JORDAN'S JOURNAL - 2013

Newtown opens old wounds, wound around the war within US. Eastern devastation raged from Sandy to Sandy Hook, which shook a nation once sodden with Bin laden, in errors that such terror was spread through time and distance. Aurora bore realistic witness and the Dark night rises once again in Portland, Rochester and Oakland, catastrophe cutting across the coasts leaving grieving parents in their wake. Will it wake us from our slumber or must the number rise before the guise of freedom is lifted from our eyes? Nays are heard but some preferred debate while we await the fate of which burden we will bear – the right to fight or the sight of further sorrows our arms can't carry on the morrows of harm's way?

The Mayans may have had it wrong but ere long we hear the voices throng that we have reached the end of the world – as we know it. Thoughts of rapture cannot capture the daze we feel as we reel from tragic consequence of what made sense but may have ceased in the Middle East and the wheels we Greeced for Euro's lapse and economic collapse amidst a dramatic Asiatic retreat. Will we exchange our hope and change for new terms of our existence, with deliria in Syria and Egypt tipped toward repression while depression looms as wheels of fortune spin within a China syndrome and a yen for Japan's stability. Our ability to see the light is compromised within the blight to reason's life fragility.

Roosevelt lectured once on fear and Obama shed a nation's tear so we could see that liberty is still our nation's cry, and why we must preserve our trust in solutions we can try. Fail better, Beckett mournfully said, and that's where we succeed, because we can't get what we want but should get what we need, as the stones roll away and the spirit sealed will soar again some day. The world won't end with whimper nor bang if what we sang we meant, as Lincoln's lament of mystic chords recalls the memory that we can nurture the better angels of our nature.

We've shown what we've sown but reaping tales so Grimm asks witch tone would give us better angles. Redemption, faith and the belief that the grief we've paid is better made for some salvation. The economy grows and we're in the throes of some clarity of where charity begins and responsibility pins its medals on those with mettle who steel themselves for challenges afresh. What risk'll we take for fiscal sake and how we will be taxed, political duels and tighter rules while pledges are relaxed. Oaths are tossed when we curse the cost of all debate stalemate, and await our fate when affairs of state will consummate at last, as Lincoln's blast is trumpeted across forgotten ages. Movies make real what we thought to feel when his wisdom was once found on pages:

> Fellow citizens, we cannot escape history. We of this Congress and this administration will be remembered in spite of ourselves. No personal significance or insignificance can spare one or another of us. The fiery trial through which we pass, will light us down, in honor or dishonor, to the latest generation. We say we are for the Union. The world will not forget that we say this. We know how to save the Union. The world knows we do know how to save it. We – even we here – hold the power and bear the responsibility.
> (Lincoln's Annual Message to Congress – 1862)

FEDERAL FOLLIES

I think the company's getting disgusted with Washington, partly because of the decline of civility in government (George McGovern, d. 2012)

As societies grow more decadent, the language grows decadent, too. Words are used to disguise, not to illuminate action; you liberate a city by destroying it. Words are to confuse, so that at election time people will solemnly vote against their own interests (Gore Vidal, d. 2012)

If we listened to our intellect…we'd never have a friendship. We'd never go into business because we'd be cynical. Well that's nonsense. You've got to jump off cliffs all the time and build your wings on the way down (Ray Bradbury, d. 2012)

As far as the men who are running for President are they aren't even people I would date (Nora Ephron, d. 2012)

Will Petraeus still dismay us, ill starred timing may betray us
As new wrinkles really rankle wearing fifty shades of kihaki
Syria has A ssad time, Korea Kimmits Seoul crimes, Egypt primes
the pump to dump the rights the fueled oil our fights with Iraqi.

The collection ere election made us wary of selection
So chose a mission aerie from which Mitt declined descent
The right lost sight of poor folks plight
Storming right until Sandy's might
Cut Romney's votive motive short with forty seven percent

The fiscal cliff encounters stiff resistance to hide sequesters
The public tiff creates a whiff of mendacity that festers
Lemmings run blind until they find the distances are too great
To leap with faith or spectral wraith that haunts them much too late

Opinions form on health reform and the dough that always rises
Without doc fix or new tax picks we can't afford surprises
It keeps changing as we're Exchanging Federal rates for states' control
Of costs we've lost and laws they've tossed to keep things on a roll

Cliff dwellers look like buyers and sellers as they grow hoarse from trading before deadlines draw lines we dare not cross. Boehner may lose his retainer, being bitten by his brethren, while Obama creates drama when he fails to act. We search for a solution, precipitated by a resolution to name a Super Committee slated to clean out pre conceptions. At inception it Bowles us ov-erskin in the game pins perceptions and we were spared the need to heed their call to stop our self deception. Affairs of state rarely rate a mention as attention's paid to plans God laid on coastal plains, where it's plain to see that Sandy came in handy for Obama. Romney sang a different tune, but was not attuned to those who turned him out, after doubt was cast by what he meant when the 47 percent weren't part of his equation. The Tea Party can't pour it on, DeMint took the hint and is long gone, his heritage toddling off with enemies Akin for fights when women's rights went south.

The fate of terror's potentates came just when errors in the rates of interest in what Grecians earn showed us that we never learn when Euros sat with bureaucrats who failed to preserve reserves. Its seriousness is still denied, gravity must be defied as lemmings leap to deep despair, left to wonder who will care for the sick, the weak, the poor. What allure will reel in party favors, when spenders crest the banks of savers, pasting pictures of new leaders along headlines of the breeders of body politic. The ReinState department (Clinton then Kerry) recycles spin on the mess we're in. Politicians' indecision may make failures of successors, ducking for now the lame excuses that follow four more years. We hope to change the hollow calls for reforming what our hallowed halls erect when we elect to redirect our present course.

A house divided itself cannot stand (Abraham Lincoln)

But you say you are conservative, while we are revolutionary, destructive or something of the sort. What is conservatism? Is it not adher4ence to the old and tried, against the new and untried? We stick to, contend for, the identical old policy on the point in controversy which was adopted by "our fathers, who framed the Government under which we live;" while you with one accord reject, and scout, and spit upon that old policy, and insist upon substituting something new. True, you disagree among yourselves as to what that substitute shall be. You are divided on new propositions and plans, but unanimous in rejecting and denouncing the old policy. (Abraham Lincoln, Cooper Union Address)

Can they do it? A mandate is now a tax, and so the IRS must be ready. Are they?

Amid charges by Republicans that enforcement of the individual mandate and the provision of subsidies for Exchange enrollees will require the addition of up to 16,000 new IRS agents, Deputy Commissioner reported to the House Ways and Means Committee that the IRS is ready to proceed and will be ready to meet the challenge posed in 15 months – with many fewer new agents than Republicans state. A former IRS Commissioner disputes this assertion, however, stating that providing the subsidies will produce a "burdensome, costly and frustrating quagmire"

Fiscal Cliff faces a stiff test but Congress looks before it leaps

What would happen

1) $536 billion in tax increases because of the end of various tax cuts and breaks
2) Expiration of temporary Social Security payroll tax cut
3) End of current unemployment benefit extension
4) $110 billion in spending cuts divided equally between military and other federal depts.
5) Stock market? Position in international economics? Economy slowdown?

What was being considered

1) Compromise in cuts or taxes – may simply restore the pre-Bush percentages
2) Raising the Medicare age from 65 to 67
3) End or modification of the employer health insurance tax break

What was decided – on the edge of the ledge

"Compromise, n. Such an adjustment of conflicting interests as gives each adversary the satisfaction of thinking he has got what he ought not to have, and is deprived of nothing except what was justly his due (Ambrose Bierce, The Devil's Dictionary)

Redefine the rich and find a way to stitch which pitch won't hitch the budget glitch – so despite what the President said in his campaign, the near rich escape intact while those who make more have taxes in store:

1) Those with incomes exceeding $400,000 (or $450,000 jointly)

    a) Capital gains goes from 15% to 20%
    b) Individual tax rate goes from 35% to 39.6%

2) A 5% bump in estate tax for those with value over $5 million ($10 million jointly)
3) A deferral in the proposed cuts at domestic and defense spending

The unemployment benefits have been extended one year but will raise the Social Security withholding tax back to its original level of 6.2% (up 2 points from the temporary reprieve)

What is not yet known – which is crucial with regards to health care reform – is whether the planned reduction in doctor fees under Medicare will be allowed to proceed

W-2 Requirement – finally

Groups that issued 250 or more W-2s were required to show the value of health insurance on that form January 2013 for 2012 wages.

Beginning in 2013, all groups are required to gather such data for reporting on W-2 on January 2014. The current rules say that there are no rules, and technically groups are supposed to wait until final regulations have been issued…but don't wait…start collecting data now.

Medicare Tax - Employer

Starting January 1, 2013, employers are required to withhold an additional 0.9% of wages from those employees who earn over $200,000 annually:

1) No employer match is required
2) No withholding until employee hits the $200,000 threshold
3) Employee filing jointly with under $250,000 joint income is entitled to credit
4) There is no requirement for the employer to let the employee know of the new requirement
5) The employer is not required to determine the employee marital status or consider their deductions – employer only needs to track the employee annual salary
6) Individual anticipating owing over employer withholding may do estimated tax and request additional tax withholding on Form W-4 but NOT request more Medicare tax withholding

Medicare Tax – Employee

Individuals owe 3.8% supplemental Medicare tax on net investment earnings over $200,000 (individual) or $250,000 (joint filing). Various rules as to what counts for earnings apply.

Social Security and Medicare – the latest survival statistics (no, they're not dead yet)

Long run actuarial deficits worsened in 2012. For Medicare, because of an increase in assumptions for long term costs, and for Social Security due to use of updated economic data and assumptions.

