



Michael E. Skindrud
(608) 284-2619
mskindrud@gklaw.com

Sections:

- Definitions..... pg. 2
- Coverage pg. 2
- Individuals Required to Have Coverage pg. 4
- Tax Issues for Individuals pg. 4
- Health Benefit Exchanges..... pg. 4
- Expanding Coverage and Access..... pg. 5
- Employers..... pg. 6
- Insurers pg. 8
- Physicians pg. 9
- Hospitals.....pg. 10
- Medical Research and Product Development.....pg. 12
- Changing the Medicare and Medicaid Delivery Systemspg. 12
- Program Integrity Provisionspg. 17
- Is the Reform Law Constitutional?.....pg. 17

The following is based on a summary of legal principles. It is not to be construed as legal advice. Individuals should consult with legal counsel before taking any action based on these principles to ensure their applicability in a given situation.

The New Health Care Reform Law: A Client Overview

Introduction

by Michael Skindrud, Health Care Team Leader

I write this introduction just one month following President Obama's signature, on March 23, 2010, of the Patient Protection and Affordable Care Act, and less than one month after he signed the Health Care and Education Reconciliation Act of 2010, which together we simply refer to as the "Reform Law."

We assembled a team of lawyers from our health care, tax and employee benefits, insurance and reinsurance, white collar counseling and defense, and litigation practice groups to review the Reform Law and prepare this overview. Charles Vogel, Thomas Shorter, Robert Dreps, Todd Cleary, Sean Bosack, Jed Roher, Claire Finando, Andrew Turner, and Bryan Cahill all contributed to this overview, and Connie O'Connell of Parrett & O'Connell provided guidance on the impacts for insurers.

Brian Pierson and Choua Vang prepared a summary of the Reform Law specifically for our Indian Nation clients. It can be found on our website at http://www.gklaw.com/news.cfm?action=pub_detail&publication_id=959.

How to Use This Overview

In this overview, we note only those matters we believe will be of interest to or have significant impact on our clients. We have not identified many other matters addressed in the Reform Law, so don't assume that because you don't find mention of a matter in this overview that the Reform Law is silent on the matter.

Our bullets below capture the core concepts of the matters they address, but they do not go into depth. Use this overview to get a feel for the Reform Law and how it tries to accomplish its purposes, and use it as a tool for later reference. Expect frustration because the bullets are not likely to answer all of your questions about how the Reform Law will be implemented. In many cases, the Reform Law requires the issuance of regulations to implement its programs and purposes.

Our overview is presented in sections in the order of the section titles shown in the left-column of this page with page numbers. If you are viewing the online version, just click on the section title to go directly to the section.

Primary Purpose of the Law

The primary purpose of the Reform Law is to extend to most Americans coverage of essential health care services at an affordable cost to them and to our society. It does this by expanding coverage for both Medicare and Medicaid beneficiaries, requiring that certain coverages be included in group health plans and policies issued by insurers, by creating new markets for private insurance through state-based exchanges, and by encouraging all Americans to obtain coverage by imposing tax penalties on those who don't.

To finance this extension of coverage, the Reform Law imposes new taxes on insurers, pharmaceutical manufacturers, medical devices, high income taxpayers, and on so-called Cadillac plans, among others. To keep coverage affordable for individuals and the nation, the Reform Law broadens the risk pools with healthy Americans (which reduces the risk borne by insurers and thereby reduces upward pressure on premiums), provides subsidies for those unable to afford the cost of their own policies, requires insurers to pay rebates to their insureds if their medical loss ratios exceed certain levels, requires pharmaceutical manufacturers to provide certain discounts on brand name drugs, and launches initiatives designed to control the cost of health care.

Secondary Purpose of the Law

The secondary purpose of the Reform Law is to begin changing the way we pay for medical care. In fact, more than half of the statutory language in the Reform Law is devoted to this purpose. For example, all IPPS hospitals will have their payments reduced, and then this pool of funds will be paid back just

to those hospitals that achieve certain performance standards that measure both quality of care and efficiency, and each hospital's performance on these standards will be published for all to see. Physicians also will be subject to Medicare payment modifiers based upon the quality and efficiency of the care they provide.

The Reform Law supports the development of new quality measures that will be used to determine the performance of physicians and other providers, data collection on their performance, and publication of the results. It provides significant funding for comparative clinical effectiveness research to produce findings that will guide coverage decisions.

The Reform Law also contains numerous demonstration projects and pilot programs designed to test alternatives to the current Medicare fee-for-service payment system, which most consider a significant problem as we try to control the cost of our nation's health care. For example, under a new shared savings program, hospitals and physicians and other providers that organize themselves into accountable care organizations will receive bonuses when they meet certain quality and efficiency benchmarks in their collective care of groups of Medicare beneficiaries, demonstrating for example that they have eliminated duplicated services and unnecessary procedures, and cut unnecessary visits to hospital emergency rooms.

The demonstrations and pilot programs are a look into the future. These programs will accelerate the ongoing integration of health care providers in our nation, because only providers working together in a coordinated manner can achieve the standards they require.

Definitions

When we use the term "**group health plan**," we mean an employee welfare benefit plan to the extent that the plan provides medical care to employees and their dependents directly or through insurance, reimbursement or otherwise. When we use the term "**insurers**," we mean insurance companies, including health maintenance organizations, which are licensed to engage in the business of insurance in a state, and which offer group or individual health insurance coverage. When we use the term "**coverage**," we mean benefits consisting of payments for medical care under any hospital or medical service policy or contract. "**Secretary**" refers to the Secretary of the U.S. Department of Health and Human Services.

Coverage

The Reform Law will impact the coverage that will be available to consumers in many ways, effective on various dates. Highlights of these coverage impacts include the following:

- **Temporary High-Risk Pool.** The Reform Law requires the Secretary to establish a temporary high-risk health insurance pool to provide coverage for persons with preexisting conditions who have not had coverage for the six months prior to application for coverage by the pool, effective June 23, 2010. This pool will remain in place until January 1, 2014.
- **New Web Portal.** The Reform Law requires the Secretary to work with the states to establish a mechanism, including a website, to make available information in a standard format for the residents and small businesses in each state on health insurance coverage options in that state, to be in place by July 1, 2010.
- **Prohibition of Preexisting Condition Exclusions.** Group health plans and insurers may not impose any preexisting condition exclusion for plan years beginning on or after January 1, 2014, except with respect to enrollees who are under 19 years of age, in which case this prohibition on preexisting condition exclusion shall be effective for plan years beginning on or after September 23, 2010.
- **Dependent Coverage.** Group health plans and insurers that provide dependent coverage of children must continue to make such coverage available for adult children (unmarried and married) until they reach the age of 26, effective for plan years beginning after September 23, 2010. With respect to a grandfathered plan (as defined below) that is a group health plan, this requirement only applies for plan years beginning before January 1, 2014, if the adult child is not eligible to enroll in an employer-sponsored plan other than the grandfathered plan.
- **Lifetime or Annual Limit Restrictions.** Effective for plan years beginning on and after September 23, 2010, group health plans and insurers may not impose lifetime dollar limits on the value of "essential health benefits" (as described below in the section entitled Health Benefit Exchanges) and annual dollar limits are restricted. Effective for plan years beginning on or after January 1, 2014, group health plans and insurers may not impose any annual limits.
- **No Rescissions.** Group health plans and insurers may not rescind a plan or coverage for an individual, once an individual has coverage, unless the individual made a material and intentional misrepresentation to obtain such plan or coverage, or there is a failure to pay the premiums, or for certain other reasons that are applied to all who are covered uniformly and without regard to health status-related issues, effective for plan years beginning after September 23, 2010.
- **Additional Coverage Assurances.** Effective for plan years beginning after September 23, 2010, if a group health plan or insurer:
 - **Primary Care.** requires or provides a participant, beneficiary, or enrollee with the right to designate a primary care provider, it must allow such person to pick any participating primary care provider who is available to accept patients.
 - **Emergency Care.** covers emergency services, no preauthorization for such care may be required, nor must the emergency physician be a participating provider, and if emergency services are provided by an out-of-network provider, the cost-sharing (co-pay or coinsurance) will be the same as if such provider were in-network.

