health care reform

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Friday, October 22, 2010
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details have not yet been established, practitioners have ample opportunity to advocate, negotiate, and litigate the labyrinthine provisions of the new legislation.

The New York Times estimates that the landmark reforms will provide health insurance to 30 million people who currently lack it and will add 16 million people to the Medicaid rolls. The nonpartisan Congressional Budget Office (CBO) calculates that the cost to the government will be about $938 billion over 10 years, and the reduction to the federal deficit will be $138 billion over that decade.

Several states are mounting constitutional challenges to Section 1501 of the PPACA, which requires individuals to obtain a minimum level of health insurance coverage or pay a fine. Seeking declaratory relief, Virginia asserted that Section 1501 violates both the commerce clause and the Tenth Amendment. In Virginia ex rel. Cuccinelli v. Sebelius, 2010 U.S. Dist. LEXIS 77678 (E.D. Va. Aug. 2, 2010), the federal government lost its bid to dismiss the action. The court rejected the U.S. government’s argument that the choice to go uninsured and not obtain coverage is an active decision to pay for future medical care out of pocket—and, because many people cannot afford the cost of surgeries and hospitalization, that choice shifts the cost of care to hospitals, taxpayers, and commercial policyholders.

While these challenges wind their way to the U.S. Supreme Court, the nation shoulders the yearly estimated burden of $43 billion in uncompensated medical costs. The CBO anticipates that the reforms will save the government in excess of $300 billion in medical care costs over 10 years.

The gravity of the healthcare crisis crushing U.S. families cannot be captured by monetary terms alone. The Centers for Disease Control and Prevention repeatedly advise that heart disease and stroke—numbers one and three of the leading causes of death in the United States—are preventable. Recovery from these and the second leading cause of death, cancer, depends on early detection and treatment. In 2007, the prevalence of the universally dreaded disease was 11,028,000 in adults and 10,400 in children, according to the National Institute of Cancer.

The reforms laudably nudge health plans, providers, and patients toward a system of quality primary care focused on prevention and include subsidies for private coverage for low- and middle-income people. Private insurers will be regulated more closely, and exclusions for preexisting conditions and lifetime benefit limits are banned. The Department of Health and Human Services has been mandated to implement pilot programs designed to prevent catastrophic and chronic disease while controlling costs.

In this issue of LAL, the contributing authors, all experts in healthcare law, explain the nuances of changes to existing law and provide an invaluable road map for practitioners. Counsel must monitor pilot programs as well as new rules and regulations so that they may advocate effectively for the interests of their clients in the development of an accessible, quality healthcare delivery system.

This special issue on Healthcare Reform heralds Los Angeles Lawyer’s effort to help practitioners navigate the legal complexities raised by the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act. Since many of the executing

Gordon Eng is a lawyer in Torrance whose practice focuses on business law and real property matters. Mary E. Kelly, a nurse attorney, is an administrative law judge II with the California Unemployment Insurance Appeals Board. Dennis Perez is a principal with the Beverly Hills law firm Hochman, Salkin, Rettig, Toscher & Perez, P.C., where he practices in the area of criminal and civil tax litigation and controversy. Eng, Kelly, and Perez are the coordinating editors of this special issue.
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Jonathan Marks, Partner
How to Properly Hire and Employ a Nanny or Housekeeper

EXECUTIVES OFTEN PAY law and accounting firms top dollar to handle their business affairs but with domestic workers permit obvious legal violations in their homes. When households hire domestic help but do not pay employment taxes or follow basic employment laws, peril looms near. Following the law means that employers will have to take some steps, but this is a worthy time investment.

Before establishing legal employment, consider who is a domestic employee and who is not. If someone cleans house once a week, earning less than $750 per calendar quarter, the employer is permitted to pay cash. Housekeepers who earn more than $750 per quarter are employees, and they must be treated as such.

Taking seven basic steps in hiring domestic employees can prevent a variety of legal problems. First, check the applicant’s references. Employers should ask applicants to provide contact information for their last few jobs. If an applicant has not recently worked in household care, the employer should ask to speak with three people who can verify the work ethic or trustworthiness of the applicant, such as a teacher, church leader, or family friend.

Second, every employer should verify an employee’s right to work in the United States. No later than the first day of work, the employer must give the employee the U.S. Citizenship and Immigration Services (USCIS) Form I-9, Employment Eligibility Verification, which is available at http://www.uscis.gov/files/form/i-9.pdf. The form has detailed instructions on how to complete the employee section and the employer section. The completed and signed I-9 form should be kept in a confidential file. It is legal to make photocopies of the employee’s identification cards that are presented to support the I-9.

Third, employers should consider background checks. A background check will verify that a new hire does not have a recent criminal record or child abuse history. If an employee will be handling money, the employer may also be able to perform a credit check. Many companies offer advice on these options and, for a fee, provide the consent forms needed to conduct a legal background check.

Fourth, every employer should obtain an employer identification number. To register as an employer of a domestic employee, notify the state tax authority. In California, employers have 15 days to register with the Employment Development Department (EDD) after paying $750 in wages during a calendar quarter to a domestic employee. To register with the EDD, complete a Registration for Employers of Household Workers (DE 1HW), which is available on the EDD Web site (http://wwwedd.ca.gov/pdf_pub_ctr/de1hw.pdf). The employer will be assigned an EDD account number. The employer also needs a federal Employer Identification Number or EIN. This number may also be obtained online (http://www.irs.gov/businesses/small/article/0,,id=102767,00.html).

Fifth, employers should determine how to handle taxes and withholdings. The employer’s share is 7.65 percent (6.2 percent for Social Security tax and 1.45 percent for Medicare tax) of the employee’s Social Security and Medicare wages. The employer must withhold the same percentages from the employee’s wages for each pay period. In California, employers are obligated to pay two additional taxes on an employee’s wages: unemployment insurance and employment training tax. How-to information is easy to find online. California tax issues are covered at this address: http://www.taxes.ca.gov/payroll_tax/household.shtml.

Sixth, obtain an employment agreement. A well-thought-out employment agreement is a great way to start an employment relationship with clear terms and expectations. An agreement should include hours, pay rate, expectations, and prohibitions. Holidays, paid vacation, paid sick days, and any other perks are always appreciated and best understood when set out in advance.

Seventh, keep records. It is recommended that household employers keep a daily log of the employee’s hours. This can be as simple as a 12-month calendar with the hours or wages written in daily. All tax documents and filings, including daily wage reports, should be kept for four years after the tax return filing date. Failure to pay taxes on household employees may subject employers to back taxes, penalties, and interest. The most common way that state or federal tax authorities learn that someone has employed a household employee is that the employee files for unemployment or for disability benefits.

Employers are not required to withhold federal income tax from the wages paid to a household employee. An employer should withhold federal income tax only if the household employee asks and the employer agrees for it to be withheld. If this happens, the employee must give the employer a completed Form W-4, known as the Employee’s Withholding Allowance Certificate, which is available from the IRS Web site. Tax withholding is generally handled by the employer. If the employee does not agree to the withholding of income taxes, he or she remains responsible for reporting all wages and paying all personal income taxes due.

In California, those who pay more than $20,000 in wages to an employee are required to submit quarterly tax payments. Those who doubt they will find the time to calculate taxes, submit quarterly wage reports, and issue payroll checks may engage a payroll service provider to assist with these tasks. The paperwork involved with legally hiring a nanny or housekeeper can also be entrusted to a CPA, who can make sure that the household employee’s wages are properly reported on the employer’s personal income tax returns. A CPA can also assist with setting up regular payments to the state and federal tax authorities online. Failure to pay taxes on a household employee may subject the employer to back taxes, penalties, and interest. There is no limitation on how many years back the government can reach to collect unpaid employment taxes.

Employers who do not pay taxes or collect withholdings on an employee’s wages are opening themselves to probes from tax authorities. Household employers may also find themselves facing an injured or aged employee who can no longer provide the services required and who has no government benefits for future support.

Lynne M. Hook is an employment law counselor in Manhattan Beach.
Changes in In-Home Care under the PPACA

“THERE’S NO PLACE LIKE HOME” is Dorothy’s refrain from the 1939 film The Wizard of Oz. Sixty years later, the U.S. Supreme Court concurred. In *Olmstead v. L.C.*, the Court found that under the Americans with Disabilities Act states must make reasonable accommodations to place individuals in the community rather than an institution. For state Medicaid long-term care systems, including California’s Medi-Cal program, fulfilling the Court’s mandate, as it turns out, is a lot tougher than tapping a pair of ruby slippers together.

More than a decade after *Olmstead*, many people still mistakenly associate Medi-Cal only with skilled nursing facility subsidies and remain oblivious to its community-based programs. The Patient Protection and Affordable Care Act (PPACA), however, may help make home, rather than an institution, the place for people when they grew old or are disabled. The PPACA expressly invokes *Olmstead*, but the act will not make it any easier for attorneys to help clients into and through the maze of California’s long-term care system. First, counsel need to understand the financial requirements for Medi-Cal eligibility, which may be considered the entry point. The next challenge involves mastery of numerous acronyms representing various Medi-Cal programs that may maximize the client’s eligibility, including those that have the most sought-after component of home care—the payment of caregivers.

The PPACA has a pioneering national long-term care insurance plan, called Community Living Assistance Services and Supports (CLASS). CLASS has enormous implications for home care in California, particularly relating to trusts and families helping the potentially working disabled. Other parts of the PPACA narrowly augment existing programs. Finally, alternative state plans offered by the PPACA can expand state home care systems, but only if adopted by California. Before obtaining CLASS or another program for a client’s home care in California, however, Medi-Cal eligibility must be considered first.

***Home Care under Medi-Cal***

A person who is disabled or age 65 or older can be eligible for Medi-Cal benefits, including those helpful for remaining home, if he or she is categorically linked to Medi-Cal by eligibility to another program, such as Supplemental Security Income (SSI), which has its own eligibility criteria. Other entry points include specified financial requirements for a number of different Medi-Cal programs. Generally, an individual on Medi-Cal must have $2,000 or less in countable resources. The Medi-Cal recipient is then only allowed to keep a specific amount of monthly income, depending upon the Medi-Cal program, with the excess income paid toward a monthly share of cost, comparable to an insurance deductible.

For a number of reasons, however, families of relatively substantial means can also receive Medi-Cal assistance, including home care. First, many resources may not be counted for the determination of Medi-Cal eligibility, because they are considered either exempt (e.g., a single or multifamily home) or unavailable (e.g., an IRA), provided certain criteria are met. Second, real property may be valued at its property tax assessed value, rather than fair market value, minus the property’s encumbrances. In California, the difference between these values can be substantial. Third, while each trust must be examined for certain disqualifying terms, assets held in various categories of trusts are not counted, including a testamentary trust, an irrevocable third-party trust if established with the property of someone other than the Medi-Cal recipient or his or her spouse, and a special needs trust established with the property of a person with a disability 65 years or younger and containing a provision to pay back the state for its expenditures from what remains in the trust upon his or her death or the trust’s termination. Finally, there are rules to prevent the impoverishment of a spouse and, in addition, opportunities to reduce assets by gifts to others, but these matters require special direction by counsel when applied to Medi-Cal for home care.

Practitioners should understand that, generally speaking, community-based Medi-Cal does not allow special protection for spouses. However, there are exceptions for some of California’s so-called home and community based (HCBS) waiver and model programs, which provide home care but may determine financial eligibility for an applicant at home as if he or she were actually in a skilled nursing facility. When there is a spouse in a skilled nursing facility, the other spouse not in a facility can retain property under the community spouse resource allowance (CSRA). The limit in 2010 is $109,560. Before paying a share of cost, the spouse not institutionalized also can either retain income (up to $2,739 in 2010) as a minimum monthly needs allowance (MMMNA) or have income only in his or her own

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*Terry M. Magady is a certified elder law specialist practicing in Los Angeles.*
name disregarded. A spouse’s CSRA and MMMNA can then be adjusted upward through a court or administrative hearing proceeding. Consequently, a married person who would be ineligible for community-based Medi-Cal and related home care without spousal protection may become eligible for home care through a HCBS waiver or model program by using spousal protection.