The Social Security expenses exceeded non interest income in 2010-11, for the first time since 1983 – and the trustees have assumed similar results for the next 75 years. Also, the reduction in the Social Security tax (employee portion) recently caused a shortfall of $103 billion in 2011 and will cause a shortfall of $112 billion in 2012

Social Security as a share of worker earnings will grow from 11.3% in 2007 to 17.4% in 2035. Medicare will grow as percent of Gross Domestic Product from 3.7% in 2011 to 5.7% in 2035

Noah more wait – the flood of new regulations begins

Post election, the Health and Human Services et al began releasing long awaited regulations:

<u>Non discriminatory wellness incentives</u>

Reiteration of 2006 regulations, which allow incentives for participation in a smoking cessation program (even if employee doesn't quit). Results based programs must still meet 5 conditions:

1) Promote health and prevent disease
2) Provide a chance to qualify for the reward at least once a year
3) Provide alternative standard for those who cannot meet standards due to medical condition
4) Describe the availability of the alternative standard
5) Cap the reward or penalty at a percentage of the total cost of coverage

Maximum reward or penalty is 30% of total coverage cost, the penalty for tobacco use may also increase to 50%. The employer must locate and pay for the alternative standard program and prohibit limits on the number of times an employee may use an alternative standard

<u>Essential Health Benefits and Actuarial Value</u>

1) Restrictions on cost sharing will not apply to self funded and large employer plans
2) Non grandfathered plans in the market must cover the 10 essential health benefits (outlined in the original law) and meet actuarial standards (values using the "metal plans")
3) States have 30 days from the date this rule is published to elect baseline benefits policy
4) Provides method to supplement the baseline plan's benefits if it does not cover all ten EHB
5) Allows policies to substitute an actuarially equivalent benefit within an EHB Category
6) States that HHS will provide a calculator to determine actuarial value (already done)
7) Provides that a plan within 2% of the metal standard would be acceptable
8) State mandates in effect as of December 31, 2011 would be considered EHB
9) Self funded and large employer plans need not provide the 10 EHB (but must provide an actuarial benefit of at least 60% and coverage for certain services at "minimum value"
10) HHS and IRS provide a minimum value calculator and safe harbor designs that self funded and large group plans could use to determine if they meet minimum value standards
11) Employer contributions to HSA or HRA are part of the actuarial minimum value calculation

The benchmark plans set by the state may include:

1) The largest plan by enrollment in any of the 3 largest products in the state's market
2) Any of the largest 3 state employee health benefit plan options by enrollment
3) Any of the largest 3 FEHBP plan options by enrollment
4) The largest insured commercial HMO in the state

If state does not select benchmark, the HHS uses option number one

STATE STUMBLING

The whole campaign was a case of mistaken identity
(George McGovern, d. 2012)

"And now," cried Max, "let the wild rumpus begin!"
(Where the Wild Things Are by Maurice Sendak, d. 2012)

Poker is a game of people…it's not the hand I hold, it's the people I play with
(Amarillo Slim, d. 2012)

We're all Bozos on this bus
(Firesign Theater – founder Peter Bergman d. 2012)

The state is Jerry manned, redistricting is planned
We're short on green and long on Brown
And can't budget though thousands cheer when we grandstand

Preserving daily disorder, a tension would be in order
To fill deficits that line our state with faults
With criminal apprehension, state pensions are in suspension
Safety forces us to reinforce our vaults

Principal interest is in taxes, seeking power like Abraxas
Raising spirits as we demonize the rich
Who run for borders north or west, leaving fewer to invest
Oye com ova? When it's too late to switch?

Medi-Cal can cut both ways, the state is ill equipped to raze
Cost inflation when the nation expands demand
The supply of doctors is short and nurses we need to import
What future is limned with the arms had on hand?

Brown is going down, the line of items he can cut, we're in a state of rut from what the pro's created. Debate has not abated, a special session on cost compression deals with transgressions of the past, with imposition on the opposition as Democrats hold fast to the margin that loomed large in last election. In bridging budget gaps, the Feds turn off the taps, dictating despite stating that we're free to catch new cards. They post guards at Golden Gates without surcase to tax increase such rates will take a toll on our business as a whole as we part with some of those we need to stay. In the throes of fiscal woes there are those who toss vetoes so it's hard to bear the thought of what we've wrought. But surely we'll adapt as businesses have tapped means to attack the many ways we've lost direction. Then again now's not like then and it's a quest to see just when we'll right the ship of state when mostly Democrats are left.

Health care's begun a war though what we're fighting for relies on lies we've told ourselves or sold to others. We're all brothers on this ride, though our sister states just might decide to play along with others in DC. We see a change in the Exchange, with many millions in its range to claim to tame the costs of which we've cost control. Yet competition rains and carriers complain It's self defeating when competing with themselves. So old plans come off the shelves nad we book new looks to delve into the fees and basic costs that we discharge.

San Francisco is laid bare to what its people wear, LA clinics care for how they share, Healthy Families have their hood moved to what we would provide provided Medi-Cal had money.

By the frame of government under which we live, this same people have wisely given their public servants but little power for mischief; and have, with equal wisdom, provided for the return of that little to their own hands at very short intervals
(Abraham Lincoln, First Inaugural Address)

Good news, bad news…one party in clear control in Sacramento

Both the Assembly and the state Senate were both granted super majorities with the November election, which means the Democrats have the power to pass any legislation they wish without having to consider the needs, demands or criticism of their Republican opponents. Must be nice…but what does this power mean? First, taxes can be unilaterally raised for the first time since Proposition 13 passed in 1978…and speaking of Prop 13, the limitation on property tax increases and their method of assessment could come under review. Some reasoned sentiment has been sounded, however, as Speaker John Perez said "we need to be very responsible with the limited resources that the state has, and we need to be thoughtful about making decisions that create the opportunities to grow jobs and get people back to work in the state" Speaker Perez added that the Democrats will actually lack the 2/3 majority for much of next year as 2 incumbent Senators leave for Congress and Assembly members run for their vacant seats. For the historians in the crowd, the last time a Senate supermajority was held was in 1965 (Democrats and the last Assembly supermajority was in 1978 (also Democrats)

A pregnant pause – carriers now required to cover maternity on individual plans

Governor Brown signed Senate Bill 222 which requires health insurance companies to cover maternity as part of their individual plans. Only 12% of individual plans offered maternity in 2012. Obviously this will add to the cost of those plans which had eliminated maternity.

The Maternity Fraternity – More laws affect pregnancy leave

New pregnancy coverage rules are effective January 1, 2013 for groups of 5 or more:

1) Expanded definition of reasonable accommodation (which include modification of duties, work practices, schedules and policies, allowing more frequent breaks, providing furniture to accommodate or modifying equipment or devices, and lactation breaks.

2) Expanded definition of pregnancy related conditions includes conditions related to pregnancy, such as lactation, severe morning sickness, prenatal care, postnatal care, bed rest, gestational diabetes, pregnancy induced hypertension, preeclampsia, etc.

3) Expanded definition of health care provider (that can make recommendations)

4) Leave is no longer a loose four months a year, but 17 1/3 weeks (determined by the hour) for any period of pregnancy

5) Definition of pregnancy expanded to include "perceived pregnancy" for purposes of discrimination testing related to hiring or firing

6) New model forms (including those in a second language) are now required

7) Employers must continue paying their share of employee health care benefits for those on Pregnancy Disability Leave.

Miscellaneous Rules (well, the Democrats do, but…)

1) Written commission agreements with rules and calculations must be taken
2) Employers prohibited from requiring employees to disclose user names and passwords
3) Breastfeeding is now protected by law
4) Payment of a fixed salary to a nonexempt employee is deemed to be payment only for the employee's regular non overtime hours

Initiative Lost its Initiative – California proposition finds opposition

It was proposed by the California Insurance Commissioner. It was proposed in the California Assembly. It was even rumored to be on the November ballot. But a 10% limit on rate increases by California carriers failed to get sufficient signatures to make it – this time.

Making a meal out of a decision – break rules decided by Court decision

California Supreme Court decision *Brinker v. Superior Court* has set standards for meal and rest periods, establishing simple guidelines for employers to follow. A non exempt employee is entitled to a 10 minute paid rest break for every 4 hours of work (exception if shift is 3.5 hours or below). The Court held that the employer should set the rest break near the middle of the 4 hour block of time, but "may deviate from that preferred course where practical considerations render it unfeasible" For meal periods, the Court stated that non exempt employees are entitled to a 30 minute uninterrupted meal break for every 5 hours of work. Under the law, it means to give the employee 30 minutes where they are free to do what they want, whether or not the employee chooses to use the time for work. The Court stated "the meal period requirement is satisfied if the employee has at least 30 minutes uninterrupted, is free to leave the premises, and is relieved of all duty for the entire period" Regarding timing, the Court stated that a first meal break must be after no more than 5 hours of work and a second meal break must be provided after no more than 10 hours of work. Further, "the employer is not obligated to police meal breaks and ensure no work thereafter is performed"

Covered California shows plans to get itself covered

As required by the federal reform law, Exchanges must eventually be self sufficient. The California Exchange, called Covered California, has outlined their plan to do just that, by 2017. The program has begun with federal seed money but will eventually make it on their own with a 2% premium assessment fee (though they have not explained how rates will continue to be competitive when an assessment is being charged). Note that this 2% assessment is a "best case scenario" however – various scenarios have been posed, with the maximum under consideration as high as 5%

Exchange is exchanging more federal funds for success

On top of the large amounts the new California Health Exchange has already requested and received ($40 million), there has been an additional appeal for $190 million to help prepare consumers to shop for health insurance. Peter Lee, the Executive Director, has said "we now have the tools to rein in healthcare costs that are a millstone around the necks of small businesses, large employers, governments and families across the state" Prophetic?

Exchange Promises…Who will take the Vows? Only 23 states now set to set up Exchanges

While the number is up since the election, only 23 states have declared their intention. Some have written letters asking for clarification from the Health and Human Services Department, but what they need to know is not really known, since the idea of the Exchange and what's behind it is clear. What is not clear is why those states that choose not to peruse the regs further would wish to cede their present prerogative in favor of federal fallback.

Wait, there's more? Will Exchanges change things or will we be more COOPerative?