- Pediatric Care. requires or provides the right to designate a primary care provider for a child, it must allow the participant, beneficiary, or enrollee to pick any participating provider who specializes in pediatrics as the child's primary care provider who is available to accept the child.
- OB/GYN. provides coverage for obstetric or gynecologic care and requires the designation of a participating primary care provider, the participant, beneficiary, or enrollee may have direct access to such care by a participating professional who specializes in obstetrics or gynecology without the requirement of prior authorization or a referral by the primary care provider.
- Closing the Donut Hole for Medicare Prescription Drug Coverage. The Reform Law provides a \$250 rebate to Medicare beneficiaries who reach the Part D coverage gap in 2010, effective January 1, 2010. It then phases down the beneficiary coinsurance rate coverage gap from 100% to 25% by 2020. Pharmaceutical manufacturers are required to provide a 50% discount on brand-name drugs filled in the coverage gap beginning in 2011, and federal subsidies for such drugs will increase to 25% by 2020. Federal subsidies toward the cost of generic drugs will increase beginning in 2011, reaching 75% by 2020.
- Preventive Services. Group health plans and insurers must provide coverage, and not impose any co-pay or other cost-sharing, for those preventive services (including immunizations and certain services for women and children) now recommended by the U.S. Preventive Services Task Force and certain other federal agencies, effective for plan years beginning after September 23, 2010. This coverage obligation does not apply to grandfathered plans.
- Preventive Services Under Medicare and Medicaid. Beginning January 1, 2011, Medicare will cover most preventive services (under current law only selected preventive services are covered), including the preparation of an annual personalized prevention plan for each beneficiary. Payment coinsurance and deductibles are waived for such services. Beginning January 1, 2013, states with Medicaid programs that include coverage for the same preventive services, and that eliminate cost-sharing for these services, will receive increased federal assistance to cover these additional costs.
- Uniform Explanation of Coverage. Group health plans and insurers are required to provide beneficiaries with a summary of benefits and coverage explanations in understandable language that meet uniform standards to be set by the Secretary, effective for plan years beginning after March 23, 2012. The summary must be provided both at the time of open enrollment and annual enrollment, and is in addition to the plan's summary plan description.
- Setting Premiums in the Individual and Small Group Market. For premiums charged by insurers for coverage offered in the individual or small group market (up to 100 employees), the only factors that may be used to set premium rates are:
 - i) whether the plan is for an individual or a family; ii) the rating area within a state; iii) age, limited to 3 to 1 variation for adults; and iv) tobacco use, limited to 1.5 to 1 variation, for plan years beginning on or after January 1, 2014.
- Prohibition of Discrimination Based on Health Status; Wellness Programs. A group health plan and insurers may not establish rules for eligibility of any individual to enroll based on any of the following health status-related factors: health status; medical condition (physical and mental); claims experience; receipt of health care; medical history; genetic information; evidence of insurability; disability; and any other health status-related factor as determined by the Secretary, for plan years beginning on or after January 1, 2014. Also, wellness programs may be undertaken without violating this prohibition so long as any premium discounts or other rewards from participation in such programs are not based on any health status-related factor, or the wellness program meets certain conditions.
- Guaranteed Availability of Coverage. Each insurer that offers coverage in the individual or group market in a state must accept every employer and individual in the state that applies for coverage, for plan years beginning on or after January 1, 2014.
- Guaranteed Renewability of Coverage. If an insurer offers coverage in the individual or group market, the insurer must renew or continue in force such coverage at the option of the plan sponsor or the individual, for plan years beginning on or after January 1, 2014.
- Comprehensive Coverage in the Individual and Small Group Market. Insurers that offer coverage in the individual or small group market (100 or fewer employees) must include the "essential health benefits package" (as defined below in the section entitled Health Benefit Exchanges) and not exceed the annual cost-sharing limits (as discussed below in the section entitled Health Benefit Exchanges), effective for plan years beginning on or after January 1, 2014.
- Prohibition on Excessive Waiting Periods. A group health plan and an insurer of group coverage may not apply any waiting period that exceeds 90 days, effective for plan years beginning on or after January 1, 2014.
- Coverage for Clinical Trials. Group health plans and insurers may not deny coverage for individuals participating in certain clinical trials, with some limitations, effective for plan years beginning on or after January 1, 2014.
- Abortion. The Reform Law permits states to prohibit plans offered through an exchange from providing coverage for abortions. If plans offered through an exchange offer abortion coverage in states that permit such plans, they must allocate premium payments to separate accounts, one for abortion coverage and one for other coverage, to ensure that no federal premium or cost-sharing subsidies could be used to pay for the abortion coverage.

- Right to Maintain Existing Coverage (Grandfathered Plans). Individuals may keep their coverage under a group health plan or health insurance coverage in which the individual was enrolled on March 23, 2010, when the Reform Law was enacted, and many of the market reforms of the Reform Law will not apply to these grandfathered plans, but some do, including the requirement of uniform explanation of coverage, reports of loss-ratios, limits on waiting periods, prohibition of lifetime and annual benefit limits, prohibition on plan rescissions, requirements for dependent coverage, and limits on preexisting condition exclusions. New family members and new employees may enroll in grandfathered plans.

Individuals Required to Have Coverage

- Individuals Are Required to Maintain Essential Coverage. Beginning with tax years after 2013, individuals are required to maintain for themselves and their dependents “minimum essential coverage,” which means coverage from government programs, or eligible employer-sponsored plans, or plans offered in the individual market, or grandfathered health plans and certain other coverages. Exemptions from these requirements exist based on certain religious grounds, persons who cannot afford coverage, and members of Indian tribes.
- Shared Responsibility Payments Imposed on Individuals. Any taxpayer who fails to maintain such coverage is required to pay a penalty for each month and each person for whom such coverage is not maintained, to be paid with his or her tax return for the tax year of the month(s) without such coverage. The amount of the monthly penalty is 1/12 of the greater of (i) a flat dollar amount for each person without coverage for whom the taxpayer is responsible (but not more than 300% of the flat dollar amount) or (ii) a percent of the taxpayer’s income that exceeds the taxpayer’s threshold income for filing a return. The flat dollar amount is \$95 in 2014, \$325 in 2015, \$695 in 2016, and indexed to \$695 thereafter. The percent of the excess income is 1% for 2014, 2% in 2015, and 2.5% thereafter. Issuers of plans and others providing essential minimum coverage are required to file an annual return with the IRS including the names and TIN of those who are covered, and other information.

Tax Issues for Individuals

- Additional Medicare Hospital Insurance Tax on High Income Taxpayers. Currently, individuals pay two types of so-called “employment” taxes on their wages and/or self-employment income: the Old Age, Survivors and Disability Insurance tax and the Medicare Hospital Insurance tax. This latter tax is imposed at the rate of 1.45% on wages and 2.9% on self-employment income. Beginning in 2013, individuals with wages or self-employment income in excess of \$200,000 (or joint filers with combined wages and self-employment income in excess of \$250,000, or married individuals filing separately with

wages or self-employment income in excess of \$125,000) will be subject to an additional 0.9% Medicare Hospital Insurance tax on their wages and self-employment income above the applicable threshold (so that the Medicare Hospital Insurance tax rate will be 2.35% on wages in excess of that threshold and 3.8% on self-employment income in excess of the threshold).

- Unearned Income Medicare Contribution Tax. Prior to the enactment of the Reform Law, individuals paid no employment taxes on their non-wage or non-self-employment income. Under the Reform Law, however, individuals with a “modified adjusted gross income” in excess of \$200,000 (or \$250,000, for joint filers; or \$125,000, for married individuals that file separately) will be subject to a 3.8% “unearned income Medicare contribution tax” on some or all of their interest, dividend, annuity, royalty, rental and passive activity income and net capital gain, less any allowable deductions properly allocable to such income or gain (“Net Investment Income”). The new 3.8% tax will be imposed on the *lesser* of (i) an individual’s Net Investment Income *or* (ii) the amount by which the individual’s modified adjusted gross income exceeds the applicable threshold. The new tax will first be imposed in 2013.
- Health Care Flexible Spending Account, Health Reimbursement Arrangement, and Health Savings Account Changes. Effective for tax years beginning after December 31, 2012, a \$2,500 cap (indexed for inflation) will be imposed on annual contributions to a health care flexible spending account (“FSA”) offered under a cafeteria plan. Additionally, effective in 2011, a health care FSA or health reimbursement arrangement (“HRA”) will not be able to reimburse over-the-counter medicines or drugs (other than insulin) without a doctor’s prescription. Similar restrictions will apply to health savings accounts (“HSAs”). The tax on HSA distributions that are not used for qualifying medical expenses is increased from 10% to 20% for distributions that occur after December 31, 2010.

Health Benefit Exchanges

The Reform Law provides for the creation of an American Health Benefit Exchange in each state (an exchange), and the establishment of the Small Business Health Options Program (SHOP) through the exchanges. Each exchange is intended to be a marketplace that operates alongside the existing market through which employers and individuals find and purchase health insurance plans. The initial focus of the exchanges is to provide a market for insurance for individuals and for small employers who today struggle to find affordable coverage.

Participation in the exchanges is voluntary. Insurers may offer plans both within and outside the exchanges, and qualified individuals and employers may purchase plans either within or outside of the exchanges as they wish.

The Reform Law provides for grants for each state to establish an exchange in each state. The exchange may be a governmental

agency or a nonprofit entity that is established by the state. Each state is required to have an exchange established by January 1, 2014.