When expediting Medi-Cal eligibility for home care, counsel should appreciate that, unless someone is categorically eligible for Medi-Cal through SSI (which has its own gifting penalties), for community-based Medi-Cal there are currently no eligibility penalties for gifts. Gifts are useful not only for accelerating eligibility but also for avoiding recovery, since the state, subject to a number of exemptions, has the right to recover its expenditures from the remaining estate of the Medi-Cal recipient upon his or her death. In contrast to community-based Medi-Cal, Medi-Cal for skilled nursing facilities has a monthly ineligibility penalty for each gift, and the formula for applying the penalty will become much more restrictive for planners if California adopts the federally enacted Deficit Reduction Act of 2005 (DRA). For planning purposes, practitioners should also be aware that there are currently some penalty exceptions. These include a gift to a disabled child, a gift of an exempt home, and, at least until California implements the DRA, separate gifts on different days below the amount of the divisor used to calculate the penalty. The timing of gifts is particularly important for home care through an HCBS waiver. For example, an individual may choose not to apply for Medi-Cal until admitted to a hospital or skilled nursing facility. By that time, however, it may be difficult or impossible for the person to make gifts to expedite eligibility if there are no applicable exceptions to the penalties for skilled nursing Medi-Cal. He or she may then miss an opportunity to obtain Medi-Cal eligibility necessary for a waiver to pay for care at home. On the other hand, if prior to admission to an institution that same person had made gifts and obtained community based Medi-Cal, which has no penalties for the gifts, he or she may have been able to obtain the waiver to get home care when leaving the institution. Since an individual either may already be in a skilled nursing facility prior to moving back home or may later need to return to a facility, it is usually prudent for a practitioner to plan as if penalties will apply.

Once a person does qualify for Medi-Cal, there are varied Medi-Cal funded supports in the community, but each one, commonly known by its acronym, has its own criteria for enrollment and generally must be accessed separately. For Medi-Cal beneficiaries residing for a threshold period in a skilled nursing facility, the California Community Transitions program (CCT) funds case management, dwelling modifications, initial setup costs, and assistive technology to transition back home. At Adult Day Health Care Centers (ADHCs), Medi-Cal recipients 18 years and older and at risk for institutional care receive health and social services at a weekday program out of their homes. Medi-Cal’s model Program of All-Inclusive Care for the Elderly (PACE) allows spouse protections and has capitated financing of a package of healthcare services, including home care, in several narrow geographic areas. Coordinated with Medi-Cal, the state-funded Supported Living Services can provide significant case management and in-home attendant care for adults with developmental disabilities. The federally funded veteran’s supplement Aid and Attendance can subsidize at-home caregivers for certain veterans or their surviving spouses.

Waivers

The HCBS waiver programs provide another financial source for in-home care-giving but only for a limited number of persons. Under an HCBS waiver, federal Medicaid requirements are waived so services can have an enrollment cap and need not be offered statewide. The services for each HCBS waiver also must be no more costly than comparable institutional care based upon alternative formulas. There are HCBS waivers for people with a developmental disability (DD waiver) or with HIV or AIDS (AIDS waiver). The multipurpose senior services program (MSSP), an HCBS waiver serving seniors living in certain districts who would otherwise medically qualify for institutional care, chiefly provides case management for home-based care but can offer only minimal attendant care. The assisted living waiver (ALW), available in select counties, has a component that pays for assisted living services from enrolled providers for individuals residing in publicly subsidized housing. In addition to meeting Medi-Cal eligibility criteria, those seeking the ALW must also consider the generally more stringent financial eligibility for federal housing subsidies, which is based upon actual or deemed income. The DD waiver, MSSP, and ALW allow for spouse protections, while the AIDS waiver does not. The HCBS waiver that may provide the best opportunity for financing caregivers is the nursing facility/acute hospital waiver (NF/AH waiver), which provides care at home for Medi-Cal beneficiaries, regardless of age, who require acute, subacute, skilled, or intermediate care. The NF/AH waiver offers services up to the cost of comparable institutional care for the individual and allows for spouse protections. A waiting list for the waiver is typical, and an applicant’s medical conditions must necessitate institutional care when he or she requests placement on the list. Yet one need not be eligible for Medi-Cal in order to be on the list. Critically, however, there may not be any wait if an application for the waiver is made when one is presently in a hospital or a skilled nursing facility, since those in a hospital are given priority, and more slots are generally available for those in a skilled nursing facility. Delaying until an individual goes home can result in a lost opportunity.

The program with the broadest range of potential individuals able to receive in-home care-giving is In-Home Supportive Services (IHSS). A perennial target for state budget cuts, IHSS has three subsets: the Medi-Cal funded Personal Care Services Program (PCSP) and IHSS Plus Option (IPO), and the state’s residual IHSS program. The residual program has its own separate financial criteria comparable to SSI, including eligibility penalties for gifts. The residual program is primarily for those who lack proof of citizenship and have limited residency. PCSP and IPO have no eligibility penalties for gifts. PCSP pays for personal care, paramedical and domestic services, as well as protective supervision. PCSP is currently exempted from estate recovery. IPO pays for PCSP services when the provider is either a spouse or a parent of a minor IHSS recipient (who would otherwise be excluded as a worker under PCSP) or the IHSS recipient is allowed advance pay or restaurant allowances (which are not provided under PCSP).

Once eligible for Medi-Cal or the residual program, the person is assessed for the time necessary to complete needed IHSS tasks and allotted a number of hours each month for those tasks. When protective supervision is authorized to safeguard the applicant due to behavior resulting from cognitive (rather than physical) challenges, the maximum number of IHSS hours may often be allotted. The IHSS recipient can then retain workers of his or her choice at an hourly rate, which varies county by county. Depending upon the collective bargaining agreement between the workers’ union and the particular county’s public authority, considered the employer of record, workers employed a minimum monthly number of hours can also be covered under group health and dental plans. This presents a unique opportunity for the IHSS recipient to benefit an uninsured family member serving as caregiver. Depending upon an individual’s circumstances, IHSS can sometimes only be obtained after an application for a waiver from another Medi-Cal program with more liberal financial standards than a typical community-based
Medi-Cal program. For example, a married applicant over 65 years old and otherwise medically eligible for MSSP can take advantage of MSSP’s spouse protections and strategically apply first for an MSSP waiver and thereafter apply for IHSS. Similarly, a parent of a minor child with a developmental disability can strategically apply for the DD waiver, which disregards the resources and income of parents, and thereafter apply for IHSS, even with a parent as the IHSS worker. For an individual with Social Security Disability Income nullifying any allotment of IHSS hours due to a prohibitively high Medi-Cal share of cost, the person or his or her family can arrange for minimal monthly employment and strategically apply for Medi-Cal’s Working Disabled Program, which provides, sometimes with a premium based on income, Medi-Cal with no share of cost without counting Social Security Disability Income.  

**CLASS**

Overlaying this complicated state system is the most transformative component of the PPACA for home care in California—CLASS, an unprecedented national long-term care insurance program. Scheduled to become effective in 2011, CLASS may not actually be implemented for an additional two years. With amounts set by the Department of Health and Human Services (DHHS) at a level necessary ostensibly to maintain program solvency, premiums will be paid by individuals via payroll deductions. For participating employers, there will be automatic withholding, unless an employee opts out. Other methods of payment will be established for nonparticipating employers and the self-employed. Only minimum monthly premiums of $5, plus consumer price index increases, will be required for an individual whose income does not exceed the federal poverty line or who is under age 22 and actively employed while a full-time student. Critical for people with any actual or potential disabling condition, no underwriting based on preexisting conditions can be used to prevent enrollment or determine the amount of monthly premiums.

For an enrollee to vest in the plan, he or she will need to pay premiums for at least 60 months. For 3 calendar years of those 60 months, however, the enrollee must earn an amount ($1,120 in 2010) that is necessary to be credited with a quarter of Social Security coverage. The DHSS will promulgate exceptions to these minimum earnings requirements for certain populations. The premiums must be paid for at least 24 consecutive months if there is a lapse in payments for more than three months from the beginning of enrollment to the date benefits are determined.

Cash benefits will then be paid for a vested enrollee who is unable to perform a minimum number of activities of daily living without substantial assistance or requires substantial supervision to protect against threats to health and safety due to substantial cognitive impairment (or has similar functional limitations as these two categories of disability). The disability must be expected to last for a continuous period of more than 90 days. The cash payments can be used on a broad variety of assistance determined by the individual, and they will not be subject to any lifetime or aggregate limits. The amount of the benefits will vary based upon measures of disability. However, CLASS projects that no less than $50 per day on average will be paid.

The relationship between CLASS and government benefits will not be counted for most means-tested government benefits, including those in California that are the source of most home care. On the other hand, CLASS beneficiaries receiving Medicaid-financed home and community based services and supports will be allowed to retain only 50 percent of their CLASS payment, with the balance applied to the costs of those services and supports. This is in contrast to Medicaid eligible residents in most institutional settings, where 95 percent of their CLASS payment will be applied to their cost of care.

Most individuals will decide upon enrollment in CLASS or another program in the same manner that they decide upon a private long-term care insurance policy (e.g., based upon the product, current finances, and anticipated need). However, counsel for an individual (or his or her family or trust) with an actual or prospective disabling condition may be able to anticipate additional considerations. For example, employment may be facilitated at a minimal level to help someone with a disability enroll in CLASS. It can help the client to maximize CLASS benefits in order to avoid arcané Medi-Cal restrictions or the recovery against the Medi-Cal recipient's estate upon death. The client or trust may benefit from the flexibility that CLASS offers regarding how available cash may be spent.

This anticipation also applies to trust drafting. Practitioners should ensure that provisions are crafted to be flexible enough to allow payments that help CLASS enrollment and allow for gainful employment. The trust should allow the trustee to pay monthly insurance premiums. In addition, the trustee must be able to hire professionals who can help the beneficiary find, coordinate, and sustain some employment and, if necessary, to provide financing for an appropriate small enterprise. The terms of some trusts for disabled beneficiaries may be overly restrictive for these purposes. For example, a provision could unnecessarily prohibit actions that diminish Medi-Cal benefits. The provision would thereby preclude helping with CLASS enrollment, which may do just that. A trust may also be poorly drafted for CLASS benefits if it denies (or fails to expressly grant) the trustee the authority to invest in or loan to a business of the beneficiary, because the loan or investment could be classified as an imprudent expenditure, then subjecting the trustee to liability.

With respect to trust administration, practitioners will need to examine SSI and Social Security work incentive programs, so that benefits (not only Medi-Cal but also Medicare resulting from Social Security) can be protected, to the extent necessary, while the three-year CLASS earnings goal is met. A person receiving Social Security Disability Insurance (SSDI) benefits can still be considered disabled and keep the benefits, for example, if he or she earns less than $720 per month (with an additional maximum monthly work requirement for those self-employed) or earns in excess of that amount (or, for those self-employed, spends more hours) for nine months within a 60-month period and thereafter less than $1,000 monthly for a consecutive 36 months. Or, an SSI recipient without other income can earn $85 each month, which is not deducted from SSI benefits, and then earn an additional amount, only half of which is counted as income until the earnings equal SSI. Medi-Cal also can be maintained with earnings up to annual threshold amounts for a disabled person under Medi-Cal’s Working Disabled Program or for a former SSI recipient under Section 1619(b) of the Social Security Act. Particulary if a SSDI or SSI recipient comes under a CLASS exception for the Social Security quarter requirement, only the most minimal earned income may be necessary for enrollment. Termination of public benefits due to earnings should thus be relatively easy to avoid within the parameters of these work incentive programs.

In contrast to CLASS, other provisions in the PPACA result in targeted incremental changes to Medi-Cal’s existing in-home programs. Most significantly for planners, commencing January 1, 2014, and continuing for five years, states will be required to include spouse protections in their waiver programs and the new optional state plans for home and community based services and supports offered in the PPACA. California already has spouse protections for most of its HCBS waivers. However, California could adopt one of the PPACA’s optional plans.

