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HEALTH LAW UPDATE

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A BAKER'S DOZEN OF SIGNIFICANT CHANGES IN HEALTH REFORM

The enactment of the Patient Protection and Affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (signed into law by President Obama on March 30, 2010) (collectively, PPACA or the Act) represents a significant legislative milestone that has proven elusive in American politics since the time of the Great Depression. The recognition of the need to act on social insurance has led seven presidents from both parties to propose (and periodically pass) a myriad of reform proposals and healthcare programs. While contemporary Democrats and Republicans often differ dramatically on their approaches, both sides acknowledge the consequences associated with escalating healthcare costs and the rise in the number of uninsured Americans.

Comprising a multitude of legislative initiatives and several forests worth of paper, Rube Goldberg would be proud of both the Act's complexity and the 15-month labyrinthine process used by Congress to reform nearly one-sixth of the nation's economy. It is unlikely that the enactment of PPACA will end the health reform debate, however, as the Act largely sidesteps measures aimed at curbing medical malpractice awards, EMTALA issues with regard to uninsured aliens and repeal of the current sustainable growth rate limitation on physicians under Medicare.

Indeed, the ultimate success of PPACA may hinge on whether the new law can successfully "bend the cost curve" associated with improving access to coverage for an additional 32 million uninsured Americans. To that end, the Act contains a number of provisions directed at initiating healthcare delivery system and payment reforms. Financed through a combination of savings from Medicare and Medicaid and new taxes and fees, the Congressional Budget Office (CBO) estimates that PPACA will reduce the federal deficit by $143 billion between 2010 and 2019 and cover 32 million uninsured in 2019 at a net cost of $938 billion over ten years.

PPACA is a comprehensive law that seeks to transform the health insurance market and the healthcare delivery system, promote quality and efficiency in the Medicare program, expand Medicaid, preserve the Children's Health Insurance Program (CHIP), restructure supplemental payments to safety net providers, impose new requirements on charitable hospitals, attract more physicians to primary care, grow a primary care workforce, prevent chronic disease and improve public health, tighten permissible arrangements under Stark Law, broaden liability under the federal False Claims Act and raise sufficient revenue to pay for it all!

Other notable changes include establishing five-year state demonstration programs for evaluating alternatives to medical tort litigation, eventually closing the Medicare prescription drug "donut hole," restructuring payment for Medicare Advantage plans, creating a national voluntary insurance program for purchasing community living assistance services and support (CLASS) and establishing new state options for long-term care services.

Providers now must begin the process of positioning themselves strategically to assure that they are prepared for the crush of changes applicable to their existing operations and for the impact of the Act's many new payment and delivery system

models. Additionally, providers must heed the call for enhanced quality in exchange for payment and recognize that their institutions and businesses will be subject to heightened scrutiny with regard to coverage, payment and compliance not only under the Medicare and Medicaid programs, but also private insurance plans.

Baker Hostetler's National Healthcare Team summarizes a "Baker's Dozen" of significant changes contemplated in the law of import to healthcare providers.

1. Transforming the Insurance System

PPACA enacts a panoply of changes to existing health insurance benefit plans and also establishes a plan to insure a large number of uninsured Americans through enhanced access via state insurance exchanges established for the benefit of small businesses and individual purchasers.

New insurance creatures, such as medical home plans and consumer operated and oriented plans (CO-OPs) are contemplated as nonprofit insurance products, certified either by the Secretary of the U.S. Department of Health and Human Services (Secretary) or created under state law.

Generally, the policy approach adopted in the Act requires most U.S. citizens and legal residents who otherwise do not have health insurance for a variety of reasons to obtain health insurance coverage. The Act attempts to systematically address each reason for an individual's failure to carry insurance, from the issue of "young invincibles" who may have access but choose not to pay the required premium to join an employer's plan, to those who cannot afford to purchase insurance due to economic circumstances. For individuals unable to access insurance due to cost and availability, the Act requires states to create an American Health Benefit Exchange through which individuals will purchase insurance, with premium and cost-sharing credits available to individuals and families with incomes between 133-400 percent of the federal poverty level (FPL) (for a family of four in 2009, 400 percent of FPL equaled $88,200). A separate exchange will be created for small businesses, incentivizing competition between plans on the business exchange to offer affordable coverage for small businesses that have had trouble obtaining coverage for their workforce. States can enter into compacts to access insurance products across state lines should a state determine it is beneficial.

