JORDAN'S JOURNAL

Abyss in Wonderland

There may be 2 or 3 or 4 steps according to the genius of each, but for every seeing soul there are 2 absorbing facts – I and the abyss (Ralph Waldo Emerson)

But I don't want to go among mad people.
Oh, you can't help that, said the cat; we're all mad here. I'm mad. You're mad.
How do you know I'm mad?
You must be, said the cat, or you wouldn't have come here.
(Alice in Wonderland)

In a wonderland they lie
Dreaming as the days go by
Dreaming as the summers die
(Lewis Carroll)

1963. Nestled on the New Frontier, a Baptist minister mounts the stage, his audience as far from Camelot as Robben Island, where martyrs serve the cause. "With this faith we will be able to transform the jarring discords of our nation into a beautiful symphony of brotherhood" King's dreams harken back to Lincoln, but darken at Dealey Plaza, where Dallas screams are echoed through the land. But Texas' favorite son looks down the barrel of bigot's guns and cites a society intended to be great. These "distant chords of memory" appealed in war torn times. The climes would ring with chimes of freedom we would sing, overcome one day with Mandela freed at last, and the sins of so much past forgiven.

But not forgotten –- for gains we'd ill conceived are still not well received and there are those that feel some laws we should repeal while others stay in ways that bring us shame. Idols fall and ideals call to passion's proud refrain. The opposition proves profane and we wait in vain for them to cool, while shootings continue in our schools, the Supremes play with voting rules and DC brings back recent duels while they battle for some honor, wars prolonged unabated, right to lifers never saved even when their brethren fight for guns. It all seems so perverse that we're stuck in guilt's reverse and can't agree on basic human rights. Who's to say what those rights are and have we really gone too far in laying blame on innocents who suffer? The buffer seems too weak if vengeance can be wreaked by those of "us" who castigate the "them"

The gap widens and we see an abyss between the seas. It brings a sense of wonder that the land is rent asunder by a less than civil war between the classes. Red and blue and those of other hue whose diversity at one time we would welcome, now give reservation to De Tocqueville's observation that this country had a chance to make not malign a difference. JFK's brave words still haunt, though his ghost may this day taunt attempts to claim our Founding Fathers are revered. "The torch (was) passed to a new generation…unwilling to witness or permit the slow undoing of those human rights to which this nation has always been committed"

Such optimistic strains the vision of what remains of hopeful legacies that would bridge our shining seas – United not Untied States which must share uncommon fates and bringt to bear some reason to debate. "Ask not what your country can do for you" and in good stead remain true to the dedication etched in epitaphs – hopes of fallen heroes who sacrificed for dreams of a democracy their children would be proud to see – and ours.

Between my finger and my thumb
The squat pen rests; snug as a gun.

Under my window, a clean rasping sound
When the spade sinks into gravelly ground:
My father, digging, I look down

Till his straining rump among the flowerbeds
Bends low, comes up twenty years away
Stooping in rhythm through potato drills
Where he was digging.

The coarse boot nestled on the lug, the shaft
Against the inside knee was levered firmly.
He rooted out tall tops, buried the bright edge deep
To scatter new potatoes that we picked,
Loving their cool hardness in our hands.

By God, the old man could handle a spade.
Just like his old man.

My grandfather cut more turf in a day
Than any other man on Toner's bog.
Once I carried him milk in a bottle
Corked sloppily with paper. He straightened up
To drink it, then feel to right away
Nicking and slicing neatly, heaving sods
Over his shoulder, going down and down
For the good turf. Digging.

The cold smell of potato mould, the squelch and slap
Of soggy peat, the curt cuts of an edge
Through living roots awaken in my head.
But I've no spade to follow men like them .

Between my finger and my thumb
The squat pen rests.
I'll dig with it.

("Digging" Seamus Heaney, d. 2013)

FEDERAL FUMBLING

I'm late, I'm late, for a very important date
(Alice in Wonderland)

How puzzling these changes are! I'm never sure what I'm going to be, from one minute to another (Alice in Wonderland)

Let us not seek the Republican answer or the Democratic answer, but the right answer. Let us not seek to fix the blame for the past, let us accept our own responsibility for the future. What is objectionable, what is dangerous, about extremists is not that they are extreme, but that they are intolerant. The evil is not what they say about their cause, but what they say about their opponents (John F. Kennedy)

I dreamed I was the President of the United States
I dreamed I replaced ignorance, stupidity and hate
I dreamed the perfect union and a perfect law undenied
And most of all I dreamed I forgot the day John Kennedy died
(Lou Reed, d. 2013)

Iran still trains Iraq my brains to follow the holocaust
Clinton's wary will John Kerry victory at hollow cost
The Middle East is not the least of what deserves desertion
Afghan hounds at Russia's bounds to Putin more coercion

Flip and flop can scandals stop titanic costs from changing
The decks and chairs Obamascares US into rearranging
New laws with flaws but common cause affects timelines which just flew
In face of hope a nation copes with the ACA anew

It's quite a mess within Congress static charges in DC
It's ACA that's in the way blocking this term's legacy
With nothing less than no progress it's worse than during Truman
Republicans can't say "I can" their chat sounding inhuman

Though Democrats employ brickbats their bouquet is turning foul
To face as well why can't they tell when to throw in the towel
Is John Boehner really saner than his foes across the aisle
Will Harry Reid ever concede an inch to McConnell's smile

Can Ryan budge it just to judge the merits of its appeal
They seem to vote as if by rote for Obama's law's repeal
When midterms come it's clear that some will fail examination
Due to shut down the their time in town that led to its cessation

New open seats from their defeats arm chairs hands to butt heads
Then until House race begins apace running Oval office treads
Joe's Biden his time and Clinton's crime was her watch as Sec of State
Ted's Cruz control Tea's up his role Christie's Minstrels sing his fate
Mister Rubio goes with the flow, Jeb's in Bushes, lies in wait
Cuomo's promo? Major domo and Ryan's expressed he's bait
(and so it goes with rhyme scheme floes as we plot our candidates)

Will we survive the sloppy C's, awash in tidal shifts and pulls as business battles bears and bulls whose droppings name guilty parties whose donkeys dance round elephant stance forgetting failures that begin within the din caused by clashing cultures.

Republican position on health care – carefully calibrated coefficients of care can contain costs and contribute considerable confidence to concomitantly conjure cost efficient economic cohorts

Democrat opposition – concerned consumers who can't control comprehensive care components, comprehend carrier contortions or contribute calm comportment, compounding complications caused by conflicting expectations

Yes, it's alliteral mess. Shaw said "A democracy is a device that insures we shall be governed no better than we deserve" But what did we do to merit (and we can't rhyme this time)

More filibusters during Obama's presidency than all the previous presidencies combined

A stalemate over a poorly played chess match checkered with rancor, recrimination and a return to budget battles that promise more of the same shame in the near future

Sequestration, a mild form of nuclear option, occurring when both sides said it would not come to pass (even though they passed the original law including it only recently)

A White House that peremptorily delays and disobeys the rules it promulgated in the ACA in the first place – which is no better than Republicans trying to upend a law they saw voted and signed (albeit under a different Speaker)

This Congress makes the famed "Do Nothing" session of the Forties prolific by comparison. Harry Truman won an upset primarily by blaming Republicans for allowing only 395 bills in the 80th Congress to reach his desk for signature. In the current 113th Congress, they couldn't even reach their own number, leaving the President little reason to fear writer's cramp with only 70 bills on his desk. The previous 112th Congress set the old record for the least productive session in history – and passed over three times as many bills (231). You can't rhyme a crime.

So with little to report on legislative sport we fix our frustration on the administration and ACA fable foibles which come again. Remember the innocent days of 2010? Now, either smarter or smarting from experience, here are some categorical cries about lies and the various flies in the health care ointment. Designed to salve nothing, but salvage a bit for discussions to bloom as mid term elections loom

I made a mistake and took a long break
Over the Fourth of July
I'd just put away the new ACA
With nothing new to decry
But then the delay to start pay or play
Made all of us question why
Obama had said and all that we read
Would let us think we could buy
Cheaper or better within the letter
Of a law so flawed we could cry
The truth we can see is health care ain't free
In fact costs are still way too high
And promises spoken are soon to be broken
By those to whom we would tie
Our fortune and fate while we're forced to wait
As they make up rules on the fly
Then the shutstorm hit, we're just out of it
But no one can even apply
For coverage or cash when the web sites all crash
As demand has exceeded supply
Or did low bidder rules make the Feds look like fools
When they've had three years to try
To bake new confections that create corrections
To a law that was pie in the sky

What more can we say about the ACA that we aren't sick of hearing about already? All during the year the fear and confusion sown by those who'd grown used to the way things are went far in their criticism, baiting and were unabating in telling everyone what went wrong. Actually there are a few things right, as the fight for the uninsured ends, simplicity attends, and the attitude of carriers bends (somewhat) to what is fair for those previously in despair.

With any large law, of course, comes the "law of unintended consequences" and the sequence of events and what the law prevents are also coming to the fore. Before we launch into attack or defense, we'd prefer to stay on the fence, and say there is good as well as bad. In some ways it's better than what we had, and we're glad for the chance to have some weight to the debate. Still…there are things we have found, which make this law resound, with rules unsound and delays to compound further confusion. So a quick list of the law's flaws and guffaws.

<u>Delays</u>

Federal SHOP – one year
Pay or Play – one year
Individual mandate from January 1 to the employer actual anniversary date
Some with cancelled coverage can buy catastrophic plans a year later with hardship exemption
One year delay on individual policy cancellation (which California promptly rejected)

<u>Lies</u>

You can keep your current health plan – and your doctor
Healthcare.gov will make shopping for insurance as simple as shopping on Amazon
Sebelius said at a hearing that they spent $174 million when they actually spent $319 million
$454 million was taken from Public Health and Prevention for Exchange publicity
Harry Reid said that Obamacare is clearly a precursor to Single Payer coverage
Health care premiums are up, down and sideways – we were supposed to save money

<u>Cuts and Changes</u>

COOP Funding
Not “exchange” but “marketplace” since “exchange” cannot be translated into Spanish
Contraception may be banned

<u>Gaffes and Laughs</u>

Federal web site (healthcare.gov) and the many navigation errors
Navigators who give incorrect information when they have so little they need to know
Employers have reduced work hours below 30 per week to comply with Pay or Play
The Federal government has to take over the Exchange work for 37 states
Cost and coverage estimates keep changing, and changing again
State abandonment of Medicaid along with Exchanges
IRS ability to enforce is questioned with insufficient staff and potential lack of funding
Doctor supply to cover the flood of new patients – will there be enough of them?
The government asking carriers for money to support their efforts in the ACA
The proliferation of non qualified plans to help bypass Pay or Play
Early renewals – so carriers could shield clients from ACA cost impact for 2 to 11 months
Grace period loopholes – and how California varies with Federal
Exchange takeup by carriers – not unanimous, and in some states almost no carriers
No income verification will be required to validate the subsidy on the Exchange
Dumping by private companies on the public Exchanges as they abandon coverage
Rise of the private exchanges to supplant public Exchanges

For those of you who haven’t been following, we actually put current events on Twitter.
Here is what we have been following during the year, now collected for your reading ---
But first, an op-ed piece

What are they exchanging and where are they going?

