JORDAN'S JOURNAL - 1997 ENTRY

There has been a persistent lack of demand
(and more than one client's direct command)
For poetry when I write.

Some say "be serious - you're not on stage"
Save your alleged wit and charm for the coming Web page
It's criticism you'll invite.

My own opinion is that it is a crime
If you can't make the dance of legislation rhyme
And that way shed some light.

So what can I say? with no clever retort
I'll try not to be funny there's too much to report
Writing's an urge I don't want to fight.

In an explosion of exuberance, last year I exhaustively exhumed and examined the extreme exigencies of legislative exactitude. Well, not exactly. But expect fewer such expectorations this year.

We follow much the same format as last year, but since consistency is the hobgoblin of little minds (and I can't find my notes) we'll do it this way:

Federal: Dole lost but Republicans won
Three new laws passed now we got fun

State: We try to warn ya in California
What starts here is Federal law next year

Trends: While legislation seems to take some nerve
It's path is behind not ahead of the curve

Outlook: A synthesis, a synopsis, a syllabus
A look at what's to become of us

Agency: Improving the old, introducing the new
To find better ways to give service to you

FEDERAL FOLLIES

If con is the opposite of pro, is Congress the opposite of progress?

Old Bob Dole was not a merry old soul
But how merry could Republicans be?
Clinton outpointed Dole in every poll
And rolled on to victory.

While the President moved to moderation
The Senator lacked articulation
The parties split wins in a power struggle
With too many legislative balls to juggle

Will Newt get the boot in his ethical plight
Will the House go left or more to the right?
Will the Senate cast their Lott with Trent
Or will reform take on a more liberal bent

It may all depend on Clinton's presidency
Or how well he establishes his residency
As those around him begin to fall
On hearing the prosecutorial call

They wanted to pillory Hillary calling her health plan detrimental
What's in store, can they do more, with an approach incremental?

I think that all ordinary, decent people are sick and tired of being told that ordinary, decent people are fed up with being sick and tired. I'm certainly not. But I'm sick and tired of being told that I am.

Republicans actually tried to live by their "Contract with America"
Without the other party's signature, this became "Conflict with Democrats"
Republicans' original electoral headlock gave way to political gridlock.
The Congressional budget showdown turned into a financial meltdown.
For their plans to save Medicare, Republicans were termed Medicareless.
The Budget balancing act then suffered because too many balls were in the air.

In the midst of this legislative rubble there emerged significant health care reform. The Health Insurance Portability and Accountability Act of 1996 was important not just for what it did but what it meant:

1) Eliminated or minimized some of the injustices often found in insurance
2) Set ground rules for market conduct without stifling innovation and freedom
3) Recognized the need to indemnify seniors against high nursing home costs
4) Followed the lead initiated by many states on health care delivery issues
5) Allowed individuals to take some responsibility for their health care expenses
6) Signaled a new spirit of cooperation absent since the Clinton health plan debate
7) Created a framework for a flexible, gradual approach to health care legislation

Or maybe it was all a dream. Consider:

1) What could be hipper than HIPAA (The Health Insurance Portability and Accountability Act)? Introducing "Son and Daughter of HIPAA":

   a) Hospital maternity stays must be a minimum of 48 hours
   b) Mental health benefits must be paid the same as other medical situations

   Both measures, while expanding coverage, will also increase its cost.

2) You've read the book, now see if you recognize the movie:

   HIPAA requires a series of defining regulations and compliance by carriers, states and employers, all within a very short period of time.

   Legislative gridlock becomes bureaucratic hammerlock, and invites more conflict and confusion with so many diverse organizations playing administrative "telephone."

3) They're being evasive about their pervasive invasiveness:

   This is a major federal incursion into what has traditionally been the province of state governments. Similar to corporate downsizing, it gives the states more work and requirements with less pay and responsibility.

