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Editors Column

Report, Report, Report!

Anybody in the senior care and living business is aware that there exist a multitude of governmental reporting requirements, and most of us remember the more common ones (indeed, state-issued license examinations contain questions on them). Known or suspected elder abuse of our residents (H. & S. Sec. 1418.91); mistreatment or neglect of a resident (CFR Sec. 483.13(c)(2); fire, major accidents, epidemics, etc. (22 CCR Sec. 72541); and many, many others are all well understood by administrators, directors of nursing, and others responsible for licensed senior care.

However, there are some less-known and in some cases, downright strange

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HEALTH CARE REFORM LEGISLATION:

These Four Programs Could Change the Way You Do Business

by

Rachel A. Coles, Esq.
and
Michael A. Manley, Esq.

[Editor's Note: Most of the animated discussion about healthcare reform over the past few months has revolved around mandatory coverage, the public option and related issues. Little has been said about how healthcare reform could affect long-term care. In this article, we try to shed some light on this poorly understood aspect of healthcare reform.]

Many Americans mistakenly think that Medicare or Medicaid will provide for their long-term care needs. As senior care professionals know, Medicare will only pay for a very limited duration of acute nursing home care, and Medicaid requires an individual to have extremely limited assets. Home care coverage is very limited, and assisted living care is not covered at all. Only three percent of Americans currently have a private long-term care insurance policy. The reality is that the vast majority of long-term care services are paid for by individuals out-of-pocket.

Despite these statistics, and despite the fact that the

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400 CAPITOL MALL, SUITE 1800
SACRAMENTO, CA 95814
TEL: (916) 492-5000 ~ FAX: (916) 446-4535

WWW.DIEPENBROCK.COM

happenings we are required to report to regulators and other “players” in the senior care business. Here are a few of them, which you might want to share with your colleagues who are responsible for the operation of senior care and living facilities:

Change in Owner’s Business: California Health & Safety Code section 1416.60, for example, requires the administrator of a nursing facility to report to the state any change (1) in the general partner of a licensed entity operating a nursing home, or (2) of any director or officer on the board of the corporate owner of a facility. Given the regularity with which licensed corporate owners of facilities may change members of their board of directors, this is a requirement easy to miss. The penalty for failure to so report could be loss of the administrator’s license.

Change in Administrator: Both the outgoing administrator as well as the licensee (the owner) is required to report a change in administrative leadership. The administrator’s report must be made to his/her licensing board (Health &

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majority of Americans will be impacted by long-term care issues at some point in their lives, long-term care is rarely discussed around dinner tables or in the media. Until the last few years, it was rarely even discussed in Congress. The four proposed programs discussed below, if they become law, could have significant implications for the long-term care and senior housing business.

The CLASS Act

Few outside of the long-term care community are familiar with a piece of legislation that has been percolating in Washington for several years: “The Community Living Assistance Services and Supports Act” (“CLASS Act” or “Act”). The CLASS Act establishes a voluntary federal insurance program to help adults purchase long-term care services so that they can remain functional and independent, regardless of any physical or mental limitations they may have. A version of the CLASS Act is included in both the House and Senate health care reform bills currently pending in Congress.

If the CLASS Act is signed into law, it could significantly affect how long-term care is delivered in this country. The Act has its critics, however, and it is uncertain whether it will survive the next few months of health care reform debate. Here are a few key aspects of the CLASS Act and some of the reasons why it is controversial.

Chronology of the CLASS Act

Up until his death last summer, Senator Edward “Ted” Kennedy (D-Mass.) was the primary driving force behind the CLASS Act. According to Connie Garner, Senator Kennedy’s policy director for Disability and Special Populations, Senator Kennedy thought long-term care should be viewed as a health care issue, not a disability issue. He wanted Americans to have the financial support to be able to stay in their homes and communities as long as they were able to, regardless of any physical or mental limitations.

The origin of the CLASS Act dates to 2003, when Kennedy sought to develop a version of the bill with

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Safety Code section 1416.60); the licensee's obligation is to report to the state Department of Public Health. (Health & Safety Code section 1422). The poor administrator, having lost his/her job, gets double-tweaked for failure to report his or her dismissal: Loss of license can result if the report is not made!

