JORDAN'S JOURNAL – 2010

(A kind of different dumb discourse (The Tempest)

Something familiar, something peculiar
Something for everyone, a comedy tonight…
Goodness and badness, panic is madness
This time it all turns out all right
Tragedy tomorrow, comedy tonight!

Yes a funny thing happened on the way to the forum, the quorum committed (or should be) to courses of action that failed before – but this time, as always, it's different, except where the referent is our own forgotten folly. Yet we Shake spears at the gods in defiance, only to lace reliance on the Bard to teach the hard lessons he posed in timeless poetry and prose. After all "the fault lies not in our stars but in ourselves" and the shelves that held folios are delved into again, reminding us "there is more in heaven and earth than are dreamt of in your philosophy"

From Osama and deserting burning Bushes to Obama and a baroque notion of richer times and milder climbs to some unseen peek into a future wrought from battles fought when wars were sought to free us. Norway is the doorway to a whole new way to look at peace, which pries our eyes from lies to mendacity, that tangle with tenacity in the cities and the farms where furrowed brows arouse fresh fears amid the tears of terror, error and the arrogance that follows hollow hearts we can't repulse.

Avon's calling on us to wring the truth, forsooth, from common themes that speak to dreams and their destruction, the debris of free will and its reduction into farce or the parsing of history's decree. Hubris, guilt and jealousy lade the stages of our lives at play and the daze through which we work our way to understanding. Actors change but not the acts. The facts remain to stain the surface of our purpose while we purport to support something more noble, suffering "slings and arrows of outrageous fortune" without knowledge, strained, with a quality of mercy.

The wars rage on, the pages pass on passing personalities, their prescient words persisting. An economy consisting of buying cycles, signs and clashing symbols, causes too much unrest to retire debt, which owes its increase to more demand for supplies. Soldiers rely on more support, and we are wound more tightly when nightly politicians put some spin on the fix we're in, as spokesmen tire of telling us it's dire, but give it to us unvarnished.

Like a juggler gone amok, the President has the pluck to string along another cause, a racket which ails the market and fails to quiet dissent despite the sheer volume of what's spent. Health care is not as transparent as is meant, the providers bent on unimpeded say and broke with what the carriers pay, though they weigh in just as heavily as what the government programs. No name is absolved of blame and the system will remain the same as all sides resolve to solve the problem – if they only knew what it was. "This is the short and long of it"

Nothing with kinds, nothing with crowns,
Bring on the lovers, liars and clowns,
Old situations, new complications
Nothing portentous or polite,
Tragedy tomorrow, comedy tonight!

Now you know the rest of the story (Paul Harvey, d. 2009)

FEDERAL FUMBLING

Government is either organized benevolence or organized madness; its peculiar magnitude permits no shading (John Updike, d. 2009)

Politicians tell people what they want to hear, and what they want to hear is what won't happen (Paul Samuelson, d. 2009)

I would to God my name were not so terrible to the enemy as it is I were better to eaten to death with rust than to be scoured to nothing with perpetual motion (Henry IV, Part 2)

The year began with dread, of what lay just ahead
Of states of confusion's conditions.
Overhead long was ignored, spending streams we can't afford,
Floods us with Obama's ambitions.

What bloc to tackle first, to guard against the worst
Of woolly thoughts' wild exhibitions
Which thread through yarns we're told, of streets all spun with gold
So tellers weave in rugged depositions

We've jumped into the fray, roped in by partners' play
To bridge the gap of far flung coalitions
But kharma claws Detroit, entreatied we'd exploit
Those Tigers wouldn't be above suspicion.

They ought to truckle more, lost luster must restore
Discarded dealers wheeling on politicians
Who returned to their norm when they spoke of reform
Giving false hope to physicians' positions.

How will he fare, this Nobel warrior. Would he foul the birds of peace when words of trust may cease and he must increase his trips to Middle East and troops to hound the Afghans? So much still to do and no time to accrue Capitol capital. He plays his cards right into the hands of those who twist right wings and stay sore at how the score has run more to moral lessons, taut from accounts of how no books can balance. With projected dreams thrust on Obama and the drama of the stage he now trods, could the President hope to make us happy as he prods the gods to smile while he plies the Hill with guile to mount an offensive against malodorous abuses of wealth, poor excuses for health and the uses of stealth in a war. Everyone is in a hurry not to worry about consequences when the sequence of events prevents reflection. The deflection of the details are stored in stories of retail resuce building to a wholesale miscue of market movement. The lies underlying our recovery are belied by the discovery that we are sliding ever further under water. Cash for cloture is a clunker, Congress hunkers down and deals, which steals the spotlight from the white House. Over states' objections to their subjection and painful public rejection when they see though Wall Street's win (Dow Jones in decks marked by sins forgiven take), voting victories are hailed amid the storms toward which we coast. A year has passed, the die is cast, and the players less patient with the malaise obscenely acting to keep us from a cure. Our craving for some saving grace is waning from self interest campaigning as a healthy withdrawal from all the fighting for both care and fairer risk.