If this happens, the expansion of spouse protections may obviate the need to apply for a waiver before applying for other applicable programs for home care. The adoption will also increase program access for married couples who are not otherwise eligible for a waiver.
In addition, federal funding of California’s CCT program will be extended another five years, and the required time in a skilled nursing facility for eligible participants will be reduced from 180 to 90 days, subtracting days covered by Medicare skilled nursing benefits. This will increase the number of potential recipients of Medi-Cal-funded case management that is designed to get people from facilities to home.

Some PPACA programs will result in the expansion of the current state waivers and other in-home care, but only if a state adopts them. Two in particular may become relevant to California. First, the state balancing incentive payments program will provide an enhanced federal Medicaid matching rate to states currently spending less than 50 percent of their total expenditures for long-term care on services in the home or community. The goal is to increase the states’ proportion of long-term care services that are not based on institutions. Whether California qualifies as such a state will depend upon the formula used for the calculation of this percentage, as well as the extent anticipated future state budget cuts diminish home care programs.

To be eligible for participation, however, states must outline a plan to establish a single entry point for access into the state’s system for long-term care, conflict-free case management, and uniform assessment instruments for determining eligibility for noninstitutional services and supports. Implementation of such a plan could initiate changes to the multiple access points and varied assessments currently existing in California.

Second, the community first choice option will give states an enhanced federal matching rate so that the states may provide a more expansive array of community-based attendant supports and services. These include deposits, one month of rent, and utilities to help transition from an institution to the state’s system for long-term care, conflict-free case management, and uniform assessment instruments for determining eligibility for noninstitutional services and supports. Implementation of such a plan could initiate changes to the multiple access points and varied assessments currently existing in California.

While Olmstead and the PPACA may not be as easy to follow as a yellow brick road, attorneys who become familiar with the complex set of government healthcare programs may at least be able to help clients go back home.

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3 42 C.F.R. §435.120.
4 42 C.F.R. §435.1223 (income limits); 42 C.F.R. §416.1205(c) (resource limits).
7 See, e.g., for an individual, maximum countable income of $1,133 under the Medi-Cal Age and Disabled program or $600 under the Medi-Cal Aged, Blind and Disabled-Medically Needy program. See All County Welfare Directors Letters 09-06 (Feb. 18, 2009), 09-08 (Feb. 24, 2009) and 09-08E (Mar. 4, 2009) (hereinafter AC WD Letters), available at http://www.dhcs.ca.gov.
8 Cal. Code Regs. tit. 22, §50425. If California adopts the Deficit Reduction Act of 2003, the value of an exempt home will be limited to $750,000, subject to exceptions. Welf & Ins. Code §14006.15(b).
9 Cal. Code Regs. tit. 22, §50488 (draft). An applicant’s IRA is considered exempt, as distinguished from unavailable, under Medi-Cal’s working disabled program, whether or not distribution has been made. Welf & Ins. Code §14007.9(b)(2).
10 Welf & Ins. Code §14006(e)(1).
15 For more detailed discussion of these and other rules for Medi-Cal skilled nursing benefits, see Terry M. Magady, Guiding Families through the Maze of Medi-Cal Eligibility, Los Angeles Lawyer, Mar. 2001, at 19.
21 Cal. Code Regs. tit. 22, §50411.3 (draft).
22 Welf & Ins. Code §14015.
23 Id.
26 See http://www.dhcs.ca.gov/services/ltc/Pages/CCT.aspx.
28 AC WD Letter No. 97-18 (May 12, 1997).
30 Welf & Ins. Code §§4689.8, 4689.8.05. While its benefits generally are not means tested, a regional center may still be able to look to “possible sources of funding for consumers.” Welf & Ins. Code §4659.
31 38 C.F.R. §§3.350(h), 3.351(b). Veteran’s Aid and Attendance benefits have income and asset thresholds.
32 Welf & Ins. Code §14132.952.
33 See, e.g., 283 or 195 depending upon the IHSS program and whether or not the person is severely impaired. PPACA, tit. II, §2401(k)(1)(B), (C), (D).
34 See PPACA,, tit. X, §10202(a)&(b).
35 PPACA, tit. X, §10202(a) (hereinafter PPACA).
36 See, e.g., annual maximums of $29,548 for an intermediate care facility, $48,180 for a skilled nursing facility, and $180,219 for an adult subacute care facility. Nursing Facility/Acute Hospital Waiver, app. B-2-1.
38 Welf & Ins. Code §14132.95(d)(1)-(2).
39 Department of Social Services California County Letters Nos. 00-35 (May 19, 2000).
40 Welf & Ins. Code §14132.95d(1).
41 Department of Social Services All County Letters Nos. 00-35 (May 19, 2000).
42 Welf & Ins. Code §14132.95d(e).
43 Department of Social Services All County Information Notice No. 1-14-05 (Mar. 21, 2005).
44 Welf. & Ins. Code §10961(c).
45 Welf. & Ins. Code §14132.952.
46 The maximum number of monthly hours is either 283 or 195 depending upon the IHSS program and whether or not the person is severely impaired. See All County Information Notice No. 1-28-06 (Apr. 11, 2006).
49 See http://www.dhcs.ca.gov/services/Pages/TPLRD_WD_cont.aspx.
50 Welf & Ins. Code §14007.9(b)(2).
51 See PPACA, tit. VIII, §§3201-3204(e)(2).
52 PPACA, tit. VIII, §3203(a)(3). The secretary of DHSS has until October 1, 2012, to designate a CLASS benefit plan.
53 PPACA, tit. VIII, §3203(b)(3).
54 PPACA, tit. VIII, §3202(6)(A)(ii).
56 PPACA, tit. VIII, §3202(6)(C).
58 PPACA, tit. VIII, §3203(a)(1)(C).
59 Id.
60 PPACA, tit. VIII, §3205(c).
63 PPACA, tit. VIII, §3203(a)(1)(D)(i).
64 PPACA, tit. VIII, §3205(f).
65 PPACA, tit. VIII, §3203(c)(1)(D)(ii).
66 PPACA, tit. VIII, §3205(c)(1)(B).
67 For further discussion of how people can work and maintain benefits, see http://www.ssa.gov/pubs/10095.html.
68 PPACA, tit. II, §2404.
69 PPACA, tit. II, §2403.
70 Another plan option can significantly expand home care services, but it removes caps, requires statewide application, and allows eligibility for those who would not necessarily be institutionalized. PPACA, tit. II, §2402(b). Because the option results in additional cost without federal financial incentives, it is unlikely to be adopted by California.
71 PPACA, tit. X, §10202(a)(k).
72 Welf. & Ins. Code §10202(a)(5).
73 PPACA, tit. II, §2401(k)(2).
74 PPACA, tit. II, §2401(k)(1)(B), (C), (D).
75 Id.
76 PPACA, tit. II, §2401(k)(1), (k)(3)(B).
Tax Changes in the New Healthcare Laws

IN MARCH 2010, CONGRESS ENACTED TWO PIECES of healthcare legislation: The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act. The new legislation mandates several significant and politically controversial changes to the nation’s healthcare system. Less noticed are the changes the acts make to the Internal Revenue Code. These changes include new taxes, penalties, and provisions aimed at curtailing abuses and raising revenue to pay for the healthcare reforms. Many of these provisions are set to take effect after 2012.

One of the most controversial provisions of the acts is the requirement, beginning in 2014, that individuals purchase essential health-care coverage for themselves and their dependents or be subject to a monthly penalty that must be reported on and paid in connection with their federal income tax returns.1 Such a requirement has never before been imposed on individuals.

The annual penalty is the greater of the flat dollar amount prescribed by law or the amount determined by the percentage-of-income method. The flat dollar amount is the sum of the applicable dollar amounts for each individual who does not have coverage and for whom the taxpayer is required to provide coverage. The applicable flat dollar amount is reduced by half for any month in which the individual is under age 18 at the beginning of the month. The total flat dollar amount for a family cannot exceed three times the applicable flat dollar amount. The statutes provide the annual applicable flat dollar amounts of $95 for 2014, rising to $325 in 2015, and $695 in 2016. Thereafter, the amount will be adjusted for inflation.2

The percentage of income method is a percentage of the excess of household income over the taxpayer’s income filing threshold. In 2014 that percentage will be 1 percent, rising to 2 percent in 2015, and 2.5 percent thereafter.3

The calculation of the penalty is actually not as complicated as it might appear. Consider, for example, a family of six—two parents with four dependents, two of whom are under the age of 18—with a household total income of $55,000 and an income tax filing threshold of $23,900 in 2016. Should this family not carry the required health insurance coverage for the entire year, it will be potentially subject to a flat dollar penalty of $3,375 (four adults at $695 each and two dependents at $347.50 each). However, the total penalty cannot exceed three times the applicable flat dollar amount of $695 per person, which equals $2,085. Thus, based on the flat dollar approach, the family would be subject to a $2,085 penalty.

Under the percentage of income method, the computation would be gross income ($55,000) less the threshold filing amount ($23,900) multiplied by 2.5 percent. The result would be $777.50. Since the penalty is the greater of the two amounts, the family would be subject to the higher amount under the flat dollar method, or $2,085.

The new legislation does provide some exceptions to the imposition of the penalty. The acts exclude those whose income is below the income tax return filing thresholds, those with short lapses of coverage, and those residing outside the United States. The acts also excuse a few very limited classes of individuals from being penalized: 1) undocumented aliens, 2) prisoners, 3) health-care-sharing ministry members, and 4) conscientious objectors to the acceptance of health insurance for religious reasons.4

Individual Tax Provisions

Another controversial aspect of the legislation is an effective increase in payroll taxes. Currently, employees are subject to two taxes on wages under the Federal Insurance Contributions Act (FICA). The first is the Old Age Survivors and Disability Tax (OASDI) of 6.2 percent imposed on an adjusted wage base of up to $106,800 (for 2010). The second tax is the Medicare Hospital Insurance Tax (HI) of 1.45 percent imposed on all wages without a ceiling. Employers match the amount employees pay for both the HI tax and the OASDI tax. Self-employed individuals are subject to both OASDI and HI taxes on self-employment earnings, but at rates equal to twice the regular employee rate—12.4 percent of self-employed earnings up to $106,800 for the OASDI tax and 2.9 percent on all self-employed earnings for the HI tax.

For regular income tax purposes, self-employed individuals are allowed to deduct half of the total self-employment tax in computing their adjusted gross income (AGI).

Under the new legislation and beginning with tax years after December 31, 2012, employees will be subject to the current HI tax of 1.45 percent and an additional .9 percent HI tax on wages that exceed certain threshold amounts—for a total HI tax rate of 2.35 percent. The thresholds are $250,000 of wages on a joint return, $125,000 of wages on a return for married taxpayers filing separately, and $200,000 of wages for other taxpayers. These amounts are not adjusted for inflation.5

To demonstrate this new tax, consider a single individual who earns wages of $400,000. Under current law, this person would owe an HI tax of $5,800 (1.45 percent of $400,000). However, starting in 2013, this person would owe an HI tax of $7,600, consisting of $2,900 on the first $200,000 of wage income (1.45 percent of $200,000) and $4,700 on the wages exceeding $200,000 (2.35 percent of $200,000). Or, consider a married couple that files a joint return and has wages of $225,000 (husband) and $100,000 (wife) for a total of $325,000. Under current law, they would have an HI tax of $4,712.50 (1.45 percent of $325,000). In 2013, their HI tax would total $5,387.50, consisting of $3,625 on the first $250,000 of wage income (1.45 percent of $250,000) and $1,762.50 on the excess wage income of $75,000 (2.35 percent of $75,000).

The taxpayer’s employer is required to withhold the additional .9 percent HI tax on employees with wages exceeding $200,000. The employer is obligated to take into account, for withholding pur-

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poses, the wages received by the employee’s spouse. Thus, in the example of the married couple filing jointly, the husband’s employer would be required to withhold an additional .9 percent HI tax for the amount the husband earned over $200,000, or $25,000. The employer would not be required to account for the wife’s earnings. It should be noted that there is no matching of the HI tax for the employer; the additional .9 percent HI tax is imposed only on the employee.