Defined contribution is a radical new concept…that was introduced in 1978
Multiple choice in carriers and designs is a radical new concept…started over 10 years ago
All this and more is the thrust behind the new Private Exchanges, brought on in response to the Public Exchanges given to us by the Affordable Care Act.
The problem is it is just a way of shifting costs, and the consultants make all the money

The latest “exodus” is Walgreen’s, which is moving 160,000 employees and follows Darden Restaurants and Sears to a private exchange run by Aon plc. Aon estimates 14 more companies with 600,000 people will participate in 2014.

What’s odd is that an employer the size of Walgreen’s essentially controls, to the extent possible, its own costs, as a group this size is self funded and costs are determined by claims. Movement to an exchange allows greater freedom of choice from among other carriers, and there are tools to help employees make choices, but Walgreen’s and others also thereby surrender control and the possible advantages that are inherent to that model. They trade potential volatility, which has both good points and bad, for stability, since they will now freeze their contribution to employee premiums and let employees choose how to spend the money.

This is similar to what many small and large California employers do already, and also has a precursor in what occurred with 401k plans years ago – the problem is that studies have shown that, despite the freedom of choice for investments provided in a 401k plan, the vast majority of employees choose the “safety” of money market funds, even when they don’t beat inflation (a primary tenet for financial planning) and recent studies by four different universities show that over 75% of people faced with a choice of health plans make the wrong selection, based on a combination of their personal variables and the cost consequences of fixed and variable expenses.

Others weighed in with their opinions as well…

Delay in Pay or Play – does it doom the ACA?

They have had three years to get it done. They didn’t. Well, they did, but no one knows what is involved and what must be done. Acknowledging complaints from businesses that said the administrative requirements to show compliance with the “shared responsibility” rules (called “pay or play”), the Obama administration agreed to forestall implementation for at least a year.

So the good news is that employers will save some money, not find it necessary to cut employees to less than 30 hours per week, and those out of compliance will save substantially in penalties.

But there is bad news. The Congressional Budget Office had allocated $10 billion of revenue for the administration due to the penalties they expected to be levied. That is now delayed a year (all assuming they were correct, of course, given that 94% of all large group employers already provide coverage). Also, the verification among large employers that coverage would or would not be of “minimum value” is also now delayed, which creates a problem for the individuals who are going to the Exchange to meet their individual requirement needs and want to qualify for a subsidy. If they don’t know whether their coverage “qualifies” they won’t know if a subsidy will apply or not.

Pundits postulate that the delay has kicked a strut from the basic structure the Obama administration sought to create, but others say this is not the case, that the pay or play mandate was a peripheral part of the law but not vital.

News of the delay has also brought howls from Republicans, who recently tried in Congress for the 38th time to repeal "Obamacare" and they wonder if this is the first in a series of changes or delays. They also question whether the administration exceeded their authority by essentially changing the law, when only Congress or the courts had that ability. As the Wall Street Journal editorialized (and not too kindly):

"All of this fits with ObamaCare's entire bloody minded history. Democrats were determined to make their rendezvous with the liberal destiny of government run health care, so they imposed this debacle on the country on a partisan vote and despite public opposition. Now that they are discovering how difficult it is to remake one sixth of the US economy, they are rewriting the law as they go and telling Americans they have no choice but to live with the consequences" So much for impartial journalism.

Without specifics from individual publications, however, there are a large number that are calling this for what they think it is - a cynical move on the part of the government to avoid admitting some partial failure and thus avoid problems in the mid term elections.

The Associated Press was fairly even handed – it said Republicans "seized upon the administration's abrupt delay of the employer mandate…as fresh evidence that" the ACA "is unworkable and should be repealed but added that the "White House's willingness to respond to the concerns of business – and avoid the specter of job layoffs due to the unpopular health care law – spares Democrats" a potential "political headache" in the midterm election. The Washington Times said that the delay caught Democrats flat footed, but they "have since regrouped and are now blaming Republicans for the situation, saying the GOP poisoned the law so badly that the administration had no choice"

If you can't stand the heat…and where is that darn kitchen anyway?

"Hold me accountable for the debacle" – Kathleen Sebelius
"Yes the administration deserves to be on the hot seat" – Pittsburgh Post Gazette
"it is really a surprise then that implementation hasn't gone smoothly?" – cnn.com
Cartoon: What he said – if you like your health care plan, you can keep it
What he meant – if I like your health care plan, you can keep it

Even her friends are turning against her…Sebelius hits a wrong note, and another, and another

Senator Pat Roberts, a long time family friend, has called for her resignation, accusing her of "failing to delay the flawed website's debut for political reasons" Senator Max Baucus, Democrat chairman of the committee and an architect of the health care law, told Sebelius he was "disappointed with the botched rollout" but Democratic Senator Bill Nelson showed some indirect support, saying of the contractors who have put the Secretary in this spot "I want you to hold them to account. I want you to burn their fingers and make em pay for not being responsible and producing a product that all of us could be proud of"

Don't Answer that Question – Obama faces the press corps

"I don't think I'm stupid enough to go around saying 'this is going to be like shopping on Amazon or Travelocity a week before the web site opens, if I thought that it wasn't going to work"

Federal Gaffe comes with a Laugh

Who will they stick with the blame as the HHS Secretary has asked the Inspector General of her own Department to develop of healthcare.gov and take corrective action

Mandate has a new date, so rate may not rate until late – without the need to legislate

On October 27, the Obama administration delayed another deadline. They will now give Americans an additional six weeks to obtain coverage before they incur a penalty. While administration officials said that the healthcare.gov technical problems were not a cause for the decision, others could not help but notice the coincidence.

Delays upon Delays – Large group rules have final reporting deadlines

The pay or play faced delay until a day in 2015 from the original 2014. The information that needs to be filed with the IRS to show compliance (Forms 6055 and 6056) do not, however, need not be filed until no later than February 28th (or, if filed electronically, March 31) of the calendar year following the year on which the taxpayer is reporting. So for those who needed to file in 2015, they have until the end of February or March, 2016 to send the IRS forms.

Promises made to be broken, on premises completely outspoken, but cancellations are token

As one journalist said, President Obama deserves heat for his misstatement (for which he has apologized profusely), but most of the plans now being canceled are pure junk. Those who "lost" their coverage may not realize, because they have not had a major claim, how little value those plans had. We hear the stories of those who "lost" but not those who were damaged. The overall individual market makes up about 6% of those covered overall and won't qualify for subsidies. But the complaint against the changes in the individual market ignore the many considerable changes in the small group market AND there is a Cadillac tax around the corner.

Hitting Singles or Moving the Bases for Single Payer? Harry Reid Agreed with Critics

The suspicion in anti Obama circles is that the Affordable Care Act is merely a gateway toward what more liberal politicians have always wanted – a Single Payer system (government run health care). In a Forbes article by noted health care columnist Avik Roy, he stated that, in answer to the inevitable question, he says that "while progressives may want single payer, I don't think that Obamacare is deliberately designed to bring about that outcome" but on Nevada Week in Review, Senate Majority Leader Harry Reid, when asked whether his goal was to move Obamacare to a single payer system, replied "yes, yes, absolutely, yes." His opinion was that the country has to "work our way past" insurance based health care. "What we've done with Obamacare is have a step in the right direction, but we're far from having something that's going to work forever"

What if you get there and don't know where you're going?

Despite the government desire to inspire Navigators to replace qualified agents and thus simplify the engagement process, people don't know the plans to which they would best be wedded. Researchers from several universities asked a national cross section of Americans to choose exchange policies that would be cost efficient for them. The vast majority – 80% - failed to choose the best plan, resulting in average annual overspending of $611

When a Mandate has no Set Date – a delay in the individual health plan requirement

The mandate was set to take effect January 1, 2014. If an employee is eligible for participation in an employer sponsored plan, however, they may delay obtaining coverage until the next anniversary date.

Sharing, Caring, Daring – don't tempt fate, but pay your rate – Individual Mandate rules

Final rules on "shared responsibility" (the mandate) are out, and they make it simple (yes, it was a government regulation). Individuals can claim an exemption from the mandate (certified by the new health insurance marketplace, employer, etc) on their federal income tax return. Those who are not exempt must maintain information to substantiate the sum of the monthly national average bronze premiums applicable to the taxpayer. Now if there are only enough new personnel in the IRS to handle all this…

What may have been ill conceived has now been compromised…oral contraception changes

The mandate for coverage of contraception in the Affordable Care Act has received a lot of flak and the government has been light stepping over the issue for some time. Now Health and Human Services is offering a compromise to religious non profits by creating a barrier between religious groups and contraception coverage, through insurers or a third party, that would still give women free access to contraception.

Oh what a tangled web (site) we weave…when we forgot about what we'd conceive

"It was a perfect storm for an IT meltdown" – John Gorman, former assistant to HCFA

CGI Group, one of the main contractors, told staff on House Oversight that the site's design was changed about a month before the October 1 deadline to prevent users from comparing prices without registering for an account

Jay Carney, White House Press Secretary: "the system was tested, and based on the expectations we had, you know, we were confident that it was going to work more effectively than it's been working"

Sanjay Singh, CEO at software contractor hCentive Inc "there was not enough time to do end to end testing. The system keeps changing, so how do you run the tests?"