Miracles happened on the Hudson, the sun goes down on a liberal lion, and Democrats foray into Bush territory by continuing the idea of economic stimulus. That the $787 billion spending binge barely passed in Obama's first 100 days was a poor harbinger for his ability to fuel a nation's hopes and help us cope with the other matters at hand. Economic expansion was felt, pooled with a Spending Bill to fill the coffers of party hacks on the backs of taxpayers was able to pass, giving $440 billion to new government projects. In 2,444 pages they handed over $3.9 billion in earmarks for 5,224 pork projects, a bit of a sham for fiscal integrity. Don't worry, we can afford it – they raised the debt ceiling, essentially forcing us to further payments when we were told we have less money than before. Go figure…

An expansive temperament found some constraint, however, with the failure of three bills of note:

1) Family Leave Insurance Act (which was sponsored by 3 California representatives and one from New York) would give 12 weeks of paid leave for those needing to care for family members or themselves (same definitions as FMLA). Funding would come from both the employer and employee as 0.2% of employee salary. There was some wage tiering but the benefit would be as much as $800 per week

2) Healthy Families Act: groups of 15 or more employees must offer 56 hours of annual paid leave (1 hour of sick pay for every 30 hours worked) with carryover – again, qualifications similar to FMLA

3) There was a movement to replace the employer tax exclusion for health insurance with a universal tax credit, but that went nowhere fast

<u>Much Ado About Nothing – Our Relationship with Reform</u>

He hath indeed better bettered expectation than you must expect of me to tell you how

In the great debate over health care's fate, Joe Wilson yelled "You Lie!," Blue Dogs asked why there had to be two sides, and great victories were held out over narrow votes while Senate holdouts were cajoled into going with the flow. It ain't over yet, but it's a sure bet that we are gambling with our future without having seen all of anyone's cards. Here is what we know now:

Rules of Attraction – The Taming of the Shrew

And thereby hangs a tale. What's past is prologue

For all the complaining, it should be remembered that there was a reason for all this debate. What is odd for those in California is that some of the rules created are not necessary, as we either don't have the situation (e.g. single carrier dominance) or the legislative holes:

1) Elimination of annual or lifetime limits (costs should increase for this, but not substantially)
2) Eliminate penalty for using non participating providers in an emergency (most carriers waive)
3) Prohibit requirement of authorization or referral for OB GYN (California law covers this)
4) No pre existing condition limitations
5) Expands the definition of a dependent
6) Guaranteed renewable (California law in small group arena)
7) Surcharges in premiums for tobacco users (but how to enforce?)
8) All Exchanges must be self sustaining within one year (but this is not defined)
9) Creates federal standards to simplify insurance forms and administrative processes

Walking Down the Aisles – Measure for Measure

We must not make a scarecrow of the law
Setting it up to fear the birds of prey
And let it keep one shape till custom make it
Their perch and not their terror

Is there a Doctor in the House?

(The devil hath power to assume a pleasing shape – Hamlet)

1) COBRA limit – employer must keep COBRA open until beneficiary gets new coverage

2) Eliminates the employer tax break for offering an equivalent to Medicare Part D plan

3) Nothing requires employers to amend plans to meet new standards BUT if they don't the plans they have are "non qualified" and thus still subject to the 8% penalty that employers that don't offer any coverage at all have to pay

4) Employer must pay (except small employers) 72.5% of the premium for an individual and 65% for a family. There is no underlying plan design to which this percentage must be attached and it certainly runs contrary (at least with family premium) to what employers typically pay for coverage.

5) The penalty to the employer may not be enough to make them offer coverage at all

6) There is a new tax on those with high income – just because (5.4% in additional federal income tax on those who earn $500,000 or more - $1 million for couples)

7) Taxes and fees take effect immediately – but not the provisions for the benefits

8) Community rating spreads are not sufficient – the younger people will bear the brunt of higher costs to subsidize older, and presumably mostly better off, people

9) Every American has to buy coverage but there are also minimum standards that the new Health Benefit Advisory Committee will create – so we have new bureaucracy, less choice and potentially higher costs depending on what the minimums may be

10) Requires health plans through the exchange and eventually with all plans to offer preventive care at no cost (good idea, but there is a maxim posed by carriers for many years that says the cost to provide preventive care exceeds the cost of the claims that would have been prevented – cynical, yes, but costly in the end)

11) Closes Part D donut hole (great – but the plan has barely been in existence and was working well and somewhat affordably – what will the cost impact be here?)

12) Includes a Public Option: the irony here is that such an option is only likely to accomplish its primary policy goal (reducing medical costs) if it is allowed advantages in the market. These would naturally include an exemption from state premium tax and loans or advances to start the plan (which is funded by taxpayers) and can later allow for universal rate negotiation

13) The penalty for the employee who does not take coverage is only a tax of 2.5%

14) Sliding scale subsidies are available for families up to 400% of Federal Poverty Level ($80,000 annually)

15) While vouchers have the potential to remove employers from the mix, that is also its biggest problem, since the employers are a layer of control or oversight that may be helpful now and in the future. What's worse, vouchers have the potential to give more control to carriers – thus we lose our best buffer at the same time those in control increase it

<u>Hamlet pork fork over Senate's Stake</u>

(with devotion's visage and pious action do we sugar o'er the devil himself – Hamlet)

1) Mandate for individuals has a fine that is far below the cost of coverage – it starts at $95 per year and that is only in 2014 – it increases only to $750 by the year 2016 with indexing

2) Public options are exchanged for state exchanges, but in an earlier version when the public option was included (and it is in the House bill) states were allowed to opt out of the larger public plan and do their own

3) States can band together to create larger exchanges (sounds good in principle, but how large must a large group be to be large enough? Diminishing returns come in somewhere)

4) CMS has already estimated that the CLASS provisions, which offer long term care as part of the package (a Senator Kennedy legacy action) will be insufficient to carry their own weight by the year 2025

5) Cap of $2,500 on Flexible Spending Accounts (though it was $2,000 – and is indexed now)

6) Vouchers – lower income employees are to use these in the individual market or exchange when they are ineligible to use subsidies in the employer plan – and employee may keep the cost difference (this last part will then encourage movement to low cost plans which may not cover the needs of the employee sufficiently)