- **Functions of Exchanges.** Each exchange will offer only qualified health plans to qualified individuals and employers. The exchanges will certify plans as qualified plans; operate a website and telephone hotlines; present the options of each plan in a standardized format; provide information on the availability of the Medicaid program, the CHIP program, and state and local public programs; determine screening and eligibility of purchasers; and in other ways facilitate the marketing and purchase of qualified plans and access to public programs. Exchanges are to be self-sustaining once up and running.
- **Qualified Individuals and Employers.** Only qualified individuals and employers may purchase plans through the exchanges. Qualified individuals must be lawful residents of the U.S. and of the state for which the exchange is established. Qualified employers are initially limited to small employers (up to 100 employees) that elect to make all full-time employees eligible for one or more qualified health plans offered in the small group market through an exchange. Beginning in 2017, large employers (more than 100 employees) may become qualified employers and purchase qualified health plans through an exchange if the state decides to allow insurers to offer plans for large employers in that state's exchange. States have the option to redefine employers as small (up to 50 employees) and large (51+ employees).
- **Risk Pools.** Each insurer is required to consider all enrollees in all health plans offered by the insurer in the individual market (including those not enrolled in plans through the exchange) to be members of a single risk pool. The same is required of insurers with respect to all enrollees in all health plans offered by the insurer in the small group market, including those who do not enroll in the insurer's plans through the exchange.
- **Qualified Health Plans.** A qualified health plan is one that: is certified by the exchange as meeting the criteria of the exchange; provides the "essential health benefits package" described below; is offered by an insurer licensed to sell insurance in the state of the exchange, and who offers in the exchange at least one qualified plan in each of the silver and gold levels, and who agrees to charge the same premium rate for each such plan without regard to whether the plan is offered through the exchange or outside of the plan, and who meets certain other requirements. Qualified health plans also include those offered through the CO-OP program of the Reform Law, a multi-state plan meeting certain requirements of the Reform Law, and qualified direct primary care medical home plans meeting criteria to be established by the Secretary.
- **Essential Health Benefits Package.** A qualified health plan provides the "essential health benefits package" if it covers at least the following services, which are defined as "essential health benefits": ambulatory; emergency; hospitalization; maternity and newborn; mental health and substance use; prescription drugs; rehabilitative and habilitative services and devices; laboratory; preventive and wellness and chronic disease management; and pediatric services; as further determined by the Secretary. The Secretary will ensure that the scope of these benefits will be equal to the scope of benefits provided under a typical employer plan. In addition, the package must limit cost-sharing (which includes deductibles, coinsurance, copayments, or similar charges) for self-only coverage and family coverage to the dollar amounts applicable to high deductible health savings accounts in 2014, and thereafter such limitations may increase by a prescribed amount. In the case of health plans offered in the small group market, the deductibles in 2014 may not exceed \$2,000 for plans covering a single individual and \$4,000 for other plans, with indexing of these limits in later years. Levels of coverage that may be offered in the package include: bronze (60% of the actuarial value of benefits provided under the plan); silver (70%); gold (80%); and platinum (90%). Certain catastrophic plans may also qualify.
- **Refundable Tax Credit Providing Premium Assistance for Individuals.** For tax years 2014 and thereafter, a premium assistance amount is available to taxpayers who purchase qualified health plans through exchanges and whose household income for the taxable year is between 100% and 400% of the poverty line for a family of the size involved. (On March 31, 2010, the line was \$22,050 for a family of four in the lower 48 states.) The premium assistance amount is determined on a sliding scale, such that households at 100% of the poverty line will pay up to 2% of household income for coverage, with the balance being covered by the premium assistance amount, and households at 400% paying 9.5%, with the balance being covered by the premium assistance amount. The premium assistance amount will be paid monthly by the Treasury to the issuer of the plan purchased by the taxpayer, upon advance determination by the exchange.
- **Reduced Cost-Sharing for Individuals.** The same taxpayers described above for the refundable tax credit are also eligible for reductions in the out-of-pocket limits under the plans that they purchase through the exchanges. Upon notification of the person's eligibility for the reduction in cost-sharing, the insurers will reduce the out-of-pocket limit on a sliding scale according to the percentage of the poverty line of the household income.

Expanding Coverage and Access

- **Medicaid Coverage Extended.** Before the Reform Law, state Medicaid programs were not required to cover childless adults under 65 who are not disabled and not pregnant. The Reform Law, beginning January 1, 2014, requires Medicaid programs to

provide benchmark benefits to these individuals with incomes up to 133% of the federal poverty level, adjusted for family size, who are not otherwise eligible under other Medicaid programs or Medicare. The cost to states for this “newly eligible” group will be borne by the federal government fully for years 2014 through 2016, and then reducing percentages thereafter until 2020, when the federal share will be 90%.

- Increased Funding for Federally Qualified Health Centers. The Reform Law significantly increases funding to FQHCs, which are community-based organizations that serve populations with limited access to health care. Annual funding for 2010 is increased to just under \$3 billion and increases annually to reach \$8.3 billion in 2015, with a formula for increases thereafter based on number of patients served and costs of such services per patient.

Employers

The Reform Law’s impact on group health plans will be broad and deep. Many provisions are effective as of the first plan year beginning on or after September 23, 2010, while others have delayed effective dates. In any case, employers should review the Reform Law now to optimize planning opportunities and ensure compliance.

Please note that several of the Reform Law’s provisions do not apply to a “grandfathered” plan. For these purposes, a grandfathered plan generally includes a group health plan in existence on March 23, 2010 (whether insured or self-insured). Consequently, many of the Reform Law’s provisions will not apply to existing plans. It appears that a plan maintains its grandfathered status even when new employees join the plan. However, further regulatory guidance explaining what it takes to remain “grandfathered” would be welcome.

Highlights of the Reform Law’s changes related to group health plans include the following:

- Lifetime or Annual Limit Restrictions. Effective for plan years beginning on and after September 23, 2010, group health plans may not impose lifetime dollar limits on the value of “essential health benefits” (as described in the insurance section) and annual dollar limits are restricted. Effective for plan years beginning on or after January 1, 2014, group health plans may not impose any annual limits.
- Preventive Services. Non-grandfathered group health plans must provide first-dollar coverage for certain preventive services (including immunizations and certain services for women and children), effective for plan years beginning on or after September 23, 2010.
- Nondiscrimination in Insured Plans. Currently, insured group health plans are not subject to certain nondiscrimination tests that apply to self-insured plans. Effective for plan years beginning on or after September 23, 2010, these tests will apply to non-grandfathered insured plans. Consequently, a non-grandfathered insured plan will not be permitted to discriminate in favor of highly-compensated individuals as to eligibility to participate or the benefits offered under the plan. Historically, some employers have established rich, fully-insured plans to cover executives. The adverse tax results posed by this change will make that approach significantly less appealing. Additionally, employers with existing insured plans that may be discriminatory must ensure that those plans retain grandfathered status.
- Prohibition of Preexisting Condition Exclusions. Effective for plan years beginning on or after September 23, 2010, group health plans may not impose any preexisting condition exclusion for participants who are under 19 years of age. For plan years beginning on or after January 1, 2014, this prohibition on preexisting condition exclusions is extended to all participants.
- Dependent Coverage. A group health plan that covers dependent children generally must continue to make such coverage available for adult children (unmarried and married) until they reach age 26, effective for plan years beginning on or after September 23, 2010. However, for plan years beginning before January 1, 2014, this requirement only applies to a grandfathered plan if the adult child is not eligible to enroll in another employer-sponsored plan. The reform law has also changed the tax treatment regarding dependent coverage, so employers should be careful when navigating those waters.
- Health Care Flexible Spending Account, Health Reimbursement Arrangement, and Health Savings Account Changes. Effective for tax years beginning after December 31, 2012, a \$2,500 cap (indexed for inflation) will be imposed on annual contributions to a health care flexible spending account (“FSA”) offered under a cafeteria plan. Additionally, effective in 2011, a health care FSA or health reimbursement arrangement (“HRA”) will not be able to reimburse over-the-counter medicines or drugs (other than insulin) without a doctor’s prescription. Similar restrictions will apply to health savings accounts (“HSAs”). The tax on HSA distributions that are not used for qualifying medical expenses is increased from 10% to 20% for distributions that occur after December 31, 2010.
- Tax Credit for Small Employers. The Reform Law provides for a temporary “sliding-scale” tax credit to help certain small employers offset the cost of health care. The credit is available for employers with 25 or fewer full-time equivalent employees whose average annual wages per employee do not exceed \$50,000 (indexed for inflation) for any year from 2010 to 2013. The credit applies only if the employer contributes at least 50% toward the cost of employees’ premiums, and is reduced if the employer has more than 10 employees or average annual wages of more than \$25,000. The credit generally is 35% (25% in the case of nonprofit employers) of the premiums the employer pays toward health coverage for its employees in tax years 2010 to 2013. For tax years beginning after 2013, the credit generally is increased to 50% (35% for nonprofit employers), subject to the reductions described

above, but the employer must participate in an insurance exchange to claim the credit, and the credit that may be taken after 2013 is limited to two consecutive tax years.

