HEALTH CARE

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SECURING MEDICAL DATA

INSURING YOUR STAFF UNDER THE ACA
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BEST OF ABA SECTIONS

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I think this issue represents a good time to take a look at some of the health-oriented mobile technology out and coming out, including some of the wearable technology that can help you keep track of health issues on the road and at home. In keeping with the new trend to make up words with stray letters in front of them to refer to a new evolution in technology, the mobile health technology industry now has its own term: mHealth (the “m” stands for “mobile”).

mHEALTH DEVICES AND APPS
The evolution of mHealth has attached itself to our telephones and tablets in the form of a plethora of apps that work to track your activities or sometimes simply accept and record information and transfer it to a storage facility in the cloud. Our computers have programs to accomplish the same thing. In addition, we have a number of relatively compact measuring devices that sync with Bluetooth, near field communication (NFC), WiFi, or sometimes a wired connection to computers, tablets, or smartphones and consolidate information in the cloud. We also have a whole wing of wearable technology that will record information about the state of our health, the amount of our activity, the intensity of our activity, and how long and how soundly we slept. Some of the devices and software simply link to storage to save information for our personal use. Some will facilitate your doctor’s use of this information by actually linking directly to your doctor’s computer or to a cloud storage database that your doctor can access.

When I went to the Consumer Electronics Show this year, the wearable mHealth tech devices on display represented a large piece of the show, much more than in times gone by, evidencing the continuing and rapid growth of this segment of the market. There is even a rumor that the soon-to-be-released Apple Watch will have the ability to measure and track blood sugar using a new testing technology that will surely win the hearts of diabetics and pre-diabetics as it supposedly will use an incredibly small device to take a very small blood sample for measurement.

You can even get small, very portable, battery-powered transcutaneous electrical nerve stimulation (TENS) units to provide muscle massage to help relax you, relieve nerve-based pain, and treat sore muscles while you travel on planes, trains, and automobiles or rest in your hotel room (or elsewhere). Speaking of planes, trains, and, particularly, automobiles, you can also get very small (pocket-sized) breathalyzers to tell you, as you leave the dinner or party, whether you should call a cab and pick up your car in the morning. Although not directly a health product, if it helps keep you out of a car wreck, it might save you a lot of pain and suffering. Even if you do not consider yourself a heavy drinker, having one of these in your car (or your pocket) when you go out makes a lot of sense and might save you a lot of dollars by helping you avoid a DUI prosecution.

Some of these devices travel in stealth mode under your clothing; others you wear more visibly, sometimes even as jewelry. As with everything tech, companies have jumped on the bandwagon, and many more will likely jump on before it reaches top speed. In truth some of them have released products that should probably not have come out yet (or ever), but many of the products work well and provide a useful and helpful (to say nothing of healthful) functionality.

A variety of testing devices has come onto the market designed to link portable devices to measuring devices to databases online or on the device. This structure, while perhaps appearing superficially cumbersome, actually works fairly well. It requires you to pair the measuring device to your mobile device and sometimes requires you to set up an account online to access the stored information (sometimes it resides on your device). Once you have it set up, all you need to do is perform the measurement, and the software and hardware do the rest. Examples of the types of measurements available include, inter alia, blood glucose, blood pressure, weight, pulse rate, and oxygen levels. You can get connected to record all this information and more. Note that in many cases you can avoid buying the vendor’s hardware and manually record the information, but you can get hardware that will automatically transmit the data from the device to your mobile unit, which is much more convenient than doing it manually.

FITNESS AND WEIGHT CONTROL
Each of us has different health needs and concerns, but we can group ourselves into rough classifications that may help us focus on the mHealth tech we will most likely find useful.

The largest group of users will likely consist of those who want to focus on tracking their activities and calories to assist them in weight control and/or fitness training. Whether you want to lose weight, gain weight, or maintain your current weight, monitoring and tracking the quantity of calories consumed as well as the efforts expended and the calories burned during the day can help you
succeed. The three best-known vendors of devices to do this recently became two as the folks at Jawbone (maker of the Up devices) bought the BodyMedia company and appear to be engaged in the process of phasing out all the BodyMedia units. I used a BodyMedia unit for several years and will be sorry to see it go as I think that the BodyMedia devices and software made a very useful package.

The two surviving companies vying for king of the hill, Jawbone (jawbone.com) and Fitbit (fitbit.com), are in the process of upgrading their hardware. Fitbit has already brought out some new devices (such as the Charge) and anticipates releasing the Surge (expected in April). Jawbone has not released any new models recently but has announced the impending release of the Up3 (also expected in April).

Jawbone’s Up3 will cost $179.99 and will come in black or silver. The Up3 charges through a USB connection and holds about a seven-day charge. It tracks activities, calories burned, steps/distance traveled, sleep, and your heart rate, and the accompanying app will help you keep track of your calorie consumption. While the Up3 has no display and does not tell time, you can use it to set alarms that vibrate when the alarm time arrives. You can sync it to most computers, tablets, and smartphones.

The Up3 will supersede the Up24 ($129.99) as the top of the Jawbone line when it ships. The Up24 provides most of the features of the Up3, but Jawbone describes the Up3 as water resistant to ten meters and the Up24 as merely “splash proof.” Other differences: You need to spring for the Up3 to get the advanced sleep mode and heart-rate monitoring.

Fitbit’s Charge ($129.95) does pretty much the same thing as the Up3 but also has a display and provides the time for you. In addition to steps taken, it also keeps track of how many stairs you climb in any given day. The Surge ($249.95) provides all the features of the Charge but with a larger display that contains more information, plus continuous heart-rate monitoring, caller ID, music control, and GPS tracking. You can pre-order the Surge now, with expected delivery around April.

For the record, while I do not consider any of these devices completely accurate, I do consider them useful. My distrust of their accuracy comes from the fact that I have worn two or three of them at one time and received (sometimes significantly) different information from them. One might say I walked 4,500 steps and another gives me 5,000 or 6,000 steps. One might say I slept for 6 hours while another says only 4.5. Simply put, I view them as giving me some useful feedback that I accept as guidance as to how I am doing. The devices do tend to be internally consistent, so if one says I walked 4,500 steps and then the next day I walk the same distance again while wearing it, it will come up with about 4,500 steps again. On the flip side of the coin, I find that the process of keeping track of what I eat helps keep me from overeating. Again, most of the time you need to look at the calories assigned to food by the accompanying software as estimates only because the recipe or serving size may not match exactly (your normal serving may be my large serving). But it still helps to keep track of how you are doing. Oh, and don’t fudge in what you record; you are only tricking yourself. If you eat two...
ounces of chocolate and record only one, your records will show a lower amount of calories than if you report two. Your body, however, responds to what you actually put into it, not what you write down, so you will still have to deal with the consequences of that second helping you ignored.

There are many other devices available that can track your activities and monitor your body (heart rate, pulse, etc.) during a workout to give you some information about your status and the effectiveness of your workout.

APPLE WATCH RUMORS
It remains to be seen what the Apple Watch will offer and whether it fits in the mHealth category or not. As usual, rumors abound, but that seems to be how Apple likes to see things go. There are rumors that the Apple Watch will come with several built-in health apps and the ability to measure such things as distance moved, workout intensity, heart rate, and blood glucose level, to list those that I have heard most about. You can find descriptions of all but one of these functions (blood-glucose monitoring) on the Apple website (apple.com), so you can consider them pretty reliable prognostications. I don’t like writing about technology that has not yet been released, particularly Apple products as Apple tends to remain secretive and let the rumor mills churn up public interest and discussion. Accordingly, I won’t say anything more about the Apple Watch here. I will write more about it after I have one in my hot little hands (or around my wrist).

SLEEP AID AND MONITORING
If you suffer from sleep apnea, you can get apps that will give you some feedback about how long you slept, how deeply you slept, and how often you woke up during the night.

If you have issues falling asleep, you can get any number of apps designed to help you fall asleep at home or on the road. Some of them simply provide “white” noise to blank out other and more offensive sounds. Others provide tones designed to lull your brain into various states of relaxation. These apps travel on a two-way street, however, and you can also get apps that generate music, sounds, and tones intended to help you wake up or energize you or focus your powers of concentration. You have the choice of playing these apps using headphones, an external speaker, or the speakers built into your device. I strongly prefer (and recommend) using headphones, especially wireless headphones, for this purpose. The quality of the sound of a good set of wireless headphones promotes the effectiveness of the sounds generated by the app and also helps insulate you from external noises and distractions. The absence of wires makes the device much easier and more comfortable to wear as you relax and fall asleep because you do not get tangled up in the wires if you move. A good set of lightweight headphones travels nicely and is less likely to prove bothersome as you try to sleep. I have found that they do not create problems for me.

A relatively new evolution in the app world respecting these sounds is the binaural sound–generating app. If you go to the iTunes App Store (apple.com) or the Android Play Store (play.google.com) and search for “binaural,” you will find a great many binaural apps, some of which are available free and others that cost varying amounts of money. Get some and try them out with a good set of headphones. You may find the results refreshing.

MENTAL FITNESS
While we are on the subject of your brain, I do want to make sure you know about the Fit Brains products, a series of apps from Rosetta Stone (the language-training people) for use on various portable devices. You can get them from the iTunes App Store or Android Play Store (search for “fit brains,” or go to fitbrains.com get more information). You will need to set up a free account to use the apps. To get the full benefit from the apps, you will need to buy a subscription, which will keep track of how well you do in the various games and exercises. You can access the programs from any Internet-connected computer or from a tablet or smartphone with one or more of the Fit Brains apps. Even if you only use the free account, it is a good way to help keep your mind sharp at any age.

HEARING AIDS
One other thing that I will mention is that, in the last few years, hearing aid manufacturers have started to release models of their products that tie to mobile phones, using them as control devices to set or modify programs. The most frequent pairings I have seen are via iPhone apps, but several companies have also released Android apps. I have located such apps for models in the Starkey (starkey.com), Seimens (usa.siemens.com), and Resound (gnresound.com) product lines. Depending on the manufacturer and the model, some of these apps allow you to use hearing aids to answer and make calls on your connected smartphone.

While this column does not cover the waterfront, it should whet your appetite and give you a basic idea of the scope of health-related tech available to those interested in using it.
Work Hard. Enjoy Your Success.

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WORK HARD. DO GOOD. HAVE FUN.

By Stephen B. Rosales

By way of introduction, I am Steve Rosales from Belmont, Massachusetts, a town of 24,000 people about three miles as the crow flies from downtown Boston. During my 35 years in the law thus far, I have practiced in both small firm and solo settings so I am aware of and have experienced all the issues and concerns, the ups and downs that these settings can provide.

I have the privilege of serving this year as Chair-Elect of the Solo, Small Firm and General Practice Division of your American Bar Association, ascending to Chair this August. We are busily planning what is sure to be a busy and exciting 2015–2016 ABA Bar Year . . . complete with valuable CLE, both in-person and virtually; our first-rate GPSolo magazine and eReport to keep you informed and up to date on the latest topics and practice methods; a regular Brown Bag luncheon series free for Division members; and two exciting Division conferences in desirable, fun locales offering opportunities to learn, network, and socialize with fellow attorneys and guests.

OUR THEME FOR THE YEAR AHEAD

In keeping with my personal philosophy of life, I have chosen the theme of “Work Hard. Do Good. Have Fun.” for my year as Chair. This theme is to remind and encourage all of us that hard work toward positive goals—whether aspirational, personal, or professional—does not need to be tedious and uninspiring. Hard work and doing good can indeed be fun. If it wasn’t, why would we do it? We work hard as attorneys, and we must not forget the need to have fun in whatever we do, with those we are with and wherever we are. During my year as Chair, I can guarantee these three things: We will work hard, we will do good, and we will have fun!

My theme is also to keep us mindful that we all, as attorneys, are blessed with the opportunities, tools, and analytical skills to give back and use our skills to “do good” in whatever large or small way we desire. Whether it be pro bono services to those in need of legal representation, public service, involvement in our communities, schools, churches, or other organizations, or doing good in other ways to the best of our abilities, we should all strive to “do good” in whatever way we can. Even random acts of kindness or paying it forward will suffice. Giving back and doing good, whether on a large or small scale, makes us all better attorneys and, moreover, better people.

Peoples’ daily lives and schedules seem more packed and stressful than ever. Many of us address and must balance an ever-increasing number of responsibilities on a daily basis. Work commitments, family commitments, financial commitments, health concerns, and the like often seem to dominate our lives, leaving little time for anything else. As Bob Seger sang, “Deadlines and commitments/What to leave in, what to leave out . . . [We’re] still running/Against the wind.” The “have fun” component is to keep us mindful that despite all our daily challenges, we must leave room for some quality-of-life activities. No matter the form and whatever your preference, we all need to enjoy ourselves and, yes, have some fun.

DIVISION MEETINGS IN 2015–2016

From September 24 to 26, 2015, our Solo & Small Firm Summit will take place in my hometown of Boston, Massachusetts. The conference will be held at the luxurious InterContinental Boston Hotel, located directly on the waters of historic Boston Harbor. The conference will offer exciting plenaries with high-profile national speakers and fabulous social events, and it will leave you with plenty of time to explore and experience all that is Boston.

So, come to be inspired. Come to learn some new things. Come to meet and mingle with colleagues from all practice areas from across the nation. This unique event, in a spectacular setting, will provide an all-in-one environment for education, networking, idea sharing, and, in keeping with my theme, fun in a vibrant, exciting city. The weather will be warm, the Red Sox will be in town, and the city beckons to be experienced.

From May 12 to 14, 2016, GPSolo will be traveling to warm and sunny Key West, Florida, for our Spring Meeting held jointly with the Group Legal Services Association. This exciting conference will offer ample CLE, opportunities for networking, idea sharing, committee work, and distinctive social events all in the laid-back tropical atmosphere that is Key West. No ties allowed! The conference will be held at the sumptuous Key West Marriott Beach Resort.

Stephen B. Rosales, guest contributor of this issue’s column, is Chair-Elect of the GPSolo Division. He is a partner with Rosales & Rosales LLC in Belmont, Massachusetts, and may be reached at s.rosales@rosalesandrosales.com.
West Marriott Beachside Resort. Feel free to come early and leave late. Just don’t forget your flip-flops and sunglasses. This is one meeting you won’t want to miss.

FOCUS ON ELDER ABUSE
During my term, I will make use of the “bully pulpit” that being Chair provides—not to harangue you all, but to raise your awareness of an ever-expanding problem being faced by the most vulnerable segment of our society: the exploitation and abuse of our elders.

The U.S. Census Bureau estimates that in 2013 more than 44 million of our citizens were aged 65 and older, the largest segment of our society. This number is expected to increase in the coming years as more Baby Boomers age and will soon comprise more than 20 percent of our entire population. Abuse takes many forms, be it physical, psychological, emotional, or financial. Other forms include abandonment or neglect. Abusers can be institutional such as nursing homes or long-term care facilities, or, more often, caretakers: family members, nurses, home health aides, guardians, or attorneys in fact under a power of attorney. As attorneys, and more importantly, as people—as neighbors, friends, relatives, or acquaintances—we have an obligation to protect those who cannot protect themselves. In the coming Bar Year we will offer programs and materials designed to help you recognize the signs of potential abuse, understand the various forms it can take, and learn what we can do about it—and how to prevent it. As Mick Jagger sang, “Time waits for no one, and it won’t wait for me.” Everyone grows older. If you are not there already, you will be soon enough. Everyone has the right to grow older with dignity and adequate care. The abused need to be protected, the abusers need to be prosecuted.

ONGOING DIVISION COMMITMENTS
But wait . . . there’s more! As if the above is not enough, GPSolo will continue to provide myriad other benefits to its members, including access to:

- ABA Solo and Small Firm Resource Center (ambar.org/soloandsmallfirms), providing marketing, technology, practice management, CLE, and substantive law resources for solo and small firm lawyers.
- GPSolo LinkedIn referral group (tinyurl.com/n24dlqt), a social media group where members can connect and make referrals.
- SoloSez (solosez.org), known as the “virtual water cooler” for solo practitioners, a listserv boasting more than 1,500 subscribers to chat and share their knowledge of myriad subjects. Just put your question out there, and you’ll be astounded at the helpful feedback you’ll receive instantly.
- Award-winning publications and books.
- GPSolo’s virtual Brown Bag luncheons (tinyurl.com/bc3rsjl), an ongoing series of hour-long seminars that are free to our members on subjects of topical interest, ranging from the cutting edge to substantive to practice management advice.

So, c’mon along. It is going to be a great year to work hard, do good, and have fun. We look forward to seeing you. Until then, be well.

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Thomson Hall, 195 Broadway, 4th Floor
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Be sure to save the date for this exciting program. You will be able to join us in person or virtually. This program is for practitioners transitioning from a larger law firm to a solo or small firm practice. You will learn practical and helpful information to make a smooth transition. CLE credits requested: 2.5 hours.

8:30 AM to 9:45 AM
CLE: Making Your Move: How to Transition from [Big] Law to Start Your Own Solo or Small Firm: What to Take and What to Leave Behind
An increasing number of associates are leaving, by choice or by necessity, from large law firm settings and are now starting their own law firms. In fact, there are as many reasons that lawyers go from a large firm setting to a small or solo practice as there are lawyers who have made the transition: frustration with office politics, the need for more independence, the desire to exert control over cases, the dream to focus a practice on a specific area of law, the goal of building a business, and the desire to do things their own way. If carefully considered and planned, the move can lead to a long and satisfying legal career.

10:00 AM to 11:15 AM
CLE: Practice Management Tools and Cloud Services for the Solo and Small Firm
Now that you will be starting your own firm, you need to learn more about cloud computing services. These tools help streamline how your law firm operates so it runs more efficiently and for less money. You will learn about the cloud concept; the benefits of cloud computing; how to securely run your law firm anytime, anywhere; how to increase your efficiency with integrated tools and mobile accessibility; and how to streamline your document drafting. Participants will receive a 20 percent discount on Technology Solutions for Today’s Lawyer by Jeffrey Allen and Ashley Hallene.

11:30 AM to 12:30 PM
Non-CLE: National Dialogue
Learn more about what it’s really like to be a solo or small firm lawyer and help shape the discussion on how to support these practitioners in your own state. The National Dialogue is a unique forum where solo and small firm lawyers, along with state and local bar leadership, discuss the common needs, challenges, and concerns of this largest segment of practicing attorneys. The National Dialogue was conceived as a discussion forum with state bar leaders representing members of the governing boards, executive committees and/or councils of solo and small firm sections, as well as executive bar leadership. GPSolo believes that bringing these leaders and constituents together generates a marketplace of ideas, which energizes and inspires these leaders to further support practitioners in their home states.

More information and registration is available at ambar.org/gpsolo. Please contact gpsolo@americanbar.org or 312/988-5648 with any questions.

2015 ABA ANNUAL MEETING
July 30 to August 2, 2015
Swissôtel Chicago
Chicago, Illinois

Save the date for the ABA Annual Meeting. Be sure to attend GPSolo’s events, including our CLE Showcase session, “Minding Your Business: Successful Advising of the Small Business Client,” attend fun networking events such as the Keith E. Nelson Memorial Military Law Luncheon and Military Dining Out, and participate in a variety of committee meetings.

Also, the 2015-2016 Division Council will elect a new Division Delegate to fill a three-year term that will conclude at the 2019 ABA Annual Meeting. Nominations must be received by the Division Secretary, Stephen D. Williams, by July 20 via hand delivery; mail c/o ABA Solo, Small Firm and General Practice Division, 321 N. Clark Street, 18th Floor, Chicago, IL 60654; e-mail to gpsolo@americanbar.org; or fax to 312/988-5711. No special form of nomination is required, and self-nominations will be accepted.

Visit the GPSolo Division website for more information.
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GPSolo Magazine – Receive a complimentary subscription to our flagship magazine, in print and online. Published six times a year, GPSolo is devoted to critical themes for solo and small firm lawyers, including the latest in technology and practice management.