4) Brother can you paradigm:

   Some consider this a "new paradigm" to invest the federal government with further, yet more obscure, involvement in the lives of its citizens.

   The wolf of the Clinton Health Security Act is back at your door, only this time wearing sheep's clothing (don't let it get started huffing and puffing)

This paradigm of incremental reform does not shift, except into overdrive. The Democratic leadership has already announced the new "spring session sorties" they intend to pursue:

The First Family introduces "Families First":

This will be a series of Democratic initiatives to both expand the provisions of the Family Medical Leave Act and introducing measures to increase health care access to children and the unemployed. These will be done both by the party leadership (Senators Daeschle and Kennedy) and President Clinton.

If Congress can quickly wreck and pillage, how long does it take a village?

1) Medicare: often referred to as the "third rail of politics" there is hope that softer, gentler reforms can replace the "Mediscare" tactics recently employed. To ensure the solvency of the Medicare trust past 2001, many incremental steps will be taken. This has the look and feel of a well run shell game:

   a) A Medicare Commission might be appointed to recommend a series of solutions that will probably resemble what Republicans already proposed.

   b) Hospital expenses will be shifted from the government supported Trust Fund to the consumer supported general Medicare fund. This transfers government expenditures directly to seniors, employees and employers.

   c) Changing payment methodology to HMOs, which have long been disproportionate to the risk taken, at taxpayer expense.

   d) Cutting payments to providers, who in turn will shift more of their losses to private payers and insurance companies -- again.

   e) Preserving Medicaid guarantees, much of which ensures the ability of many seniors to pay Medicare premiums. One budget washes the other.

2) Balanced Budget: Not normally a health care issue, except for the size of the Medicare problem. Both Republican and Democrat proposals for Medicare reform in the last session were actually part of budget bills.

3) Managed Care: After considerable media attention, Congress finally turns to correcting perceived "abuses" of the system. New rules granting permission to physicians to freely discuss treatment options, access to emergency care, and general consumer and quality protection orders will all be raised.

4) Federal Mandates: New coverages building on what HIPAA wrought, extended eligibility for COBRA, funding health plans for unemployed and "working poor."

5) Regulatory Guidance and Cleanup Legislation: Now that they passed the new laws, what do they do with them? Three major agencies (Labor, Treasury and Health and Human Services) must have coordinated rules by April 1, 1997.

The Health Insurance Portability and Accountability Act of 1996

What's minor and what's at its core
The maternity legislation it bore
How it gives mental health more
And analysis of what's in store

Unlike many major bills, this was developed slowly and then rushed through so everyone could try to get reelected on at least one piece of positive legislation. To show they were serious, Congress also imposed a number of deadlines that are triggered in rapid succession, which guarantees that the repercussions of the law will be felt more lastingly than the initial explosive force of its passage.

HIPAA Major:

Small Group Reform (January 1, 1998)

Congress fiddled with debate while California burned with the rage of reform. While the merits of the Clinton plan were being argued nationally, California and other states passed meaningful health care reform locally. Some differences remain, but the primary issues are similarly addressed:

1) Guaranteed Issue:

   All carriers must provide medical insurance to companies with 2 or more employees, regardless of medical history, claims experience, disability or health status. New employees and dependents must also be offered coverage on a guaranteed basis, unless they initially waived (exceptions: "open enrollment" periods and waivers due to other group coverage which is subsequently lost). California did all this three years ago, and our minimum group size goes down to two employees on July 1, 1997.

2) Guaranteed Renewals:

   State and Federal Match: all group plans must be renewed unless due to fraud or non-payment, or the carrier's departure from that state's market.

3) Pre-Existing Conditions

   a) Considered a medical situation manifesting itself in the 6 months prior to the inception of coverage.

   b) In such a case, payment may be denied for related expenses incurred in the first 12 months on the plan.

c) "Credit" toward the definition period will be given if other individual, group, and certain other sponsored coverage was in force within **63** days prior to the inception date of employment (even if the employee must serve a waiting period for coverage to begin).