Change in Key Staff:

No doubt our knowledgeable readers realize they must report a change of the director of nursing to the state (H. & S. sec. 1422), but how many are aware that any change in the director of staff development must likewise be reported to the Department of Public Health (Title 22, CFR, sec. 71829)?

Disciplinary Action

Directed at Other Staff: If any LVN employed by a licensed facility is suspended or terminated for abuse, theft, falsification of medical records, drug or alcohol use, or (here's a big one) gross negligence or incompetence, a report must be made by the facility (not the administrator this time) to the individual's licensing board. (Business & Professions Code sec. 2878.1).

Unauthorized Disclosure of Medical Information: State

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Senator Charles Grassley (R-Iowa). Grassley, however, thought the focus of a long-term care program should be on tax credits rather than a national insurance program, so Grassley and Kennedy did not continue their collaboration.

In 2005, Senator Kennedy took up the CLASS Act again, this time with Senator DeWine (R-Ohio). They introduced the CLASS Act into Congress in November 2005, but it failed passage. In 2007, Senator Kennedy tried anew, this time introducing the CLASS Act into Congress with Senator Harkin (D-Iowa) and Representatives Pallone (D-New Jersey) and Dingell (D-Michigan). Again, the bill failed to pass. Finally, Kennedy re-introduced the CLASS Act in March 2009, with Representatives Pallone and Dingell as co-sponsors.

On July 15, 2009, the Senate Health, Education, Labor, and Pension ("HELP") Committee, chaired by Senator Kennedy, passed its version of the health care reform bill. The HELP Committee's bill contained the CLASS Act. The Senate Finance Committee, the other Senate committee charged with developing a health care reform bill, introduced its version of a health care bill on September 16, 2009 (the "Baucus bill"). The final bill was approved by the Finance Committee on October 13, 2009, but the bill did not include the CLASS Act.

Over the past several months, Senate Majority Leader Harry Reid (D-Nevada) has overseen the merging of the two Senate committee bills. On November 19, 2009, the Senate released its merged version of the health reform bill, entitled, "The Patient Protection and Affordable Care Act". The CLASS Act is contained in this Senate bill.

Earlier this year, in the House of Representatives, three committees developed separate proposed health reform bills: the Committee on Energy and Commerce, the Committee on Education and Labor, and the Committee on Ways and Means. The three committees introduced a combined bill in the House on June 19, 2009 as "America's Affordable Health Choices Act of 2009" (H.R. 3200). This first version did not include the CLASS Act, but the House Energy and Commerce Committee, chaired by Rep. Pallone, successfully amended H.R. 3200 to include its provisions. H.R. 3200 emerged from the full

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law prohibits the unauthorized access to, use, or release of patients' medical information, with serious results for violation: Penalties of up to \$25,000 per patient can result. And, such reports must be made within five calendar days of discovery. (Health & Safety Code sec. 1280.15).

A multitude of other reporting requirements exist: Serious injury or death of an employee (Title 8, CCR sec. 342, a Cal OSHA requirement); breaches of patient privacy, beyond medical records (42 USC 1793, a new federal law becoming effective in 2010); lump sum payment of a settlement of a malpractice claim to a Medicare beneficiary (42 USC 1395y(b)97-8)); that a medical device did or could have caused or contributed to the death or serious injury to a resident (21 CFR sec. 803.30).

The above is only a once-over review of some (not all) of the reporting requirements that the owners, administrators, and others involved in operating a licensed facility are required to make, with sometimes devastating results if no report is completed. If readers are interested in a further examination of these requirements for their staff,

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House of Representatives on October 29, 2009 as the "Affordable Health Care for America Act" (H.R. 3962). It is this latter bill that was approved on November 8 as the House's response to President Obama's call for healthcare reform. It includes the CLASS Act provisions.

While the final Senate and House health reform bills contain slightly different versions of the CLASS Act, they are for the most part identical.

Overview of the CLASS Act of 2009.

If legislation containing the CLASS Act is signed into law, all employed individuals over the age of 18 would be automatically enrolled in the program. There is no health screening or underwriting process. Under the Act, an employed individual is someone who has earned an amount equal to the amount of wages that an individual must have in order to be credited with a quarter of coverage under Section 213(d) of the Social Security Act. In other words, a person must earn approximately \$1,100 in wages per year to qualify for the program. Non-employed spouses of eligible employed workers are also eligible to participate.