GPSolo eReport – Enjoy the Division’s monthly online e-newsletter, which provides valuable practice information, news, technology, trends, feature articles, and tips on substantive practice areas.

KIND – Volunteer with Kids in Need of Defense, GPSolo’s Pro Bono and Public Service Project and winner of the 2014 SOC Meritorious Service Award. Assist children who otherwise would be forced to represent themselves in immigration court.

Solo and Small Firm Resource Center – Find the resources you need on marketing, technology, practice management, CLE, and substantive law—including hundreds of books, videos, e-books, and forms for your immediate use. Log in at ambar.org/soloandsmallfirms.

SoloSez™ – Connect with the e-mail discussion forum for solos and small firm lawyers, featuring 1,500+ subscribers discussing everything from tech tips and legal opinions to what to wear to court.

GPSolo National Conference and Meetings – Attend our gathering of solo and small firm lawyers each fall, as well as our Division Spring Meeting and Annual/Midyear programming, for continuing legal educational, business networking, and social opportunities.

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Visit us at www.americanbar.org/gpsolo
How to Advise Your Physician Clients under the Affordable Care Act

By Kathryn Hickner-Cruz
Most physicians find the Patient Protection and Affordable Care Act (ACA)—and federal health care reform in general—rather distasteful. Even physicians who support the underlying policies of the ACA often feel that the law is just too complex. The ACA itself was, depending on the compilation referenced, hundreds or thousands of pages long. And the federal regulations that continue to be proposed and finalized and revised are collectively even more abundant. Simply stated, it’s a lot of information.

Although the media often focuses on those aspects of federal health care reform that relate to individual health care coverage and the employer mandate, many of the less controversial and less understood reforms relate to improving the health care delivery and payment system in this country. And, during the past five years or so, these are the reforms that have perhaps impacted the daily life of physicians the most.

As seasoned health care attorneys have worked with their physician clients during the past five years to implement compliance plans and reviews, enter alignment structures, pursue new reimbursement opportunities, and address governmental audits and scrutiny, they have noticed some changes in their physician clients’ practices as a result of the ACA. Below are a few examples.

ADJUSTING TO A NEW PAYMENT REGIME

Federal health care reform seeks to reduce health care costs while simultaneously improving access to care, quality of care, and overall population health. There is a commonly held belief that achieving this objective will require significant change in the way that health care providers are reimbursed. Accordingly, the ACA reflects a desire to reimburse physicians and health care providers for value (i.e., the quality and efficiency of health care provided) instead of volume alone. Note that this trend is not limited to Medicare, Medicaid, and other federal health care programs under the ACA but has been advanced by commercial payors as well.
In addition to the Medicare Shared Savings Program (described further below), one example of an ACA initiative that impacts the manner in which physicians are reimbursed is the Center for Medicare and Medicaid Innovation (Innovation Center), established under Section 3021 of the ACA. ACA Section 3021 states that the purpose of the Innovation Center is to “test innovative payment and service delivery models to reduce program expenditures . . . while preserving or enhancing the quality of care furnished to individuals . . .”

Many physicians directly or indirectly participate in the Innovation Center’s shared savings, bundled payment, value-based purchasing, and also because of the financial and human resources that are required to build the infrastructure and take on the financial risk necessary to succeed.

The current wave of physician alignment activity occurs along a spectrum of integration. Some models of alignment involve relatively limited integration (e.g., physician-hospital co-management arrangements and population health joint ventures) while others involve substantial integration (e.g., employment of formerly independent physicians and hospital acquisition of physician practices). Also consider that, in addition to more traditional asset and stock purchases, many hospital acquisitions of physician practices include hybrid arrangements whereby the hospitals and the physician groups have an ability to unwind the transaction relatively easily if the integration is not successful. Further, some physician “super groups” are formed to have the least amount of integration necessary to pass muster under the state and federal health care regulations (e.g., the Stark Law and the Anti-Kickback Statute, both federal).

Even in alignment relationships that involve a substantial degree of clinical and financial integration, there is often a tension between the level of integration that is required to thrive under ACA payment reform (e.g., flexibility to enter incentivizing financial relationships, share information, and coordinate care) and the current federal and state health care, tax exempt, and anti-trust regulations that restrict such alignment activity. Accordingly, the federal government has and continues to promulgate helpful guidance to assist in resolving these tensions and ambiguities.

Consider for example the waivers promulgated by the U.S. Department of Health and Human Services Office of Inspector General (OIG) and Centers for Medicare & Medicaid Services (CMS) and the guidance promulgated by the Internal Revenue Service (IRS), Federal Trade Commission (FTC), and U.S. Department of Justice (DOJ). Also consider the proposed rule issued by the OIG on October 3, 2014, that would amend the safe harbors under the federal Anti-Kickback Statute and modify and add flexibility under the Civil Monetary Penalties Law.

Irrespective of this increased flexibility, it is important for physicians and their attorneys to remember that the federal fraud and abuse laws remain alive and well. Integration transactions and related arrangements among health care providers remain subject to such laws despite the fact that such integration may advance the laudable goals of improving quality and efficiency. Attorneys representing health care clients need to assist their clients to work through this maze of ambiguities and determine the current state of the ever-changing federal health care laws, regulations, and guidance in this area.

Despite new flexibility under the ACA, federal fraud and abuse laws remain alive and well.

other programs, as well as similar programs adopted by the commercial payors. For attorneys assisting their clients to participate and comply with such federal programs, the best source of information is typically the Innovation Center website (innovation.cms.gov), which has an abundance of helpful webinars, data, reports, resources, and guidance.

INTEGRATING WITH OTHER HEALTH CARE PROVIDERS

Many physicians have realized that they need to align with each other and with other health care providers (e.g., hospitals and health systems) in order to thrive under the new health care payment regime that increasingly focuses on reimbursing physicians for the value instead of the volume of services provided. This is true not only because of the care coordination and information sharing needed to achieve the payment program quality and efficiency benchmarks, but

ORGANIZING, LEADING, AND JOINING ACCOUNTABLE CARE ORGANIZATIONS

To further advance its goals of improving the quality of care and decreasing expenditures, the ACA embraced the concept of accountable care organizations (ACOs). Although there are many definitions, ACOs are ultimately groups of health care providers that voluntarily come together to be accountable for the quality and efficiency of services provided to a certain population. In general, ACOs participate in shared savings programs that allow the ACOs to profit when savings are achieved and quality benchmarks are satisfied. Each shared savings program has unique requirements of participating ACOs, but must require some degree of clinical and administration coordination and information sharing — whether through contractual arrangements alone or highly integrated networks.

There are several types of Medicare ACOs and shared savings programs. The Medicare Shared Savings Program

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(MSSP) was established under Section 3022 of the ACA. Additional information regarding the MSSP, including the latest guidance such as the December 8, 2014, MSSP proposed rule, can be found on the CMS website (see, for example, tinyurl.com/pgtlway).

Many ACOs also participate in the Medicare Pioneer ACO Model and the Medicare Advance Payment ACO Model, which are implemented through the Innovation Center. The Innovation Center website has much more information about each of these shared savings programs. In the Medicare context, the shared savings paid to ACOs under these programs are in addition to the fee-for-service compensation that their participants already receive from Medicare. It is important to remember that, although the ACA focuses on the shared savings programs and ACOs established by Medicare, ACOs participate (sometimes simultaneously) with shared savings programs established or sponsored by hospitals, commercial payors, and Medicaid.

Physician clients often feel overwhelmed or confused when reviewing their ACO participation options and lack negotiating leverage when reviewing their ACO participation agreements. That being said, it is very important that they understand the terms to which they are agreeing and maintain flexibility to the extent possible given the uncertainty in this context. Attorneys can assist in this regard.

GUARDING THE PRIVACY AND SECURITY OF PATIENT HEALTH INFORMATION
The ACA also builds on and strengthens the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the regulations promulgated under HIPAA. For example, the ACA imposes new rules for HIPAA transactions, new standards for electronic funds transfers and electronic health care claims, and related certification and penalty provisions.

Although not necessarily attributable to the ACA, physicians are, since the passage of the ACA, increasingly aware of and affected by HIPAA and the other federal laws and regulations designed to protect the privacy and security of patient health information. These laws require consumers and the government to be notified of certain breaches in the privacy and security of health information; require the federal government to audit the compliance by physicians, other covered entities, and business associates with HIPAA; and require the federal government to address complaints. Non-compliance with HIPAA can result in a variety of repercussions, including civil monetary penalties and criminal liability. (For a summary of the federal government’s HIPAA compliance activity and guidance regarding how to comply with HIPAA, visit hhs.gov/ocr/privacy.) As a result of this enforcement activity, many physicians realize that they must continuously review and strengthen their health information privacy and securities policies and procedures.

STRENGTHENING COMPLIANCE PROGRAMS AND PREPARING FOR AUDIT AND ENFORCEMENT ACTIVITY
Lastly, the ACA (especially Title VI) has strengthened the federal fraud and abuse laws adopted to protect the federal health care programs from fraud and waste. For example, the ACA has enhanced the monetary penalties, expanded the Recovery Audit Contractor (RAC) program, increased certain transparency and disclosure requirements, and allocated more resources toward the enforcement of the federal health care regulations.

Consistent with these initiatives, Section 6401 of the ACA mandates that all providers and suppliers establish compliance programs as a condition of Medicare enrollment. Although the core elements of such mandatory compliance programs have not yet been promulgated, more and more physician practices are realizing the importance of compliance and are developing compliance plans. Attorneys drafting such compliance policies and procedures are guided by existing OIG guidance. For example, the OIG Roadmap for New Physicians (tinyurl.com/kluuox9) is one of

Physicians are realizing that, for good or bad, the status quo is no longer an option.

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CONCLUSION
The trend today is for health care providers to align with one another to coordinate care and adopt initiatives designed to improve the quality and efficiency of the health care services that they provide. At the same time, the federal government is actively and strictly enforcing its complex and robust regulatory regime. Many physicians are realizing that, for good or for bad, the status quo is not an option. Attorneys are working with their physician clients to navigate the federal law and guidance and help poised their physician clients for future success in this rapidly changing health care environment under the ACA.
The Affordable Care Act and People with Disabilities

By Silvia Yee

The significance of the Patient Protection and Affordable Care Act (ACA) for many solo practitioners and attorneys who work in smaller partnerships and practices extends beyond the law’s relevance to clients. The ACA increases insurance options for attorneys without employment insurance and makes affordable insurance a possibility for attorneys with disabilities, chronic conditions, or dependents who have disabilities. Obtaining insurance is not, however, the same as having adequate coverage, and the American health care system remains complex and difficult to navigate even after ACA-initiated reforms. Although the ACA made important changes to public health programs such as Medicare and Medicaid, this article will mostly focus on private health insurance reform and the marketplaces. As with any major legal change, there is some good news and some not-so-good news. Following are some of the major health care reforms and remaining barriers for people with disabilities.

**GOOD NEWS**

**No refusal for a pre-existing condition.** The ACA is a complex piece of legislation. Some changes affect all health insurance companies and plans, some are directed primarily at health insurance offered within the marketplaces, and some components are aimed at public programs such as Medicare and Medicaid. One of the most positive and broadly applied reforms for people with disabilities is the prohibition on health insurance companies’ denying issuance because of a pre-existing condition such as cancer, asthma, or another chronic condition. Insurers also cannot refuse treatment or charge more for treatment under a policy that is issued to a person with a disability. This holds true for health insurance that is sold through a marketplace, insurance products sold outside of a marketplace, employment insurance, and Medicaid and Medicare. The one exception is for individual grandfathered plans (individually purchased plans that existed as of March 23, 2010, and that have not substantially cut their benefits or increased costs since that time).

It would be hard to overstate the difference this single reform makes to the lives of uninsured or underinsured people with disabilities. Even though health insurance companies are not exempt from the Americans with Disabilities Act of 1990 (ADA), people with disabilities have historically been treated differently in the realm of insurance because of the ADA’s “safe harbor” provision that allows certain insurance plans to have terms that treat people with disabilities differently on the basis of “underwriting risks, classifying risks, or administering such risks.” In theory, this provision only allows insurers to make coverage distinctions for people with disabilities when these differences are based on legitimate actuarial evidence. In practice, insurers often refuse insurance or offer only very expensive and inadequate coverage policies to people with a wide range of various disabilities, ranging from developmental disabilities that are present at birth to conditions acquired later in life such as breast cancer or traumatic brain injury. Many of these conditions do not necessarily shorten life span or equate with ill health, and insurers had little or no actuarial evidence to refuse or impose restrictions on health and life insurance.
Children on parents’ insurance until 26 years of age. Another positive change enacted early on by the ACA was one that allowed dependent children (i.e., a child for whom a parent claims a personal exemption tax deduction) under the age of 26 to remain on, or return to, their parents’ or a parent’s health insurance policy. An estimated 4.1 million young people age 15 to 24 have disabilities. An additional 500,000 reach adulthood each year and face losing health coverage. This change helped many families and adult children with disabilities at a critical time in their lives. Transitions commonly occur for students with disabilities after they turn 18 as they graduate from high school, attend or graduate from college, and seek employment and a more independent living situation, which could vary from one’s own apartment to a residential care facility. This provision of the ACA gives families and young adults with disabilities additional time to prepare for and get through these multiple life transitions while preserving critical medical and mental health provider relationships, as well as better coverage for durable medical equipment, assistive technology, and prescriptions than what may be available through student insurance or the employment insurance offered in one’s first few jobs.

Moreover, children with significant disabilities, who may have benefited from a pediatrician’s care coordination and other state Medicaid benefits and services geared specifically toward children with certain developmental disabilities, can face a jarring transition upon reaching adulthood. The switch to adult primary care doctors who frequently have little or no training with regard to disabilities, fewer specialists, and a greatly reduced array and availability of service providers can be very difficult to negotiate. A few extra years to plan and interview future providers can be invaluable.

**Essential health benefits.** One of the most significant reforms affecting the private insurance market is the requirement that insurance must offer specified categories of “essential health benefits” (EHBs) in order to be certified for the individual and small group marketplaces.

EHBs must include items and services within the following ten categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. States that choose to expand their Medicaid program must also offer the EHB categories to their expansion population, though not to their “traditional” Medicaid populations.

For the general public, the establishment of the EHB categories generally means an end to individual “junk” insurance products that provide wholly inadequate coverage, for example by setting very low daily or annual limits on something as basic as a hospital stay. For people with disabilities, the categories themselves are critical, especially the inclusion of prescription drugs, mental health and substance use disorder services, and rehabilitation and habilitation treatments and devices. Habilitative treatments, services, and devices allow one to acquire, keep, or improve functional abilities, as compared to rehabilitation, which covers the restoration or improvement of functional abilities that have been lost. The distinction is important to someone who has a congenital condition, for example; a young child may be working on gaining and improving communication skills that she has never had before.

While federal law establishes certain parameters for the EHB categories, states have also been given a great deal of flexibility in establishing the details of each category. Each state gets to choose its own “benchmark” plan, which in turn becomes the model plan that defines the EHB coverage that all other plans in a marketplace must offer. For people with disabilities, this flexibility has led to some difficulties. Again, looking at the category of habilitation, state insurers have not even traditionally used the term. The kinds of treatments and products that would fall into the category, ranging from wheelchairs and other durable medical equipment to physical and speech therapy, have usually been subject to a variety of historical controls such as annual caps, visit limits, or “replacement value” limitations (e.g., there is no annual or lifetime limit on a beneficiary’s power wheelchair, but only 50 percent of the replacement chair will be covered). When these limits are imbedded in the plan that a state chooses as its benchmark plan, the limits are theoretically imported into what that state will accept as allowable coverage of an essential health benefit.

It has also been difficult for people with disabilities to get the kind of coverage details needed to make an informed decision among marketplace products. Typically, insurance customer service representatives speak to you after you provide your member number. Marketplace plans are required to make a relatively standardized and easy-to-read “summary of benefits” available, but it will rarely provide the kind of weedy
detail that a person with particular disabilities or chronic conditions may need to know about specific drug or therapy coverage, applicable visit limits, durable medical equipment caps, or community-based rehabilitation program coverage. You may find that all your hard-earned abilities as a litigator and skilled negotiator will meet its match when you try to figure out, for example, whether and how a given marketplace plan covers your child’s need for augmentative communication therapies and devices.

Non-discrimination requirements. For anyone whose practice encompasses civil rights actions, Section 1557 of the ACA is highly significant. Section 1557 explicitly adopts and applies existing federal laws that prohibit discrimination on the ground of race, color, national origin, sex, age, or disability under “any health program or activity, any part of which is receiving Federal financial assistance . . . or under any program or activity that is administered by an Executive agency or any entity established under [Title I of the ACA] . . . .” Section 1557 applies to all the health insurance marketplaces created under the ACA, just as Section 504 clearly applies to federally conducted programs and activities such as Medicare and Medicaid. It is worth specifically noting that when the U.S. Department of Health and Human Services (HHS) issued the EHB regulations, it included lesbian, gay, bisexual, and transgender (LGBT) individuals by identifying discrimination on the basis of sex stereotyping and gender identity as a prohibited facet of discrimination on the basis of sex, even though there is no existing federal LGBT civil rights law. The HHS Office for Civil Rights expressly stated in spring 2014 that insurance companies could not discriminate against individuals on the basis of sexual orientation or gender identity, for example by refusing to insure same-sex spouses with respect to spousal coverage, and it stated that it would accept LGBT-based complaints in the health care context.

THE NOT-SO-GOOD NEWS
The above positive developments each took effect at different times, applied to different forums and types of insurance, and occurred within a complex mix of private and public health insurance that remains structurally unchanged. ACA reforms mean that the threshold problem of being uninsured has been fixed or alleviated for millions of Americans, including people with disabilities. In 2010 as many as 3.5 million adults with disabilities living in their communities had household incomes between 100 percent and 133 percent of the federal poverty level (FPL). A great majority of these individuals did not qualify for Medicaid and were likely uninsured, underinsured, and simply shut out of the private insurance market because of a pre-existing condition. In 2014 many of these adults benefited from their state choosing to participate in the ACA’s Medicaid expansion for people earning up to 133 percent of the FPL. Others who do not qualify for Medicaid expansion have gained insurance through the marketplace and possible eligibility for insurance tax credits. However, the next step of finding and keeping affordable adequate coverage remains immensely complicated.

Few of us live with the assurance of stable jobs and incomes for prolonged periods. Those of us whose income may vacillate near the FPL occasionally or from year to year are already subject to “churning” between expansion Medicaid and marketplace coverage. Individuals with disabilities can be subject to fluctuating income levels because changes in a disability or chronic condition can directly affect one’s employment capacity, and they also are subject to increased complexity because they are potentially eligible for traditional Medicaid coverage, expansion coverage, and marketplace coverage in any given year. Although many states that expanded Medicaid chose to offer the expansion population the same benefit package that was offered through traditional Medicaid in the state, this is not true in every state, and there is no requirement that the benefit packages remain equal in future. Each change of insurance category brings potentially significant changes in coverage, affecting the drugs one can receive, the doctors one can see, the number of treatments one can have, and the out-of-pocket expenses and deductibles to which one is subject.