Subject to certain hardship or religious exemptions, beginning January 1, 2014, all U.S. citizens and legal residents will be required to obtain coverage or face a tax penalty. The law provides that individuals with employer-based coverage will be able to retain their coverage through certain grandfather provisions. Employers are incentivized to offer coverage through a stick approach -- a fee assessed per full-time employee for failure to offer insurance.

Those without employer plans can obtain coverage through newly organized state exchanges, which must be established no later than 2014. Subsidies would be provided to low-income individuals to purchase their coverage from the exchange. The Act contemplates the eventual phasing of the Medicaid and CHIP programs into the exchanges, having the state exchanges eventually host Medicaid and CHIP plans for beneficiaries after 2019.

Small businesses with 25 or fewer employees and average annual wages of less than $50,000 that purchase insurance will be provided with a tax credit beginning in 2010.

Initially, to address immediate coverage of those with preexisting conditions, the Act requires that the Secretary, within 90 days of enactment, establish a temporary high-risk pool to provide those individuals with access to insurance until the state exchanges are created by 2014.

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While many legislative policies do not come into effect under the Act until 2014, the following immediate changes must be implemented within six months of the law's enactment:

- Group health plans and insurance issuers are prohibited from establishing lifetime or unreasonable limits on benefits;
- Rescissions of health insurance policies are prohibited;
- All plans are required to cover preventive services, immunizations, certain child preventive services recommended by the Health Resources Service Administration (HRSA) and certain preventative services for women, without any cost sharing;
- Dependant coverage is extended up to age 26;
- Insurance company administrative expenses are capped -- a minimum medical loss ratio is prescribed;
- Plans offering coverage for emergency medical services must cover emergency services without requiring preauthorization or network participation, regardless of the terms of coverage and in the same manner as in-network emergency services are covered under the plan.

Other insurance reforms required by 2014 include guaranteed issue and renewal and bans on the imposition of any waiting periods of more than 90 days for insurance coverage. Additionally, beginning in 2014, an individual's participation in a clinical trial may not be denied. Routine patient costs in connection with the clinical trial also shall be covered.

2. Transforming the Healthcare Delivery System

The Act contains a number of policy proposals which attempt to initiate delivery system reform that moves away from fee-for-service medicine toward many of the innovations health policy analysts, economists and industry specialists have promoted or proposed for many years. All these policy initiatives are aimed directly at cost containment and changing treatment patterns and incentives in the current healthcare delivery system. To that end, the new law creates a Center for Medicare & Medicaid Innovation within the Centers for Medicare & Medicaid Services (CMS) for testing and expanding new payment models that encourage higher quality and lower cost.

PPACA provides for voluntary, comprehensive Accountable Care Organization (ACO) pilot projects in Medicare that reward physician groups working with hospitals and other providers of care that provide high-quality, low-cost care over a sustained period. Incentive payments will be made to ACOs that exceed performance targets. Participation requirements include a three-year minimum commitment, a formal legal structure that allows for the receipt and distribution of shared savings payments, a sufficient number of primary care professionals to treat a minimum of 5,000 Medicare beneficiaries and a leadership and management structure that includes clinical and administrative systems. As potential building blocks for ACOs, the new law also directs the Secretary to award grants for the testing and funding of medical home payment models. A medical home is a clinical setting that serves as a central resource for a patient's ongoing care.

Experimentation with models that allow payment for broader bundles of service under Medicare and Medicaid are permitted by the Act. These include (1) the development of a voluntary Medicare payment bundling pilot program by January 1, 2013, that encourages doctors, hospitals and post-acute care providers to increase collaboration and improve coordination of patient care and to allow them to share in the savings; and (2) a demonstration project in Medicaid to evaluate the use of bundled payments for acute and post-acute care and/or concurrent physician services in up to eight states by January 1, 2012.