4) Rates:

   There are no federal rules regarding the rates carriers may charge for any of their plans, even after these reforms have been initiated. In California, there are specific rules regarding permitted variations from those base rates filed by each carrier for each of their plans with the state.

Individual Health Insurance Reform (July 1, 1997)

This is the "portability" portion of the law, designed to ensure continuity of coverage for those who:

1) Have been continuously covered by group insurance the previous 18 months
2) Are not eligible for Medicare, Medicaid or other group health insurance
3) Have no other coverage
4) Have exhausted their COBRA continuation coverage

Coverage must be issued and renewed on a "guaranteed" basis, with no pre-existing condition limitation imposed. There are a few exceptions and concessions:

1) No regulation on the rates carriers may charge, and they may leave the market (and cancel existing plans) with only 90 days (by policy form) or 180 days (state withdrawal) notice.

2) A state may implement an "alternative mechanism" that meets the primary goals of the legislation or using a model already proposed by the National Association of Insurance Commissioners.

3) Carrier does not need to make all their individual plans available for issue, but must allow enrollment in either their two most popular plans or two policies using a weighted average of all their available individual products.

Medical Savings Accounts (January 1, 1997)

Contract guarantees on the one hand, economic responsibilities on the other. Proponents contend that MSAs will drive down health care costs because of the fiscal involvement of the patient in treatment. Opponents claim MSAs will "skim the cream" of health care risks, ultimately shifting a greater cost burden on providers and other patients.

Congress compromised by calling Medical Savings Accounts a “demonstration project” limiting eligibility to 750,000 accounts, held by self employed individuals and employees of participating small companies. There are three distinct parts:

1) Medical Insurance:

   A base policy must be purchased, meeting the following criteria:

   a) Annual deductible of $1,500 to $2,250 (maximum 2 per family)
   b) Patient liability, including deductible, of $3,000 (or $5,500 per family)
   c) No special “first dollar” coverages (e.g. preventive care at 100%)
   d) Individual must not be covered under any other regular health plan

2) Savings Accounts:

   a) May deposit up to 65% of the annual deductible (75% family) tax free each year into a custodial account by the tax filing date (e.g. April 15). Individuals may not contribute if their employer already does for them.

   b) Tax free account withdrawals may be made to cover the following:

      -- Deductible and out of pocket liability under the medical insurance
      -- Health expenses allowed under the tax code (including dental and vision)
      -- To pay for COBRA continuation premiums
      -- To purchase long term care insurance
      -- To purchase individual health insurance while drawing unemployment

   c) Deposits may be made up to the allowance each year, even if there are no withdrawals taken during that year

   d) Interest earned on the accounts is tax exempt

   e) Tax free withdrawals may also be made at age 65 for any reason. This is why MSAs are sometimes referred to as “medical IRAs.”

3) Administration:

   a) Accounts must be held in trust through: insurance company, registered trustee, bank, savings institutions or brokerage.

   b) Reporting will be done on contributions and withdrawals by the trustee (form to be decided, but will probably be similar to a W-2P)

   c) Account holder has the burden of proof to show expense eligibility

Long Term Care (January 1, 1997)

With significant growth in our elderly population and a rise in average life expectancies, the need for respite, nursing and facility care has grown apace. The financial burden to affected individuals and their families has been exacerbated by the absence of any tax breaks for expenses or coverages. This is rectified:

1) Qualified Contract: solely for long term care, guaranteed renewable

2) Qualified Care: required treatment for chronically (not terminally) ill, defined as having lost two of five ADLs (Activities of Daily Living) for 90 days or requiring substantial supervision due to cognitive impairment (e.g. Alzheimer's)

3) Maximum covered expense per day of $175 or its aggregate equivalent with indexing after 1997

4) Maximum covered insurance premium is based on an age schedule, with indexing allowed after 1997. Table ranges from $400 per year for those 40 and under to $2,500 for those age 70 or older)

HIPAA Minor:

IRA Distributions and Health Insurance

Individuals who have received unemployment compensation for at least 12 weeks may use IRA funds to pay health insurance for themselves and covered dependents until they have had subsequent employment for at least 60 days.