Under the new legislation, self-employed individuals will also be subject to an additional HI tax. The same threshold self-employment income amounts will apply as do on wage-earning taxpayers—$250,000 of self-employment income for a joint return, $125,000 of self-employment income for a married couple filing a separate return, and $200,000 of self-employment income for all others. The tax rates will be 2.9 percent for the base rate with a rate of 3.8 percent (.9 percent plus the additional .9 percent) applied to income exceeding the threshold.

For example, if in 2013 a single individual has self-employment income of $400,000, that individual would pay a total HI tax of $13,400, comprising HI tax of $5,800 on the first $200,000 of self-employment income (2.9 percent times $200,000) and $7,600 on the excess $200,000 of self-employment income (3.8 percent of $200,000). Under present law, this individual would be subject to HI tax of $11,600 (2.9 percent of $400,000). Should a married couple filing a joint return in 2013 have self-employment income of $225,000 (husband) and $100,000 (wife) for a total of $325,000, the couple would owe a total HI tax of $10,100, consisting of HI tax of $7,250 on the first $250,000 of their combined self-employment income (2.9 percent of $250,000) and $2,850 on the excess $75,000 of self-employment income (3.8 percent of $75,000). Under current law the HI tax would be $9,425 (2.9 percent of $325,000). In addition, self-employed individuals will not be able to deduct the additional .9 percent taxes paid on excess self-employment income from their income tax. They will only be entitled to a deduction for the HI taxes paid at the 2.9 percent rate.7

Under current law, there are no FICA taxes on investment income such as interest, dividends, annuities, royalties, rents, and capital gains. However, with tax years beginning after December 31, 2012, the acts impose a new Medicare contribution tax on unearned income for individuals, estates, and trusts. The new tax is imposed at a rate of 3.8 percent on the lesser of modified adjusted gross income (MAGI) in excess of an applicable threshold amount or net investment income. Net investment income is investment income such as dividends, interest, annuities, rents, royalties, and capital gains, reduced by expenses and deductions properly allocable to that income. MAGI is adjusted gross income increased by net foreign earned income that is otherwise excluded for regular income tax purposes. The threshold amounts are $250,000 for joint returns of married couples, $125,000 for married persons filing separately, and $200,000 for other taxpayers.

For example, consider a married couple filing a joint return in 2013 that has net investment income of $60,000 and MAGI of $240,000. The couple will not be subject to the Medicare contributions tax since their MAGI is less than the threshold amount of $250,000. However, if in 2013 the married couple has net investment income of $60,000 and MAGI of $300,000, the couple would be subject to a Medicare contributions tax liability of $1,900. This is calculated as follows: the excess of MAGI over the threshold amount of $50,000 ($300,000 less $250,000) is compared to net investment income of $60,000, and the lesser amount is subject to a tax at the rate of 3.8 percent, which would be $1,900 (3.8 percent of $50,000).

The Medicare contribution tax of 3.8 percent on net investment income is in addition to the .9 percent HI tax on wages and self-employment income. Thus taxpayers with high wages or self-employment income plus high unearned investment income would be subject to both new taxes.

The new legislation also effectively increases taxes by raising the floor for medical expense deductions. Under current law, an individual who itemizes deductions on Schedule A of Form 1040 can deduct unreimbursed medical expenses after these expenses exceed 7.5 percent of AGI. This includes expenses paid for oneself, a spouse, or dependents. Thus, if an individual has an AGI of $50,000 and medical expenses of $10,000, the individual can deduct $6,250 of these expenses, which is the amount of total medical expenses exceeding 7.5 percent of $50,000 AGI.

The acts increase the floor for the deduction for medical expenses as an itemized deduction to 10 percent of AGI, effective for tax years beginning after 2012. Thus, in 2013, if an individual has an AGI of $50,000 and unreimbursed medical expenses of $10,000, the itemized medical expense deduction is only $5,000—the amount of medical expenses exceeding 10 percent of $50,000.

This increase in the floor for itemized medical expenses will not apply if either the taxpayer or the taxpayer’s spouse turns 65 prior to the end of the year. However, this exception applies only for the four years beginning after December 31, 2012. Effective for the tax years beginning after December 31, 2016, the 10 percent floor will apply to all taxpayers, regardless of age.

Note that the 7.5 percent floor for individuals over the age of 65 will apply during those four years whether or not the taxpayers file jointly or married filing separately. In some cases, however, it can be beneficial for a married couple to file separately to obtain an increased medical expense deduction for one or both spouses.

For taxpayers subject to the alternative minimum tax, current law allows a deduction for medical expenses only to the extent they exceed of 10 percent of AGI. This rule does not change under the new legislation. California state income tax law has not been reformed to the increase to the 10 percent floor for itemized medical expenses.

**Employer Provisions**

The acts also provide penalties for certain large employers who fail to provide their employees with adequate health insurance coverage after 2013. The penalty will be imposed even if employee coverage is offered, but the coverage fails to meet certain standards. A large employer is one with 50 or more employees.

The new laws also provide certain small employers benefits to help pay for the cost of healthcare coverage for their employees. Under current law, an employer can deduct as an ordinary business expense the cost of health insurance for its employees. The employee is not subject to income or payroll taxes on the health insurance coverage provided by the employer. Under the new law, a qualified small employer can also claim a tax credit for the cost of purchasing health insurance for employees. An eligible small employer is one that 1) has no more than 25 full-time equivalent employees for the tax year, 2) the average annual wages of these employees do not exceed $50,000 for years beginning in 2010, 2011, 2012, and 2013, indexed for inflation in later years, and 3) the employer contributes at least 50 percent of the cost of the premiums.

The number of full-time employees is determined by dividing the total number of service hours for which wages were paid by 2080 (52 weeks per year times 40 hours worked). Self-employed individuals (including partners and sole proprietors), S corporation shareholders owning more than 2 percent of the corporation, and shareholders owning more than 5 percent of the employer’s company are excluded from the definition of full-time employees.

Generally the requirement that the employer pay at least 50 percent of the premiums for an employee is satisfied if the employer pays an amount not less than 50 percent of the premium for single coverage of the employee. Thus, if the employee pays a higher amount for coverage (for example, to include a spouse or family), the employer is...
not required to pay at least 50 percent of the cost of the higher coverage.

The amount of the tax credit is equal to the lesser of the amount paid by the employer for qualified health coverage for the year or the amount of contributions the employer would have made if each employee had enrolled in coverage. During the transitional years of 2010 through 2013, the credit is 35 percent of the employer’s nonelective contributions toward the employees’ health insurance premiums. For tax years beginning after December 31, 2013, the credit will increase to 50 percent. The credit phases out as the employer’s firm size and average wage base increase. The employer is entitled to a trade or business deduction for the amount of the employer contribution less the dollar amount of the credit claimed. California tax law does not yet provide for a comparable credit.15

The healthcare legislation also imposes a new excise tax on high-cost, employer-sponsored healthcare coverage—so-called Cadillac plans. Under current law, these plans have not been subject to any taxes. For years beginning after December 31, 2017, the new tax will be imposed on Cadillac plan administrators, certain employers, and insurance companies when the annual value of employer-sponsored health coverage exceeds $10,200 for a single individual and $27,500 for family coverage.16 These amounts are subject to a health-cost adjustment that is based on the actual costs of health coverage between 2010 and 2018 compared to the expected change in healthcare coverage over the same period.

More liberal thresholds apply for coverage of retired individuals who are 55 or older and are not otherwise eligible for Medicare. Larger thresholds are still available to an employer if a majority of its employees participate in high-risk professions, such as law enforcement, ambulance crews, longshore workers, construction, mining, agriculture, forestry, and fishing. The threshold amounts, as adjusted for the healthcare adjustment percentage and the retired and high-risk occupation adjustments, are further indexed to the Consumer Price Index beginning in 2019.

The excise tax rate is 40 percent and will be imposed on coverage providers, including health insurers, employers, and plan administrators. The new excise tax on coverage providers creates an incentive to cap insurance premiums at amounts equal to the thresholds.

The legislation also codifies and clarifies the longstanding judicial economic substance doctrine. Under this doctrine, courts may deny claimed tax benefits of transactions, which, while at least purportedly meeting the technical requirements of the law, lack any economic substance apart from the claimed federal income tax benefits. The basis of the doctrine is the concern that taxpayers under-

take such transactions solely to claim tax benefits that Congress never intended. However, courts have not applied the doctrine uniformly and have used a variety of tests and interpretations when doing so.

The healthcare legislation adds new Internal Revenue Code Section 7701(o), entitled Clarification of the Economic Substance Doctrine. Under this new provision, a transaction will be treated as having economic substance, and therefore respected for federal income tax purposes, only if 1) the transaction changes the taxpayer's economic position in a meaningful way (apart from the federal income tax consequences) and 2) the taxpayer has a substantial non-federal income tax purpose for entering into the transaction. Thus, Congress codified the economic substance doctrine to require both an objective economic change apart from the federal income tax consequences and a subjective non-federal income tax purpose, such as an independent business purpose, for entering into the transaction.

Although the new law clarifies the doctrine itself, existing case law still governs the threshold issue of when the doctrine should be applied to a transaction. The Joint Committee on Taxation stated that this new law does not change the present standards on determining when to use the economic substance analysis.18 It notes that tax benefits should not be disallowed as long as they are consistent with the congressional purpose or plan. For example, the Joint Committee on Taxation addressed the lingering question of whether a transaction that generated substantial tax credits but had little or no potential to generate profits apart from the tax credits would be subject to application of the economic substance doctrine. The joint committee answered that the doctrine is not meant to disallow tax credits as long as the taxpayer is undertaking the type of investment Congress intended to encourage with the credits.

The codification of the economic substance doctrine is intended to raise tax revenue to help pay for the healthcare portions of the new legislation as well as discourage taxpayers from entering into sham transactions for tax benefits only. The normal accuracy-related penalty rate of 20 percent is increased to 40 percent if the taxpayer does not adequately disclose the relevant facts of the transaction on the return or in an attachment to the return.19 There are no exceptions to this penalty, not even for reasonable cause or good faith reliance on a tax opinion. Experts are still debating whether the new law will have its intended consequences.

**Coverage for Dependents under Age 27**

Reflecting the growing tendency of young adults to remain dependent on their parents...
longer, even if they no longer live with their parents, the legislation provides parents and their adult children with certain benefits, effective in 2013, as long as the children are under the age of 27. Under current law, self-employed individuals are allowed to deduct the cost of health insurance for themselves, their spouses, and their dependents. However, they are not allowed to deduct these costs if they, their spouses, or their dependents are covered by a health insurance plan maintained by their employer or their spouse’s employer. Moreover, if an adult child lives apart from the taxpayer and no longer qualifies as a dependent, the taxpayer cannot maintain coverage for the adult child and receive a deduction for the expense.

The new law continues to allow self-employed individuals to deduct these costs for themselves, their spouses, and their dependents, but, in addition, will allow a deduction for any child who has not attained age 27 as of the end of the tax year. Thus, taxpayers are permitted to deduct the health insurance premiums paid for children under the age of 27, regardless of whether they are dependents of the taxpayer for income tax purposes—even though the child is living apart from the taxpayer, is self-supporting, and files his or her own income tax return and claims an exemption for himself or herself on the return.

Similarly, the legislation extends this benefit to employees who maintain a nondependent child on their employer-provided health coverage. Under current law, employees are required to include the value of such coverage in their gross income. The new laws extend the exclusion from gross income to any taxpayer’s child who is under age 27 as of the end of the tax year even if that child does not qualify as a dependent.

**Information Reporting**

Effective in 2012, the healthcare legislation expands the class of payments made for services and property for which reporting is required, most commonly referred to as 1099 reporting. Under current law, taxpayers engaged in a trade or business are generally required to file an information return (usually on Form 1099) for payments aggregating $600 or more in any tax year (although reporting requirements may vary under different circumstances). Payments subject to reporting include fixed and determinable income or compensation and includes such items as salaries, wages, commissions, fees, or other forms of compensation, and interest, rents, royalties, annuities, pensions, and other gains, or profits. These requirements are intended to assist taxpayers in preparing their income tax returns and to help the IRS determine whether the returns are correct and complete. Current law exempts businesses

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from issuing information returns to corporations. The acts make two key changes to Form 1099 reporting: 1) reporting is required not only for services but also for goods, and 2) reporting is required for payments made not only to individuals but also to corporations.