- Reinsurance for Early Retiree Coverage. The Reform Law establishes a temporary reinsurance program to reimburse group health plans for a portion of eligible claims incurred by early retirees who are age 55 or older and not eligible for Medicare. The subsidy must be used for certain purposes related to the health plan, rather than as “general revenue” for the employer. Plans will need to apply for assistance under the program. Government funds will be available on a “first-come, first-served” basis.
- Large Employers Required to Automatically Enroll Employees. If a large employer (more than 200 full-time employees) offers employees enrollment in one or more health plans, the employer must automatically enroll new full-time employees and continue the enrollment of current employees in such plans, effective March 23, 2010, although the Secretary of Labor is to issue regulations for this requirement. Employees must have the right to opt out. The automatic enrollment program must provide adequate notice to employees.
- Simple Cafeteria Plans. Effective for plan years beginning in 2011 and later, a small employer (100 or fewer employees during either of the two preceding years) may create a “simple” cafeteria plan which will be treated as meeting certain nondiscrimination tests. However, the employer will be required to satisfy certain contribution requirements.
- W-2 Reporting Obligation. Starting in 2012 (for coverage in 2011), employers will be required to report the annual cost of health plan coverage received by employees on the employees’ W-2 forms.
- Uniform Explanation of Coverage. Prior to March 23, 2012, group health plans will be required to provide participants with a summary of benefits and coverage explanations in understandable language that meet uniform standards to be set by the Secretary. The summary must be provided both at the time of open enrollment and annual enrollment, and is in addition to the plan’s summary plan description.
- Earlier Disclosure of Changes. Group health plan participants must be notified at least 60 days in advance of material changes regarding the health plan. The effective date of this new rule is not yet clear.
- Retiree Health Deductions. Starting in 2013, an employer’s deduction for retiree drug claims must be reduced by the Medicare Part D subsidy the employer receives.
- Prohibition on Excessive Waiting Periods. A group health plan may not apply any waiting period that exceeds 90 days, effective for plan years beginning on or after January 1, 2014.
- Shared Responsibility Payments Imposed on Employers That Do Not Offer Coverage. Beginning in 2014, if an employer with 50 or more full-time employee equivalents during the preceding calendar year fails to provide “minimum essential coverage” to full-time employees for any month, and at least one full-time employee receives federal premium assistance under an exchange (described below) for that month, then the employer is required to pay a fine equal to \$166.67 times the number of its full-time employees (minus 30 employees) for each such month. For this purpose, a full-time employee is generally one who works an average of 30 hours per week, determined on a monthly basis, and the number of employees is calculated on a “controlled group” basis.
- Shared Responsibility Payments Imposed on Employers That Do Offer Coverage. Beginning in 2014, a fine generally will be payable if an employer with 50 or more full-time employee equivalents during the preceding calendar year offers “minimum essential coverage” to full-time employees for any month, and at least one full-time employee opts out of that coverage and receives federal premium assistance under an exchange. In that event, the employer generally must pay a fine equal to \$250 times the number of employees who receive the federal premium assistance for the month. The monthly fine is capped at \$166.67 times the number of full-time employees (excluding the first 30 employees). For this purpose, a full-time employee is generally one who works an average of 30 hours per week, determined on a monthly basis, and the number of employees is determined on a “controlled group” basis.
- Free Choice Vouchers. Beginning in 2014, an employer that offers “minimum essential coverage” and pays any portion of the premium must provide “free choice” vouchers to qualified employees to purchase coverage in the exchange. For this purpose, a qualified employee is one (i) who does not participate in the employer’s plan, (ii) whose household income does not exceed 400% of the federal poverty limit, and (iii) whose required contribution for the employer’s minimum essential coverage would have exceeded 8%, but would not have exceeded 9.8%, of household income. The voucher amount is equal to the employer portion of the health plan contribution for the plan to which the employer contributes the highest portion of the cost. The voucher is tax-deductible by the employer, and an employer that provides vouchers is not subject to the “shared responsibility payments” described above with respect to those employees.
- Exchanges. Under the Reform Law, each state will be required to establish a “health benefit exchange.” (See section above entitled Health Benefit Exchanges.) Employers will be required to notify employees that the exchange exists, that they may be eligible for a subsidy under the exchange when the employer’s share of the total cost of benefits is less than 60%, and that they will lose the employer’s contribution to the employer’s health plan if they purchase a policy through the exchange. An employer who purchases coverage through an exchange may permit employees to pay for that coverage with pre-tax contributions under the employer’s cafeteria plan.
- Cost-Sharing Allocations. As of January 1, 2014, non-

grandfathered health plans' "out-of-pocket" cost-sharing limits generally may not exceed the limits that apply to "high deductible health plans" compatible with HSAs.

- **Wellness Programs.** As of January 1, 2014, an employer will be permitted to offer wellness program incentives or penalties of up to 30% of the total cost of health plan coverage. (The current limit is 20%.) In addition, the Secretaries of Labor, Health and Human Services, and Treasury have the authority to increase the limit up to 50% of the cost of coverage. Also, the Secretary will develop a program of grants to employers with less than 100 employees to help them establish wellness programs, with \$200 million appropriated for use during 2011 through 2015. The Secretary will issue program criteria and application forms.
- **"Cadillac Plan" Tax.** See the Insurer section below for a description of this tax. Although the excise tax applies directly to insurance companies and plan administrators, it is expected that these costs will be passed through to the health plan sponsors.

Insurers

Insurers should review the **Coverage and Health Benefit Exchange** sections above. All references in those sections to "insurers" apply to insurers. In addition, the following provisions of the Reform Law impact health insurers:

- **Annual Fee Imposed on Health Insurers.** The Reform Law imposes on each entity that provides health insurance (excluding self-insured employers, governmental entities and certain tax exempt organizations) a fee beginning in calendar year 2014. The aggregate fees to be paid by all such entities will equal the "applicable amount" for the calendar year in question. The applicable amount is \$8 billion in 2014, rises to \$14.3 billion in 2018, and increases for each year thereafter at the rate of premium increases. The fee that each entity will pay will be equal to the percent of such entity's net premiums of the aggregate net premiums written by all such entities during the preceding calendar year. Tax exempt entities pay one half of what they would have to pay were they not tax exempt, entities with net premiums of \$25 million or less will have no amount taken into account in this calculation, and entities with net premiums of more than \$25 million but less than \$50 million will have only 50% of their net premiums taken into account for this calculation.
- **Rebates if Minimum Medical Loss Ratios Not Maintained.** Insurers (including grandfathered plans as described below) are required to submit to the Secretary for each plan year a report showing the percentage of its premium revenue (with certain adjustments) that it spends on health care services and activities that improve health care quality, and to pay each enrollee in the plan an annual rebate of the amount by which its expenditures for health care services and health improvement activities is less than 85% of its premium revenue in the large group market, and 80% in the small group and individual markets (or higher percentages set by states), reporting requirements effective for plan years beginning after September 23, 2010, and rebate provisions effective on and after January 1, 2011. The Secretary will post the reports on the department's website.
- **Medicare Advantage Plan Minimum Medical Loss Ratio.** Medicare advantage plans must maintain their medical loss ratio at no less than 85%. If a Medicare advantage plan fails to reach a medical loss ratio of 85%, then the plan must pay a penalty equal to the product of the plan's total revenue and the difference between .85 and the actual medical loss ratio. If the limit is exceeded for three consecutive years, the plan must suspend enrollments for the second succeeding contract year. If it is exceeded for five consecutive years, the plan's contract is terminated. This provision takes effect for the 2014 contract year.
- **Medicare Advantage Plan Payments Restructured.** For 2011, Medicare advantage plan payments will be frozen at 2010 levels. Starting in 2012, Medicare advantage plan benchmarks will be reduced relative to current levels. The new benchmarks will take into consideration how local Medicare spending compares with other areas of the country, with the highest spending quartile receiving a benchmark that is 95% of the local Medicare fee-for-service cost and the lowest spending quartile receiving a benchmark that is 115% of the local Medicare fee-for-service cost. Payments will be further adjusted based on quality and beneficiary satisfaction ratings, with increases reaching 5% for high scoring plans by 2013. All plans will complete the transition to the new benchmark formula by 2018.
- **"Cadillac Plan" Tax.** Starting in 2018, the Reform Law will impose a 40% excise tax on the "excess benefit" when the aggregate cost of certain employer-provided health coverage exceeds applicable dollar limits. The annual limit generally will start at \$10,200 for individual coverage and \$27,500 for family coverage, but will be adjusted for inflation. Although the excise tax applies directly to insurance companies and plan administrators, it is expected that these costs will be passed through to the health plan sponsors. Stand-alone dental and vision coverage will be excluded from the cost calculations, and limited adjustments to the thresholds will be permitted to reflect participants' age and gender.
- **Quality Reporting.** Group health plans and insurers are required to provide the Secretary and beneficiaries and the public with annual reports on whether the benefits or coverage and provider reimbursement structures under their plans improve health outcomes, prevent hospital readmissions, improve patient safety and reduce medical errors, and implement wellness and health promotion activities. Such reports will be required after the Secretary issues reporting requirements no later than March 23, 2012.
- **Nondiscrimination Against Health Care Providers.** A group

health plan and insurers may not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license under state law. However this does not require that the group health plan or insurer contract with any provider willing to abide by the terms for participation, and reimbursement rates may vary based on the provider's quality or performance measures. This is effective for plan years beginning on or after January 1, 2014. We interpret this as a prohibition on the exclusion from provider panels of any class of providers by provider type, if they are licensed to provide health care services under state law.

- Limitation on Compensation to Certain Employees of Insurers. The Reform Law denies a tax deduction for health insurers to the extent they pay compensation to any individual for services rendered that exceeds \$500,000, effective for tax years beginning in calendar year 2013 and thereafter. Special rules apply for deferred compensation.
- Multi-State Compacts. Two or more states may enter into an agreement under which health plans may be offered through exchanges in the individual market in their states but be subject to the regulations of only the state in which the plan is written or issued, except for each state's requirements related to market conduct, unfair trade practices, network adequacy, and consumer protection. The Secretary will issue regulations governing such compacts by July 1, 2013, but compacts may not be effective until 2016.

Physicians

One of the disappointments with the Reform Law is that it did not permanently fix the annual cuts to Medicare reimbursements for physician services. Most Medicare payment rates are adjusted for inflation. However, the rates for physician services are set by the Sustainable Growth Rate formula (SGR). The SGR was implemented by Congress and took effect in 1998. When growth in health care costs exceed economic growth, as has been the case over the last few years, the SGR formula cuts physician reimbursement rates. For seven consecutive years, Congress passed legislation to suspend cuts in reimbursement rates called for by the SGR formula. On April 15, 2010, Congress and the President postponed the reduction through June 1, 2010. CMS is reprocessing claims paid in early April that reflected the 21.3% cut automatically. Between now and June 1, Congress is expected to extend the postponement to October 1, 2010. The Senate has already passed such a measure.

Physicians should review the **Coverage and Health Benefit Exchange** and **Expanding Coverage and Access** sections above to understand the increasing numbers of patients they will see with coverage.

Physicians should also review the section below entitled **Changing the Medicare and Medicaid Delivery Systems**, in particular noting discussion of the physician quality reporting system and payment modifiers based upon quality of care. This section also

shows the direction of public policy on cost and quality, and the efforts change the fee-for-service payment system. Physicians will need to assess the ways these initiatives may impact their practices, their relationships with other physicians, and the larger provider systems they operate within.