Self Employed Tax Deduction

Current personal income tax deduction of 30% is raised to 40% in 1997 for sole proprietors, partners and 2% shareholders of Subchapter S Corporations. The amount of the deduction increases in stages until it hits 80% in 2006.

Cafeteria and Retirement Plans

401k and Cafeteria plan salary deferrals will **not** be included as "compensation" for the purpose of retirement plan discrimination testing

Fraud and Abuse

New regulations and enforcement policies granted through Health and Human Services (HHS), Department of Justice (DOJ) and Federal Bureau of Investigation (FBI) to curb or prosecute abuses of federal health care programs.

Administrative Simplification

The ultimate Washington oxymoron, the law has new and updated reporting requirements to allow government and carrier payment and compliance tracking

COBRA

New rules on the definition of dependents and qualification if disabled

Miscellaneous

1) Corporate Owned Life Insurance: new phase out and phase in rules
2) Accelerated Death Benefits (for terminally ill): new rules imposed
3) Adoption: tax credits for adoption of child with special needs
4) Punitive Damages: if received for emotional distress, now treated as income
5) Education Benefits (IRC 127d): retroactive restoration and extension to 7/1/97
6) S Corporation: may now have up to 75 shareholders, up from previous 35
7) Earned Income Credit: modified rules and new phaseout on allowance
8) Highly Compensated Employees: new, simplified definition

Daughter of HIPAA: Newborn and Mothers Health Protection Act

This grants a minimum hospital stay of 48 hours for mothers giving birth, and 96 hours if birth is by cesarean. There is some flexibility in the law:

1) Only applies to those plans that already have maternity benefits
2) Doctor and mother may agree to an earlier discharge date
3) Carrier may apply deductibles and other cost sharing for maternity coverage
4) No penalties imposed nor authorization required for following these rules
5) Applies to all group and individual plans, including those that are self funded

Son of HIPAA: Mental Health Parity Act

Where a plan offers mental health benefits, coverage must be on the same basis as "any other illness." There are several exceptions and interpretations:

1) Only applies to groups of 50 or more employees
2) A plan is not required to cover mental health -- if it does, then the rules apply
3) There is no definition of mental health benefits -- it is left to the plan.
4) Requirements are due to expire after September 30, 2001.
5) Can be revoked if provisions cause the cost of plans to rise by more than 1%
6) No standards are imposed on the terms and conditions of mental health coverage, such as amount, duration, scope of coverage, level of cost sharing, limits on number of days of coverage or requirements for medical necessity

Analysis Paralysis

Sorry, but my karma just ran over your dogma

Implementation can be fun, unless you are still waiting for final regulations, as jointly issued by three major Federal departments (Treasury, Labor, and HHS):

1) Administrative Confusion:

   a) Federal law prevails except where it doesn't. If a state law is more stringent in a certain area, it may be enforced. This continues the patchwork of overlapping and conflicting regulations, which hampers the administration of insurance, particularly for multi state employers.

   b) Documentation: How do you report MSA distributions, creditable former coverage, exhaustion of administrative relief prior to getting individual coverage

   c) States and Individual Plans: May substitute an "alternative mechanism" for provision and enforcement, with several samples already given.

   d) Pre Existing Conditions: Though waiting periods may be waived if there is previous "creditable coverage" that may be interpreted only to apply to specific conditions outlined in the previous coverage.

   e) Long Term Care: California's statutes on qualified coverage conflict with the federal statute. Therefore, currently California policies would not qualify for the tax break just created.

   f) Medical Savings Accounts: There appear to be some loopholes, such as the allowance of annual contributions even if the plan is not used, and whether an individual may simply pay for unreimbursed expenses out of their pocket rather than withdraw payment from the MSA.