In contrast to Medicaid, the CLASS Act does not contain a means test or maximum asset requirement. Receipt of CLASS Act benefits would not affect an individual's eligibility for Medicaid, Social Security Disability Insurance, Supplemental Security Income, or Social Security Retirement benefits.

Individuals who do not want to participate in the CLASS Act program can opt out of the program, but they must do so affirmatively. Participating individuals would pay monthly premiums via an automatic payroll deduction set up through the participant's employer. For self-employed individuals, or for individuals working for employers that have elected not to participate in the program, the Secretary of the Department of Health and Human Services ("DHHS") will develop an alternative method of enrolling in the program.

After paying premiums for a minimum of five years (60 months), an individual who is expected to be unable to perform at least two activities of daily living

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Diepenbrock Harrison will be happy to assist you. We are also available to conduct in-service training on this topic.

Health care reform is in the wind these days, and it touches significantly on long term care. We invite you to consider this issue's main article on the subject by me and attorney Rachel A. Coles of our firm. What you read may surprise you!

Michael A. Manley, Esq.,
Editor

About Diepenbrock Harrison

Diepenbrock Harrison has roots in Sacramento, California's capital, which date back to the 1800s. Our practice focuses on acquisition, development and protection of property, permits and business opportunities, and resolving regulatory disputes. We are active in the legal aspects of the healthcare arena, and specialize in representing senior care and living providers. We are members of Aging Services of California and the California Association of Health Facilities.

("ADLs") for at least 90 days, as confirmed by a licensed health care practitioner, would be eligible to receive cash benefits of at least \$50 a day.

Benefits would be scaled upwards according to the number of ADLs that the individual is unable to perform. Benefits are indexed for inflation and would increase every year. Benefits could be used to help offset the cost of a residential nursing home, as well as to help pay for a wide variety of in-home support services, including personal care services, nursing services, accessible transportation, assistive technological improvements, and home modifications.

What Will the CLASS Act Premiums Be?

One key unknown element of the CLASS Act is how much the premiums will be. The 2007 version of the CLASS Act explicitly set the premiums at \$30 a month, and the initial version of the CLASS Act of 2009 explicitly set the premiums at \$65 a month. However, there were concerns that the program would quickly become insolvent if such low premium amounts were used.

According to Kennedy aide Garner, while the CLASS Act was in the Senate committee this summer, Senator Gregg (R-New Hampshire) requested that the fixed \$65 premium amount be replaced by a requirement that the Secretary of HHS be allowed to set the premiums at whatever amount would allow the program to remain solvent over 75 years.

Senator Gregg's amendment was adopted, and it is contained in both the Senate and House versions of the CLASS Act. Once an individual's premium rate is set, this rate will generally be locked in for the remainder of the individual's participation in the program. However, if the Secretary determines that a premium increase is critical for the sustainability of the program, the Secretary is authorized to raise premiums.

In the Congressional Budget Office's ("CBO") original analysis of the CLASS Act, it estimated that premiums of \$123 a month would allow the program to be financially

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sustainable. Over the last few months, several CLASS Act opponents (including Connie Garner) have cited this \$123 figure as the likely premium amount.

On November 20, 2009, the CBO issued an updated report regarding the financial impact of the CLASS Act. In its report, the CBO stated that its original analysis did not take into consideration the fact that non-employed spouses were eligible to participate in the program. In the CBO's opinion, non-employed spouses were likely to have more functional limitations than the average enrolled worker, which would make these spouses more likely to draw CLASS benefits in the future. In light of this new information, the CBO revised the necessary premium amount for the CLASS Act to be sustainable to \$146 per month.

Who Opposes the CLASS Act?

The CLASS Act is opposed by numerous businesses and other organizations, including the Concord Coalition, the Center for Long-Term Care Reform, the American Council of Life Insurers, America's Health Insurance Plans, the American Association for Long-Term Care Insurance, and several moderate Democratic senators. The American Academy of Actuaries and the Society of Actuaries (collectively, "Actuaries") are also skeptical of the CLASS Act. Most of the opposition is centered around the argument that the financial underpinnings of the CLASS Act are not sustainable.

