JORDAN'S JOURNAL 2012

Twin Towers tragedy and the fateful flight of 93 weighs heavily as we acknowledge the anniversary of 9/11. We've been laden with Bin Laden too long, and as Obama laughs along at dinner the Navy Seals a winner when Osama is dispatched. We only seek to see for the sake of history but Taliban is not one man and there are many stops to make as we take what is said seriously even as they move mysteriously among enemies and allies alike.

It causes pause to contemplate on something besides interest rates while the fates of many countries stay unstable. Congress came in with Republican spin, back on top with a surprising win but taking stock they brought deadlock and discredit. Fortune bonded right with righter and the margin for error grew slighter when right and left wings were clipped and popularity slipped for all who were a party to the madness. Super groups were formed but poorly they performed as debts were not conformed to any revenue. Memorials were raised and young heroes often praised but we struggled to maintain a piece of peace both here and overseas.

Seizing opportunity too many sought immunity when their acts of wanton greed deafened need to heed the warning bells that sounded in Sino Soviet quarters. Our attention to the deficit brought disorder on our borders and the books we made to balance trade lacked spine enough to bluff a happy ending. We owe our soldiers but withdrew, we painted prosperity but overdrew, we owe neighbors near and far, and somehow promised hope has changed and we have less with which to cope, mourning losses anew in the decade we've been through, now more afraid of that we cannot see. But our spirit doesn't dim when we faintly hear the hymn of faded glory's story and the seas that we will swim to reach the green light on the shore which beckons, always beckons, as it calls on us for more.

"No, we don't know where it will lead. We just know there's something bigger than any of us here"
(Steve Jobs 1955-2011)

FEDERAL FUMBLING

I don't think the government is out to get me or help someone else get me but it wouldn't surprise me if they were out to sell something or help someone else sell something. I mean, why else would the Census Bureau want to know my phone number?
(Andy Rooney 1919 – 2011)

You don't adjust – you just dominate
(Al Davis 1929-2011)

You will not be able to stay home, brother
You will not be able to plug in, turn on and cop out
Because the revolution will not be televised
(Gil Scott-Heron 1949-2011)

Cain wasn't able to round the table
His past a pie eyed slate of affairs
Mitt might hit pause, denying Mass laws
Mor man made than answers to prayers
There are man hunts for Jon who has lost too much yuan
Michelle's death knell might Bach the wrong man
Ron's maul may soon pall, Random splits spare us all
A tension to deficits they span
Newt's route to Whiter House allows him to espouse
Loud fidelity to all that is right
But sound judgment is lacking, a false front to his backing
Being cornered in conservative fight
Cities are occupied with damage to their pride
There's no lyin about catastrophic movement
Developments arrest growth of what we ingest
From swallowed tales coating jokes of what invest meant
Depression still reigns despite leadership strains
To attune old world strings tied to currency
Silvio got the boot and Greece played with lost loot
What's Germane is that lyres can't finance France fliers
Downing Euro's soared hopes during infancy

Dial 999 and get turned upside down because the devil is in the details. The Hermanator raised Cain retailing his story, Perry remembers the Alamo, while wheels fell off for those who misspoke, went broke or were a joke that failed to humor hosts of colorful parties impaled to a T. Ghosts were resurrected and spirits misdirected as toxic talk made Republicans walk a narrow plank. Gott Mit? Uns…believable with Romney married to too many principles, versus Newt with none but his intellectual eft, Bachman digging holes but will Gopher it anyway, Huntsman searching for a clue when his campaign got Shanghaied. Rick Santorum penciled votes in vain, Hilary's always on a plane, Dean has cowered in a corner of the country, Palin drones on reflexively, Weiner got too big for his britches and Nader's run is unsafe at any speed.

Floored by a debt ceiling revealing more about excess than process, there was no room inn which to maneuver, the oeuvre of this Congress showing no progress much less work of lasting value. Focused on the rear view we can't get behind one mind over which matters may forestall walls of future opposition. Simpson Bowles is an Odyssey, Ryan's tolls Badgered for their fantasy, but those tools you'll miss ease no one's pain it's plain to see. So Wall Street is preoccupied and dissenters will not be denied their option to take stock of a selfish situation. We now know what MF really stands for, a Corzine vaccine is one debt dies for, and Solyndra So large we sell suborned lies for, and the games begin and end the same, with only names changing, as dollars flee along with our good sense.

Japan rolls in waves of desperation while California braces for radiation biting budget bullets. Natural disasters are severe, but those of man made nature appear to cause greater tidal disruptions, with housing titles lost, higher credit costs and less hiring letters embossed with the signature touch of folly fed by freedom as practiced everywhere when we pretend to be mobile in a global economy. In a year of unrest we were put to the test to leave the rest to themselves, but Qaddafi is killed despite a last ditch plea, other dictators are forced to flee as the Arabs spring surprises and prise no cry for compromise. A Sad site in Syria, a crop of police in Greece, Cairo practically bent out of shape, but have we gypped the Middle East by deserting with the least support in port or was this the sort of war no one ever wins?

Congress

The House leaned to the right when the Republican fight was won and the possibility of either democratic partnership or complete deadlock gripped the nation. But as they opt to coopt those further right (but politically incorrect) the winning wing found it was no Tea Party and what began as revolution simply became revolting in the convolutions of opposition to Obama that followed. The combat style went on file early on when an inflammatory title was bestowed on what Republicans felt was owed those who would stand with them. Their first bill fit the bill as "Repealing the Job Killing Health Care Law Act" With rhetoric like that, why are we surprised that the victory so prized was tarnished by their refusal to even offer a perusal of what others might propose? Instead we had to face the idea of repeal and replace and other bills so named: Save our States Act, Preserving Patient Choices Act, Preserving our Promise to Seniors Act, Restoring Consumer Driven Health Care Act – all failed to pass but not without notice about what had come to pass as sides were drawn and hope withdrawn of any sort of progress from an obstinate Congress.

1099: An expansion of rules for those subject to 1099 reporting was a means to make money for the passage of the ACA, which even Congress saw had ways in which we'd pay. Even President Obama saw the folly of this one and lobbied for repeal, and the deal was closed mid year.

Mediscare: As if it didn't have enough problems, doctors were set to receive a reimbursement reduction of 27%. Congress passed a "doc fix" in the waning hours of the 2011 legislative session. This avoided the cut and with it the imminent threat of an expected collapse of medical availability to seniors, as suggested by the AMA and others. Unfortunately, the Medicare reimbursement delay is only for two months, and Congress has to pick this up again in early 2012. Despite the concern over Medicare costs, the Part B premium (non hospital care) was increased only $3.50 per month, and those now paying $115.40 will see their base rate drop to $99.90

Social Insecurity: What fixed the docs also helped workers, as the same bill also extended the payroll tax cut for Social Security to 4.2% -but only for 2 months. What's odd is that it has long been established we do not have enough workers to pump enough money to keep going what is clearly the world's largest Ponzi Scheme – Social Security. If we cut the amount paid now it will cost workers later, when it is time to retire, as Social Security could expire earlier than desired.