Additional demonstration and pilot projects in the Act directed at testing and evaluating new payment models include evaluating integrated care around a hospitalization (Medicare), the independence at home medical practice demonstration (Medicare), pediatric ACOs (Medicaid), global capitated payments to safety net hospitals (Medicaid) and extending the gainsharing demonstration program (Medicare).

PPACA terminates the Federal Coordinating Council for Comparative Effectiveness Research created under the American Recovery and Reinvestment Act of 2009 (ARRA) in favor of a new nonprofit Patient-Centered Outcomes Research Institute funded by a fee imposed on insurers and the self-insured beginning in 2012. The Institute will be responsible for setting a research agenda and will provide for the conduct of comparative effectiveness research. Under the Act, the Secretary may only use evidence and findings from comparative effectiveness research to make Medicare coverage determinations "if such use is through an iterative and transparent process which includes public comment and considers the effect on subpopulations." The new law also provides for a number of safeguards on the use of comparative effectiveness research with regard to rationing healthcare.

3. Promoting Quality and Efficiency in the Medicare Program

Seeking to transform the Medicare program from "a passive payer to an active purchaser of higher quality, more efficient health care," the Act contains various financing and reimbursement provisions that seek to tie payment to performance on quality and efficiency. It also directs the Secretary to develop a national quality strategy by January 2011 and to establish an interagency working group on healthcare quality no later than the end of the 2010 calendar year.

PPACA transitions the Medicare Inpatient Prospective Payment System (IPPS) hospital value-based payment (VBP) program from pay-for-reporting to pay-for-performance beginning in FY 2013. Reimbursement to IPPS hospitals will be reduced by one percent in 2013, transitioning to two percent in 2017 and beyond to fund incentive bonus payments to hospitals achieving certain quality-based performance scores. Hospitals that score poorly related to hospital-acquired conditions (HAC) will be subject to an additional one percent penalty in 2015.

The new law identifies skilled nursing facilities, home health agencies and ambulatory surgical centers as priorities for transitioning to VBP and directs the Secretary to report to Congress with an implementation plan. It also calls for the implementation of quality reporting programs and related demonstrations for long-term care hospitals, inpatient rehabilitation facilities, PPS-exempt cancer hospitals and hospice providers.

PPACA extends the Physician Quality Reporting Initiative beyond 2010. Physicians who fail to report quality measures in 2014 will be subject to reduced Medicare payment. Beginning in 2015, Medicare will transition physicians to a VBP system using quality and cost measures to be established by the Secretary in 2013. The Act also provides for the development of a Physician Compare Internet website no later than January 1, 2011, and directs the Secretary to make the website available to the public by January 2013.

Beginning in FY 2012, Medicare payment will be reduced for IPPS hospitals with "excess" readmission rates (based on 30-day readmission measures) related to a number of specified conditions. Hospitals determined by the Secretary to have historically high readmission rates will be eligible for participation in a "quality improvement program" established by the Secretary within two years of enactment.

The new law also creates a 15-member Independent Medicare Advisory Board responsible for submitting binding recommendations for cost-savings proposals when Medicare spending rises beyond a specified threshold, which recommendations Congress may oppose. While this provision is effective for payment years 2015 and beyond, hospitals are excepted from the cost reductions proposed by the Board through 2019.

4. Deferring the Physician Fee Schedule Fix … Again

A repeal of the sustainable growth rate (SGR) formula used to calculate yearly updates to the Medicare physician fee schedule was excised from PPACA prior to it becoming law. As a result, the month of March saw multiple stopgap measures by Congress to forestall the 21.2 percent payment cut required by the Medicare SGR, including the passage of the Temporary Extension Act (H.R. 4691) that delayed the cut through the end of March 2010. The Senate adjourned on March 26 for a two-week recess without voting on a measure (H.R. 4815) that would have delayed the reduction until April 30, 2010. A spokesperson for CMS said the agency intends to hold claims filed after the deadline for ten business days in an effort to avoid implementing the physician payment cut. Meanwhile, after the recess, Congress is expected to continue negotiations on a bill (H.R. 4213) to delay the cut until October 1, 2010.