On October 23, 2009, seven U.S. senators, (Conrad, Lieberman, Bayh, Nelson, Warner, Lincoln, and Landrieu), wrote to Senator Reid, requesting that the CLASS Act not be included in the final merged Senate health reform bill. The Senators explicitly cited the fact that the CLASS Act premiums will be placed into a trust fund like the Medicare and Social Security trust funds. The senators expressed "grave concerns" that the CLASS Act would evolve into "a new federal entitlement program with large, long-term spending increases that far exceed revenues."

Who is in Favor of the CLASS Act and How Have They Responded to the Criticisms?

According to the American Association of Homes and Services for the Aging ("AAHSA"), 135 organizations support the CLASS Act, including those representing the disabled, elders, religious groups and unions. Significantly, on July 6, 2009, Department of Health and Human Services Secretary Kathleen Sebelius wrote to Senator Kennedy stating that the Obama administration supports the CLASS Act.

Supporters of the CLASS Act counter opponents by making these arguments:

1. "Passage of the Act will significantly ease the pressure on state Medicaid budgets."

Because nursing home care is so expensive, long-term care is by far the largest expenditure in state Medicaid budgets. Proponents of the CLASS Act argue that the Act will allow individuals to use their benefits for home and community-based services ("HCBS"), which are much more cost effective than nursing home care. According to the American Association for Retired Persons ("AARP"), HCBS can be provided to three people for the same cost as serving one person in a nursing home.

Proponents also argue that the passage of the CLASS Act will prevent those who need some support services, but not full-blown nursing home care, from “spending down” all of their assets in order to qualify for Medicaid. This will further decrease the pressure on Medicaid budgets.

2. “The CLASS Act was not intended to compete with the long-term care insurance industry.”

According to Kennedy aide Garner, the CLASS Act was not designed to compete with the long-term care (“LTC”) insurance industry. In fact, while drafting the CLASS Act, Kennedy’s office reviewed and considered many of the long-term care insurance products that were available in the LTC industry. Garner has stated that the CLASS Act proponents have always worked with the LTC industry and plan to continue to do so. Some believe the LTC industry has been “flat” for decades, and that passage of the CLASS Act could “jump start” the marketplace.

3. “The CLASS Act benefits are not too small.”

Garner contends that the CLASS Act was never intended to be the “end all, be all” of long-term care programs. Rather, the Act was meant to provide some financial assurance to people that would not affect their eligibility for Medicaid and disability benefits. Garner acknowledges that \$50 a day, or \$1500 a month, might not be sufficient by itself for some individuals. But, as one member of the Senate HELP committee stated during negotiations, \$1500 a month would have made a big difference to her when she had a functional limitation and needed help with transportation services in order to get to work.

4. “The CLASS Act is financially viable.”

In July 2009, the Actuaries issued a report questioning the financial sustainability of the CLASS Act. Most of the critics focus on this report, and claim that the premiums will either be too high to attract a sufficient risk pool, or not high enough to pay for the program on a sustainable basis. Critics say that if the necessary premium increases are implemented, the program will be even less attractive for younger, healthier workers. Only the sickest individuals most likely to collect benefits will participate, resulting in a phenomenon known in the insurance industry as “adverse selection.”

In response to these criticisms, CLASS Act proponents point out that the Actuaries’ analysis was based on the June 9, 2009 version of the Act—the version that contained an explicit \$65 monthly premium. As discussed earlier, the final version of the CLASS Act was amended to allow the Secretary to set the premiums at an amount that will allow the program to be sound over a 75-year period. CLASS Act proponents say they are confident that the inclusion of the sustainability requirement will ensure that the program is financially sound.

MEDICAL HOME PILOT PROGRAM

Another proposed piece of health reform legislation that is of interest to the long term care and senior housing business focuses on the concept of a “medical home.” The American Academy of Pediatrics (“AAP”) coined the term “medical home” in the 1960s. According to the AAP, a

medical home is “a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.”