“Despite the president’s assertion that we’re well into a tech surge, neither the White House nor HHS is providing additional details about which private sector companies have been engaged or whether they are being engaged through the appropriate procurement processes” – Darrell Issa

Others are remembering other launches, other times. The Massachusetts plan, which is a precursor to Obamacare, also had problems, only enrolling 18,000 of the state’s 300,000 eligible enrollees in its first two months, and the Bush Part D plan was no picnic

Washington Post: “the computer snafu was self inflicted incompetence”

What’s the difference between an agent and a navigator – well, it is at least acknowledged

CMS (Medicare) is taking a firm stand about how the Navigator role differs from brokers and agents – they’re different. In testimony to Congress, Gary Cohen, the director of CMS said navigators “are not making recommendations, they’re not selling…I think you go to an agent because you want to ask the agent sort of the bottom line question ‘what do you think I should do?’ and if a Navigator is asked that question they’re going to say ‘I can’t tell you what to do’

Unaffordable vs. Unfunded – Will the IRS be available to do the job?

In light of the recent IRS scandal, Nevada Republican Senator Dean Heller has proposed to block funding to the agency to implement the ACA, writing to the HHS “it is necessary that both Congress and the Department of Health and Human Services look closely at the money given to the IRS through the healthcare law” Senator John Thune has written the administration demanding the IRS be removed from its duties implementing the ACA and Senator Dave Heller added an amendment to a Senate farm bill designed to prevent the IRS from receiving funds to implement the ACA.

Let me just ask…no wait, don’t tell anyone I asked, and there’s no pressure

Kathleen Sebelius, secretary of Health and Human Services, has come under considerable criticism for her making phone calls seeking private funds to help with ACA implementation. Part of this has come about because the Federal government did not anticipate the fallout from the states, the majority of which have refused to implement the Exchanges. Now with the federal government responsible for its own Exchange, they find there is no provision in the law for administrative funding. So the government, which is tasked with saving us money, is asking for money, from those but from those who it may or may not help directly. What’s odd is that the support is for Enroll America, a private non profit run by veterans of the Obama administration. Only in politics.

The justification for all this is that the ACA included $1 billion to be used for overall implementation of the law. CBO projections now believe that federal agencies will need between $5 and $10 billion to get the law operational over the next decade, with an additional burden created due to state refusal to assist the federal government in this respect.

The law of unintended consequences…the rise of unqualified plans

Large employers seeking to blunt the impact of the possible penalties they face for non compliance are not looking to set up a comprehensive medical plan for their employees but instead researching “skinny plans” Since the ACA left vague some definitions on what is to be offered and how, naturally loopholes are looping the circuit. According to Robert Kocher, a former White House health adviser who worked on passage of the law “We wouldn’t have anticipated that there’d be demand for these types of band aid plans in 2014. Our expectation was that employers would offer high quality insurance” Had any of the administration had business experience, of course, they would have anticipated such a situation…businesses of course will look for the less expensive alternative, BUT they are still going to providing some type of coverage for employees who previously may have gone without. So isn’t that good?

The ACA – again – costs more than what we originally thought – what do we exchange the Exchanges for?

The cost of health insurance exchanges has swelled to $4.4 billion for fiscal 2012 and 2013 and will reach $5.7 billion according to the President’s budget. Critics blame the ambitious timetable for the inception of the Exchanges, as well as the federal government need to take over the responsibility for the 34 states that will participate. Summing it up nicely, The American Enterprise Institute, which advises the Congressional Budget Office, said “It’s a lot more complicated than anybody imagined”

Forbes contributor Avik Roy writes that “increasingly officials in the Obama administration are worried that the rollout of the exchanges will be chaotic, given the law’s complexity and unrealistic deadlines” Roy quotes the Henry Chao of the CMS, who said at a conference, “we are under 200 days from open enrollment. I’m pretty nervous – I don’t know about you” At the same conference, official Gary Cohen said “it’s only prudent to not assume everything is going to work perfectly on day one…as we move closer to October, my hopes are the range of things that could go wrong gets narrower and narrower”

They should warn ya, it’s good to be in California – we can avoid some suits (on subsidies)

Don’t get excited. This does not affect us. There will be some publicity, however, about a new lawsuit filed in federal court against the subsidies being paid by the federal government for those whose income is below a qualifying level. Basically, it says that only states that have a state exchange can allow the penalty. The federal government, which has taken over the exchange at many states’ request, is not allowed to do so under the Affordable Care Act.

I promise to tell you the truth about what I earn – the government won’t verify income

California may be different, as they have publicly stated, but the federal government (which has now requested an additional $460 million to fund new IRS employees) has stated that those who apply for individual coverage and request a subsidy will not have to provide any written or other verification that they meet the income requirements. They will require it next year, but for now will just test a “statistically significant number of people with large income discrepancies” Have they heard of the mortgage crisis?

The costs are down, no they're up, no they're…where are they? Hurray for the ACA?

Kaiser Health News reports it best: "premiums will skyrocket next year? Premiums will be lower than expected? Premiums will be about the same" All true, depending on where you live, what plan you are reviewing and what media outlet you read or believe. In New York, regulators said average premiums will be half of what they cost now (have you seen what they were before the study?), while Indiana warned of an average 72% increase. Florida is worried about increases of 30 to 40% while the White House has claimed that rates in 10 states and the District of Columbia will average 18% less than forecast (what was the forecast, and why was it so high, and so wrong – but note it doesn't say they are going down 18%, but are just less than what was initially feared). So KHN gives you 4 tips for reviewing the cost of coverage:

1) Comparing apples to apples is virtually impossible: policies must be issued on a guaranteed basis, they must include "essential benefits" that were not previously included and there is a cap on the amount that may be charged in the event of a major claim.

2) Look for which premiums state regulators are using for their comparisons

3) You are not average – and many of the estimates are based on averages

4) Subsidies will offset costs for many people – so the net cost may be lower

Exchange what? With what? Minimal exchange participation in other states

The idea was competition. Create an exchange that would be populated by a group of carriers, create new plans, and thus lower the cost of health care. Sounded good. Whether it happens or not is another question. In some states, like California, the same carriers that are already are in the private market (and there are a considerable number) will also be present in the Exchange (Covered California) – but that changed this week when Anthem Blue Cross said they would participate with individual but not group plans.

Then there are the states where competition will still not exist. In New Hampshire, only one carrier is in the Exchange. In Alaska, they have twice as many – 2, and 1 of those is Premera, the state's largest carrier (by a wide margin).

The loopholes loop longer and wider…grace period fiasco

The Health and Human Services Department denies it's a problem, but…a loophole in the health care law allows a family a three month grace period to pay their premiums, but the carrier must only pay during the first month. This can leave providers short, which certainly was not intended. This only applies to those getting a subsidy for their plans, but that number is large.

What to make of the snake…COBRA still exists in the wake of the ACA

Individual plans can now be issued on a guaranteed issue basis with no pre existing condition limitations, so who needs COBRA? Well, that depends:

1) COBRA still exists, so letters must still be sent to those who lose eligibility
2) The HIPAA Certificate of Coverage must still be sent with the COBRA letter
   BUT – only until December 31, 2014

Embarrassment of riches amid all the hitches causes Congressional ditches of Obamacare

The House scorned the threat of a veto and had 39 Democrats break ranks to vote for a simple, one page bill that allows consumers to keep the coverage they had…this after the President announced a one year delay to the requirement contained in the Affordable Care Act to upgrade policies which resulted in the cancellation of a number of contracts throughout the country

The President was scheduled to meet with the CEOs of a number of insurance companies to see if they could "work out a solution" – to a problem he created.

That, in turn, was shortly after the President announced that he would delay the requirement for insurance plans to meet new minimum standards, which would have upgraded, but also raised the price, for many health plans. The President did issue an apology, of sorts, for the problems caused, but covered by saying that it only affected 5% of the population.

That decision by itself has caused, as usual, unintended consequences. State insurance commissioners have already warned that a delay would undermine a key construct of the law, which is the creation of a larger insurance pool for people without access to employer based coverage. A market fracture like this could disrupt that and lead to still higher premiums. Of course, there is also the complete chaos that this continues to put the market through, but that has not been mentioned.

Ah, political maneuvers…just in time to see what happens with the mid term elections in 2014.

Labor labored long to get along with the ACA, and then when it didn't go their way…

The unions were vocal supporters of the Affordable Care Act. Then they saw what was written and mewed like scared kittens as if they never knew what was there. The President quite clearly stated he would not give in to union demands for an exception…and then weeks later his administration has said it may exempt some union plans from one of the law's substantial taxes. While other self funded plans are required to pay a reinsurance fee of $64 per plan member per year, Taft Hartley trusts will now be exempt.

Oh, there was some other news…

The Tea Party Bash – whither go Republicans

Boehner caved, but the republic still saved if not the publicans themselves, by the recent shutstorm in Washington. Only 28% of Americans now have a favorable rating of the party, which is the lowest rating for any party in the last 30 years. Of course, they could do what they did in Boston, and toss the Tea Party overboard, which would reinvigorate the party and rally more support. Per David Frum in CNN.com "extremism "contaminates the whole Republican brand" which has led to losses of at least 6 otherwise winnable Senate seats. In the New Republic, however, Nate Cohn said this was not feasible, as the Tea Party makes up 49% of the GOP primary electorate and 37% of the Republican and Republican leaning voters

New rules on pediatric dental and vision – what does an employer have to do?

The Affordable Care Act mandated that dental and vision care be included with medical plans effective 2014. Rumors have swirled that this means that separate plans must be written, and even worse that the only way to comply is to get coverage through the state Exchanges. First, there are the exceptions:

1) Does not apply to groups with 50 or more full time equivalent employees
2) Does not include group medical plans that are "grandfathered"
3) The groups has stand alone dental or vision coverage

The other exception is that the group medical plan (and many are expected to apply) may already cover pediatric dental or vision care (at an additional cost of course)

Who needs Washington? They can't keep up with the Joneses

Dave Jones, the California Insurance Commissioner, first told Blue Shield that they had to delay the imposition of individual plan cancellations for 90 days. Now the same is affecting Anthem Blue Cross, with the commissioner stating that Anthem missed the October 1 deadline to inform some policyholders of the need to move into different policies, which Anthem has called a "mailing glitch" (oh). Of course, Mr. Jones may have to delay his gubernatorial campaign for now, as all of the exchange policies (Covered California) will be under the jurisdiction of the Department of Managed Health Care come January. Yes, California needs two separate departments to run one set of insurance circumstances.

Will Medicare make it? Every year the projections change…here are the 2013 highlights

"Medicare cost (projections) are highly uncertain, especially when looking out several decades"

Projections in the report assume that CMS will implement 25% physician pay reduction rate

"However, it is a virtual certainty that lawmakers, cognizant of the disruptive consequences of such a sudden, sharp reduction in payments, will override this reduction as they have every year since 2003"

“Given these uncertainties, future Medicare costs could be substantially higher than shown in the Trustees’ current law projection”

“Medicare’s actual future costs are highly uncertain and are likely to exceed those shown by the current law projections in this report. Therefore the Board recommends that readers interpret the current law projections as an illustration of the very favorable financial outcomes that would be experienced IF the physician fee reductions were implemented and IF the productivity adjustments and IPAB measures in the ACA could be sustained in the long range.”