2) Administrative Burden:

   a) COBRA: Increased administrative requirements always leave open room for misinterpretation and the potential for non compliance. Requirement that COBRA be used before getting guaranteed individual coverage will also increase COBRA enrollment.

   b) Pre-Existing Conditions: Plan limitations are waived for future employees if they can show proof of having previous, "creditable" coverage. Former employers are required to keep such records, in case they are requested, from July 1, 1996, forward.

c) Mental Health: How does a plan show that the imposition of parity caused the cost of a plan to increase more or less than 1% overall?

d) Cafeteria Plans: How (or will) they coordinate with some of the changes? Their existing rules have not been modified by these new laws.

e) Medical Savings: Tracking distributions, proving spouse does not have other MSA or other coverage with another carrier.

3) Ins and Outs:

a) Mental Health: The law's coverage allowances range from severe mental illness (schizophrenia) to attitude adjustments. Carriers may reduce coverage for both through the artifice of creative plan design. This law also only applies to groups of 50 or more employees.

b) Administrative Simplification: The use of electronic claims for Medicare processing will improve data collection and payment but also allow less privacy and invite data piracy.

Medical Savings Accounts:

The cap of 750,000 accounts is either a meaningful start or a guarantee of failure, depending on your view of quantifiable data analysis. Actually, the law permits an unlimited number of accounts between now and August 31, because the "counting" will not occur until then. Despite this opportunity, however, the absence of any final regulations, the appearance of a limited market and good old bureaucratic foot dragging has hindered development of needed products. In California, for example, only one carrier (and a new one at that) offers a group sponsored MSA. There are three offering a plan to the self employed, but two of those have had their final approval held up by the Department of Corporations.

What is Missing:

Medicaid/ Medicare Reform: Defeated by "Mediscare" and "Medi-Bandaid" cries
Malpractice Reform: Doctors fought the law and the law won
Insurance Affordability: We give you access and now you want low prices?

AFFAIRS OF STATE

A government that robs Peter to pay Paul can always count on the support of Paul.

While Curt did flirt with Conservatives, with Democrats he should mingle
His popularity dips, he's not in the chips, even though he is a Pringle
Republicans fail, Democrats set sail, on a Bustamente Cruz
Did you hear the one on what term limits have done -- some guys we'll never lose.

We set new rules to create more pools, which many agents push
And HMOs may be led by the nose by Commissioner Quackenbush
The HIPC admits new benefits, MR MIP adds an HMO
New federal laws give us pause, in what direction should we go?

MSAs will be just a phase unless we become reliant
On the state to cut the tax rate - will the Assembly be compliant?
And how will we fare under long term care with certain rules required
Do we intend to amend what we have done or is a different end desired?

In '98 there'll be a new head of state, since Wilson won't re-Pete
Will we give way to shades of Gray or is Lungren the one to beat?
Perhaps a senatorial face in the race there's talk of it in town
Willie's position supports a rainbow coalition as long as it turns out Brown

Rites of Passage - What was of note

Major:

Rules: "Small group" for health care reform will be defined as companies with 2-49 employees from the current 3-49 effective July 1, 1997.

Pools: Health Insurance Plan of California was set up by the state. California Choice was set up by private industry, under a special waiver issued by the Department of Corporations. These are now joined by the ability of private industry to set up their own pools, under Senate Bill 1559. This is the third leg of a triangle of needed competition among health care purchasing groups.

Fools: The Department of Corporations now runs HMOs. A task force has now been convened to study the feasibility of having HMOs run by the Department of Insurance. Just follow the bouncing ball...

Drools: In a last minute flurry of activity, California passed enabling legislation that mirrored the federal rules for Medical Savings Accounts. The same tax break allowed under federal taxes is therefore also permitted in California.

