

INSIDE: Delaware's Implementation Plan, New Fraud Rules, The Impact on Employers and More

# Delaware Lawyer

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**HEALTH CARE'S  
NEW FACE:**  
How the PPACA is  
Changing The Rules

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**TRANSPORTATION AVAILABLE**

Teresa A. Cheek

Everyone knows that the Patient Protection and Affordable Care Act of 2010 (“PPACA”) has been controversial, but last year the Supreme Court upheld the constitutionality of most of the PPACA in *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012), repeated efforts to repeal the PPACA have failed, and the government and the public are now focusing on implementation.

I’m happy about that. The PPACA will expand access to healthcare and the Congressional Budget Office has projected that it will reduce Medicare costs and the deficit. As of January 1, 2014, insurers will not be permitted to discriminate based on gender or pre-existing medical conditions or impose annual spending caps in health insurance policies.

Medicaid coverage and funding are being expanded and tax credits will be available for small businesses to help them offer insurance to their employees. Our articles in this issue look into additional aspects of the PPACA.

Bettina Twardy Riveros gives us a view from inside the Governor’s office of Delaware’s preparations for the next phase of implementation of the PPACA, including the design and creation of Delaware’s health care exchange and development of an innovative plan to reform its health system payment and service delivery models.

Sarah Noonan Davis explains how community health

centers fit into the healthcare reform picture. The federal community health center program has received bipartisan support because it helps reduce overall healthcare costs by making quality primary care readily available to low-income people.

Nathan Trexler points out that the PPACA includes many new provisions relating to the prevention, detection, and punishment of fraud and abuse in Medicare, Medicaid, and other federal health care programs.

Dr. Stephen J. Kushner explains some areas in which many physicians wish the PPACA had gone farther, to deal with ongoing issues with Medicare payments, medical malpractice liability, and the need to expand the physician workforce.

Kent Evans describes the effects of the PPACA on employers who are (or are not) providing healthcare insurance benefits to their employees.

Finally, our *Of Counsel* feature profiles Sheldon N. Sandler, my mentor in my former life at Young Conaway Stargatt & Taylor. He was and is an inspiration. I wish I had had the space to say more.



Teresa A. Cheek

## The Delaware Bar Foundation Thanks its IOLTA Program Prime Partner Banks!

The Bar Foundation would like to thank the financial institutions listed below, and also listed on its website at [www.delawarebarfoundation.org](http://www.delawarebarfoundation.org), for choosing to participate in Delaware’s IOLTA Program at the highest level as a Prime Partner Bank. The IOLTA Program supports the operating budgets of Delaware’s three legal services agencies: CLASI, DVLS and LSCD. Participation in the IOLTA Program enables lawyers at these agencies to secure safe, affordable housing for their clients and protect victims of domestic violence and elder abuse, among other things. The following Prime Partner Banks pay the highest rate on IOLTA accounts, translating into more funds for legal services for those Delawareans most in need:

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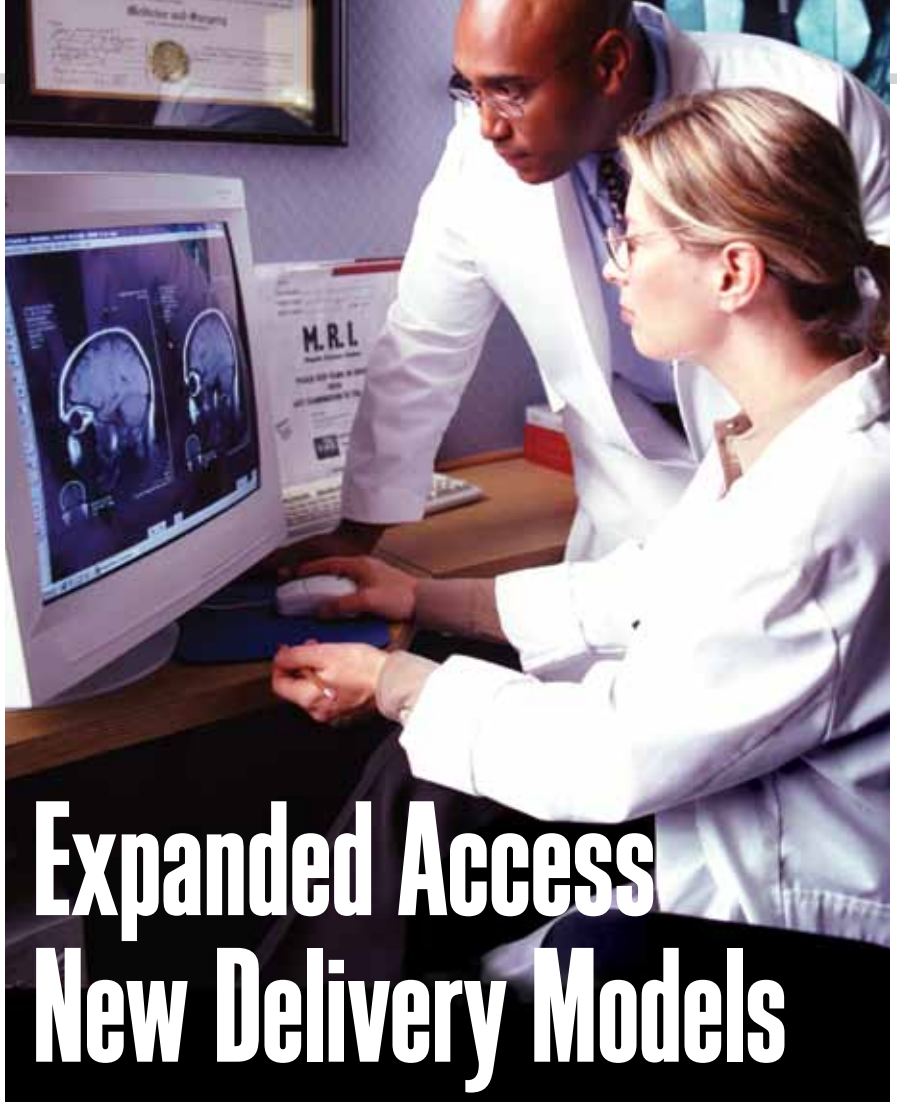
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# The PPACA in Delaware: and Expanded Access New Delivery Models

With implementation  
of Delaware's  
Health Insurance  
Exchange just  
around the corner,  
the First State is on  
the cutting edge  
of innovation.

On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (“PPACA”), a bill designed to expand access to affordable health care for millions of Americans.

**T**he State of Delaware, through the Delaware Health Care Commission, has worked in collaboration with stakeholders throughout Delaware since January 2011 to implement the requirements of the PPACA, to support exciting innovations in the health care arena, and to enable the transformation required to improve health, support access to quality health care, and lower costs.

Addressing health care transformation presents a particularly complex public policy issue. This is an exciting — and fluid — arena in which both agility and a focused strategy are prerequisites to success. Access, quality, and costs remain the magic triad for health policy, often complicated by a multitude of practical concerns and consumer realities.

Health insurance exchanges, health information technology, data and analytics, care coordination, medical homes, accountable care organizations, evidence-based medicine, consumer transparency, workforce development, value-based purchasing — these popular terms and competing demands can swirl in and around the maze of issues that must be addressed as part of a comprehensive health care strategy.

The critical issue, however, is to keep the patient at the center of the discussion and to provide quality affordable care and support to enable the best health outcomes for each patient.

Access to health services invokes issues of costs and coverage, via employer-sponsored or individual health insurance policies, or public programs including

Medicaid, the Children's Health Insurance Program ("CHIP"), and Medicare coverage.

For those seeking health insurance on the individual market, the denial rate in Delaware is approximately 30 percent. The PPACA brings a monumental shift to this insurance market with the introduction of guaranteed issue of insurance, its individual mandate counterpart, the severe limitation of rating factors, and the compression of rating bands.

### **Health Insurance Marketplace**

Perhaps the most apparent change will be the First State's Health Marketplace — a new insurance marketplace supported by the PPACA under the state-federal partnership exchange model. This exchange marketplace will enable individual consumers to access an online portal, easily compare health policies at tiered price points, explore eligibility for Medicaid, identify available federal subsidies available for defined income levels, consider the healthcare providers that will be available for each plan, and enroll in coverage.

Delaware has been a national leader in implementing the PPACA's requirements for a health insurance exchange. The state-federal partnership exchange model was first put forward by the U.S. Department of Health and Human Services in September 2011. This model permits Delaware to partner with the federal government in administering the state's health insurance exchange marketplace, with the ultimate goal of making quality health care and coverage affordable and accessible to all Delawareans.

As of October 1, 2013, Delawareans should be able to utilize the federal exchange portal to enroll in a health insurance plan with coverage beginning on January 1, 2014. As a partnership exchange state, however, Delaware will be recommending plans for certification, evaluating plans under state certification standards and administering programs to help consumers understand their coverage options.

Delaware is a state of neighbors, and this model provides operational efficiency and financial stability while per-

mitting the state to evaluate insurance plans, set state certification requirements and advise consumers in ways that are most responsive to local needs.

Delaware began its planning for the health insurance exchange by completing a comprehensive feasibility study to determine the optimal approach to meet the state's needs. The study's financial analysis raised concerns about the financial sustainability of a state-based exchange in light of Delaware's small population. The cost of operating a state-based exchange, including a state-specific eligibility and enrollment system and call center, had the potential to significantly impact premium costs for consumers.