Estimated depletion date for HI trust fund is 2026, 2 years later than projected last year

“under current law, expenditures will increase in future years at a somewhat faster pace than either aggregate workers earnings or the economy overall”

Oh, they never lie. They dissemble, evade, prevaricate, confound, confuse, distract, obscure, subtly misrepresent and will fully misunderstand with what often appears to be a positively gleeful relish and are generally perfectly capable of contriving to give out an utterly unambiguous impression of their future course of action, while in fact intending to do exactly the opposite, but they never lie. Perish the thought
(Iain Banks, d. 2013)

In my country we go to prison first and then become President
(Nelson Mandela, d. 2013)

STATE STUMBLING

Will you tell me please, which way I ought to go from here?
That depends a good deal on where you want to get to
I don't much care where
Then it doesn't matter which way you go
(Alice in Wonderland)

If you agree with me on 9 out of 12 issues, vote for me.
If you agree with me on 12 out of 12 issues, see a psychiatrist
(Ed Koch, d. 2013)

You're making a mistake
I've made em before
(Tom Laughlin, aka Billy Jack, d. 2013)

Go see Cal
(Cal Worthington, d. 2013)

Moonbeams glow in Sacramento budget ballots align cash flow
Against the stream of public tide though deficits had been decried
In sob stories told just last year. But Code Brown has flushed away the fear
As surplus waylays Lady Loss, and cross ones now don't need Blue Cross
Which blew across deserted field cancelling contracts with Blue Shield
The Fed's cheap plans disappear an affront to those in arrears

Dynamic tension creates static, ACA's not automatic
The manual for states states they may say the way they wish to pay
For Medicaid and marketplace, waiting times and times to replace
Policies newly discarded trumping mandates disregarded
Protecting rights right here at home which left the White House all alone
When states withdrew depositing few, investing interest to save face

Health reform continues to wither on the vine, Washington waits to get on line
Raisin expectations expressed as sour grapes, but our state stressed
California has you Covered, bureaucrats eagerly hovered
Over details meant to replace all shreds of the old marketplace
The fix is definitely in because despite political spin
Single Payer is the layer the Golden State wants discovered

While Congress slept lawmakers leapt to the fray as many bills swept
Into view with means to imbue ways to write the left's passage through
Insuring goals by changing roles of carriers' rates and state's poles polls
Stop loss must yield wage floors the ceiled Healthy Family's leaving annealed
San Fran can extend ends as well which means surcharges will not sell
When restaurants won't pass on tolls and ACA harms SF controls

There's little doubt (and the word's out) that the new agency flouts its authority, duping Democrats and bureaucrats into thinking that's the only way to play in health insurance. Covered California cannot mix with carriers they want to fix, and few are digging the bids they're rigging for sales. What's the point of purchasing joint plans with a third party (as if it's not fun already). When the rates are all the same and the blame aims at another name when the claim game leads us to exclaim "wait, haven't I been here before?" yes there's nothing new except the view that navigators without a clue, web sites tangled getting through and phone calls in an endless queue are somehow less askew than what we knew already – it's the subsidies – no, discounts – no, a "cap on the maximum premium" – that create support for an agency that would fall short without even more subsidies. In California, funding is at $500 million – to give away even larger amounts.

To those that find premiums affordable only to the extent their hands are out. The irony. Those Obama needs the most will likely be the least engrossed because they net the poorest rate break. So with new rules for guarantees, the need to generate extra fees, competition to provide a squeeze, why did this state state the need to bring a different state of delivery? Yeah, we got you Covered. Somehow our "Exchange" will help the market change, but at least the range of issues with which we've dealt put more on deck than the speck spotted from our ship of state. Minimum wage war leaving families more, and taking Medi-Cal for "the team" seem to solidify our boasts as the leftist of coasts. But with the premise that the promise will be kept and service cuts over which we wept will allow deficits to be swept away forever. So Jerry Brown can come to town and bring capital to our capitol. And so it goes.

San Francisco spans apace, but it looks like we have lost the race for weirdest city in the face of Ford's Canadian Karma as he dodged recall, but in New York they recall Weiner's fallacy and roasted his mayoral chances by dousing him with a Spitzer spritzer. The only question seems to be if the odious restaurant fee can be charged when the city is not reaping what was so much about health care. Even we're not sure of what the cure may be for higher health prices, as the ACA dices definitions of HRA and SF gets an F in educating us on the new realities of where the HCSO will go after the throw they caught from new IRS lines.

<u>Covered California – the Fix is In</u>

There are three problems (well, there are more but these are the main ones):

> Things need to be fixed, but we're doing better than the Federal Exchange
> There is a fix, but it's in the way the government makes everyone bend for this program
> Aside from the exclusive means to get a subsidy, why does Covered California exist?

Of the three, the one that is most insidious and disturbing is how the state government has allowed large powers to Covered California – not just to do what they are doing but to make everyone else do what they are doing, including sponsoring legislation (which was signed) that minimizes market choices for employers who may not necessarily wish to follow along with a new, standardized format nor continue the funding support of plans through premiums when they are not getting a premium for their investment (self funding). Here is a short list of what is happening and what is not going to be happening:

Things fixed betwixt what's mixed with in between – Covered California covers all angles

To their embarrassment, they had to drop Alameda Alliance, which wasn't licensed to sell
The total amount given them to proceed is $864 million - $290 million for advertising
Included in that spending allowance is the cost of 21,000 unlicensed Navigators
While they're at it, they are also going to use the program to help Voter Registration
Why did cost projections decrease? Because so did the lists of available medical providers
Carrier quality ratings will not be posted because they would interfere somehow with decisions
Financial disclosure by Covered California was also suspended – by Covered California
That of course wouldn't have anything to do with the following:

> They have been given $864 million - $290 million for advertising
> They built in an administration fee (to get self sustaining) – passed on to consumers
> Carriers selling outside the Exchange must match rates inside the Exchange
> (so what are they going to do with the fee that they extract when they match?)
> Covered California must be economically self sufficient by January 1, 2016

Truth? Or just consequences

SB 161 was passed, which puts high requirements on the deductible for self funded plans
Metallic plans, while a good idea, are now running fairly universally through the market
California Choice, a private exchange, was forced to limit options by the carriers
While some carriers are not in the SHOP exchange, they are offering mostly similar plans
Again, the carrier charges fees internally, but then keeps the fees – for…profit?

Stopping Loss by stopping loss by amending Stop Loss Coverage

For all partially or fully self funded plans issued September 1, 2013 and beyond, new rules are:

1) Individual attachment point minimum for specific stop loss is $35,000 ($40,000 in 2016)
2) The aggregate attachment point must be less than the greater of one of the following:

    a) $5,000 times the total number of group members
    b) 120% of expected claims
    c) $35,000 ($40,000 in 2016)

New Laws and Extensions of Others – Not many so read slowly

> Autism – SB 126 – extends full coverage for autism through 1/1/17
>
> Infertility – AB 460 – infertility must be covered as any other medical expense
>
> Paid Family Leave – SB 770 – broadens the definition of family members eligible for the California Paid Family Leave Act to include seriously ill siblings, grandparents, grandchildren and parents in law

San Francisco Family Friendly Workplace Ordinance – effective January 1, 2014, employers with 20 or more employees must allow any employee with a minimum of 6 months of employment (working at least 8 hours per week) to request a flexible or predictable working arrangement to assist with caregiving responsibilities. The employee may request the flexible or predictable working arrangement to assist with care for:

A child or children under the age of 18
A person with a serious health condition in a family relationship with the employee
A parent (age 65 or older) of the employee

Affordable costs money – California to hire 21,000 Exchange "Navigators"

Affordable but not necessarily understandable. There are those, astonishingly, who do not really understand insurance (we know, we've spoken to them…oh wait, it's our job to educate). So even though agents are licensed and trained and some even experienced, Covered California finds it necessary to hire 21,000 new personnel to, according to an article in Congressional Quarterly, "will be armed with the know how to untangle the complexities of insurance coverage"

In addition, the state will open 3 call centers staffed by 1,200 customer service representatives who will explain the law and guide callers through their purchases.

New trends in Medicaid (Medi-Cal here) – why not let the private market do it?

States have been arguing for a while as to whether they will continue to participate in Medicaid, which is the vehicle for covering medical expenses for lower income residents. Several have said they would rather forego the federal subsidy than have to incur the considerable additional expense they will incur just for running the program…now with expanded definition of eligibility (going from 100% of the Federal Poverty Level to 133%). The state of Arkansas has now floated the idea of a "private option" The New York Times reported March 22 that the White House "is encouraging skeptical state officials to expand Medicaid by subsidizing the purchase of private insurance for low income people, even though that approach might be somewhat more expensive" In Arkansas, Bloomberg News said that Arkansas cut a deal with the Health and Human Services Department, stating "rather than expanding Medicaid, it will offer private insurance plans to poor people and the federal government will still pick up almost all of the costs"

ACA "Not My Job" says the Governor of Alabama – will others follow?

Alabama Governor Robert Bentley told HHS Secretary Kathleen Sebelius that the state's "insurance regulators will not enforce the consumer protection provisions of the Affordable Care Act" and that "Washington – not Montgomery – is responsible for making sure health insurance plans sold in the state comply with requirements such as covering people who have pre existing medical conditions"

Baghdad by the Bay is now in a family way – new San Francisco Ordinance

Effective January 1, 2014, San Francisco is officially family friendly (we didn't know they didn't like families in the first place). Any employer with 20 or more employees (does not indicate if they must be based in San Francisco). The ordinance grants employees with 6 months or more working as few as 8 hours per week to request changes to help them meet responsibilities to care for a child, spouse, domestic partner, parent, sibling, grandchild or grandchild with a serious health condition; or a parent 65 or older. They can request accommodations for the number of hours they work, their schedule, work location, work assignment or the predictability of their work schedule.