7) The Deals Struck to get approval

   (We've already established what you are – now we're just haggling over price – Shaw)

   a) Bill Nelson (Florida) – Medicare Advantage plan unchanged for 800,000 seniors
   b) Chris Dodd (Connecticut) – funding of $100 million for new university hospital
   c) Mary Landrieu (Louisiana) -- $100 million in 2011 for Medicaid funding
   d) Patrick Leahy (Vermont) - $600 million in additional Medicaid funding
   e) Bernie Sanders (Vermont) - $10 billion increase in community health center funding
   f) Max Baucus (Montana) – 2,900 Libby residents get help in Medicare enrollment
   g) Ben Nelson (Nebraska): exempt from long term Medicaid expansion costs, get millions more in Medicaid funding, Blue Cross/Blue Shield of Nebraska will be exempt from the carrier tax

   It is one of these deals, the Nebraska exemptions, that is the target of thus far ten states attorneys general and their suit against the federal government

8) Ten year grant for a demonstration project for state public and private partnership to provide coverage for the uninsured at reduced fees (isn't this what the exchange is supposed to do?)

9) $50 million five year grant for state based demonstration project on medical liability options

10) $200 million in funding for workplace wellness (wouldn't an employer want to implement on its own merits and the potential savings not just on medical but Workers Comp and productivity?)

11) The fees that are being charged insurance companies ($6.7 billion), drug companies ($2.3 billion), medical device makers ($4 billion) and clinical labs ($750 million) will all be passed on to consumers in the form of higher health care costs (or am I being too cynical?)

12) The insurance company tax will not kick in until rates for 2010 will have been set – thus the market will bear the pass through of this tax twice in 2011

13) Provides for sale of national plans with uniform benefits across state lines (sounds good in practice, but this will squeeze domestic carriers limited to one state and how will this be enforced and by whom?)

14) Employer penalty for failure to conform (groups of 50+) is too low

15) States must have a Consumer Advocate Ombudsman (and what of the State Insurance Departments and their current role?)

16) States must do "maintenance of effort" for Medicaid until the Exchanges are in place, but that is not until 2013

17) Agents are still included in the process, but the Exchanges, in consultation with the Small Business Administration, can include educational and ombudsman services. This, of course, duplicates the role of the agent – do we need both? Do we need a new layer or level of service when it already exists?

Rules of Engagement – A Comedy of Errors

Find out the cause of this effect
Or rather say, the cause of this defect
For this effect defective comes by cause
(Hamlet)

1) 47 million uninsured – but there are 1/3 who qualify for an existing public program and 1/3 who make enough money to afford insurance – so who are we helping and who are we forcing to take something that they either don't want nor need?

2) We spend more on health care than other countries with less to show -- but we also spend more on marketing those things which are detrimental to our health, affecting lifestyle with no ill effects in retailers' bottom line but leaving a little too much corporate fat

3) Public option will work – except all the places where it hasn't. Maine has tried on a small scale and now scaled back, Massachusetts added some minor points but is not pointed in the wrong direction, and California had a hiccup with their HIPC which had many iterations but not the one that would save it

4) Fraud – well, yes, it does exist, in Medicare and elsewhere, but what is curious is how all the bills contain funding to find fraud then laud the measures for its eradication, when it must have already been discovered (how else could it be measured?) and the money saved from what is recovered exceed what the bills have covered – so why wait until later?

5) Tax on High Premiums – if it were a case of excessive behavior rather than cost then it may make sense, but a "flat tax" does not take into account variations in costs caused by age, geography, and gender makeup of the groups in question. In small groups in California, rates are spread by age bracket and region, and families have an inflated cost because those covering only spouses or children are given a break.

6) Monopoly money: Kathleen Sebelius (HHS Secretary): "The government needs to create a public health insurance plan because many parts of the country are monopolized by a single health insurer" This is true in certain areas, but the solution is not necessarily to create one plan that would also affect those states, like California, that have a viable and competitive market. Also, the end effect of a public plan, with the natural advantages it will contain, could create a monopsony – and which "mono" is the worse disease?

7) Medicare expansion is good – there are those in Congress who still argue that Medicare is the most efficient form of paying for health care and that is a viable program that should be expanded, even to the point of having the government run the entire system in like manner. There are many arguments against this, but three can easily be kept in mind:

    a) The cost shifting caused by Medicare fee negotiations is responsible for part of the medical inflation that affects purchasers and carriers
    b) Medicare not only does not cover everything, but also decides what, if anything, will be covered and how with one simple set of rules – that keeps costs down a bit, but also choice
    c) The trustees continually show that Medicare cannot be trusted, as they continue to show a shelf life for this product of only another five or six years with its current rate of funding – which will be accelerated as the baby boomers retire

8) Tax Credits: will they be enough to motivate small employers to buy coverage. First, they must have average wages of less than $40,000, and second, they must have less than 25 employees. Those companies then get a credit of 35-50% of the premium – which still costs them money. This assumes they were going to offer it if it only cost them half as much. And what is their basis for an assumption of a large scale takeup with this assumption?

9) HHS says that small businesses pay 18% more in premium that a similar large group policy. There are several flaws inherent in the logic here, and there is substantial evidence in California that this is not true. Carriers use different rating matrices in the large group arena (50 or more employees) and rates, in the end, are determined less by some internal administrative charges than by the demographics of the group itself. Older groups pay more, size notwithstanding.