The state-federal partnership model provides the best opportunity to achieve the goals of keeping the cost of health plans as low as possible while still giving Delaware influence over plan certification and consumer assistance standards. Delaware has worked closely with the U.S. Department of Health and Human Services in creating and supporting the partnership exchange model for the insurance marketplace and has served as a national leader in that model.

Ensuring a voice in setting the state certification standards for the insurance plans to be sold in the exchange marketplace, known as qualified health plans ("QHPs"), gives Delaware the opportunity to leverage the exchange to promote state health policy goals.

Supporting innovation in the health care arena demands integration of state activity across multiple initiatives: ensuring access through the exchange marketplace, Medicaid and CHIP programs; sustaining Delaware's innovative technology and health information exchange infrastructure; supporting Delaware's federally qualified health centers as a critical component of the health care delivery system; enabling quality and population health goals; supporting workforce development; and advancing critical cost containment and payment reform initiatives.

For example, the PPACA requires health plans sold via the exchange marketplace to adopt a quality improvement

strategy, defined as payment reforms intended to result in improved health care outcomes. In establishing state certification standards for exchange health plans, Delaware is requiring health insurance issuers to participate in a coordinated quality improvement workgroup and in innovation initiatives. These efforts are intended to standardize plan strategies, to maximize their alignment with state public health goals, and reduce the burden on providers by streamlining performance benchmarks.

Delaware views its relationship with health insurance plan carriers that sell on the exchange marketplace as critical to the shared long-term objectives of reducing costs and improving health outcomes. Central to this initiative is Delaware's Health Information Exchange ("HIE") technology infrastructure, the Delaware Health Information Network ("DHIN"). The DHIN was a vision ahead of its time that became law in 1997 due to the leadership of former Governor of Delaware, Senator Thomas R. Carper, and the Delaware General Assembly, and it continues to advance through the strong support of Governor Jack A. Markell.

The DHIN technology foundation is a statewide HIE that supports the aggregation of health information from disparate health care providers, enabling true coordination of patient care to achieve the best possible outcomes, reducing duplication of services and supporting a broadened use of "medical homes," which are advanced primary care practices.

In addition to improving care, the DHIN provides the foundation for innovation, population health research, new outcomes-based payment models, and a cost and claims database that can ultimately support reduced health care costs.

The state-federal partnership exchange provides an opportunity to ensure continued support and utilization of the DHIN infrastructure via the state certification requirements.

Delaware has been working closely with the U.S. Department of Health and Human Services ("HHS") and with

the Center for Consumer Information and Oversight (“CCIIO”) to design Delaware’s exchange marketplace. In December 2012, Delaware became the first state HHS conditionally approved to operate a state-federal partnership exchange, with open enrollment expected to begin on October 1, 2013, for plan coverage starting on January 1, 2014.

**Benefit Plans**

Delaware already has completed a number of key milestones necessary to establish its exchange marketplace. Under the PPACA, each individual and small group market plan must cover a defined list of benefits, with specific coverage details defined in a benchmark “essential health benefits” plan.

The Delaware Health Care Commission defined the essential health benefits package by selecting a benchmark plan last September and finalized state-specific criteria for certifying the QHPs last November. In December, the Delaware Department of Insurance published a bulletin documenting certification standards and setting a certification timeline.

The Delaware Department of Insurance has established an internal policies and procedures manual providing staff with an understanding of the role they will play in plan certification. Department of Insurance staff members are also working with technical staff at the National Association of Insurance Commissioners (NAIC) to customize the software that health plan issuers will use to submit their plan information for state review.

Delaware is poised to review and certify plans by late July and expects to be ready to transmit approved plan information for upload to the federal exchange portal in time to support open enrollment on October 1, 2013.

The health insurance plans Delaware will send to the federal portal will reflect local decisions made in Delaware. For example, the definition of the scope of services to be covered, known as the “essential health benefits,” will be consistent with one of the largest small group plans in the state, and the state certification standards will reflect Delaware’s

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**In preparation for consumer assistance activities, Delaware has proposed to contract with a wide variety of organizations to serve as Delaware Marketplace Assisters (MPAs).**

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comprehensive health care strategy.

**Marketplace Assisters**

In preparation for consumer assistance activities, Delaware has released a Request for Proposal to contract with a wide variety of organizations to serve as Delaware Marketplace Assisters (MPAs). MPAs will be the main outreach arm into the communities they serve, acting as the first point of contact for the majority of consumers. The MPAs will help Delaware consumers understand their enrollment responsibilities and the spectrum of coverage options available to them.

Delaware’s MPA program reflects the close cooperation of state agencies in managing exchange administration. All MPA entities will be managed by a multi-agency organization, consisting of the Delaware Department of Insurance and the Division of Medicaid and Medical Assistance (DMMA). The Department of Insurance will handle the main program management duties associated with the MPA program, while DMMA will provide support for training and will administer MPA entity grants.

At the time of this writing, Delaware was on track to select its Marketplace Assisters and begin working with selected agencies in April to establish programs and train staff. Delaware Marketplace Assisters will be ready to support October 1 open enrollment.

**SHOP Exchange**

Supporting Delaware’s consumers also means supporting the state’s small businesses, and Delaware’s business community overall, in understanding the requirements of the Affordable Care Act and minimizing disruption to current insurance.

For Delaware’s small employers, the Small Business Health Options Program, known as the SHOP Exchange, provides an opportunity to help make covering employees easier and potentially more affordable. The SHOP is designed to enable small employers to purchase coverage via the exchange and for their employees to access the exchange and select from plan options their employers provide.

In Delaware, the small group market is generally well-served by existing distribution channels, including a private exchange-like purchasing option for small employers and an active agent and broker community. Delaware’s employers have long relied on agents and brokers to help them find the right plan for their business.

Based on the Delaware Health Care Commission’s extensive stakeholder outreach, the state anticipates that agents and brokers will continue to play an important role in advising Delaware’s small business community. Providing information and assistance to this community also will be a key component of Delaware’s consumer outreach strategy.

**Assuring Access**

Access to health care means more than having coverage. True access to care requires sufficient capacity in the statewide health care provider delivery system to meet the demands of Delaware’s population and to support prevention and wellness, as well as acute care needs.

As health care consumers, Delawareans should be able to actually access the care they and their families need, whether they live in Newport, Camden or western Sussex County. They need to be able to find a child mental health provider, secure a dental appointment, or establish a primary care relationship that supports prevention and chronic

disease management.

Currently, Delaware is officially designated by the federal government as a “Health Professional Shortage Area” in several critical need areas, including mental health, primary care, and dental services. Specifically, Delaware has a shortage of at least four psychiatrists, seven primary care providers and 31 dentists statewide, according to the U.S. Department of Health and Human Services’ Health Resources and Services Administration.

Added to the complexity of our present and future needs is our state’s demographic profile. Delaware’s population is aging and has a high incidence of chronic disease and significant risk factors, including two-thirds of all adults being classified as overweight or obese.

Proactive management of chronic diseases, aggressive prevention and early detection initiatives, population health programs, and environmental supports for healthy lifestyles are all critical components of a comprehensive strategy. As a state we already have made significant progress, as evidenced by the substantial investment in the Walkable Bikeable Delaware project, and these initiatives will be critically important as we move forward together.

Delaware also must plan to grow the health care workforce to support future health care needs. Developing our state’s present and future workforce — growing and recruiting primary care providers, behavioral health specialists, and dental providers — is a critical initiative the Delaware Health Care Commission began to address in 2012 and will continue to address as a component of a statewide strategic plan.

### **State Health Care Innovation Plan**

In September 2012, the State of Delaware sought model design funding from the Center for Medicare and Medicaid Innovation (CMMI) to develop a comprehensive State Health Care Innovation Plan. This Plan would transform Delaware’s health system with new payment and service delivery models, ready to test in 2013, delivering improved health and health care for Delawareans, and reducing health care costs.

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In February 2013, CMMI selected Delaware as a model design grant recipient with funding to support the development of the State Health Care Innovation Plan. With this model design funding, Delaware will work to accelerate the adoption of payment and service delivery models across public and private payers; extend the technology base for care coordination and outcomes-based payment models; and integrate workforce development and behavioral health and public health initiatives. As a microcosm of the nation, Delaware’s transformation can serve as a scalable model for America.

Delaware has the foundation and support for transformation, including: (1) a population and health care landscape in which the models can impact nearly 80 percent of residents; (2) advanced health information technology infrastructure to support care coordination and value-based purchasing; (3) data analytics sophistication; (4) health policy leadership, innovation, and experience; (5) educational alliances supporting workforce transformation; (6) broad support from stakeholders, including nearly 60 letters of participation, and a tested engagement strategy; and (7) strong state and private payer relationships.

Participants include all the state’s hospital systems, our state’s two current CMMI innovation grantees (Christiana

Care Health System and A.I. duPont/Nemours), the Delaware Health Sciences Alliance, Highmark Blue Cross Blue Shield of Delaware, the Health Care Association, the Medical Society of Delaware, and many others.