Minor:

Backlash: Three "anti-gag" bills were passed, which prohibit plans from penalizing physicians for patient advocacy and disclosure of treatment options

Rehash: Prohibits financial incentives inducing health care provider to deny, reduce, limit or delay medically necessary and appropriate treatments. At the same time, another bill says "capitation" payments do not represent an inherent conflict of interest for participating physicians.

Mishmash: The State Attorney General must consent to the conversion or merger of a non profit hospital with a for profit entity, and may also place conditions on it

Not rash: Disclosure and treatment rules for providers getting Medicare/Medi-Cal financing, provider groups and plans must allow for treatment by a licensed nonphysician or pharmacist with reimbursement provided by the HMO.

Wrongs of Passage - Didn't get the vote

California Ballot Propositions 214 and 216

Don't worry. Backers say they'll be back (so watch your back) Riddle:

When is total rejection of a legislative suitor considered an embrace of principles? When it is a ballot initiative. Stop rejecting them -- it only encourages supporters.

Prohibitions on gag clauses and financial inducements to withhold or reduce care
Requirements that managed care plans enlist "any willing provider" who signs
Creation of "full risk" services taken by doctor/hospital combinations (like insurance)

Don't miss -- or they'll get you by the throat

HMO: IF you are receiving acute care and loss of access to your provider would have a negative impact on your treatment, you may continue using that same provider and be reimbursed, even if they have been dropped from the HMO plan.

COBRA: Employees and spouses age 60 or over at time with at least 5 years of service when terminated may extend coverage to age 65 rather than 18 months.

Back Door Passage - What does this denote?

San Francisco requires companies doing business with the city to offer health insurance, where otherwise provided, to registered domestic partners of employees on the same basis as spouses. If unable to do so (e.g. carrier prohibition) then a cash equivalent must be offered.

FRIENDS IN TRENDS

You can see a lot just by observing (Yogi Berra)

There has been an alarming increase
In things we know nothing about
Mergers in quantity without surcease
It's only the quality that's now in doubt

And when carriers splurge as they frantically merge
What will emerge when interests diverge?
Will activity surge in a management purge?
Or will they urge that their cultures converge?

Legislation cannot keep up with the demands and challenges of new systems. The antiquated regulatory framework, created to deal with industrial monopolies, fairly creaks through the Service Age. Once the floodgates of change are opened, it is impossible to stem the tide that sweeps the health care landscape. It's like trying to contain a bomb by throwing a coat over it -- "well suited" for the moment, but only disconnected threads the next.

Trends in health care delivery follow many paths, but lead in only a few directions. We have seen the following in the past year alone:

Industry:

1) Major Carrier Coordinations:

   a) Aetna and U.S. Healthcare
   b) United Health Care and MetraHealth (formerly Metropolitan-Travelers)
   c) Wellpoint buying John Hancock and Massachusetts Mutual group business
   d) Health Net and Foundation Health
   e) PacifiCare and TakeCare
   f) CIGNA group and Prudential group

2) Hospitals and Physicians

   a) Stanford and UCSF medical systems merged as "Newco"
   b) Brown and Toland is the name for UCSF and California Pacific IPA
   c) Tenet Acquired OrNda and is California's largest hospital chain
   d) Hospital Expansion: among the many mergers:

      -- Columbia/HCA with Sharp in San Diego and Santa Clara groups
      -- Catholic Healthcare West with Sequoia Hospital
      -- CHS Systems (Alta Bates, Marin General, Mills Peninsula and beyond)

e) MSO (Medical Service Organization) Expansion:

-- MedPartners is publicly traded and has bought several group practices
-- General growth of Phycor, Caremark and UniHealth
-- FPA Medical Management bought Foundation's health practices