5. Expanding Medicaid and Preserving CHIP

Key to accomplishing the stated policy goal of extending coverage to the majority of uninsured Americans, the new law's expansion of the Medicaid program and support of CHIP are fundamental for expanding access and assuring children receive essential health insurance coverage. PPACA sets a new federal floor for states by assuring the program covers all U.S. citizens and legal residents up to 133 percent of FPL beginning in 2014. States may voluntarily expand coverage to these populations beginning April 1, 2010. While many children and pregnant women currently receive access to care under Medicaid, most childless adults are not covered under state Medicaid laws.

The Act preserves the CHIP program through 2019, extending funding through 2015 and increasing the federal match 23 percent for fiscal years 2016-2019, subject to a cap of 100 percent.

States will receive considerable assistance for expanding Medicaid, including a 100 percent matching rate for all newly eligible Medicaid individuals from 2014-2016. This assistance is scaled back to 95 percent in 2017, 94 percent for 2018, 93 percent for 2019 and 90 percent by 2020 and thereafter.

While the Nebraska and Florida enhanced Medicaid provisions that caused such controversy were removed from the new law prior to enactment, Louisiana will receive a limited extension of federal assistance, originally provided under ARRA, to compensate for the effects of Hurricane Katrina.

While the enhanced funding will help states absorb the additional influx of Medicaid beneficiaries, many states continue to find a large number of eligible, but unenrolled individuals who qualify for coverage but are not enrolled in either Medicaid or CHIP. As such, these individuals continue to be lost to the healthcare system and, as a result, the states pull down no additional federal funding associated with these individuals. Because the Act does not take this issue into account, this could continue to provide for additional budgetary pressures on states and their safety net healthcare systems. Additionally, many states with huge budgetary shortfalls are looking at provider reimbursement rate cuts which will stress those hospitals and physicians providing care to more vulnerable populations even further.

PPACA provides some relief specifically directed at increasing reimbursement rates for physicians who provide services to Medicaid beneficiaries. For primary care physicians, defined to include family medicine, general internal medicine and pediatric medicine, PPACA requires that Medicaid reimbursement must be no less than 100 percent of Medicare payment rates for 2013 and 2014. States will receive 100 percent of the federal financing required to support the increased reimbursement rates.

Other Medicaid provisions include the application of some existing Medicare quality policies to Medicaid, notably, the prohibition of federal payment for Medicaid services related to HACs, effective July 1, 2011. The new law also extends the incentives to create reforms in healthcare delivery in the Medicaid program by authorizing the creation of pediatric ACOs via demonstration project and calls for pilot programs in bundled payment for hospital and physician services.

6. Restructuring Medicare and Medicaid Disproportionate Share Payments

Logically, with an impending decrease in the uninsured, policymakers argued that the programs established under Medicare and Medicaid to compensate providers -- hospitals and physicians-- that deliver a disproportionate amount of care to the indigent or to Medicaid patients (commonly referred to as DSH payments) should be reduced and phased out over time. As such, the Act provides for reductions in Medicaid DSH payments by an aggregate of $500 million for 2014, $600 million for 2015, $600 million for 2016, $1.8 billion for 2017, $5 billion for 2018, $5.6 billion for 2019 and $4 billion for 2020.

Hospitals quibbled with the initial legislative methodology, educating legislators that the complex statutory formulas established and under which many safety net hospitals receive additional funding were not only or directly tied to the number of uninsured, but also were intended to help to compensate such facilities for the financial shortfall associated with providing services to a disproportionate number of Medicaid beneficiaries due to the failure of the Medicaid program to fully reimburse hospitals and physicians for services.

Legislators listened, and the final language in the new law appears to reflect that DSH reductions should not be tied solely to increases in the number of uninsured. Rather, it directs the Secretary to develop a methodology for reducing federal DSH allotments to all states, recognizing those states that have a low percentage of the uninsured or that target DSH funds to hospitals with high Medicaid volumes or uncompensated care.