But the state loves families too – new bill signed by Governor Brown

California Paid Family Leave Act has been expanded to allow workers to take up to 6 weeks paid time off to care for seriously ill siblings, grandparents, grandchildren or in laws. The current law only allowed time off to care for spouses, parents and children. The total benefit is 55% of wages up to a maximum of $1,011 a week

And the state loves the workers too – new minimum wage rules

California is the first state to put in place a law bringing the minimum wage to $10 per hour, joining with Maryland, Massachusetts, Illinois and Minnesota. The current minimum is $8 per hour, increasing to $9 per hour on July 1, 2014 and $10 on January 1, 2016

The forces are tipped against the restaurants – San Francisco says they shirk their duties to the health care fee requirement

Dozens of San Francisco restaurants are under investigation for exploiting the city health program by keeping customer surcharges instead of spending them on employee health care City Attorney Dennis Herrera said "the offending restaurants have until April 10 to spend at least half the fees collected on employee health care or face consumer fraud lawsuits. Unspent fees must then be turned over to the city"

BUSINESS BUMBLING

Either it brings tears to their eyes, or else…
Or else what? said Alice, for the Knight had made a sudden pause
Or else it doesn't, you know
(Alice in Wonderland)

You fail all the time but you aren't a failure until you blame someone else
(Bum Phillips, d. 2013)

Money won't create success. The freedom to make it will
(Nelson Mandela, d. 2013)

We are not afraid to entrust the American people with unpleasant facts, foreign ideas, alien philosophies and competitive values. For a nation that is afraid to let its people judge the truth and falsehood in an open market is a nation that is afraid of its people.
(John F. Kennedy)

One chord is fine. Two chords is pushing it. Three chords and you're into jazz
(Lou Reed, d. 2013)

Cash cow? So how now goes the Dow, it's what the market will allow
Out you win your place or show zero it depends on how your track your dough
Pundits' patter doesn't matter, Talking Heads mad as a hatter
Stop making cents as recompense when dollars turn to doughnuts hence
Is this time different? referent. We'll see where all the money went
Once flush now drained dreams may shatter if upward arcs skids marks flatter

Webs tangle the economy selling good on line tax free
We're afraid foreign trade won't fade and come to everyone else's aid
Ignoring our domestic strife yet promising a better life
For those abroad and home alike will unions soon be priced to strike?
Maybe if they can organize the low wage workers who lose the prize
Or race, skills, society's ills compete for how we pay the bills
For systems sick and health care rife with smoke and bloat needing a knife
On practice habits unalike and other cuts we will dislike

Inflation's still an illusion, insurance is in collusion
With published rules and rating tools, books advising to build risk pools
Dug in fear and speculation, lacking concrete facts' foundation
With commone sense and dollars lost we focus more on price than cost
Causing difficult decisions banked on prayers to save precision
Economic hope's salvation change with each expense creation

As if premiums weren't enough legal standards will make it tough
Gaining plaudits for new audits who at DOL had thought it?
New revenue now coming through from US and state fines too
More revenue on compliance forces company alliance
With brokers to make them richer in the belief that the picture
Frames relief and not frustration with firms' strong administration

It's no longer in free fall but the economy continues to stall with fits and starts as some parts come together. Recovery begets discovery that there's a health care price of success, as excess in the industry continues confounding punditry. Experts still have not a clue as to what allowed for some breakthrough not in medicine itself but a remedy not off the shelf for what ails us all. It's spending, not cost, and surely cost not price that drive decisions with less concision than required. Inflation's not a marker, the truth is deeper, darker and the reality is starker than desired. We get mired in the wrong numbers, making us number to the facts that tracks the actual expense of which only actuaries make sense (occasionally)

Big business thinks it's fond the cure, so sure that privately exchanging their own plans for cool tools in a pool created by brokers (getting richer) to let them share their price point pain with many others (so how are savings derived? Yet it's all a bit contrived). Public or private, the general feeling is we'll still get corporal punishment, as major changes in small group rules retain only a kernel of what we ranked before. The new score shows reversal in a rehearsal for what the ACA has staged, and carriers act from fright creating comedies with cancellations and canned renewals, only delaying a cruel accrual of inevitable rate explosion with early renewals. As if that's not enough, the government will make it tough to avoid the cost of doing business in health care. New laws, new rules from a 2,000 page act that has faced its facts with 20,000 additional sheets in stacks which attracts more notice(s)

The budget may not balance and projections so much valance, but revenue venerated will easily be generated with fines and taxes levied to the maxes with fewer damn breaks. Some rulings allow plan retoolings but others hammer those whose legal grammar lags and screws those who fail to recognize the revolution. Bolting will occur, as companies exchange what they run for the fun of private exchanges, or plans which were planned to exploit the government's exploitations in managed economies. Retail clinics pop up in stores and down side streets as i9nnovation meets status quo, where doctor merge in ACOs and health care traffic flows to those whose economies of scale manage better sales to face the winds of change. The government's always one step back, as private enterprise attacks, defies and often flies between right and left wings to keep us better grounded.

Is health care spending slowing? And note that slow does not mean it is decreasing

Studies published in Health Affairs show health care spending is slowing, but it is difficult to say if this trend will continue. Researchers found that only a third of the reduction in growth of health spending could be attributed to the 2007 to 2009 recession but that fully 55% is unexplained. This may be due to lasting changes, such as a slower introduction of medical device technology and new pharmaceuticals and a trend toward higher cost sharing (which cuts the tendency to utilization). Harvard economist David Cutler says projections of government spending on health care would plummet by $770 billion over the next 10 years.

Preventive Care Guidelines are Expanded…Again

The Department of Labor issued new guidance 2/21/13 on what is to be considered as preventive services covered at 100% under group plans:

> If a carrier does not have any in network providers to provide a particular preventive service as outlined, the carrier is required to pay for such expenses using out of network providers; and -- aspirin

There has been confusion about what, exactly, plans are supposed to pay for preventive care, not helped by the fact that the Administration simply deferred judgment to "guidelines" established by the various ruling bodies dealing with general medicine. The government has now made guidelines more official, issuing an FAQ clarifying that:

1) Out of network preventive care must be at no cost if no in network providers are available
2) Preventive over the counter drugs must be paid at 100% if OTC is prescribed
3) Routine immunizations must be covered beginning with the plan year starting one year after recommendation adopted by the CDC
4) When screening or immunization is recommended for those who are "high risk" it is the attending physician that determines whether the person is high risk
5) If a polyp is removed during a screening colonoscopy, the entire procedure must be covered without cost sharing as a preventive service
6) BRCA and genetic testing must be paid at 100% if the attending provider determines the woman is at high risk for the BRCA mutation based on family history
7) Required contraceptive coverage does NOT include male contraceptives
8) Plans may not limit coverage to oral contraceptives and must cover IUDs, implants, sterilization, device removal, etc. Plans may impose reasonable management techniques, such as limiting first dollar coverage to generics unless use of the generic would be medically inappropriate for the individual
9) Annual HIV testing and triennial HPV DNA testing covered as part of well woman care

So we are safe now…we have all our forms, contracts…or do we? DOL Audits on the rise

Where once wage and hour audits were how the Department of Labor stayed in business, they have taken on a few more enterprises and are expanding audits in the areas of:

> ERISA – particularly on Summary Plan Descriptions
> FMLA
> Independent Contractor classifications
> HIPAA
> More wage and hour audits, to include overtime, meals and breaks, exempt/non exempt
>
> And soon to be coming…Affordable Care Act (ACA) audits

Our friends are talking…brokers around the country have recently filed the following stories:

1) A company with 25 employees had the Department of Labor camp out for a full week

2) An associate of ours with 12 employees got a letter regarding a seemingly "random audit" and ended up being quite extensive, including a request for monthly bank statements to validate HSA contributions and lack of discriminatory practices. The request letter asked:

   a) Most recent W-4 for employees, along with 1099 and 1096 forms
   b) Trial balance year end, along with detailed general ledger and payroll ledger
   c) Documentation regarding unemployment payments
   d) Copy of employee handbook and benefit options given to employees
   e) Copies of employment contracts
   f) Summary copy of pension plan provided
   g) Copy of cafeteria plan offered to employees
   h) Copy of health insurance plans

3) Group of 500, well coached by their broker and given time to prepare (3 days of prep) still had the auditors stay for 3 full days (the client passed)

Just the start, as rumors fly that the DOL is looking to audit nearly 100% of businesses in the coming four years

The Department of Labor has traditionally limited its random audits to ERISA notices, content of SPD (Summary Plan Description) and COBRA…but the DOL is now examining employer and insurer compliance with the portability and other select provisions of HIPAA, wellness programs under HIPAA, health factors used in setting rates or employee contributions, certificates of coverage and related provisions.

But now we have the Affordable Care Act…and the DOL will be examining records demonstrating plan sponsor compliance with the ACA, including grandfather status, age 26 notices, etc.

Not to mention new or improved laws which require additional compliance: the Mental Health Parity and Addiction Equity Act (MHPAEA), the Genetic Information Nondiscrimination Act (GINA) and wellness programs in general.

Well, Well, new rules on Wellness are finally published – this time it is final (HHS 5/29/13)

Two kinds of programs – participatory and health contingent – the first are those without rewards nor penalties (e.g. free flu shots) or simply rewards participation (paying for gym membership). There are no rules for these. For the health contingent, however:

1) Subdivides them into outcomes based and activity only programs
2) Outcomes based includes programs that reward or penalize based on achieving a certain health status (cholesterol levels, BMI, blood pressure level)

3) Activity only provides rewards or penalties for participating, or not participating, in things like a walking program, nutrition counseling, smoking cessation program, etc. A program that requires those with a particular health condition to complete a specific educational program is considered a health contingent program

A wellness program with health contingent requirements must:

1) Be reasonably designed to promote health or prevent disease, and
2) Give ees a chance to qualify for the incentive at least once a year, and
3) Cap the reward or penalty at a prescribed percentage of the total cost of coverage, and
4) Provide an alternative way to qualify for the incentive for those who have medical conditions, and
5) Describe the availability of the alternative method of qualifying for the incentive in written program materials

Beginning with 2014, group health plans may have a reward or penalty of up to 30% of the cost of coverage if the incentive is not related to tobacco usage. If there are multiple parts to the program the maximum total reward or penalty for all parts of the program is 30%

Plans may have an incentive of up to 50% of the cost of coverage for non use of tobacco. If the program includes non tobacco rewards or penalties, too, the maximum total reward is 50% of the cost of coverage. An incentive may either be a reward (premium discount) or a penalty, such as a premium surcharge.