The model design process will occur in six key areas: (1) payment reform; (2) health care delivery system transformation; (3) enhanced health data collection and analytic capacity; (4) health policy and purchasing redesign and alignment; (5) workforce transformation; and (6) population-based approaches to health promotion, including behavioral health. Working groups will move forward in parallel with supporting technical assistance and expertise. A leadership team will provide strategic integration across work streams.

Each work stream will be critical to developing a sustainable, affordable, and self-reinforcing system of health. Creating new payment models that focus on value and outcomes, rather than simply fee-for-service, is one component of a comprehensive health system transformation plan that recognizes the need for:

- A work force that is capable of delivering care more efficiently and effectively;
- A streamlined population health data system;
- Data and analytics that improve care coordination, drive quality improvements, support research, improve consumer transparency, support new payment models, and reduce duplication of services;
- Alignment of public health care purchasing strategies across state agencies;
- Active involvement and support from the business community and commercial insurers; and
- A broader population-based approach to health and wellness, including integration of behavioral health services.

Together, the work streams comprise a common platform and overarching strategic approach that Delaware will be prepared to test in 2013.

Delaware’s commitment to access to (See **EXPANDED ACCESS** on page 27).



# Community Health Centers:

# On the Frontlines of Reform

Community health centers play an important role in making healthcare reform successful and economical.

For nearly 50 years, federally qualified health centers (FQHCs), also known as “community health centers,” have served as the “safety net” provider of critical primary healthcare services, caring for the poorest and most medically underserved communities across our nation.

Community health centers were initially launched as part of the federal “War on Poverty,” initiated in 1965 in response to tremendous health disparities noted in southern communities, both rural and urban. The community health center program founders, Drs. Jack Geiger and Count Gibson, aligned their efforts with those of the civil rights movement and developed a unique model for health care, targeting poor communities and eliminating financial barriers to access.

Their vision included comprehensive, high-quality medical care, patient-driven programs, and culturally based patient education. The community health center movement’s core principles emphasized community empowerment and

participation in decision-making for the organization, accomplished by requiring that the majority of the community health center’s board members be patients themselves.

By establishing primary-care medical practices in poor communities, employing staff who speak a variety of languages, understanding the culture and daily lives of the patients they serve, and providing a sliding fee schedule, community health centers work towards the elimination of racial and ethnic disparities in medical outcomes by providing affordable medical care to those who would otherwise go without.

Community health centers are non-profit organizations that satisfy certain Medicare and Medicaid requirements

**EXPANDED ACCESS** under Section 330 of the federal Public Health Service Act.

Section 330 grants, administered by the U.S. Health Resources and Services Administration, help community health centers support the cost of care for uninsured patients, although the grants do not fully support the cost of care for the uninsured or the supportive social services that are also provided at the centers. Section 330 grants also enable community health centers to serve more patients by creating new health care access points, expanding their medical capacity, increasing the types of services they provide, planning for future growth, and implementing health information technologies.

Community health centers also rely on revenues from several other sources, including reimbursement for services from Medicaid, Medicare, the State Children's Health Insurance Program (SCHIP), and private medical insurance; out-of-pocket payments by patients; state and local government grants; charitable foundation grants; donations from supporters; and their own fund-raising and financing efforts.

The present-day community health center program now has more than 9,000 health center locations serving more than 23 million patients annually across the nation. Most health center patients have low incomes, are uninsured or publicly insured, and are members of racial or ethnic minority groups.

Delaware's three community health center organizations have grown significantly over the past 10 years as a result of increased demand for affordable quality healthcare services. The three organizations — Westside Family Healthcare, Henrietta Johnson Medical Center, and La Red Health Center — collectively operate 10 health center locations serving communities statewide.

In 2011, Delaware's health centers cared for nearly 40,000 patients, 39 percent of whom were uninsured and 97 percent of whom were living below 200 percent of the federal poverty level. Services provided at these centers include family medicine, internal medicine, pediatric medicine, obstetrics and gynecology, basic dental services, and

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## Section 330 grants, administered by the U.S. Health Resources and Services Administration, help community health centers support the cost of care for uninsured patients.

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behavioral health care, as well as myriad social and support services including interpretation for patients with limited English proficiency, social work, and nutrition counseling.

Services provided at the health centers are tailored to meet the unique needs of the communities that they serve. These CHCs are not only providing critically important healthcare services in medically underserved low-income communities, they are also acting as economic engines, providing stable employment and career opportunities for members of the communities they serve.

Bi-partisan support for the community health center program has fueled its growth, particularly over the past 10 years, due at least in part to the fact that the program has been viewed for years as a cost-saver by the U.S. Government Accountability Office (GAO). Community health centers provide one quarter of all primary care visits for the nation's low-income population,<sup>1</sup> and generate \$24 billion in annual savings.<sup>2</sup>

A large contributor to the cost savings is the reduced use of the hospital emergency department (ED); Medicaid beneficiaries who rely on health centers for routine care are 19 percent less likely to use the ED and 11 percent less likely to be hospitalized for ambulatory care sensitive (ACS) conditions (conditions that are potentially preventable, such as hypertension) compared to beneficiaries

relying on other providers.<sup>3</sup> Counties with federally qualified health centers have 25 percent fewer ED visits for ACS conditions than those counties without such a facility.<sup>4</sup>

Another factor that helps community health centers reduce healthcare costs is the person-centered quality-care model that is central to the program. Health center patients, who are from traditionally underserved and at-risk populations, receive more screening and health promotion services than patients of other providers. The Institute of Medicine (IOM) and the GAO have recognized health centers as models for screening, diagnosing, and managing chronic conditions such as diabetes, cardiovascular disease, asthma, depression, cancer, and HIV.<sup>5</sup>

Community health centers significantly reduce the expected lifetime incidence of diabetes complications, including blindness, kidney failure, and certain forms of heart disease, improving patients' quality of life and yielding significant savings in health expenditures.<sup>6</sup>

These cost-effective outcomes are achieved through health centers' ability to successfully coordinate care, implement evidence-based practices, motivate patients to become more actively involved in changing their health-related behaviors and receiving necessary care, and utilize multiple health professionals with varied skills through a multidisciplinary team approach.

Team-based models involve physicians, nurse practitioners, physician assistants, nurses, social workers, case managers, behavioral health specialists, dental providers, health educators, outreach workers, and others. Research shows that coordinated team-based care improves patient outcomes<sup>7</sup> and reduces health disparities.<sup>8</sup>

Given their bi-partisan support and strong financial and clinical quality performance outcomes, it should be no surprise that community health centers were tapped as a main strategy for achieving increased access to primary and preventative health care through the Patient Protection and Affordable Care Act (PPACA). Under the PPACA, substantial expansion in Medicaid eligibility and premium and cost-sharing

subsidies and the implementation of the new insurance exchanges will enable more than 30 million Americans to obtain the health insurance they need to be able to access primary healthcare.<sup>9</sup>

According to the Delaware Healthcare Commission, 50,000 Delawareans will become newly insured as a result of Medicaid expansion and the state health insurance exchange. The demographics of the newly insured will shift dramatically from those of the current insured cohort. The newly insured will generally be less educated, more racially diverse, and more than twice as likely to speak a primary language other than English.

They also will be more likely to be under-employed or unemployed, with many crossing back and forth between Medicaid, subsidized coverage through the health insurance exchange, and lack of insurance.<sup>10</sup>

Community health centers will play an increasingly critical role in providing access to primary and preventive health care for the newly insured, many of

**Despite the expansion of coverage provided by the PPACA, there will continue to be a significant number of uninsured individuals who will continue to rely on community health centers.**

whom will have insurance for the first time in their lives. As trusted community healthcare providers, health centers will assist with outreach and enrollment activities within the historically underserved communities where the newly

insured will live and work.

Despite the expansion of coverage provided by the PPACA, there will continue to be a significant number of uninsured individuals who will not qualify for the Medicaid expansion or state-based exchanges and who will continue to rely on community health centers for their care.

In view of the significant number of newly insured expected to result from the PPACA, a multifaceted approach was taken by its authors to strengthen the community health centers program and bolster the ability of health centers to care for more people, particularly in underserved communities.

The PPACA invested \$11 billion in new funding, spread over a five-year period, directly for the community health centers program. Of this funding, \$9.5 billion was allocated to enable health centers to expand their operational capacity to serve nearly 20 million new patients and to enhance their medical, oral, and behavioral health services. The

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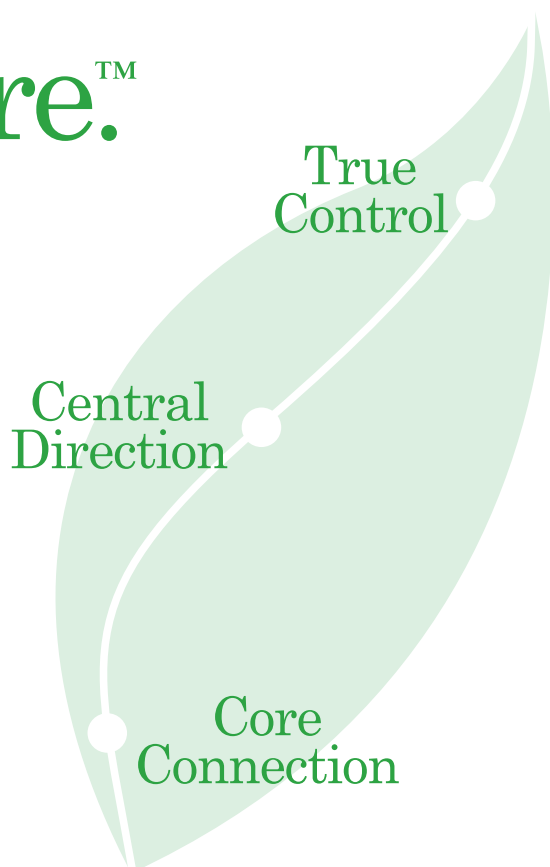
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other \$1.5 billion was allocated for the capital that health centers would need to expand and improve existing facilities and to construct new sites.