The Medical Home Pilot Program (“MHPP” or “Program”) is contained in the House-passed bill, H.R. 3962, but is not contained in the Senate bill. The MHPP authorizes the Secretary to reimburse qualified medical homes for medical home services that are furnished to Medicare patients. The MHPP defines “medical home services” as services that, among other things, do the following:

1. Provide beneficiaries with direct and continuous access and communication to a primary care or a principal care physician (i.e., specialist) or nurse practitioner;
2. Coordinate the care provided by a team of individuals and led by a primary care or principal care physician or nurse practitioner, in both office and home settings;
3. Either provide for all of the patient’s health care needs or take responsibility for arranging for this care at all stages of a patient’s life;
4. Provide support for patient self-management, family caregivers, and coordination with community resources;
5. Use patient-centered processes in providing this care.

The MHPP, which applies only to Medicare beneficiaries, designates two types of medical homes that may receive reimbursement under the Program: the Independent Patient-Centered Medical Home (“IPCMH”) and the Community-Based Medical Home (“CBMH”). An IPCMH is defined as a medical home that provides medical home services to “high need” Medicare beneficiaries, *i.e.*, those beneficiaries who have a Medicare risk score within the upper 50th percentile of Medicare beneficiaries.

A CBMH is defined as a nonprofit community-based or State-based organization that provides Medicare beneficiaries with medical home services under the supervision of and close collaboration with a primary care or principal care physician, nurse practitioner, or physician assistant. A CBMH also employs community health workers to assist the primary health provider in activities such as chronic care management, nutritional counseling, and transitional services.

In order to qualify for reimbursement, both IPCMHs and CBMHs must first be certified as a qualified medical home under the Program. The MHPP does not explicitly describe the criteria that will be used for certification, but instead authorizes the Secretary to develop a certification process.

When deciding whether to certify a site as a CBMH, the Secretary is allowed to give preference to entities that seek to eliminate health care disparities. The Secretary may also give preference to State entities that propose to use a medical home model for Medicaid beneficiaries.

Medical homes participating in the Program will be reimbursed on a prospective basis. The language of the legislation provides few other details regarding how medical homes will be reimbursed under the Program; rather, it authorizes the Secretary to establish a payment methodology for the Program.

The Program is scheduled to last for five years. At the conclusion of the Program, the Secretary will evaluate the success of the Program according to the following criteria:

1. Improvement in quality and coordination of care under the Medicare program, especially the care of complex patients;
2. Improvement in reduction of health disparities;
3. Reduction of expenditures and of preventable hospitalizations;
4. Prevention of readmissions;
5. Improvement in efficiency, health outcomes and patient satisfaction

If the Secretary determines that the Program successfully improves quality of care and reduces costs, the Secretary is required to implement the Program on a larger geographic scale, to whatever extent is practical. However, the Secretary can only implement of the Program permanently if the implementation would be budget neutral.

A medical home cannot simultaneously receive reimbursement under the MHPP and another pilot program discussed below, the Independence at Home Demonstration Program.

INDEPENDENCE AT HOME DEMONSTRATION PROJECT

The Independence at Home Act (“IAH”) was first introduced into Congress in May 2009 by Senator Wyden (D-Oregon) and Rep. Markey (D-Massachusetts). The final versions of both the House and the Senate health reform bills contain versions of the IAH, formally referred to as the “Independence at Home Demonstration Program.” While there are a few differences between the House and Senate versions of the IAH, for the most part they are identical.

According to a May 2009 press release from Senator Wyden’s office, the IAH will allow qualified Medicare beneficiaries with multiple chronic conditions to obtain primary care medical services in their own homes. The goals of the program are to improve quality of care, reduce expenditures, and increase patient and caregiver satisfaction. This, too, is a Medicare-only program.

Up to 10,000 “qualified beneficiaries” may voluntarily participate in the IAH program. The IAH defines a qualified beneficiary as someone who is eligible for Medicare and who has:

1. Two or more chronic illnesses, such as heart failure, diabetes, dementia, and other conditions which result in high Medicare costs;
 2. Had a non-elective hospital admission within the past 12 months;
 3. Received acute or subacute rehab services within the past 12 months;
 4. Two or more functional dependencies requiring the assistance of another person.
-

Medical practices that are accepted into the IAH program are referred to as “Independence at Home Medical Practices” (“IAHMP”). To be eligible for participation in the program, an IAHMP must be comprised of an experienced group of physicians or nurse practitioners (“NP”) (or an individual physician or NP) that works as a team with other experienced health and social services staff to provide home-based primary care to beneficiaries.