In addition, we all undergo unplanned major life events: job loss, divorce (which can lead to changes in household size and income), the birth of a child, changes in employment hours, or a move to another

ADDITIONAL RESOURCES
- Engaging true stories about the barriers experienced by people with various disabilities when they seek standard and specialized health care, compiled by the Disability Rights Education and Defense Fund (DREDF), are available at dredf.org/healthcare-stories.
- Enrollment options for the 2015 enrollment period in the federal marketplace (covering the individual market for 37 states) can be viewed at healthcare.gov. The 13 state-run marketplaces have their own websites.
- The Center for Consumer Information and Insurance Oversight (CCIIO) is part of the U.S. Department of Health and Human Services and oversees implementation of those portions of the ACA that relate to private health insurance. Topic-specific fact sheets and Q&As are available at cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/index.html.
- The National Disability Navigator Research Collaborative (NDNRC) provides topical fact sheets and a guide written in lay language intended to support federal marketplace navigators and assisters when giving technical assistance to applicants with disabilities at nationaldisabilitynavigator.org/ndnrc-materials/fact-sheets.
- The Kaiser Family Foundation provides in-depth policy analysis and information on the ACA, including information on public programs such as Medicare and Medicaid, at kff.org/health-reform.
state for work or personal reasons. All these events can now trigger changes in insurance eligibility, whether that insurance is sourced in employment, the marketplace, or a public program. People without disabilities experience the same life changes and uncertainties as those with single or multiple disabilities or chronic conditions, but there is a vital difference. The fact of disability intensifies the urgency and daily priority of the need for health insurance. People who don’t have disabilities or dependents with disabilities can think that, as with making a will or starting a retirement fund, they can deal with their health needs “later” when they will have more income or be at a more stable place in their lives. People with disabilities can’t afford that kind of self-delusion, not including provisions that require data collection on where people with disabilities get access to health services and where accessible facilities can be found, but these provisions remain unfunded. In practice, many consumer surveys and health care quality measures continue to treat disability as only a health outcome rather than a population characteristic. If people with disabilities cannot be distinctly identified within a population, the quality of care that they receive or fail to receive cannot be accurately determined or compared.

Third, Medicaid remains the single public source of long-term home- and community-based services (HCBS), and it is only available to low- and very-low-income individuals. Health care insurance reform under the ACA has not succeeded in establishing or even encouraging private financing of the services and supports that people with disabilities of all ages need to maintain productive lives in their communities. The American public may be unwilling to “go gentle into that good night,” but we are somehow resigned to living out our final years in nursing homes because we refuse to prepare realistically for the likelihood of needing HCBS as we age. Young people with disabilities and chronic conditions, on the other hand, are not in denial concerning their need for HCBS, but very few have the wherewithal to pay for significant out-of-pocket medical expenses and current personal assistance needs while simultaneously saving for anticipated future health care and HCBS. People with significant disabilities whose income or assets are currently too high to qualify for Medicaid face the unpalatable fact that they can never afford to retire.

Taken together, these remaining deficiencies mean that the American health care system, at its core, remains unprepared to adequately serve our parents, our spouses, ourselves, and our children as we age. Ultimately the call for health care reform that serves the needs of people with disabilities is not a matter of altruism or charity but a matter of self-interest. The ACA initiated some very significant first steps. Let’s finish the job.

Some health care issues unique to people with disabilities have only just begun to be addressed.

POSTSCRIPT
As of the time this issue went to press, the U.S. Supreme Court had not yet heard arguments in King v. Burwell that are scheduled for March 4, 2015. The high court granted certiorari November 7, 2014, for the case, which in a nutshell will decide whether the ACA authorized federal tax subsidies in the 34 states that are operating through the federal marketplace instead of establishing an independent state-run marketplace. Further discussion of the ramifications of the Supreme Court’s decision in King is outside the scope and space of this article, but additional information and analysis can be found at tinyurl.com/kqpc4jc.

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False Claims Act Litigation under the Affordable Care Act

By Brett W. Barnett and Jason S. Greis
Since its enactment during the Civil War, the False Claims Act (FCA) has served as one of the government’s primary civil remedies for redressing false or fraudulent claims for funds allocated under federal health care programs (today most typically Medicare). In its simplest form, the FCA allows for an individual (known as a “relator”) to file suit on behalf of himself/herself and the United States. The cases are initially filed under seal while the government conducts its investigation of the alleged fraudulent activities and determines whether it will intervene on the relator’s behalf. Ultimately, if the government chooses to intervene on the relator’s behalf and proceeds successfully with the action, the relator can recover between 15 percent and 25 percent of any proceeds; if the government chooses not to proceed with the action but the relator decides to proceed independently, the relator can recover between 25 percent and 30 percent of the proceeds. 31 U.S.C. § 3730(d)(1)-(2).

The Patient Protection and Affordable Care Act (ACA) amended several key portions of the FCA and related federal fraud and abuse statutes. These amendments have minimized the effect of several formidable FCA defenses and have made it easier for relators to keep their cases alive. Although one cannot attribute the increase in the number of relator-initiated FCA cases entirely to these ACA amendments, it bears noting that there has been a dramatic increase in the number of FCA cases in the health care arena each year since the ACA’s passage and that the number of relator-initiated suits in 2013 was nearly double the number of such suits in 2009—the year before the ACA’s passage.
This article provides an overview of two of the more significant amendments to the FCA brought by the ACA: the lessening of the public disclosure bar and the creation of additional reporting obligations for overpayments from federal health care programs.

**The Public Disclosure Bar**

Prior to the ACA, the public disclosure bar served as one of the strongest and quickest ways to dismiss a false claims action. Broadly speaking, this defense required a court to dismiss an FCA claim where it was discovered that the underlying allegations were based on a public disclosure by someone other than the relator. The ACA drastically undercut the public disclosure bar by (1) limiting the effect of a public disclosure finding, (2) granting the government discretion over a dismissal owing to public disclosure, (3) limiting what constitutes a public source, and (4) providing a relator with a lower standard to qualify as an “original source.”

The ACA dramatically limited what constitutes a public disclosure.

First, the public disclosure of the underlying allegations no longer serves as a jurisdictional bar to an FCA case. Prior to the ACA, the public disclosure statute provided that “[n]o court shall have jurisdiction over an action under this section based upon the public disclosure of allegations.” The impact of a public disclosure finding was clear: The court no longer had subject matter jurisdiction over the case. In its current form, however, the statute reads: “The court shall dismiss an action or claim under this section unless opposed by the Government, if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed.” 31 U.S.C. § 3730(e)(4)(A). Gone from the text is an indication that a public disclosure finding divests the court of jurisdiction.

The question of whether a public disclosure still serves as a jurisdictional limitation under the ACA amendments has divided courts. On the one hand, the court in *United States ex rel. Beauchamp and Shepherd v. Academi Training Center, Inc.*, 933 F. Supp. 2d (E.D. Va. 2013), found that despite the removal of the word “jurisdiction” from the statute, the public disclosure bar remains jurisdictional because courts are still commanded to dismiss actions. The majority of courts, however, have found that the ACA removed the jurisdictional bar and that a public disclosure defense is akin to dismissal for failure to state a claim. See, e.g., *United States ex rel. May v. Purdue Pharma*, 737 F.3d 908 (4th Cir. 2014); *United States ex rel. Ping Chen v. EMSL Analytical, Inc.*, 966 F. Supp. 2d 282 (S.D.N.Y. Aug. 16, 2013).

The practical consequences of eliminating the jurisdictional bar from a public disclosure challenge are three-fold. First, as alluded to above, whereas jurisdictional challenges can be made at any time under Federal Rule of Civil Procedure 12(b)(1), Rule 12(b)(6) is the proper vehicle for challenging non-jurisdictional issues and such motions can only be brought before or at trial. Moreover, while under Rule 12(b)(1) a court may look beyond the pleadings and review any extraneous evidence, a court’s review is generally limited to the pleadings under Rule 12(b)(6). Second, whereas under Rule 12(b)(1) the plaintiff bears the burden of demonstrating jurisdiction is proper, under Rule 12(b)(6) the plaintiff’s allegations are taken as true. Finally, defendants must now plead a public disclosure as an affirmative defense, which means that the defense is subject to waiver arguments.

Next, as indicated above, under the ACA the government is given the opportunity to oppose dismissal owing to public disclosure. Although this amendment generated substantial commentary upon its passage, it appears that it has yet to be used by the government, or at least that no court has been confronted with addressing this amendment. See *United States ex rel. Sanchez v. Alhabarba*, No. 10-61673 (S.D. Fla. June 4, 2012) (the court noted that the government had indicated that it would not exercise its discretion and oppose dismissal on the basis of a public disclosure). Consequently, the government has not indicated what criteria or factors it will consider when deciding whether to oppose a public disclosure challenge.

Third, the ACA dramatically limited what constitutes a public disclosure. In the months prior to the passage of the ACA, the U.S. Supreme Court resolved a circuit split and held that administrative reports, hearings, audits, and investigations at the federal, state, and local levels all constituted sources for public disclosure. *Graham County Soil & Water Conservation District v. United States ex rel. Wilson*, 559 U.S. 280 (2010). The ACA effectively gutted the Court’s *Graham County* ruling, however, as the statute now clarifies that public disclosure sources are limited to federal criminal, civil, and administrative proceedings in which the government is a party; federal reports, hearings, audits, and investigations; and news media. As such, state and local proceedings and cases in which the federal government is not involved no longer qualify as public sources.

Fourth, the ACA modified the “original source” exception to the public disclosure bar. By way of background, in cases where there has been a public disclosure, the “original source” exception allows for a relator to proceed with an FCA claim where it can demonstrate
that the relator had “direct” and “independent” knowledge of the information. The ACA, however, eliminated the “direct” knowledge requirement, and now a relator can qualify as an “original source” so long as a relator has independent knowledge that “materially adds” to the publicly disclosed allegations. Of significance, “materially adds” is an undefined term.

Although the “materially adds” requirement was apparently intended to ease the requirements for qualifying as an “original source,” courts thus far have imposed a somewhat heightened standard for relators. For instance, in United States ex rel. Paulos v. Stryker Corporation, 762 F.3d 688 (8th Cir. 2014), the court found that the relator could not qualify as an original source because regardless of whether the relator’s knowledge was gained independent from the publicly disclosed sources, the relator was unable to explain how this information would contribute to the government’s case. See also United States ex rel. Kraxberger v. Kansas City Power & Light Company, 756 F.3d 1075 (8th Cir. 2014) (holding that the relator’s knowledge did not materially add to what was publicly disclosed because it was similar to what had already appeared in public documents); United States ex rel. Lockey v. City of Dallas, Texas, No. 3:11-cv-354-0 (N.D. Tex. Jan. 23, 2013) (same).

OVERPAYMENT REPORTING OBLIGATIONS

Although the public disclosure amendments have created the most commentary among the FCA bar, the ACA’s amendment of the reporting and repayment obligations for health care providers and suppliers receiving overpayments from federal health care programs will have a significant impact in FCA litigation going forward.

By way of background, in 2009 the Fraud Enforcement and Recovery Act redefined the term “obligation” under the FCA to include “the retention of any overpayment” from one of the federal health care programs. 31 U.S.C. § 3729(b)(3). The ACA did not create new liability under the FCA for the reporting and returning of overpayment; instead, it attempted to provide guidance on the procedure for identifying an overpayment and the timetable for returning such an overpayment. Unfortunately, the ACA had the opposite effect and created confusion among health care providers and suppliers.

Under the ACA a medical provider is required to report and return any overpayment within 60 days of identification of the date any corresponding cost report is due. A provider’s failure to timely report and return any overpayment constitutes a per se FCA violation.

The ACA, however, did not explain what triggers the 60-day period; “identified” is an undefined term. As such, providers were uncertain as to whether they had an affirmative obligation to search through Medicare and Medicaid payments to determine whether there had been an overpayment or whether the statute only prohibited the knowing retention of an identified overpayment where the provider had an obligation to ensure proper payment. Additionally, providers were uncertain whether the 60-day clock started when the overpayment was first identified or whether it started on the date the erroneous data was submitted that caused the overpayment.

On May 19, 2014, more than four years after the ACA was passed, the Centers for Medicare & Medicaid Services issued a Final Rule, explaining how it plans to interpret and enforce the ACA amendment. The Final Rule clarifies that the date of identification begins when the provider “has determined or should have determined through the exercise of reasonable diligence” that it received an overpayment. (The Final Rule only applies to Medicare Part C and Part D programs; Medicare Part A and Part B providers are still awaiting a Final Rule for interpretation as to how the report and return requirements will apply to them.) Given how recently the Final Rule was issued, much uncertainty remains as to how tenacious the government will be in its enforcement of the report and return overpayment rules. Nevertheless, given the strict requirements for reporting and the short time frame a provider has to return an overpayment, it seems likely that this will be an area of increased FCA litigation in the near future.

CONCLUSION

Although the ACA was passed more than four years ago, we are still just beginning to see its impact in the FCA arena as it works its way through the courts. The changes to the public disclosure bar and the report and return obligations for providers constitute two of the more significant changes created by the ACA, and going forward we expect to see the next wave of creative defenses and recurrent litigation in these two areas.

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Storing and Electronic

Protecting Medical records in the Age of HIPAA and storing electronic

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The term HIPAA can refer to a great many legal concepts, given that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) covers a broad range of issues. For the purposes of this article, however, the term refers to the federal laws and regulations governing the use and disclosure of medical records. These laws and regulations are often referred to as the “Administrative Simplification” statute and rules.

**THE FOUNDATION OF HIPAA ADMINISTRATIVE SIMPLIFICATION**

The Administrative Simplification statute is set forth under Title II, Subtitle F, of HIPAA, codified as Section 1171 through 1179 of the Social Security Act. Its core purpose is to improve the Medicare and Medicaid programs—and the efficiency and effectiveness of the health care system in general—by establishing standards and requirements for the electronic transmission of health information. In other words, as the health care system began moving away from paper-based medical records and toward electronic health record systems, Congress deemed it important to unify the digital format for electronic medical information transactions. The rules created to address this issue are known as the HIPAA Transactions and Code Set Standards.

Unifying the format of medical information makes it more likely that different entities will be able to exchange health information accurately and effectively, and also provides a clear set of software criteria that can be used to design and build interoperable electronic health record systems. However, encouraging electronic medical records and interoperable software brings about heightened concerns with respect to the privacy and security of the sensitive patient information contained therein. For this reason, the HIPAA Transactions and Code Set Standards are accompanied by three specific regulatory structures designed to protect the privacy of both paper and electronic patient information, as well as the security of electronic patient information.
The U.S. Department of Health and Human Services Office for Civil Rights (OCR) is the federal agency that created, administers, and enforces the Administrative Simplification rules. All these rules, together with a wealth of commentary, guidance, and FAQs, can be found on the OCR’s Administrative Simplification website (hhs.gov/ocr/privacy).

There are three core Administrative Simplification rules: the HIPAA Privacy Rule, the HIPAA Security Rule, and the HIPAA Breach Notification Rule. Generally speaking, the HIPAA Privacy Rule provides the circumstances under which intentional uses and disclosures of patient information are permitted; the HIPAA Security Rule provides the safeguards required to prevent unintentional uses and disclosures of patient information; and the HIPAA Breach Notification Rule describes the notifications that patients are required to receive if an unintentional use or disclosure of patient information occurs.

For lawyers, the most important concept in the HIPAA Security Rule is encryption.

The Administrative Simplification rules apply to “covered entities” and, to a somewhat lesser degree, “business associates.” The two main types of covered entities are: (1) health plans (including many employer-sponsored group health plans) and (2) health care providers who transmit health information using the HIPAA Transactions and Code Set Standards. Business associates are entities that provide administrative services to a covered entity using the covered entity’s patient information. For example, a law firm that represents a hospital in a medical negligence claim and receives patient data from the hospital in the course of the representation would most likely be considered a business associate. By contrast, a law firm that represents the plaintiff in a medical negligence claim is not a business associate, even if it receives patient information as part of the representation, because it is not providing administrative services to a covered entity.

The Administrative Simplification rules protect a particular category of information, referred to as “protected health information” (PHI). PHI encompasses all health information that is created or received by a covered entity and which relates to: (1) the past, present, or future physical or mental health condition of an individual; (2) the provision of health care to an individual; or (3) the past, present, or future payment for the provision of health care to an individual. PHI excludes health information that does not identify an individual so long as there is no reasonable basis to believe the information could be used to identify the individual.

Great care should be used when applying the exception for health information that does not identify an individual. In March 2010 the OCR held a series of health information de-identification workshops that resulted in its “Guidance Regarding Methods for De-identification of Protected Health Information in Accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule” (tinyurl.com/a4lf65x). The OCR’s de-identification guidance provides a safe harbor for making health information “de-identified,” and complying with the safe harbor requires one to remove at least 18 types of identifying information (including all geographic subdivisions smaller than a state). Thus, one can’t assume information is outside the scope of PHI simply because common identifiers such as name and address have been taken out.

The HIPAA Privacy Rule
The HIPAA Privacy Rule provisions are, more or less, divided into two categories: (1) rules about when and how PHI can be used or disclosed; and (2) rules for preserving a patient’s rights with respect to his or her PHI. The first category, rules about using and disclosing PHI, can be summarized with the following rule of thumb: A covered entity or business associate may not use or disclose PHI unless (1) it has first received a HIPAA-compliant authorization that has been signed by the patient identified in the information or (2) a specific exception set forth in the HIPAA Privacy Rule applies. Thus, having an authorization signed by the patient generally avoids the need to analyze whether any given use or disclosure is permissible under the HIPAA Privacy Rule.

Nevertheless, many uses and disclosures are permitted without a patient’s authorization. For example, covered entities may disclose patient information for treatment purposes, to obtain payment for services, and to manage their operations (frequently referred to as the “treatment, payment, and health care operations” exception). Exceptions also exist for several other scenarios, such as judicial proceedings, public health reporting, law enforcement, and medical research. All the HIPAA Privacy Rule exceptions contain details about when and how they are to be applied, so it’s important to fully understand the use or disclosure exception being utilized when a patient authorization has not been obtained.

The second category of the HIPAA Privacy Rule, rules for preserving a patient’s rights, addresses how covered entities must interact with patients about their PHI. Most importantly, all covered entities must publish a notice of privacy practices that is designed to inform patients about the uses and disclosures to which their PHI might be subjected. Additionally, patients...
have the right to access and copy their PHI, the right to be provided with an accounting of certain uses and disclosures that have actually been made, and the right to amend their PHI if they believe it is not accurate. Like the use and disclosure rules, each of the HIPAA patient rights contains many details and exceptions, and it’s important to fully understand these details and exceptions when applying them to any specific case.

THE HIPAA SECURITY RULE
The HIPAA Security Rule is divided into three categories: (1) rules designed to ensure the technical security of PHI (such as virus protection, firewalls, and encryption); (2) rules designed to ensure the physical security of PHI (such as locks, security cameras, and restricted access areas); and (3) administrative rules designed to ensure that secure practices are followed (such as written security policies, password management practices, and sanctions for policy violations). In this author’s opinion, the single most important concept in the HIPAA Security Rule that attorneys should be familiar with is that of encryption.

Encryption can be understood on three levels, and the citations that follow are taken from the OCR’s “Guidance to Render Unsecured Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals” (tinyurl.com/mxt3sjt). The first level is “data at rest,” which refers to electronic information that is being stored for later use (such as on a hard drive or flash drive). This type of information should be encrypted in accordance with National Institute of Standards and Technology (NIST) Special Publication 800-1. The second level is “data in motion,” meaning electronic information that is being transmitted from one storage location to another (such as between a laptop and a cloud storage service). This type of information should be encrypted in accordance with NIST Special Publications 800-52, 800-77, 800-113, or others that are Federal Information Processing Standards (FIPS) 140-2 validated. The third level is “data at end of life,” which refers to paper documents or electronic media being thrown away or recycled. Electronic media in this category should be cleared, purged, or destroyed consistent with NIST Special Publication 800-88. Paper, film, or other physical information should be shredded or destroyed in a manner that makes it realistically impossible to be read. The OCR has specifically excluded redaction alone as a method of data destruction.

THE HIPAA BREACH NOTIFICATION RULE
Most importantly, note that PHI that has been encrypted as described above is not subject to the HIPAA Breach Notification Rule, even if it is lost or stolen. Beyond that, any use or disclosure that is not permitted under the HIPAA Privacy Rule is generally considered a “breach” if it compromises the security or privacy of the PHI. A breach is presumed unless the covered entity or business associate can demonstrate a “low probability” that the PHI has been compromised. To make this demonstration, the covered entity or business associate must perform a written risk assessment using specific factors set forth by the OCR, and this risk assessment must be kept for at least six years. Assuming a breach has occurred and the written risk assessment doesn’t show a low probability of compromise, the covered entity and business associate must undertake a detailed notification process, and it must happen without “unreasonable delay” (but in no case later than 60 days after the date the breach is discovered or should have been discovered with reasonable diligence).