3) Kaiser - both hospital and medical group, and scene of frantic activity:

   a) Merger of the Northern and Southern divisions
   b) Now works with brokers statewide after *50 years* of direct sales
   c) Closing or halting construction, or reducing hospital services in some areas
   d) Outsourcing to other hospitals (particularly in Oakland)
   e) Engaging in more strategic alliances with a variety of medical groups

4) Hospitals and Carriers:

   a) Columbia/HCA hospital chain bought Blue Cross/Blue Shield of Ohio
   b) Humana Hospital bought Employers' Health, a national carrier

5) Other:

   a) Anthem Health has bought a number of Blue Cross/Blue Shield plans
   b) BPS, partly owned by Anthem, has started their own California HMO
   c) California Medical Association started the "California Advantage" plan

Contracting:

1) Growth of PHO (Physician Hospital Organization)
2) Growth of MSO (Medical Service Organization)
3) Managed "Care" -- Movement away from capitation payments:

   a) "Demand Management": cut costs by focusing on consumer needs
   b) "Hub and Spoke": hospital and MSO work jointly, sharing equity and risk
   c) "Virtual Integration": gain sharing and medical protocol management

4) Managed "Reimbursement" -- Movement toward more capitation:

   a) Increase in regional hospital capitation
   b) Outsourced capitation with ancillary services (lab, X-ray, pharmacy)

5) Telemedicine: expansion of ability of companies and medical professionals to treat remote patients "telephonically" or "electronically"

6) Pharmacy:

    a) Pharmacy Benefit Management company growth to the point of ubiquity
    b) Drug cards were followed by plan design issues (generic vs. name brand) which were followed by the use of formularies, which now stand to be superseded by the use of Disease State Management programs

7) Legislative:

    a) In the last California session, a bill sponsored by the California Hospital Association proposed letting medical providers take “full risk” for all health care services. This has normally been done by insurance carriers.

    b) State legislatures have passed enabling or mandatory legislation on the creation of purchasing pools for employers, or the use of integrated service delivery or professional service networks (ISDNs and PSNs). The latter was even considered as a stand alone option for Medicare risk contracts.

Administration:

1) Department of Justice and Federal Trade Commission regulations have been published for antitrust enforcement in the health care area.

2) California has permitted the use of limited “Knox Keene” licensing. This allows MSOs and other integrated medical organizations to take on more health care risk, as carriers have done traditionally.

3) Growth of Medicaid risk contracting either in block, or simply moving the Medicaid (Medi-Cal in this state) to managed care coverages.

4) With or without employer support, coverage rules for domestic partners are being issued

Employers:

1) Internal and external push to allow coverage for domestic partners
2) Increased use of outsourcing techniques, such as employee leasing
3) Large and small are banding to form health care purchasing groups

OUTLOOK (Look Out!)

It's tough to make predictions, especially about the future (Yogi Berra)

Madness takes its toll. Please have exact change.

After obnoxiously obfuscating your orientation
I leave you with legislative lamentations
Advancing my armies of alliteration
In imminent hope of interpretation

Legislation: Whither goest thou?

Death by a thousand cuts is the ultimate horror, but watching it comes close. Federal legislation has gotten off the beaten path of radical reform, but runs on a parallel track, less easily seen, toward the same goal. Some of what the Clinton Administration desired four years ago has come to fruition, creating a temptation to see how far the whole system can be pushed. The new legislative agenda for both sides continues the debate about Medicare and other major social issues, while pursuing a parallel agenda of reform. We will see expanded access, expanded coverage and an expansion of power through federal mandates and a Congressional inclination to usurp the historical prerogatives of the states.

Industry: How dost go the Dow?

Rule Number One: Insurance and managed care companies must make money
Rule Number Two: Refer to rule number one, or take two aspirin and don't call

There will continue to be mergers, among similar and disparate industries. There will also be an increased blurring of the distinctions between traditionally different industries, as they all seek vertical integration. Hospitals will buy insurance plans and vice versa, doctor groups merge with each other and then hospital chains, etc. Fuel will be added to the fire of consolidation as companies pool their resources and then use that marketing power to make substantial demands for increased and improved services, lower prices and equity and other risk sharing accommodations.