Plans that include health contingent incentives must provide an alternative way to meet the health contingent standard and provide the same incentive for meeting the alternative as would have been provided if the person had met the actual standard. For activities only requirements, the alternative only needs to be provided if it is medically inadvisable or unreasonably difficult for the person to participate because of a medical condition. For outcomes requirements outcomes based requirements an alternative must always be available. Employers who choose to use educational programs as a reasonable alternative must locate or help the employee locate an acceptable program. The employer must pay the cost of the program, including membership fees (but not required to pay the cost of food under a weight loss program). An employer may not limit the number of times an employee may use an alternative standard but it may require a different alternative standard if previous ones have failed. The employer does not have to provide the same alternative to all employees.

Inflation inflates expectations

Four Factors for deflation in 2014:

1) Care continues to move outside hospitals to more affordable retail clinics and mobile health
2) Major employers now contact directly with big name health systems for costly, complicated (use of high performance networks and centers of excellence)
3) Feds new readmission penalties take direct aim at waste in health systems
4) Growth of HDHP adoption means more consumers make more cost conscious choices

Four Factors for inflation in 2014:

1) Generics started to help but there is a rise of expensive complex biologics
2) Health industry consolidation continues which leads to higher prices in some areas

PwC HRI projects that 2014 medical cost trend will be 6.5% (last year was 7,5%)
Net growth rate after accounting for benefit design changes (e.g. HDHP) is 4.5%

Lower medical trend due to: lower general medical service utilization with fewer visits to the doctor's office, postponed procedures, cut back on medications and reconsidered imaging and elective surgeries.

Cost trend, or growth rate, is influenced primarily by:

1) Changes in the price of medical products and services, known as unit cost inflation
2) Changes in the number of services used, or per capital utilization increases

New care venues are gaining in popularity and will slow the rise in medical costs next year
Consumer use of retail clinics nearly tripled over the last five years

Milliman Notes:

1) 6.3% increase of 2013 vs. 2012. Last year it was 6.9, prior was 7.3, prior 7.8, prior 7.4
2) Drivers to downturn: economic downturn combined with increased member cost sharing, more provider integration (e.g. ACO) or sharing of information via electronic medical records, possibility of new blockbuster drugs was not enough to offset effects of generics
3) At 5% the inpatient facility category grew at a lower rate than any other category

Why get it wholesale when retail might be cheaper? The rise of retail health clinics

The growth rate of in store health clinics lingered at between 50% and 150% from 2001 to 2008, went lower to 1-3% in 2009 and 2010 and then picked up 15% in the last two years…but in coming years, walk in medical clinics at big box retail stores will increase by an annual rate of 25 to 30%, raising the number of such clinics from about 1,400 in 2012 to 2,800 by 2015. According to CQ Health Beat, retail clinics could handle about 10.8 million patient visits annually and account for 10% of non primary care outpatient visits by the end of 2015

If you want something said, ask a man
If you want something done, ask a woman
(Margaret Thatcher, d. 2013)

JUDICIARY JUMBLING

My dear here we must run as fast as we can just to stay in place, and if you wish to go anywhere you must run twice as fast as that
(Alice in Wonderland)

In University, they don't tell you that the greater part of the law is learning to tolerate fools
(Doris Lessing, d. 2013)

The great enemy of truth is very often not the lie – deliberate, contrived and dishonest – but the myth – persistent, persuasive and unrealistic. We enjoy the comfort of opinion without the discomfort of thought
(John F. Kennedy)

What Founding Fathers once intended has been seemingly upended
When filibusters bust debate and lines are drawn with Housing wait
For slots to fill with needed bills, inaction on the Hill instills
Mountains of regs from bureaucrats whose drawers are stuffed from backroom chats
But they're not our fiduciary that's up to the judiciary
To settle socres of laws across what's brought down from Exec branch boss
Whose fiats drive opponents wild, as he shifts gears with orders filed
Fueling courts to court new combats, Republicans and Democrats
In pieces war unsuspended, battling barriers never blended
Which brings the mix into the states to sooner fix than legislate
The peoples' wills dispensing frills to see what federal froth it kills

Contraception sees inception as church means of interception
What passed for law's equality ignored inherent quality
Of living so domestically in partnership politically
Moms and Pops abound, props are downed and other family ways are found
Expanding with more privacy, prevention with no added fee
Waiting periods are weighted, HRAs are newly freighted
With delivery placed, rules effaced, even FSA funds are chased
To catch up economically, mustered and relished critically
Acclaimed to claim an exception, to initiate misperception
Of spending trend so plans amend their plans and tend to better blend
And give less grounds to fears of bounds that leap to hound as year end rounds

If you can't go straight go around and change a date to amend unsound expectations. Republican lamentations go unheard and the ACA stays in play if not in place as Obama moves within the space of interpretation left open until the courts resort to what's best to lay to rest misrepresentation. Aside from this confusion, some definite conclusions were drawn from rules forgone as sketchy. The good news is new rules rule, yet duels gun dual considerations as administration policies go under the knife. Cuts butt in, as how many "buts" are left in documents mean to mean one thing can now let others bring in other options:

1) New waiting periods for employee medical plans is 90 days – but
   In California it is 60 days

2) Domestic partners may now be married and get proper rights – but
   Only if married in states where recognition

3) Up to $500 in unused FSA funds may be rolled over to the following year – but
   Only where the plan administrator approves

4) Contraception charges are covered – but
   Religious organizations may be exempt from this

5) HRAs may no longer pay premiums or non integrated expenses
   But integrated medical plans may continue existence

So voice is given to choice but only rejoice if you're in the right place at the right time as liberal measures exist at the pleasure of those who treasure freedom. Which may seem right except to those whose rights are denied, with unions civil now retried as the Supremes cavil with voting, voting to return us back to 1963. Thus we come full circle, with progress we thought we'd never see now facing darker history.

It's not just ACA – HIPAA is being amended as well in a flood of new regulations

New penalties, modification of rules for breach notification, business associates are directly liable for compliance with certain privacy and security rules and modifications are made to notices of privacy practices

FMLA – after years of helping families, they take leave to expand the rules

Passed in 1985, all was well…until it needed to be changed (after 17 years?). There are now two updates, issued by the Department of Labor:

1) When lave may be taken by a parent to care for an adult child with a disability

   a) The adult child must have a disability as defined under the ADA (as amended)
   b) The adult child must be incapable of self care because of the disability
   c) The adult child must have a serious health condition
   d) The parent is needed to care for the adult child

   All FOUR prongs must be met for a parent to qualify for FMLA leave to care for an adult child with a disability

2) For military leave provisions and best practices

Not too bad, actually. Sometimes they know when to leave well enough alone.

State Expands What the Feds do – a shorter waiting period coming in 2014

The Federal Affordable Care Act requires that the maximum waiting period for the onset of medical coverage, beginning in 2014, is 90 days. California passed AB 1747 on January 1, 2013, which will require a maximum waiting period for new employees of only 60 days.

Surrender Dorothy! No wait, you can keep some of it – FSA/Cafeteria plan rules change

1) Cafeteria Plans may be amended to allow $500 of unused amounts to roll to next year
2) Carryover does not affect the maximum amount of salary reduction ($2500 maximum)
3) Employer "at its option" may amend the document to allow for carryover of up to $500
4) The amount may be used for expenses incurred in the prior OR current plan year
5) Amount applies to account balances that are unused after the plan's run out period
6) The plan may specify a lower amount than the $500 maximum permitted here
7) Plan adopting carryover provision may not also still have a grace period for health FSA
8) In any one year, the employee may not claim more than the $2,500 plus the $500
9) The plan is not permitted to allow unused amounts to be cashed nor converted
10) Carryover equal to lesser of any unused amounts or $500 (or amount allowed by plan)
11) Any unused amount remaining in FSA as of employment termination is also forfeited
12) Uniform coverage rule still applies to regular amounts as well as the carryover amount
13) This new rule does not have any effect on the ability of a plan to allow a run out period (just as a run out period can also be run contemporaneously with the grace period)
14) Unused amounts from prior plan year used to reimburse a current year expense
15) If amended, must be adopted before last day of applicable plan year
16) If plan has a grace period, must be amended to exclude if carryover is included

HRA goes away except where it doesn't…among other unexpected changes

IRS Notice 2013-54 was published on Friday the 13th (September) which spelled bad luck for some provisions that have been held fast by many benefit practitioners for some time:

1) HRA may not be used to purchase health insurance in the individual market or Exchange
2) HRA may only be used for health expenses if it is integrated with a qualified group plan
3) A qualified group plan can also be that held by an employee's spouse
4) HRA that is not integrated may only be used to pay for dental and vision expenses
5) A stand alone HRA for medical expenses may only exist if it is for retirees
6) HRA integration can apply to any employer plan including that of a spouse
7) Limited scope benefits (e.g. stand alone dental and vision) are permitted for an HRA

What is not related to HRA but was incorporated into the rules was a new rule on "premium only" payment plans for individual coverage. No pre tax premium payments for *individual* plan sare allowed, though the pre tax payment for employer sponsored group plans is still permitted (as are any post tax payments)

There is also a restatement of the health FSA rules which includes a maximum amount of reimbursement that is reasonably available to a participant is less than 500% of the value of such coverage and the *employer* contribution is limited to $500.

DOMA Doomed by Supreme Authority, aroused from COMA as Prop 8 meets its fate

The defense of DOMA was weakened by the offense given. *US vs. Windsor* had the Supreme Court holding that federal law will recognize all "lawful marriages" between members of the same sex. It left open the question of "lawful" to the state but there was no decision as to whether it was state of domicile or state of "celebration" (where the marriage took place)

Fourteen states and the District of Columbia currently recognize same sex marriages: California, Connecticut, Delaware, Iowa, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, Rhode Island, Vermont, Washington.

Left in place was the rule allowing states to avoid recognizing same sex marriages performed in other states. Also left in place was the rejection of California's Proposition 8. The Supreme Court said it did not actually have jurisdiction to hear the case. So the US District Court's decision to overturned Proposition 8 as unconstitutional and this was upheld by the US Court of Appeals, both rulings stand and same sex marriages may being again.