Additional provisions of the Reform Law that impact Physicians include:

- Medicaid Payments to Primary Care Providers Increased to Medicare Rates. The Reform Law provides that the payment for evaluation and management services and services related to immunization administration provided during 2013 and 2014 by physicians who are family practice, general internal medicine, or pediatrics will be paid at 100% of the rates for such services under the Medicare program. The same is required under Medicaid managed care plans. States will be reimbursed this amount by the federal government.
- Medicare Incentive Payments to Primary Care Providers and to Surgeons in Health Professional Shortage Areas. The Reform Law provides a bonus of 10% of the amounts already due certain primary care practitioners for primary care services furnished during 2011 through 2015. Primary care practitioners include physicians whose primary specialty designation is family medicine, internal medicine, geriatric medicine, or pediatric medicine, and includes nurse practitioners, clinic nurse specialists, or physicians assistants, provided that primary care services accounts for at least 60% of their allowed charges. General surgeons providing major surgical procedures during the same time period in health professional shortage areas will also receive a 10% bonus.
- Nondiscrimination Against Health Care Providers. See this description above under the Insurer section.
- Changes to the Whole Hospital Exception to the Stark Law. For years, there have been efforts to change or end the whole hospital exception under the Stark Law. This exception allows referrals by physicians to certain hospitals in which they have an ownership interest if the referring physician is authorized to perform services at the hospital, and the ownership or investment interest is in the entire hospital itself (and not merely in a subdivision of the hospital). The Reform Law imposes many new restrictions upon physician-owned hospitals that significantly narrow the whole hospital exception, e.g. the requirement that such hospitals: must have physician ownership and a Medicare provider agreement in place no later than December 31, 2010; may not add any more operating rooms, procedure rooms or licensed beds beyond the quantity held on March 23, 2010; must annually report to the Secretary the identity of each physician and other owners and the nature and extent of all ownership interests in the hospital; must disclose to the patients being referred the ownership interest of the referring physician and if applicable, the ownership interest of the treating physician; and other restrictions. In effect, the Reform Law has closed the door to any more physician owned hospitals that meet the requirements of the Stark Law whole hospital exception.

- Disclosure of Payments to Physicians and/or Teaching Hospitals. Beginning March 31, 2013, and annually thereafter, any manufacturer of a covered drug, device, biological, or medical supply that provides a payment or other transfer of value to a physician or teaching hospital must submit to the Secretary any information the Secretary deems appropriate, e.g. the name of the recipient, the amount of the payment, the dates on which the payment was provided, the form of payment, and if the payment is related to marketing, education, or research specific to a covered drug, device, biological, or medical supply, and the name of that covered drug, device, biological, or medical supply. Certain transfers of value are exempted from the reporting requirements, including product samples intended for patients and educational materials directly benefiting patients.
- Disclosure of Physician Ownership in Pharmaceutical Companies or Group Purchasing Organizations. Beginning March 31, 2013, and annually thereafter, any applicable manufacturer or applicable group purchasing organization must submit to the Secretary information regarding any ownership or investment interest (other than an ownership or investment interest in a publicly traded security and mutual fund) in the applicable manufacturer or applicable group purchasing organization during the preceding year, including the dollar amount invested, the value and terms of each such ownership interest, and any other information regarding the ownership interest the Secretary determines appropriate.
- Disclosure Requirements for In-Office Ancillary Services. The Reform Law imposes disclosure requirements on the in-office ancillary services' exception to the Stark Law for MRI, CT, PET, and any other designated health services that the Secretary determines appropriate. The Reform Law requires the Secretary to establish by regulation a requirement that at the time of referral, the referring physician must inform the patient in writing that the patient may obtain the services for which the referral is made from suppliers other than from the referring physicians and the referring physician's group, and must provide the patient with a written list of suppliers who furnish such services in the area in which the patient resides. This requirement applies to services furnished on and after January 1, 2010.

Hospitals

Hospitals should review the **Coverage and Health Benefit Exchange** and **Expanding Coverage and Access** sections above to understand the increasing numbers of patients they will see with coverage.

Hospitals also should review the section below entitled **Changing the Medicare and Medicaid Delivery Systems**, to see the direction of public policy on cost and quality, and the efforts change the fee-for-service payment system, and to assess the likely impacts these initiatives will have on their services, and their relationships with physicians and other providers.

Additional provisions of the Reform Law that impact Hospitals include:

- Hospital Value-Based Purchasing Program. Beginning October 1, 2012, hospitals that meet performance standards will receive Medicare value-based incentive payments. The Secretary will establish the standards that will include measures covering acute myocardial infarction, heart failure, pneumonia, surgeries, and healthcare-associated infections. They also will include measures of efficiency, namely measures of Medicare spending per beneficiary. Each hospital will receive an aggregate performance score. The aggregate incentive payments to be paid will equal to the aggregate reductions in the base operating DRG payment for every hospital of 1% in fiscal year 2013, 1.25% in 2014, 1.5% in 2015, 1.75% in 2016, and 2% in 2017 and following fiscal years. The Secretary will make public the aggregate performance score of each hospital and the performance of each hospital with respect to each condition or procedure measured.
- Payment Reductions for Hospital-Acquired Conditions. IPPS hospitals that rank in the top quartile nationally for hospital-acquired conditions will have their payments for all discharges reduced by 1%, beginning in fiscal year 2015. Hospital-acquired conditions are those designated by the Secretary that have a high cost and/or high volume for Medicare, results in the assignment to a diagnosis related group that has a higher payment when present as a secondary diagnosis, and could reasonably have been prevented through the application of evidence-based guidelines.
- Payment Reduction for Excess Hospital Readmissions. Beginning with discharges on and after October 1, 2012, the Secretary will pay a reduced amount to hospitals for discharges from excess readmissions arising from applicable conditions. Applicable conditions are selected by the Secretary from readmissions that represent high volume or high expenditures for Medicare and for which measures have been endorsed by National Quality Forum. Beginning October 1, 2015, the Secretary will add applicable conditions beyond the three conditions for which measures have been endorsed to include the four conditions that have been identified by the Medicare Payment Advisory Commission in its report to Congress in June, 2007, and to others as determined by the Secretary.
- Market Basket Adjustments. Market baskets are fixed-weight indexes used by CMS to determine the cost to providers of providing services to Medicare and other beneficiaries, and in turn used to update payments and cost limits in various CMS payment systems. The Reform Law incorporates a productivity adjustment into market basket updates for many payment systems as well as some additional reductions to some market baskets. The productivity adjustment is based on the ten-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity. The specific timing and adjustment amount vary by payment system.

- Reduction in Medicaid Disproportionate Share Hospitals Allotments. States receive an annual federal Medicaid allotment for hospitals that provide a disproportionate amount of care to low-income patients. Under the Reform Law, the federal government will reduce the states' collective total allotment by a fixed amount each year starting in 2014. The reduction will be shared among the states, with the greatest deductions imposed on states which have the lowest percentage of uninsured individuals or do not target their DSH payments on hospitals with high volumes of Medicaid inpatients or uncompensated care.
 - Adjustments to Medicare Disproportionate Share Hospital Payments. For fiscal year 2014 and each subsequent year, disproportionate share hospital payments will be adjusted as follows: (i) the DSH payment will be reduced to an amount equal to 25% of what the hospital would have otherwise received, plus (ii) an additional amount based on a formula which considers both the percentage of the population which is uninsured and the amount of uncompensated care provided by the hospital.
 - Hospital Charges Made Public. Each hospital in the U.S. is required to make public its standard charges for items and services, including for diagnosis related groups, effective September 23, 2010.
 - Extension of Existing Rural Initiatives. The Reform Law extends a number of already existing rural health care initiatives for a few more years. For example, the Medicare Rural Hospital Flexibility Program (MRHFP) is extended through fiscal year 2012 and the Medicare-Dependent Hospital (MDH) Program is extended through October 1, 2012. In addition, certain rural demonstration programs are either expanded geographically, or by a few years' time, such as the Rural Community Hospital Demonstration Program which now runs through 2014 and is expanded to include twenty states and up to thirty hospitals.
 - New Rural Initiatives. A few new initiatives are included in the Reform Law as well. For example, the legislation establishes a Medicare Payment Advisory Commission (MedPAC) study of the adequacy of Medicare payments for health care providers serving in rural areas. MedPAC will conduct a study on the adequacy of payments for items and services furnished by providers of services and suppliers in rural areas under the Medicare program, analyzing: (i) any adjustments in payments to providers of services and suppliers that furnish items and services in rural areas; (ii) access by Medicare beneficiaries to items and services in rural areas; (iii) the adequacy of payments to providers of services and suppliers that furnish items and services in rural areas; and (iv) the quality of care furnished in rural areas.
- a calendar tax year, these requirements will apply beginning in 2011). These new requirements include:
- Community Health Needs Assessment. By the end of 2013, and at least once every three years thereafter, every tax-exempt hospital must conduct a community health needs assessment (i) based on current information and (ii) that takes into account input from persons representing the broad interests of the community served by the hospital, and must adopt an implementation strategy to meet the needs identified in the assessment.
 - Financial Assistance Policy. Each tax-exempt hospital must adopt a written financial assistance policy that specifies the eligibility criteria for financial assistance, whether such assistance includes free or discounted care, the basis for charges to patients, the method for applying for financial assistance, the actions the tax-exempt hospital may take in the event of non-payment and measures to widely publicize the policy within the community served by the hospital. Each tax-exempt hospital must also adopt a policy that requires the hospital to provide emergency medical care without discrimination and regardless of a patient's qualification for financial or government assistance.
 - Limit on Charges. In charging individuals who are eligible for financial assistance for emergency or other medically necessary care, a tax-exempt hospital may only charge the amounts generally billed to individuals who have insurance covering such care. Legislative history suggests that this amount is intended to be either the best or an average of the three best negotiated commercial rates, or Medicare rates. As a result, tax-exempt hospitals may no longer use their "charge master" rates as a basis for such charges.
 - Billing and Collection. A tax-exempt hospital must use reasonable efforts to determine whether an individual is eligible for financial assistance before the hospital undertakes any collection effort against the individual. While the IRS is tasked with defining "reasonable efforts," the legislative history indicates that reasonable efforts will include notifying the individual of the hospital's financial assistance policy at the time of the individual's admission, and in written and oral communications with the individual regarding the individual's bill.
 - Reporting Requirements. In its Form 990, each tax-exempt hospital will need to describe how it is addressing the needs identified in its community health needs assessment, describe any community health needs that are not being addressed and explain why those needs, if any, are not being addressed. Each tax-exempt hospital must also provide the IRS with its audited financial statements.