The Act reduces Medicare DSH payments by an estimated $22 billion over ten years beginning in 2014 and redistributes a portion of the funds that otherwise would have been paid to hospitals with high uncompensated care.

7. Imposing New Requirements on Charitable Hospitals

Reflecting the results of numerous investigations conducted over the last decade by Sen. Charles Grassley (R-Iowa) with regard to the community benefit practices of tax-exempt hospitals, the Act imposes new requirements applicable to any Section 501(c)(3) entity that operates a "hospital facility." Specifically, each hospital facility will be required to conduct a community health needs assessment "at least once every three years" and adopt an implementation strategy to meet the community needs identified in the assessment. Under the new law, charitable hospitals must disclose, in their annual information reports to the Internal Revenue Service (i.e., Form 990 and related schedules), the manner in which they are addressing the needs identified in the assessment and, if all identified needs are not addressed, the reasons why. Hospitals that fail to complete the required community needs assessment would be subject to a $50,000 penalty.

Additionally, PPACA requires that charitable hospitals (1) adopt, implement and make widely available their financial assistance policies, which must specify eligibility criteria and, for discounted care, how they determine amounts that are billed to patients; (2) restrict charges of uninsured, indigent patients to those amounts generally charged to insured patients; and (3) notify patients of financial assistance policies through "reasonable efforts" before initiating various collection actions or reporting accounts to a credit rating agency.

Such changes apply to taxable years beginning after the date of enactment except for the community health needs assessment provisions which become effective two years thereafter.

8. Attracting More Physicians to Primary Care

To ameliorate an anticipated shortfall of some 40,000 family practitioners predicted by the American Academy of Family Physicians to occur in 2020, the new law contains millions of dollars directed toward attracting more physicians to the field through reallocating graduate medical education (GME) reimbursement and increasing payments to primary care physicians. It also directs the Secretary to award grants to teaching health centers for the purpose of establishing new accredited or expanded primary care residency programs.

PPACA increases GME training positions for primary care through a redistribution program for currently unused training slots and provides for the redistribution of a hospital's unused residency training positions for the training of primary care physicians starting July 1, 2011. Additional dollars are allocated to providing medical residents with training in preventive medicine and public health.

The new law directs the Secretary to establish a process for the redistribution of medical residency slots from a hospital that has closed to qualifying hospitals located first in the same core-based statistical area, state or region and finally to hospitals outside of such areas if slots remain. Under PPACA, time spent by residents who train in a non-provider setting will be counted toward indirect medical education (IME) and GME if the hospital incurs the costs of the stipends and fringe benefits.

In addition to increased payment in fee-for-service and managed care for primary care services under Medicaid, the Act provides for a ten percent bonus payment to primary care physicians in the Medicare program for five years beginning January 1, 2011.

9. Growing a Primary Care Workforce

PPACA contains a multitude of provisions directed at increasing the healthcare workforce and creating more community health centers and nurse-managed clinics to accommodate the swelling ranks of the newly insured. To that end, the Act establishes a National Health Care Workforce Commission as a "national resource" for the development and evaluation of education and training activities aimed at addressing an upsurge in the demand for healthcare workers.

Key changes under the new law include funding for existing scholarship, loan repayment, training and retention grant programs focused on strengthening the need for primary care nursing and public health professionals; interdisciplinary training programs emphasizing medical homes, management of chronic disease and integrated medical and mental health services and the establishment of a competitive healthcare workforce development grant program for comprehensive workforce development at the state and local levels.

To address workforce shortages in rural and underserved areas, PPACA expands the National Health Services Corps, provides grant money to the states for funding providers that treat a substantial percentage of the medically underserved and directs the Secretary to create a grant program directed at recruiting students to practice in underserved rural communities.

Additional grants and funding are provided for training and loan repayment programs for allied health professionals employed by public health agencies, training programs for geriatric medicine and long-term care and for funding mental and behavioral health education and training.