Zeroes from Heroes: The Super Committee didn't have extraordinary power, as they failed to reach agreement, blaming politics, etc. Why did they do it all again, when Obama had a plan, Paul Ryan showed his hand, and solutions struck by Simpson Bowles may end up being what we have in the end. Oddly, their failure does not mean any sort of stalemate, as the large cuts proposed in the budget proposal will now simply go through (e.g. an overall reduction in Medicare spending of 2%, or $123 billion over the next decade) with unknown economic effects to come.

Darkness Darkness: A more rapid demise of both Medicare and Social Security continue to be predicted which has prompted further calls for cuts…for Medicare anyway, which are part of the ACA as well as the budget compromise reached when the Supercommittee was formed. Absent the doctors' reductions mentioned above, there is still plenty of pain to go around.

Solyndra put new light on government investment, and Standard and Poors, which was unable to call the Wall Street meltdown (which this year claimed 213 hedge funds which collectively lost $85 billion), still saw fit to reduce their rating for the US government from AAA to AA+ which will further exacerbate our problems as the cost of borrowing increases.

No Sale? The small business tax credit was expected to have over 4 million taxpayers apply with an estimated cost to the Budget of $2 billion for 2010 and $37 billion over a decade, but as of May 2011 only 228,000 taxpayers had claimed the credit and for only $278 million

Irony Posted: One of the hallmarks of choice, selection, price stability and "how a purchasing pool" should work has not been Massachusetts but the Federal Employee Health Benefits Plan (FEHBP). It's good enough for Congress, so should be good enough for all of us. Apparently the Postal Service does not subscribe to this theory and has asked to withdraw from the FEHBP to find something that offers greater cost control.

HEALTH CARE HUMBLING
A Special Section danced during Federal Follies

Health care reform has been reformed as Republicans informed Democrats that their vision was deformed and so was formed a collision of coalitions with one side for demolition and the other performing acts of contrition over creating something so large because the man in charge said he would take charge of the entire matter even as it splatters all over his party.

This is not to say the government won't get its way but there are bills to pay and the Supremes have yet to weigh in or sing of things that bring freedom to the fore. What we see is the peace of initial agreement now in pieces as parts are being picked apart to survive or fail.

This started long ago, but it's the most recent stuff we know, with a decent amount of concern…

She may be now be Secretary of State, but 16 years ago Hillary Clinton created a state of concern, confusion and suspicion, as she undertook the labor of delivering the Democratic Dream of health care reform. The spectacular start was stymied by political posturing and private policymaking and, in the end, high minded ideals and details of deals doomed the best chance for change we'd ever had.

Too much, too soon, too little awareness of where opposition would position itself, and nothing happened, nothing changed, and the insurance industry, the industrial medical complex and the infighting between the many parties of interest resumed their warring ways over this giant piece of consumer spending. Hillary was gone, banished, disgraced, and Bill would furrow in other pastures. But suddenly, after years of Republican wrack and ruin, a spark was struck, a phoenix rose, McCain disabled, and a new voice clanged his clarion call for justice, equality and hope

And we return to the beginning…

Reform ideas are dusted off and sweeping systems modifications evaluated, a campaign cornerstone created and laid at our feet, a new structure begging to be built, but we wonder what hurry is required. Bills which toss a trillion dollar tag on an overburdened budget, proclamations over perceived profits to be preserved through vague and unproven concepts not yet deployed and the "First Year Agenda" which promised peace among nations, a financial future replete with opportunity and a revision of the rules regarding health care, is, while still desired, delayed.

We are working with something that touches all our lives in a purely personal manner, involving important decisions, myriad methods of delivery and sacrifice, in some form, even if that "simply" means to make small changes across the system, including our own behaviors.

The pundits aren't predicting Clinton redux, where hubris was hoist on its own petard, but posing questions, ruminating on restraint and wondering whether a headlong rush will conjure a law of consequence – but unforeseen, unknown and, ultimately, unintended.

Reform is needed, rules are required and standards should be set. The excesses of private insurance and the medical markets in drugs, supplies and equipment should be curtailed, patient integration is paramount, penalties for reckless medical behavior, fraud and the unnecessary variety in regional practice patterns and pricing should be adopted, imposed and pursued. Most of all, voices, not of reaction but of reason, not of political expediency or convenient catch phrases, but cutting across all phases of the health experience, should be heard – carefully – and understood. Choice must be expanded and explained, some federalism fettered, experimentation encouraged and funded, with the federal government using its power to weave a stronger safety net but catch the problem engendered by its own very real presence in the market.

Real reform began in California a generation ago – guaranteed issue for group coverage, rules on pre existing conditions and rollovers, and rate banding. We've seen COBRA continuation, HIPAA protections for certain events and the uninsurable, HMO expansion, coverage rights for domestic partners, Medicare drug plans and extended family coverage with FMLA and SCHIP. There have been experiments in cost control with DRGs and community planning, and some today believe that the Massachusetts Exchange program may prove successful (though an equal number believe the opposite). Guarantees of access, issue and rates – and still not enough to stem the tide of rising prices and costs without a concomitant increase in real value. Everyone wants something else, those that have it don't always know it, and programs are now so bloated with mandates they may even be too rich for what we need – but new demands always follow.

Some have suggested changing the tax policy with regard to health plans, others believe an expansion of Health Savings Accounts is the way, but more fundamental change, one that allows greater integration of health care delivery and payment systems, is required. That integration is not in the federal proposals, simply because, absent a government takeover and revamping of the entire health system, it is not possible. It is being done at local levels, but there still seems little motivation to do so. Even then, costs may rise simply because of our own bad behaviors, yet no one wants to be penalized for smoking or being overweight and certainly not just being a greater "risk" due to necessary or unnecessary overall plan utilization.

I insist, I am not a polemicist…I don't know what happened there, but now I have come up for air.

What is more important is a review of where we've been, where we're going in the near term and where we seem to be going beyond that. The government has posted regulations and suggestions:

COOPS – non profit organizations which will offer competition to established carriers
Exchanges – what they are, how they are to function, why they are the hope for the future
Essential Health Benefits – what must be contained in plans to qualify for tax subsidies

What is interesting is how all of these are being pushed back to the states for creation, definition, and ultimately administration. The Federal Government admits it has not the money, the time, nor the inclination to get deep into the details of how it should all work – they just passed the law.