10) House Bill Cost: official cost projected is $1.1 Trillion – but that excludes at least 2 dozen unfunded programs that will need money later

11) Senators cite obscene carrier profits – AP, which is a more objective resource than either the Senate or the carriers, said that carrier profits are really only 6% (although, given the state of the economy, that's not terrible) – Senator Jay Rockefeller said that carrier profits have soared more than 400% sine 2001. He was, however, only going through 2007 (if 2008 included it is 249%), only ten carriers were studied, and the study ignored increases in profits resulting from carrier consolidation (so profits for bigger companies look bigger, even as the size of the industry remains the same)

12) Medicare savings were double counted – the cuts were seen as a way to bring the bill under budget, but at the same time they were seen as a way to save Medicare – they cannot be both, as the CMS and other agencies quickly pointed out.

In Decent Proposals – Love's Labour's Lost

The words of Mercury are harsh after the songs of Apollo. You, that way: we, this way

1) There is rate banding based on group or individual characteristics, but no rate banding as we see it in California small group reform, where there are upper and lower limits on the overall rate table being used for a plan, based on the health status of the group. The rate bands in California do not exceed 10% - they are much larger in neighboring states – and the federal bill does not have them at all

2) Simplicity of Plan Choice: is there something inherent in the market that requires each carrier provide so many different plan designs, especially when the similarities are so striking? If there were 7 or 8 common designs that all carriers had to offer, carriers would be forced to compete more on service, plan design costs would be eliminated, some marketing and printing costs would decrease, claims administration would be made simpler (and thus less expensive) and there would be considerably less confusion in the market (especially as carriers change features in their plans at least annually)

3) Strong mandate – why have one if it is so much cheaper to pay the penalty than buy the insurance?

4) Focuses on the financing of health care and not its underlying cost

5) Congress is not using its regulatory power to fix the playing field and make sure carriers are competing on a clearly tangible basis (see plan choice above)

6) OMB Director said $700 billion in annual medical spending goes to services that do not improve health care – no bills have addressed a way to redress this situation

7) Medical liability reform was reduced to a study project – which is doubly nonsensical since California already has a long standing and workable system with MICRA

Left at the Altar – Midsummer Night's Dream

What visions I have seen! Methought I was enamoured of an ass

The final bills were thick, but much tossed just would not stick (we had enough to make us sick)

1) Elimination of employer tax exemption
2) Drug reimportation – finding a way to get drugs from Canada at a lower cost
3) Estate tax changes
4) Increased taxes on alcohol
5) Taxes on soda
6) Limit the itemized deductions on high earners (though that would not any impact anyway)
7) Medicare expansion
8) Negotiated rates within the public option (but this may be back)
9) Medicare tax on capital gains
10) Medicare buy in at age 55
11) Windfall profit tax on insurance companies (but was passed in a modified form)
12) Death panels
13) Anti trust exemption for carriers being eliminated
14) Giving tax breaks to Domestic Partners
15) Premium discounts for those who quit smoking, lose weight and eat right
16) Government health plan to be included in the Exchange
17) Prevent employers from cutting retiree benefits to achieve parity with active employees
18) Mandate a large cross section of included benefits
19) Exempted more small businesses from mandates (86%)

Disavowals – As You Like It (or dislike it – criticism from the wings)

Neither rhyme nor reason

1) Part D approval for drugs may require manufacturers to give a 50% discount – will this save money or have the effect of cutting coverage due to the lack of needed medications

2) There will be an elimination of "mini-med" or limited medical benefit plans – but these are now offered for part time employees and those not usually found in the employer sponsored marketplace. Is there still a place for these products and is their elimination a good thing?

3) There may be coverage for participation in clinical trials – but this may be a license for drug companies and others to steal, or at least get money from carriers and employers to cover their development costs

4) Hospitals are to publish an annual list of their standard charges. Do hospitals even have standard charges any longer, given their dependence on PPO and HMO contracting? And, if someone has a PPO or HMO, what difference will knowledge of the "standard charges" do them when they are paying charges after the discount is applied? This also adds to what a new Medical Reimbursement Data Center is going to provide.

5) Plans must now have internal and external appeals processes – this comes in addition to the creation of a new ombudsman (which in itself is in addition to State Departments of Insurance) and the supposed expansion of education that is to come. Having the process is good, of course, but what additional oversight and enforcement will be entailed (and at what cost, either in the policy or in taxpayers carrying another bureaucracy)

6) The Department of Labor is to do annual studies of self funded plans – but it does not say what the purpose of such studies are, or why they would be necessary.

7) The Exchanges, as proposed, can be multi state, but this will leave purely domestic carriers out of the loop (e.g. Blue Shield of California, or Kaiser, if one of the states is not covered by them) and also begs the question of how big it must be.

8) More puzzling with regard to the Exchanges is that they would be regulated or overseen by the Office of Personnel Management in Washington, presumably because they have experience in overseeing the Federal Employee Health Benefit Plan. There is a question about their expertise, of course, as well as needed manpower and its costs.

9) What will the true cost of CLASS be, given that it collects so much money up front and then begins to pay out benefits after a few years. At some point, we will see a catchup, or concerns over growing premiums as the number and amount of claims escalates.

10) CBO Score on Senate Plan: Says the cost will be $829 Billion – but this does not include the impact the bill will have on premium costs, the possibility of pool deterioration as some move in and out of the public option and a significant increase in the number of insured (which is what caused the initial cost of Medicare to skyrocket well past initial projections) Also the CBO score assumed a 21% cut in Medicare payments (see #7 above) which was later reversed by the Senate (which now adds $247 billion back to the bill) and assumes revenue generated by CLASS (long term care provisions) for the first five years before claims are paid (and what happens when claims ARE being paid?) The Senate Republican Budget Committee therefore says the true cost over ten years is more accurately $2.5 Trillion.