HITECH AND THE ELECTRONIC STORAGE OF MEDICAL RECORDS
On February 17, 2009, Congress enacted the Health Information Technology for Economic and Clinical Health Act (HITECH). The fundamental purpose of HITECH is to encourage investment in health information technology, and the act specifically authorized administrative incentive programs to improve quality of care, patient safety, and health care efficiency through new adoption of technology. The core program used to accomplish this goal, called Meaningful Use, is carried out through Medicare and Medicaid incentive payments for certain providers and hospitals that adopt certified electronic health record technology (CEHRT) and use it to achieve specified objectives. The current foundation for electronic storage of medical records is the set of technical standards being established by the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC).

In addition to incentivizing providers to adopt CEHRT, the Meaningful Use program is creating an impetus for providers to use their CEHRT to make electronic patient information available to other providers who might treat the same patient. Two technologies are rapidly emerging to meet this need: health information exchange software (HIE) and health information service provider software (HISP). HIE is a software platform used to connect the CEHRT of several different providers in a manner that allows each to search and retrieve medical records from the other. HISP is a software platform used to securely transmit medical records directly from one CEHRT to another. In combination, the rapidly developing technologies of CEHRT, HIE, and HISP are hoped eventually to create a secure global network of health information whereby any medical provider would have access to the most relevant and current information possible about each of its patients.

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Unravelling the Mysteries of the Family and Medical Leave Act

By Daniel A. Schwartz and Christopher Engler

Just as the Patient Protection and Affordable Care Act (ACA) was the signature health care achievement of President Barack Obama’s first term, the Family and Medical Leave Act (FMLA) was an early health-related priority for President Bill Clinton. Its acronym is now firmly in the lexicon of lawyers, politicians, and the public. But despite being the law of the land for more than two decades, the FMLA remains a source of trepidation and confusion for attorneys, judges, and clients. No article could attempt to solve all the mysteries associated with the law, but we’ll try to resolve at least a few.

Although this article will focus exclusively on the federal FMLA, it’s worth noting that several states have enacted laws guaranteeing somewhat greater family and medical leave benefits than the FMLA; Connecticut has gone even further by offering paid sick leave for some workers. This article will not tackle such state-by-state provisions, but there are ample online resources for lawyers and employers to do so.

Simply stated, the FMLA provides eligible employees with unpaid leaves of absence for certain family and medical reasons. From this general proposition we can pull three key questions. First, what sort of leave does the FMLA provide? Second, for which medical or family reasons may someone take leave? Third, what is an eligible employee? We will tackle the first two questions together before moving on to the third.

Benefits

The purpose of the FMLA is to provide eligible employees with unpaid and job-protected leave for certain medical and family reasons and to ensure their return to the same position.

The first and most obvious takeaway from this and the most misunderstood provision is that the leave is unpaid, not paid. Although some employers might allow (or be required by contract to allow) their employees to receive pay during an FMLA leave, such as by utilizing sick or vacation time, such conduct is not required by the federal law.

A second point is the nature of the job protections. Following the end of an employee’s FMLA leave, that employee must be returned to the previous job or an equivalent job. An “equivalent” job must have similar terms and conditions of employment, including salary and benefits. On a related note, the FMLA also requires employers to continue an employee’s health insurance coverage during the employee’s FMLA leave as if the employee had not taken a leave. In other words, if the employer usually pays 90 percent of premium costs, it must continue doing so during the employee’s
PAID SICK LEAVE

Although the FMLA does not require that a leave of absence be paid, this fact is not necessarily the end of the story. A growing number of cities and states have enacted legislation guaranteeing paid sick leave for some employees.

San Francisco became the first jurisdiction to guarantee paid sick leave in 2006. The city’s law, which was enacted by a ballot initiative, provides paid sick leave to all employees. Other major cities, including New York City and Washington, D.C., have since followed suit in some manner. In places such as New Jersey, where a statewide bill has not yet been considered by the full legislature, municipalities both big and small have taken it upon themselves to pass ordinances.

On the state level, Connecticut took the lead when its paid sick leave law went into effect on January 1, 2012. With some exceptions, this law applies to employers with 50 or more employees and provides an hour of paid sick leave for every 40 hours worked (up to 40 hours per year). However, it only applies to “service workers” who work in one of 68 listed occupations. As of February 2015, California and Massachusetts have both passed similar laws. Both states’ laws are more generous than Connecticut’s, in terms of both breadth of eligibility and rate of accrual of paid sick leave. Other state legislatures across the country have considered or are considering variations of these laws.

The future of paid sick leave is hard to predict. A bill guaranteeing some form of paid sick leave has been introduced in Congress regularly since 2004. However, even if Congress were to pass a uniform law that applied nationwide, the legislation already enacted by states and municipalities would continue in effect unless the federal law was more generous. In the meantime, expect this trend to continue in a patchwork pattern.

A key remaining question is how the growth of paid sick leave will affect the FMLA. While the variety of eligibility requirements and benefit guarantees makes it difficult to generalize, it seems safe to say that the two types of leave will at most complement each other. That is to say, just as many employers who voluntarily grant paid sick leave already require an employee to utilize any available paid time off as part of an FMLA leave, so, too, will many of the employers covered by these new requirements. As a result, the mechanics of FMLA leaves will not be significantly affected.

leave. The employee remains on the hook for the remaining 10 percent.

The leave entitlements are relatively straightforward. The FMLA grants up to 12 weeks of leave during a 12-month period (which can be calculated in different ways by an employer) for any of a number of reasons. Permissible reasons are the birth, adoption, or foster placement of a child; caring for a spouse, child, or parent with a serious health condition; the employee’s own serious health condition; or certain “qualifying exigencies” related to the fact that a spouse, child, or parent is on active duty in the military. In addition, the FMLA also grants up to 26 workweeks during a 12-month period to care for a member of the military with a serious injury or illness if the servicemember is the employee’s child, spouse, parent, or next of kin.

To qualify for standard FMLA, an employee’s own serious health condition must render the employee either unable to work or unable to perform an essential function of the job. The serious health condition of an employee’s spouse, child, or parent may also be a trigger if that family member is unable to care for him- or herself or is in a condition that necessitates the employee to provide transportation or psychological comfort to the family member.

But the FMLA is not without its quirks. For example, the FMLA does not require that the leave be taken all at once. Employees can take intermittent FMLA leave using only a few hours at a time, either on a regular basis or periodically. An employee taking intermittent leave still only receives the equivalent of 12 weeks of leave.

In order to use FMLA leave, an employee must comply with the employer’s standard requirements for requesting leave. The employee must also provide enough information for the employer to decide if the requested leave could be an FMLA leave. The FMLA requires employees to request leave at least 30 days in advance when possible, but it recognizes that an employee’s need for a leave is not always foreseeable.

The FMLA has obligations for employers, too, including the requirement to provide notices. In addition to posting information about the FMLA on the company’s bulletin boards or handbook, the employer must recognize when an employee’s requested leave falls under the FMLA. The employer must then inform the employee of his or her rights and eligibility under the FMLA. Reading between the lines, this requirement puts the burden of classifying a requested leave as FMLA leave on the employer, not the employee who makes the request. The employee need not even mention the FMLA in his or her request; it’s up to the employer to take action.

However, the employer does not need to take an employee’s request for leave at face value. If the request relates to the serious health condition of the employee or a covered family member, an employer can require medical certification from a health care provider. The employer can even require second or third opinions.

The FMLA provides employees with two options for enforcing their rights. They can either file a complaint with the U.S. Department of Labor’s Wage and Hour Division or bring a private lawsuit. Although there is some debate about the causes of action provided by the FMLA, an employee’s claim will generally fall into one of two categories: interference or retaliation. In an interference claim, the issue is simply whether the employer somehow prevented the employee from exercising his or her rights under the FMLA. A retaliation claim alleges that the employer subjected the employee to an adverse employment action because of the employee’s exercise of rights under the FMLA. FMLA retaliation claims resemble retaliation claims under anti-discrimination statutes.

ELIGIBILITY

There are four prongs to the FMLA eligibility analysis. Two of these relate to the individual’s employment history and
two relate to the individual’s employer.

First, the employee must have worked for his or her current employer for at least 12 months. Generally speaking, the 12 months do not need to be consecutive. As a result, seasonal workers will often satisfy this requirement even if they work only a few months each year. Employees who leave a job and return later will also often qualify, as long as the break in service was less than seven years. Even if the employee’s break in service was longer than seven years, other sources of law—such as a collective bargaining agreement or the Uniformed Services Employment and Reemployment Rights Act (USERRA)—may require an employer to count the employee’s time worked cumulatively.

Second, the employee must have logged at least 1,250 hours for his or her current employer in the previous year. For the purposes of this requirement, the FMLA looks at the 12-month period immediately preceding the employee’s leave of absence. As a point of reference, an employee working 40 hours each week will log 2,080 hours in a year. This 1,250-hour requirement translates into full-time work for roughly 31 weeks, or 24 hours per week for a full year. Therefore, employees who regularly work half-time or less will typically not be eligible for FMLA, and neither will seasonal employees who work for an employer for a few months per year.

Third, the employee must work at a worksite that is within 75 miles of at least 50 employees of the employer. A worksite can be a single location or a group of adjacent buildings, such as a college campus. An employee’s worksite is the location to which the employee usually reports. For employees without a fixed worksite, such as traveling salespeople and construction laborers, the Department of Labor’s regulations use the location from which the employees’ work is assigned. The distance is not measured as the crow flies but as the employee drives. In other words, the analysis considers the shortest distance via roads and highways to determine what lies within 75 miles. Suffice to say that this analysis is easier with a website such as Google Maps.

Fourth and finally, the employee must work for a covered employer. It is the expansive definition of this term that gives the FMLA such a broad reach. Different definitions apply to the public and private sector. In the public sector, a “covered employer” is any public agency, regardless of how many employees it has. All federal, state, and local government agencies are considered public agencies under the FMLA. By regulation, the Department of Labor has clarified that the definition also includes both public and private schools. Therefore, the FMLA applies equally to an enormous federal agency with tens of thousands of employees and a small rural police department with only a handful of deputies. Of course, some states have different ideas, but we’ll save that for another article.

The definition is somewhat more complicated in the private sector. A “covered employer” is any private employer that has employed at least 50 employees in at least 20 workweeks in the current or previous calendar years. In calculating whether an employer meets this threshold, the Department of Labor’s regulations count all employees who are on the employer’s payroll on the first working day of a given calendar week. Therefore, an employee who starts work on a Wednesday will not count for that week if the employer’s workweek is Monday through Friday.
However, for purposes of determining who is “on the payroll,” part-time and full-time employees are counted equally. Employees who are temporarily out of work on paid or unpaid leave are also counted, so long as the employer expects that the employees will eventually return to active duty. This would include employees taking FMLA leave and even employees who have been suspended for disciplinary reasons.

An employee’s FMLA eligibility is unrelated to the “covered employer” analysis.

To better understand how these concepts work together, consider a commercial landscaping company. This company serves customers throughout a mid-sized metropolitan area. The company employs four full-time office workers year-round at the company’s office. The company also employs two mechanics who work 20 hours per week throughout the year maintaining the company’s landscaping equipment, also at the company’s office. Each May, the company hires 45 seasonal workers. These landscapers work throughout the spring and summer and are laid off in October when the seasons start to turn. Their hours during this period vary depending on the weather and customer demands.

In any given December, which employees are eligible for FMLA leave?

Start with the “covered employer” analysis. Because this is a private company, the 50-employees/20-weeks threshold is at issue. For six months (January through April and November through December), the company has only six employees on the payroll. However, during the landscaping season the company employs 51 employees. It does not matter that the mechanics work half-time or that the landscapers have inconsistent hours. The landscaping season is roughly six months, which exceeds the 20-week requirement. As a result, the company is a covered employer.

Tweaking the facts slightly, assume that both mechanics were fired the prior year for joyriding in a tractor. Although this modification brings the company’s labor force down to 49 employees for the current year, the company remains a covered employer because it satisfied the requirement in the previous calendar year. Similarly, if both mechanics had been suspended for their misconduct instead of being fired, the company would have fewer than 50 active employees. Nevertheless, if the company reasonably expects the two mechanics to return to their jobs at the conclusion of the suspension, both workers are counted and the threshold is met.

All employees also satisfy the worksite requirement. The company’s office is clearly the worksite for the four office workers and the two mechanics. As for the seasonal landscapers, even if they go straight to their worksites and do not report to the company’s office each day, they all get their daily assignments from the central office. The central office is therefore regarded as the worksite for all employees.

Turning to the 12-month longevity requirement, the analysis is straightforward for the year-round office workers and mechanics. For the seasonal landscapers, the key question is whether each of the workers also worked for the company in previous years. Because the 12 months need not be consecutive, two six-month stints with the company would suffice to satisfy this requirement.

Finally, each employee’s hours of service in the past year must be considered. Again, this analysis is straightforward for the full-time office workers. At 40, or even 35, hours per week, these employees easily surpass the 1,250-hour requirement. In contrast, the mechanics do not satisfy this requirement. Their 20-hour-per-week schedule nets only 1,040 hours per year. They are therefore not eligible for FMLA leave. The seasonal workers are also probably ineligible. A six-month employee would need to average 48 hours per week to meet the eligibility threshold. Given the inconsistency of the landscapers’ schedules, on these facts it is unlikely that any of them worked that many hours.

This example highlights an important element of FMLA eligibility: An employee’s eligibility has no relationship to whether the employee is counted for the “covered employer” analysis. There is no requirement that the employees have worked a minimum number of hours or months before being counted. The “covered employer” threshold is more of a snapshot analysis—it simply looks at how many people are on the employer’s payroll, without regard to the employees’ work histories or other characteristics. Conversely, merely being counted for purposes of the threshold does not transform an otherwise ineligible individual into an eligible employee.

CONCLUSION

At its core, the FMLA strives to enable employees to care for themselves and their families with minimal disruption to themselves or their workplaces. With clear and open communication between the requesting employee and his or her employer, both parties can help ensure that this goal is achieved.

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Out of the Darkness

Overcoming Depression among Lawyers

Whenever Richard Cory went down town,
We people on the pavement looked at him:
He was a gentleman from sole to crown,
Clean favored, and imperially slim.
And he was always quietly arrayed,
And he was always human when he talked;
But still he fluttered pulses when he said,
“Good-morning,” and he glittered when he walked.
And he was rich—yes, richer than a king—
And admirably schooled in every grace;
In fine, we thought that he was everything
To make us wish that we were in his place.
So on we worked, and waited for the light,
And went without the meat, and cursed the bread;
And Richard Cory, one calm summer night,
Went home and put a bullet through his head.

— “Richard Cory,” Edwin Arlington Robinson

Bob was a practicing lawyer for more than 30 years. He participated in bar association events and was a frequent CLE speaker. Outside of his practice, he attended his local church and sang with community choirs. He fished and hunted and on occasion savored a single-malt scotch. He was gregarious, outgoing, and had more friends than could be counted.

And one cold winter night, in the depth of despair that he never shared, he went into his garage, got behind the wheel, turned on the engine, and went to sleep forever.

“Bob” was a real person. Unfortunately, his story is not unusual for the legal profession.

By Andrea Ciobanu and Stephen M. Terrell
Depression, suicide, and other mental health issues continue to plague the legal profession in numbers that far outstrip the general population. It is an issue of which the profession, and everyone in it, needs to be aware.

**A SPECIAL BURDEN**

Simply stated, the legal profession is prone to higher incidences of depression than the general population. One study in 1990 by Johns Hopkins University found that lawyers as a group are nearly four times more likely to suffer from depression than the average person.

In 2007 the United States had more than 34,000 suicides, which is a rate of 94 suicides per day, or one suicide every 15 minutes. It is the second leading cause of death among 25- to 34-year-olds and the third leading cause of death among 15- to 24-year-olds.

We must break through the confines of stigma and stereotype and see depression for what it is.

As many as one in four lawyers suffer from psychological distress, including anxiety, social alienation, isolation, and depression. Heavy law school debt frequently forces graduates into high-paying jobs at private firms, where intense deadlines, staggering billable-hour requirements, and grinding hours are routine. The conflict-driven nature of the profession also plays a role, as does traditional legal training, which conditions lawyers to be emotionally withdrawn, a trait that can help them professionally but hurt them personally. Additionally, lawyers are known to be high achievers, perfectionists, and workaholics, all of which can lead to high stress and depression rates. According to a 1991 Johns Hopkins University study of 105 professions, lawyers top the list in the incidence of major depression. Other studies indicate that the rate of substance abuse among lawyers is double that of the national average.

Not surprisingly, there is a correlation between incidents of suicide and depression, substance abuse, and other mental health issues. Statistics suggest that a high percentage of individuals who commit suicide are under the influence of drugs or alcohol. One study showed that one-third of those who committed suicide tested positive for alcohol and one in five had evidence of opiates.

In 2008 the United States had 376,306 people who were treated in emergency departments for injuries that were self-inflicted. Approximately 163,489 of those individuals were hospitalized.

As with depression, the rate of suicide among lawyers is higher than among all other occupations. The National Institute for Safety and Health found that male lawyers age 20 to 64 are more than twice as likely to die from suicide than are men the same age in a different occupation.

**DEPRESSION AND THE LEGAL MIND**

Psychologist Martin Seligman notes that the legal profession is unique in that it is the only profession where pessimists — those who see problems as the norm and not the exception — out-perform optimists. According to Seligman, the legal profession calls for caution, skepticism, and anticipation that things will go wrong. “Unfortunately, what makes for a good lawyer may make for an unhappy human being” (quoted in “The Dirty Secret in the Lives of Lawyers” by Stephen M. Terrell, Res Gestae, June 2006). As such, we must be on the lookout to protect ourselves and our colleagues from the adverse consequences of such tendencies.

Lawyers seem to have a particular reluctance to seek help for depression and mental health issues because they are concerned about appearing weak or negatively affecting their reputation. Lawyers we may be, but we are human, after all. In 2004 a study was completed at Cottonwood de Tucson, a behavioral health treatment center in Arizona, where lawyers recovering from mental illness were interviewed. These individuals indicated that one main obstacle preventing them from accessing care was that they believed they could handle it on their own. Additionally, these lawyers were afraid that seeking help would negatively impact their reputation.

In some states, bar exam applicants are required to disclose whether they have been treated for mental health issues. This could exacerbate the problem; future lawyers may not seek treatment in order to avoid the question of whether they have been treated for mental illness, thereby raising questions as to whether they are “suitable” to practice law.

**ASSISTANCE FOR LAWYERS**

Dealing with a mental illness does not make a lawyer less intelligent, less strong, or any less of an attorney. In many instances, it takes more courage to seek assistance than to stay silent. Anyone practicing in the field of law should not be afraid to speak up if they are battling a form of mental illness. We must make sure that we assist ourselves and our colleagues to access help whenever necessary.

There is ample confidential assistance available for lawyers. The ABA provides educational materials for lawyers about substance abuse, stress, depression, and other mental health issues, and it works closely with lawyer assistance programs (LAPs) run by state and local bar associations. The website of the ABA Commission on Lawyer Assistance Programs (americanbar.org/groups/lawyer_assistance.html) is a great tool for any lawyers who find themselves in a
Recognizing Depression

But just what is depression, and how do we know if we, or someone close to us, is suffering from it? Depression is not simply being sad or having “the blues.” Depression is a gut-wrenching, debilitating, hopeless despair that impacts every phase of life. It is a deep trench. No matter how many people tell you what a beautiful world there is outside the trench, you simply cannot see it.

Depression is not just emotional, but physical. Those who suffer depression may have an imbalance or inadequacy in certain chemicals in the brain that regulate mood (serotonin is the most commonly known). The condition is no different than a diabetic’s inability to process sugar. But the effect of depression does not have an easily measurable physical manifestation such as blood sugar level. Rather, depression is a complex syndrome that produces behavior that alienates its victims from their friends, family, and coworkers. And this alienation exacerbates the isolation, driving the depression deeper and deeper.