Foreword (not to be confused with forward, as in progress, as in we don't know)

"This law will lower premiums. It is limiting costs..it is reining in the worst abuses of the insurance industry with some of the toughest consumer protections this country has ever known" (President Obama)

"A recent analysis by our department shows that the ACA will sharply reduce the cost of health Insurance for millions of Americans" (Department of Health and Human Services)

ACA Pay

Summary

Reform was estimated to save the economy billions and reduce the size of the deficit
Savings remain projected but premiums are unprotected – ACA impact is 3 to 3.5%

Status – cost drivers

Dependents covered to age 26 – even if not tax dependent, even if living elsewhere
No pre existing condition limitations for children up to age 19 (adults in 2014)
No lifetime limits on any charges (annual limits may still apply)
All preventive care is free – no co payments, deductibles, co insurance payments

Future Cost Increases: as government garners revenue, consumers will pay a premium:

Penalties for insurance carriers who do not meet Minimum Loss Ratio requirements
Tax on the pharmaceutical industry
Tax on medical device manufacturers
Tax on insurance carriers in general
Carrier payment for "high value" plans exceeding established premium threshold

Federal government set up a number of programs but failed to appropriate - $150 million
The federal government is the default organization for Exchanges – with no funding

There is a glitch in Medicaid – Social Security income is excluded from setting up the Qualifications for enrollment, which means a number of middle class people will Be able to enroll when they could not previously – anticipated cost of $13 billion

HHS has already given $220 million to 13 states to start their Exchanges
HHS has also rolled out $3.8 billion in loans to non profits to set up and offer COOPs
The Federal budget has a line item of $473 million devoted just to administering the ACA

High Risk Plan: "states are finding that the population of enrollees is even more costly than those in the state based programs that will continue alongside the new federal program"

Solutions

Carriers will strictly enforce the rules on preventive care guidelines
Annual limits may still apply and there is a phase in through 2014
Employers need to be more watchful on dependent coverage and do audits

Taxes and Maxes

Summary

Flexible Spending Accounts will be limited to a maximum of $2,500 per person per year
W-2 must contain information on the value of employee benefits
Tax on “excessive value” of benefit plans beginning in 2018
Medicare payroll tax addition of .9% for the value of benefits for higher income taxpayers
Investment earnings tax of 3.8% imposed for higher income taxpayers
Small Business Tax Credit is now available for qualifying organizations
Schedule A health care deductions must exceed 10% of AGI in 2013
Wellness grants will be provided to qualifying businesses in 2011 - 2015
The penalty for non medical withdrawals from HSA and MSA is raised to 20%
1099 rules expanded for 2012 to include incorporated businesses and services
Health Insurance Premium Adjustment Refundable Credit is permitted in 2014
Discrimination testing for non grandfathered plans – penalties to Highly Compensated

Status

FSA rules take effect with plan years beginning 1/1/13 – Some repeal bills introduced
Over the Counter drugs may not be paid under FSA or HSA without prescription
W-2 rules have been clarified as to what constitutes benefit “value”
W-2 reporting pushed out to January 1, 2013 for 2012 reporting – possibly longer
So called Cadillac tax has not yet been debated – does not take effect until 2018
No debate at this time on Medicare payroll tax nor investment earnings tax
Small Business Tax Credit availed by very few businesses – is anyone testing?
The Schedule A deduction amount remains but is delayed for those 65+ until 2017
No wellness grants have been provided and there is currently no funding (though budgeted)
The 1099 rule has been repealed
Discrimination testing on hold until IRS and DOL can determine and clarify actual rules
Carriers are now stepping in to declare end of grandfathering provisions

Mechanics

Medicare payroll tax applies to earnings over $200,000 ($250,000 married) - no employer match
Investment income is applied to investment earnings exceeding $200,000 ($250,000 if married)
Investment tax on lesser of net investment income or modified AGI (AGI + foreign income)
Net investment income does NOT include: Interest on tax exempt bonds, Veterans Benefits gains from the sale of a principal residence, retirement plan distributions and amounts subject to self employment tax

Tax on “high value” plans 40% of premium over $10,200 individual or $27,500 with dependents Tax on high value plans is imposed not on the consumer but on the CARRIER

W-2 Valuation Includes employee pre tax and dental and vision premiums (if bundled)
W-2 Valuation Excludes contributions to HSA, FSA, and Long Term Care coverage
W-2 also excludes “voluntary plans” -- specified disease or illness or hospital indemnity plan

The Health Insurance Premium Adjustment Refundable Credit:

1) IF employer does not offer plan with actuarial value of at least 60%; OR
2) IF employee share of premium exceeds 9.5% total household income; AND
3) Employee purchases a Qualified Health Plan through an Exchange in home state; THEN
4) Premium credit phased if between 133% and 400% of Federal Poverty Level
5) Credits may be advanced to the employee by the employer
6) Cost sharing credits exist for those enrolled in the Silver Exchange Plan (sliding scale)

The credit is the premium amount divided by scaled percentage times income
Premium assistance is lesser of the premium for individual Exchange plans OR
excess of the adjusted monthly premium for the applicable second lowest cost Silver Plan
divided by an amount equal to 1/12 of applicable percentage times household income

Solutions:

Employers are exempt from FSA maximum if they adopt a “Simple” Cafeteria Plan (groups under 100 employees require either a flat 2% OR the lesser of 6% of each employee’s annual compensation; or twice the salary reductions for each qualifying participating employee)

Discrimination Testing:

1) Raise salary of the Highly Compensated Employees to cover penalty; OR
2) Raise salary and then have HCE reduce pay by the amount of the excess; BUT
3) This latter solution subjects HCE to Cafeteria Plan discrimination testing
   (penalty here may be smaller than under standard Discrimination testing)
4) Does not involve sole proprietor, partner, 2% S Corporation shareholder, LLC member
5) Other option is to opt for lower cost plan option and then purchase supplement
   (though these may be outlawed under the general Discrimination ruling later)

CLASS Lost its…Way – and was dismissed

Summary

Legacy to Kennedy no remedy for ills befalling elderly and relief from their long term cares

Subscribers would pay premiums for five years before they could collect
Annual premium would be based on an actuarial analysis stretched over 75 years
Exceptions in projections allowed much later, but not for those paying in for 20 years
Benefit would only be $50 per day, which is not nearly enough to cover typical needs
Policies issued on a guaranteed basis to anyone that wants them

Status

This was attacked fiercely by not only Republicans but objective economic observers
The initial funding for the infrastructure was suspended
HHS said they were not supporting the program any longer – though it is THEIR program
The Administration said they have not abandoned hope – just the program

Mechanics

It was to be a voluntary program communicated and sponsored by employers
But both voluntary and guaranteed would have only drawn the riskiest population
Vicious cycle of cost associated with risk would further drive up cost which dooms the plan
(despite the promise of a 75 year actuarial projection)

Solutions

The CLASS Act did bring attention to a class of consumers that may need such coverage
Long Term Care is not just for elderly but for any that may be infirm – think Christopher Reeve
There are long term care deductions allowed for employer or consumer paid insurance
The W-2 valuations will not include payments for Long Term Care
Long Term Care insurance can also be purchased with HSA funds