The legislation expands the class of payments for which reporting is required to include gross proceeds paid in consideration for property or services.22 Thus if a company purchases a machine for use in its business for $2,500 from a manufacturing company, the purchasing company will be required to file an information return with the IRS for the $2,500 payment to the manufacturer. Under the new laws, businesses are required to file an information return for all payments aggregating $600 or more in a calendar year to a single payee, including corporations (other than tax-exempt corporations). The current exclusion for corporations relieved a substantial amount of the compliance burden in day-to-day business transactions. This new rule will increase the compliance burden on businesses that routinely make payments to corporate entities or make purchases of property. Thus, in a typical case, if a business purchases $1,000 of office supplies from a supplier in any single year, it will have to issue a Form 1099 or like information return to the supply company.

In addition, the legislation also provides for premium assistance coverage (in the form of tax credits) for low- and middle-income individuals,23 restrictions on reimbursements from flexible spending accounts,24 and employer vouchers to certain employees who do not participate in an employer-sponsored plan.25 While most of these new provisions have adverse consequences for taxpayers, they must be seen in context of the larger goals of the healthcare reform legislation. Only then can one judge whether or not these new provisions are worth their price.

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1 I.R.C. §5000A, added by the Patient Protection and Affordable Care Act §1501(b).
2 I.R.C. §5000A(c)(3), added by the Patient Protection and Affordable Care Act §1501(b).
3 I.R.C. §5000A(c)(2), added by the Patient Protection and Affordable Care Act §1501(b).
4 I.R.C. §5000A(e), added by the Patient Protection and Affordable Care Act §1501(b).
5 I.R.C. §3101(b)(2), added by the Patient Protection and Affordable Care Act §9015(a)(1)(D).
6 I.R.C. §3102(f)(1), added by the Patient Protection and Affordable Care Act §9015(a)(2).
7 I.R.C. §164(f), added by Health Care and Education Reconciliation Act §1402(a)(10).
8 I.R.C. §1411(a), added by Health Care and Education Reconciliation Act §1402(a)(10).
9 I.R.C. §213(a), amended by Patient Protection and Affordable Care Act §9013(a).
10 I.R.C. §213(f), amended by Patient Protection and Affordable Care Act §9013(b).
11 I.R.C. §56(b), amended by Patient Protection and Affordable Care Act §9013(c).
13 I.R.C. §4980H, added by Patient Protection and Affordable Care Act §1513.
14 I.R.C. §45R, added by Patient Protection and Affordable Care Act §1421.
15 FTB Summary, supra note 12, at 21.
16 I.R.C. §4980I, added by Patient Protection and Affordable Care Act §9001.
19 I.R.C. §6662(ii)(1), amended by the Health Care and Education Reconciliation Act §1409.
20 I.R.C. §162(l)(1), amended by the Health Care and Education Reconciliation Act §1004(b).
21 I.R.C. §105(b), amended by the Health Care and Education Reconciliation Act §1004(b)(1).
22 I.R.C. §6041(h), added by Patient Protection and Affordable Care Act §9006.
23 I.R.C. §36B, added by Patient Protection and Affordable Care Act §§1401, 1411, and 1412. No credit is available for California income tax purposes. See FTB Summary, supra note 12, at 11.
24 I.R.C. §125(c)(1), amended by Patient Protection and Affordable Care Act §9005.
25 I.R.C. §139D, added by Patient Protection and Affordable Care Act §10108.
The new healthcare reimbursement provisions are designed to offset the cost of expanding healthcare insurance coverage.

Media attention has largely and understandably focused on the insurance provisions of the recent healthcare reform legislation but mostly ignored the provisions that directly affect reimbursement to healthcare providers through Medicare and Medicaid. However, the reimbursement provisions in the Patient Protection and Affordable Care Act (PPACA)1 ultimately may have a greater and more long-lasting impact on the healthcare system.

If the PPACA’s insurance-related provisions have the intended effect of expanding the availability of insurance coverage to a larger number of patients, providers seemingly have the potential to realize positive financial effects from the resulting increase in patients with insurance. Nevertheless, the reimbursement provisions of the PPACA are structured to create government savings that offset the expenditures required to support the expansion of health insurance programs. As a result, the majority of the PPACA’s reimbursement provisions reduce, or have the potential to reduce, payments to providers of healthcare services.

These provisions are expected to save the government more than $300 billion over 10 years and affect all types of providers, from physicians to hospitals to nursing homes.2 Healthcare organizations are likely to consider significant consolidation and realignment as they look for new ways to achieve the cost savings and quality improvements necessary to compete in the PPACA reimbursement environment.

The general approach of the PPACA reimbursement provisions is to reward high-quality, efficient care. While some provisions may actually result in increased reimbursement, the ultimate goal of minimizing the overall cost of the healthcare system cannot be achieved without a reduction in reimbursement. Avoiding or mitigating some of these reductions is within the control of those healthcare providers that prepare for the impact of the PPACA’s reimbursement provisions.

Attorneys who work with providers should become familiar with the reimbursement provisions, understand their likely effect, and develop strategies for reducing their negative implications. While many of the new measures do not take effect for several years,
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inadequately prepared providers could face substantial reductions in government reimbursement when that time comes.

Pilot Programs

One clear focus of the PPACA is to move reimbursement models away from those that encourage providers to deliver services in isolation from one another and toward those that reward collaboration and coordination of patient care among providers. Although the PPACA does not create any new incentive payment systems for coordinating care among types of providers, it authorizes several pilot programs that may lead to new payment system models.

The PPACA creates the Medicare Shared Savings Program (SSP), under which the U.S. Department of Health and Human Services (HHS) is required to establish a pilot program to test payments to accountable care organizations (ACOs). ACOs are groups of providers that join together to improve efficiency and quality while capturing and distributing cost savings among participants.4 Although some ACOs were formed and began to operate before the PPACA, prior law significantly restricted the ability of providers to form ACOs by limiting joint negotiations and sharing of payments necessary for ACOs to succeed. The PPACA reduces these barriers and encourages the establishment of ACOs by creating SSP payments to promote accountability for a patient population and coordinate inpatient and outpatient care.

To participate in the SSP, each ACO must accept accountability for the quality, cost, and overall care of at least 5,000 assigned Medicare beneficiaries and participate in the SSP for at least three years. The fact that the Congressional Budget Office (CBO) has estimated that the SSP will save the government almost $5 billion over the next 10 years suggests that there is significant risk that this model will result in a reduction in reimbursement—both during the demonstration period and, if healthcare providers are subsequently mandated to form ACOs, across the Medicare program.4

The PPACA also encourages coordination among multiple providers with a new national pilot program to evaluate the quality improvements and cost savings that may be achieved by making a single payment to all the providers that deliver services to a patient during a period of care for a specific illness or condition.5 Under the payment bundling program, HHS is required to establish a program to pay for integrated care during an episode of care that begins 3 days prior to a hospitalization and ends 30 days after discharge.

This approach is significantly different from the current reimbursement system’s payment to separate providers of care before, during, and after an individual is hospitalized. For example, if a patient suffers a broken hip, the current system pays separately for the care provided by the patient’s physician, the hospital stay, and posthospitalization rehabilitation care. Under a bundled payment program, a single payment might be made at a preestablished rate to cover all care associated with the broken hip. The payment would then be shared among the physician, hospital, and nursing home.

The pilot program—beginning January 1, 2013—will initially focus on up to eight medical conditions selected by HHS using criteria set forth in the PPACA.6 Although this provision is not expected to result in any reductions in reimbursement during the term of the pilot program, the clear implication is that payment bundling in the manner of the program has the potential to do so. This is because of perceived unnecessary spending resulting from the current lack of incentive to coordinate care among providers.

The PPACA establishes a new Center for Medicare and Medicaid Innovation (CMI) for testing innovative payment and services delivery models intended to reduce program expenditures and preserve or enhance quality of care.7 Scheduled to open its doors by January 1, 2011, the CMI is authorized to test various new methods beyond those for which the PPACA explicitly creates pilot programs. These include 1) systemic changes to reimbursement methods, such as replacing the current fee-for-service compensation system with comprehensive risk-based or salary-based compensation and reimbursements paid to deliver care to groups of patients in specific geographic areas, and 2) service-specific models, including those that adhere to guidelines on medical imaging, medication therapy management, and geriatric assessments and care plans. The CMI’s authority is limited to implementing demonstration programs. However, practitioners should alert their healthcare provider clients to begin working now with their advocacy organizations to ensure that their interests are represented by identifying appropriate individuals for nomination to the IPAB. In addition, to prepare for potential reimbursement reductions, healthcare providers and their counsel should monitor the Medicare per capita growth rate and its effect on year-to-year changes in the IPAB’s authority to make payment reductions.

Provider-Specific Provisions

The reimbursement provision of the PPACA that is anticipated to save the government the most money—and result in a correspondingly large reimbursement reduction to providers—is the implementation of productivity and inflation adjustments to payments for virtually all entities reimbursed for services by Medicare.11 This provision alone is expected to save more than $156 billion over 10 years.12

Under current law, Medicare payments are updated yearly to account for inflation. Beginning with payments made in October 2010 or January 2011, depending on the type of provider, the PPACA institutes an annual productivity adjustment to the yearly update, which will likely result in overall lower payments. This provision of the PPACA also requires specific reductions in the inflation adjustments for certain types of
prising that the bulk of savings and payment cuts fall on hospitals. Although the CBO estimates that the various spending cuts to hospitals will save well over $100 billion over the next 10 years, there are some payment improvements for hospitals as well. Specifically, the PPACA will reward “highly efficient” hospitals with approximately $400 million in additional payments during FYs 2011 and 2012. Because the PPACA defines efficiency as low per-beneficiary Medicare spending, the hospitals most likely to benefit will be those in more sparsely populated states in the South, Northwest, and Midwest, which have low numbers of high-cost, chronically ill Medicare beneficiaries.

Based on the proposed methodology for identifying hospitals eligible for the additional payments, six hospitals in California counties (Humboldt, Yolo, and Placer) would be eligible to receive payments totaling $2.18 million in additional payments during FYs 2011 and 2012. Because this provision provides additional funding to reward the efficient hospitals, noneligible California hospitals will not be penalized by this provision. However, advocates for California hospitals should review the proposed formula for determining eligibility and pay close attention to the implementation of this provision to ensure that counties and hospitals that are legitimately eligible are not excluded.

Another significant reimbursement change affecting hospitals involves inpatient payments to most acute care hospitals. These payments will reflect a “value-based payment adjustments in later years, but for FY 2013, the program must include measures that address acute myocardial infarction, heart failure, pneumonia, surgery, and health-care-associated infections. In FY 2014, HHS must add measures related to efficiency, including Medicare spending per beneficiary.

Similar to this provision and its focus on payment based on quality outcomes, beginning in October 2011 the PPACA will reduce payments to hospitals based on the percentage of preventable readmissions according to three specified conditions, which will be expanded to seven by October 2014. Also beginning in October 2014 is a 1 percent reduction in payments to hospitals in the top quartile for hospital-acquired infections.

The PPACA makes significant changes to the reimbursement calculation methodology for supplemental payments made to Medicare Disproportionate Share Hospitals (DSHs), as total DSH payments are expected to be reduced by $22.1 billion between FY 2015 and FY 2019. Supplemental payments to DSH hospitals were originally intended to compensate hospitals for higher costs associated with treating low-income patients. However, in more recent years DSH payments have become a way to reimburse hospitals for costs related to uncompensated care. Beginning in FY 2014, the PPACA reduces DSH payments to 25 percent of current levels while adding a payment based partially on the remaining burden of uncompensated care. This provision will not take effect until October 2013, but current DSH hospitals should be aware of the forthcoming change. The new payments will shift DSH payments toward hospitals with higher volumes of uncompensated care, so DSH hospitals that have not already established systems for accurately tracking and documenting the volume of uncompensated care they provide should do so.