Deprived of needed interaction with others, the lawyer withdraws into his or her own thoughts. It becomes a deadly spiral. And when, like “Bob,” word of a suicide comes, friends express surprise, saying, “I never knew he was having those problems.”

What are the signs of depression? The seven most common warning signs of depression consist of the following:

1. Loss of interest in most all activities
2. Loss of pleasure or enjoyment in what were enjoyable activities
3. Indecisiveness
4. Fatigue
5. Difficulty sleeping or sleeping too much
6. Significant weight gain or loss without dieting
7. Feelings of worthlessness

The U.S. Department of Health and Human Services has issued warning signs for suicide, which include:

1. Threatening to hurt or kill oneself
2. Talking about wanting to hurt or kill oneself
3. Talking or writing about death, dying, or suicide
4. Looking for ways to kill oneself, such as purchase of a gun
5. Making funeral or burial plans, making wills, or organizing insurance documents
6. Withdrawing from friends, family, and society
7. Feeling rage or uncontrolled anger
8. Feeling trapped like there’s no way out
9. Feeling anxious, agitated, or unable to sleep, or sleeping all the time
10. Experiencing dramatic mood changes

11. Increasing alcohol or drug use

If you have a friend or associate who shows any signs of depression, you should never be afraid to ask about suicide. Simply ask, “Has it been so bad that you’ve thought about suicide?” Just the simple act of asking this question can reduce the risk of suicide. Studies show that 75 percent of those who commit suicide talk about it or display other warning signs before attempting it. In fact, a common myth is that people who talk about suicide are simply “seeking attention” and are not “serious.”

If you know a person who is in so much emotional pain that suicide seems an option, act immediately. Call your local suicide prevention number. Contact the judge/lawyer assistance program in your area. (See the list of resources above.) These experienced professionals are ready to help lawyers with the many challenges that accompany our profession. And stay with your friend. Do not leave them alone with their thoughts while professional help arrives.

Whether it is you, or someone you know, the answer is not to hide, not to ignore the issue. Don’t be judgmental if someone confides in you. Don’t be “sworn to secrecy.” Take a single courageous step to seek help and to make “that” call. If you are aware of a person who needs your assistance, guide the troubled person to help.

We must move this hidden secret “out of the darkness.” We must reverse the grim trend of recent statistics by breaking through the confines of stigma and stereotype, by understanding that depression and other mental health issues are real (not contrived, nor a sign of weakness), by recognizing the suffering of our friends and colleagues, and by urgently seeking and encouraging assistance.

There have already been too many “Bobs” in the legal profession. We don’t need more.

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Resources for Help

- National Suicide Prevention Lifeline: 800/273-TALK (800/273-8255)
- State and Local Lawyer Assistance Programs: tinyurl.com/oang22p
- National Helpline for Lawyers: 866/LAW-LAPS (866/529-5277)
- National Helpline for Judges Helping Judges: 800/219-6474
- International Lawyers in Alcoholics Anonymous (ILAA): ilaa.org/home
- Other National Resources: tinyurl.com/kvk6pck

Courtesy of the ABA Commission on Lawyer Assistance Programs, americanbar.org/groups/lawyer_assistance.html.
How to Insure Employees under the Affordable Care Act

By Liliana Salazar
As they navigate through hundreds of thousands of pages of new regulatory guidance issued by the U.S. Department of Labor (DOL), the U.S. Department of Health and Human Services (HHS), and the Internal Revenue Service (IRS), employers wonder what the Patient Protection and Affordable Care Act (ACA) means to their business and, more importantly, what impact does the ACA have on how employers purchase coverage for their employees? In order to understand the options available to employers, it is important to first discuss the key market reform changes introduced by the ACA.
**Creation of Insurance Marketplaces and Medicaid Expansion**

The ACA impacts the insurance market by requiring the creation of an insurance marketplace or exchange in every state. The marketplaces may be administered by the state (a state exchange), by a joint agreement between the state and the federal government in a partnership exchange, or by the federal government in the federally facilitated marketplace (FFM).

Marketplaces also automatically enroll individuals and families in Medicaid if they qualify for Medicaid coverage, as defined by the state in which the individual or family resides.

Medicaid eligibility in states choosing to expand Medicaid coverage is only based on the individual’s household income, which may not be greater than 138 percent of the FPL, regardless of the individual’s gender, disability status, or age. As of early 2015, the following states had chosen to expand Medicaid eligibility: Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Indiana, Iowa, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Washington, and West Virginia. The District of Columbia has also expanded Medicaid eligibility.

Marketplaces offer small employers the opportunity to purchase insurance coverage and can assist an employer in establishing an IRC Section 125 plan (also called a “cafeteria plan”) that allows employees to pay for premiums on a pre-tax basis. Certain employers purchasing coverage from the SHOP may also qualify for the Small Business Health Care Tax Credit (SHCTC) for up to two consecutive years if the employer meets all of the following criteria:

- The employer has fewer than 25 full-time and full-time-equivalent employees.
- The average employee salary is about $50,000 per year or less.
- The employer pays at least 50 percent of its full-time employees’ premium costs.
- The employer offers coverage to its full-time employees through the SHOP marketplace.

The tax credit is worth up to 50 percent of the employer’s contribution toward employees’ premium costs (up to 35 percent for tax-exempt employers). To learn more about an employer’s eligibility for the SHCTC, visit tinyurl.com/adkpy4k.

**Market Reforms Affecting Certain Coverage**

The ACA also introduced a series of amendments to the insurance market impacting individual and group insurance plans. Some of the most critical provisions include:

- Elimination of pre-existing condition exclusions from medical coverage. The ACA requires that all health insurance policies offered on an individual or group basis eliminate pre-existing condition exclusions no later than the policy’s renewal date in 2014. However, some individual and small group policies may enforce pre-existing condition exclusions until October 2016 if the policies remained grandfathered since March 23, 2010 and the state where the policy was issued adopted the grandfathered extension.

- Elimination of restrictive lifetime and annual dollar limits
The ACA required that all policies issued in the individual, small, or large insurance market, regardless of grandfathered plan status or funding (insured or self-insured), remove lifetime or annual dollar limits on what the ACA categorizes as the ten essential health benefits: ambulatory services, emergency services, hospitalization, laboratory services, maternity care, mental health and substance abuse, pediatric vision and dental, prescription drugs, preventive wellness services, and rehabilitative services. This requirement effectively eliminated an employer’s option of offering limited medical plans that imposed annual limits on one or more of these benefits.

**Community rating for the small group market.** The ACA required that in 2014 all states adopt community rating for the small group market (employers with 50 or fewer full-time and full-time-equivalent employees). Under community rating, premiums for coverage could not be based on factors other than: age (the oldest adult not being charged more than three times more than the youngest insured); tobacco use (tobacco users not being charged more than one and a half times more than non-tobacco users; note also that states such as California chose not to impose a tobacco surcharge); and geographic rating area. Rates in the small group market would no longer be based on employees’ health status, claims experience, or other traditional underwriting factors but rather on the three criteria described above. Community rating combined with the new ACA mandate requiring individual and small group policies to cover all ten essential health benefits resulted in a double-digit increase in the cost of coverage for employers offering coverage to younger, healthier employees, while reducing the cost of coverage for small employers with older and sicker populations.

**Individual mandate.** Under the individual mandate the ACA requires that all legal residents and citizens of the United States retain minimum essential coverage or face the imposition of a penalty for failure to be insured for more than three consecutive months in a calendar year.

- **Employer-shared responsibility (play-or-pay mandate).** Effective in 2015, applicable large employers (ALEs—employers with 100 or more full-time and full-time-equivalent employees, based on IRS controlled group rules) are subject to an annualized penalty of $2,000 multiplied by the total number of full-time employees (minus the first 80 employees in 2015, or the first 30 employees in 2016 or later) if the employer does not maintain a group medical plan that is offered to at least 70 percent of all full-time employees (at least 95 percent of all full-time employees in 2016 or later), as defined in IRC § 4980H(a). If this penalty does not apply, ALEs could still be subject to an annualized penalty of $3,000 multiplied by the number of full-time employees who are not offered coverage under the employer’s plan that is affordable (cost for employee-only coverage is 9.5 percent or less of the employee’s household income) and that provides minimum value (actuarial value of 60 percent or more), as defined by IRC § 4980H(b).

Following 2014 these penalties will be adjusted for inflation. Please note that either penalty will only apply if the full-time employee purchases coverage from an insurance marketplace and receives a federal subsidy to help pay for the coverage. This play-or-pay mandate will not apply to employers with 50 to 99 full-time and full-time-equivalent employees (based on controlled group rules) until the first plan year beginning in 2016 if the employer qualifies for transition relief, which requires the employer to satisfy a five-part test as described in the final Employer-Shared Responsibility Regulations. If the employer with 50 to 99 employees does not qualify for transition relief, it is subject to the play-or-pay mandate effective January 1, 2015.

The play-or-pay mandate also gave rise to new insurance products intended to minimize an employer’s exposure. The most popular products are the minimum essential coverage (MEC) plans or “skinny MEC” plans that only provide...
coverage for preventive care services as defined by the U.S. Preventive Task Force (tinyurl.com/m6zwtn6). These MEC plans tend to cost on average no more than $40 per employee per month and are not subject to a co-pay or deductible. The MEC plans exempt the employer from the IRC § 4980H(a) penalty if the plan is offered during 2015 to at least 70 percent of all the employer’s full-time employee population and also exempts individuals from the individual mandate penalty. However, offering the MEC plans will not exempt

Small employers might want to encourage employees to purchase individual plans from the exchange.

the employer from the $3,000 penalty under IRC § 4980H(b), if an employee pursues coverage from a marketplace and receives a subsidy. In order to address this potential exposure, insurance carriers and third-party administrators are offering employers minimum value plans. The minimum value plans (MVPs) have a 60 percent actuarial value and can be offered on an insured or self-insured basis. These plans customarily have high deductibles (annual deductibles for an individual can range from $3,000 to $6,350), relatively low co-insurance (the plan may pay 70 percent of allowable charges), and tend to cost significantly less than traditional plans, allowing the employer to meet the affordability requirements of the ACA. Many of these MVPs are high-deductible health plans allowing employees to establish health savings accounts (HSAs).

- **Prohibition on employers reimbursing premiums paid for individual policies and offering stand-alone health reimbursement arrangements (HRAs).** In September 2013 the HHS, DOL, and the Treasury Department issued guidance prohibiting tax-advantaged, employer-provided dollars from being used to obtain coverage from the individual insurance market or a public exchange (IRS Notice 2013-53, DOL Technical Release 2013-03). This guidance was amended in February 2015 by IRS Notice 2015-17 to allow the reimbursement of individual policies in four limited circumstances: (1) when the employer is not an ALE for 2014, and for January 1 through June 30, 2015, for employers who are not ALEs for 2015; (2) for coverage purchased by a 2 percent or more shareholder-employee in an S-corporation; (3) for Medicare Part B and/or Part D premium and Medigap policies for active employees as long as the employer offers a group health plan that is minimum value (note that Medicare Secondary Payer Rules may prohibit this practice for certain employers); and (4) for TRICARE-related HRAs. The following arrangements will be considered to constitute a group health plan if they reimburse the cost of individual coverage and will subject the employer to penalties under IRC § 4980D:

- **Health reimbursement arrangements**
- Employer payment plans (as defined in Revenue Ruling 61-146 to include arrangements in which an employer directly or indirectly pays, on a tax-excludible basis, the premiums for non-employer sponsored health insurance)
- Health flexible spending accounts (FSAs) that do not provide excepted benefits

**EMPLOYERS’ BENEFIT PLAN CHOICES UNDER THE ACA**

Under the ACA, an employer’s choice to offer benefits to its employees is governed primarily by the employer’s size. Employers who are not subject to the employer play-or-pay mandate (employers with fewer than 50 full-time and full-time-equivalent employees and employers with 50 to 99 employees that qualify for relief until 2016) have more choices in 2015 than employers who are subject to the play-or-pay mandate, as failure to offer coverage to full-time employees does not result in the imposition of penalties.

**Employers with fewer than 50 full-time and full-time-equivalent employees (small employers).** Small employers may choose to purchase coverage from the SHOP (note that participation in the SHOP is generally extended to employers with up to 50 full-time and full-time-equivalent employees) as it provides their employees greater choice and, if the employer meets certain criteria, may also entitle the employer to claim the SHCTC. The employer may also choose to purchase a plan from the small group market, as policies in the small group market are guaranteed issued and also are subject to guaranteed renewability provisions. The employer may also want to encourage
employees to purchase individual plans from the individual insurance market if the employer does not offer coverage to staff, as medical underwriting and pre-existing condition exclusions no longer apply to individual policies. A small employer with a high number of low-income employees may also encourage employees to enroll in Medicaid, as that would allow employees to pursue insurance coverage for very little cost (not more than 3 percent of household income) or no cost and avoid the imposition of the individual mandate penalty for being uninsured. Lastly, if an employer has fewer than 50 employees, the employer may also want to empower employees to purchase coverage directly from an insurance marketplace, as those employees’ receiving subsidies from a marketplace or exchange would not trigger a penalty for that small employer. Employers with 50 or more full-time and full-time-equivalent employees (large employers). Large employers, subject to the play-or-pay mandate, have fewer choices than small employers, as only those large employers with up to 50 employees are eligible to purchase coverage from the SHOP. Large employers also face the imposition of penalties if the coverage they offer to their full-time employees fails to meet the criteria established by the ACA. The large employer’s compliance with the play-or-pay mandate is predicated on the employer’s size and the large employer’s eligibility for transition relief, as described above. Large employers interested in avoiding the imposition of penalties under the ACA’s play-or-pay mandate are required to offer full-time employees minimum essential coverage that is affordable and meets the minimum value requirements. Large employers can accomplish this task by offering an insured or self-insured basis medical plans that are high-deductible health plans such as HSAs or, if they have a mixed population, pursuing a plan design that resembles coverage under a marketplace (tiered plan). Under a tiered plan, the lowest cost plan would be a MEC plan that only provides coverage for preventive care services, which the employer would pay in full, followed by a minimum value plan (60 percent actuarial value plan), such as an HRA or HSA that is affordable per the ACA, and a richer actuarial value plan, such as a preferred provider organization plan (PPO), which employees may purchase by paying a larger portion of the premium cost. This design would allow employees to select the plan they deem best suited for their family and financial needs and also avoid the imposition of the individual mandate penalty. Firms should also consider educating low-income employees on the benefits of enrolling in Medicaid, as employees who enroll in Medicaid will not be eligible to receive subsidies under a marketplace; will not be subject to the individual mandate penalty; and will not be counted against the carrier participation thresholds, which generally require employers to insure 75 percent of their full-time eligible employees. 

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In my 27-year career as a long-term care insurance specialist, I have witnessed quite a few changes. What started out as almost a cottage industry product grew into a mainstream financial services product. However, part of the growing pains included benefit changes, higher premiums for new products, and rate increases on in-force policies. The one thing that has remained constant throughout this period of time is the need for care and consequently the need for proper planning.

What is the foundation for proper long-term care planning? Well, let’s take a look at some numbers:

- **12 million**: The number of Americans expected to need long-term care by 2020.
- **$94,170**: Average national cost for one year in a private nursing home room. Assuming a three-year stay and 4 percent inflation, this care event would exceed $290,000.
- **$41,124**: Average national cost for one year in an assisted living facility.

These numbers are even more alarming when we contrast them with the fact that the baby boomers’ proportion of the population is growing and that it is expected that by 2030 those age 65 and older will account for 25 percent of the population.

Dealing with the need for long-term care is of extreme importance, not only to us as individuals but to the nation as a whole. The financial impact to families and the economy in general will be severe if this risk is not insured to a relatively large extent. So what should we do as professionals who influence clients where matters such as these are discussed?
1. Know the products available and how each one works to protect your clients and their needs.
2. Start the process of planning earlier.
3. Have the conversation with your clients. Seventy percent of all long-term care policies are purchased only because the clients ask their planner about it, and oftentimes that is too late.
4. Partner with a brokerage firm that specializes in and has a track record with long-term care insurance.

WHERE TO START?
Look at your own family and make comparisons or decisions based on that history. Have you had or do you know of loved ones who went through an extended care situation that required help in either their home or in a facility? If so, were they covered by an insurance policy that offset some of the cost or did they pay dollar for dollar out of their savings? How did it affect the entire family’s physical, emotional, and financial well-being? Who made the sacrifice to make sure that Mom or Dad was taken care of? What did that really cost?

This need is real. It isn’t fiction. It’s fact. Families get torn apart when an illness leads to extended care. Days at work are missed, kids’ activities get pushed to the side, financial decisions get caught up in the interworking of relationships already strained. That was never part of the plan. Parents rarely stop and think how inclusive this care is; they never planned or wanted to become dependent on the children they raised to be independent.

PRODUCTS AVAILABLE
- **LTCi.** Individual long-term care insurance (LTCi) has been on the market the longest and is what most clients and professionals think of when the topic of extended care is brought up. Advantages of these plans include their ease of use come claim time, their extreme flexibility, their relative affordability (in many cases the cost is as low as $100 a month), and the fact that they work off a “pool of money” concept and generally pay for all levels of care (within reason).

- **Hybrids.** These products are tied to a life insurance policy. They represent the fastest growing product line in the long-term care coverage marketplace. The reasons for this are many; however, be sure to understand exactly how and where benefits are to be paid and the influence on the life insurance coverage should you need coverage for long-term care. These policies tend to differ greatly, and if you have questions, be sure to contact a long-term care insurance specialist so your clients have a proper understanding of implied value.

- **Annuities.** The appeal of these instruments is that they are typically not medically underwritten, and, if they are, only minimally — the reason being that the payout is the “insured’s own money first.” These products are primarily used with an older subset of the population, those over age 75 where traditional long-term care insurance is not an option.

- **TAX DEDUCTIBILITY**
This is an area of particular interest to business owners and the self-employed. In general, long-term care insurance premiums are fully deductible when they are paid by an employer on behalf of an employee. Depending on the type of incorporation, premiums paid on behalf of owners/partners may be fully or partially deductible. (Always consult your tax professional with respect to the deductibility of any premium.)

- **NEXT STEPS?**
Partner with a firm that specializes in long-term care insurance and has done so successfully. Knowledge, experience, and flexibility are all critical success factors. I assure you the one-plan-fits-all days have come and gone. Hybrids and annuities do not fit into everyone’s plan, but they can be very effective. Traditional long-term care insurance plans are the most flexible, but if they are initiated too late in life, medical underwriting or pricing may make them inaccessible or prohibitively expensive.

I cannot sufficiently stress the importance of planning for long-term care and identifying and allocating the appropriate monies. Currently, I have three family members on claim, paying nothing out of their own pocket for care either in their home or in a facility. They chose to put their families first and put a plan in place early in life in case an extended care situation should occur.

What’s the risk of waiting? Your health. Waiting might prevent you from qualifying for the plan you prefer. Take the next step and consult a long-term care insurance professional. I think you will be pleasantly surprised at how affordable these plans are.

Have the conversation. Make the plan. Your client’s family—and your own—will be forever grateful.

Kyle Metcalf (kmetcalf@armltc.com, 800/269-2622) is a national sales executive for Advanced Resources Marketing, one of the largest marketing, distribution, and enrollment companies in the long-term care insurance industry.

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Have the conversation. Make the plan. Your client’s family—and your own—will be forever grateful.
When HIPAA became law in 1996, the move already had begun from a paper-based patient data system to an electronic one. This migration poses complex security and privacy issues. Over the next six and a half years, the HIPAA implementation took place with the following goals in mind:

- Improve access to health insurance
- Minimize health care billing fraud, waste, and abuse
- Increase efficiency and effectiveness of the health care system

HIPAA for the General Practitioner provides specific, strategic, and practical information pertaining to what each state has done in response to the HIPAA preemption provisions.