Mandate Update

Summary – all rules in 2014

Individual: All US citizens must have purchased minimum qualifying coverage by 2014
Group: Organizations with 50 or more employees must offer coverage or pay a penalty
Carriers: Must issue coverage on a guaranteed basis with no pre existing limitations
New rating rules pertaining to age, geography, tobacco use and dependents

Status

Individual mandate objections have been brought forward in several Federal suits
Decisions of the courts have varied based on particulars of the cases, favoring both sides
The major case, joined by 26 states, is now before the Supreme Court
Major claim is that Congress has exceeded their authority under the Commerce Clause

This also becomes a referendum for states' rights, or federalism, vs. federal rights themselves,

Mechanics

Individual: buy acceptable coverage (not yet defined) or pay a penalty.
Penalty is greater of $95 (in 2014) or 1% of annual household income
Penalty is greater of $695 (in 2016) or 2.5% of annual household income

Consider a 50 year old person with an annual income of $100,000. A typical health insurance premium for a standard PPO plan would easily run $3,500 per year now. By 2014 it could easily be $4,200. In 2014, if they went without coverage, the penalty would be either $1,140 or $1,000 and thus $1,140 BUT by 2016 it would be $8,340 or $2,500 and thus $8,340 not to mention the accumulation of previous years without coverage (which would total $14,220)

Group: There are a number of exceptions and requirements here:

1) IF group has 50 employee UNITS (part time employees are counted using a formula)
2) IF that number of units was in place for more than 120 days during last calendar year
3) IF at least one employee receives a government subsidy for health coverage
4) IF the employer does not offer "minimum essential coverage"

THEN

Employer pays penalty for each full time employee UNIT (after subtracting the first 30)
that is the lesser of $2,000 annually OR
number of full time units getting subsidies x $3,000 annually

Employers are also required to provide a "free choice" voucher to qualifying employees
Employees must enroll in a plan offered by the Exchange to qualify for voucher
Voucher is tax exempt and equivalent to what the employer would have paid for any coverage.

Qualifying income is generally defined as sliding 8 to 9.5% of household income

Carrier: mostly concerns rating rules:

1) Age spreads may not deviate beyond 3:1
   (has effect of younger people paying more to subsidize older who will now be paying less)
2) Geography will be a factor, with areas to be set by the state
3) Smokers may be surcharged, but not more than 50% of the base premium
4) Family structure allows some latitude – either use a four tier or three tier system

Solutions:

The only remedy for individuals will be in the courts
For groups, some movement for those coming close to 50 to outsource services
(we have seen this in San Francisco, which has a mandate for groups of 20 or more)

Plan Plans

Summary

HHS has promulgated rules on rate increases - and California may try this as well
Carriers may not collect more than 20% for administration, profits and taxes
Part D Medicare Prescription Drugs are now subsidized by the federal government
Each state is required to set up Health Care Exchanges or default to a federal solution
Non profit COOP plans may also be created for the distribution of health insurance

Status

New HHS rules have a threshold of 10% rate increases in group and individual markets –
Violators will have names posted on www.healthcare.gov web site
California AB 52 made the threshold a mandate but it failed to pass – may come back
Medical Loss Ratios: carriers now sending information requests to small groups
Debate continues on MLR definition of administrative expenses – does it include broker fees?
Part D subsidy raised from $250 to 50% of the cost of drugs falling in the "donut hole"
California first state to pass enabling legislation for the creation of a Health Care Exchange.
Guidelines for multi state COOPS promulgated – some state activity to create new carriers

Income for purposes of voucher qualification now defined as employee W-2
(previous rule would have employers trying to determine an employee's household income)

Mechanics

The "limit" on medical increases only requires carrier to post explanation on a public site
(which gives more impetus to California movement to legally require such limits)

Medical Loss Ratio requirement is that carrier spend at least 80% of premium on claims

The Exchanges have a set of rules:

Individual plans are called American Health Benefit Exchanges
Group plans are called Small Business Health Options Program (SHOP)
Federal subsidies for plan creation are available through the first year (2014)
Eligible are those without access to "affordable" group coverage nor Medicare/Medicaid.
Eligible small employer is under 100 employees (may be under 50 in 2014 and 2015)
Qualified Health Plans in Exchange must have Minimum Essential Benefits Package
Five plans offered with varying values – Bronze, Silver, Gold and Platinum and Catastrophic
Deductible limits in a SHOP group plan exchange may not exceed $2,000 per year
Plans sold outside exchange may be Qualified – non profit COOP, multi state, direct care
Networks must have Essential Community Providers – for low income, medically underserved
Subsidies for plan participants only available to those enrolling within the Exchange

Solutions:

Carriers employing new set of strategies to avoid problems with rates and MLR:

Cutting back or altering plan designs while raising rates
Movement to new rules to allow more monitoring of prescription drug costs
Discontinuing plans that are no longer meeting profit projections
Declaring some plans no longer grandfathered to avoid further confusion and pool mixture

Expansion on Exchanges:

We must first consider the issuance of a report on the rules for setting up COOPs, which will not be exchanges but may participate in them as a competitive carrier. About these, the HHS said "these consumer run, private nonprofit insurers will be a vehicle for providing higher quality care that is affordable, coordinated and responsive" OK…now they just have to set them up so we can see.

Exchanges are also fairly new, but at least there is some history with these. Though they failed in California in public, there is a successful privately run Exchange (California Choice) though one major carrier (Kaiser) continues to take a bigger and bigger portion of participation.

The first rule for Exchanges and "qualifying plans" for tax credits is that they offer a package of Essential Health Benefits. This was to have been set by the Federal government, but at the end of 2011 they issued technical guidance that deferred definitions to the states. While still needing to abide4 by the 10 basic coverage categories outlined in the ACA, the "benchmark" plan must be:

1) One of the three largest small group plans in the state by enrollment; or
2) One of the three largest state employee health plans by enrollment; or
3) One of the three largest federal employee health plan options by enrollment; or
4) The largest HMO plan offered on the state's commercial market by enrollment.

There are set categories in the ACA, and there is also a requirement that states defray the cost of their own mandates in excess of the Essential Health Benefits to see efforts by states to back into the "benchmark" plan that incorporates the highest number of the state's benefit mandates.

Following is a summary from a Federal Government White Paper on Exchanges issued in 2011

Introduction

For individuals without affordable employer sponsored coverage, health insurance exchanges will help make coverage accessible and affordable. Exchanges serve an important role for employers, who can use exchanges to give employees a meaningful choice of health plans and moderate the ballooning costs of providing health insurance. There is already reliance on private exchanges for Medicare eligible retirees and provisions in the ACA make certain exchange enrollment will grow.

Purpose

Exchanges are a centralized service whereby individuals can compare and purchase qualified health plans. Exchanges will certify health plans based on standards for covered benefits and provider networks, and assign quality ratings to promote transparency and accountability. Those without employer coverage will rely on exchanges to determine eligibility for Federal financial assistance and public health programs. Employers may send employees to an exchange with financial assistance to meet coverage responsibility or make insurance affordable for employees.