The health reform package also included \$1.5 billion over five years for the National Health Service Corps (NHSC), a national loan repayment and scholarship program for clinicians who dedicate two years to serving in a community-based site in a high-need Health Professional Shortage Area. The NHSC funding was intended to support the placement of an estimated 15,000 primary care providers in provider-shortage communities; many of them were expected to work in community health centers.<sup>11</sup>

The availability of the funding allocated to strengthen the community health centers network has been largely undermined by the significant federal budget cuts to the health centers program since 2011, which have prevented the vast majority of the planned expansion. Incremental expansion and federal investment has occurred nationally, as well as locally in Delaware. However, full investment, as intended in the PPACA, would have supported community health centers in achieving necessary capacity to provide high-quality, cost-effective care to the more than 30 million newly insured Americans who will need a primary-care medical home.

Despite budgetary cuts that have resulted in the realignment of PPACA funds and adversely affected health centers' capacity to serve the newly insured, community health centers continue to forge forward as leaders in the expansion of the PPACA-supported medical home model. The medical-home model emphasizes access to care, coordination of care, and a partnership between the primary care clinician and interdisciplinary team, on the one hand, and the patient (and where applicable, the patient's family), on the other.

Enhanced information technology in community health centers, including implementation of Electronic Health Records (EHR) and collaboration with state health information exchanges like the Delaware Health Information Network (DHIN), have further driven community health centers forward in

an effort to improve clinical outcomes, continuity of care, quality and efficiency of health care services.

Community health centers are dedicated to access, ongoing quality improvement and efficiency, and are widely viewed as part of the solution in reforming our nation's health care system. ♦

#### FOOTNOTES

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# Fraud and Abuse: Key Provisions in the PPACA

The Act generates new exposure under existing federal health care fraud and abuse laws.

Following passage of the Patient Protection and Affordable Care Act (the “Act” or “PPACA”), as amended by the Health Care and Education Reconciliation Act of 2010, much of the public’s attention focused on the issues addressed in the constitutional challenges culminating in the Supreme Court’s opinion in *National Federation of Independent Business v. Sebelius*.<sup>1</sup>

**O**n the face of a seeming overhaul of the American health care system, the individual mandate and establishment of insurance exchanges remained at the center of debate, but the Act contained numerous new provisions designed to prevent, detect, and take enforcement action against fraud and abuse in Medicare, Medicaid, and other federal health care programs.

This article describes some of the key fraud and abuse provisions of PPACA and their impact on health care providers, from enrollment obligations to key changes to the federal anti-kickback statute and expansion of False Claims Act liability.

Occasionally, reference will be made to regulations promulgated by the Department of Health and Human Services (“HHS”) pursuant to authority granted by PPACA in an effort to help clarify some of the general provisions of the Act.

#### Provider Screening and Disclosure

With the passage of PPACA, the process for detecting and preventing fraud and abuse begins, for the first time, with provider and supplier enrollment. Section 6401 of PPACA created a national pre-enrollment screening process for all providers seeking participation in Medicare, Medicaid, and the Children’s Health Insurance Program (“CHIP”).

For providers and suppliers enrolled prior to March 25, 2011, PPACA created revalidation of enrollment procedures in order to subject those providers and suppliers to the screening process.

The Secretary of HHS (the “Secretary”) was directed to establish screening procedures based on the risk of fraud, waste, and abuse with respect to each category of provider or supplier. Under PPACA, the specific screening procedures include — as the Secretary determines appropriate for each category — licensure checks, criminal background checks, fingerprinting, and unscheduled, unannounced pre-enrollment site visits.

HHS issued a final rule specifying provider/supplier categories of risk and corresponding screening requirements.<sup>2</sup> For example, physicians and group practices are considered “limited categorical risk,” while newly enrolling home-health agencies and durable medical equipment providers are considered “high categorical risk.”

Individuals with certain ownership interests in high categorical risk entities are required to provide fingerprints in connection with enrollment screening; other individuals are excluded from the fingerprinting requirement.

Section 6401 also created increased disclosure requirements during the enrollment process. Specifically, providers and suppliers who submit an enrollment application must disclose any current or previous affiliation with any provider or supplier that has uncollected debt; has been subject to a payment suspension; has been excluded from participation in the federal health care programs; or has had its billing privileges denied or revoked.

With Section 6401, Congress provided HHS the tools necessary to bring fraud prevention and detection activities to the very beginning of provider and supplier participation in federal health care programs, demonstrating the commitment to make the fight against fraud more proactive.

#### **Anti-Kickback Statute**

The federal anti-kickback statute (“AKS”) makes it a criminal offense to knowingly and willfully offer, pay, so-

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## **Under PPACA, specific screening procedures for providers or suppliers include licensure checks, criminal background checks, fingerprinting, and unscheduled, unannounced pre-enrollment site visits.**

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licit, or receive any remuneration to induce, or in return for, referrals of items or services payable by a federal health care program.<sup>3</sup> A conviction for an AKS violation can result in a fine of not more than \$25,000, imprisonment for not more than five years, or both.

The AKS has several statutory exceptions and regulatory safe harbors that fully insulate from AKS liability, though failure to comply with either does not result in a per se violation of the statute. Section 6402(f) of PPACA made two significant amendments to the AKS, potentially expanding liability.

First, PPACA provides that any claim submitted as a result of an AKS violation shall constitute a false claim for purposes of liability under the federal False Claims Act (“FCA”). Penalties for FCA violations are in addition to the specific penalties already provided by the AKS, and include a civil penalty between \$5,000 and \$10,000 per false claim, plus treble damages.

Prior to the enactment of PPACA, the government and whistleblowers relied on the “false certification” theory of liability under the FCA, but many courts limited liability to instances where the defendant expressly certified compliance with certain laws or where a statute or regulation requires compliance as a condition of payment.<sup>4</sup>

After PPACA, these limitations no

longer exist, and a claim submitted in violation of the AKS is necessarily a false claim under the FCA.

The second significant amendment to the AKS by PPACA essentially overruled the Ninth Circuit’s holding in *Hanlester v. Shalala*, which provided that the scienter element of the AKS required a showing that the defendant knew of the AKS and that the defendant specifically intended to violate the law.<sup>5</sup> Section 6402(f) amended the AKS, such that “a person need not have actual knowledge of [the AKS] or specific intent to commit a violation of [the AKS].”

#### **Stark Law**

The Physician Self-Referral Law, commonly referred to as the Stark Law, prohibits a physician from referring certain designated health services payable by Medicare, Medicaid, or other federal health care programs, to an entity with which the physician or the physician’s immediate family member has a financial relationship.<sup>6</sup>

Currently, the statutorily defined designated health services (“DHS”) include: clinical laboratory services; physical therapy services; occupational therapy services; radiology services, including ultrasound, MRI and CT scans; radiation therapy services; durable medical equipment; parenteral and enteral nutrients; equipment and supplies; prosthetics, orthotics and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services.

The law not only prohibits the referral for DHS, but also prohibits the submission of a claim for DHS provided as a result of the prohibited referral. Stark is a strict liability law, meaning an exception must apply to the otherwise prohibited conduct.

One such exception to Stark is the in-office ancillary services exception.<sup>7</sup> In-office ancillary services are services such as diagnostic tests that are provided on-site by the physician, another physician in the same group practice, or by someone who is supervised by the physician or a group practice physician. The exception requires the physicians to be organized as a group practice, and to

satisfy certain key tests related to site-of-service, billing, and performance of services.

Section 6003 of PPACA amends this exception by providing the additional requirement that a patient referred for certain imaging services be informed in writing at the time of the referral that the patient may obtain such services from another provider of such services. Furthermore, the referring physician must provide the patient with a written list of suppliers of such services in the area where the patient resides.

Section 6409 of PPACA also called for the Secretary to establish a self-disclosure protocol for actual or potential violations of Stark. The self-disclosure protocol was released on September 23, 2010, and since that time more than 100 providers have submitted self-disclosures. The Centers for Medicare and Medicaid Services (“CMS”) publishes select settlements regarding self-disclosed conduct on its website.

The benefit of the self-disclosure protocol is that the Secretary is authorized to reduce the amount due for violations of Stark based on certain factors, including the timeliness of a self-disclosure and cooperation in providing information related to the disclosure.

### Overpayment Obligations

One of the most significant expansions of liability stems from Section 6402(a) of PPACA and the new affirmative obligation upon providers, suppliers, and others to report and return overpayments received from federal health care programs such as Medicare.

The Act, in a sense, serves to expand upon the Fraud Enforcement and Recovery Act of 2009, which amended the reverse false claim provision of the FCA, making the retention of an overpayment an obligation under the FCA. Under PPACA, “overpayment” is defined as “any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled.”