11) Mandate: this will create a bigger pool for the carriers, assuming that the penalty is sufficient to drive such volume, but those that enter the pool may not be in optimal health, which will drive up costs for everyone as we subsidize illnesses as well as income shortfalls

Divorced from Reality – King Lear (rage from off the stage)

Oh, that way madness lies; let me shun that

Mitt Romney: public plans are a “Trojan Horse…a way of getting government into the insurance business so they can take over health care”

Wall Street Journal (June) – said government will ration health care when universal coverage fails to cut costs

Town Hall (Hell) Meeting with Senator Arlen Specter and HHS Secretary Kathleen Sebelius:
"I look at this health care plan and I see nothing that is about health or about care. What I see is a bureaucratic nightmare, Senator. Medicare is broke. Medicaid is broke. Social Security is broke and you want us to believe that a government that can't even run a cash for clunkers program is going to run 1/7 of our US economy? No, sir, no"

Sen. Joe Lieberman: "There is no reason we have to do it all now, but we do have to get it started. I'm afraid we've got to think about putting a lot of that off until the economy is out of recession"

Newt Gingrich: overall says the bills increase the power of government while decreasing individual freedom, saying you can't spend $1 trillion of taxpayer money and reduce the role of government – instead you will get new bureaucracies, new regulation and more complexity so you have less control of your health care

Politico (Washington Magazine): "More than anything else in…Obama's presidency so far, health reform has exposed the 'get a deal at any cost' side of Obama that infuriates his party's progressives…some liberals could barely hide their sense of betrayal that the White House and Congressional Democrats have been willing to cut deals and water down what they consider the ideal vision of reform"

Washington Examiner: Ten Reasons why the Public Won't Buy the Senate Health Care Plan:

1) Exploding Costs (estimates are that the final cost over ten years will be $2.5 Trillion)
2) Losing Coverage – at least 5 million will lose their current employment based plans
3) Job killing taxes on employers
4) Budgetary Gimmick – tax now, spend later – the fees and penalties precede plan changes
5) Increasing future spending – CBO says federal government will spend $160 billion themselves
6) Cost shifting – bill said it would save by cutting Medicare 21% - but this was reversed
7) Taxpayer financed abortion (final language still being worked out)
8) There will still be 24 million uninsured
9) Scarce subsidies – only 19 million will qualify for help with their costs
10) Mandates cause higher premiums and more uninsured

National Association of Health Underwriters – specifically on CBO Scoring:

1) It does not adequately address the potential for adverse selection
2) Does not factor in that newly enfranchised/insured may be less healthy, thus more costly (adding more people to a pool does not necessarily make the pool more profitable)
3) Uses a different definition of large employer than the bill
4) Does not properly address the new fees and taxes that being in 2010

    a. Excise tax on "Cadillac plans" may not be collected when people change plans
    b. Premium tax will increase the baseline premium by at least 1.5%
    c. Additional taxes on medical devices and drugs will also increase costs (pass through)

And in the end we can only hope that "All's Well that Ends Well"

STATE STUMBLING

No, no, you're not thinking – you're just being logical (Niels Bohr, d. 2009)

I think we all have a need to know what we do not need to know (William Safire, d. 2009)

His promises were, as he then was, mighty
But his performance, as he is now, nothing
(Henry VIII)

True Lies beget outcries, regret
It's a given we've been taken
Get Out! We say, we cannot pay
From our Golden dreams we're shaken

So Arnold sold our future hold
With no grasp on what we're spending
His ballot measured a lot we treasured
Panned as his Hollywood ending

He's ready to leave at this stage,
His term in a tor, rent of rage
A debt so big he can't budget
The net now so small we can't judge it

It's time to reflect on whom to elect
And ship this state into good shape
Jerry Brown wore this crown, and Meg Whitman's bid's down
Gavin Newsom old money but his prospects weren't sunny
In a fog he could not escape

Single payer has new legs, but armed with backing it dregs
Up qualms of who handles the bill
Will the reigning Democrats flood healthcare with bureaucrats
Who bank their future on the Hill
On whose interests will still fill?

Massachusetts miracles seem less empirical as studies show the plan is doomed to fail. New York states that rates aren't right and Cuomo comments rebates are in sight but the vision for new sites is filled with indecision. We've read few are in the black as the feds feed off their back and health reform will need a Medic's aid. Funding raids from Washington will pound their dollars down a ton while victory's claimed and state bodies maimed in continuing conflict. California still performs as a nonconformist with HSA and our array of dependent definitions, while conditions are created for a new regime that's slated to layer single payer in our structure. When we don't have any money it is no longer funny how we act as if the cuts we make will somehow take us to another stage of fiscal prudence. Sacramento has insufficient capital, Barbara's Boxer skills are deficient as Sen. Ben Nelson capitalizes on her half hearted conception of abortion rights, without a portion of pork forked over during her ham handed handling of health care's inspection. Meg is nuts but cash used to pique an interest in battling Brown with a jerry rigged campaign may net her votes in E. Bay and beyond.

Forecast with Precipitation

Surprise! We have a deficit of the highest order. But wait, it's growing, no, wait, there's another report, no, it's bigger than we thought as more monsters come from the shadows and this looks like poor Grade B entertainment. At least Hollywood is making money and Arnold has a home when all this is over. In the meantime, he proposed:

1) Personal income tax rate increase of 0.25%
2) Increase in sales tax and auto licensing fees
3) Reduced state tax credit on Day Care from $300 to $100
4) Etc, etc.