The new law also provides for a commissioned Ready Reserve Corps under Section 203 of the Public Health Service Act for service in time of a national emergency. Commissioned officers of the Ready Reserve Corps will be appointed by the President and are subject to call to active duty by the Surgeon General for meeting routine public health and emergency response missions.

10. Preventing Chronic Disease and Improving Public Health

In attempts to further bend the cost curve, the Act seeks to make an investment in coverage of preventive health services under Medicare and Medicaid and invests in the public health infrastructure. As a result, the new law establishes a National Prevention, Health Promotion and Public Health Council to coordinate federal prevention, wellness and public health activities.

PPACA eliminates cost-sharing for "proven" preventive services in the Medicare and Medicaid programs effective January 1, 2011. A one percent increase in the federal matching rate is provided under the Medicaid program for preventive services recommended by the U.S. Preventive Services Task Force as well as recommended immunizations.

Incentives are provided to Medicare and Medicaid beneficiaries to complete behavior modification programs.

For small employers, grants will be provided for up to five years to establish wellness programs.

Additionally, the Act requires chain restaurants and food sold from vending machines to disclose the nutritional content of each item.

11. Tightening Permissible Arrangements Under Stark Law

The exceptions permitting physician ownership in hospitals, included in the Stark Law since its enactment in 1989, have long been under attack. PPACA ends the controversy, eliminating the whole hospital exception for physician ownership and hospital ownership by physicians in the rural provider exception. The Act grandfathers physician-owned hospitals that have a provider agreement with Medicare by December 31, 2010. However, the new law prohibits increases in the total physician ownership percentages of grandfathered hospitals, effective on the date of enactment. Grandfathered hospitals also would be prohibited from increasing the number of beds, operating rooms or procedure rooms, effective on the date of enactment for those hospitals that are licensed as of the date of enactment, and as of the date on which a Medicare provider agreement is granted for new hospitals that meet the grandfather date. A process is established for grandfathered hospitals to seek an exception to the facility growth restrictions, although availability of an exception is limited to hospitals in high-growth areas and those serving a high Medicaid patient population. Finally, grandfathered hospitals will have to file annual reports, identifying physician owners, and disclose the fact that the hospital is physician-owned to referred patients and on the hospital's website and advertising materials.

In keeping with the transparency goal, the Act also imposes a disclosure requirement when MRI, PET or CT scanning is furnished to patients by physicians under the in-office ancillary services exception to Stark. Specifically, the referring physician must provide the patient with a written list of suppliers in the area in which the patient resides and inform the patient in writing that he or she may obtain the service from an entity other than the referring physician. Interestingly, the effective date of this requirement is January 1, 2010. The Secretary is given the discretion to add services to the disclosure requirement.

The third Stark Law-related change involves the availability of a protocol to self-disclose Stark violations, which was eliminated by the OIG one year ago. The Act obligates CMS to develop a self-disclosure protocol specifically for actual and potential Stark violations. The protocol must be established within six months of enactment, and instructions for making submissions under the protocol must be displayed on the CMS website. The new law also authorizes the Secretary to compromise payment and penalty amounts due and owing for Stark Law violations.

12. Broadening Liability Under the Federal False Claims Act

Recognizing the revenue-generating capabilities of fraud enforcement, PPACA allocates significant additional funds to the fight against fraud and expands the arsenal available to enforcers. Already significantly expanded in legislation enacted last year, PPACA includes another round of expansion to the False Claims Act and its reach. One key provision includes the declaration that any claim submitted in violation of the anti-kickback statute is considered "false" under the False Claims Act, an issue that has been subject to differing opinions in court cases. This revision provides prosecutors and whistleblowers with an easier case to pursue than existed prior to the Act with higher penalties. The Act also narrows the public disclosure bar of the False Claims Act (allowing more whistleblowers to pursue claims), broadens who will be considered an "original source" and allows the government to bar the dismissal of a whistleblower who fails to qualify as an original source. Finally, the Act confirms that the retention of an overpayment will be considered a violation of the False Claims Act and establishes that claims submitted to a health insurance exchange that include federal funds will be subject to the False Claims Act.