In addition to the provisions applicable to all hospitals, several provisions of the PPACA are directed specifically at teaching hospitals. In general, these provisions seek to increase the total number of physicians practicing in primary care specialties and, in particular, the number of primary care physicians practicing in geographic areas that currently face a shortage of these physicians. Although hospitals are permitted to offer as many residency positions as they want, the Medicare program generally only provides Direct Graduate Medical Education (GME) and Indirect Medical Education (IME) payments based on hospital-specific caps on the number of reimbursable slots. Therefore, the PPACA seeks to increase the number of primary care physicians by increasing the residency program slots available to these specialties.

One way the PPACA aims to address this goal is to redistribute some of the historically unused slots to primary care physicians. Effective July 1, 2011, residency programs that had unused slots prior to the passage of the PPACA will have their residency caps reduced by 65 percent. Residency programs at rural hospitals with fewer than 250 beds, certain hospitals already participating in residency cap reduction programs, and the Martin Luther King Jr. replacement facility in Los Angeles are exempt from these reductions. The unused slots will be redistributed to programs located in rural areas and in states that have either resident-to-population ratios
in the lowest quartile or one of the 10 highest populations living in a federally designated Health Professional Shortage Area (HPSA). California is not projected to be one of the states eligible for the redistributed residency slots. Therefore, nonrural hospitals in California may lose residency slots but will not have an opportunity to gain slots.

The PPACA includes only a few changes that directly affect Medicare-certified Ambulatory Surgery Centers (ASCs), but these changes may foreshadow greater reimbursement changes in the future. As with hospitals, ASCs will be subject to adjustment based on productivity gains in the general economy.22 Productivity adjustments for ASCs will take effect beginning January 1, 2011. Unlike hospitals, ASCs are not immediately subject to a value-based purchasing program. However, by January 1, 2011, HHS must develop, and submit to Congress for approval, a plan for implementing such a program for ASCs.23 Although there is no guarantee that Congress will act to implement the plan, ASCs should be prepared for performance-based payments in the near future.

Although the PPACA includes extensive and far-reaching provisions to address concerns regarding the quality of care in nursing homes and skilled nursing facilities (SNFs), as with ASCs, the reimbursement provisions are not as dramatic as those affecting hospitals.24 In fact, several of the short-term reimbursement changes relating to SNFs will actually have a positive financial impact. SNFs will receive their full update to account for inflation in 2010 and 2011, and the PPACA delays the implementation of a new reimbursement methodology for SNFs—the Resource Utilization Group (RUG)-IV payment system—for all services other than certain therapy services until October 2011, at the earliest.25 The RUG-IV changes were previously scheduled to take effect in October 2010 and were expected to result in a net payment reduction for SNFs in FY 2011.26 However, SNFs will be subject to a productivity adjustment beginning in 2012 that could result in reduced reimbursements.27 In addition, HHS is required to submit to Congress a plan for implementing a value-based purchasing plan for SNFs by October 1, 2011.28

**Physician Reimbursements**

The most significant issue facing physician reimbursement in recent years has been the effect of the sustainable growth rate (SGR) adjustment. The SGR adjustment is intended to ensure that physician payments do not increase more quickly than a target spending rate. However, because application of the SGR adjustments to physician reimbursements would have resulted in a significant reduction, Congress has postponed application of the SGR adjustments for each of the last 12 years. Because of the manner in which the government accounts for spending related to the delayed application of the SGR adjustment, repealing the SGR adjustment would create an estimated $210 billion cost to the government. Although some suspected that repeal of the SGR adjustment would finally occur with the passage of the PPACA, the substantial cost of doing so prevented its inclusion in the legislation. Instead, the PPACA contains very few physician-specific provisions—and those that were included generally do not reduce overall spending for physician services.

One important physician-related change implemented by the PPACA is the creation of a new value-based payment system for physician services that will be phased in over the next five years. This payment system requires that HHS establish a “modifier” to be added to patient bills that indicates the relative quality and cost of care provided by the physician or physician group.29 HHS’s determination of comparative quality will take into account risk-adjusted measures, including those related to health outcomes. The cost measure will be based on expenditures per individual and adjusted to take into account geographic variations in payment rates, demographic characteristics, and health status. The specific measures will be available by January 1, 2012. The payment adjustment will be implemented for some physicians and physician groups by January 2015 and for all physicians and groups by January 2017. The PPACA extends the current physician quality reporting initiative through 2014. By 2012, the PPACA will require HHS to track resource use by physicians and provide physicians with reports that allow them to compare their practices with others.30 The provisions of the PPACA with the most immediate impact on physicians are revisions to the geographic practice cost indices (GPCIs). The GPCIs adjust physician payment rates based on the cost of operating a physician practice by geographic area.31 For the past several years, Congress has established an artificial floor on the GPCIs to adjust for the amount of time and skill a physician must use in providing services (known as the “work” GPCI) so that no locality would receive an adjusted GPCI multiplier of less than one. The PPACA extends this protection through the end of 2010.32 The same section of the PPACA revises the methodology for calculation of the GPCI to adjust for the cost of physician office overhead (known as the “practice expense” GPCI) so that all areas with practice expense GPCIs of less than one will also receive a payment increase for 2010 and 2011. No areas of California will receive payment increases under this provision. However, because Congress chose to implement these provisions with additional funding, California physicians will not suffer a reimbursement reduction to offset the increases.

Some California physicians and other practitioners may be eligible for a 10 percent payment enhancement for providing certain primary care and surgery services. For five years, beginning in 2011, physicians in family medicine, internal medicine, geriatric medicine, and pediatrics—as well as nurse practitioners, clinical nurse specialists, and physician assistants—will be eligible to receive an additional 10 percent payment for specified evaluation and management services performed as office visits, nursing facility visits, or home visits if at least 60 percent of the services furnished by the physician or practitioner involve the specified services.33 During this same period, general surgeons performing certain surgical procedures in designated HPSAs will also be eligible for a 10 percent payment enhancement.34 Over 140 census tracts in Los Angeles County appear to qualify for this payment enhancement.35

Apart from the potential for reductions due to the value-based modifier, the overall outlook for physician reimbursement is less dire than for other providers. However, physicians may experience some cuts either by participating in multiprovider demonstration programs or as a result of the future implementation of programs by the CMI or the IPAB. As with other providers, physicians will need assistance from their attorneys to understand, prepare for, and help shape these reimbursement changes.

**Life Sciences**

The health reform legislation offers many opportunities for life science companies. The greater number of individuals who will have coverage as a result of the PPACA’s insurance provisions will also have access to drugs and biological products as well. However, the cost containment programs and reimbursement reductions affecting all providers under the PPACA are likely to create pressure for price cuts and other cost and utilization controls.

To receive payment for pharmaceuticals dispensed to Medicaid program enrollees, manufacturers must offer significant discounts to the state. Prior to the PPACA, the required rebates ranged from 11 percent of the Average Manufacturer Price (AMP) for generic drugs to 15.1 percent of the AMP for name-brand drugs. The PPACA increases these rebates for drugs purchased on or after January 1, 2010, to 13 percent for generic drugs and 23.1 percent for brand name drugs except for blood-clotting factors and pediatric outpatient drugs, which are increased to 17.1
percent. The PPACA permits states to increase the amount they reimburse for Medicaid-covered drugs and removes prohibitions on coverage for certain classes of drugs, but these options are unlikely to offset the reimbursement reductions.

Participation in the Medicaid program also requires that pharmaceutical manufacturers offer rebates at the Medicaid rate to facilities that serve a large percentage of low-income and uninsured patients. These facilities participate in what is known as the 340B program. The PPACA expands eligibility for participation in the 340B program to certain children’s hospitals, cancer hospitals, and rural hospitals that were previously excluded from the program despite serving volumes of low-income and uninsured patients equal to those served by facilities that could participate in the program.

While the expansion of the program to additional facilities is likely to expand access to pharmaceuticals and increase sales volumes, it will also require additional rebates on the drugs sold to these individuals. In light of recent litigation regarding the proper application of Medicare and 340B rebates, attorneys need to be prepared to assist their pharmaceutical manufacturer clients participating in the Medicaid rebate and 340B program in determining when the rebates apply and in implementing processes that track and audit program compliance.

While the PPACA offers opportunities for additional funds to flow to some healthcare providers, most are likely to experience an overall reduction in reimbursement, both immediately and in the coming years. Healthcare attorneys should begin now to help their clients prepare to navigate these payment reforms. The PPACA will be strong medicine for many healthcare providers. Nevertheless, these providers can thrive in a rapidly changing reimbursement environment with the assistance of informed counsel.
whether a condition has significant variation in the number of readmissions and the amount of expenditure for postacute care spending under the Medicare program, 5) whether a condition is high volume and has high postacute care expenditures under the Medicare program, and 6) whether the conditions are most amenable to bundling across the spectrum of care, with regard to practice patterns under the Medicare program.

Note 2, at tbl. 2.

PPACA, Pub. L. No. 111-148, §§3401, as modified by §10309. Payment reductions will be based on readmissions for heart attack, heart failure, and pneumonia in 2011, with chronic obstructive pulmonary disease, coronary artery bypass grafts, percutaneous transluminal coronary angioplasty, and other vascular issues to be added in October 2014.

Letter to Nancy Pelosi, supra note 2, at tbl. 5.


Letter to Nancy Pelosi, supra note 2, at tbl. 5.

PPACA, Pub. L. No. 111-148, §3401, as modified by §10319 and HCERA, Pub. L. No. 111-152, §1105. “Primary care residences” are defined as residences in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice.

PPACA, Pub. L. No. 111-148, §§3401, as modified by §§7101-7103, as modified by HCERA, Pub. L. No. 111-152, §1041; Letter to Nancy Pelosi, supra note 2, at tbl. 2.


PPACA, Pub. L. No. 111-148, §3401, requires additional disclosures of facility-specific financial and ownership information for SNFs and Medicaid nursing facilities (NFs) when requested by various state and federal officials. Moreover, §6101 requires that this information be made public following the development of a standard reporting format. §6103 requires that information about staffing turnover as well as state surveys and certifications be made available via the Nursing Home Compare Web site. §6105 requires that HHS develop a standard complaint form for use by facility residents making complaints to state authorities. It also mandates each state to develop a process for resolving complaints. §6106 requires that within 2 years of enactment of the PPACA, facilities must submit audit-ready data on staffing levels, turnover, and resident census data.


The GPCIs were established to allow for different payments in higher- and lower-cost areas with an average of 1. For example, the GPCIs for Los Angeles are above 1, while the GPCIs for Fort Worth, Texas, are below 1. PPACA, Pub. L. No. 111-148, §§3401, 3025, 3026.


The Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA) provide for the expansion of healthcare coverage for approximately 32 million currently uninsured Americans. How will this vast new entitlement, and steadily rising Medicare and Medicaid costs generally, be financed? Most of the focus in the popular media has been on new and increased taxes and cuts to payments to providers and suppliers. But the third leg of the health reform financing stool will be vigorous enforcement of current and new laws designed to prevent, root out, and punish illegal conduct that adds to Medicare and Medicaid program costs.

The Federal Bureau of Investigation and the National Health Care Anti-Fraud Association estimate that 3 to 10 percent of our national healthcare spending is lost to fraud and abuse. With healthcare spending at $2.5 trillion in 2009 and growing, it is estimated that $75 to $250 billion is lost each year to fraud and abuse. These losses dwarf the highly successful enforcement efforts by the U.S. Department of Justice (DOJ) and U.S. Department of Health and Human Services (HHS). The most recent DOJ/HHS Health Care Fraud and Abuse Control Program Report states that in fiscal 2009 alone, antifraud efforts resulted in recoveries of $2.51 billion for the Medicare Trust Fund and $441 million of federal Medicaid expenditures. Attorneys should note that much of the money was recovered from large, and presumably well-represented, pharmaceutical companies and hospitals. But physicians and other smaller industry players have also been frequent targets for enforcement actions.