The Governor's ballot attempt was met with contempt. Yes, it's serious, but he can't be serious – so those things for which the government is primarily responsible are cut, along with availability of those who work for it.

Three Reels of Solutions

Every great and deep difficulty bears in itself its own solutions – it forces us to change our thinking in order to find it (Niels Bohr, d. 2009)

Meanwhile, before all the shooting started, a Bipartisan Commission on Tax Reform was appointed and released their findings at nearly the time the referendum was called. They said:

1) Cut the highest personal tax rate to 7.5%
2) Eliminate the corporate income tax
3) Eliminate most of the state sales tax
4) Income brackets should be cut from 6 to 2
5) All this will be replaced with a 4% Value Added Tax

Buy the Book (by the way)

There was discussion of having HSA conforming legislation so that it would be state tax exempt but, in the middle of a budget crisis, this was unlikely…and did not pass

There was also discussion, as there is every session, of a Single Payer system, but this stands a better chance if there is a Democrat as governor, and even then it is difficult to conceive of California taking this on when it cannot even get its own finances together, much less an undertaking of this magnitude.

President Obama signed a Defense Authorization Act that included a COBRA extension and expansion. This has not yet passed the California legislature but is expected, which lets small groups that are subject to California COBRA, conform to the national law.

By the Book By the Bay

Yet another appeal to repeal the San Francisco health care tax was rejected, this time by the 9th US Circuit Court. The Golden Gate Restaurant Association, which is still serving the papers, has vowed to take the matter to the US Supreme Court

Altered States

The Massachusetts Model is cited as the basis for national reform, even as it is being challenged. The primary provisions are instructional, and mainly emulated by Congressional conduct:

1) Expanded Medicaid coverage
2) Individual mandate
3) Subsidized private insurance
4) Quasi public health insurance vendor (called the Connector) – which is similar mostly to the Senate proposed exchange but bears a resemblance to the House public option – what is interesting to note is that the public bought private health insurance sold in the open market by a 10-1 margin vs. what was sold through the Connector

What has happened since, however, should have received more attention from Washington:

1) They now want (or need) to end fee for service payments and use global caps
2) The original bill did nothing to address rising costs (as politically risky) – now they are high
3) Uninsured dropped from 8% to 2.6% - but the addition of 428,000 members also cost a great deal more money, which had not been budgeted

In Maine, universal coverage was enacted in 2005. Premiums are up 74% since then and so many residents have dropped coverage as a result that the uninsured rate in the state is back to 10%

Of course, various state are talking about and not passing anything like Single Payer legislation, though this may reappear in the spring in Sacramento.

BUSINESS BUMBLING

Commentators quote economic studies showing market downturns predicted 4 of the last 5 recessions. That is an understatement. Wall Street indexes predicted 9 of the last 5 recessions. And its mistakes were beauties (Paul Samuelson, d. 2009)

Prediction is very difficult, especially about the future (Niels Bohr, d. 2009)

I can get no remedy against this consumption of the purse; borrowing only lingers and lingers it out, but the disease is incurable (Henry IV, Part 2)

The clouds methought would open and show riches
Ready to drop upon me that, when I waked
I cried to dream again (The Tempest)

Businesses bailing, more banks are failing
The government's passing the buck
Debts spiral and grow, some rise with fresh dough
Though down below TARP some will duck

Inflation worries reign, as funding flurries feign
In the winter of our Dow discontent
A summary of bills that finance fallen frills
In deficit disorder more was spent

Some companies fight back, since While House blew toward black
But it will cost some greater contributions
IN lobbies and the shop, more coverage will drop
In painful loss of gainful restitution

Anecdotal antidotes force total upsides down our throats
Bitter pills will kill care reformulation
Healthy raises follow campaign praises hollow
Words to herds of a cowed population

High ceilings make a room lighter but the gloom that pervades abrades the soul when the goal is to get out of debt. The fallout from the bailout may be determined by ballot, though Democrats can't bear the brunt of blame. The shame is that many discredited practices seem cached in company manuals as they automatically revert to what hurt them originally. Businesses don't want scrutiny, execs are ready to mutiny over such an onus on their bonus. Many banks are bankrupt and stocks are sure to erupt given the economy's seismic shifts. Sunny soothsayers have answered our prayers by preying on our need for good news, but funny numbers are used, employment abused and the Feds infused much of our growth. Social networks will work against the social order as we border on personality banality, sharing more and putting store in the privacy retailers invade. Health care concerns grow without ceasing, amid rumors of rates that will still be increasing, though politicians promise (Shakespeare quote)

Stock Answers:

Everyone praised how the economy raised in the third quarter, but it was quickly pointed out that the Cash for Clunkers program and the Homeowners Tax Credit were largely responsible, along with the still felt effects of the government's $787 bailout engineered in the first quarter. Still, stocks rumbled along and recovered some of what they lost, even as prognosticators are saying that the worst is yet to come.

Companies who sought TARP protection found the quarters too close to make sense and sought repayment so they could back to their former ways. Not all were so lucky, as General Motors and Chrysler filed Chapter 11. Mergers continue, acquisitions are up and down and the stock market stays guardedly optimistic. Of course, it's hard to tell how it is really doing if you follow the Dow, where companies are brought on or dropped off the index to suit the whims of Wall Street.

People are still complaining about how AIG escaped, but not their poor judgment to pay and entertain executives as if nothing had happened, while the layman still can't understand what happened at Lehman or how exactly the United States got into the car business.