The carriers are all staying. ACOs will continue to grow. We are exchanging what was a simple and straightforward market for the additional choices provided by the Health Benefits Exchange. And Governor Jerry Brown recently signed a bill that will allow the creation of Consumer Owned and Operated Plans (CO-OPs) effective January 1. Insurance Commissioner David Jones said "one of the most pressing issues facing Californians is the lack of options for obtaining affordable health coverage (that's funny…what was the Exchange and the ACOs supposed to do in addition to the 6 major carriers we have already?). CO-Ops can serve as one option avaialbel to nearly one million low income individuals and their families (so much for Medi-Cal). Without this bill we couldn't move forward in creating these CO-Ops, which could help drive down insurance rates" The state rules will allow CO-Ops to get federal funding and offer insurance products in the Health Benefit Exchange.

Managed care for all? California finally gets in the swing of things and shifts Medi-Cal patients

Though managed care (HMOs) are widely accepted forms of health care reimbursement and delivery, Medi-Cal patients have not been required to use this more restricted system of access and provider reimbursement. California is beginning the process of shifting 1.1 million of the state's population into managed care. First counties are Los Angeles, Orange, San Diego and San Mateo. Projected savings to the state are $679 million in the next fiscal year and $1 billion the following year. What impact this will have on providers and whether a full complement of services can be maintained with more restrictive payment methods is not made as clear.

Healthy Families move to a new medical neighborhood – Medi-Cal

The 800,000 children currently covered under the Healthy Families program will be moved, due to legislative inaction, to Medi-Cal managed care plans. The California Children's Health Coverage Coalition said "(We) consider the end of session developments as a huge loss for California children, a missed opportunity to secure the $200 million in badly needed revenues from the Managed Care Organization assessment and to delay or stop the pending transition of children from the Healthy Families Program to Medi-Cal" The first phase of the conversion begins January 1, 2013

Brown Turned Down – on Medi Cal cuts no ifs, ands or buts

Part of Governor Brown's budget paring is a $500 Million cut to Medi-Cal expenses, which will involve cost sharing on the part of recipients and more flexibility on how payments are made. The Obama administration has turned down his request once, and he has asked again that Washington give California some consideration…with the same response.

Microcosm of problem – a reverse Field of Dreams (what if you build it and too many come?)

In Sacramento, they are concerned that the expected influx of new patients guaranteed when guarantees are provided will overwhelm the system. Key issues identified: below average regional capacity in community health clinics, growing demand, roughly half of the region's community clinics are losing money, the safety net is overly dependent on high cost hospital and emergency department services, community clinics and emergency rooms will likely reach capacity before 2016, the newly insured population is expected to be sicker than the current population in public programs, about 60% of the new patients will be covered by Medi-Cal, the number of federally qualified health centers is lower than the state average and other regions, and the current safety net lacks a lead agency, coordination and integration. Other than that…

Tobacco dollars go up in smoke – states spend under 2% of settlement billions on prevention

As states scramble to address their budget problems, they will divert almost all their tobacco settlement funds on programs other than smoking prevention, according to a recent report of public health organizations. In the last four years, state spending on such programs has declined by 36% to $457 million, where the CDC estimated that tobacco related healthcare spending is nearly $100 billion annually.

What starts in Oregon…a second try at reform

Governor John Kitzhaber, when he was president of the Oregon Senate, famously drove through legislation to reform the state Medicaid system and use a points system to stratify patients. The first model of its kind (and one not emulated elsewhere) it was withdrawn over public protest. Kitzhaber then ran successfully for governor, and has not yet let his dream die. A former practicing physician, he believes strongly in the need for better coordinated care, which should make health care delivery more efficient and allow for greater cost management. Starting in April, a new law affecting Oregon doctors, hospitals and other care providers will find out how they will be affected, with changes from a per service or per day reimbursement system now morphing into a fixed fee, reminiscent of the DRG experiment (Diagnostic Related Group) that was attempted by Medicare many years ago.

Insurance Costs to Decrease – but how?

The premise of the Affordable Care Act – the promise of the Affordable Care Act – is that the effects of reform would be to lower costs while enfranchising the uninsured. What is contained in the law, however, mitigates against this possibility in California, at least for some:

1) Age Bands: plans typically use 8 or 9 bands, in 10 or 5 year increments. The new law compresses the bands so that an older individual pays no more than 3 times what a younger individual would pay. Therefore, costs can decrease for the older enrollee – but increase for those who are younger

2) Exchanges: Carriers selling through the Exchanges will no longer be able to charge different premiums based on a person's health status – in other words, a form of community rating. In community rating, healthier individuals pay more to subsidize those who are more medically needy

3) The absence of pre existing condition limitations, guaranteed issue for all and the inclusion of a package of "essential health benefits" all conspire to "raise the bar" of quality of coverage, but also the quantity of coverage itself – and thus cost.

4) The Uninsured: When Medicare was first implemented in 1965, it was unknown exactly how much the previously disenfranchised seniors would utilize medical services that were previously unavailable (or at least not easily accessed). There were some predictions about the expected cost of this effect and the cumulative effect it would have within 5 years. Unfortunately, the economic predictions were off – by 1,300%

Reiterates limits on permissible premium variations for policies based on: age (3:1 ratio), tobacco use (1.5:1 ratio), geographic location and family size. It includes proposals to:

1) Set rates by totaling costs calculated separately for each covered individual
2) That all carriers use one year age bands with a prescribed age band table
3) Individuals enrolled in non grandfathered plans be considered one risk pool
4) Let states set up to 7 geographic regions for rating purposes
5) Allow contribution and group participation requirements to reduce adverse selection
6) Require that all rates be submitted to HHS

CAL PERS Rate increase – a bellweather for the California market

The claim is made that if we set up Exchanges, or find a way for small businesses to get the same "breaks" as larger businesses, that rates will return to normal and everyone will be treated fairly. Good in theory – but large businesses suffer their own losses, as the final numbers are based purely on their experience and their demographics, just as you would have in any pool. The California Public Employee Retirement System is a pool of over 1 million employees, including those working in the UC educational system, municipalities and others. This large group has announced that rates will increase 9.6% in the coming year, more than double what the increase was last year. "We introduced a number of initiatives over the past 3 years to help stabilize rates, but today's rate reflect the overall continuing upswing of health care costs" said Priya Mathur, the chair of the CalPERS pension and health benefits committee

LA leads the way…county attempts at health care reform on their own

Los Angeles County is hoping to register as many as 550,000 patients and will assign them at no cost …to the patients. The program is called Healthy Way LA. Eligible adults must have been county residents for 5 years and earn less than 133% of the Federal Poverty Level. The expected cost is $300 million for which the federal government will pick up half.

Never say never again – Sutter returns with its own health plan

After the failure many years ago of the Omni Health Plan, Sutter Health has decided to enter the HMO game again. With the rise of Kaiser and the sway of WHA, Sutter feels the pressure to keep its system going, in the best way possible…by owning the means to entry. The current plan is to launch a plan in 2014, starting in Sacramento. As CEO Pat Fry naturally explains "offering a health plan enables us to partner directly with patients to manage their total health needs, including their ongoing care experience and the total quality and cost of their care" That, and they won't have to take more attacks from carriers who think the Sutter prices are too high.

Market expansion – Western Health Advantage moves to Marin, Sonoma and Napa

A successful enterprise launched in Sacramento, Yolo, El Dorado, Placer and Solano Counties several years ago by Mercy Hospital has gone head to head with Kaiser and Sutter Health, and is now taking them on in 3 new counties. State approval is pending, with an anticipated launch date of January 2013. The core network will be Meritage (formerly Marin IPA), which has 600+ member physicians, and it will partner with Marin General, Sonoma Valley Hospital, Palm Drive, Healdsburg District and the three St. Joseph affiliates (Queen of the Valley, Santa Rosa Memorial and Petaluma Valley Hospitals)

Then in Baghdad by the Bay…

Too Many Wieners

Tony took to tweeting which became self defeating and then the Supes shout Great Scott! Nudity has taken crudity to new lengths in San Francisco, but Mr. Wiener was hard pressed and stressed "did I dream of coming into office and writing legislation with the words 'anal region' in it? No, I didn't" The end.

A false sense of security – San Francisco health fees are not going to workers

Businesses collected almost $14 million in additional fees from patrons last year, seeking to comply with the city's landmark universal health care ordinance. But an Associated Press analysis of records shows that roughly 40% of that money has not been spend on workers' health care. Businesses have pushed back, blaming confusion on reporting, that they are saving money for the future, or had works who did not take full advantage of the free money for medical expenses (the last of which may be reduced due to new laws on holding money in reserve for a period of time after a worker leaves their employ)

BUSINESS BUMBLING

I wish I had known more firsthand about the concerns and problems of American businesspeople while I was a US Senator and later a presidential nominee. That knowledge would have made me a better legislator (George McGovern, d. 2012)

I want my children to have all the things I couldn't afford. Then I want to move in with them (Phyllis Diller, d. 2012)

Mongo just a pawn in the game of life
(Alex Karras d. 2012, in Blazing Saddles)

Money, it does not bring you happiness, will at least help you be miserable in comfort
(Helen Gurley Brown, d. 2012)

Economy autonomy, yes cars are coming back
Though right to work as union perk has brewed a fresh attack
More housing starts to cause the parts that slipped to pick up slack
Leaving us believing the CPI is in the black
More dough is raised insourcing through abrasion of Asian knack
Offshoring can't be scoring when their costs are out of whack
The Smiley Curve lost its verve and now GE leads the pack
Recovery's discovery illuminates the crack
In businesses' witnesses who thought they saw a lack
In our agility, ability and stability.

Despite such emendation what's lost in the foundation
Is currency transparency the banking industry
Is shadowed more than ever. The UK now too clever
To Labour under LIBOR, Cameron high places for
The guilty party's framing. Barclay, UBS us blaming
Checks of (blanking) banks with thanks the fines weren't maiming

Hostess Snowballs down laugh's track, no more Ho Hos on the rack
Perks and Recreation hack at ways to labor with new tack
Our symbols of ruin's wrack crash as clacks of angry claques
Who came to scoff and wrote us off now try to take it back

Innovation drives the nation keeping us one step ahead of regulations we dread. Instead of looking overseas we move forward with our tendencies to create, develop and see the final picture of our labor finished here. Insourced resources are returning and fewer fossil fuels we're burning with backyard discoveries and the recovery of what we thought we lost. The euro is a paean to economic union but as bonds break and we take less tock in its viability, there's more liability to growth. We take our power back and let watt lessons lack amplify our cause. We pause to remember when and we can do it all again and do what should be done can return us to our number one ranking while we're banking on success. Rational exuberance knows of some protuberance of optimism before our fate is set. Yet we see indications that new permutations of the systems we created may soon change.