Any overpayment must be reported to the Secretary or applicable contractor by the later of 60 days after the overpayment is identified or the date any corresponding cost report is due, if applicable.

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## One of the most significant expansions of liability of PPACA requires providers, suppliers, and others to report and return overpayments received from federal health care programs.

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In reporting and returning an overpayment, the reporting party must notify the Secretary or contractor of the reason for the overpayment. The duty to report and return an overpayment within the required time is considered an obligation under the FCA, and, as such, the failure to report and return can form the basis for FCA liability.

CMS published a proposed rule in February 2012 regarding the obligation to report and return Medicare overpayments (though not Medicaid or other federal health care program overpayments), which if finalized would generate additional burdens for Medicare providers and suppliers.<sup>8</sup> The proposed rule provides that an overpayment is “identified” if the individual has actual knowledge or if the individual acts in “reckless disregard” or “deliberate ignorance” of the overpayment.

Essentially, the proposed rule would not allow providers and suppliers to ignore information that may indicate that an overpayment exists, and CMS proposes that providers must make a “reasonable inquiry” to confirm whether or not an overpayment exists, and must do so with “all deliberate speed.” Most significantly, the proposed rule would require individuals to report and return any overpayment that is identified within 10 years from when it was received.

Taken together, these provisions may result in a significant burden on provid-

ers to engage in extensive retrospective audits in order to satisfy their obligations to conduct a “reasonable inquiry.” The proposed rule generates significant concerns regarding the breadth of the PPACA obligation, but CMS has not issued a final rule.

Health law attorneys should closely monitor the Federal Register for publication of the final rule in order to advise their clients on the scope of the obligation to report and return overpayments.

### Mandatory Compliance Programs

Prior to the enactment of PPACA, compliance programs were wholly voluntary, though advisable, mechanisms to help providers establish policies and procedures to conduct their business in accordance with federal health care laws. Generally, larger entities — and those subject to integrity agreements negotiated with the HHS Office of Inspector General (“OIG”) as part of the settlement of FCA-related investigations — maintained such programs.

However, Section 6401(a) of PPACA has made compliance programs a condition of enrollment in Medicare, Medicaid, and CHIP for providers of all types and sizes. The timeline for implementation shall be set by the Secretary, who was tasked with developing “core elements” of the mandatory compliance programs by distinct industry category, such as hospitals, individual and small-group physician practices, and hospice providers.

The Secretary has not yet taken action to define these elements in regulations, but it is likely that the core elements will be based on the seven elements of effective compliance programs found in the Federal Sentencing Guidelines and the OIG’s published compliance guidance.

Despite the fact that HHS has not promulgated regulations establishing an effective date for implementing compliance programs, PPACA provides a clear statutory directive such that providers should begin implementing an effective program.

Congress opted to immediately address compliance programs for skilled nursing facilities (“SNF”) and nursing facilities (“NF”). Section 6102 of

PPACA requires that every SNF and NF have a compliance program in operation within 36 months after the date of the enactment of the Act (i.e., by March 23, 2013), “that is effective in preventing and detecting criminal, civil, and administrative violations.” The Act identifies eight required components of SNF/NF compliance programs, including written policies and procedures, identification of a compliance officer, and employee compliance training.

### Suspension of Payments

Under Section 6402(h), Medicare and Medicaid payments may be suspended upon a “credible allegation of fraud” against a provider or supplier. Medicare payments may be suspended upon such an allegation unless the Secretary determines there is good cause not to suspend the payments. Prior to suspension, the Secretary shall consult with the OIG in deciding whether the allegation is credible.

In regard to Medicaid payments, PPACA provides that the federal payment to the States shall not be made for services if the State fails to suspend payments pending an investigation of a credible allegation of fraud, as determined by the State, unless the State determines there is good cause not to suspend such payments.

HHS promulgated regulations to implement and further clarify Section 6402(h).<sup>9</sup> The regulations indicate that allegations are credible if they have the “indicia of reliability.” The source for such allegations may be anonymous fraud hotline complaints, claims data mining, patterns identified through provider audits, and law enforcement investigations.

Further, the regulations define the “good cause” exceptions and the process governing the suspension of payments. A provider need not be given advance notice or opportunity to challenge the determination prior to the suspension of payments.

For providers with a large Medicare and/or Medicaid beneficiary patient population, suspension of payments could have disastrous effects, particularly if investigations move slowly.

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## Under Section 6402(h) of PPACA, Medicare and Medicaid payments may be suspended upon a “credible allegation of fraud” against a provider or supplier.

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### Medicaid Recovery Audits

PPACA continues the expansion of audit activities into the Medicaid program by establishing the Medicaid Recovery Audit Contractor (“RAC”) program, modeled after the Medicare RAC program, which utilizes auditors paid on a contingency basis to identify Medicare overpayments and underpayments.

Pursuant to Section 6411(a) of PPACA, the RAC program is expanding to Medicaid, and States are required to contract with an auditor that will be paid a percentage of the funds the RAC recovers, the same payment structure providers have criticized as promoting overly aggressive audits in the Medicare program.

States must ensure that there is an “adequate process” for providers to appeal adverse determinations by the RAC, but it is unclear whether current state procedures will be deemed adequate. Importantly, the Medicaid RAC program does not replace the currently operational Medicaid Integrity Program, which utilizes Medicaid Integrity Contractors (“MICs”) to identify Medicaid overpayments. The MICs are expected to coordinate with the RACs to avoid duplicative audits.

Nevertheless, with the expansion of the RAC program it is clear that the addition of another audit contractor focusing solely on Medicaid payments

will increase audit activity for Delaware Medicaid providers.

### Qui Tam Provisions

The Act also amended key provisions of the FCA relating to qui tam — or whistleblower — lawsuits, limiting one of the most effective arguments for obtaining dismissals of such actions. Prior to PPACA, the public disclosure bar divested courts of jurisdiction over FCA suits brought by a relator (whistleblower plaintiff) where the suit was based on allegations that were publicly disclosed in a criminal, civil, or administrative hearing, in a congressional, administrative, or Government Accountability Office (“GAO”) report, hearing, audit, or investigation, or in the news media.

The Supreme Court’s decision in *Graham County Soil and Water Conservation District v. U.S. ex rel. Wilson*,<sup>10</sup> expanded the bar to state and local sources as well. Prior to PPACA, the relator could survive the public disclosure bar, however, if he or she was the “original source” of the information.

PPACA, however, significantly limits the public disclosure bar. First, it provides that the government may waive the bar even if it clearly applies to the situation. In other words, the public disclosure bar is no longer a jurisdictional issue for only the court to decide. Second, PPACA effectively overruled *Graham County* and explicitly limited the bar to only federal sources and news media.

PPACA also significantly amended the definition of “original source” of information. Prior to PPACA, in order for the qui tam action to survive the public disclosure bar, the relator was required to demonstrate he or she was an original source of the information by showing direct and independent knowledge of the allegations beyond the public disclosure of the information.

PPACA amended the definition of “original source” such that direct knowledge is no longer required; rather, the relator must either (1) provide the information prior to the public disclosure or (2) have independent knowledge of and materially add to the publicly disclosed allegations. The standard of whether

(See **FRAUD & ABUSE** on page 27).

Stephen J. Kushner,  
D.O., FAAFP

# The Affordable Care Act:

# Concerns and Uncertainties



Although Delaware physicians have accepted universal health care coverage as a positive step, they are still worried.

We live in uncertain and evolving times. Medicine nationally has been affected by unprecedented changes and challenges. The implementation of the Patient Protection and Affordable Care Act (“PPACA”) stands to change the health care landscape forever in this country by adding more than 30 million Americans to the ranks of the insured. There are a number of ongoing issues that physicians in Delaware and elsewhere agree are not adequately addressed by the PPACA.

### Sustainable Growth Rate Formula

First, the PPACA fails to eliminate the Medicare Sustainable Growth Rate (SGR) formula. Congress enacted the SGR in 1997 as a way to try to control spending by physicians.<sup>1</sup> It attempts to ensure that Medicare expenses do not exceed annual growth in the Gross Domestic Product (GDP).

For the past 10 years, physicians have faced the constant uncertainty of severe SGR-induced payment reductions, with Congress enacting 15 separate laws from 2003 through 2013 to avert additional SGR-driven cuts to physician fee

schedules for Medicare beneficiaries.

The SGR has continued to present a major barrier to health care delivery and payment reforms that could improve the quality of patient care while decreasing costs. Now, with practice costs continuing to rise and Medicare payments for physicians’ services frozen for more than a decade, some physicians are refusing to see Medicare patients, making access to care for the present 45 million Medicare patients, and the anticipated 60 million Medicare patients who will be in the system as of 2021, a virtual medical access nightmare.

In addition, the Budget Control Act signed into law in 2011 threatens an additional 2 percent sequestration cut for Medicare provider payments. This budget sequestration will only hasten reduction in access to care for Medicare patients. Physicians want to continue to provide high-quality health care to senior Americans who rely on Medicare, but it is becoming cost prohibitive. Repealing the SGR is the very first step in resolving this problem.