Consequences of the Ruling:

1) Plan sponsors and insurance policies must define "spouse" to include the California definition of spouse, which includes those who have made same sex marriages

2) Registered Domestic Partners who are now married are subject to imputed income rules, which means joint tax returns and the "marriage penalty" imposed therein

3) Multi state employer with California sitused policy should recognize same sex marriage only in those states where same sex marriage law exists

4) FMLA and other leaves – must recognize the right of the employee to care for their same sex spouse

5) Section 125 Cafeteria Plans – pre tax premium paid for "spouse" is allowed under the law, and those with registered same sex marriage are allowed this deduction

6) Employers who pay for spouses as part of the benefits package may now deduct the premium paid for same sex partners who are now considered spouses

7) HIPAA special enrollment rules apply when an employee becomes married (may add coverage for new spouse within 30 days of the event) and this now must be expanded to include *any* legally recognized marriage in California

8) Same sex spouses are legally entitled to COBRA continuation coverage as a "qualified beneficiary" and, as with any QB, have a separate right of election

9) Same sex spouses are now given equal rights for coverage under the Medicare Secondary Payer rules

10) Dependent Care – this is a negative. Previously, each "partner" could claim up to $5,000 per plan year for qualified expenses incurred. With a same sex spouse now having a legal qualification as a spouse, the "household" is limited to $5,000 in the aggregate.

11) Individual coverage subsidy – also a negative. The subsidies for obtaining medical coverage through the Exchange (Covered California here) depend on the family income. If a same sex spouse is added to the family earnings equation, an individual who was previously qualified for a subsidy may lose this opportunity if the earnings change their position with respect to the Federal Poverty Level

In Revenue Ruling 2013-17, the IRS announced that the state of celebration would be the one recognized, regardless where the couple ultimately lives. Marriage does not include domestic partnerships, civil unions or other formal relationships falling short of marriage. This applies to ERISA benefit plans (including retirement).

Note that the ruling does not apply to "registered domestic partnerships, civil unions or similar formal relationships

The ruling takes effect September 16, 2013 on a prospective basis. The ruling also has guidance on retroactive tax filing issues resulting from the decision:

1) May include spouse as tax exempt under Section 125 plans
2) No more "imputed income" for "non legal" spouse for health insurance premium
3) Eligibility for COBRA
4) Eligibility for Dependent Care Assistance reimbursement
5) 401k retirement plans will treat same sex spouses upon participant's death

6) Individuals must file federal tax returns for 2013 forward as married filing jointly or married filing separately

7) Tax qualified benefits that are affected are:

    a) Health, dental and vision coverage
    b) Qualified tuition reduction plans
    c) Meals and lodging provided to employees on business premises
    d) Fringe benefits (transportation, moving expenses, employee discounts)

New couples may also file amended personal income tax returns for open tax years (2010-2012) to recoup over withheld federal income taxes resulting from imputed income and after tax cafeteria plan participants…if they refile, however, it must be as married for ALL tax purposes, not just to obtain the refund or credit

IRS Notice 2013-61 sets forth optional, streamlined ways for employers to claim refunds of over withheld employment taxes applied to imputed income/same sex spouse benefits in 2013 and prior open tax years. Normal process varies according to whether employer is seeking an adjustment or a refund of withholding taxes"

1) Identify the amount of over withholding
2) Repay the employee's portion to the employee in cash
3) File IRS Form 941-X for each quarter affected, to recoup the employer portion of the tax
4) Obtain written statements from affected employees that they will also not claim a refund of over withheld FICA taxes, and if an employer is seeking a refund of over withheld taxes, obtain affected employees' written consent to the refund

Two streamlined correction methods permit use of single Form 941 or 941-X for all of 2013

Method One

1) Identify and repay or reimburse employees' share of excess income tax, FICA tax withholdings resulting from same sex spousal benefits on or before 12/31/13

2) Make corresponding reductions in affected employees' wage and income tax withholding amounts on the fourth quarter 2013 Form 941

Method Two

Available if the employer does not identify and repay or reimburse the employees' share of excess income tax, FICA tax withholdings until after 12/31/13. In that case:

1) Files one single form 941-X in 2014 seeking reimbursement of employer's share of tax with regard to income for same sex spouse benefits reported in all quarters 2013

2) In addition to regular Form 941-X filing requirements, including obtaining written statements or consents from employees, employers must write "WINDSOR" at the top of the Form 941-X and must file amended Form W-2s (IRS Form W-2x) for affected employees, reporting the reduced amount of wages subject to FICA

This second correction method can apply only to FICA taxes. Employers cannot make adjustments of overpayments of income tax withholding for a prior tax year unless an administrative error has occurred.

Other notes:

1) Employers may also recoup *their* share of FICA taxes for earlier open tax years using one Form 941-X for all four calendar quarters that is filed for the fourth quarter of each affected year. In addition to marking the Form "WINDSOR" the employer must also file amended From W-2s for affected employees, reporting the reduced amount of wages subject to FICA withholding

2) Employers making use of the mentioned correction methods must take account of the Social Security Wage Base in effect for applicable years.

California Accommodations: excludes from state gross income, any amount received by an employee from an employer to compensate for additional federal income taxes incurred by the employee due to the federal government's failure to recognize same sex marriages

Pay or Play – and Reporting

You may already comply. You may already be providing employees with full and free coverage and they may tell you how appreciative they are at your weekly barbecues. Then again, you may not offer any coverage…but that no longer saves you from filing a pile of paperwork.

Reporting

To administer the individual mandate (proof that the employee or dependent actually has coverage), IRS Section 6055 requires information reporting by the employing entity:

1) Name, address and taxpayer ID number of primary insured and each covered individual
2) If health insurance coverage offered is a qualified health plan through public exchange
3) For qualified plan, amount of advance payments of premium tax credit to the individual

Where minimum essential coverage is provided through an employer's group health plan, the statute also requires the reporting to include:

1) Name, address and employer identification number of employer maintaining the plan
2) Portion of the premium (if any) paid by the employer
3) Any other information needed by the Treasury Secretary to administer the tax credit

Well that's Form 6055. Then there is Form 6056…which must be completed by all applicable large employers (those with 50 or more full time equivalent employees). Every applicable large employer must file a return with respect to each full time employee, showing:

1) Name, address and tax identification number of the employer
2) Name and telephone number of employer contact person
3) Calendar year for which information is reported
4) Months during the calendar year for which coverage was available
5) Number of full time employees for each month during the calendar year
6) Certification of whether employer offered full time employees (and their dependents) the opportunity to enroll in minimum essential coverage under sponsored group plan
7) Each full time employee share of the lowest cost monthly premium (self only) for coverage providing minimum value offered to that full time employee, by month

The employer must then also provide each full time employee identified on its return with a written statement that shows the relevant information for the employer and what was shown

Who is Counted – What Groups are Eligible

Basis is groups of 50 or more Full Time Equivalents:

1) IRS control group rules apply
2) Employees working outside the US will not be counted toward the threshold
3) Seasonal employees are those working 120 days or 4 calendar months
4) Sole proprietor, partner or 2%+ shareholder in S Corporation is not counted

Transitional Relief

1) Employer may use any 6 month consecutive period in 2014 to measure group size rather than the full 12 months of the 2014 calendar year
2) Was coverage offered to at least 33% of employees at the most recent open enrollment period before 12/27/13 (applies to all employees, not just those who are full time) OR
3) Did the plan cover at least 25% of all employees (can use any date between 10/31/13 and 12/27/13)

Who is Counted – What Employees are Eligible

Basis is 30 or more hours per week (or 130 hours per month):

1) Employer must establish a 12 month measurement period (begin no later than 7/1/13)
2) First measurement period must be in 2013 (may be shorter than 12 months)
3) An administrative period may be set up following the measurement period
4) Employer is treated as offering coverage to FTE for a month if it offers coverage for that month to all but 5% or, if greater, 5 of its FTE
5) The corresponding stability period must be in 2014 (end no later than 90 days before the first day of the first plan year beginning on or after 1/1/14

What to Count:

1) Each hour for which an employee is paid, or entitled to payment;
2) Includes vacation, holiday, illness, incapacity, layoff, jury or military duty or LOA

If employees are not paid by the hour, calculation may use one of three methods (and may use different methods for different classes of employees):

1) Count the actual hours worked and any hours for which the employee is entitled to pay
2) Days worked equivalency method (all credited for 8 hours of service for each day they would be credited with at least 1 hour of service)
3) Weeks worked equivalency (automatically credited for 40 hours of service for each week that they are credited with at least 1 hour of service)

Employer may not use a method that would substantially understate true hours of service
Hours worked for services performed outside the United States do not count

(Employment Breaks Allowed) – For employees treated as continuing employees that have employment breaks of at least 4 consecutive weeks, the employer must either determine the average hours of service per week for the employee during the measurement period (excluding the employment break) and use that average as the average for the entire measurement period, or treat employees as credited with hours of service for the employment break period at a rate equal to the average weekly rate at which the employee was credited with hours of service during the weeks in the measurement period that are not part of an employment break period (but not more than 501 hours of service for any employment break period)

Exceptions and Breaks in Testing

1) The $2,000 penalty – exclude the first 30 employees who fail
2) The $3,000 penalty – applies for each employee who enrolls in tax subsidized exchange
3) The $2,000 penalty – does not apply where employer offers coverage to substantially all full time employees (greater of all but 5% or 5)
4) Overall: only applies to employees working the entire month (new or terminated), the employer must allow the employee to accept or elect and the employer does not need to cover or count the employee if they do not pay their premium on time

Notes

1) Seasonal employees who work 120 days or less are not counted for determination

2) FTE equivalency for PTE is to take total number of hours in a month and divide by 120

3) Rehired employees considered new employees if break at least 26 consecutive months

4) May use administration of up to 90 days following the measurement period and apply a 3 month grace period for new employees, but 90 days cannot extend the time beyond a year from the date of hire to enroll FTE

5) Employer is permitted not to treat the employee as a FTE during the stability period that follows the initial measurement period. The stability period must not be more than one month longer than the initial measurement period and must not exceed the remainder of the standard measurement period (plus any associated administrative period) in which the initial measurement period ends

6) Special rule says if an employer's workforce exceeds 50 FTE for 120 days or fewer during a calendar year, and the employees in excess of 50 who were employed during that period of no more than 120 days were seasonal workers the employer is not an applicable large employer

7) A rehire may be treated as new with a break of at least 4 weeks and that is longer than their original period of employment

8) Non payment: if an employee enrolls in coverage but fails to pay their contribution on a timely basis, the employer is not required to provide coverage for the period for which the contribution is not timely paid, and that employer is treated as having offered that employee coverage for the remainder of the coverage period (typically the remainder of the plan year)

Wellness

New regulations show 2 programs types: participatory and health contingent wellness programs