Healthcare.gov quote “An Exchange is a mechanism for organizing the health insurance marketplace to help individuals and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality. By pooling people together, reducing transaction costs and increasing transparency, Exchanges create more efficient and competitive markets for individuals and small employers”

Impact on Employers

Employers who send employees to exchanges for coverage will be able to limit employee plan selection to one plan, plans within one coverage level, plans from multiple coverage levels, or allow employees to enroll in any available exchange plan. Employees who access employer sponsored coverage through the exchange will benefit from the personalization of individual health plans, freedom of choice and the value of an open market Another benefit for employers who send employees to an exchange is the security in knowing that the exchange health plans are certified to offer minimum coverage levels and adhere to insurance reform rules in the ACA

Exchange Functions and Operations

The primary customers of exchanges will be individuals and employees enrolling in a health plan with the support of robust and interoperable online and call center technology. Underlying the exchange’s Internet website and call center will be electronic integration with participating carriers.

Integrated Website and Call Center: online cost calculator, side by side plan comparison, standardized benefit display, decision support tools, etc.

To guide individuals through the eligibility, plan selection and application process, exchange websites should give individuals a secure account where they can store their personal information. This information fuels decision support tools that filter plans based on individual preferences and medical needs. A toll free telephone line will be available for individuals who prefer to talk to an advisor about their choices, or for those who need extra support as they navigate the web site. Interoperability of the website and call center is critical to a successful customer experience.

Governance – states to use one of two models

Active Purchaser – uses market leverage of enrollees to evaluate plan bids and selectively offer plans or negotiate to restrict cost growth of plan offerings (e.g. Massachusetts)

Market facilitator or open marketplace – exchange relies solely on qualified health plans meeting minimum standards for entrance into the exchange, and allows market forces to set plan premiums (e.g. Utah)

Conclusion – Exchanges have 4 values: Flexibility, Value, Decision Support and Freedom

STATE STUMBLING

I did my own stunts
(Peter Falk 1928-2011)

I haven't read any of the autobiographies about me
(Elizabeth Taylor 1932-2011)

I can't afford to die. It would wreck my image.
(Jack LaLanne 1915 – 2011)

Code Brown! We're going down! Not flush with cash we'll drown
Swimming in a sea of debt that laps on quaking shores
Jerry rigged solutions absent guilt's ablutions
Present our pols with polls that show that tax and tolls
Will tarnish all the luster we bear beneath the bluster
Dollars dolors color visions ever duller
Of a grizzly end to spending all our once golden stores

Other states hesitate, awaiting federal fate
Exchanges change the funding game and their common sense
Obama causes drama, a federal diorama
Built to stage in stages so parties may engage
In vacillating moods and prepared platitudes
That matter more than manners or attitudes of planners
Bucking trends, fawning for dough, in debt's best rate defense

Medicaid soon might fade courting fears unalloyed
By the Supremes chiming in amid disharmony
But states won't wait putting weight in pulling rates
And designs with new fines and cuts behind the lines
When co pays raise with ways to manage means to faze
Miscreants who can't chance losing spots to enhance
The odds of getting care while they kiss our money (goodbye)

Single payer lacks a prayer but Leno makes us laugh as he says we spend the money in a way that's kind of funny but for which we get no credit. The blame falls on the carriers who claim expense calls for raises but praise is at a premium despite what pass for medium adjustments. Legislative will was weak but our Commissioner still seeks a way to limit pricing which sounds like it's enticing until companies start dicing designs to find some signs of profit lurking. Some plans will improve but may prove too costly to move as autism gets attention, maternity grows and the Feds let states stand in their stead while deciding what's essential.

Counties are a breeding ground for new found methods to rebound from responsibility. Our area holds HRAs at bay and LA has a say in Fed funds disposition through its imposition of a new "Healthy Way" – and so go society's ills, as the mills of mediocrity grind new bills that have no hope of passage as they adit to the pile. It would make you smile were there hints of humor but we are in a serious state.

Sacramento

No more moonbeams, he is serious it seems, and succeeding in alienating everyone with a draconian budget that Jerry Brown crowns the only way to get us back on track after years of inhaling fiscal crack. Medicaid got waylaid to the tune of $1.4 billion even as the Feds cut the odds and filled our hods with mor tarrific funding even as they seek to make their own ends meet.. Such a feat will end up displacing many doctors who are facing threats to overcome debts that all concur will occur from Medicare and Medicaid reductions. California could also change direction and carve out a section of what is paid to have the responsibility laid at the feet of those using services rather than those handing them out, but that would put in doubt the ethos of having the rich stitch the safety net, thus weaving a more insidious web of debt from which we suffer, allowing us to keep following our station as one of the poorest states in the nation in terms of health care spending

There are also attacks to form a tax to soak the rich who are still defined, in what some earlier lined, as civilians earning a quarter million. As if the top tax rate doesn't rate enough disfavor, the hike has enough flavor to entice some to heed advice that others should foot the bill. At least there are some egalitarian parliamentarians who say a sales tax would offer equal whacks to everyone.

These are costs that affect us on a backwards basis. Moving forward:

1) Individual health plans must now cover maternity (only 12% do so now)
2) A core cost of autism treatment must now be covered by plans from 2012-2014

The Rand Corporation takes the stand that the ACA will help allay the health care fears of 6 million Californians gain coverage but will cost the state an additional 7% in total health care spending when fully implemented in 2016, mostly due to Medicaid costs (despite the proposed budget cut)

Of course, we could solve all this with a Single Payer solution – but wouldn't it help if we could balance our budget before spending what is estimated to be $200 billion for a state program?

Health Care for All says “single payer has gone from how it might solve the health care problem in California to now being the way to solve the fiscal crisis in California” Sponsoring Senator Mark Leno says that we spend the $200 billion proposed already – so why not spend it through the government (what logic am I failing to follow here?)?

Assembly Bill 52 dissembled some of the facts that caused its failure, proposing that imposing a max on carrier charges would change their ways. It nearly made it, but they misplayed it and have to try again. The law would follow what the Feds allot, which is not a lot with limits at 10%. The national edict is not too strict with threats to cite some names on their web site. The local law would lack this flaw and fine those who define their increases above the line. Now its held that Harvey Rosenfeld, who propped up Prop 13, will do a number on those who each year act dumber by not seeing employer fleeing and flaying employees with a greater share of cost.

Not wanting to be caught napping, carriers started capping their rates, mapping a strategy that may rout the route of legal bootstrapping. Rates fell below the level set so we can revel in an interim solution. Of course, what carriers lost in cost is tossed in with their calculations resulting in creation of new plan designs and pools. Money does not just appear but we fear it will fall on us all to come up with any difference.