In health care new demands have supplied us with new hands in dispersing how delivery arrives. Hospitals form insurers and carriers aren't surer of how well they'll hold in new market's fold. Exchanges won't change need (nor will they reduce greed) but may bring better speed to ways in which plans may be best laid. What's paid will surely rise, and physician supplies may diminish before we finish but the petition for competition was addressed. It just de3pends on where it's going, as there isn't any slowing, in the rate increases we'll continue seeing. New models come into being and there will be some fleeing from standard models of coverage and care. What will be there is not yet known, but results display a way in which we might control things better. ACO or HMO, COOP or funding flow, they will be more to know as we progress.

We can succeed only by concert. It is not "can any of us imagine better?" but "can we all do better?" The dogmas of the quiet past are inadequate to the stormy present. The occasion is piled high with difficulty, and we must rise – with the occasion. As our case is new, so we must think anew, and act anew. We must disenthrall ourselves, and then we shall save our country.
(Abraham Lincoln, Annual Message to Congress – 1862)

You want how much? Benefits as a percentage of total compensation continue to rise

The Bureau of Labor Statistics reported that, based on an average of $30.81 per hour worked, benefits for civilian workers in private industry and state and local governments averaged $9.39 per hour worked, or 30.7% of total compensation costs. This represents a continued rise over the past three years from the base line then of 27.4% In private industry alone, the amount was $8.52 per hour on an average wage of $28.80, or 29.6% of total compensation.

Latest Labor Statistics on the cost of legally required benefits – 8.2%

Total employer compensation costs for private industry workers averaged $28.78 per hour in March 2012. Wages and salaries were only 70.4% of these costs, or $20.25 per hour. Benefits averaged a cost of $8.53 per hour and of those, legally required benefits were a total of 8.2% Social Security was the largest portion of this at 4.7% ($1.36 per hour), Medicare was 1.2% (.33 per hour), Workers Comp 1.4% (.41 per hour), state unemployment insurance (0.8% or .22 per hour) and federal unemployment insurance (.1 % or .03 per hour)

Health Care Inflation - Reports

Altarum Institute said health spending from 2010 to 2011 increased 4.4%, the third lowest growth rate in 50 years. Health care price inflation reached its lowest rate since 1998 at 2.1%.

Agency for Healthcare Research and Quality said just 1% of Americans accounted for 22% of health care costs in the US in 2009 and 5% for 50% of health care costs

Overall, national health spending grew at a lower rate than the GDP in 2010 (3.9% vs. 4.2%)

The Health Care Cost Institute "found that costs rose 3.3% in 2010 even though people actually used fewer services…because the services themselves got more expensive" – the study is based on aggregated data from Aetna, Humana, Kaiser and UnitedHealthCare.

A study by PriceWaterhouseCoopers said cheap walk up health clinics, lower costs for drugs and medical supplies and state laws requiring more transparency on hospital pricing have all contributed to a slowing in health care costs, which are expected to rise 7.5% in 2013. This is the fourth year in a row that PwC shows medical cost increases below 8%

Statins clog the system – named top unnecessary health care cost

According to researchers, the top unnecessary medical cost is not "defensive medicine" which results in unnecessary tests but doctors prescribing brand name statins without first trying generics. This has generated $5.8 billion in unnecessary spending each year.

Necessary but expensive – autism now a covered expense

Autism is now required to be a covered expense under all California health plans. There are no true estimates on what the cost will be…other than huge.

The weight of being overweight – burden on the system

Gallup poll says that just "1 in 7 US workers is of normal weight without a chronic health problem" The estimate is that obesity costs the economy $153 billion a year in lost productivity and increased sick days

Waste on simple studies said to be $6.8 billion – conservatively

Physician study shows that $6.8 billion is wasted on unnecessary tests and treatments. Blood and other diagnostic tests are often ordered even for patient who have no related symptoms or related risk factors. There are 12 tests in all that are identified as potentially wasteful because their use is often not indicated., and that the figure used is considered conservative.

Wellness seems to be improving its own health

A study of nearly 2,000 employers representing over 20 million employees and dependents found that 84% now offer employees incentives for participating in a health risk questionnaire, 64% offer an incentive for participation in biometric screenings and 51% provide incentives to employees who participate in health improvement and wellness programs. The use of monetary incentives for participating in disease management programs almost tripled from 17% in 2011 to 54% in 2012. Of companies offering incentives for program participation, 58% do this for completing lifestyle modification programs (e.g. smoking cessation, weight loss), with 25% for progress or attainment made towards meeting acceptable ranges for biometric measures such as blood pressure, body mass index, blood sugar and cholesterol. Jim Winkler, chief innovation officer for Health and Benefits at Aon Hewitt, said "incentives solely tied to participation tend to become entitlement programs, with employees expecting to be rewarded without any sense of accountability for better health. To truly impact employee behavior change, more and more organizations realize they need to closely tie rewards to outcomes and better results rather than just enrollment" Employers are also requiring more of participants in order for them to be eligible for enhanced benefits, such as Value Based Insurance Designs (VBID)

Do you know your ACO? Coming attractions

ACO = Accountable Care Organization, another way for physicians to form partnerships with other medical providers and service centers to manage care effectively (no, really, this time it's different). This has been successfully piloted in Sacramento with an alliance of Hill Physicians IPA, Blue Shield and Dignity Health (formerly Catholic HealthCare West) and is also being launched in Contra Costa County with John Muir and Blue Shield. Now Aetna has entered into a risk sharing agreement with PrimeCare Medical Network in California and CIGNA has added 9 in Nevada and Oregon to its roster of 33 organizations (which include a partnership with Brown and Toland Physicians in San Francisco). Under these arrangements, physicians share in the risk and are thus "accountable" – on the back side they are eligible to receive performance based payments tied to quality and cost targets

Medicare Advantage puts enrollees at a disadvantage

It's not enough that the "donut hole" is closing, that the premiums for those earning under $80,000 have stabilized, and that the general Medigap market is also holding steady. Seniors want lower prices and Medicare Advantage plans, which are a fancy way of saying HMO, have delivered on that desire. Unfortunately, the market is increasingly unstable, with fewer providers willing to take the earnings hit and carriers unable to get their pricing right. And so…we see markets being left open with little warning. The latest in these decisions was the announcement by Anthem Blue Cross to leave Sonoma County in the last month. Others are expected to follow, although who and where is not known. What is ironic is the recent announcement by the CMS (which runs Medicare) about how Medicare Advantage plans are scoring higher in the government backed rating systems, with 127 of the plans available nationwide getting a ranking of 4 or 5 stars.

New assignment for Healthy San Francisco

On November 7 the San Francisco Health Commission voted to drop transgender surgery from a list of uncovered procedures. Uninsured transgender residents now have access to all the procedures necessary to allow sexual reassignment.

It Ain't Over Yet – Carriers making noise in the individual market already

We have seen some stability in the group insurance market, with the rate increases for most plans offered by all the major carriers coming in below 10% for "trend" The individual market, in the meantime, has been continually deteriorating and there is considerable concern that the upcoming mandates, coupled with guaranteed issue rules and the absence of pre existing condition limitations, will force rising rates to escalate more rapidly. Anthem Blue Cross has already fired the first salvo (in a move reminiscent of what allowed final movement toward the Affordable Care Act) this past week. They will raise rates an average of 18% for over 630,000 individual policyholders and some rates will rise as much as 25%. Other carriers have made large raises as well, but not for the same number of policyholders and not to the same extent. Health Net is averaging 14% for 30,000, United 10% for 5,500, Aetna 19% for 70,000 while Kaiser, which has the largest number of those announcing (220,000) show an increase of "only" 8% (which is 2 points higher than their group trend). Blue Shield has not yet made an announcement, their coyness similar to what they have done in the past…waiting for the others to make the fatal move, and then coming in behind either to match or reduce in an effort to gain or sustain market share. Let the games begin…

New perks are brewing – it's not just free coffee any more

Evernote in San Francisco is now offering every full time worker free house cleaning service twice a month. Facebook gives new parents $4,000 in spending money. Stanford School of Medicine is piloting a project to provide doctors with both housecleaning and in home dinner delivery. Genentech offers take home dinners and helps employees find last minute baby sitters when their child is too sick to go to school. Deloitte subsidizes personal trainers and nutritionists and offers round the clock counseling for help with issues such as marital strife and even infertility. Cynics say relieving people of chores at home allows them to work more, but David Lewin, a UCLA professor, says he views these perks as part of a growing effort by American businesses to reward people with time and peace of mind instead of more traditional financial tools (e.g. stock options and bonuses)

JUDICIAL JUMBLING

Under the guise of protecting us from ourselves. The right and the left are becoming ever more aggressive in regulating behavior (George McGovern, d. 2012)

Andy – Hey Barn, what if I was to ask you if you could sing a cappella, what would you do?
Barney – Why I'd do it. A capella, a capella…well I don't remember the words
(from the Andy Griffith show, Andy Griffith d. 2012)

The problem became this – we became a caricature of ourselves. We were after light and it began to look as though we were after heat, not to reveal some information or not to find out the story (Mike Wallace, d. 2012)

DOMA's on defense, pickets more intense
Prop Eight debate breaks through the gate
To see which way the vote will swing
When Supreme justice dares to bring
Treasured measures to rule with common sense

Roberts rule conserves disorder
Taxing patients' rights in order
To take what's left of ACA
Engage the mandate – pay or play
Pinning law to partner points of order

Arizoning laws border on some flaws
Writing in districts, righting vote restricts
The flow of those below some bounds
Republicans release the hounds
Of war on those whose poverty gives pause

With pregnant hopes our state now copes
With sheaves of leaves we won't relieve
Though the system stresses fairness
We'll develop more awareness
When the need for weed is ceded on the ropes

Conservation of conservatism is colored by new prisms, casting light on what we liberally fight. Fear of prison is a joke as harsh laws go up in smoke as some wanna marijuana law without society going to seed. DOMA's in a coma as more courts court displeasure with the measures they've taken, now partnered with the proposition that California made. Though SCOTUS gave a poor reception to the birth of contraception suits delivered to their door. What's more they're pulling back, pushing some of the large stack of what's at stake in the wake of summer's ruling on ACA dueling definitions.