Participatory Wellness programs

1) Reimburses employees for all or part of the cost for membership in a fitness center
2) A diagnostic testing program that provides a reward for participation in that program and does not base any part of the reward on outcomes
3) Encourages preventive care through the waiver of the co payment or deductible requirement under a group health plan for the costs of pre natal care or well baby visits
4) Reimburses employees for the costs of participating, or that otherwise provides a reward for participating, in a smoking cessation program without regard to whether the employee quits smoking
5) Rewards employees for attending a monthly, no cost health education seminar
6) Provides a reward to employees who complete Health Reimbursement Assessment

Health contingent wellness programs

Requires an individual to satisfy a standard related to a health factor to obtain a reward

Activity only wellness programs – requires an individual to perform or complete an activity related to a health factor in order to obtain a reward but does not require the individual to attain or maintain a specific health outcome

Outcome based wellness program (form of health contingent wellness program) – requires an individual to attain or maintain a specific health outcome (e.g. not smoking or attaining certain results on biometric screenings) in order to obtain a reward. Program has two tiers:

1) Compliance with educational program or alternate activity to achieve same reward
2) Alternative is the second tier

Reward may not exceed the applicable percentage of the total cost of employee only coverage under the plan (or dependents if they are rewarded for participation as well)

Health Contingent Wellness program requirements:

1) Must give eligible individuals an opportunity to qualify for the reward at least annually
2) Reward must not exceed 30% of the total cost of employee only coverage under the plna or 50% to the extent the program is designed to prevent or reduce tobacco use
3) Reward must be available to all similarly situated individuals
4) Must be reasonably designed to promote health or prevent disease. Thus must have a reasonable chance of improving the health of, or preventing disease in, participating individuals, and not be overly burdensome nor a subterfuge for discriminating based on a health factor

5) Must provide an alternative. In lieu of providing a reasonable alternative standard, a plan or issuer may always waive the otherwise applicable standard and provide the reward. Facts and circumstances are taken into account:

   a) If the reasonable alternative is completion of an educational program, the plan or issuer must make the educational program available or assist the employee in finding such a program and may not require an individual to pay for the cost of the program
   b) The time commitment required must be reasonable
   c) If the alternative is a diet program, the plan or issuer is not required to pay for the cost of food but must pay any membership or participation fee
   d) In an individual's personal physician states that a plan standard is not medically appropriate for that individual, the plan or issuer must provide a reasonable alternative standard that accommodates the recommendations of the individual's personal physician with regard to medical appropriateness

Plans and issuers cannot require verification by the individual's physician that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy, the otherwise applicable standard as a condition of providing a reasonable alternative to the initial standard.

Transit plan in transition – changes in total amount being allowed retroactive to January 1, 2012

The original rules for 2012 allowed for qualified parking limit of $240 and general transportation for $125. Under the American Taxpayer Relief Act (ATRA) the transportation amount was amended to $240 – but retroactively to January 1, 2012. Employees may now make those claims retroactively and employers may make adjustments to what now exists as an overpayment on FICA taxes using Form 941X for each quarter in which the excess was or would have been reported. IRS Notice 2013-8 provides a special administrative process to obtain a refund for the excess FICA paid.

Private no more – final (finally) HIPAA rules are now public

At a mere 563 pages, was it worth waiting 3 years? The "Final Rule" addresses many of the compliance issues and unanswered questions facing covered entities and business associates. The effective date is March 26, 2013 with a compliance date of September 23, 2013. There are now a list of civil monetary penalties:

Did Not Know	$100 to $50,000 with a maximum possible for ALL of $1,500,000
Reasonable Cause	$1,000 to $5,000 with same maximum
Willful Neglect (Corrected)	$10,000 to $50,000 with same maximum
Willful Neglect (Not Corrected)	$50,000 with same maximum

Most of the new rules pertain to disclosure allowed by covered entities and not the employer

Audits on the Rise – DOL Letters coming to you soon? What they will request:

1) General request for plan documents, SPDs and related documents –since January 1, 2010, including those relating to eligibility, annual and lifetime limits, provider network makeup and other terms. It also requires production of plan amendments, SPD, SMM and documents sent to participants or beneficiaries regarding benefits or claims procedures

2) General request for insurance, reinsurance and TPA contracts – same dating, and requires all contracts for claims processing, administrative services and reinsurance plus documents concerning the adoption, execution or amendment of such contracts

3) Wellness and Disease Management Programs

4) Age 26 Mandate Compliance

5) Grandfathered Plan Status

6) Choice of Provider Notice – non grandfathered plans must provide a copy of each form of notice informing participants of the right to designate their choice of certain providers and a list of participants who received the notice.

7) Claims and External Review Documents – for non grandfathered plans, must provide samples of the plan's notice of adverse benefit determination, and notice of final external review decision used since September 23, 2010 plus contracts with any independent review organization or TPA providing external review

8) Mental Health Parity Compliance Efforts

Waiting Periods – California is different (as usual)

The federal ACA law says that the maximum waiting period that may be charged a new employee is 90 days. California law came out subsequently making the waiting period a maximum of 60 days. No exceptions. No excuses. The only good news is that it does not apply until the first plan anniversary in 2014.

You know some people got no choice
And they can never find a voice
To take with that they can ever call their own.
So the first thing that they see,
That allows them the right to be
Why they follow it
You know what it's called?
Bad luck
(Lou Reed d. 2013)

MY BACK PAGES

(heartfelt humbling)

Language is a lovely thing. Sustaining me through sales and the travails of ales public life. We all have our stories and sometimes glory in their telling. Mine are somewhat darker, confined to an interiority that sees light from within, even where the brightness may lead me other places. When I began this journal it served as summary to what was seen and the scenes played out on national and smaller stages, the pages leant to rhyme schemes to put distance to the pain that those who reign inflict on people caught in the intermittently meshing gears of business, politics and law.

Increasingly, as I survey the jumble of notes taken during the year, I reflect less on the meager gains of our sister systems and more on the major losses, of those who helped to shape our world, our thinking and our spiritual consciousness. Or mine, at least. Whether it's the wonder of a mind that can play so loosely yet quickly with reality, like Jonathan Winters, the courage of a female Prime Minister moving her country right, the unquestionable valor, heroism yet full humanity of Nelson Mandela, or to merely mark the milestones of history with King and Kennedy anniversaries. We see the sweep of words and deeds, of talent given freely so others may find the freedom to laugh, cry, sing and dance within the richness of legacy brought full.

This year the losses took on a more personal meaning with the passing of three with nothing in common but me. They say we all remember where we were when we heard the news of John Kennedy's assassination (I was in our small den across from my parents' bedroom, watching a small black and white Motorola). With time, memory is drawn from a broader palette – the moment I met my true love, the first cries of children, holding grandchildren and even great grandchildren (yes, I am old before my time), a book, a poem, a song, a father's life celebrated and the hope the misted veil would not be pierced. I mourn the loss of many heroes, some shared, some mine alone, and what they gave me to become who I am. Like it or not…

Seamus Heaney

Called "the poet of soil and strife" (New York Times) I found him late in life on a boat to Uruguay. It was a short and simple poem, describing farm implements, their heft, their look, their color in language so precise and measured it took a second reading, then a third to fully gauge the art, the craft that impelled the use of those specific words, separated by a simple dramatic tension that underlay the ordinariness, but stark beauty, of the scene that all could behold but only he could properly describe.

Shortly before his death, I saw him on stage in Boston good naturedly jousting with another Nobel Laureate (Derek Walcott) who brought other island sounds to his oeuvre. The moderator lost her place in the midst of 2 gifted men bestowing on us the blessings of their devotional discourses of what poetry was meant to be. This annual exercise of word play, pliable prose and juxtaposed meanings and messages is really my attempt to clear the rubble from my mind's cave. Thus I may discover interior treasures too long hidden and express them with a mere sliver of the heart and passion in possession of poetic Irish heroes.

"When language does more than enough, as it does in all achieved poetry, it opts for the condition of overlife, and rebels at limit"

Noli Timere (don't be afraid) – last text message to his wife

Lou Reed

From the language of open fields to the urban underground, Lou Reed roamed among denizens we hoped to never meet, bringing their humanity to the surface and saying "I'll be your mirror…reflect what you are" Oddly it was in staged irony that I found him, posing in glam rock decadence and doing arena rock when his words were meant to be barbed and quiet, a whispered snarl instead of a shout. "There one fine day (I) turned on a New York station and couldn't believe what (I) heard at all…my life was saved by rock and roll" never the pop practitioners who preached pap with sappy lyrics and limpid tunes, nor the noise merchants or the thuggish street rappers who lacked the merit of distant observation, I wanted my anger cold and Lou Reed intersticed the droning chords with bite, malice and a remote affection. From "White Light/White Heat" to the time he "Set the Twilight Reeling" While Heany set music to words, Reed set words to music. I never stopped listening, and found a world within ja world that sound helped me discover, even through unsound minds.

Various Moments

Just a perfect day – you made me forget myself
When you think the night has seen your mind – I'll be your mirror
When I'm rushing on my run, and I feel just like Jesus' son
Holly came from Miami FLA
They said, hey baby, take a walk on the wild side

Final Moments

As the twilight sunburst gleams
As the chromium moon it sets
As I lose all my regrets
And set the twilight reeling

Julie Harris

My first play in London. A woman alone on a stage, channeling "The Belle of Amherst." A clash of crafts, blended with original and appropriated writing, telling the story of that most enigmatic of poets, mistress of the epigram and ellipsis, Emily Dickinson. As she once said of the capabilities of good poetry to "lift the top of my head off" so I was struck dumb by the richness fo the language, the power of the imagery, and the bleakness of the vision rendered in the still comfort of reclusiveness and ennoblement by one so few would know but many would find. Julie Harris, one of the finest actresses of her generation yet famous only in certain circles, gave life to one we merely overheard and gave point to the barbs quietly thrown from her window overlooking those who could not see. In two hours, I fell in love with two women I would never know except for the effect they would have on me, still wildly resonant after 35 years.

Words are my life. I look at words as if they were entities, sacred beings. There are words to which I lift my hat when I see them sitting on a page.

To find that phosphorescence, that light within, that is the genius behind poetry

On Death

My life closed twice before its close,
It yet remains to see
If immortality unveil
A third event to me
So huge, so hopeless to conceive
As these that twice befell
Painting is all we know of heaven
And all we need of hell

(Emily Dickinson)

Their faces pass before me, alive from what they've left, who can be bereft with so many gifts bestowed, in the knowledge that they're owed nothing more than grateful memory. Afflictions, addictions, pain and wondrous joy, my heart filled with buoyant laughter and concomitant depression that must be felt to better know the wonder of it all, the wonder of divine grace under which I'm blessed to live.