Elsewhere:

Other states in the nation are troubled, as health costs have all doubled, and now they can’t be sure if they want to change Federal money for Exchange creation, or just ignore the fact of Affordable Care Act (as if they could). Some have publicly denounced the funds but not renounced them, still trying to deal with how the wheels of justice turn with pending suits sending hopes of coming out ahead. So they form Exchanges to conform but keep their options warm to avoid the heat they’d face if things go wrong.

Utah’s plan is doing well, but the Bay State’s may soon go to...somewhere else besides the way the tides are turning, with deficits now earning greater interest. It’s what concerning Mitt, who says he had nothing to do with it, even though the signed what others had designed to allow the government to insure those who were meant to be covered all along.

And speaking of the Bay, our area still has its say in the unusual way they force businesses to pay for what employees need but have not themselves decreed of prime necessity. Restaurants add to their bills, forcing patrons the cost of ills that befall those who no longer wait for services the city offers to those who line their coffers with money added to their daily wages.

San Francisco: Change in City Ordinance – January 1, 2012

1) A contribution to HRA or HSA that is not paid irrevocably to a third party will NOT qualify as a health care expenditure UNLESS:

   a) It is calculated to benefit the employee
   b) It remains available to the employee for at least 2 years after the employer funds the contribution
   c) Any unused balance from the 2011 account carries over to the 2012 account
   d) The employee receives a notice within 15 days after the contribution is made that provides:

      Name, address and phone of any third party to whom the contribution is made
      The date and amount of the contribution
      Changes to the account balance since the last account summary was provided
      The current balance in the account
      The applicable expiration dates of the fund in the account

2) If an employee voluntarily or involuntarily terminates employment and has a positive balance in his or her account:

   a) Any balance available for reimbursement must remain available for at least 90 days after termination; and
   b) Within 3 days after termination, the employer must notify the employee of the current account balance and the applicable expiration dates of the funds in the account

3) Employers that use an HRA to comply with the ordinance must report to the San Francisco Office of Labor Standards Enforcement the terms of the HRA, including the expenses eligible for reimbursement

4) Covered employers must conspicuously post a notice at any workplace or jobsite where covered employees work, informing them of employee rights and employer obligations under the Ordinance. The notice must be available in English, Spanish, Chinese or any other language spoken by at least 5% of the employees at the worksite. The OLSE will make such notice available each December 11, 2011

5) Employers that impose a surcharge on customers to cover any part of the health care expenditures under the Ordinance must file an annual report with the OLSE. If the amount a covered employer collects from the surcharge exceeds the amount spent on health care, the employer must pay or designate the difference for health care expenditures for its covered employees. This payment or designation is irrevocable

BUSINESS BUMBLING

Now that I know what I want, I don't have to hold on to it quite so much
(Lucien Freud, 1923-2011)

Computers make it easier to do a lot of things, but most of the things they make it easier to do don't need to be done
(Andy Rooney, 1919-2011)

There is no reason for any individual to have a computer in his home
(Ken Olson, 1926-2011 – but his computer company, DEC, predeceased him)

Hedge funds were trimmed yet prospects dimmed
That a sure stop to a sheer drop
Would lighten the mood on Walled Streets
Hopes of a minor recovery accompanied the discovery
That statistics employed found fewer jobs destroyed
Thus mined us a plus on balance sheets

The Euro is trashed then Greece burned and crashed
The thread of Italian suits follows Silvio's pursuits
Merkel's boner keeps countries off base
News of the World unfurled hacking apart what sons whirled
The Cameron the Brits gave the PM mourning fits
All beyond their perfidious place

The ACA won't pay its way, so many more employers say
Worker contributions lack sufficient capital to crack
The hardened heart of health care inflation
While it is slowing, it fails to cease growing
Cost controls can't check the savings we wreck
From disinterested observation

It should be clear that among the cause of the recent financial crisis was an unjustified faith in rational expectations, market efficiencies and the techniques of modern finance. That faith was stoked in part by the huge financial rewards that enabled the extremes of borrowing, the economic imbalances, and the pretenses and assurances of the credit rating agencies to persist so long. A relaxed approach by regulators and legislators reflected the new financial zeitgeist

(Paul Volcker, very much alive, opinionated and quoted in the New Yorker in 2011)

What grew from a financial void we managed to have destroyed despite the unalloyed greed that weakened our position. Calamities paired with pieties while property was a casualty and insurance paid $100 billion. Vermillion becomes the primary color when black won't come back and rumor of a recovery humors the masses except the classes most affected. Some still carp about TARP and the political cover it offered, but prophets proffered better times by now yet profits don't appear.

Tax breaks don't generate interest but gains in weight will not abate and lower greater output. AARP is probed, court cases disrobed, and Congress prodded and poked, but no one joked with growth going unstoked, revenue tanking and fewer institutions banking on giving business needed funds. Government almost ceased to function, MF Global was given extreme unction and the Supercommittee failed to fix the system's flaws, old tax laws or even the clause that would lead us to the brink again. We think a leading edge is good but when we stood looking over ledgers that bled, what was going through our head – and even now, when the Dow seems bound to rebound, does it redound to our credit when we continue to be at a loss?

Carrier News:

When Dave got a Jones for commissioning a law that would dictate carrier costs, guess who got nervous and suddenly found a way to reduce the amount we pay so they could say they did not need to be regulated? The extreme seemed like a dream when Blue Shield decided to yield a lower "profit" *(yes they are non profit) and actually return money to their subscribers. This may mess up many books but at least it looks good to those who feel they are prescribers of what is right and wrong in the long run. Other carriers somehow followed suit and in pursuit of narrower gains but more afraid of he who reigns, they reined in their rates as well, coming in below 10%.

Of course, with gain comes pain and we saw designs laid more open to interpretation, interpolation and interesting changes which actually give and take and you have to be awake to see where. It also allows them to create new pools within which they play us like fools thinking that we're drinking from the same well, which we can ill afford. When the heat is off so go the gloves, and rates may once again see raises in the double digits, which we may give them in return.

"Everyone has a photographic memory; some just don't have film (Steven Wright)

Employer Views:

Even employers get into the act, playing with what employees are paying by raising the amount required and, in a performance inspired by the ACA, breaking out the way they charge for newly covered dependents (unit rather than collective pricing for each covered family member)

What's odd is that in the end some employers still spend too much, based on designs that impose fines for better benefits (when related to their less expensive brethren), opting against HSAs and even ignoring ways to get some credit for what they offer (the Small Business Tax allowance only generated $278 million when the ACA budget anticipated returns of over $2 billion)

McKinsey sent a study to seemingly everybody that 33% would drop coverage due to the leverage provided under the Affordable Care Act. Their results were in dispute, and they gained some disrepute, but others say that plans will get the boot once we see what can be Exchanged (Towers Perrin floats 10%, the Urban Institute cites a higher number, Market Strategies edges toward 9%)

Inflation Clues:

As usual, rates will still increase but there is instilled some peace of mind about the kind of numbers we'll be seeing. Ranges vary (big surprise) but the general compromise is that costs have risen 6 to 8% in the past year.