The judiciary's not the only beneficiary of scrutinized results as bigger screws are turning under lamplights ever burning in DC. Just past the election a considerable selection of drafts and regulations were sent by different stations for administrative training (though they're straining to comply with what the Feds let fly without the party's wings to plainly pressure what they'd fling) most concern the ACA which clearly had its day as judicial sway and where the votes did weigh pound the private sector, which will pay to keep its benefits or give them fits if they don't play.

My countrymen, one and all, think calmly and well, upon this whole subject. Nothing valuable can be lost by taking time. If there be an object to hurry any of you, in hot haste, to a step which you would never take deliberately, that object will be frustrated by taking time; but no good object can be frustrated by it. Such of you as are now dissatisfied still have the old Constitution unimpaired, and, on the sensitive point, the laws of your own framing under it; while the new administration will have no immediate power, if it would, to change either. If it were admitted that you who are dissatisfied, hold the right side in the dispute, there still is no single good reason for precipitate action. Intelligence, patriotism, and a firm reliance on Him who has never yet forsaken this favored land, are still competent to adjust, in the best way, all our present difficulty. (Abraham Lincoln, First Inaugural Address)

DOMA is doomed or DOA – the courts keep finding it unconstitutional

In Windsor v. US and Pedersen v. US Office of Personnel the courts ruled that DOMA violated the right to equal protection under the Constitution because the discriminatory treatment of same sex spouses was not closely enough related to any of DOMA's possible objectives (which include defending heterosexual marriage and traditional notions of morality, encouraging responsible procreation and child rearing and preserving scarce government resources)
When is someone really considered "full time" – now the government has decided what it means

Two more federal courts have heard cases. The first (Windsor vs. US) involved a same sex spouse in New York who was required to pay more than $350,000 in federal estate taxes because, due to DOMA, her deceased partner was not recognized as a spouse under federal law. In another (Pedersen vs. US Office of Personnel Management), several same sex couples were adversely affected in various ways due to DOMA not recognizing their marriages for federal law purposes. In both cases, the courts rules that DOMA violated the right to equal protection under the US Constitution because the discriminatory treatment of same sex spouses was not closely enough related to any of DOMA's possible objectives.

US District Judge Jeffrey White ruled 2/22 that the US government cannot deny health benefits to the wife of a lesbian court employee by relying on a 1996 law that bars government recognition of same sex unions. “Because the Defense of Marriage Act unconstitutionally discriminates against same sex married couples, the governmetn’s refusal to furnish health insurance to Karen Golinski’s wife is unjustified. The Court finds that DOMA, as applied to Ms. Golinski, violates her right to equal protection of the law…by refusing to recognize her lawful marriage to prevent provision of health insurance coverage to her spouse”. This is the third time in less than two years that a federal court has found DOMA to be unconstitutional

Social Insecurity – Can Medicare Part A be waived while receiving retirement fund benefits?

The US Court of Appeals for DC has upheld a lower court ruling (Hall v. Sebelius) saying that individuals age 65 or above cannot opt out of Medicare Part A if they want to receive Social Security payments. The suit originated when the plaintiffs argued that they suffered harm due to having Part A because private insurers reduce benefits once Part A comes into effect. They preferred to receive all benefits from their employer’s group health plan. While the Court did agree that someone could reject Part A, they tied it to a rejection of Social Security benefits as well, since Part A is automatically provided when Social Security qualification begins at age 65

Overtime reversals – what was favorable for employers has just been changed

In Arechiga vs. Dolores Press (2011), the California Court of Appeals (4th Circuit) ruled that a non exempt employee’s salary could provide compensation for more than 40 hours of work in a week. This was difficult to reconcile with the California Labor Code, however, which specifically states the hourly rate of a salary paid, non exempt employee is the salary divided by 40.

Mandate mandates a lawsuit – Catholic groups get health care reform in a collar tie

43 Roman Catholic institutions filed lawsuits against the Obama administration over its contraception mandate. There were 12 lawsuits filed and for the first time included all 13 dioceses run by all the archbishops. Discussions and negotiations have been held for some time, but the Obama administration stood firm on its position to require birth control to be a mandated coverage under Health Care Reform, which, of course, mandated a religious response

Final Summary of Benefits and Coverage (SBC) regulations issued

Must be included with all plan renewals the first anniversary following 9/23/12

No separate SBC needed for FSA or HRA that are integrated with medical, nor for HSA integrated with HDHP. Instead, plans can prepare the SBC for the HDHP and denote the effects of the account based plans on the appropriate spaces on the SBC for deductibles, etc.

1) Carrier/issuer must automatically provide SBC to plan or sponsor upon application, upon request (7 day max), if there is any change before the first day of coverage, when a policy is renewed or reissued and no later than 30 days before new plan year.

2) Must provide for each benefit package offered for which the participant is eligible. Must distribute with application materials or no later than the first date the participant is eligible to enroll. Special enrollees must receive SBC no later than the date by which the SPD is required to be provided under ERISA (90 days after enrollment)

3) SBC must be in uniform format not exceeding four pages in length, utilizing 12 point or larger font (Depts have interpreted the law as referring to four double sided pages)

4) Need not be a stand alone document – may be incorporated in SPD or other summaries
5) There is a template, so issuers have little discretion in description
6) For those already covered, the SBC may be issued electronically
7) SBC does not have to include plan premiums or cost of coverage
8) SBC must initially include only 2 coverage examples (diabetes and maternity)

9) Contents:

   a) Uniform definitions of standard insurance and medical terms
   b) Description of coverage and cost sharing for each category of benefits
   c) Exceptions, reductions and limitations on coverage
   d) Cost sharing provisions, including deductible, co insurance and co payments
   e) Renewability and continuation of coverage provisions
   f) Examples to illustrate common benefits scenarios and related cost sharing
   g) With respect to coverage beginning on or after 1/1/14, a statement as to whether the plan provides minimum essential coverage and whether it meets the applicable minimum value requirements
   h) Statement that the SBC is only a summary and not the official plan document
   i) A contact number to call with questions and an Internet address where a copy of the actual group certificate of coverage or individual policy can be reviewed and obtained

10) If more than 10% of a county's population speaks a particular non English language, the SBC must be made available in that language

Comparative Effectiveness Research Fee
Patient Centered Outcome Research Fee (PCORI)

ACA created private, non profit, PCOR Institute
Effective first anniversary on or following October 1, 2012

Fee - $1 x average number of covered lives for 2012/13
$2 x average number of covered lives for 2013+

Must include retiree plans

Plan sponsor pays CEA fdor self funded HRA and FSA (employer funded FSA only)
Controlled group – each pays but you can designate one as the payor

Average lives may use one of the following methods:

1) Actual count – actual number on each day of plan year/365
2) Snapshot – taken on at least one day of the quarter – then add and divide by 4
   Can look at individuals – or employees x 2.35
3) Members months
4) State form (5500) – first day and last day – add and divide by 2

Payment and report – Form 720 (Quarterly federal excised tax return) – due July 31 of the calendar year following the planyear for which assessed – COBRA counts

The Affordable Care Act and The Law of Unintended Consequences

The Supreme Court put it back in our court. The election did not cause its rejection. We have been replete with information about the health insurance reformation, what it will deplete and the promises it should complete. And complete it is, but the Affordable Care Act is ultimately not about affordability, which we are spending considerable time and money to discover. So should we hope, change, hope to change or change our hopes? Or at least our expectations.

Like ClintonCare before it, the Affordable Care Act supports laudable social goals, and should really be titled the Accessible Care Act, as it seeks to enfranchise many who could not previously obtain coverage, inject competition, streamline efficiency and allow the creation of new and more standardized formats for all of us to see and follow. This, of course, makes sense from a global viewpoint, and what other view can the Federal government harbor?

The problem, of course, is not with the law itself, or its intentions, but the fact that it is national in nature, and by its very nature cannot account for the fact that we all don't fit so well in a federal framework, but in a federalist framework. Put more simply, all politics, and markets, are local. What we need in California, or in the North Bay, will be dictated less by Washington and more by our own unique situation and what can naturally rise as a result. At the same time, what is imposed, while composed with the best of intentions, will create as much harm as good, as there is the law…and the law of unintended consequences. Here are a few to consider:

Health Insurance Costs: there are taxes on the medical device, pharmacy and health insurance industry (which will all be passed to you), funding for the Exchanges, the elimination of pre existing condition limitations, expanded allowances for dependents and guaranteed individual coverage. This all falls on top of what is still an exceptional medical system which meets our many needs…at considerable and continued expense.

In addition, small group rating will change in 2014. Age categories will compress (which will cause rates to increase for younger employees) and risk factors are eliminated (which raises rates for healthy groups while it reduces them for the less healthy).

Supply and Demand: Roemer's law says that as the supply (of health care) increases, so does demand, which sets cost efficiency on its head. More and better drugs and systems combine with a large influx of newly insured patients along with greater cost pressure on doctors through the expansion of Medi-Cal (with its notoriously low reimbursement levels) and Medicare cuts (which now nearly rival Medi-Cal rates and are coming closer). If you build it, they will come, but what if the structure can't support the game with its new rules?

The Exchanges: In some states it is true that competition may breed cost compression. In California, with 7 major viable carriers and several strong regionals, that argument does not hold. Enter the California Exchange ("Covered California") which takes the same carriers, with a slightly expanded eligible population, and, with $190 million of federal money, attempts to justify its existence. To be sure they succeed, however, California may change the rules on self funding medical plans in December, the Exchange will have some power to direct how carriers may "play" in and outside it and the federal government will provide subsidies to those who meet income qualifications…which may only be claimed when the subscriber enrolls in the Exchange. Also, since some states have opted not to create an Exchange, the federal government will create one for them, while at the same time setting up two national plans, which will also be offered under Covered California.