The IAHMP “team members” must be available 24 hours, seven days a week to carry out an individualized plan of care that is tailored to a beneficiary’s chronic condition. Furthermore, the IAHMP must possess documented experience in providing home-based primary care services to chronically ill beneficiaries, must use electronic health information systems, and must serve at least 200 beneficiaries eligible to participate in the IAH program.

When evaluating applications from potential IAHMPs to participate in the IAH program, the Secretary will give preference to practices located in high-cost areas of the country which have experience providing health care services to beneficiaries in the home and use EHR.

If an IAHMP’s annual aggregate expenditures under the IAH program are less than a pre-established “target spending level” that the Secretary has set for the year, the IAHMP is eligible to receive an incentive payment from Medicare. The IAH does not specify the exact formula that will be used for these incentive payments. Rather, the Secretary is authorized to determine the formula at a later date.

COMMUNITY FIRST CHOICE OPTION

The Community First Choice Option (“CFCO”) would allow a state to amend its Medicaid plan to provide home and community based services and supports (“HCBS”) to Medicaid beneficiaries. The CFCO is contained in the final Senate version of the health reform bill but is not contained in the House version. The House version, however, does contain a “sense of the Congress” statement that expresses the House’s support for the CFCO.

To be eligible for HCBS under the program, a Medicaid beneficiary must require the same level of care that would otherwise be provided in a hospital, nursing home, or other medical institution. While a beneficiary could choose to receive HCBS, a state could not force a beneficiary to receive the benefits.

The CFCO does not exhaustively define the types of HCBS that would be eligible for coverage. Generally, any services that would be necessary for the individual to accomplish activities of daily living (ADLs) and other health related tasks would be covered. In addition, transitional living costs, such as the first month’s rent and utilities on an apartment, bedding, basic kitchen supplies, etc., that would help an individual make the transition from a nursing home to community-based home setting where the individual resides, may also be covered. Room and board costs, special education services, assistive technology devices, home modifications, and other medical supplies and equipment would not be covered services under the CFCO.

If a state chooses to participate in the CFCO, the Federal government will increase its Medicaid financial participation match for services provided under the CFCO program by six percentage points.

CONCLUSION

Each of the four programs described in this article could have significant implications for providers of long-term care and services to seniors. Organizations which provide housing and health care to seniors, such as continuing care communities, should welcome into their midst new residents who are covered for long term care under the CLASS Act. In the same sense, in the event Medical Home pilots are authorized, providers might wish to consider partnering with other facilities and with medical groups to provider such services to their residents and to others in the community who might be considering senior care residence. Moreover, there is nothing in the Independence at Home program that would prohibit a resident living in a seniors-restricted facility from receiving covered services in their own home. Finally, the Community First Choice Option can steer medical recipients (Medi-Cal in California) to home-based services more readily, which holds the possibility of reducing pressures on Medicaid budgets. “Of Counsel” will carefully monitor and report on the progress of these programs as the legislative process moves ahead in the coming months.

RACHEL A. COLES IS AN ASSOCIATE ATTORNEY IN THE REAL ESTATE AND BUSINESS LAW DEPARTMENT AT DIEPENBROCK HARRISON. TO REACH RACHEL WITH QUESTIONS OR COMMENTS, PLEASE EMAIL RCOLES@DIEPENBROCK.COM OR CALL (916) 492-5076.

MICHAEL A. MANLEY IS OF COUNSEL FOR DIEPENBROCK HARRISON. HE HAS SPECIALIZED IN HEALTH, LONG TERM CARE, AND SENIOR HOUSING LAW FOR THE PAST 30 YEARS. TO REACH MICHAEL WITH QUESTIONS OR COMMENTS, PLEASE EMAIL MMANLEY@DIEPENBROCK.COM OR CALL (916) 492-5066.

Diepenbrock Harrison is an associate member of Aging Services of California and The California Association of Health Facilities.

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