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The government hopes to reduce fraud and waste in healthcare by substantially strengthening compliance provisions.

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According to Attorney General Eric Holder and HHS Secretary Kathleen Sebelius, the healthcare reform law will give the DOJ and HHS important new tools to “fight fraud, strengthen consumer rights and protect taxpayer dollars.” Enforcement officials will also have more money to back their efforts. The healthcare reform law provides for an additional $350 million over the next 10 years for the DOJ/HHS Health Care Fraud and Abuse Control Program and the Medicare Integrity Program.

While many key provisions of healthcare reform do not take effect for several years, most of the new enforcement tools are available immediately. These can be roughly divided into three sometimes overlapping categories: 1) Amendments to the Stark Law, 2) Strengthened fraud and abuse rules, and 3) Program integrity and transparency.

The Stark Law—named after its original author, California Congressman Fortney “Pete” Stark—prohibits a physician (or an immediate family member of the physician) from making a referral for the furnishing of Medicare-covered “designated health services” (DHS) if the physician (or an immediate family member) has a financial relationship (through ownership, investment, or a compensation arrangement) with the entity that is the recipient of the referral. DHS includes clinical laboratory services, physical therapy, radiology services, durable medical equipment, outpatient prescription drugs, and hospital inpatient and outpatient services. The Stark Law also prohibits the entity from billing for DHS furnished pursuant to a Stark-prohibited referral—unless an exception applies. Exceptions are potentially available for a variety of qualifying financial relationships, including in-office ancillary services, publicly traded securities, rental of office space and equipment, bona fide employment relationships, personal service arrangements, and fair market value compensation.

The penalties for violating the Stark Law include the refunding of amounts paid by Medicare pursuant to prohibited referrals, civil monetary penalties (CMP) of $15,000 for each service for which a claim was submitted in knowing violation of the Stark Law, up to three times the amount claimed pursuant to a prohibited referral, CMP of $100,000 for “circumvention schemes,” and exclusion from the Medicare and Medicaid programs.

Further, if an entity knowingly submits a claim pursuant to a Stark Law prohibited referral, the submission can lead to a violation of the False Claims Act (FCA) and substantial per claim civil penalties plus treble damages.

Unlike the Medicare-Medicaid antikickback statute, the Stark Law is a civil statute and therefore does not require that the government prove criminal intent. While it is, in theory, easier to prove a violation of the Stark Law, in practice—perhaps due to the complexity of the Stark Law and its implementing regulations—federal prosecutors have focused on simpler cases, such as physicians who refer patients to hospitals who pay them an above fair market value amount for medical director services or charge a below fair market value amount for renting office space.

Changes to the Stark Law

The healthcare reform law makes three important changes to the Stark Law. The first change is to the “in-office ancillary services” (IOAS) exception to the Stark Law. Assuming its requirements are met, the IOAS exception permits physicians who have a financial relationship with their own medical group to make referrals to the group for the furnishing of DHS and permits the group to bill for the DHS.

Section 6003 of the PPACA adds two new requirements in order to qualify for the IOAS exception with respect to magnetic resonance imaging (MRI), computed tomography (CT), and positron emission tomography (PET) services provided to Medicare patients. The referring physician 1) must inform the patient, in writing, at the time of the referral that the patient may obtain these services from someone else, and 2) provide the patient with a written list of suppliers who furnish the service in the area in which the patient resides.

“Suppliers” include other medical groups and independent diagnostic testing facilities, but not hospitals.

HHS has the authority to apply the notice requirements to other DHS in addition to MRIs, CT, and PET.

By its terms, Section 6003 of the PPACA applies to services furnished after January 1, 2010. Given that the PPACA was not signed by President Obama until March 23, 2010, this creates a legal impossibility with respect to services rendered before March 23, 2010.

The Centers for Medicare and Medicaid Services (CMS) has resolved this anomaly in its proposed 2011 Medicare Physician Fee Schedule (MPFS) by providing that the new disclosure requirements do not go into effect until the CMS issues its final regulations. The proposed 2011 MPFS anticipates that the effective date of the new disclosure requirements will be January 1, 2011, and further provides that the disclosure notice to the patient must include a list of at least 10 other suppliers located within a 25-mile radius of the physician’s office location. If there are fewer than 10 suppliers within a 25-mile radius, then all those suppliers must be listed.

Further, the proposed 2011 MPFS requires the list to include each supplier’s name, address, telephone number, and distance from the physician’s office location. Finally, under the proposed 2011 MPFS, a record of the patient’s signature on the disclosure notice must be maintained in the patient’s medical record.

While the new law applies only to services involving Medicare patients, California Business and Professions Code Section 650.01(f) has long required referring physicians to disclose their “financial interest in their own practices and groups to the patient, or the parent or legal guardian of the patient, in writing, at the time of the referral or request for consultation.” Section 650.01(f) applies to all payers, not just Medicare, and covers in-office referrals for all diagnostic imaging services, physical therapy, lab services, and other covered services. Counsel should alert their physician clients of their continuing obligation to comply with this California disclosure requirement.

The second change to the Stark Law apparently ends the long-running debate about the future of physician-owned hospitals. Section 6001 of the PPACA amends the Stark Law to prohibit physicians from referring their Medicare patients to hospitals in which they have an ownership or investment interest unless the hospital has in place both the physician ownership and a Medicare provider agreement by December 31, 2010. Further, hospitals that meet those requirements (with limited exceptions for those with patient populations that contain a high proportion of Medicaid recipients) will not be able to increase the number of operating rooms, procedure rooms, or beds beyond what they are licensed for as of the latter of March 23, 2010, or the date of their provider agreement. In addition, currently qualifying hospitals will not be able to increase the percentage of the total value of the ownership or investment interests held by physicians beyond the percentage held by the physicians as of March 23, 2010.

The third change to the Stark Law is a welcome one. Section 6409 of the PPACA provides that by September 23, 2010, HHS must establish a protocol that enables providers and suppliers to disclose an actual or potential violation of the Stark Law.

Further, HHS is authorized to reduce the amount due for those Stark Law violations that are disclosed, based on factors such as the nature and extent of the violation, the timeliness of the self-disclosure, and the cooperation in providing additional information related to the disclosure. Previously, the CMS had stated that it did not have authority to reduce the penalties for self-disclosed Stark Law violations, giving providers little incentive to make such disclosures voluntarily. Nevertheless, depending upon how
The Centers for Medicare and Medicaid Services (CMS) has always had the authority to reduce Stark Law penalties for providers who voluntarily disclose possible violations. True. False.

Violations of the Stark Law prohibition on physician referrals applies to: A. All services paid for by Medicare. B. All services covered by private insurance. C. A and B. D. Only “designated health services” covered by Medicare. False.

A Stark Law violation requires the government to prove criminal intent. True. False.

Amendments to the Stark Law will severely restrict physicians who are not already investors in hospitals from becoming owners of hospitals to which the physicians refer Medicare patients. True. False.

The Stark Law prohibition on physician referrals applies to: A. All services paid for by Medicare. B. All services covered by private insurance. C. A and B. D. Only “designated health services” covered by Medicare. False.

The federal government wants to shift its healthcare enforcement emphasis from “pay and chase” to fraud prevention. True. False.

The CMS considers durable medical equipment (DME) and home health services to be low-risk areas for fraud and abuse. True. False.

Under the PPACA, a physician seeking Medicare payments must have a face-to-face or “telehealth” encounter with his or her patient before ordering DME or certifying the patient’s need for home health services. True. False.

The PPACA expands the Recovery Audit Contractor (RAC) audit program to include: A. Medicare Part C. B. Medicare Part D. C. Medicaid. D. All of the above. False.

Manufacturers of drugs and devices covered under Medicare and Medicaid will not be required to report transfers of value to physicians and teaching hospitals until March 31, 2013. True. False.

The U.S. Department of Health and Human Services (HHS) can require a compliance program only for providers who have entered into a corporate integrity agreement with the Office of Inspector General. True. False.

The PPACA gives HHS authority to suspend Medicare payments to providers only after an investigation of possible fraud has been completed. True. False.
Perhaps the most important goal that the federal government hopes to achieve with its new enforcement tools is to nip potential fraud and abuse in the bud. The DOJ and HHS believe that the healthcare reform law “will help shift the emphasis from the old model of ‘pay and chase’ to a new model that puts a premium on fraud prevention and program integrity.”

Amending Fraud and Abuse Laws
The PPACA makes several important changes to the Medicare-Medicaid antikickback statute and other fraud and abuse laws. The antikickback statute makes it a crime to offer, pay, solicit, or receive any form of remuneration to induce referrals for the furnishing, or arranging for furnishing, of goods, items, or services covered by Medicare, Medicaid, and other federal healthcare programs or to induce a person to purchase, lease, or order those goods, items, or services. Violators can be punished by fines of up to $25,000, imprisonment for up to five years, or both, and be excluded from participating in federal healthcare programs.

Section 6402 of the PPACA modifies the antikickback statute by adding that “with respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.” This change appears intended to eliminate the defense that providers in the Ninth Circuit were able to make under Hanlester Network v. Shalala, which required the government to prove that the person specifically believed the challenged conduct was illegal under the statute. Section 6402 further amends the antikickback statute to provide that claims for items or services resulting from a violation of the statute also constitute false claims for purposes of the False Claims Act, thus subjecting violators to the FCA’s substantial per claim civil penalties and treble damages.

Section 6402 of the PPACA now requires Medicare and Medicaid overpayments to be reported in writing (including the reason for the overpayment) and refunded within the later of 60 days of being “identified,” or after the date any corresponding cost report was due (if applicable). The retention of identified overpayments after the 60-day period constitutes an “obligation” under the FCA, thus exposing violators to penalties under the FCA. Exactly when an overpayment has been identified is not specifically stated and presumably will be clarified in implementing regulations. The 60-day period for making a report and repaying the overpayment is short, so clients should inform the original source of the information upon which the claim is based.

Moreover, the definition of “original source” has been modified. Previously, to qualify as an original source, the relator was required to have direct and independent knowledge of the information upon which the claim was based. Under the new law it is sufficient if, prior to a public disclosure, the relator has either voluntarily disclosed to the government the information upon which the claim is based or the relator “has knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and...has voluntarily provided the information to the Government before filing” his or her qui tam action. Thus, a relator can now qualify as an original source even if his or her claim is based upon second-hand information. Most observers believe these changes will increase the number of qui tam lawsuits that will be brought.

Program Integrity and Transparency
Perhaps the most important goal that the federal government hopes to achieve with its new enforcement tools is to nip potential fraud and abuse in the bud. The DOJ and HHS believe that the healthcare reform law “will help shift the emphasis from the old model of ‘pay and chase’ to a new model that puts a premium on fraud prevention and program integrity.”

Rightly or wrongly, durable medical equipment (DME) and home health have been identified as high-risk areas for fraud and abuse. Section 6405 of the PPACA provides that beginning July 2010, DME and home health services for Medicare patients can be ordered or certified only by a physician or other appropriate professional who is a Medicare provider. Section 6405 also authorizes HHS to extend these requirements to all other Medicare-covered items and services. In addition, Section 6406 provides for disenrollment from Medicare for up to one year if...
a physician or supplier fails to maintain, and upon the request of HHS provide documentation relating to, written orders or requests for payment for DME, certifications for home health services, and referrals for other items or services by the physician or supplier.36

Further, as a condition of payment by Medicare, Section 6407 requires that a physician ordering DME or certifying the need for home health services must have had a face-to-face encounter with the patient (though the doctor and patient also can meet via “telehealth” technology) before the order or certification.37 In the case of DME, the face-to-face encounter can also be performed by certain other designated healthcare professionals, including a physician assistant or nurse practitioner.38 Finally, Section 6407 authorizes HHS to extend the face-to-face encounter requirement to other Medicare-covered items and services.

Section 6411 of the PPACA provides that by the end of 2010, the Recovery Audit Contractor (RAC) audit program will be expanded to include Medicare Part C (the Medicare Advantage program) and Part D (the prescription drug benefit)39 as well as Medicaid.40 RACs are paid, in part, based upon a percentage of the amounts they recover. There have been many complaints that past RAC audits of hospitals and physicians have intentionally overstated the amount of improper claims in order to increase the percentage-based bounty for the RACs.