Administration: As if they didn't have enough to do already, employers must contend with how to properly distribute MLR proceeds, provide plan reporting to the Exchange, increase communication with employees (using new SBC designs and alerting employees to the availability of the Exchange), report to governmental entities who has which plans, reporting on income for subsidy qualifications, possible penalty and tax collection, W-2 reporting (for larger employers), determining the value of "pay or play" (entities with over 50 employees). This while sorting out continually increasing costs, a variety of new options…and, you know, running the organization.

Along with new taxes, new maxes and a lack of possible axes to the ACA agenda with the president's return to his residence and a super Democrat majority in Sacramento, you may fill in your own words for ACA (Absolutely Confused Already?), but one thing we know for sure…the only constant here is it is Always Changing Accountability.

As complete as it is, the Affordable Care Act is ultimately not about affordability, which we are spending considerable time and money to discover. So should we hope, change, hope to change or change our hopes? Or at least our expectations. As well as the nature of our questions. It's not a game, but there are at least 20 questions:

1) Can doctors and hospitals handle the influx of new patients when coverage expands?
2) If they can, how much time will each of us get with doctors when waiting rooms are full?
3) Will cost shifting increase when the number of Medi-Cal recipients expands?
4) Will Accountable Care Organizations survive a highly competitive environment?
5) Will carriers or other financial entities support ACOs in the long term as markets shift?
6) What carriers can stay in the California market as the Exchange creates more rules?
7) How will HSAs change (and then survive) with impending market and Exchange changes?
8) How does Kaiser change its model or pricing with increased competition in the North Bay?
9) What will Exchange rules and market shifts mean to the advent of "skinny networks?"
10) Will the state legislature decimate self funding for smaller groups this December?
11) What value is the advent of so called "private exchanges" against "Cover California?"
12) Are "small group" employers aware of the coming rate model changes?
13) How do coming rate model changes affect employer contribution schemes?

14) What is the marginal cost of insurance when the new 90 day waiting period takes effect?
15) What impact will new discrimination have on employers and the market when promulgated?
16) Have small businesses actually looked at the viability of the Small Business Tax Credit?
17) Will employers choose to "play" with the mandate or "pay" the penalty alternative?
18) For that matter, what will individuals do on "pay or play" when the mandate takes effect?
19) What communication strategies do employers have for the myriad changes coming?
20) What is the impact of the two new "federal plans" proposed by the Obama administration?

Actually, we have more, but it's more about what's in store for the market relative to the laws of the state and affairs of state when we finally rate what ranks highest in our priorities, and whether the economic weather will allow us to grow or go…to other states, other models, or other plans?

1) With Republicans still in the House, will the Exchange subsidies survive?
2) What steps will Sacramento take (with a Democratic super majority) to help the Exchange?
3) Has anyone considered that, regardless of the ACA, Sacramento may support Single Payer?
4) Are employers fully aware and capitalizing on the "wellness program" credits available?
5) What impact will wellness have when there is no market credit nor price transparency?
6) How does Medi-Cal survive with expiring federal subsidies, tax cuts, and Long Term Care?
7) How much cost shifting will the new taxes on pharmacy, medical equipment and carriers have?
8) Will carriers cut the number of plans or continue confusion as they compete with the Exchange?
9) Will we see the rise of Direct Contracting among larger employers (see Boeing and Walmart)?
10) What is medical tourism and will it come increasingly into play for self funded plans here?
11) What strategies can and will employers use to support "defined contribution" funding?
12) How much will individual rates increase in 2014 with the advent of "guaranteed issue?"
13) Will increased individual rates force more dependents back onto employer plans?
14) How does an employer offer both Exchange and open market opportunities – and can they?
15) Who will bear responsibility for education of employees with increasing choices? How?
16) Will carriers begin to allow partial self funding within high deductible plans and how?
17) How much administrative responsibility will employers bear for reporting and collection?
18) Do employers understand how to characterize full and part time employees for the mandate?
19) Will employers on the mandate border move more to part timers to avoid the cut line?
20) Can the IRS handle the new tax/penalty collection burden and how?

Then there are the random thoughts, quotes, questions and considerations

So what will it cost?

OK, we know that compliance with the Affordable Care Act has a cost – ask any employer, carrier or broker. Now the conservative American Action Forum (no, I haven't heard of them either) has estimated that compliance with the health care law has "cost states and private companies more than $27 billion" with 18,000 workers nationwide dedicated to complying with the new law. A bit of hyperbole, to be sure, but certainly there is a cost…while an op ed piece in the New York Post says that the debate continues on Medicare, which one candidate say cost seniors billions while the other says it saved an equal amount of billions.

In 2010, the non partisan Congressional Budget Office estimated that nearly 4 million would not comply with the new individual mandate and pay a penalty. They have now revised that estimate to 6 million. It is noted that this is still a small percentage of the currently estimated 30 million uninsured, but the larger question is "what changed the estimate" when nothing else has changed in the last two years?

The Obama administration says the new law "forcing" regulators to justify premium increases of 10% or more has saved consumers $1 billion this year, conveniently forgetting that the law was originally intended to do just that, but instead opted for publicizing those carriers who exceeded a 10% increase. No carrier was forced to make any changes or even justify the increases – their names were simply posted on a web site (though some states took a much harsher and harder stance). The administration also said that the regulations on Medical Loss Ratios (profitability of carriers) saved $1.1 billion, which was paid to 13 million consumers. Not only does this only work out to an average of $84.62 per person for the year, but does not account for the untold millions in expenses forced on carriers to do the accounting, and then the employers who also had to do accounting to figure who got the refund and for what amount.

Over time, the Congressional Budget Office, a non partisan arbiter of the cost of government programs, has come up with several different projections on the cost or savings of the Affordable Care Act. In 2010 CBO estimated that the spending on new programs begun under the ACA would be $929 billion from 2013-2019 and $944 billion over a period of ten years. In 2011, still before the true economic impact of the law could be felt, the figures were changed to $956 and $1.442 billion respectively. In 2012, when a few of the provisions could have their impact felt but still before the major provisions take place (which is in 2014) estimates again have been raised to $1,053 billion and $1,856 billion, thus nearly doubling the initial "guess" which was made a scant two years ago. All this at a time when the CBO has also estimated that state cutbacks in the Medicaid program, in the wake of the Supreme Court ruling, would reduce government spending by $84 billion from 2012-2022. Other oddities:

1) CBO scoring doesn't include the impact of the exchange subsidies
2) Medicare cuts were originally estimated at $443 billion but are now $384 billion
3) Deficit reduction is now estimated to be not $140 billion, but only $4 billion

Government forecasts changed again

The CBO revised estimates yet again by saying 2 million fewer people will gain coverage by 2016, which would leave about 27 million people uninsured by 2016. The overall coverage, however, is now expected to cost $1.083 trillion over the next 10 years, a downward revision of $50 billion. This, however, is the prediction only for the first 10 years, which is held somewhat lower because the first three years are still involving overall implementation. When taking into account more years of full implementation, the projected price tag is now $1.76 trillion, which is TWICE what the original price tag was meant to be. The full accounting is now, according to Senator Jeff Sessions (ranking Republican member of the Senate Budget Committee) really $2.6 trillion, and that does not even account for the administration costs of implementation.

With Exchanges come dollars…and how much change?

They haven't even begun to fight for our savings, and already the amount provided by the federal government to create Health Care Exchanges has passed the $2 billion mark. And not all states have taken action…yet. Some have decided to turn things over to the federal government and let them run their own exchange. No action has yet been taken, but it appears there is plenty of money still to be spent.

How do you define "success?" By excess? Massachusetts amasses a mess of cost

Massachusetts has served as the model for the Affordable Care Act (despite Mr. Romney's disavowal and the muted acknowledgement given by President Obama during the election). Whatever…the problem is that, while certainly successful in enfranchising a greater number of the previously uninsured (a social success) Massachusetts has ranked in the last two years as having the most expensive health insurance in the country (a fiscal mess)

Architect of Obamacare and RomneyCare backtracks

Jonathan Gruber, an MIT economist who helped devise former Governor Mitt Romney's Massachusetts health care reforms has backtracked on an analysis he did for the White House in support for the 2010 Affordable Care Act, informing officials in 3 states that the price of insurance premiums will dramatically increase under the reforms (Wisconsin, Minnesota and Colorado). For Wisconsin specifically, Gruber stated "after the application of tax subsidies, 59% of the individual market will experience an average premium increase of 31%" – the reason is that 40% of Wisconsin residents who are covered by individual market insurance don't meet the ACA minimum coverage requirements

Will Exchanges Change enough to make you want to exchange your current plan?

In 1978 Congress created Cafeteria Plans, which would let employers set a flat amount for employee use in selection of a variety of health plans and other tax free or taxable benefits. This was adopted by companies of all sizes, and only market limitations depleted the type and number of choices available.

Nearly 20 years ago, California created the first public exchange, which later went bankrupt, but not before spawning the creation of a private exchange, which is still viable today. Other states have followed suit, though in different ways (Massaachusetts and Utah have exchanges). An exchange allowed employees to choose medical insurance from a variety of carriers and plan designs, also ostensibly using the "defined contribution" model created by Cafeteria Plans.

In response, in California carriers finally realized they would have to offer choices within their own product portfolio. They may limit the number of choices available, but all are available for initial selection by the employer. There are even "special programs" that compete alongside Kaiser and, while limiting choices, relax the standard participation guidelines.

The Affordable Care Act gave impetus to the creation of more exchanges, with the idea that increased competition would lower costs and that greater freedom of choice would require employees to make their medical purchases more responsibly. A good idea, but not with much foundation given California's experience, and also a notion that may work well in states where only one or two carriers dominate, but not in those states where there is a large number of choices (California has 7 major markets), or where the flexibility desired already exists (again, as it does here).