### Independent Payment Advisory Board

Second, the PPACA created an Independent Payment Advisory Board (IPAB) tasked with achieving specified savings in the Medicare program without affecting coverage or quality. Fifteen panel members, to be chosen by the President, are entrusted with cutting costs and spending through a year-to-year spending target system, which will then be fast-tracked through the legislative approval process.

However, the current authority and design for the IPAB has raised serious concerns that it may further reduce Medicare payments to physicians and exacerbate the problem that the SGR created. Unfortunately, there is little guarantee that this panel, which has limited flexibility and is primarily charged with cutting costs and spending, is at all concerned with high-quality care or access to care. The absence of physician representation on this panel is both curious and very concerning.

### Medical Malpractice Liability Reform

Third, the PPACA has no provisions for medical malpractice liability reform. Many physicians in practice and in training are practicing evidence-based medicine not only for the purpose of providing high-quality health care, but also to reduce the costs of unnecessary testing. For those physicians that struggle daily with the burden of practicing defensive medicine, fear of liability concerns will continue to be drivers of high-cost health care.

The American Medical Association supports “provider shield” legislation to ensure that practice standards and

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As the population continues to age and live with chronic diseases, there is grave concern that there will be additional access to care issues.

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guidelines for health care providers established by the PPACA do not lead to new causes of action against these physicians and other health care professionals.<sup>2</sup>

Safe harbors for the practice of evidence-based medicine would reduce the cost of U.S. health care by billions of dollars. Safe harbors would also encourage physicians to be more prudent stewards of the resources available for patient care.

Fundamental reform is essential to rejuvenating our health care system. President Obama has pushed health care to center stage with the creation of the PPACA and certain provisions in the PPACA are favorable and embraced by the physician community and others. Coverage for youth under their family’s health insurance plans to age 26 and elimination of pre-existing conditions are two such examples.

The PPACA also provides for new insurance exchange models through which consumers can shop for coverage options. States can either partner with the government or set up their own exchanges. In Delaware, the partnership may result in a “win-win” situation in which state officials can manage plans and consumer education while benefiting from structural and financial support from the federal government.

Providers anticipate being invited to governing boards or marketing groups

that are established by the state to protect the interests of patients and develop sound policies and responsible standards for patient care.

### Workforce Issues

Workforce estimates by the American Medical Association predict that the U.S. will face a shortage of 62,900 physicians in 2015 and that the shortage will increase to 130,600 across all specialties by 2025.<sup>3</sup> With the PPACA calling for expansion of Medicaid coverage and the development of health care exchanges, the demand for health care services will significantly increase.

As the population continues to age and live with chronic diseases, there is grave concern that there will be additional access to care issues. Medicare plays a major role in paying for the training of new physicians, but residency training positions funded by Medicare have been capped since the Balanced Budget Act of 1997. Although medical school enrollments are expanding to meet future needs, the number of Graduate Medical Education (GME) positions has lagged behind. As a result, U.S. medical school graduates will exceed the number of slots available to them as early as 2015.

Budget sequestration cuts to federal funding for GME would be devastating to physician supply, further eroding patients’ access to care.

The PPACA has certainly garnered the attention of physicians in Delaware and across the nation and is presently a work in progress. Repealing the SGR and IPAB are necessary measures for Congress to accomplish, and then Congress must support legislation to provide available transition to new Medicare physician payment policies that are predictable and stable so that physicians can prepare for and participate in health care reform.

This will allow for growth and exploration of Patient-Centered Medical Home models and Accountable Care Organizations (physician-led entities promoting quality and efficiency measures).

(See **CONCERNS & UNCERTAINTIES** on page 27).

# Interpreting the PPACA:

# What's Next for Employers?

Employers are looking ahead to changes that will become effective during and after 2013 under health care reform.

One of the major objectives of the Patient Protection and Affordable Care Act (“PPACA”) is to reduce the number of uninsured individuals. Several provisions promote that goal, including the “Employer Shared Responsibility” (“ESR”) payment provisions, sometimes referred to as the “play-or-pay” tax.

The objective of expanding health care insurance coverage is also facilitated by the health insurance exchanges created under the law and the federal financial assistance made available to certain individuals who purchase coverage through the exchanges.

### ESR Provisions

Starting on January 1, 2014, “applicable large employers” — defined as those with 50 or more full-time employees — may be required to make an ESR payment unless they meet statutory requirements for health coverage for their full-time employees.

No guidance has yet been issued on this excise tax, but the IRS acknowledged in a recent request for comments that determining whether the tax ap-

plies and calculating the amount of the tax raise many detailed definitional issues.

Large employers are subject to the ESR payment provisions. Smaller employers will not incur liability for the ESR payment regardless of what coverage they offer (or do not offer) to their employees.

Each calendar year, an employer will determine whether it is a large employer based on the number of employees it had during the previous calendar year. Thus, for 2014, the first year that the provision is effective, employers will count the number of employees they had during 2013 to determine whether, on average, they had 50 or more full-time employees.



The ESR provision of the statute explains at least some of the rules governing this determination, including:

- A full-time employee with respect to any month is an individual who works, on average, for at least 30 hours per week.
- Part-time employees are treated as fractions of full-time employees and counted toward the total when making the large employer determination. Thus, a half-time employee would be one who works at least 15 hours per week.
- Seasonal employees may be excluded from the large employer determination if they work fewer than 120 days during the year and qualify under a Department of Labor definition.
- New employers that did not exist in the prior calendar year will make the large employer determination based on the average number of employees reasonably expected to be employed in the current calendar year.
- Only work performed in the United States is counted when making the large employer determination; employees working abroad do not count regardless of whether they are U.S. citizens.

Many details of the rules for identifying which entities are large employers are not yet specified. The IRS has issued a Notice of Proposed Rulemaking<sup>1</sup> and has indicated that future guidance will address such issues as whether to count hours of paid or unpaid time off, how many hours of service to count for non-hourly employees, when to treat multiple companies as a single employer, whether to count particular types of workers (e.g., independent contractors) as employees, and how to address fluctuations in hours worked. The following describes the rules currently in place.

### **ESR Payment Liability**

Liability for an ESR payment is determined on a monthly basis. A “large employer” will incur liability if two conditions are met in a given month: (1) the employer fails to offer the opportunity to enroll in “minimum essential coverage” (MEC) through an employer-sponsored health plan to its full-time

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**A large employer may be subject to liability for an ESR payment if its coverage is “unaffordable” or if it does not provide “minimum value” within the statute.**

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employees and their dependents, and (2) a full-time employee of the employer is certified to the employer by a health insurance exchange as having received a premium tax credit or cost-sharing reduction in connection with health coverage purchased through the exchange.

Thus, a large employer may be subject to liability for an ESR payment if its coverage is “unaffordable” within the meaning of the statute, or if it does not provide “minimum value” within the meaning of the statute.

The definition of “full-time employee” used when determining whether the two conditions noted above have been met is the same definition as is used for determining whether an employer is a large employer. That is, for any calendar month, a full-time employee is one who is employed, on average, for at least 30 hours of service per week.

Unlike the determination of whether an employer is subject to the ESR provision at all (i.e., whether the employer is a large employer), when determining if a large employer must make an ESR payment, the status of part-time employees is irrelevant and seasonal employees may qualify as full-time employees. A large employer that has seasonal employees apparently may incur ESR payment liability with respect to those seasonal employees if they work an average of at least 30 hours per week during a month.

### **Health Coverage Standards**

A large employer will not incur li-

ability for an ESR payment if it offers its full-time employees and their dependents “minimum essential coverage” that is both affordable and sufficiently valuable. Several aspects of this standard remain to be defined in future guidance, but the statute provides some parameters.

“Minimum essential coverage” means the kind of coverage that is offered by an employer group health plan to an employee through a “governmental plan” (as defined by the Public Health Service Act), through any other group health plan offered in the large or small group market, or through a grandfathered plan offered in the group market.

“Minimum essential coverage” does not include “excepted benefits” such as accident benefits, disability income benefits, liability benefits, workers’ compensation benefits, automobile medical insurance payments, credit insurance, coverage for on-site medical clinics, and benefits that are offered through separate policies, such as limited scope vision or dental benefits, long-term care benefits, coverage for specific types of diseases, hospital indemnity payments, Medicare supplemental health insurance, CHAMPUS supplemental programs, and similar supplemental coverage.<sup>2</sup>

As of February 11, 2013, no regulations have been issued interpreting the term “minimum essential coverage.” The above-referenced IRS Notice of Proposed Rulemaking indicates that regulations under section 5000A of the PPACA are expected to provide further guidance. When issued, regulations might make standards for the level or scope of coverage part of the definition of minimum essential coverage.

As health coverage providing non-excepted benefits, however, minimum essential coverage is subject to various legal requirements, including some or all of the Public Health Service Act coverage reforms discussed later in this article.

Because the term “minimum essential coverage” is similar to another statutory term, “essential health benefits,” it sometime is incorrectly stated that an employer must provide essential

health benefits in order to avoid incurring ESR payment liability. “Essential health benefits” are also to be defined in future guidance so that they are similar in scope to typical employer-provided health benefits and include coverage in the following essential health benefit categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and rehabilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

While essential health benefits are defined with reference to employer-sponsored health plans, there generally is no requirement under the PPACA that employers ensure that their plans provide essential health benefits. Insurers may be subject, however, to state mandates to ensure that the group policies they sell to employers in the small group market or through an insurance exchange provide essential health benefits.