There is also a report on how generics will be branded for their failure to save money:

1) Drug recalls and plant shutdowns have reduced drug supply
2) More manufacturing from overseas of the raw material needed, which increases volatility
3) Generics are now so cheap that manufacturers say they are not even worth making
4) As brands expire drug companies seek to make money elsewhere

So despite how carriers fight for how we might save them money, their solution has precipitated additional concerns.

AARP Abuse:

We wouldn't carp about the way they fish for compliments within the complement of who seem too old to notice…oh, wait, I am in that state and did see the many notices posted about their support for what purports to be a gain for "senior citizens" Early in the fray, they backed the ACA, and now Republicans want to investigate AARP's actual state of financial participation with their plans. They say that the organization, to be blunt, is nothing but a front for those they "endorse" This probe will not soon run its course but of course they will deny it…expect more fliers calling Congress liars..

Wall Street Blues:

MF Global bet the farm but investigators aren't even warm in finding out how much harm was done to those that thought what Corzine wrought could pay back what they bought…if they could only find the money many sought which it's feared has disappeared.

A Final Word – Quote from Business Week about Insurance Pique:

No other market has all the characteristics of health care. Customers don't know exactly what they need or sometimes how to obtain it. Their decisions affect others, competition is limited, medical care is unavoidable, expensive and can't ethically be denied, costs of care are routinely shifted onto people or institutions with deeper pockets"

So of course a federal challenge to how we pay for care can't help but work…

LEGAL JUMBLING

Design is not just what it looks like and feels like. Design is how it works
(Steve Jobs 1955-2011)

I am too weary to listen, too angry to hear
(Daniel Bell, 1920-2011)

There is a distinction between fact and truth. Truth has an element of revelation about it. If something is true, it does more than strike one as merely being so
(Lucien Freud, 1923-2011)

We can't stop now, in the name of law's love
Supreme Beings rule from high courts above
Despite appeals giving labor a shove
They'll decide on precedence
Not the needs of Presidents

Mental Health Parity is permanent
But no one knows what the Labor Board meant
W-2 rules are in a state of ferment
DOMA dooms its preference
ERISA looms in deference

To carriers who will administrate
HHS throws benefits to the state
ADA charges what will mitigate
CA expands maternity
And I/C get a penalty

Reform requires a stand alone section
Exchanges can change your plan selection
CLASS dismissed after further reflection
Mirroring moods of dissension
Who vote against retention
Of what merited much mention
Creating public tension
Which will carry to the next election

The road to perdition is paved with erudition streaming forth from steaming scholars who are screaming for their dollars at the doors. The Supremes will Court debate over individual mandate and some feel it's too late to stop Obama any more. They can pull judicial lever to get the rule to sever or decide to simply kill it all at once. Arguments will soon be heard, which will augment the written words of many who weigh in when they have no way to win or lack sufficient standing in the hunts – for clarity, morality, equity or what will tease the Tea Party which is sworn to law's defeat. No matter what the bench decides both parties have to wrench aside their differences instead of beat retreat. A ruling can affect the polls and no one wants to play the roles required for Republican extremes. They may sing in unison but regardless what is done we will soon preserve protection by Supremes (unless they throw it out, leaving endings still in doubt which means we'll hear resounding the same themes – and in the next election can we count on course correction or will anything be like it never seems?)

With legal gladiators clad in arguments both good and bad we have a chance we've never had to debate about whether a mandate is a necessary thing or if freedom extends even when others spend to support our folly. But will we ever be able to sever the facts from legal fiction since despite political friction there seems to be conviction that those we will not play should be made to pay in one way or another? Many states do not agree and most state we are free to choose what plans we use or even if we play the odds that surprising ends justify a lack of means. A major suit is in pursuit of who can have the right to fight for federal law or federalism. States stake their claim and assess the blame for Medicaid on jaded politicians who elect to use the premise that their promise to the poor can not properly endure the crush of patients rushing for their care. They'll take it even further stating costs that they incur were not intended by the law at all.

The Supreme Court is asked to take up two issues that concern individual freedom, state rights, the reach of federal law, and whether the ACA itself can be taken up in pieces or as a whole:

Medicaid – Does a state have a right to impose their own budget restrictions on a program that is decreed and run (under the Center for Medicare and Medicaid Services, CMS) under the auspices of the federal government. Since the state has to provide a substantial amount of the funding, they argue that they may control its allocation more fully. The Federal government, of course, imposes the merits of a higher social order which underlay the foundations of Social Security, Medicare and Medicaid originally. Whether a welfare state is what we want is for greater minds to ponder.

Affordable Care Act: The key issue under consideration is the individual mandate, which 26 Attorneys General said was under the purview of the states and not the federal government. There have been several District Court decisions with varied circumstances all seeking to overturn this aspect of the law (and with varied results), taken up on Appeals (with the Florida decision being the one that is formally under consideration) which also split on their findings

Here are the highlights:

*Florida – findings of Judge Roger Vinson: "*Because the individual mandate is unconstitutional and not severable, the entire act must be declared void…regardless of how laudable its attempts may have been to accomplish these goals in passing the Act, Congress must operate within the bounds established by the Constitution"

Issues raised in this decision:

Severability: What is the scope of Congress to enact a law under current Constitutional strictures
The law was somehow passed without a severability clause, which means that if one part is found to be unconstitutional, the entire law is unconstitutional

Further Florida "It is not really about our health care system at all. It is principally about our Federalist system, and it raises very important issues regarding the Constitutional role of the federal government"

Issues:

States rights on regulating insurance or health care (basis for Attorney General suit)
Virginia had actually given their citizens the legal right not to buy insurance

Commerce Clause: does the purchase or failure to purchase health insurance have an impact on commerce, and is this strictly held as a state issue or does it cross state lines? The Supreme Court has repeatedly made clear that Congress can regulate any economic activity and even noneconomic activity when doing so is an essential part of a larger regulation of such activity. Further, a citizen who decides to forego medical coverage affects markets since very few can afford to pay a major claim when it happens (and hospitals and medical providers must shift the loss they suffer, since they are required to treat, to others who can pay) The Commerce Clause was invoked as early as 1824 but it was *Wickard v. Filburn*)1942) that gave it currency

Necessary and Proper Clause: Judge Vinson does not believe the power of Congress includes invocation of this clause when it comes to health care. The clause refers to powers that may not have been granted by the Constitution but are "necessary and proper" to the exercise of these powers (e.g. *McCulloch v. Maryland* allowed the US to create a bank during the term of Chief Justice Marshall and reaffirmed in several other decisions since)

Virginia – Judge Hudson – allowed Virginia to claim standing to defend its own nullification law and also said that the law was a penalty and not a tax (citing 1922 decision on child labor)

Issues:

State Rights: The Supreme Court has long held that states cannot challenge the constitutionality of a federal law in the abstract, but Hudson said it was clearer than that