California was given $190 million to develop an exchange – and we will soon see what better pricing, better choices, and better or more streamlined management will be offered. Given the variety of plans and markets already available, in an environment that already has tight regulations on rates (which will be made tighter still with the advent of new federal rating restrictions in 2014), what possibility of success really exists here? Well, let's spend the $190 million first and then see.

Of course, the private sector does not want to be left behind. You will hear more and more of "private exchanges" which are now offered by independent companies and even large brokers. What they offer is…more of the same, but it sounds and looks cool, and there are promises to keep (and miles to go before we sleep)…promises that have been made before and broken, using tools that have existed for many years, and offering choices that exist in many markets.

Pay or Play…what's the better way?

One of the concerns behind the Affordable Care Act is the employer mandate, which affects what must be offered, and how, to those employees considered to be full time. The IRS has issued a formal notice stating that employers may use a retrospective measurement period lasting between 3 and 12 months to determine whether an employee's hours meeting the definition under the ACA. Therefore, if an employer uses temporary or seasonal employees and a 12 month determination period, those lasting less than a year will not have to be counted for coverage/penalty purposes. The catch? Employers will be required to keep any employees deemed full time in their health plan for a period of time equal to the measurement period chosen. The IRS rules also allow employers to use different measurement periods for different classifications of workers. The ruling obviously helps retail businesses and at the moment does not make any rules on rehiring employees, who could now have the "employment break" work in favor of the employer.

Starting January 1, and regardless of the plan year, sponsored health plans must have a waiting period for the coverage of new employees of no longer than 90 days and those of 50 or more full time employees must meet minimum payment standards for a minimum designated plan design. Just when you think you know what a full time employee should be, the IRS has come out with some safe harbor guidelines. They, of course, are not simple.

The basic rule is that if an employee is not reasonably expected to work full time when hired, the employee's status as a full time employee will be determined by looking back at hours worked over a "measurement period" The employee is then treated as part time or full time for purposes of the subsequent "stability period" regardless the number of hours actually worked during that period. The measurement period may be between 3 and 12 months and then a stability period of 6 to 12 months that is at least as long as the measurement period. Full time is defined as working at least 30 hours per week. The start date and duration should be consistent but may differ among designated categories of employees.

Whether a new employee is full time depends on expectations at the time of hire, based on the facts and circumstances of the hire. If the time cannot be so determined, they are considered a variable hour employee and the measurement and stability periods are put into play.

Safe harbor rules also provide for an administrative period intended to accommodate employers who might need some time between the measurement period and the associated stability period in order to determine which employees are eligible for coverage and for other administrative purposes. The administrative period may be no longer than 90 days. The pay or play mandate will not be imposed during the administrative period, but to prevent a gap in coverage, it must overlap with the prior stability period. Also, the initial measurement period and administrative period together cannot extend beyond the end of the thirteenth calendar month following the employee date of hire.

Which Glitch? Problems continue to be found in the Affordable Care Act

First they had to dump some of the portions that were unworkable (Long Term Care) then they had to amend certain sections to make them more workable (elimination of vouchers within the Exchanges) and now there are questions about what is or what is not workable. The new mandate (effective 2014) for organizations with more than 50 employees requires a penalty for those that fail to provide "affordable coverage" This is defined as assessing employees more than 9.5% of their household income. It was revised – the government realized that it would be impossible for an employer to account for any employee's total wages, etc. An amendment was published saying that the rule would now apply only to W-2 earnings as well BUT only to the "single coverage" premium and not the family premium. Critics say this was not intended and employers should be penalized based on the affordability of the family premium, calling it a "serious glitch" in the government's interpretation of its own law intended to provide a social and economic safety net. Of course, one side has to "lose" in this. If the rule is broadened to include the entire family income, then this would also broaden what the government has to provide in terms of subsidies, thus costing taxpayers more. If the rule is broadened in this way it will also cost employers more, as most do not provide dependent premium payments, which will result in higher consumer costs as organizations raise the price of goods and services to make up the financial shortfall that results from the imposition of penalties.

Build it and they will…what if no one is there to greet them?

The goal, and promise, of the Affordable Care Act to enfranchise previously uninsured citizens in the hundreds of thousands is laudable, necessary and contains the means to accomplish this purpose. The problem is what to do with the onrush of medical demands that will follow once those who previously lacked access or payment ability suddenly have it to use. There must be doctors there…and it is increasingly clear that shortages are increasing. The Association of American Medical Colleges estimates that in 2015 the country will have 62,900 fewer doctors than needed, an that that number will more than double by 2025 as the expansion of insurance coverage and the aging of baby boomers further drive up demand for care. While medical school enrollment is increasing but not as fast as the population – and not as fast as demand.
Obama ACA Scorecard -- Kaiser Foundation study on the second anniversary of the ACA

Provision	2010 Projected Impact/Cost	Actual as of 1/1/12
Pre Existing Condition Insurance Program for those who have been uninsured for 6 months with condition	200,000 to 400,000 enrollees at a cost of $5 billion authorized through 2013	49,000 covered Cost of $618 million
Expand Insurance Coverage for young adults to age 26	1.2 million covered Average cost 0.7% addition to insurance premium	2.5 enrolled Cost of 0.9% added to insurance premium
Children under 19 with pre existing conditions may not be denied coverage	72,000 with premium increase of 1% or less	No results available
Small business tax credit	More than 4 million businesses would qualify with a cost of $6 billion by September 2011 and $37 billion through 2019	So far only 309,000 have qualified or submitted with a cost of $435 million
Early Retiree Reinsurance Program	Cost of $3.8 billion through 2011 and $5 billion through 2013	2,800 with cost of $4.7 billion
Addition of full preventive benefits at no cost	41 million beneficiaries in 2011 with a cost of 1.5% of the insurance premium	54 million but at a cost of only 0.4% of insurance premium
Rebates of $250 for prescription drugs under Medicare Part D	4 million with a cost of $200 million	3.8 million but a total cost of $946 million

Obama Administration Summary

1) No more pre existing denials for children – helps 17.6 million children
2) No more lifetime limits on coverage – removes caps for 105 million Americans
3) Insurance companies may no longer drop coverage when you are sick
4) No more coverage denials without appeal
5) Coverage for young adults has increased to add 2.5 million previously uninsured
6) Free preventive services gives greater access to 54 million more Americans
7) Coverage without pre existing conditions – new program enfranchised 50,000 Americans
8) New rules under ACA have saved $14.8 billion for health care providers and $2.4 – 3.6 billion by changing the way the health care industry pays bills
9) The newly established Innovation Center has introduced 17 new initiatives involving over 50,000 health care providers

Will states delay the ACA? Or derail it altogether?

Although the Supreme Court upheld the individual mandate as a "tax" they did not impose any requirements on states, which still have it in their power to change the course of reform. First, the Supreme Court said that the federal government could not impose particular conditions for the acceptance of funding for Medicaid. Second, there is nothing to control the Exchanges, which many states are now opting to forego.

The Exchanges are a means to get individuals who may find individual or their share of group coverage otherwise unaffordable a means to not only obtain coverage on a guaranteed basis but to be subsidized at the same time. But not if there isn't an Exchange, and many states are now refusing to create them. This means the responsibility for management of the Exchange falls back on the federal government, which has already blankly stated that they do not have either the financial nor administrative means to run an Exchange themselves.

With the state allowance to determine more of their fate with respect to the Medicaid (Medi-Cal in this state), some governors have pulled back funding and decided that they will not support any expansion of Medicaid, which puts a large hole in the plans of the Obama administration and the Democratic controlled Congress that saw passage of the ACA.

In California, we are continuing with the idea of the Exchange, and we knew this was going to happen even should the Supreme Court have ruled against the ACA. The state has received hundreds of millions of federal dollars to create the Exchange – though that does not guarantee its success. If other states do not follow suit, it creates holes, disunity and the possible withdrawal of additional federal funds, funds which are necessary to support the subsidy.

Medicaid is already under attack, with states often not having enough to continue supporting it. The federal government has promised additional funds for the next three years, but these do run out, and states know it.

Not only does Medicaid put a strain on already struggling state budgets, it also puts a strain on doctors and hospitals. They are already getting severe cuts in their revenue stream from private industry managed care and Medicare, but the Medicaid reimbursement rates are the lowest of all contracts they might sign. The question now is whether they will continue to accept payment, .and thus patients, under this system, at the same time the Obama administration has estimated the addition of tens of millions of previously uninsured citizens – to Medicaid. Like a reverse Field of Dreams, if you build it they might come…but who will serve them when they get there?

States that have thus far refused to proceed with the creation of Exchanges include Florida, Oklahoma, Kansas, Alabama, New Jersey, and Louisiana. Also, 73 senators and representatives have signed a letter to the National Governors Association urging its members to fight against the ACA.

Now that it's a tax, who will collect it?

Justice Roberts articulated the majority opinion of the Supreme Court in their ruling on the Affordable Care Act, terming the individual mandate a "tax" and thus enforceable as part of the law. But how will it be collected, and is the IRS up to the task? Over the next 18 months the IRS has to figure out a means to flag the tax returns of the 3 million (yes, that's 3 million) people already expected to skip insurance. There must also be a system for doling out the tax subsidy for premium payment to the estimated 18 million citizens who earn below $45,000 and yet another mechanism to deliver yearly tax credits to small business while ensuring that no one games the system (fortunately on this last point they have not found that many small businesses taking advantage of this benefits tax credit) Overall, the IRS has to enforce 47 tax provisions under the ACA, at a time when the IRS is still failing to collect an estimated $385 billion in taxes due to evasion, and this won't be easier, since Congress has forbidden the IRS from using liens or wage garnishments to collect the mandate penalty (I mean tax). If they can do it, and there is some doubt the IRS can, estimates are that putting these systems in place will cost $881 million through 2013 according to the Treasury Department commission Douglas Shulman, who asked Congress for $13.1 billion in fiscal 2013, an increase of 11% from 2011.