In addition, the Reform Law requires tax-exempt hospitals to meet a variety of new requirements in order to maintain their tax exemption (note that if a health care system has more than one tax-exempt hospital, *each* hospital in the system must meet these new requirements). Except as noted below with respect to community health needs assessments, these requirements are effective for tax years *beginning* after March 23, 2010 (*i.e.*, for a hospital with

Medical Research and Product Development

The Reform Law authorizes up to \$1 billion in tax credits and grants for Qualifying Therapeutic Discovery Projects (QTDP). QTDP tax credits and grants are available to businesses involved in the research and development of products for the diagnosis, treatment,

and prevention of disease. QTDP tax credits and grants will be awarded through a competitive application process administered by the Treasury and Health and Human Services Departments. The application process must be developed by these Departments no later than May 21.

- **Businesses Eligible for QTDP Tax Credits and Grants.** A business will be eligible for QTDP tax credits and grants if it has 250 or fewer employees and it:
 - conducts pre-clinical activities, clinical trials or clinical studies, or carries out research protocols, for the purpose of securing approval of a product to treat or prevent diseases or conditions under the Federal Food, Drug, and Cosmetic Act or the Public Health Service Act;
 - develops molecular diagnostics to guide therapeutic decisions by diagnosing diseases or conditions or by determining molecular factors related to diseases or conditions; or
 - develops a product, process or technology to further the delivery or administration of therapeutics.
- **Amount of QTDP Tax Credits and Grants.** Tax credits or grants, if awarded, will equal 50% of the costs paid or incurred by businesses in tax years beginning in 2009 and/or 2010 for expenses that are necessary for and directly related to one or more of the above activities. In determining these expenses, a business may not include any amount paid or incurred (i) to compensate its chief executive officer and, if it is publicly traded, its four other highest compensated officers, (ii) for interest expenses, (iii) for facility maintenance expenses (such as mortgage or rent, insurance, utilities, maintenance, etc.) or (iv) for administrative overhead. Certain other limitations also apply.
- **Criteria for Awarding QTDP Tax Credits and Grants.** An applicant must demonstrate that its QTDP shows reasonable potential (i) to result in new therapies to treat areas of unmet medical need or to prevent, detect or treat chronic or acute diseases and conditions, (ii) to reduce long-term health care costs in the U.S. or (iii) to significantly advance the goal of curing cancer by May 21, 2040. Further, in evaluating whether an eligible business will receive an allocation of QTDP tax credits or grants, the Treasury Department is instructed to consider which businesses have the greatest potential to both create and sustain high-quality, high-paying jobs in the U.S. and advance U.S. competitiveness in the fields of life, biological and medical sciences.
- **QTDP Grant in Lieu of Tax Credit.** A business may apply for a grant from the Treasury Department in the amount of and in lieu of the QTDP tax credit; however, applications for grants for expenses paid or incurred in a tax year beginning in 2010 cannot be submitted until after the last day of that tax year. Also, the Treasury is not allowed to award grants to

governmental entities, tax-exempt organizations under section 501(c) of the Internal Revenue Code, and tax-pass-through entities with governmental or tax-exempt members.

- **Strategy for Applying for QTDP Tax Credits and Grants.** While the QTDP tax credits and grants will be allocated on a competitive basis, they will also be allocated on a rolling basis, as Congress mandated that each application for QTDP tax credits and grants be approved or denied within 30 days of submission. As a result, businesses that qualify for QTDP tax credits and grants should consider the timing of their applications and the risk that the full \$1 billion of QTDP tax credits and grants may be allocated before applications from all qualifying businesses are received. In particular, for expenses incurred in a tax year beginning in 2010, a business should carefully evaluate whether to submit an application for QTDP tax credits as soon as qualifying expenses are paid or incurred, or whether to delay submission of an application until after the last day of the tax year (in order to apply for a grant in lieu of the QTDP tax credits).

Changing the Medicare and Medicaid Delivery Systems

The provisions of the Reform Law noted in this section of our overview present a look into the future. How can we contain the rise in Medicare costs while transforming the way we pay for care? Patients, providers, and payors all are aligned in their goals. We all want to keep patients healthy, limit medical services to those that evidence tells us are necessary and effective, maintain access to high-quality and efficient care, while continuing innovation of new treatments, drugs, and devices. What payment system will support our aligned goals? The fee-for-service payment system does not serve us well, but how can we change that?

The Reform Law contains many concepts for change, and invites experimentation. In the coming years, the ideas described in this section that work are likely to be incorporated into the public payor systems, and eventually into the private payor systems. Today's integrated, quality-driven, efficient delivery systems are in the best position to take advantage of what the Reform Law offers. We have included items in this section in greater detail than other sections not only because we think it is the future for our clients, but also because our clients want to know their opportunities under the Reform Law.

Independent Medicare Advisory Board

The Reform Law establishes the Independent Medicare Advisory Board ("IMAB") to reduce the growth rate of Medicare expenditures. If the Centers for Medicare and Medicaid Services (CMS) projects that Medicare's spending per beneficiary would grow more rapidly than the medical inflation rate or the growth in per capita medical spending, IMAB must propose changes to the Medicare program to limit its spending growth, beginning in 2014.

- **Proposals Adopted Without Congressional Approval.** IMAB's proposals go into effect automatically unless Congress votes to

block them. The Reform Law limits Congress' ability to modify the proposals. IMAB's proposals must fit within statutory guidelines, and cannot ration health care, restrict benefits or eligibility requirements, and have a limited ability to change payment rates. The Board is charged with targeting reductions in areas of "excess cost growth." The Board's proposals will likely focus on Medicare Advantage plans and on payments to medical providers.

- **Board Composition.** The voting fifteen members of IMAB will be appointed by the President, with the advice and consent of the Senate, for staggered six-year terms, based upon nominations from both parties. The Secretary of the HHS, the Administrator of CMS, and the Administrator of the Health Resources and Services Administration will serve as non-voting members of the Board.

Quality Initiatives

- **National Health Care Strategy.** Under the Reform Law, the Secretary is required to establish and annually update a national health care strategy, outlining specific health care priorities. The strategy will aim to improve the delivery of health care services, patient outcomes and overall health of Americans. The initial strategy must be submitted to Congress by January 1, 2011. The Secretary is directed to work with state agencies responsible for the administration of Medicaid and the CHIP programs.
- **Quality Measures, Data Collection and Reporting.** The Secretary must identify gaps where no quality measures exist, or quality measures that exist but need replacement or improvement. Quality measures are standards for measuring the performance of population health, of health plans, and of health care providers. The Secretary will develop and implement new quality measures through grant awards and contracts with entities with expertise. The Secretary will complete this work during fiscal years 2010 through 2014. In addressing quality measures, the Secretary is required to prioritize:
 - health outcomes and functional status of patients;
 - the management and coordination of health care across episodes of care and care transitions for patients across the continuum of providers, health care settings, and health plans;
 - the experience, quality, and use of information provided to and used by patients, caregivers, and authorized representatives to inform decision-making about treatment options, including the use of shared decision-making tools and preference sensitive care;
 - the meaningful use of health information technology;
 - the safety, effectiveness, patient-centeredness, appropriateness, and timeliness of care;
 - the efficiency of care;
 - the equity of health services and health disparities across

- health disparity populations and geographic areas;
- patient experience and satisfaction; and
- the use of innovative strategies and methodologies.

Once developed, the quality measures will be free of charge to users of the measures, and will be publicly available on the Internet.

Additionally, the Secretary will establish and implement public reporting of performance information. The Secretary will collect and aggregate data on quality and resource use measures from information systems used to support health care delivery. The Secretary will align its collection and aggregation efforts with health information technology systems, the interoperability of such technology systems, and related standards that are in effect on March 23, 2010.

- **Improving the Physician Quality Reporting System.** The Reform Law extends through 2014, the current program of incentive payments to certain professionals if they submit data on quality measures for a year and meet certain other requirements. Beginning in 2015, if a designated professional does not satisfactorily submit data on quality measures for covered services for the year, the fee schedule amount will be adjusted to be either 98.5% of the amount that would otherwise apply in 2016, or 98% in 2015 and each following year. The Secretary must develop a plan by January 1, 2012, to integrate reporting of quality measures with reporting requirements associated with electronic health records.
- **Payment Modifier Based Upon Quality of Care.** Payments to physicians will be adjusted based upon the quality of care furnished relative to cost during a performance period. The quality of care will be evaluated, to the extent practicable, on a composite of measure of the quality of care furnished. The costs will be evaluated based upon a composite of appropriate measures of costs established by the Secretary. The Secretary will publish the measures of quality of care and costs, the dates for implementation of the payment modifier and the initial performance period no later than January 1, 2012. The Secretary will implement the payment modifier during 2013 through the rulemaking process for the physician fee schedule. The payment modifier will begin for certain physicians specified by the Secretary no later than January 1, 2015, and for all physicians by January 1, 2017.
- **Comparative Clinical Effectiveness Research.** The Reform Law supports research that compares the clinical effectiveness of medical treatments, through the establishment of a new nonprofit organization called the Patient-Centered Outcomes Research Institute. The Institute will prioritize research projects and contract with qualified organizations to conduct the research, and will release the research findings. The Institute will have 17 members appointed by the Comptroller General, plus the Directors of the National Institutes of Health and the Agency for Healthcare Research and Quality, or their designees. The Reform Law creates and funds the Patient-Centered Outcomes Research Trust Fund to support the work of the Institute. The Secretary may use the

evidence and findings of the research to make determinations regarding coverage provided such determinations are transparent, with public comment and consideration of impact on subpopulations, subject to certain limitations.