This book demystifies the 692-page HIPAA law and explains what general practitioners need to know to help their clients. A companion CD is included, featuring forms to be used as a guide to drafting HIPAA provisions.
Your Spouse’s
What to Prepare,

By J. Anthony Vittal

In our youth, “end of life” is a concept so distant that we ignore it as an improbable event. As we age, we inevitably encounter it—but as something that affects others because we remain convinced of our invincibility, if not immortality. Time, however, marches on, eventually exposing us to the reality that those closest to us will fall victim to the fate awaiting us all.
Terminal Illness
How to Cope
GETTING YOUR ATTENTION
If you haven’t had advance warning, such as decades of exposure by your spouse to toxic agents or behaviors, the day will come when your doctor announces in the course of a routine exam that there is something he or she “doesn’t like” and wants to evaluate further. In my case, I had dragged my wife of almost 37 years—J.P.—to our pulmonologist because she was having difficulty climbing a flight of stairs. J.P. hated doctors and only would consult with one as a last resort.

He arranged for a CT scan that evening (a Friday), then called me early Monday morning to instruct us to come in to his office ASAP that day. He announced that the scan had revealed anomalies that passed the “duck test” for advanced lung cancer and that he had referred us to an oncologist who was waiting to see us that afternoon; and he admonished us to keep the appointment.

The oncologist advised us that we needed confirmation of “the duck.” Accordingly, he had my wife undergo a CT-guided biopsy of several of the tumors. Half of the samples went to the local lab for confirmation of the tentative diagnosis. The other half went to a genomics lab in Arizona to determine whether the tumors had any genetic defects that might make them susceptible to one or more of the “silver bullet” therapies that are being developed with increasing rapidity. In the meantime, he had my wife undergo targeted CT-guided computer-driven radiation therapy using an electron beam—18 daily treatments administered five days a week—to shrink the largest tumor, which had squeezed off the primary airway to one of her lungs. The radiation therapy was successful in that the tumor shrank away, the airway was opened, and J.P. could breathe again—within the limits of her emphysema.

THE INITIAL REALITY CHECK
On conclusion of the radiation therapy, having learned the tumor was not genetically esoteric, we commenced “ordinary” first-line chemotherapy in the ephemeral hope that we could prolong her life in the face of her best-case prognosis of six months to live. The chemotherapy cocktail was actually pretty sophisticated: Two of the components interfered with genetic coding at the DNA level, precluding the expression of particular enzymes by the cancer cells, and the third was a platinum-based biological poison. With Medicare and a Medicare supplement policy, we were not concerned about cost. (More about that, and the ephemeral hope, below.)

The radiation treatments, while generally well-tolerated, were debilitating. The staff nutritionist insisted that J.P. consume at least 80 grams of protein a day, and someone needed to ensure that she did so. In addition, the radiation irritated her lungs, necessitating the onset of oxygen therapy. Someone had to help her in and out of her bath. Bathe her. Wash and dry her hair. Prepare meals and make sure she ate them. All the little things that consume chunks of time over the course of a day made it difficult for me to maintain my law practice, and she refused to have any “strangers” in the house—even the licensed vocational/registered nurse couple who had cared for my father in the last months of his life and had become part of our extended family.

■ TIP: Get long-term care insurance for you and your spouse. If unmarried but in a serious relationship, have your significant other get the coverage. Do this at the earliest possible time, as the premiums increase significantly the older you get.

■ TIP: Reach agreement early about who the primary caregiver(s) will be to avoid arguments when their services are needed. Make arrangements with them so they will be available when the time comes.

THE NEXT REALITY CHECK
Like a good lawyering family, we turned our attention to end-of-life documents. I provided J.P. with the customary detailed estate planning questionnaire as the simple will she had made before our honeymoon was inadequate for her purposes. I also prepared a durable power of attorney for health care, a directive to physicians, and the customary companion documents for her signature. Perhaps indicative of her tenacious hold on life, she never completed the questionnaire and never executed the other documents, always claiming that she would “get to them in due course.” It didn’t happen. She later claimed to have executed a holographic will, but we were never able to find it. When the time came, we fell back on the old simple will.

In the meantime, the chemotherapy

At this point, it became evident that I had a new role in life: live-in, round-the-clock caregiver. When we had contracted for my long-term care insurance some time earlier, we had made the decision that we didn’t need coverage for J.P. at the premiums quoted. Thus, the role of caregiver fell to me. No one forced this on me. It was a role I willingly undertook, perhaps in discharge of my “due bill” to her for having devoted so much of my time over the years of our marriage to my legal practice, the legal system, and the bar.

Given the prognosis, we were confident that our resources were more than adequate to cover a six-month reduction in my income-generating activities. Silly us. Murphy was alive and well and targeting us.
dwindling financial reserves.

**TIP:** Make sure what that meant in terms of a toll on our chronic but treatable disease! Needless to say, we were ecstatic, until we realized revised their prognosis to—big surprise—a her lungs were reducing. The doctors re­nodes had vanished and the tumors in apex responder. The tumors in her lymph nodes had vanished and the tumors in her lungs were reducing. The doctors rev­vised their prognosis to—big surprise—a chronic but treatable disease! Needless to say, we were ecstatic, until we realized what that meant in terms of a toll on our dwindling financial reserves.

**TIP:** Make sure you have med­ical insurance adequate to carry you through a catastrophic illness such as this. Lifetime caps on benefits are to be avoided like the plague. We could not have afforded this complex course of therapy, even up to the point of the revised prognosis, much less for the many months beyond that, without Medicare and the supplemental coverage we had obtained through AARP. Very few could. If you are not yet Medicare eli­gible, check into every available plan, including those offered by the American Bar Endowment. Get the best coverage you can, and constantly improve it, to en­sure that you can access the best available doctors and therapies when needed.

**TIP:** Make sure that you each have signed a durable power of attorney for health care, a di­rective to physicians, and the customary companion docu­ments, including a power of attorney for financial matters. Review them every few years to ensure they are up to date, and revise them as necessary.

**TIP:** Make sure that you each have executed documents con­sistent with your estate plan—whether they are wills, trusts, annuity contracts, etc. Don’t postpone doing this. Review them every few years to ensure they are up to date, and revise them as necessary.

PREPARE FOR THE UNEXPECTED

While taking a break from the chemotherapy, we continued to monitor the tumors with PET/CT scans every eight weeks. When the tumors’ deterioration ceased and they started to become more biologically active, we resumed the che­motherapy (eliminating the platinum­based poison). J.P. continued to maintain her progress against the disease—until Murphy reappeared in the form of an asymptomatic urinary tract infection that became septic, crashed her blood pres­sure, and drove her into a coma while she was sleeping. As I was attending an early­morning funeral out of the county, one of my sons, who was watching her for me, called to advise he could not awaken her. She was transported to the emergency room, intubated, eventually revived, and stabilized after 11 hours, whereupon she was transferred to the intensive care unit. Because she never wanted to be intubated and always had expressed a desire for do­not-resuscitate (DNR) treatment, she obviously was incensed when she awoke to find tubes down her throat. I told her I had made an executive decision to have her intubated and resuscitated so that she could have a chance to say goodbye to the kids—and to me, if she wasn’t too upset with me. With a wry smile and a “thumbs up,” she agreed with my de­cision and forgave me—that once—for violating her unwritten wishes.

That episode, which included two sojourns in the intensive care unit, re­sulted in a month­long hospitalization ending in a battle with the “utilization committee” over the duration of our stay. (Both here and in the respiratory rehabilitation hospital to which we later moved, I literally lived in J.P.’s hospital room, sleeping on rollaway beds.) When the hospitalists threatened to physically move us out of the hospital and into a convalescent care facility (i.e., ware­house) pending the availability of a bed in the only suitable respiratory rehab­ilitation facility in the area, we had the hospital’s outside counsel get involved. Realizing that J.P. could not be ejected using self­help and could not be removed without a lawsuit and judgment, the hos­pitalists suddenly were able to find space for her in the respiratory rehabilitation hospital to which the treating physi­cians, our pulmonologist, J.P., and I all had wanted her transferred. Two hours later, J.P. was en route to that hospital.

**TIP:** Talk with each other about what to do in case of an unexpected event, such as J.P.’s coma, when strict adherence to a DNR instruction may not really be desired. Document whatever decision is made—even if on a sticky note written by the patient and affixed to the DNR instructions or Directive to Physicians.

**TIP:** Many jurisdictions, such as California, require you to...
have a “covering” attorney to cover your practice in the event of illness, death, or other disability. If you don’t have one, you should.

**TIP:** As soon as you identify the need, make arrangements for your staff, your “covering” attorney, and/or other lawyers to handle client matters and the operation of your law office while you care for a loved one 24/7 or are ill yourself, even if only to provide you backup if you can’t manage on your own with a laptop, hospital room landline, and hospital WiFi connection. If the hospital won’t give you access to one of its network printers, bring in an inexpensive laser printer.

**TIP:** Learn the limitations on the ability of any hospital in your jurisdiction to eject a patient whose condition “does not warrant further treatment in an acute care facility” in the opinion of the members of the utilization committee (who can act more like bean counters than doctors). Be prepared to push back, while appealing to their humanity. Demand an independent review of the utilization decision. If necessary, invoke the assistance of the hospital’s patient advocates and its outside counsel. Learn the identity of the consumer rights reporters at the local major newspaper and network radio and television stations; threaten to tell your story to them and to get them involved. As a last resort, force the hospital to start eviction proceedings. You are the advocate for your partner. Do not let the hospital warehouse him or her in a convalescent care facility until such time, if ever, that space becomes available in a suitable rehabilitation facility.

**THROWING IN THE TOWEL**
The respiratory rehabilitation hospital was the perfect environment for J.P. It was a small facility on the edge of an expansive municipal park; the grounds were attractive, and the staff was exemplary. We confirmed by PET/CT scan that her cancer was stable. The only problem we had during the four months she remained in that facility was a repetitive recurrence of the urinary tract infection that had first put her in a hospital. Every time it recurred, the rehabilitation therapy had to be started over again when she recovered. This problem was exacerbated by the ever-increasing deterioration of her lungs owing to her acute emphysema.

Eventually, J.P. had had enough. She announced to me on a Friday night, as we were saying good night to each other, “I didn’t sign up for this, you didn’t sign up for this, we didn’t sign up for this, and I just want it all over . . . NOW! Just MAKE IT HAPPEN!” Working with the chief pulmonologist and the respiratory therapists, we were able to accomplish that without opiates so that she was able to pass peacefully, surrounded by immediate family and closest friends, a few days later.

**TIP:** Because only Oregon has “right-to-die” legislation in force and so many hospitals are owned and controlled by religious organizations that eschew anything remotely approximating implementation of a patient’s right to die, choose your acute and other health care facilities carefully to ensure no interference if and when your patient decides to exercise that right and seeks the assistance of his or her physician in doing so.

**TIP:** Explore these issues candidly with the physician in charge of your loved one’s treatment and, if necessary, the medical director of the hospital to ensure that everyone is on board with the protocol—which typically involves nothing more than the patient’s informed refusal of further therapy or intervention.

**FINAL PREPARATIONS**
No matter how much time you have to prepare, no matter how real the impending death may be, the reality of it is a tangible thing that grabs you by the heart and rends your soul, overwhelming the positive emotions experienced from your caregiving. While dealing with this reality, you have to make arrangements for a funeral home, cremation (if that is your choice for disposition) or other processing of the body, final disposition of the remains (which requires issuance of a permit to ensure that final disposition of the remains is consistent with the requirements of the law of your jurisdiction), and a memorial service. You have to obtain death certificates yourself unless you are prepared to await mail delivery from the funeral home after it has obtained them from the registrar or other official. You have to write and arrange for publication of an obituary unless you choose not to publicize the death in the press.

You have to decide whether to have a combined funeral and memorial service or separate services. In either case, you
have to decide whom to invite. In our case, because of travel constraints, we did the memorial service first, and then later performed a “funeral” for closest family and friends at which we cast J.P.’s ashes into the sea from a motor yacht 500 yards offshore from the beach where I had proposed to her—exactly where she wanted to be. In our view, the memorial service is an event for those left behind and those who support them. We were fortunate to have close friends volunteer their estate for the catered memorial service a few days before Christmas but nonetheless attended by about 150 friends and family members, some of whom had traveled from Toronto, New York, and the entire length of the Pacific Coast. Many were lawyers and judges. It was an audio-visual celebration of J.P.’s life. We compiled a slide show covering her entire life, with musical backup, and everyone who wanted to say something had the opportunity to do so. We filmed the event so that we could share it with those invitees who were unable to attend.

- TIP: Don’t wait, as I did, to compile the list of invitees to the memorial service and funeral, unless you are having such a small group you can list the names on the back of an envelope and can invite them by phone.
- TIP: Make advance arrangements with a funeral home, crematorium or mortuary, cemetery or columbarium, for handling the remains of your deceased loved one. Many offer discounts for pre-arrangements. If you plan to have a customary interment, and if there is no family plot or space in a columbarium, acquire the plot or space well in advance, as the choice may best be made jointly.
- TIP: Unless you intend working with an event planner and/or caterer, make the arrangements for the memorial ahead of time. They should include the venue, the food and beverage selection, sound system (microphone and loudspeakers for those who will be memorializing the decedent), flat panel display(s) for any audio-visual presentation, and a valet parking service unless choosing a commercial venue with its own parking lot.

- TIP: As early as you can, prepare a schedule of all assets subject to disposition upon death, such as retirement accounts, bank accounts, the contents of safe deposit boxes, etc. This will help you marshal these assets after death and, if you can administer them in a trust or a small estate (exempt from formal probate), will help you do so. Similarly, prepare a schedule of all life insurance policies and beneficiaries and determine what each policy requires for a claim.

CLOSING COMMENTS
No matter how “together” you are, no matter how great your support structure may be, prepare yourself for the fact you will be severely depressed and discombobulated by this experience. Do not hesitate to seek help from a mental health professional, who may prescribe an antidepressant for you. If prescribed, take the drug. It will help—a lot. Take advantage of the support groups that are available through the health care facilities and your community. Take extra time with your work, as you will have lost focus. Be candid with your clients and colleagues and the judges on your cases. They will understand and will be accommodating. Be candid with your friends and family. They will help to support you.

Once you have dealt with the disposition of assets, if you can afford the time and money, take a trip to somewhere you would love to go but never have been (to avoid the pain of shared memories) to simply chill out and start the long process of recovery. The first year will be the worst, but the first anniversary of your loved one’s passing will be a marker upon which you will actually realize that there is a life to be lived ahead of you. Live it well, knowing that you will eventually find love again. In the meantime, your friends and colleagues will be there for you. They may be shy and might not want to intrude—reach out to them.

J. Anthony Vittal (tony@vittal.net) is the principal of The Vittal Law Firm of Los Angeles, California, providing services to prevent and resolve complex business, commercial, and real estate disputes, as well as services concerning privacy and data security. He is a member of the State Bar of California and the Editorial Board of GPSolo magazine. Although this article is written from the perspective of a spouse, its advice can be applied to the terminal illness of any close family member.

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By Edward Poll (ABA Solo, Small Firm and General Practice Division; 2014; 5150466; $149.95; GPSolo member price $135.95)
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HIPAA FOR THE GENERAL PRACTITIONER
By Melanie D. Bragg (ABA Solo, Small Firm and General Practice Division; 2009; 5150435; $69.95; GPSolo member price $54.95)
This book demystifies the HIPAA law and explains what general practitioners need to know to help their clients. A companion CD provides helpful forms.

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THE ADVISOR’S GUIDE TO LONG-TERM CARE
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CONFRONTING MENTAL HEALTH EVIDENCE: A PRACTICAL GUIDE TO RELIABILITY AND EXPERTS IN FAMILY LAW
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CRIMINAL MENTAL HEALTH AND DISABILITY LAW, EVIDENCE AND TESTIMONY: A COMPREHENSIVE REFERENCE MANUAL FOR LAWYERS, JUDGES AND CRIMINAL JUSTICE PROFESSIONALS
By John W. Parry (ABA Commission on Disability Rights, Criminal Justice Section; 2009; 4410209; $110; ABA member price $99)
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THE FAMILY AND MEDICAL LEAVE ACT, WITH 2013 CUMULATIVE SUPPLEMENT
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PHARMACEUTICAL LAW: REGULATION OF RESEARCH, DEVELOPMENT, AND MARKETING, WITH 2014 CUMULATIVE SUPPLEMENT
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Edited by Brad Leneis, Patricia Davis, and Rob Vogel (ABA Section of Public Contract Law; 2014; 539G290; $64.95; ABA member price $59.95)
This book offers a convenient, single-volume resource to each state’s False Claims Act and how it compares to and differs from the analogous provisions in the federal FCA.

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By Jonathan E. Anderman and Matthew R. Fisher, edited by Donald H. Romano (ABA Health Law Section; 2014; 5630122; $49.95)
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By Thomas S. Crane, Samantha Kingsbury, Karen Lovitch, and Carrie Roll (ABA Health Law Section; 2014; 5630129; $49.95)
Learn how the Anti-Kickback Statute protects the health care system and beneficiaries from the influence of money on referral decisions.

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MANAGED CARE LITIGATION AND THE AFFORDABLE CARE ACT

By Joseph Friedman, Jeremy D. Bowen, Elizabeth Collura, and Neda M. Ryan

The managed care industry has begun gearing up for increased litigation resulting from the Patient Protection and Affordable Care Act (ACA).

Overtaching litigation issues. The ACA expands the administration of health care in numerous ways, including granting more responsibility to states to administer its requirements. With the administration of state health insurance marketplaces (the “exchanges”), health plans are now more susceptible to liability under the state and federal fraud and abuse laws because of the influx in federal funding to pay or subsidize costs.

ERISA and private actions. Before the ACA, most individuals’ health insurance was supplied by employers and thus subject to the Employee Retirement Security Act of 1974 (ERISA), which set forth minimum standards for health benefit plans established by employers. With the increase of individual health insurance policies being purchased at the exchanges, which policies are not subject to ERISA, the door has been opened for additional state and federal law claims, including claims by individuals and providers suing to enforce the ACA rules applicable to these individual policies.

The ACA is silent as to whether it provides the right of a private party to seek judicial relief from injuries caused by another’s violation of a legal requirement. In 1975 the U.S. Supreme Court established a four-part test to determine whether Congress intended a private right of action to exist. After passage of the ACA, the Government Accountability Office determined that, under the four-part test, the quality enhancement provisions of the ACA’s Section 3512 would not lead to an implied private right of action.

Although the ACA does not explicitly establish a private right of action, it has been held that portions of the ACA are incorporated into ERISA and are enforceable by ERISA plan participants in accordance with the terms of Section 502(a) of ERISA. Section 502(a) permits private plaintiffs to bring actions against plans to recover benefits, enforce their rights, or clarify their rights under ERISA-regulated plans. Therefore, some ACA claims may be raised by “piggybacking” on ERISA’s private right of action.

Litigation regarding coverage and payment of benefits. The ACA prohibits non-grandfathered group health plans and health insurance policies in the large group market from imposing annual or lifetime dollar limits on essential health benefits (EHBs). These EHBs must include items or services in ten benefit categories. Although litigation targeting and/or involving health plans has not yet begun, there has been a significant uptick in challenges to the ACA itself, often on constitutional grounds, which discuss the EHB requirements and the contours of EHBs. On the other hand, qualified health plans (QHPs) and insurance policies sold in the individual and small group markets are required to provide EHBs in order to follow established limits on cost sharing and to meet other requirements.

The ACA requires that the EHBs be equal in scope to the benefits offered by a “typical employer plan.” As such, EHBs are defined according to a state-specific benchmark plan. All policies required to provide EHBs must offer benefits that substantially equal the benefits of the benchmark plan.

Between now and 2016, states will define EHBs differently with varying degrees of benefits, some requiring more expansive benefits than others based on current state-mandated benefits, among other factors. The differences among states will likely be leveraged by potential litigants to argue what some states should include as EHBs in state-regulated health plans.

The ACA introduces considerable non-discrimination requirements. In addition to the EHB requirements, in the ACA’s general provisions at Section 1557, an individual may not be excluded...
from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity, any part of which is receiving federal financial assistance, on the basis of race, color, national origin, sex, age, or disability.