What the Courts have Conceived…Highest court lets Supreme decision rest with appeals

The Supreme Court ordered the Fourth Circuit Court of Appeals to consider several issues left unresolved in their June ruling that upheld the Affordable Care Act. The main issue is one alleging that the act's insurance mandate violates the constitutional guarantee of religious freedom and equal protection, all pertaining to the ACA requirement for expanded rights of protection against conception. While overtly about the freedom for plans to choose whether or not to require coverage for contraception, it also becomes a back door review of the individual mandate, on which the Supreme Court already ruled in June.

A Seventh Circuit December ruling temporarily barred the government from enforcing the contraception rule against an Illinois construction company and the Eighth Circuit halted the mandate in another test case. The Tenth Circuit has refused to issue such an order.

THE AFFORDABLE CARE ACT – LOOKING BACK, FORWARD AND JUST LOOKING

Review 2010 - 2012

Dependent age allowance raised to 26
No pre existing conditions for children
Small business group health tax credit instituted
HSA excise tax raised to 20%
Over the Counter drugs require a prescription
Full preventive care mandated – BUT only following prescribed standards

Changes for 2013

FSA limit imposed for employee contributions - $2500 as of 1/1 regardless of plan year
2.3% excise tax added on medical devices – which will be passed on to consumers
New Summary of Benefits and Coverage must be disseminated at renewal
Medical expense deduction must exceed 10% of AGI for those under age 65
3.8% tax on net investment income over 200/250,000
Medicare employee surcharge increases .9 if $200/250,000 – no employer match
New tax on self funded plans - $1-2 per head
W-2 reporting on medical costs only for groups of 250 or more W-2 recipients
  Medical costs include HSA, FSA and Long Term care contributions
  Costs do NOT include unbundled dental, vision and voluntary
  Costs are for the entire amount paid for health care, including employee pre tax contributions

Changes for 2014 – other than the Big Four

Pre existing condition limitations removed for adults as well as children
Medical insurance may not have any annual limits
90 day maximum waiting period for new employees eligible for medical insurance
Wellness discounts on health premiums increase to 30% and may go to 50%
Carriers will be assessed an $8 billion tax – climbing to $14.3 billion by 2018
Dependents covered to age 26 *even if* they have other coverage
Auto enrollment of employees on health plans (regulations pending)
Medi-Cal extends to those earning up to 200% of the Federal Poverty Level (was 133%)
Risk Factors will disappear in small group plans
Age bands will disappear in small group plans, and ratios of 3:1 imposed
Tobacco surcharge of 1.5:1 may be imposed on rates

Future – 2018

Cadillac tax on rich insurance plans (40%of the “excess benefit” of high cost employer sponsored health insurance, defined as an annual premium of either $10,200 or $27,500)

The Big Four in 2014

INDIVIDUAL MANDATE

The Supreme Court put it back in OUR court. It is not a penalty but a tax. And it must be paid. Those who cannot show proof of having coverage (and no, we do not know how or when the IRS will be prepared to gather this data) must pay either:

1) The amount of the national average premium for Qualified Health Plans that offer Bronze level coverage for a size matching the taxpayer's family; or

2) The sum of months without coverage – 1/12 of the greater of

   a) A flat dollar amount ($95 in 2014 climbing to $695 in 2016); or
   b) An applicable percentage of income (1% in 2014 climbing to 2.5% in 2016)

GUARANTEED ISSUE PLANS

Not only may carriers no longer impose pre existing condition limitations, but they must take all applicants regardless of their health history. It is yet to be determined what will happen to existing individual plans and whether they must be lumped in with new plans (which means rates will rise), and whether carriers may still have an "underwritten rate" or a flat rate.

EMPLOYER MANDATE

Applies to employers with 50 or more full time equivalents (rules were just published on this) not offering a minimum essential coverage program (rules were just released on this, but states have yet to weigh in with their own interpretation) are subject to penalties ONLY if at least one employee receives a subsidy for health coverage (employees whose contribution to the Minimum Essential coverage sponsored by the employer (which the federal government has said is a Kaiser plan) exceeds 8% of household income up to 9.5% of household income) These subsidies are available only through enrollment in the Exchange, which is open to individuals, and such enrollment may harm the "spread of risk" and thus the rates in whatever plan the employer does hold. Note that the original law also had a provision for employer vouchers vs. direct credits but this was later eliminated.

The penalty is the lesser of

1) $167 per month ($2,000 annual); or
3) The number of FTE getting subsidies x $250 per month ($3,000 per year)

With both penalties, however, the first 30 employees are exempt from the calculation

THE EXCHANGES

These are available to individuals and to small groups employing less than 50 employees (which will be raised to groups of under 100 in 2017). Essentially, the Exchange offers a choice between five plans, four of which have metallic names (Bronze, Silver, Gold, Platinum) and the fifth of which is a more "catastrophic" plan for those under the age of 30 where the Bronze plan would exceed 8% of their income. Recent regulations say that an HSA could be in this mix, though with a maximum deductible of $2,000 (which will see rampant rate increases in this market). Regulations have also just been published showing the "actuarial value" differences between plans, suggestions of what the base plan would be (on either a federal or state basis) and confirming the 10 essential benefits that must be included in these plans.

The California plan is named "Covered California" They have received $190 million to set it up, will be spending another $90 million for consumer outreach, and must be self sufficient in a few years. They need to hurry, however, as employers are supposed to be notifying employees of the availability of the Exchange by the end of the first quarter 2013.

Here's what's interesting:

1) Continued debate on conformity required between plans in and outside Exchange
2) What carriers will participate in the Exchange and with what plans
3) How rates inside the Exchange may or may not differ with plans outside it
4) The various scenarios pointing to self sufficiency say that a surcharge of 2 to 5% will be necessary. This subverts the idea of using Exchange to make markets more competitive
5) Recent trend is the greater use of self funding plans, but these are seen as potentially detrimental to the success of the Exchange, so there is legislation that was defeated but may be returning in a special December session to require a minimum specific stop loss of $95,000, which makes self funding too risky for groups with less than 200 employees

This, of course, are all the things we can see. But here are a few we can't

1) Will employers decide it is less expensive, even if more harmful, to pay rather than play
2) What will the final discrimination tests promulgated (though delayed) look like
3) How do we handle the influx of previously uninsured in a shrinking medical market
4) With increases in Medi Cal eligibility and fewer doctors taking Medi-Cal, where will they go
5) The effects of increased cost shifting from MediCal and Medicare cutbacks on the market
6) What effect will creation of two new national Exchanges in Washington have on the market
7) Will California continue to consider Single Payer legislation if the Exchange fails
8) Will there be new legislation compelling carriers to limit rate increases to 10%
9) How does the Exchange actually save money in a robust market, with surcharges
10) What will happen to the individual and Exchange market if employees pay rather than play

The Unknown

1) How employers cope not only with increasing cost of coverage but administration

    a) SBC distribution
    b) Reporting on income for subsidy qualifications
    c) Collection of penalties?
    d) W-2 reporting of medical premiums
    e) Plan reporting to the state on who took what and whether it was in the Exchange
    f) Distribution of MLR proceeds
    g) General education and communication with more plan choices in the market
    h) Internal review of Exchange vs. market, pay or play options

2) What does the flood of regulations now pouring out mean to the market (and who can keep up?)

3) How much have the Democrats really gained in the election? Some have postulated that we may even see the beginning of the end of tax exemption for health insurance premiums as the debate over how to leap the fiscal cliff continues

4) What effect does the first supermajority in California since 1933 have on health care law, tax law, and myriad other cost issues for those who haven't yet left for Nevada?

5) What are skinny networks and why are we just now hearing about them in Northern California? Will they survive reform and will the Exchange or DOI permit them to exist?

6) What will the market do? After all, we have changes occurring right in our back yard:

    a) Rise of ACO – Meritage, Dignity Health/Blue Shield/Hill partnership
    b) Self funding – if it is not killed next month
    c) Sutter is now acting like Kaiser, Sharp and Scripps and setting up its own health plan
    d) Western Health Advantage is coming here and is competitive with Kaiser
    e) Will wellness have any effect on the cost of health care or the plans which support it

THE PRICE OF AFFORDABILITY

President Obama said we can keep what we have, though we won't know what we had until it's gone, and did it dawn on anyone that there may be no way to afford costs across the board?

1) Temporary Reinsurance Program: carriers will be assessed $5.25 per covered employee per covered month in 2014 (decreasing to $3.52 in 2015 and $1.82 in 2016)
2) Federal Exchanges will charge an administration fee of 3.5%
3) California Exchange has proposed an administration fee of 2 to 5%
4) Risk adjustment premium – low risk carriers pay a fee to those carrying high risk insureds
5) PCORI fee for self funded plans - $1 per covered employee rising to $2 in 2014
6) Medicare surcharge of 3.8% on net investment income
7) Medicare surcharge of .9% when earning over $200,000 per year
8) Tax on Pharmaceutical companies of $2.5 billion, increasing to $4.2 billion in 2018
9) Tax on Carriers of $8 billion, increasing to $14.3 billion in 2018
10) Tax on Medical Device Manufacturers of a 2.3% sales surtax
11) Limit on employee deferred money in Flex Plans to $2,500
12) New state rules on elimination of risk factors and new age ratios
13) Individual mandate charge of $95 or 1% AGI (increasing to 2.5%)
14) Pay or play mandate for groups of 50 or more employees (several penalties)
15) Over $2 billion has already been spent by the federal government to set up Exchanges
16) Demand on an already overburdened medical system
17) $63 charge per covered employee to meet the cost of covering pre existing conditions
18) Expansion of coverage: preventive care, women's health and contraception, autism, dependents now covered to age 26, no pre existing condition limitations, all medical insurance written on a guaranteed issue basis

Alphabet transfers – HHS gives $500 million to the IRS to implement the ACA

The Obama administration has diverted $500 million to the IRS to help implement the federal health care law. As the Republicans try to cut funding, the Democratic administration is finding other means, drawing on the $1 billion "implementation fund" already approved for use by the Health and Human Services Department. While enforcement is part of the ACA and the IRS is responsible for imposing penalties and taxes, there was no specific earmark for enforcement, and thus the Obama administration is showing that it all falls under the rubric of implementation. The transfer is legal, of course, but it now brings into question how the funds were intended to be used and whether HHS will have enough remaining to meet their own obligations under ACA