- Evidence-Based Medicine. Reform Law provides funding for the testing and implementation of a number of evidence-based initiatives. For example, it establishes the U.S. Preventive Services Task Force that will assess evidence of the success of various preventive services and assign a grade to each, with low grades becoming ineligible for payment. The Reform Law allocates funds for grants for demonstration projects testing the use of evidence-based incentives for Medicaid beneficiaries in the prevention of chronic disease. It also establishes demonstration projects for evidence-based initiatives to improve immunizations for high-risk populations.
- Health Care Delivery System Research and Quality Improvement Assistance. The Reform Law charges the Center for Quality Improvement and Patient Safety (of the Agency for Healthcare Research and Quality) with identifying, developing and providing training in innovative methods for quality improvement in the delivery of health care that represent best practices. It will identify health care providers that today deliver consistently high-quality and efficient services, and will provide funding for these organizations to share their expertise with others.

Demonstrations, Pilots, and Other Programs

- The Center for Medicare and Medicaid Innovation. A Center for Medicare and Medicaid Innovation (CMI) is created within CMS, with a broad scope of powers that in some cases exceed those previously extended to the agency. CMI's mission is to establish pilot programs, testing new ideas for reducing costs and innovating Medicare. CMI must be up and running by January 1, 2011. Health care providers should track CMI's development throughout 2010, and should monitor projects adopted by the agency after its launch in 2011.
 - Broad Scope of Authority. Without Congress' approval, the Secretary can establish and expand pilot programs to reduce spending and improve the quality of care. Additionally, CMI may select programs best suited to its objectives from a number of payment or delivery models. Examples include:
 - » payment and practice reform in primary care, including patient-centered medical home models for high-need individuals, medical homes that address women's health, and models that transition primary care practices away from fee-for-service-based reimbursement and toward comprehensive payment or salary-based payment.
 - » contracting directly with groups of providers of services and suppliers to promote new care delivery models, such as through risk-based comprehensive payment or salary-based payment.
 - » utilizing geriatric assessments and comprehensive
- \$10 Billion Budget. CMI has a \$10 billion budget through 2019. CMI's projects do not need to be budget neutral during the initial testing period.
- Medicare Shared Savings Program. The Reform Law establishes a shared savings program by January 1, 2012, to reward Accountable Care Organizations ("ACOs") for the provision of high-quality care or inexpensive care relative to a benchmark.
 - Definition of ACO. ACOs are groups of providers or suppliers, or networks of groups, that are jointly responsible for the cost and quality of health care. These organizations receive bonuses when they provide high-quality, efficient care. Providers must work together, reducing the duplication of services, eliminating unnecessary procedures, cutting unnecessary visits to the ER, all to further improved care at a lower cost.
 - Qualifications as an ACO. ACOs may include ACO professionals in group practice arrangements;
- » promoting care coordination between providers of services and suppliers that transition health care providers away from fee-for-service based reimbursement and toward salary-based payment.
- » varying payment to physicians who order advanced diagnostic imaging services according to the physician's adherence to appropriateness criteria for the ordering of such services.
- » improving post-acute care through continuing care hospitals that offer inpatient rehabilitation, long-term care hospitals, and home health or skilled nursing care during an inpatient stay and the 30 days immediately following discharge.
- » developing a collaborative of high-quality, low-cost health care institutions that is responsible for:
 - * developing, documenting, and disseminating best practices and proven care methods;
 - * implementing such best practices and proven care methods within such institutions to demonstrate further improvements in quality and efficiency; and
 - * providing assistance to other health care institutions on how best to employ such best practices and proven care methods to improve health care quality and lower costs.
- » facilitating inpatient care, including intensive care, of hospitalized individuals at their local hospital through the use of electronic monitoring by specialists, including intensivists and critical care specialists, based at integrated health systems.

care plans to coordinate the care of individuals with multiple chronic conditions and either an inability to perform two or more activities of daily living or cognitive impairment, including dementia.

networks of individual practices of ACO professionals; partnerships or joint venture arrangements between hospitals and ACO professionals; hospitals employing ACO professionals; and such other groups of providers of services and suppliers as the Secretary determines appropriate. However, ACOs must have an established mechanism in place for joint governance.

- Requirements to be an ACO. ACOs must meet the following requirements:
 - » ACOs must be accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to them.
 - » ACOs must enter into an agreement with the Secretary to participate in the program for at least a three-year period (the “agreement period”).
 - » ACOs must have a formal legal structure that would allow the organizations to receive and distribute payments for shared savings to participating providers of services and suppliers.
 - » ACOs must include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to them.
 - » At a minimum, each ACO must have at least 5,000 such beneficiaries assigned to it.
 - » ACOs must support the assignment of Medicare fee-for-service beneficiaries to an ACO, the implementation of quality and other reporting requirements, and the determination of payments for shared savings.
 - » ACOs must have leadership and management structures that include clinical and administrative systems.
 - » ACOs must define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.
 - » ACOs must demonstrate that they meet patient-centeredness criteria specified by the Secretary.
- Payments to ACOs. ACOs participating in the program will continue to receive their regular Medicare payments, but they will additionally receive payments for shared savings if they meet quality performance standards established by the Secretary, *and* if the ACOs’ estimated Medicare costs are a certain percentage below a benchmark set by the Secretary. ACOs will receive a percentage of that shared savings.
- Partial Capitated Basis Model Option. Additionally, the Reform Law enables the Secretary to establish other payment models, including a partial capitated basis model, where an ACO is at financial risk for some (but not all) items and services covered by the Medicare program.
 - The Secretary may choose to limit the partial capitation model to ACOs that are capable of bearing risk.
- Program for Payment Bundling for Episodes of Care. The Reform Law creates a national, voluntary pilot program focusing upon payments for bundled services. The new pilot program for bundled payments must be launched by January 1, 2013.
 - Comprehensive Payments. The bundled payment must cover the costs of applicable services furnished to an individual during the episode of care. Applicable services include acute care inpatient services, physicians’ services delivered within and outside of an acute care hospital setting, outpatient hospital services including emergency department services, and post-acute care services, including home health services, skilled nursing services, inpatient rehabilitation services, inpatient hospital services furnished by a long-term care hospital, care coordination, medication reconciliation, discharge planning, transitional care services, and other patient-centered activities as determined appropriate by the Secretary.
 - Episode of Care. The “episode of care” is the period including the three days prior to the admission of the beneficiary to a hospital for the applicable condition, the length of stay of the beneficiary in the hospital, and the 30 days following the discharge of the beneficiary from the hospital.
 - Eligible Entities. Eligible entities will be providers of services and suppliers, including participating hospitals, physician groups, skilled nursing facilities, and home health agencies. Entities must show that beneficiaries will have an adequate choice of providers of services and suppliers under the pilot program. The bundled payment will be made to the entity admitted to participate in the pilot program, for redistribution to its providers and suppliers.
 - Program-specific Quality Measures. To verify that patients receive adequate care under this system, the Secretary will develop quality measures pertaining to the episodes of care and post-acute care.
- Community Health Teams to Support Medical Home Models. The Reform Law creates a program of grants and contracts for community-based, interdisciplinary health teams to provide support services and capitated payments to primary care providers in hospital service areas served by eligible entities. The primary care providers furnish a care plan for each patient and access to patient health records, meeting with the health team on a regular basis to ensure integrated care.
 - Eligible entities. States, and state-designated entities and Indian tribes or tribal organizations may submit applications to the Secretary with plans that demonstrate long-term financial sustainability; ensure the entity’s health team includes an interdisciplinary,

interprofessional team of health care providers; and agree to provide services to eligible individuals with chronic conditions.