The U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) oversees and enforces Section 1557. Individuals believing to have been victims of discrimination may file a complaint with the OCR. It is expected that these complaints will be used as a mechanism to ensure and/or enforce the ACA’s non-discrimination provisions.

In addition to prohibiting discrimination against individuals, the ACA prohibits discrimination against providers. Litigation against health plans from providers believing to have been victims of discrimination can arise from a number of various provisions enacted under the ACA, ranging from general prohibitions on discrimination against providers, the implementation of the exchanges and payment for out-of-network emergency services, and requirements that QHPs have providers accessible to beneficiaries.

Litigation regarding plan administration and oversight. The ACA provides enrollees both an internal and an external claims appeals process on health plans or policies that were created or purchased after March 23, 2010. Group health plans and health insurance issuers offering group or individual health insurance coverage must implement an effective internal appeals process for appeals of coverage determinations and claims. Such appeals process must, at a minimum, have an internal claims appeals process; provide notice to enrollees, in a culturally and linguistically appropriate manner, of the available internal and external appeals process; and allow the enrollee to review his/her file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

In June 2011 the U.S. Department of Labor, U.S. Department of the Treasury, and HHS promulgated final regulations adding additional requirements for group health plans and group health insurance issuers as well as for individual health insurance issuers. Health insurance issuers offering individual health insurance coverage must provide for only one level of internal appeal and must maintain for six years records of all claims and notices associated with the internal claims and appeals process and must make such records available for examination upon the claimant’s or a state or federal oversight agency’s request.

These additional requirements expose insurers to a great deal of potential litigation. Specifically, claimants will likely raise issues pertaining to notice and whether notice was properly tendered. If, after an internal appeal, a plan still decides to deny payment, the ACA gives individuals the right to have an independent review organization decide whether to uphold or overturn the plan’s decision. Group health plans and health insurance issuers offering group or individual health insurance coverage must comply with the plan’s applicable state external review process, or if a state has not established an external review process, it must implement an effective external review process that meets minimum standards established by the HHS secretary. The regulations set forth 16 minimum standards for state external review processes.

Potential litigation may arise under the external review during the transition period where litigants may argue that they fell through the cracks owing to the numerous and confusing administrative requirements. Plans can also expect litigation to arise owing to the numerous procedural requirements associated with the state, federal, and private external review process.
Biomarkers for Concussions: Legal Implications

By Betsy Grey, Gary Marchant, and Cory Tyszka

Concussions, also known as mild traumatic brain injuries (TBIs), are a growing public health problem. In response, scientists have made significant progress in identifying biomarkers of concussion susceptibility and effect. Biomarkers of effect may interact with biomarkers of susceptibility such as genetics and previous brain injuries, as well as confounding factors such as sex, age, and ethnicity. Development of these biomarkers of effect and susceptibility raise a number of legal applications and issues that will be briefly surveyed in this article, focusing on sports-related concussion risks.

Duty to screen individuals with increased risk. Developing a commercially feasible screen for susceptibility to concussion will likely engender a duty on schools and sports organizations to screen athletes for susceptibility, whether screening players of all sports or just high-risk sports. This duty will stem from the duty to provide a relatively safe environment to engage in sports. Because concussions are more common in certain high-risk sports, the duty may vary depending on the type of sport involved. Such screening may also implicate a duty to exclude those individuals with susceptibility biomarkers from high-risk sports activities, monitor them more closely, provide accommodations, and implement additional preventive measures to avoid concussion.

Duty to warn versus privacy interests. Screening results that show an increased susceptibility to concussion will also raise questions surrounding whether and to whom to release this information. The entity performing or ordering the screening will likely be held to a duty to warn the susceptible individual of an increased risk and perhaps also the individual’s coach, employer, or parents. However, releasing this information to others may conflict with the individual’s privacy interests in his or her medical information.

On a related matter, requiring routine screening may result in information that the individual does not want others, such as insurers and employers, to know. If a school, for example, requires wide-scale screening for concussion susceptibility, a number of otherwise healthy students could receive information that has the potential to exclude them from life insurance, disability insurance, and long-term care insurance.

Assumption of risk. Even if an individual is found to be susceptible to concussion, whether by biomarker or because of previous injury, and a school or organization has a consequent duty to monitor or exclude that individual from the high-risk activity, the question remains whether students (or their parents) can validly assume the risk of injury. This may depend on the degree of susceptibility the test indicates. At the same time, the capacity to consent may change over the course of successive injuries, as the cognitive function of the individual potentially can decrease with each injury. Even if students can validly assume the risk under some circumstances, there may be a certain level of susceptibility that would always require exclusion. The difficulty is defining the applicable cutoff.

Potential liability under the eggshell skull doctrine. Under general tort law, the eggshell skull doctrine means that a negligent actor takes his plaintiff as he finds him. Accordingly, someone who is more susceptible to injury nevertheless has a right to be compensated for that injury when he is harmed by someone else’s wrongful actions. Even under this doctrine, the question remains whether a susceptible individual has the same right to recovery as a nonsusceptible individual, or whether the injured party’s compensation would be reduced based on comparative fault or assumption of risk.

Potential application of idiosyncratic response defense. In contrast to the eggshell skull doctrine, a tortfeasor may potentially assert the idiosyncratic response defense when an individual’s susceptibility to concussion is rare and...
Biomarkers of effect. Scientists now know that a peptide called amyloid-B that is associated with Alzheimer’s disease starts accumulating in an affected person’s brain 15 to 25 years before memory loss starts. Building on this research, scientists have started using positron emission tomography imaging to identify molecules such as amyloid-B and tau in the living brain.

Scientists also have been looking for indicators of concussion injury in bodily fluids. Research shows that in the early stages of Alzheimer’s, tau increases and amyloid-B decreases in the fluid around the brain and spinal cord. Scientists are searching for similar changes in cerebrospinal fluid in acute head injury that could be monitored with a spinal tap. Other scientists report progress in identifying blood-based biomarkers of brain injury that could be used to provide an objective marker of brain damage from concussive hits using only a blood test.

Return-to-play determinations. Between 2009 and 2014, all 50 states plus the District of Columbia enacted legislation to address TBI, much of which specifically targets youth sports-related concussions. Frequently, this type of legislation uses the subjective absence of signs of concussion to make return-to-play determinations. This standard is largely inadequate, however, because many concussions are diagnosed based on self-reported symptoms. Moreover, concussion symptoms may evolve for days following the injury, and players may mask their symptoms. Owing to the difficulty in detection and the reliance on an athlete’s own impressions of the seriousness of the harm, many athletes return to play too early, placing them at greater risk for successive injury.

Development of biomarkers of effect will have a direct impact on this type of legislation. They will permit more effective return-to-play determinations, and a school or organization could be liable for the failure to test for them. Once the technology is available for widespread use, liability for successive injury would likely attach when a player is not timely screened or is permitted to return to play with the continued presence of concussion biomarkers.

Medical monitoring requirements for biomarkers. Successive concussive injuries implicate a latent risk for chronic traumatic encephalopathy (CTE), as CTE may take years to develop. Latent risk claims may seek recovery for the increased risk of CTE, as well as medical monitoring costs. This risk is not stable; it increases with more injuries. Courts often limit recovery for latent risks and medical monitoring because of the fear of limitless liability and the speculative nature of the claim. With biomarkers of effect, these claims will become less speculative.

Use of biomarkers to prove causation and injury. Proving injury and causation are two major challenges to bringing a lawsuit to recover for concussive injuries. Biomarkers of effect may soon be used by both plaintiffs and defendants as objective evidence to prove or disprove injury and causation. Plaintiffs will be able to use biomarkers as an objective diagnostic measure to show concussive injury. Defendants will also be able to dispute the injury through the absence of biomarkers.
PATIENT VOICES IN CLINICAL PRACTICE GUIDELINES

By David E. Matz, Allen Zerkin, Amy Rebecca Gay, and Nicola Truppin

Integrating the perspectives and experiences of patients into the delivery of America’s health care is a key initiative of the Patient Protection and Affordable Care Act. This article describes the authors’ experiences facilitating the development of clinical practice guidelines in a multi-stakeholder panel including patient representatives and experts.

Background. The PSA test, which measures the amount of prostate-specific antigen in a man’s blood, is used to identify men who might have prostate cancer. Until recently, doctors routinely recommended the test to their patients 50 years of age and older. But in 2012 the U.S. Preventive Services Task Force published a report recommending that the PSA test not be routinely used, concluding that the number of lives saved by PSA screening is small because most men with prostate cancer will not die from it and that the harms stemming from unnecessary treatment outweigh the benefits. Not everyone agrees, however, and many argue that the task force guidelines go too far, estimating that the benefits of PSA screening should not be lost, and that advances in diagnosis and treatment of prostate cancer make many of the harms avoidable.

Concerned by this uncertainty, Dr. Roger Luckmann, a clinician and associate professor of medicine at the University of Massachusetts Medical Center, initiated a project to involve patient representatives in the development of guidelines for the PSA test and engage professional facilitators to assist them. The hope was that clearly reasoned guidelines created by such a broad-based group would be convincing to both doctors and patients.

The process. Luckmann organized a management team composed of four groups: an evidence group that summarized research articles and responded to panelists’ questions; a logistics group that recruited panelists, scheduled meetings, and made all meeting arrangements; a facilitation group that designed the process and facilitated the meetings; and a research group. The panel had six primary care physicians, six patient representatives, two health systems representatives, two health insurers, two public health representatives, and three urologists.

Recruiting panelists. The facilitation team recommended to the management team that patient representatives and primary care physicians have the largest representation on the panel so that the target audience would have the loudest voice in the process. Concern about vested interests also led the facilitators to recommend that “consensus” be defined as a consensus among the constituent panelist groups so that no individual urologist or payer, for example, could block the outcome, with the proviso that any individual who disagreed with his or her group could write a dissenting opinion that would be published as part of the clinical practice guidelines.

The recruitment of African American patient representatives was also a concern. Among black men, prostate cancer occurs more frequently, tends to manifest earlier in their lives, may be more aggressive, and more often causes death than among white, Asian, or Hispanic men. The logistics team was able to find only two African American patient representatives willing to participate, including, as it turned out, a panel member who dropped out because of scheduling. The facilitators were concerned about how the African American man would feel about being responsible for representing all black men and also how being the only black man on the panel would influence his participation. But the most important implication of this—discussed below—was a complete surprise.

Values and science. Weighing benefits against risks is always problematic: How does one compare the worth of a life saved with the value of avoiding various harms?
various harms? When, as in this case, the potential harms are substantial but overwhelmingly nonfatal, while the benefit of lives saved is a relatively small number, the value conflict is more difficult.

Initially, a working group was not able to come to a conclusion and left the question open for the next panel session. The facilitators thus faced the question of whether to let the panelists debate it until they came to a consensus or to suggest leaving the issue unresolved. And then, in a lucky break, a research team previously unknown to the group, working on the same problem and using mathematical modeling in addition to the existing research, was able to produce a set of harms-to-benefits ratios that converted the language of value tension into the language of quantitative choice. With this tool, the panelists were able to decide on what became the crucial point: Should screening start at 45, 50, or 55? Going into the final panel, there was general agreement that screening for average-risk men should begin at 50 and for high-risk men at 45, the conventional ages at which to begin screening.

Moving playing field. At the fourth panel meeting, two matters caught the facilitators off guard and nearly derailed the process. The first surprise came at the beginning of the meeting when most of the panel members, including the facilitators, learned that the American Urological Association (AUA) had recently released a revised guideline. There was general agreement that both the panel’s guidelines and the AUA’s would likely be more persuasive if they were consistent.

One element in the AUA guideline, though seemingly noncontroversial, proved very troublesome. The AUA had concluded that by raising the age at which screening should begin from 50 to 55, there would likely be a meaningful reduction in harms and a negligible reduction in lives saved. These relative values of harms and benefits fit those articulated by the panel, so there was no reason to anticipate any resistance to following the AUA. But raising the starting age from 50 to 55 implied that the beginning age for screening high-risk men should also be raised by five years, from age 45 to 50.

At this moment, the panel faced its second surprise. The sole black patient representative and the representative from the Massachusetts Department of Public Health shared with the group that for years a public health campaign had been in place in African American communities to promote the age of 45 as the starting point for screening African American males. The community groups had concluded that by raising the age at which screening should begin from 50 to 55, the American Urological Association (AUA) had recently released a revised guideline. There was general agreement that both the panel’s guidelines and the AUA’s would likely be more persuasive if they were consistent.

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RENTS, REFI’S, AND REEFER MADNESS

By J. Marcus Painter

To real estate owners, legalization of marijuana has been the deus ex machina filling vacant industrial and retail space while the rest of the commercial real estate market languished in a world of tepid demand, tumbling rents, and expanding vacancies. Some lenders also saw it as a panacea for poor-performing loans during the Great Recession. But the initially curious anomaly of legalized marijuana in a few states has grown into a large economy across the country, which has opened a Pandora’s box of problematic legal issues for landlords and real estate lenders.

Federal regime. Marijuana is listed as a Schedule I narcotic under the Controlled Substances Act (CSA) of 1970; it is illegal to possess, grow, or dispense it or to conspire with or aid anyone else to do so (including renting space to, accepting deposits from, or securing a loan with property leased to a marijuana operation). The Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended, and related federal statutes allow federal seizure of any real property used in conjunction with illegal drug trade, including property leased to such operations.

Legalization at the state level. Since 1996, 23 states and the District of Columbia have approved legal medical use of marijuana, through either popular vote or legislation. In 2012 Colorado and Washington legalized recreational as well as medical use of marijuana; Alaska, Oregon, and the District of Columbia joined them in 2015.

Attempts to reconcile federal and state laws. The public’s increasing acceptance of and comfort with some form of legal use is jarringly out of step with the federal laws on the books. As momentum has increased among the states to validate some form of marijuana use, so have efforts to bridge the chasm between state and federal laws governing the drug.

But while the proverbial camel’s nose of medical marijuana is well inside the political and public opinion tent, make no mistake: The “legality” of all medical and recreational marijuana businesses is a fiction existing only by the good graces of the Obama administration’s directives to the Justice Department to stand down enforcement. Until predictability is created by removing marijuana as a Schedule I narcotic, the risks of changes in policy, or that a marijuana operator’s conduct might cross the boundaries of the limited enforcement directives, loom large for real estate owners and their lenders.

Seizures and the innocent owner/lender defense. Both civil and criminal forfeitures are available to the government to enforce violations of the CSA. The ever-present and heightened risk of other criminal activity, coupled with raids and other enforcement actions, put a bank’s collateral and an owner’s property at frighteningly significant risk. Federal law not only permits the seizure of marijuana-related real estate assets but also the stripping of otherwise legitimate lien rights of lenders.

Banks’ and owners’ ability to fight seizure and retain their collateral and ownership positions is very limited. Once the government establishes a nexus between the property and the illegal conduct, the burden shifts to the owner or lender to show it is entitled to enforce violations of the CSA. Both civil and criminal forfeitures are available to the government to enforce violations of the CSA. Banks and owners would be well advised to undertake regular audits of their 

LEGALIZED MARIJUANA HAS OPENED A PANDORA’S BOX FOR LANDLORDS AND REAL ESTATE LENDERS.

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in 2017, one cannot know how strictly laws against marijuana operations or possession (and association with the same through the ownership of buildings housing such tenants or lending to such building owners) will ultimately be enforced. Until predictability is created by removing marijuana as a Schedule I narcotic, the risks of changes in policy, or that a marijuana operator’s conduct might cross the boundaries of the limited enforcement directives, loom large for real estate owners and their lenders.

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properties/collateral to ensure that none of the space is being used to “facilitate” a federal drug felony.

Anti-money laundering. Owners and lenders must also understand the risks associated with common “structured” transactions. The federal anti-structuring laws are designed to address the ruse of breaking down large monetary transactions into many smaller transactions to avoid reporting requirements or to hide a large and illegal transaction from detection. By necessity, structured transactions are the typical manner in which bank deposits are made and tenant rents are paid in the legalized marijuana economy. Landlords may be paid in cash or in a series of small-denomination payments into deposits with their bank—conduct that should result in the bank filing a “Suspicious Activity Report” (SAR) for that landlord with federal regulators (something that cannot then lawfully be disclosed to the landlord) or risk as individual bankers and banking organizations massive federal fines and personal imprisonment.

Rather than take such risks, banks instead notify the landlord of an “illegality” default because the loan payments are derived from the rents of an illegal marijuana operation. Banking lawyers are finding a growing workload in the area of default notices threatening acceleration and foreclosure if a marijuana-related operation is not removed from the collateralized real property.

Concerns for borrower-landlords. A borrower-landlord receiving such a default notice may face difficulties in simply evicting the offending tenant. Although banking law is generally federal, landlord-tenant law is not. A tenant being evicted on the basis of a federal law violation may well argue successfully in state court that federal banking issues are the landlord’s problem. The court may then rule that the landlord is estopped from seeking eviction because not only is the tenant’s operation lawful under state law, but at the time of leasing the landlord knew of and consented to the marijuana-related use. At that point, unless the landlord can use the lender’s acquiescence to the marijuana-related lease as a potential defense to the bank’s acceleration of the debt, a loan payoff or buyout of the tenant may become the very expensive, and only, options for avoiding foreclosure.

Adding to these risks is the mounting evidence with both grow and dispensary operations that the presence of marijuana plants, products, and processes can create significant impacts—structural, electrical, ventilation, and environmental—on the premises and beyond. These issues lead to large re-tenanting expenses that can impact replacement reserves, capital calls, and income covenants. They can also result in lower appraisals and loan curtailment payments to rebalance loan-to-value ratio covenants.

Landlords should broaden their right to terminate such leases via expanded default provisions covering issues including general nuisance, odor, illegal smoking or other consumption, criminal conduct, loitering, interference with other tenants, fire hazards, cancellation or increases in costs of insurance, violations of other tenants’ rights, increased utility costs, damage from operations, and more. But more effectively, landlords should install trap-door clauses in their leases allowing discretionary termination of the lease at the first sign of trouble.

Conclusion. Lenders and owners may have a variety of economic incentives to roll the dice with marijuana-related tenants. But in so doing, these lenders, owners, and their attorneys must be aware of the many criminal, civil, and financial risks involved.
SUCCEEDING AT FAILURE

By Benjamin K. Sanchez

All of us fail at one thing or another in our lives, but not everyone succeeds at failure. Succeeding at failure does not come naturally but rather is an acquired skill born of experience, learning, and emotional maturity. We have a tendency to fall down in life and either wallow in the fact that we fell or pull people down to join us. I suggest that those who’ve been down the path of failure and have learned how to fail successfully are far and away ahead of the game. Their success comes from the simple fact that they know you can fail backward or forward, and they consistently fail forward.

ACHIEVING VS. AVERAGE

In his book Failing Forward, leadership expert Dr. John C. Maxwell notes that the major difference between achieving people and average people is their perception of and response to failure. Discussing why the path to success is paved with failure, Maxwell notes that the best heroes, experts, businessmen, and truly great people of this world all experienced failure but learned how to use it and turn it into a stepping-stone for success. When I first read the book and learned to appreciate its truth, I was able to take hold of my life and deal with all the obstacles that have come my way since.

I’d like to share with you the three big takeaways I have learned through my experience with and study of failure. When I have the opportunity to give motivational speeches, I invariably discuss this idea of failing forward. When you get knocked down in life and know how to fail forward, you’re in a position to succeed as soon as you get back up.

FIRST FAILURE TRUTH: YOU CHOOSE YOUR OWN REACTION

In the simplest form, there are two types of human reactions: voluntary and involuntary. Most people forget which is which because they’ve been telling themselves they can’t help how they react or that it’s natural to react a certain way. In reality, the dichotomy is much simpler.

An involuntary human reaction involves a physical reflex that is virtually impossible to escape. A familiar example is the “knee-jerk reaction” that results when a doctor taps your knee with a rubber mallet in order to test your nerves. In medical terms, this is a “mono-synaptic reflex” because the impulse only has to jump from one nerve to another once, without ever involving the brain. Your body doesn’t give your brain a choice in the matter.