In addition, employers need not provide essential health benefits in order to avoid the ESR payment. Among other things, the term “essential health benefits” is used in connection with the restrictions on annual and lifetime dollar limits on benefits.

Minimum essential coverage is considered affordable if a full-time employee’s required contributions for self-only coverage are no greater than 9.5 percent of household income. The definition of affordability is problematic for employers because in general employers are aware only of the income of the employee, not the income of the employee’s household.

Minimum essential coverage is sufficiently valuable if it has an actuarial value of 60 percent or more. A plan’s actuarial value is the percentage of average costs for covered benefits that a plan will

cover. A plan with a 60 percent actuarial value will pay, on average, 60 percent of covered expenses.

The plan may pay a higher or lower percentage in the case of particular expenses, and any covered individual might be responsible for more or less than 40 percent of covered expenses.

Regulations are needed to fully define this term, but the determination will be based on providing essential health benefits to a standard population (even if the plan does not actually cover a standard population).

**ESR Payment Calculations**

Offering minimum essential coverage that is both affordable and sufficiently valuable to full-time employees and their dependents allows an employer to avoid liability for the ESR payment. Even if an employer is not able to avoid payment liability, however, it can minimize the payment it might incur by offering minimum essential coverage, even if that minimum essential coverage falls short of the affordability or value standard noted above.

An employer that offers minimum essential coverage (e.g., a “mini-med” plan) that is either unaffordable or insufficiently valuable may incur ESR payment liability, but the payment will generally be lower than the payment that would be required if the employer did not offer minimum essential coverage.

Offering virtually any coverage that reimburses medical expenses (including mini-med coverage) will preclude application of the higher level of the ESR payment.<sup>3</sup>

If minimum essential coverage is not provided, the 2014 ESR payment will be \$166.67 per month for each of the employer’s full-time employees (excluding the first 30 full-time employees) if, for that month, the employer fails to offer minimum essential coverage to full-time employees and their dependents, and one or more of the employer’s full-time employees is certified for federal assistance in connection with coverage purchased through the exchange based on an individual employee’s hours of employment, health coverage, and qualification for federal assistance during that month.

The IRS has acknowledged that

the month-by-month determination of full-time employee status creates “uncertainty and inability to predictably identify which employees are considered full-time and, consequently, inability to forecast or avoid”<sup>4</sup> liability for the ESR payment.

Therefore, the IRS has committed to providing guidance that alleviates these difficulties. The guidance is likely to allow an employer to treat an employee as having or not having full-time status for a particular month based on hours worked during a look-back period.

If minimum essential coverage is provided, the 2014 ESR payment will be the lesser of (1) the payment that applies if minimum essential coverage is not provided and (2) \$250 per month for each full-time employee who is offered minimum essential coverage that, under the standards noted above, is unaffordable, insufficiently valuable or both, and who opts out of that employer-sponsored coverage, and who is certified for federal assistance in connection with coverage purchased through the exchange.

For calendar years after 2014, the \$166.67 and \$250 monthly amounts will be adjusted for inflation.

**Automatic Enrollment**

Companies that offer coverage and have more than 200 full-time employees must automatically enroll new full-time employees in health coverage. These automatic enrollment provisions will require notices and opt-out capability. Companies subject to this requirement must also continue enrollment of current employees in coverage.

The only guidance that has been issued on these provisions states that federal agencies will not enforce the requirements until regulations are issued. That guidance was particularly helpful because nothing in the statute specifies an effective date and, until regulations are issued, it will not be clear what employers must do to fulfill their responsibilities under this provision.

While the provision could take effect as soon as regulations are released, more likely it will take effect in 2014.

Among other things, regulations will define the full-time employees who are entitled to automatic enrollment. The

definition for this purpose will most likely be coordinated with the definition of full-time employee under the ESR payment provisions described above. It will also be important for regulations to define the type of coverage that must be automatically applied to newly eligible full-time employees.

Another matter that will be addressed is the obligation to continue enrollment of current employees. For example, it is not clear what requirements will apply if one of several coverage options is eliminated.

### Individual Shared Responsibility

The PPACA includes a requirement that individuals have medical coverage or face liability for an “Individual Shared Responsibility” payment, payable at tax time each year. The Treasury Department and the IRS issued proposed regulations on the “Individual Shared Responsibility” provision on January 30, 2013.<sup>5</sup>

The payment is required for each month in which the individual did not have coverage. There are a number of exceptions to the general rule. The payment is relatively modest and cannot exceed the national average premium based on the individual’s family size for bronze-level qualified health plans (i.e., plans with 60 percent actuarial value) offered through the state health insurance exchanges.

For most people, the penalty will be substantially less than the cost of obtaining health coverage. For example, the maximum penalty in 2016 for an individual whose household income is \$100,000 will be \$2,500. The penalty applies to individuals who do not have “minimum essential coverage,” unless they are exempt from the requirement.

As discussed above, almost any medical coverage that an employer provides for its employees will meet the statute’s definition of minimum essential coverage.

In addition to the ESR payment structure explained above, this feature of the individual mandate — along with employers’ desires to help employees meet the mandate — provides an incentive for employers to maintain their plans even after other options become available through the health insurance

exchanges.

Of course, these factors must be balanced against the difficulty of making any changes to the employer-provided health coverage that are necessary to comply with other provisions of the health care reform law.

### Health Insurance Exchanges

The health care reform law contemplates that by January, 1, 2014, each state will establish an insurance marketplace for individuals and small employers known as an “exchange.” The exchange is intended to be a new competitive market outlet offering standardized plans that are easily comparable. The health insurance exchanges promise individuals and small employers improved access to health coverage and lower administrative costs.



States are not required to establish exchanges. The law requires HHS to award grants to states for planning and establishing the exchanges. If HHS determines that a state will not have an operational exchange by 2014, HHS will establish and operate the exchange.

The exchanges are to be open to individuals and employers with 100 or fewer employees. However, until 2016, states may elect to limit availability to individuals and employers with 50 or fewer employees. States are permitted, but not required, to open the exchanges to larger employers (those with more than 100 employees) in 2017.

Even though all exchange plans must provide essential health benefits, they may offer various levels of coverage based on the individual plans’ cost-sharing provisions. The exchanges will classify the different levels of coverage based on actuarial value, as described above: bronze (60 percent), silver (70 percent), gold (80 percent) and platinum (90 percent).


All carriers are required to offer at least one silver plan and one gold plan. In addition, carriers may offer individual policies providing catastrophic coverage to individuals up to age 30 and to those who are exempt from the individual mandate to purchase coverage.

In most cases, an employer will not




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be permitted to include the option of paying for exchange-purchased coverage on a pre-tax basis under its cafeteria plan. If, however, an exchange-eligible employer purchases coverage for its employees through an exchange, that employer may also offer its employees the opportunity to pay for the coverage on a pre-tax basis under a cafeteria plan.

An exchange-eligible employer is, in tax years beginning after December 31, 2013, a small employer that elects to make all of its full-time employees eligible for one or more qualified health plans offered in the small group market through an exchange.

The health care reform law did not include a government-run health care plan, but financial assistance may be available to certain individuals who obtain coverage through an exchange. The details of the assistance available to individuals are beyond the scope of this article. As explained above, however, an employer may incur liability for an ESR payment if one or more of its full-time

employees qualifies for an applicable premium tax credit or cost-sharing reduction in connection with coverage obtained through an exchange.

Such federal financial assistance generally would arise if the employer's coverage is unaffordable or does not provide minimum value within the meaning of the PPACA. Under the PPACA, the exchanges are required to report such assistance to the relevant employer.

Most health care reform provisions apply across the board to all types of employers that sponsor health plans for their employees. Plans maintained by church and governmental employers generally are subject to the same requirements as those maintained by private sector employers (although the remedies available for noncompliance differ).

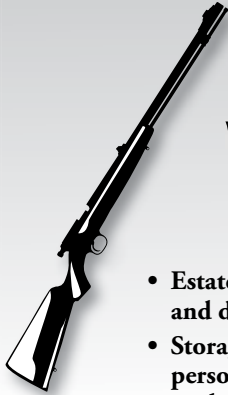
Plans of both for-profit and not-for-profit organizations are likewise subject to the requirements, and there is no general exemption for small employers. (Some provisions have specific small-employer carve-outs, however.)

Employers are currently focused on compliance, workforce planning (full-time vs. part-time and the 30 hours per week threshold), and the employee value proposition (recruit, retain, and motivate.)

One thing we can count on from Washington is that this significant piece of legislation will continue to be fluid in its modification and implementation.<sup>6</sup> ♦

FOOTNOTES

1. See <http://www.irs.gov/pub/newsroom/reg-138006-12.pdf>.
2. See 45 C.F.R. § 148.220 – Excepted benefits.
3. However, “mini-med” plans that impose annual dollar limits on benefits will not be permissible beginning in 2014. See <http://policyinsights.kff.org/2011/july/what-is-a-mini-med-plan.aspx>.
4. IRS Notice 2011-36, available at <http://www.irs.gov/pub/irs-drop/n-11-36.pdf>.
5. See <http://www.irs.gov/PUP/newsroom/REG-148500-12%20FR.pdf>.
6. The content of this article is not intended to represent legal or tax advice and has been prepared solely for informational purposes. You may wish to consult your attorney or tax adviser regarding issues raised in this article.

