Bond Measures	The proposal would allow Maine to borrow \$5 million to expand access to dental care by creating a new school for dentists and expanding community-based clinics around the state.	The bond issue would include \$1.5 million to create and upgrade community health and dental clinics, and the \$3.5 million to help create a teaching dental clinic would address the state's dentist shortage.	PASS
New Mexico	<u>Constitutional Amendment 3</u>	L	Health Elections	The Amendment modernizes election language.	The election language that discriminates against those with developmental disabilities would be removed from the state constitution.	PASS
Oklahoma	<u>Question 756</u>	L	Health Federal Government Insurance	Amends the Oklahoma constitution by barring any rules or regulations that would force state residents to participate in a health care system.	As state law conflicting with federal law has no effect, Question 756 is largely seen as a referendum on federal health reform, and as a mechanism to give the state standing to challenge the ACA in federal court.	PASS

STATE	BALLOT MEASURE	TYPE*	TOPIC AREAS	PROPOSAL SUMMARY	IMPACT	PASS/FAIL			
Oregon	<u>Measure 74</u>	I	<table border="1"> <tr><td>Health</td></tr> <tr><td>Drug Policy</td></tr> </table>	Health	Drug Policy	Measure 74 would permit the distribution of medical marijuana through state-licensed dispensaries, regulated by Oregon DHS. DHS marijuana related activities would be funded by dispensary licensing fees and a 10-20% gross receipts tax paid by dispensaries.	Amends Oregon’s medical marijuana law, <u>Measure 67</u> , to establish a regulated supply system	FAIL	
Health									
Drug Policy									
South Dakota	<u>Initiated Measure 13</u>	I	<table border="1"> <tr><td>Health</td></tr> <tr><td>Drug policy</td></tr> <tr><td>Criminal Justice</td></tr> </table>	Health	Drug policy	Criminal Justice	Changes the law to legalize marijuana possession, use, distribution and cultivation by persons registered with the state.	In 2006, SD rejected a statewide medical marijuana proposal that would have legalized the medical use of marijuana for adults and children, <u>Initiated Measure 4</u> . Initiated Measure 13 is similar, in that it would permit children to use medical marijuana with a parent’s consent.	FAIL
Health									
Drug policy									
Criminal Justice									
AGING AND DISABILITY-FOCUSED INITIATIVES									
Louisiana	<u>Amendment 3</u>	L	<table border="1"> <tr><td>Veterans Affairs</td></tr> <tr><td>Disabilities</td></tr> <tr><td>Tax & Revenue</td></tr> </table>	Veterans Affairs	Disabilities	Tax & Revenue	The measure would allow local parishes to hold elections concerning further allowing the value of a home occupied by veterans with disabilities to remain tax-free. The exemption would only extend and apply in a parish if approved by a majority.	If approved at the local level, in addition to Louisiana’s homestead exemption, the next \$7,500 of assessed property value owned and occupied by a veteran with a 100% service-connected disability could be exempt from the state’s ad valorem tax.	PASS
Veterans Affairs									
Disabilities									
Tax & Revenue									

STATE	BALLOT MEASURE	TYPE*	TOPIC AREAS	PROPOSAL SUMMARY	IMPACT	PASS/FAIL				
Missouri	<u>Constitutional Amendment 2</u>	L	<table border="1"> <tr><td>Veterans Affairs</td></tr> <tr><td>Disabilities</td></tr> <tr><td>Tax & Revenue</td></tr> </table>	Veterans Affairs	Disabilities	Tax & Revenue	The measure calls for a property tax exemption for prisoners of war who have a total service-connected disability.	If passed, the fiscal impact is unclear. Since the number of qualified former prisoners of war and the amount of each exemption are unknown. Revenue to the state blind pension fund may be reduced by \$1,200.	PASS	
Veterans Affairs										
Disabilities										
Tax & Revenue										
New Mexico	<u>Bond Question A</u>	L	<table border="1"> <tr><td>Aging</td></tr> <tr><td>Bond Measures</td></tr> <tr><td>Tax & Revenue</td></tr> </table>	Aging	Bond Measures	Tax & Revenue	The measure seeks voter approval to issue \$7,790,320 in general obligation bonds to improve senior citizen facilities.	The sale of this bond issue would fund 93 senior citizen facility projects in 27 New Mexico counties, including the Navajo nation and pueblos.	PASS	
Aging										
Bond Measures										
Tax & Revenue										
Virginia	<u>Ballot Question 1</u>	L	<table border="1"> <tr><td>Aging</td></tr> <tr><td>Disabilities</td></tr> <tr><td>Local Government</td></tr> <tr><td>Tax & Revenue</td></tr> </table>	Aging	Disabilities	Local Government	Tax & Revenue	Amends the Constitution of Virginia to approve a property tax exemption for adults over the age of 65, or who have a permanent disability.	The proposed Amendment would strike existing language which authorizes property tax exemptions for adults 65 or older, or who have a permanent disability, only if such persons bear “an extraordinary tax burden.” Instead, localities would determine their own income or financial worth limitations for these tax exemptions.	PASS
Aging										
Disabilities										
Local Government										
Tax & Revenue										
Virginia	<u>Ballot Question 2</u>	L	<table border="1"> <tr><td>Veterans Affairs</td></tr> <tr><td>Disabilities</td></tr> <tr><td>Tax & Revenue</td></tr> </table>	Veterans Affairs	Disabilities	Tax & Revenue	Asks voters to approve or reject a property tax exemption for veterans or their spouses if the veteran had a 100% permanent and total disability relating to military service.	Currently, Virginia does not grant real estate tax exemptions specifically to veterans.	PASS	
Veterans Affairs										
Disabilities										
Tax & Revenue										

Composed in part with materials provided by the National Conference on State Legislatures, www.ncsl.org

*L = Legislative Referendum I = Citizen-Initiated