PPACA includes several provisions related to overpayments. One provision of the Act requires providers to report and return overpayments, which was always an obligation under various authorities. However, the Act requires that refunds be made within 60 days of being identified. Moreover, PPACA requires a provider to furnish the government with written notification of the reason for all refunds. This requirement raises questions for all the providers and entities who make routine claims adjustments as part of the normal course of operations. One has to question whether the payors want to receive written notification of all routine claims adjustments.

PPACA adds sanctions, ranging from criminal to civil penalties, to numerous program integrity provisions. For example, the Act allows the government to suspend payments to providers pending an investigation of a credible allegation of fraud against the provider. This provision grants the government the power to financially make or break an entity. One wonders

how this will play out with the use of the False Claims Act and allegations of misconduct being under seal typically for years. The Act includes new provisions under which a person can be subject to a civil monetary penalty, including failing to make a refund of an overpayment; making a false statement or material misrepresentation on any application or agreement to participate or enroll as a provider in a federal health program, including Medicare Advantage; and failure to grant timely access to the Office of Inspector General (OIG) for audits, investigations, evaluations or other statutory functions. The making of a false statement or misrepresentation of material fact on any application or agreement to participate or enroll as a provider in a federal health program, including Medicare Advantage, is also added to the list of acts under which the government can exclude an entity or individual. With respect to criminal penalties, the Act mandates that the Federal Sentencing Guidelines be amended to increase penalties for federal healthcare offenses.

Finally, the Act provides government enforcers with additional tools to fight fraud. For example, the OIG is granted the authority to obtain information for the "purposes of protecting the integrity of the programs" from any individual or entity that directly or indirectly provides, orders, manufactures, distributes, arranges for, prescribes, supplies or receives any medical or other item or service that is paid by a federal healthcare program, regardless of how or to whom such payment is made. Information can include "any records necessary for the evaluation of the economy, efficiency, and effectiveness of the programs." This is a sweeping authority that reaches beyond providing support for any claims submitted by a provider.

13. Raising Revenue to Pay for It All

During the course of the debates over the Act, the "cost" as scored by the CBO became extraordinarily important to assure that the CBO score did not exceed $1 trillion. Taxes and other revenue raisers are, therefore, an essential ingredient in understanding the Act and its implementation.

As noted above, while employers are not required to provide insurance coverage, employers with more than 50 full-time employees (30 hours) that do not offer adequate coverage to all employees and dependants are subject to penalties if any employee purchases healthcare through a state exchange and receives a government subsidy. The penalty is $166.67/month for each full-time employee (although the first 30 employees are exempt from payments) or $250/month for every full-time employee who actually receives a subsidy, whichever is lower.

An estimated $210 billion is raised by increasing the tax on the employee portion of the Medicare benefits by .9 percent for wages in excess of $200,000, or $250,000 for married wage earners filing jointly. In addition, a new 3.8 percent Medicare tax is imposed on unearned income, such as capital gains, dividends and interest, if modified adjusted gross income exceeds $200,000, or $250,000 if married and filing jointly.

Contributions to flexible spending accounts will be limited to $2500, and definitional changes were made to qualified expenses in FSAs. Beginning after taxable year December 31, 2012, only prescription drugs may qualify for FSA reimbursement, eliminating the beneficial treatment currently afforded unprescribed over-the-counter medications.

Several taxes will be imposed as a result of the Act, including taxes on indoor tanning services (ten percent excise tax), drug manufacturers and importers of branded drugs, health insurers and medical device sales (beginning in 2013). Additional revenue raisers included a repeal of the "black liquor biofuel" credit; a new requirement for corporations to file a return and provide additional information related to reporting payments to corporations, estimated to raise an additional $17.1 billion; and the codification of the "economic substance" doctrine.

Finally, the law provides for student loan forgiveness to enhance the service of health professionals in underserved areas and an increased credit for adoption applicable to taxable years beginning after December 31, 2009.

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