- Requirements for Health Teams. To obtain a grant or contract, a health team must: establish contractual agreements with primary care providers for support services; support patient-centered medical homes; collaborate with local primary care providers and existing state and community-based resources to coordinate disease prevention and chronic disease management; and undertake certain other tasks in support of the contract.
- Community-Based Care Transitions Models. The Reform Law creates a new program to fund entities furnishing care transition services to high-risk Medicare beneficiaries. The term “high-risk Medicare beneficiaries” will be defined by the Secretary, but may include patients with cognitive impairment, depression, a history of multiple readmissions, or any other chronic condition or risk factor.
 - Eligible Entities. The program is open to community-based organizations providing transition care services through arrangements with hospitals, provided they have governing boards with a good representation of multiple health care stakeholders, and to hospitals with high readmission rates, as recognized by HHS. The hospitals will be required to partner with community-based organizations. Eligible entities will submit applications for admittance to the program to the Secretary.
 - Term. The program will extend for a five-year term, beginning January 1, 2011.
 - Funding. \$500 million is allocated to this program for 2011 through 2015.
- Medicaid Quality Improvements and Demonstration Projects. The Reform Law contains a number of new Medicaid modifications and demonstration projects.
 - Adult Health Quality Measures. The Secretary must establish core adult health quality measures for Medicaid eligible adults to be disseminated by January 1, 2012. The Secretary must establish a Medicaid Quality Measurement Program, akin to the already existent pediatric quality measures program, and will award grants and contracts to organizations for the development, testing and validation of the evidence-based quality measures.
 - Payment Adjustment for Health Care-Acquired Conditions. The Secretary is required to develop a list of health care-acquired conditions (HACs) for Medicaid based on those defined under Medicare and current state practices. The Secretary must identify current state practices that prohibit payment for HACs and incorporate practices appropriate for application to the Medicaid program in regulations. The regulations must prohibit payment to states for any amounts expended for providing medical assistance for HACs. These regulations must be in effect as of July 1, 2011.
 - State Option to Provide Health Homes for Enrollees With Chronic Conditions. Beginning January 1, 2011, states will have the option of enrolling eligible Medicaid beneficiaries with chronic conditions, such as mental health conditions, substance use disorders, asthma, diabetes, heart disease and being overweight (with a BMI over 25), into a health home. Health homes would be composed of a team of health professionals and would provide a comprehensive set of medical services, including care coordination. The Secretary will establish qualification standards for a designated provider to be eligible to operate as a health home.
 - Demonstration Project to Evaluate Integrated Care Around a Hospitalization. The Reform Law establishes a demonstration project to evaluate integrated care around a hospitalization by studying the use of bundled payments for hospital and physician services under Medicaid. The demonstration project begins on January 1, 2012, and ends on December 31, 2016, and will be conducted as follows:
 - » Limited to Eight States. The demonstration project will be conducted in up to eight states, selected by the Secretary. A selected state may target the demonstration project to particular categories of beneficiaries, beneficiaries with particular diagnoses, or particular geographic regions of the state.
 - » Limited Episodes of Care. A state selected to participate will specify one or more episodes of care the state proposes to address in the project, the services to be included in the bundled payments, and the rationale for the selection of such episodes of care and services.
 - » Robust Discharge Planning Programs. Hospitals participating in the project must have or must establish robust discharge planning programs to ensure that Medicaid beneficiaries needing post-acute care are appropriately placed in, or have ready access to, post-acute care settings.
 - Medicaid Global Payment System Demonstration Project. A Medicaid global payment system demonstration project is established, in coordination with the CMS Innovation Center, which allows participating states to adjust their current payment structure for eligible safety net hospital systems or networks from a fee-for-service model to a global capitated payment structure. An eligible safety net hospital system or network is a large, safety net hospital system or network that operates within a state selected by the Secretary. This demonstration project must operate during a period of fiscal years 2010 through 2012. The Secretary of HHS may not select more than

five states to participate in the project.

- Pediatric Accountable Care Organization Demonstration Project. A Pediatric Accountable Care Organization demonstration project is established to permit qualified pediatric providers to be recognized and receive payments as Accountable Care Organizations (ACO) under Medicaid. This demonstration project parallels the ACO Pilot Program established under Medicare. This demonstration project will begin on January 1, 2012, and end on December 31, 2016.
- Demonstration Programs for Alternatives to Tort Litigation. The Reform Law authorizes the Secretary to award grants to states for the development and evaluation of alternatives to current tort litigation for resolving disputes over injuries caused by health care providers. The Reform Law appropriates \$50 million to be awarded over a period of five fiscal years beginning with fiscal year 2011. States that already have alternatives that balance the interests of all stakeholders will be preferred in awarding grants.

Program Integrity Provisions

In recent years, the government has aggressively investigated and prosecuted cases of health care program fraud and abuse. The Reform Law suggests this trend will continue. The Reform Law ratchets up enforcement, oversight, and penalties for federal health care plan fraud and abuse. However, it also offers new opportunities for health care providers seeking to self-disclose past violations. Highlights include the following:

- A New Stark Self-Disclosure Protocol. Previously, health care providers had few attractive options for self-disclosing Stark Law violations, in part because the OIG limited its self-disclosure protocol to providers with a colorable anti-kickback violation of at least \$50,000. The Reform Law requires the Secretary to create a new self-disclosure protocol for actual or potential violations of the Stark Law. The protocol must be in place by September 23, 2010.
- Amounts Due and Owing Under Stark Negotiable. Closely linked to the creation of the self-disclosure protocol is HHS's new ability to negotiate the repayment of overpayments pursuant to a Stark violation. The Reform Law gives the Secretary discretion to reduce amounts due and owing from Stark violations in consideration of factors such as the nature and extent of the improper or illegal practices, the timeliness of the self-disclosure, and cooperation in providing information. This provision is effective immediately.
- Recovery Audit Contractor Program Expanded to Medicare Parts C and D. The Recovery Audit Contractor Program (RAC) authorizes certain third-party firms to audit health care providers for Medicare Part A or B program overpayments. The Reform Law expands the RAC program to Medicare Parts C and D by requiring the Secretary to ensure that each MA plan under Part C and each prescription drug plan under Part D has an anti-fraud plan in place and to review the

effectiveness of the plans. This expansion is to be in place by December 31, 2010.

- Recovery Audit Contractor Program for Medicaid. The Reform Law expands the RAC program to Medicaid. This provision requires that states contract with one or more RACs by December 31, 2010.
- Enhanced Fraud Sentencing Guidelines. The Reform Law stiffens the penalties for program fraud and abuse. It directs the United States Sentencing Commission to increase the penalties for persons convicted of health care fraud offenses in appropriate circumstances and to ensure that Federal Sentencing Guidelines and policy statements reflect the serious harm associated with health care fraud. The Reform Law also expands the Department of Justice's subpoena authority relating to health care fraud. This provision is effective immediately.
- Modified Intent Standard for Anti-Kickback Violations. The Reform Law relaxes the level of intent required to violate the Anti-Kickback statute. Some courts had previously ruled that finding an Anti-Kickback violation required a showing that a person had actual knowledge of the statute and specific intent to violate it. This provision clarifies that knowledge that the conduct is unlawful is sufficient. The section also applies to several health care fraud statutes. This provision is effective immediately.
- Adverse Action Data Banks Consolidated. Currently there are two distinct data banks to which certain health care entities, government agencies (among others) must report certain adverse actions taken against health care providers - the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Databank (HIPDB). The Reform Law consolidates these two data banks by requiring the Secretary to establish a process to transfer information from the HIPDB to the NPDB and then terminate the HIPDB.

Is the Reform Law Constitutional?

Two lawsuits challenging the constitutionality of the Patient Protection and Affordable Care Act were filed within minutes after President Obama signed the legislation. The first action was brought by Virginia's Attorney General and the other by Florida's Attorney General along with those of twelve other states (subsequently joined by five other states' AG's). Both suits contend that the Act exceeds the power of the federal government, and usurps powers reserved to the states under the Tenth Amendment, by mandating that individuals have health insurance coverage or pay a tax and by forcing states to use their resources to expand Medicaid and administer portions of the Act.

Most legal commentators believe the lawsuits have little chance of success. They argue that the federal government's power to regulate interstate commerce has been well established since President Roosevelt's New Deal legislation was upheld in the 1930s. This power has been extended even to purely intra-state

activity that merely affects interstate commerce – such as the growing of wheat for a farm family’s personal consumption in a case decided in 1942. More recently, the Supreme Court in 2005 upheld the federal government’s power to regulate marijuana grown solely for personal consumption in accordance with state laws authorizing medicinal use, reaffirming the federal government’s broad authority over interstate commerce. Similarly, the federal government’s power to mandate expanded eligibility as a condition of participation in the Medicaid program, which is 60% federally funded, also is well-established. That a state’s option to decline participation in this and other federal programs is not politically viable, has never been held to limit the federal government’s spending power under the Constitution.

We share the general consensus that these lawsuits are unlikely to succeed. There is a strong presumption that duly enacted legislation is constitutional, making any such challenge a long-shot. The principal objection to the Act’s “mandate” seems misplaced, moreover, because the law does not require anyone to purchase private insurance. Rather, it penalizes with a tax those who do not already have insurance, through an employer or otherwise, and who decline to purchase coverage through programs established under the Act. While this legislative scheme differs in some respects from others it has addressed, the Supreme Court since 1937 has upheld the constitutionality of every federal taxing and spending program it is has considered.

However, the current Supreme Court showed its willingness to upset decades of settled law and expectations in its recent ruling that the federal ban on corporate speech in electoral campaigns violates the First Amendment. Accordingly, the Act’s proponents would be wise to take seriously these constitutional challenges.

Health Care Team Members

Appleton office:

Jeffrey Riestler

(jriester@gklaw.com)

Michael Lokensgard

(mlokensgard@gklaw.com)

Choua Vang

(cvang@gklaw.com)

Madison office:

Jon Anderson

(janderson@gklaw.com)

Robert Dreps

(rdreps@gklaw.com)

Jeffrey Femrite

(jfemrite@gklaw.com)

Claire Finando

(cfinando@gklaw.com)

Paul Karch

(pkarch@gklaw.com)

Kevin O’Connor

(koconnor@gklaw.com)

Jed Roher

(jroher@gklaw.com)

Thomas Shorter

(tshorter@gklaw.com)

Michael Skindrud

(mskindrud@gklaw.com)

Andrew Turner

(aturner@gklaw.com)

Milwaukee office:

Robyn Arnold

(rarnold@gklaw.com)

Sean Bosack

(sbosack@gklaw.com)

Kristine Cherek

(kcherek@gklaw.com)

Todd Cleary

(tcleary@gklaw.com)

John Donahue

(jdonahue@gklaw.com)

Daniel Flaherty

(dflaherty@gklaw.com)

Charles Vogel

(cvogel@gklaw.com)