Deficit Attention:

The U.S. debt ceiling was raised to $12.4 Trillion after the deficit reached $1.4 Trillion. Remember when Everett Dirksen said, tongue in cheek "a billion here and a billion there and pretty soon it adds up to real money"? He'd be swallowing that tongue now.

Look who caught a clue

General Motors announced that 24,000 salaried employees would have their health insurance changed to a High Deductible Health Plan (which qualifies them for HSA creation). Not to be outdone, GE did the same – for 75,000 employees. Not only does this allow greater HSA growth, but trustees are happier, having been given the opportunity after the first of the year to get kickbacks from fund management fees. Vanguard, which prides itself on low fees, got the boot almost immediately from the portfolio of some of the larger plan trustees.

A kernel mustered in plain view

That's the general term, but it includes cost and spending, all of which add either to the deficit or our ability to afford its repayment. Health care inflation is still seen, as it has in past years, as coming at 10 to 12%, even though the general CPI rate is hovering near 3%. There are many reasons for this, covered in previous Journals (and staying the same), but now we'll be adding some new factors as a result of health care reform. No matter what the various economic pundits of the government say about the final cost, as with all public projects it's best to take their number and double it.

There was an amendment to the Health Care Reform bill proposed that would have allowed importation for medications from Canada, in the belief that Canadian drugs are less expensive. This is true – for brand names. The Fraser Institute, a Canadian think tank, shows differences ranging from 43 to 53% in the last 5 years. For generics, however, prices have been much higher, ranging from 78 to 115%. Granted, brand name drugs are less expensive, but there is also more manipulation of pricing that is tailored to the individual market and its average income rather than to some special Canadian magic that just creates cheaper drugs – after all, what we have in common besides a border is also the same drug dealers.

JUDICIAL JUMBLING

Though justice be they plea, consider this
That in the course of justice none of us
Should see salvation; we do pray for mercy
And that same prayer doth teach us all to render
The deeds of mercy
(Merchant of Venice)

The first thing we do, let's kill all the lawyers (Henry VI)

Despite the parade of Congress displayed
On papers, C-Span and Town Halls
Some progress was made when spotlights did fade
With writs and wrists raised in roll calls

Finally given a glint, finely buried in print
Amid disinterested writers
Unknown consequence but shown precedence
When signed then maligned by in citers

Some rules are amended while others extended
We're swimming in alphabet soup
The ARRA of our ways was coiled in COBRA plays
Which aspired to jump through new hoops

Champions of our rights are left challenged to fights
Which have prejudged them prejudicial
With squawks of foul ringing, the talks have votes swinging
By electing to make it official

The A's have it as naysayers horse around and daily sound off on nightmares dreamed by legislators who'd sooner OK a new law then review flaws in the last one. ADA can shout down HRA, FMLA expands its hands over to NDAA. HSAs remind of some corrections, ARRA's resigned to COBRA collections and GINA realigned our family connections while HIPAA refined the complexion of what we faced with enrollment elections. We need no longer despair of mental parity, the sentimental charity of an eponymous ruling (Michelle's Law) or fooling Medicare whose clarity in defining dependents may avoid fining employers. Of special note is the health care vote, where sealing the deal was all too real for states which feel that stealing appropriations was inappropriate. Suits are being tailored to tie Congressional hands, fingered by AGs as requiring increased investment in what is broken, simply by what they bespoke but many failed to hear.

Here is our annual index – and glossary – of what passed the bench and made for a better game

ADA (Americans with Disabilities Act)

Health Risk Appraisal (HRA) cannot be used to disqualify someone who has a medical challenge from qualifying to participate in a self funded plan

ERISA (Economic Retirement Income Security Act – health plans overarching regulatory rubric)

A carrier who conducts a standard of review for a medical claim and also pays the claims may have a conflict of interest

(CHIP) Children's Health Insurance Program:

The CHIP Program was reauthorized on April 1, 2009, and expanded the state SCHIP plans:

1) Subsidy: states may elect to offer a premium assistance subsidy to eligible low income children and their families for "qualified employer sponsored coverage" as defined (this does NOT include FSA or HAS) –subsidy may be direct payment to the employer or the employee

2) Enrollment Rights: group health plan must permit employees and dependents who are eligible but not enrolled for coverage to enroll in two additional circumstances (this expands the HIPAA special enrollment rules):

    a) If Medicaid or SCHIP coverage terminated as a result of loss of eligibility and the employee request coverage under employer plan within 60 days of this loss

    b) Employee or dependent becomes eligible for a subsidy under Medicaid or CHIP and and the employee requests coverage under the employer plan within 60 days of this qualification

3) Notice to Employees: must provide written notice to employees, informing them of the potential opportunities for premium assistance in their state of residence to help pay for health coverage for employees or dependents (HHS to have state specific model notice by February 1, 2010). Employers may provide these notices along with other plan materials notifying employees of health plan eligibility, with open enrollment materials or when providing an SPD.