On the other hand, your brain is given the choice to act in almost all other matters involving a specific intention. The beauty of the mind is that it allows us to exercise our free will in almost any area we choose. Thus, we get to choose how to react to failure. Although it may be debatable as to whether or not we can control failing in the first place, there is no debate that we can control our reaction to failure. It is imperative that we choose a positive reaction. The first key to failing forward is the decision to do so.

SECOND FAILURE TRUTH: YOU MUST TAKE ACTION

Once you have made the important decision to react positively to failure, the next step is to take action. Too many people let failure stop them in their tracks. This is the worst thing you can do because the effect of failure multiplies the longer you stay still.

The way I view the effect of inaction to failure is with a graph, wherein the X axis (horizontal) marks the amount of time of inaction following a failure and the Y axis (vertical) marks the adverse consequences of the failure (see illustration on next page). If we start the line at 0,0 and increase the line at 45 degree angle up and to the right, then we can see the direct correlation between the two. The longer the inaction, the greater the adverse effect. The quicker action is taken, the lesser the adverse effect.

If you can train yourself to make the decision to react positively to failure and take immediate action, the chances of the failure becoming a huge burden is minimal. For example, if a long-distance runner falls down in a race, the longer the runner stays down, the more likely the runner will damage her finish in the race.

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In the practice of law, the longer you wait to react to a mistake you made, the more problematic the mistake becomes. I often have found that the quicker I react to a mistake I’ve made, the higher the chances the mistake can be rectified.

**THIRD FAILURE TRUTH:**
**YOU MUST REVIEW AND LEARN**
Deciding to react positively and taking action don’t mean much if, at the end of the day, you don’t review the failure and learn from it. Not all action that you take in reaction to failure will necessarily be productive or fruitful. It is only when you review the failure and your reaction to it that you then learn whether the failure could have been avoided and if your reaction was the appropriate one. You may learn in your moment of stillness that a procedure could be put into place to avoid the failure or a different action step would have yielded a better result.

For example, suppose you miss a deadline in a litigation matter you are handling. After you realize the mistake and you ask opposing counsel to agree to extend the deadline or you file a motion with the court to minimize the effect, you may realize upon further reflection that you need to tweak your procedure for ensuring that deadlines get entered in your calendar or that you ought to institute a double-entry system (as most malpractice carriers suggest). In my firm, our primary calendar is electronic, but we also have a paper calendar as the back-up. This system came in place owing to a missed hearing years ago.

There is a caveat to this third truth: You must be able to analyze based on experience and study. A beginning attorney may not be able to realize much about how things could have been different based on experience, but further study (CLE articles, blogs, etc.) might help the attorney learn how the problem could have been avoided or handled better. The good thing about failing often is that we get to learn often. If everything goes our way, then it will be more difficult to know the errors of our ways. So I encourage you to read often, seek out mentors and be a mentor, and analyze your practice and life habits from time to time (even when you’re not facing failure) in order to learn how to be and do better.

**NOW GO FORTH AND FAIL!**
I hope that you will undertake failure with a new approach. You should welcome failure not as a way of life necessarily, but as a moment of opportunity. We all fail, but not all of us succeed as a result of our failures. The other day I put a little graphic on my Facebook page that encourages people not to give up after failing. It reads:

- If Howard Schultz gave up after being turned down by banks 242 times, there would be no Starbucks.
- If J.K. Rowling stopped after being turned down by multiple publishers for years, there would be no Harry Potter.
- If Walt Disney quit too soon after his theme park concept was trashed 302 times, there would be no Disneyland.
- One thing is for sure: If you give up too soon, you’ll never know what you’ll be missing. Keep going and never quit!

I encourage each of you to internalize these fundamental truths about failure and change your failure process for three months—you will see dramatic improvements in how you deal with failure, stress, and setbacks. I’ve been told that I am one of the most positive people you can meet, but that is not because I haven’t had a ton of failures. My positivity comes from knowing that every failure is a chance to learn and improve.
The theme of this issue of GPSolo is health care, and thinking about the topic from the viewpoint of a Mac computer and iOS device user, I will focus here on health care and medicine as they might positively affect our lives and, as a result, make us better lawyers and people. Plus, I’m writing this just after the new year, and we all know about making resolutions to become healthier, don’t we?

There are whole websites, books, and seminars providing health care resources. So this column will only be able to scratch the surface, but perhaps it will serve as a resource for people wishing to research ways to improve their health—or that of others. I did a little looking myself, as my 2015 started with a desire to cook better and smarter, exercise, and generally improve my health. I’m aging, and I’d like to age gracefully.

One excellent resource for technological information relevant to Macs or iOS devices (and other platforms as well) is the online magazine/website MakeUseOf (makeuseof.com). Searching there on health and related topics, I found articles collecting links to a number of websites providing diets, workouts, exercise regimes, and other resources. For instance, “How to Work Out Without Going to the Gym” (tinyurl.com/kq2z8vd) shows examples of websites focused on personalized exercise programs in your own home. Another recent article, “10 Websites to Help You Stick to Your 2015 Resolutions” (tinyurl.com/k3hauzk), contains a wealth of diet and fitness-related links. So, for a start, go to MakeUseOf and do a search for whatever it is you need; you’ll be sure to find something (with links to follow up on) for whatever device or OS you are on. And in addition to the articles, don’t forget to check the comments, which often have helpful links as well.

Focusing my research on more Mac/iOS-centric resources, I uncovered many apps that would be useful in the quest to improve one’s health. As I went along compiling the information, I decided to jettison the entire topic of iOS apps dealing with health and wellness issues, as it is just too huge a topic to cover here. Most people know about the Fitbit and other trackers, and some are waiting for the Apple Watch with its HealthKit application (about which, see tinyurl.com/qcdykw). But I will leave the discussion of using small devices to monitor, track, and educate about health and wellness to the “Road Warrior” column (see page 4). This “Mac User” column will focus on Mac computer applications and access to websites that might be of assistance, although I will mention some iOS resources as needed, particularly as many of the Mac computer programs have companion iOS apps that can be found on the iTunes Store (apple.com) or the developer’s parent website. I will call the reader’s attention, however, to the May 2013 issue of MacLife magazine (maclife.com) as well as several articles on MakeUseOf (tinyurl.com/nmorkon, tinyurl.com/mph7be9, and tinyurl.com/ksvx3hj) that discuss health-related iOS resources.

visiting the app store

First, for those with Macs, a trip to the Mac App Store (now helpfully reachable by going to the little Apple in the upper left-hand corner of your computer’s display, moving down the list to App Store, and clicking) can be an overwhelming experience. However, the Mac App Store is organized by categories, and you can find what you want by going to the Health & Fitness, Lifestyle, Sports, or Medical categories and starting there. Or you can insert a search term such as “health,” “exercise,” “workout,” “diet,” “recipe,” etc. and find all sorts of apps for each of these topics.
These categories also can be found in the Top Charts areas if you are looking for popular, crowd-sourced applications. Mac apps are collected into groups of Top Paid, Top Free, and Top Grossing, which might be one way to cut through the clutter of a store with close to 500,000 items to choose from. (A helpful article from MacWorld gives tips on how to find the needle in the App Store haystack: tinyurl.com/ljcctcd.)

The same breadth and searching methodology is also true of the iTunes App Store, which focuses on iPhone and iPad apps. In both cases you can select the Health & Fitness, Lifestyle, or Medical category to find health-related applications. If you’re away from your Mac (or Windows computer) and want to find iTunes apps on the web, you can start at apple.com/itunes/charts/free-apps and explore.

iTunes can be overwhelming, but its search function is exceptionally powerful and can provide a variety of ways of gaining information. I opened it on my laptop and selected the iTunes Store (not just Music or other subparts) and put the word “workout” in the search box. It came up with many results categorized by areas: Albums (mostly music to work out by), Songs (likewise), Music Videos, iPhone Apps, iPad Apps, TV Seasons and TV Episodes, Podcasts and Podcast Episodes, Books and Audiobooks, Movies, Collections, iTunes U Episodes, and Courses and iTunes U Materials. Be sure to hit “See All” if you like a certain method of imparting knowledge as the front page is only a sampling. Then you can play whatever it is you find on your computer (or iOS device) and move toward better health.

I want to focus particularly on two sources of information on health-related issues that are freely available on iTunes but rarely searched for such purposes: Podcasts and iTunes U.

Podcasts are free, easily downloaded, frequently updated, and dedicated to a host of topics—serious, comedic, and informative. Podcasts are great to listen to as you walk, drive, or exercise. Clicking on the iTunes Essentials: Podcasts link took me to podcasts on the general topics of Running and Yoga, as well as others. And going into the Podcast area of Running I found all sorts of podcasts, including some on how best to do it and providing workout music as well. In addition to the Essentials collection, in the Podcast area there are the Health and Science & Medicine categories. Clicking on these links will take you to a plethora of podcasts related to these topics.

iTunes U is another area of iTunes that I search when I’m pulling together resources. The list of topics covered in iTunes U and its providers is extensive. Again, by narrowing your focus to topics of health, science, medicine, wellness, nutrition, and the like, you can find courses from reputable colleges and universities dealing with these topics. For instance, under the category of Health & Medicine is the topic of Food & Nutrition; one course provided by the University of California deals with “Diet and Nutrition,” and another by Cornell University has sessions on “Health and Nutrition.” There are courses on baking, meditation, cycling, and health-related topics.

A quick look at the iTunes Store’s book (and audiobook) holdings also reveals some books on the topics of diet, eating, food, stress, and the like. So, just by going to iTunes on your Mac (or PC using the Windows version of iTunes), you can find all sorts of resources to access on the topics of health and wellness.

As I looked into particular sites or apps that could be used or accessed on a Mac, I found several that particularly intrigued me and that I thought might be helpful for lawyers. After all, we can only take care of clients and others if we take care of ourselves. I’ve broken out some of the topics below; there are plenty more, but this should give you a sense of what is out there.

**MEDITATION, CONCENTRATION, SLEEP, AND MENTAL WELLNESS**

White Noise Lite offers a collection of images and sounds to help you fall asleep: thunderstorm, rain, beach waves, crickets, cat purring, etc. It’s quite an assortment and can be accessed with ads (free) or without ($4.99). In addition to the Mac version, there is also an iPhone/iPad version. For those on other platforms, there are other versions at the website (tmsoft.com/white-noise). Similar apps include Sleep Pillow, which is free and also has versions for your iPhone or iPad (clearskyapps.com), and Relax Melodies (including variants such as Relax Melodies Oriental and Relax Melodies Seasons; ipnossoft.com), which is also free.
but has a paid-upgradable option, as well as iPhone or iPad versions. This set of apps uses musical instruments and their sounds in addition to nature sounds to provide a calming background.

If you’re looking for something to force you to stop and smell the roses as you sit scrunched in your chair at the desk, reading and writing or searching on the computer, there’s an app called Time Out (dejal.com/timeout) that is easily configurable and dims your screen and forces you to take micro-breaks (to catch your breath, un-tense, and change your eyes’ focus) and regular breaks from computing. The program is free, but it is donationware, so you should make a donation if you find it useful.

Another app for the Mac that will remind you to sit back, stand up, and move is Water Break (lifetouch.com/home.php, also listed in the App Store under Health & Fitness); it lets you schedule a reminder to take a water break, which you also can use as a reminder to stand up, stretch, and move around. It cost me 99 cents—pretty close to free—and there’s also an iPhone and iPad app. The developer’s website lists a number of other simple apps for Macs and iOS devices that can help with many of your daily tasks beyond remembering to drink water and take stretch breaks.

An interesting app available free for the Mac (as well as other platforms and as a browser extension) is Optimism (findingoptimism.com; also on the App Store), which bills itself as a “self-tracking applications, designed to help you increase your understanding of all the things that affect your mental health.” Once you learn the patterns of your life, you can then address them. The website has screenshots and information for how best to use the app and benefit from that use. For instance, when you start the app, there are a number of questions to fill out: how many hours you slept, how long you exercised, your feelings, and the “stay well strategies” you have employed during the day. You enter data each day and make notes, and at the end of a period you can chart the results and know more about what works for you (or doesn’t) and how to address issues facing you.

As part of my research, I visited with Joy Schiller, director of the Wellness Center at Des Moines University (dmu.edu/wellness-center), about websites and other resources having to do with health and wellness. She and the Wellness Center provided me with a long list of websites on the topic, and I’ll provide just a few of them here:
- Fitness Blender (fitnessblender.com): full-length, at-home workouts
- Self NutritionData (nutritiondata.com): complete nutritional information—including a calorie counter—for any food or recipe, helping you select foods that best match your dietary needs
- SparkPeople (sparkpeople.com): recipes, exercises, and all sorts of assistance
- TheWalkingSite (thewalkingsite.com): hiking and walking as exercise

For those looking for Mac apps focused on assisting with exercising, there are a number in the Health & Fitness area of the App Store. First I went to this category and looked for free apps to give me a sense of what might be available. While there were not all that many, there were enough to start learning how to do better, focused exercises. For instance, Daily Ab Workout FREE provides you with a video of ten basic exercises, each about 30 seconds long, for a total of five minutes (or you can select a workout length of 7.5 or ten minutes) focusing on various exercises that improve your abs. Once you set up your Mac and play these videos, your exercise is timed and different options are provided. If you like this free introduction of these video demonstrations, the Daily Workout Apps developers have other (paid) options for you, including workouts for various body parts and yoga. Similarly, there are a number of other applications that will provide you at least a starter, after which you can buy other types of workouts. One of these on the App Store for the Mac is Personal Workout, which provides free workouts and in-app purchases. For instance, what is your goal? Lose weight? Keep fit? Tone muscles? Select the goal and the app will suggest exercise routines for you and show you how they are best done. If you can’t go to the gym or hire a personal trainer but are dedicated enough to task yourself with exercise routines, this is a good app to get.

### Technology Can Make the Process of Improving Your Health Consistent, Productive, and Easy to Do.

The list goes on and on. (For a more generous serving of helpful websites, see the sidebar on the next page.) You can find loads of additional resources by using the search engine on your Mac or by contacting your local university or extension service.

### Working Out and Exercising

Using apps to track your progress on a Mac mainly involves finding relevant websites and registering, logging in, and making sure your device/tracker will send in data to the site. (See “Road Warrior” on page 4 for an overview of tracking devices by Fitbit and Jawbone.) There are loads of tracker apps to track exercise, steps, sleep, how much or fast you run or...
WELLNESS WEBSITES

CALORIE COUNTERS/WEIGHT MANAGEMENT RESOURCES
- Self NutritionData: nutritiondata.com
- SparkPeople: sparkpeople.com
- SparkRecipes: sparkrecipes.com
- CalorieKing: calorieking.com
- MyFitnessPal: myfitnesspal.com
- Live Healthy Iowa: livehealthyiowa.org/default.aspx
- Iowa State University Healthy Living and Eating page: extension.iastate.edu/healthnutrition

NUTRITION RESOURCES
- ChooseMyPlate: choosemyplate.gov
- Eat Right: eatright.org
- Centers for Disease Control and Prevention (CDC): cdc.gov
- American Heart Association: americanheart.org
- Nutrition Facts: nutritionfacts.com
- Whole Grains Council: wholegrainscouncil.org
- Iowa Girl Eats: iowagirleats.com

RECIPE RESOURCES
- Hungry Girl: hungry-girl.com
- Cooking Light: cookinglight.com
- Skinny Mom: skinnymom.com/recipe-index
- Skinnytaste: skinnytaste.com

AT-HOME WORKOUTS
- Fitness Blender: fitnessblender.com
- SparkPeople Full Body Dumbbell Challenge: tinyurl.com/kmzzhsr
- SparkPeople Focused Workout (no equipment): tinyurl.com/kr4pxax
- SparkPeople Beginner’s Resistance Band Workout: tinyurl.com/pn9exd2
- SparkPeople Standing Workout Challenge (no equipment): tinyurl.com/1r4bqps

HIKING, WALKING, AND BIKING TRAILS
- The Walking Site: thewalkingsite.com
- Trails.com (previously webwalking.com): trails.com
- Bicycle Federation of America: bikefed.org
- Iowa Bicycle Trails: iowadotmaps.com

WALKING/RUNNING PROGRAMS
- American Running Association: americanrunning.org
- Running Planet: runningplanet.com
- Active.com: active.com
- Fitness Sports (listing of Iowa area races): fitnesssports.com
- Capital Striders (Des Moines, Iowa, running club): capitalstriders.org
- Des Moines Marathon: desmoinesmarathon.com

ALCOHOL/NARCOTICS-FREE RESOURCES
- Alcoholics Anonymous: aa.org
- Al-Anon/Alateen: al-anon.alateen.org
- Narcotics Anonymous: na.org

TOBACCO-FREE RESOURCES
- CDC Smoking and Tobacco Use page: cdc.gov/tobacco
- Smokefree.gov: smokefree.gov
- Quitline Iowa: quitlineiowa.org

OTHER RESOURCES
- American Cancer Society: cancer.org
- American Diabetes Association: diabetes.org
- ElderWeb: elderweb.com
- Men’s Health: menshealth.com
- Strong Women: www.strongwomen.com

List compiled with assistance of the Des Moines University Wellness Center (dmu.edu/wellness-center).

cycle, and many other types of endeavors. Most are geared to your iOS device, but many also provide you with website access via your Mac. And because you pay your taxes, the federal government at the U.S. Department of Agriculture’s website provides you with a free method for keeping track of your health and finding information to improve it: SuperTracker (supertracker.usda.gov/default.aspx).

AN APPLE A DAY
This topic might seem narrow, but once you lose yourself on the Mac App Store, you will be swallowed up in it. And, as noted above, for most Mac apps there is a corresponding iOS application and website. So, try out the free apps, talk to knowledgeable people who can suggest helpful sites and apps, and be patient testing each one. The main point of using technology to improve your health and well-being is to make it consistent, productive, and easy to do (and to remember to do). Technology is a tool we can use to reach the goal of an improved life and law practice.
am immortal. That is what I told my doctor when he asked why I waited 20 years after graduating law school before scheduling my first checkup. The fallacy of my self-diagnosis was evidenced by the test results—while I was in reasonably good health, better diet, more exercise, and cholesterol control would become part of my everyday life.

I was lucky. Had something been seriously amiss, my long delay could have created significant issues.

My sole excuse for neglecting health care was age. As a young lawyer, I felt strong and energetic. I did not wish to waste time visiting doctors who would tell me what I already knew: I was healthy. Neither did I wish to dwell in the alphabet city of the American health care system (HMO, EPO, POS, PPO), a world akin to acronyms on steroids. My time was better spent at work or at home, the two places that framed and defined my life. It was only as my kids grew older and I began to experience some of the inevitable challenges of age that I decided to incorporate health care into my everyday life. In retrospect, I should not have waited.

Neither should I have remained enrolled in an expensive PPO (preferred provider organization) during my period of inactivity. PPOs are all about choice, which comes at a price, while HMOs (health maintenance organizations) strictly limit users to in-network providers and pay nothing if users visit doctors or hospitals outside the network. I was, effectively, paying more not to choose. I would have been significantly better off enrolled in an HMO or similar plan with lower premiums accompanying sporadic visits to doctors.

Users today are not limited to HMOs and PPOs. They may also enroll in EPOs (exclusive provider organizations) or POSs (point of service plans), effectively blends of the HMO and PPO business models, with varying degrees of choice given to users. A POS is similar to an HMO in that it requires primary care physician approval before a specialist may be consulted. Unlike an HMO, however, a POS will allow and pay for visits to out-of-network providers. An EPO, like a PPO, will not require primary care physician approval for a specialist visit. Unlike a PPO, however, the EPO enrollee will be limited to in-network specialists.

In addition to cost (and paperwork that you ignore?)

![Image](https://via.placeholder.com/150)

**Beyond Immortality: Basic Choices in American Health Care**

By Elio F. Martinez Jr.

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