Power to Tax: the mandate could be held reasonable when considered as part of the power Congress has to tax, but President Obama initially said it was not a tax (and later changed his mind) and Judge Vinson supported this, saying that the mandate is a penalty and not a tax

Appeals Court – reviewing Thomas More decision: "Regulating how citizens pay for what they already receive, never quite know when they will need, and in the case of severe illnesses or emergencies generally will not be able to afford, has few parallels in modern life. Not every intrusive law is an unconstitutionally intrusive law. Time assuredly will bring to light the policy strengths and weaknesses of using the individual mandate as part of this national legislation, allowing the peoples' political representatives, rather than their judges, to have the primary say over its utility"

"the requirement that all citizens obtain health insurance does not depend on them receiving health care services in the first place. Individuals must carry insurance each and every month regardless of whether they have actually entered the market for health services"

USCA 8th Circuit Brief filed by California AG Kamala Harris and 9 other Attorneys General:
"The law strikes an appropriate, constitutional balance between federal and state authority over the health care system. It establishes federal standards, backed by federal funding, to expand access to affordable coverage while conferring considerable latitude on states to design systems that work best for their citizens" (and guess which state was first to set up an Exchange? Bueller? Anyone?)

Bachman vs. US Department of Health and Human Services and US Department of Treasury
"This case concerns the precise parameters of Congress' enumerated authority under the Commerce Clause of the US Constitution. Specifically, the issue is whether Congress can invoke its Commerce Clause power to compel individuals to buy insurance as a condition of lawful citizenship or residency. The court concludes that it cannot. The power to regulate interstate commerce does not subsume the power to dictate a lifetime financial commitment to health insurance coverage. Without judicially enforceable limits, the constitutional blessing of the minimum coverage provision would effectively sanction Congress' exercise of police power under the auspices of the Commerce Clause, jeopardizing the integrity of our dual sovereignty structure"

"(re 6th Circuit)…the unprecedented nature of the individual mandate, its broad scope and the congressional findings supporting it, the court concluded that the individual mandate embodied no limits and exceeded Congress' Commerce Clause powers. For the 11th Circuit, the federal government's assertion of power, under the Commerce Clause, to issue an economic mandate for Americans to purchase insurance from a private company for the entire duration of their lives is unprecedented, lacks cognizable limits and imperils our federalist structure. The court therefore affirmed the district court in striking down the individual mandate as unconstitutional."

Legal News You Can Use:

EEOC Revisions to the Americans with Disabilities Act

Broad Concepts:

1) The definition of disability – an impairment that poses a substantial limitation in a major life activity (MLA) – must be construed in favor of broad coverage of individuals to the maximum extent permitted by the terms of the ADA and should not require extensive analysis
2) MLA includes "major bodily functions"
3) Mitigating measures such as medications and devices that people use to reduce or eliminate the effects of an impairment, are not to be considered when determining whether someone has a disability and
4) Impairments that are episodic or in remission, such as epilepsy, cancer, and many kinds of psychiatric impairments, are disabilities if they would "substantially limit" MLA when active

Under the ADAAA, an individual is "regarded as" having a disability if:

1) An individual establishes that he or she was subjected to an action prohibited under the ADA (e.g. demotion or employment termination) and
2) The action was taken because of an actual or perceived impairment whether or not the impairment actually limits or is perceived to limit a major life activity

Impairments that will consistently meet the definition of a disability are defined:

Deaf, blind, intellectual disability, partially or completely missing limbs, mobility impairments requiring the use of a wheelchair (a mitigating measure), autism, cancer, CP, diabetes, epilepsy, HIV/AIDS, MS, MD, major depression, bipolar disorder, PTSD, OCD and schizophrenia

Generally:

1) Major life activity is defined through a lengthy but non exhaustive list of examples.
2) Deletes prior references to basic activities that most people can perform fairly easily
3) "substantially limits" is not defined, but several rules of construction are provided
4) Any notion that a substantially limiting impairment must last 6 months is rejected
5) Episodic impairments are to be analyzed in their active states
6) Mitigating measures may only be used to determine if an individual is qualified, poses a direct threat to safety or needs a reasonable accommodation
7) Drops reference to surgical interventions as mitigating measures (too confusing)
8) Reemphasize importance of an individualized assessment in determining whether an impairment is substantially limiting, giving examples and dropping those that would apply to some but not to others
9) Add the concept of "condition, manner or duration" to expand instances in which an impairment would be deemed substantially limiting

10) To determine "substantially limiting" – in major life activity of *working* the concept of an individual being unable to work in a class or broad range of jobs has been resurrected
11) Whether person has a record of an impairment that SL a MLA is to be construed broadly in favor of finding coverage under the statute
12) Individual who is "regarded as" having a disability must also show they were qualified for the job and prove discrimination due to a perceived impairment. EEOC states that the issue is simply too complex for regulations.
13) If a disability is not apparent or obvious, employers may request supporting medical information and individuals requesting accommodation must provide such information
14) There is no cause of action for reverse disability discrimination

Defense of Marriage Act (DOMA)

Though signed by a Democratic president the current Administration said they would not defend its constitutionality in recent pending cases, essentially meaning that lawyers seeking to uphold DOMA's forced inequality must be prepared to more fully justify the government's preferential treatment of heterosexual married couples

ERISA

An insurer may be sued for benefits when acting as the de facto plan administrator
(in this case, where a carrier decided who would qualify, or not, for disability benefits)

Mental Health

Parity law is now permanent, requiring health insurance plans to treat mental health conditions as "any other illness"

National Labor Relations Board

Though having a rocky start, final rules were implemented saying that all businesses must post notices informing employees of their right to form a union

Wage Reporting

All employers must provide non exempt employees not subject to Collective Bargaining:

1) Rate of pay – hour, day, week, shift, piece, commission, overtime
2) Allowances claimed as part of minimum wage, including meals and lodging
3) Employer designated pay day
4) Employer name and dba, physical and mailing address, phone number
5) Name and address and phone number of Workers Compensation carrier
6) Notice of any change in any of this information within 7 days of the change

W-2 Wage Reporting

Seems to be required for 2013 reporting for 2012 wages but new rules may still allow this to be voluntary. Guidelines have been published on what is counted, however. Essentially, it applies to health care premiums only, whether based on employer or employee contribution. Exempt are: Dental and vision not integrated into medical, self funded not subject to COBRA, W-2 furnished before year end at employee request, Long Term Care, General Liability, Excepted HIPAA benefits (long and short term disability, supplemental liability, accident), Workers Compensation and any contributions made to FSA, HSA or MSA

CALIFORNIA

Independent Contractors

Penalties ($5 to $25,000) for willfully misclassifying an employee as an independent contractor

Pregnancy

Employer with five or more employees as of January 1, 2012 must pay 4 months of insurance premium (employer share) when an employee takes a pregnancy disability leave