Regulation: What shall we do now?

Expertly tailored based on current measurements and assumptions, only to find they are "ill suited" to a rapidly evolving industry, state and federal legislatures can't keep up. Not only do they not fit, but can impede, or harm, those they are designed to cover, thus spawning even more corrective legislation which causes further detriment. If medical care were delivered this way, the patient would die, as we find interpretations not of statutes, but of the "laws of unintended consequences."

AGENCY DEVELOPMENTS

At this moment, we are subsumed in the vortex of criticality (Al Haig)

There is no match for starting from scratch because of what we're taught
It helps us know which way to go and avoid our being caught
Between never ceasing at increasing our total clientele
And being nervous we might not service the cases that we sell
We've added staff again by half to justify your reliance
On our plan solutions, claims resolutions, and manuals for compliance
We're convinced that we've evinced throughout our history
Our ability to show that we know "What a Benefits Firm Should Be"

Because we want to "wed" our clients to the agency, we have used tested techniques to ensure its success rather than employ a "shotgun" approach:

Something Old:

COBRA: Rather than be snakebit over regulations, we will do the notifications

We will send appropriate forms and outlines about rights and privileges under state **and** Federal law to new and terminated covered persons. We will collect the initial premium payment and send forms and payment back to you.

Pharmacy: We abhor how drug costs soar, and helped create a local coalition

The North Bay Pharmacy Coalition was formed last year to consolidate marketing and purchasing costs for independent pharmacies and help both carriers and employers find constructive ways to reduce medical costs through reliance on drug therapies and disease state management

HR: Between what you know and we know, we thought we'd get someone in the know

We have employed Personnel Perspective in Santa Rosa to provide phone service free to our clients, and offer research and other projects at a discount

Community: Through service we extend our reach, so we practice what we preach

We continue our help with board development and fund raising for both Big Brothers/Big Sisters of Marin and Sonoma Counties. We also helped with various projects and committees, and continue to stay involved, with the North Bay Children's Center. Our financial support continues for all three of these organizations, and the San Francisco Volunteer Center.

Something New:

Access: What a tangled web we weave, when information burdens we seek to relieve

By the end of spring, compliance materials, resources and other items of value to you and your employees can be accessed at our new Web Site -- the registered domain name is **http//www.jsia.com** We can also be reached by e-mail at **104676,115@compuserve.com**

Something Borrowed:

Concepts: Before anyone heard of virtual integration, we had virtually done it

We have always had a number of loose affiliations with outside professionals and insurance agencies, but in the past year some of these have become more formalized. We now "borrow" the services of a number of firms in Marin and Sonoma County to meet a variety of needs continually expressed by our clients:

Property/Liability Insurance	Human Resource Consulting
Payroll Services	Commercial Real Estate
Executive Compensation Planning	Life and Disability Insurance
Management and Tax Accounting	Workers' Compensation
Organizational Training/Consulting	Labor and Tax Law
Investment and Retirement Planning	Professional Search/Placement

Something Blue:

Agency Advisory: It helps to be on the inside, so we can help those on the outside

We remain on the *Blue Shield* agent advisory council, worked with them on their MSA project and are in discussions about our pharmacy coalition. We remain on the agent council for *Health Plan of the Redwoods*, which has certainly gotten interesting as they have tried to reinvent themselves. We have just been asked to be on the Northern California region of the *Kaiser* agent advisory council, which has its first meeting in February.

Post Mortem: If you don't try a few new things you won't know what really works

We worked at putting together a coalition of employers, providers and agents in Sonoma County to find a suitable alternative to the current medical plans available in that market. With the movement of Health Plan of the Redwoods toward what other carriers offer and the opening of Kaiser to new ideas and delivery mechanisms, this idea has more credence than ever, but the timing is still not quite right.