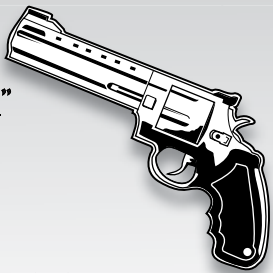



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**EXPANDED ACCESS** (from page 11).

quality, cost-effective health care, as evidenced by the extensive work of the Delaware Health Care Commission, includes: (1) close collaboration with HHS on the PPACA state-federal partnership exchange marketplace, including an extensive stakeholder process; (2) planned expansion of Medicaid; (3) the Delaware Health Information Network (“DHIN”), Delaware’s nationally-recognized statewide health information exchange; (4) the ongoing work and recommendations of the

Governor’s Council on Health Promotion and Disease Prevention, which incorporate the Healthy People 2020 and National Prevention and National Quality Strategies; and (5) the proven success of the Delaware Cancer Consortium, particularly in the area of early detection, prevention, and treatment of colorectal cancer.

With this CMMI State Innovation Model grant, Delaware will develop a comprehensive State Health Care Innovation Plan including the scalable

payment and delivery system transformations necessary to sustain value-based care initiatives focused on outcomes and improved health.

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**FRAUD & ABUSE** (from page 19).

something “materially adds” to the publicly disclosed allegations is not defined by statute.

Together, these amendments may diminish the effectiveness of the FCA public disclosure bar.

**Conclusion**

With the above PPACA provisions, Congress has continued the aggressive trend toward battling fraud and abuse in Medicare, Medicaid, and other federal health care programs. While this article summarized some key provisions, PPACA includes numerous others aimed at saving significant amounts in health

care expenditures related to fraud and abuse, including, among others, new and amended OIG exclusion authority, new and amended civil monetary penalties, provisions directed specifically at durable medical equipment suppliers and pharmaceutical manufacturers, and new investigative authorities.

It is clear that federal and state activity fraud and abuse prevention, detection and enforcement activity will only increase, and health care providers and attorneys must stay abreast of the latest activity to effectively navigate the ever-changing regulatory landscape. ♦

**FOOTNOTES**

- 132 S. Ct. 2566 (2012).
- See 76 Fed. Reg. 5864-5907; 42 C.F.R. § 424.518.
- 42 U.S.C. § 1320a-7b(b).
- See, e.g., *United States ex rel. Wilkins v. United Health Group*, 659 F.3d 295 (3d Cir. 2011).
- 51 F.3d 1390, 1400 (9th Cir. 1995).
- 42 U.S.C. 1395nn.
- 42 U.S.C. 1395nn(b)(2).
- 77 Fed. Reg. 9179.
- 42 C.F.R. § 405.370 *et seq.* (Medicare payments); 42 C.F.R. § 455.23 (Medicaid payments)
- 559 U.S. 280 (2010).

**CONCERNS & UNCERTAINTIES** (from page 21).

Embracing electronic health records, transitioning from fee-for-service to alternative payment models, working in team-based collaborative care models that put the patient’s interests first, will only improve care, lower costs, and contribute to high patient satisfaction.

Although the PPACA is imperfect, it can serve as a template for the redesign and restructuring of our health care system. ♦

**FOOTNOTES**

- N.C. Aizenman, *Medicare’s “SGR” formula has snowballed to budget-busting juggernaut*, WASHINGTON POST, Dec. 16, 2011, at [http://articles.washingtonpost.com/2011-12-15/national/35288225\\_1\\_sgr-formula-medicare-patients-physician-payments](http://articles.washingtonpost.com/2011-12-15/national/35288225_1_sgr-formula-medicare-patients-physician-payments); J. Froelich, et al., *What’s Behind the SGR Formula?*, AAOS NOW (July 2012), at <http://www.aaos.org/news/aaosnow/jul12/advocacy2.asp>; *House Republicans Vow to Permanently Repeal, Replace SGR Formula*, CALIFORNIA HEALTHLINE (February 14, 2013), at <http://www.californiahealthline.org/articles/2013/2/14/house-republicans-vow-to-permanently-repeal-replace-sgr-formula.aspx>.
- American Medical Association Policy

H-435.947, “Liability Reform in Health Care Reform,” at <https://ssl3.ama-assn.org/apps/ecom/PolicyFinderForm.pl?site=www.ama-assn.org&uri=/amal/pub/upload/mm/PolicyFinder/policyfiles/HnE/H-435.947>. HTM.

3. Testimony of the American Medical Association before the Institute of Medicine Committee on the Governance and Financing of Graduate Medical Education, presented by Susan E. Skochelak, MD, MPH, (Dec. 19-20, 2012), at <http://www.ama-assn.org/resources/doc/washington/graduate-medical-education-testimony-19dec2012.pdf>; A. Wayne, *Doctor Shortage May Swell to 130,000 With Cap*, BLOOMBERG NEWS (Aug. 29, 2012) at <http://www.businessweek.com/news/2012-08-29/doctor-shortage-may-swell-to-130-000-with-u-dot-s-dot-cap#p1>.

Teresa A. Cheek

# OF COUNSEL: Sheldon N. Sandler

Sheldon N. Sandler, admitted to the Delaware Bar in February 1966, retired as a general partner of Young Conaway Stargatt & Taylor, LLP on December 31, 2011 and is now “Of Counsel.”

These days Sandler is launching a mediation practice, attending to his volunteer legal work, occasionally testifying as an expert on Delaware law — including a recent case in Montreal — playing the banjo and fiddle, and spending time with his wife of 47 years, Susan, and their family, including two daughters and four grandchildren.

Sandler grew up in Lowell, Massachusetts. The first in his family to attend college, Sandler received his B.A. from the University of Michigan in 1962 and his L.L.B. from the Law School of the University of Pennsylvania in 1965.

In college, Sandler developed a lifelong interest in traditional music and began teaching himself to play the five-string banjo. In law school, he met Carl Goldstein, who was learning to play guitar. In 1972, Sandler and Goldstein founded The Brandywine Friends of Old Time Music to help preserve and encourage the performance of traditional American music.

The BFOTM sponsors monthly concerts and every Labor Day Weekend for 42 years has presented the Delaware Valley Bluegrass Festival. Sandler plays banjo with a band, “Tater Patch,” which has just issued its first CD. He is now also learning to play the fiddle.

Sandler began his career as a Delaware lawyer working for Robert O’Hara. When O’Hara became a judge, John Bader took over O’Hara’s practice. Sandler’s pay was \$100 a week plus half of the proceeds from any business he originated which, he jokes, “wasn’t much because I didn’t know anyone.”

From 1969 to 1971, Sandler served as the part-time Executive Director of what later became Community Legal Aid Society, Inc. (CLASI). Sandler also volunteered to handle cases for the Delaware Chapter of the ACLU, through which he met Jake Kreshtool.

Eventually he joined Bader, Dorsey & Kreshtool, and Kreshtool and Sandler began doing labor work for unions, launching Sandler’s labor and employment law career. He received an LLM in Labor Law from Temple University in 1978. In 1981, Sandler became Young Conaway’s first lateral partner and, with Barry M. Willoughby, founded its Employment Law Department, and began doing management-side



labor and employment work.

Sandler has handled more than 200 reported cases, many of which have been cutting edge. For example, in *Aumiller v. The University of Delaware*, Sandler represented a gay man who managed the University of Delaware Theater. The University’s President fired Aumiller after reading an interview that Aumiller had given in his capacity as the faculty advisor to a gay student organization.

Sexual orientation was not a protected characteristic, so Sandler filed a lawsuit relying on the First Amendment right of free speech. In a widely-cited decision, the Court found in favor of the plaintiff and awarded punitive dam-

ages against the University’s President.

Sandler has always been committed to his community. He has served as chair of the Lawyers’ Advisory Committee to the Court of Appeals for the Third Circuit; president of the Federal Bar Association’s Delaware Chapter; member of the Delaware Court of Chancery and Delaware District Court Rules Committees; founding chairperson of the DSBA Labor & Employment Law Section; and as a leader of several ABA employment law committees.

He currently serves on the Boards of the Wilmington Senior Center and The Todmorden Foundation. He is also handling cases in the Court of Appeals for Veterans Claims for the Veterans Consortium Pro Bono Program.

Sandler has been recognized repeatedly by *Chambers USA*; *Who’s Who Legal*; *The Best Lawyers In America*; *Delaware Super Lawyers*; *Human Resource Executive* magazine and *Lawdragon*. He was the first Delaware lawyer to be inducted as a Fellow of the College of Labor and Employment Lawyers.

He has also been active in the Employment Law Alliance, a network of law firms that provides employment, labor, and immigration expertise in every U.S. state and more than 120 countries. In September 2011, the ELA established the Sheldon N. Sandler Award for Distinguished Service to the Employment Law Alliance, to be awarded annually to one member of the ELA “in recognition of extraordinary service and commitment to our organization.” Sandler received the first award.

Sandler’s career has indeed been one marked by extraordinary service, commitment, energy, and expertise. He says, “I consider myself very lucky to have, almost by chance, ended up practicing law in Delaware, with its superb bench and bar, and tradition of civility.” ♦



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