4) The state is the secondary payer under this program after a group health plan

COBRA Subsidy (Consolidated Omnibus Budget Reconciliation act – reconciled through ARRA)

As part of the Federal response to the fiscal emergency and rising unemployment, a provision was added to ARRA and hastily implemented. Then, just as employers and carriers were feeling less pressure to comply, the act was both extended and expanded in December:

1) Employees who are *involuntarily terminated* are entitled to a 65% subsidy of their COBRA premium. The law originally said this would be for 9 months – it is now **15 months**

2) The termination must occur not later than February 28. In an update to the first iteration of the law, it is now clear that it is the termination date which qualifies a person and not the date they actually end their coverage (since someone laid off in mid February would normally have coverage continue through the end of the month, at which time they would have not been made eligible for the subsidy)

3) There is no subsidy for someone earning $145,000 per year ($290,000 if joint return). The employer is still required to comply and apply the subsidy, but the employee will have to add the amount to their federal income tax return

4) The Federal law also said it would apply to any state COBRA law…but the states had to pass conforming legislation. California did this rather quickly, but was in recess when the extension was passed, and so will need new conforming legislation in 2010

5) Those who made full premium payment in November or December 2009 may apply for the subsidy retroactively since the amount of time has now been lengthened to 15 months

There was some initial confusion over the term "involuntary termination" – it means what it says, of course, but the Department of Labor did engage in a public Q&A to clarify. It does not mean termination for cause, a reduction in work hours, retirement, employee election of termination in return for a severance package, or the termination of coverage due to another qualifying event (e.g. divorce or child no longer eligible due to age limitations). It can include the employer's failure to renew a contract or an employee resignation due to an employer action that causes a material negative change in the employment relationship (e.g. transfer to new location)

Federal Contractors (ARRA – American Recovery and Reinvestment Act)

ARRA extended the 1931 Davis Bacon Prevailing Wage regulations to contracts taken through legislative acts providing funding through grants, insurance, loans and loan guarantees (e.g. a state highway project that has some funding through the Department of Transportation)

Also of note, since we're on the subject, are the federal contractor requirements to adhere to the McNamara-O'Hara Service Contract Act of 1965 and the Walsh-Healy Public Contracts Act of 1936. Only worth mentioning since the Department of Labor Wage and Hour Division is adding 150 new investigators for general Wage/Hour enforcement and 100 under ARRA for compliance with the new stimulus project requirements

FMLA (Family Medical Leave Act)

Final regulations were published and clarified or finally defined key terms and conditions:

1) Serious health condition
2) Rules for perfect attendance awards
3) Treatment of light duty assistance
4) Guidelines for substitution of paid leave
5) Medical certification and recertification process
6) Fitness for duty certification
7) Changes to employee notice obligations
8) Expansion of Injury and Illness and exigent circumstances to take leave for members of the armed forces (under NDAA – National Defense Authorization Act)

GASB 45 (General Accounting Standards Board)

Public employers must report retiree life and health experience on an accrual basis and not either cash or “pay as you go” – this is not a requirement to fund, but to define the obligations of there is actual retiree funding

GINA (Genetic Information Nondiscrimination Act)

Applies to group, individual, self funded, Medicare, Medicaid and state high risk pools:

1) No collection of genetic information for underwriting or in connection with employment
2) No request for or requirement of genetic information
3) No adjusting group insurance premium or contribution rates based on genetic information

This has also been ruled to apply to companies using Health Risk Assessments when they are combined with either wellness or Disease State Management programs

HIPAA (Health Insurance Portability and Accountability Act)

There are new and clear rules on notifying affected individuals when their “unsecured” Personal Health Information is breached. There are also now two new special enrollment rules (see CHIP)

HSA (Health Savings Account)

1) An employer failing to make comparable contributions is subject to an excise tax. Those who are considered “highly compensated” for purposes of this test are those who are 5% owners (current or prior tax year) or an employee earning at least $110,000 per year (and, if elected by the employer, also in a gro9up consisting of the top 20% of employee compensation)

2) An HSA participant may contribute the full annual amount if they became eligible for a qualifying High Deductible Health Plan as late as the last month of the year – but they must stay on the HSA for at least 12 months after the end of the tax year

3) An employer may pro rate contributions for mid year eligibility if all are treated the same

Medicare Secondary Payer (CMS – Center for Medicare and Medicaid Services)

CMS, which runs Medicare, is now requiring the Social Security numbers of any employees or dependents who are age 55 or above, or anyone under 55 who is known to have Medicare. The carriers are responsible for collecting this information, and will send out notices to employers when they are not certain they have what they need.

Mental Health Parity

The insanity of this act is how long it took to move from an annual renewable rule, which put everyone in a state of anxiety, to a permanent fixture with large employers (51+) lighting the way. This is an employer law, though carriers in some areas have to modify their contracts to make payment for mental health claims at the same level as other medical claims:

1) Applies to groups of 51 or more employees for the majority of the prior calendar year (this counts all part time, uncovered employees and those subject to collective bargaining)

2) Groups that are self funded (non governmental) or who can show that the actuarial cost of the plan will rise by 1% or more due to this law may opt out

3) An employer is never obligated to offer mental health coverage, but IF they do they are subject to the parity rules (absent opt outs, above)

4) Substance abuse benefits must be treated the same as mental health benefits

While the idea of parity is clear there are several exceptions. A plan may:

1) Cover mental health services just provided within a network (though the plan may be paying for out of network services in non mental health cases)

2) Increase co payments or limit the number of allowed visits

3) Impose limits on the number of covered visits, even if the plan does not do this for other medical services.

4) Have different cost sharing arrangements, such as higher coinsurance payments

What a plan may NOT do is put a limit on the number of visits, etc. **together** with a fixed dollar limit, a feature found in many plans now

Michelle's Law

Dependent eligibility normally requires that the student be enrolled full time. In the case of a student who takes a Leave of Absence due to medical necessity, the carrier or plan is required to extend coverage – maximum of 12 months.

UCR (Usual, Customary and Reasonable)

New York Attorney General Andrew Cuomo filed a suit against Ingenix, which is responsible for providing data on medical charges for many carriers. The data bases were found to "intentionally skew UCR downward through faulty data collection, pooling procedures and lack of audits" – there are large fines being paid by Aetna, United and other carriers as a result and the state physicians group or the AMA may file suit for reparations themselves