Section 6002 of the PPACA seeks to mandate greater transparency in the financial relationships between manufacturers of drugs and devices and physicians. Beginning March 31, 2013, and annually thereafter, manufacturers of a covered (by Medicare or Medicaid) drug, device, or biological or medical supply must report to HHS any payments or other transfers of value to a physician or teaching hospital.41 Substantial CMPs may be imposed for failing to make the required reports.42 Transfers of value basically include anything with a value over $10 or $100 in the aggregate for the calendar year, subject to an inflation adjustment.43 In addition, Section 6002 requires that manufacturers and group purchasing organizations (GPOs) that purchase, arrange for the purchase, or negotiate the purchase of a covered drug, device, or biological or medical supply must also report ownership or investment interests held by physicians and their immediate family members in the manufacturers and GPOs.44 This requirement does not apply to ownership or investment interests in publicly traded companies. Beginning September 30, 2013, HHS will make these reports available to the public through a searchable Web site.45

Section 6401 of the PPACA, which takes effect 180 days after the new law’s enactment, authorizes HHS and the Office of Inspector General of HHS (OIG) to establish procedures to screen providers and suppliers to the Medicare, Medicaid, and CHIP programs.46 The goal is to prevent fraudulent enrollment of providers and suppliers in these federal programs. The screening procedures must include a licensure check47 and may also involve fingerprinting and unannounced site visits.48 HHS also may require that providers and suppliers, as a condition of enrollment in the Medicare program, establish a compliance program that contains “core elements” applicable to a particular industry sector or category.49 HHS will designate these elements. Prior to the passage of the PPACA, mandatory compliance programs usually applied only when a supplier or provider entered into a corporate integrity agreement with the OIG.

Section 6408 of the PPACA provides for enhanced civil monetary penalties for making or using false records or statements material to a claim for payment under Medicare, Medicaid, and other federal healthcare programs. These enhanced penalties also apply to those who fail to grant the OIG timely access for audits, investigations, or evaluations.50 The new penalties are up to $50,000 for each false record or statement, and up to $15,000 for each day that timely access is not provided.51

Pursuant to Section 6402 of the PPACA, HHS has the authority to suspend Medicare and Medicaid payments to providers and suppliers pending an investigation of a credible allegation of fraud, unless HHS determines that good cause exists for not suspending the payments.52 Thus, under the PPACA, those suspected of fraud can have their Medicare and Medicaid payments suspended before having the opportunity to respond to allegations.

With the passage of the PPACA and the HCERA, the federal government will be focusing more intensely than ever before on preventing, uncovering, and punishing not only intentional fraud and abuse but also the failure to comply with new provisions for program integrity. The government will have a substantially enhanced set of enforcement tools and funds—and be under enormous budgetary pressure—to vigorously pursue fraud and abuse. Given the potentially ruinous penalties for even technical non-compliance, healthcare providers and suppliers will need sophisticated and pragmatic legal advice to navigate this new compliance minefield.

1 Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-14, §111; and the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152.


7 A “circumvention scheme” is defined as “an arrangement or scheme (such as a cross-referral arrangement) which the physician or entity knows or should know has a principal purpose of assuring referrals by the physician to a particular entity which, if the physician directly made referrals to such entity, would be in violation of the Stark Law. 42 U.S.C. §1395nn(f)(4).

8 Social Security Act §1877(g), 42 U.S.C. §1395nn(g).

9 31 U.S.C. §§3729-3733

10 42 C.F.R. §§411.350 et seq.


13 42 C.F.R. §411.355(b).


15 Social Security Act §1861(d).


17 75 Fed. Reg. 40,142 (July 13, 2010).


19 75 Fed. Reg. 40,142 (July 13, 2010).

20 Id.


22 Id.

23 Id.


25 42 U.S.C. §§1320a-7a(a), 1320a-7b(b)(1) & (2).

26 Hanlester Network, v. Shalala, 51 F. 3d 1390 (9th Cir. 1995).

27 42 U.S.C. §1320a-7(b).

28 Social Security Act §1128(d), 42 U.S.C. §§11301 et seq.

29 Id.

30 Id.

31 42 U.S.C. §1320a-7a(a)(6).


34 See News Release, supra note 4.

35 42 U.S.C. §§1395m(a)(11)(B), 1395m(a)(2).

36 42 U.S.C. §1395u(b)(1).


41 42 U.S.C. §1320a-7a(a)(1)(A).

42 42 U.S.C. §1320a-7g(b).

43 42 U.S.C. §1320a-7g(a)(10).

44 42 U.S.C. §1320a-7g(a)(2).

45 42 U.S.C. §1320a-7g(c)(1)(C).

46 42 U.S.C. §1395cc(g), 1396a(a).

47 42 U.S.C. §1395cc(i).

48 Id.


50 42 U.S.C. §1320a-7a(a)(8), (9).

51 Id.

52 42 U.S.C. §§1395y, 1396b(i)(2).
One of the key objectives of the Patient Protection and Affordability Act of 2010 (PPACA) is to reduce healthcare costs while improving the quality of care. Whether the new healthcare reform law will actually achieve this objective is the billion-dollar question. Inside the PPACA’s bag of tricks is the Shared Savings Program, which authorizes the formation and recognition of accountable care organizations (ACOs). ACOs will be eligible to participate in certain shared savings with Medicare.

The model for the PPACA’s ACO program came to the attention of Congress in June 2009, when the Medicare Payment Advisory Commission (MedPac), an independent agency that advises Congress on issues affecting the Medicare program, recommended ACOs as an option for reforming Medicare’s healthcare delivery system. The ACO model contemplates the assignment of Medicare beneficiaries to groups of providers, which use efficient medical management to render necessary care at a lower cost than under the current Medicare system. Doing so will create savings that can be shared between the government and the ACOs. However, unlike managed care models, ACOs cannot require Medicare beneficiaries to only use certain providers. Rather, ACOs must obtain savings through efficiency and recommendations to their patients. Indeed, the patients might not even know that their providers participate in an ACO.

Although the Shared Savings Program is not expected to be implemented until January 1, 2012, the prospect of ACOs already has triggered a flurry of new activity in the area of provider integration and affiliation. These actions are being driven by the PPACA’s requirement that ACOs possess the capacity...
to provide a specified level of primary care and an established infrastructure to ensure the quality of that care.

The development of ACOs may lead not only to savings but also to new trends in litigation involving healthcare providers. The litigation may arise over physician exclusion or participation, antitrust issues, managed care rules under California’s Knox-Keene Health Care Service Plan Act or the Insurance Code, and tort liability. At the same time, the underlying goal of ACOs to achieve financial savings will encourage providers to spend less and recommend more economical healthcare choices to their patients. Thus, many of the same incentive issues that arise in malpractice cases in the managed care context also are likely to occur with ACOs.

Moreover, disputes may emerge among providers in ACOs over a variety of matters, including how shared savings bonuses from Medicare are allocated among the group. These conflicts may be particularly pronounced regarding providers who choose to enter or leave a group, since the bonuses from Medicare likely will arrive one or more years after the periods in which the savings are realized. However, the prospect of large bonus payments from the Medicare program can and probably will overcome these potential difficulties.

An ACO is a group of providers and suppliers with a shared governance structure who have agreed to be accountable for the cost and quality of overall care for the Medicare fee-for-service beneficiaries assigned to the group. If the ACO is able to achieve both quality and cost targets, it will receive a bonus from the Medicare program, which may be allocated among its participating physicians and other providers. In theory, the bonuses will be substantial enough to overcome the existing incentives under the Medicare fee-for-service system to increase utilization, thereby resulting in a slower growth in Medicare spending. The PPACA also allows the Department of Health and Human Services (HHS) to establish other payment models, including making payments on a partially capitated basis, to provide further incentives for the adoption of ACOs.

Under the PPACA, the groups of providers that are eligible to participate as ACOs include:

- Professionals in group practice arrangements.
- Networks of individual practices of professionals.
- Partnerships or joint venture arrangements between hospitals and professionals.
- Hospitals employing professionals.
- Other groups of providers that HHS determines appropriate.

This list of eligible providers may cause changes in the relationships of healthcare providers. It demonstrates the law’s apparent goal to encourage individual and small physician groups to consolidate, network, or affiliate. Due to the current California prohibition against the corporate practice of medicine, most hospitals in the state, absent a change of state law, likely would have to form partnerships or joint venture arrangements with physicians and other professionals to be eligible to participate as ACOs.

Some providers are better positioned to take advantage of the ACO initiative. Hospitals that already have established strong partnerships or joint ventures with their physicians, particularly if those arrangements have mechanisms for controlling excessive utilization, may be best positioned to become ACOs. Large capitated medical groups also may have an advantage, because these groups have experience operating under a managed care delivery system. Capitated medical groups will be entitled to participate because the new law expressly contemplates “networks of individual practices.”

Physician groups also may seek to expand the scope of their practices in response to the new law. For example, dedicated specialist groups that do not have primary care capability may find it desirable to acquire or affiliate with primary care groups to become eligible to participate as ACOs.

Requirements for Participation
An ACO must meet a number of requirements to participate in the program. It must have at least 5,000 Medicare beneficiaries assigned to it as well as a sufficient number of primary care professionals for these fee-for-service beneficiaries. Accordingly, the participation of primary care providers is an essential element of an ACO. The statute specifies that Medicare beneficiaries be assigned to an ACO based on their utilization of specified primary care services. Even though patients will be assigned to an ACO, they will be able to choose their physician— even from outside the ACO. In fact, nothing in the statute requires patients to be notified that they have been assigned to an ACO. So a person can be assigned to an ACO but never utilize its services. The ACO must have a leadership and management structure that includes clinical and administrative systems. Additionally, the ACO must define the processes it will implement to encourage evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of “telehealth” (visits with patients via telecommunications), remote patient monitoring, and other similar technologies. The ACO also must demonstrate that it meets patient-centered criteria specified by HHS, such as the use of patient and caregiver assessments or individualized care plans.

If an ACO meets these requirements, it may apply for an agreement with HHS to participate in the program for not less than a three-year period. HHS has sole discretion in determining whether or not to enter into a contract with the applying ACO. If a contract is executed, the ACO is subject to substantial reporting requirements, particularly regarding quality-of-care measures.

Providers who participate in an ACO will continue to be paid for their services under the Medicare fee-for-service program in the same manner they did before becoming an ACO. But the participating provider also can receive an allocated portion of a bonus if the ACO meets quality performance standards and achieves shared savings under its contract with the Medicare program. An ACO is eligible to receive the bonus for shared savings only if the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries, adjusted for beneficiary characteristics, is at least the percent specified by HHS below an applicable benchmark. The benchmark is set for a three-year period for each ACO by using the most recent available three years of per-beneficiary expenditures for Medicare fee-for-service beneficiaries assigned to the ACO. If the ACO is able to achieve savings to the Medicare program under this calculation, a percent of the savings will be shared with the ACO. The PPACA does not specify what percent of the savings will be shared with the ACO and leaves this entirely up to the discretion of HHS.

An effective ACO may be able to achieve significant savings during the initial three-year contract period, since the benchmark against which the savings are measured is the three-year period prior to the implementation of the clinical protocols. However, it may be more difficult to achieve further savings during the next three-year period. The benchmark is reset at the start of each agreement period, so the second three-year contract would measure savings against a lower benchmark. As currently structured, there will be little incentive after the first three-year agreement for providers to continue as an ACO if they cannot reduce costs any further. However, HHS may decide to tweak the program by creating new incentives to induce ACOs to continue with it.

To thwart participants who may try to game the system, the PPACA also grants HHS discretion to impose appropriate sanctions against an ACO that has taken steps to avoid high-risk patients to reduce the likelihood of increasing costs. ACOs must realize their savings by adopting appropriate health protocols,
practices, and policies rather than cherry-picking low-risk patients and refusing to see high-risk patients.

Another mechanism for addressing the long-term efficacy of ACOs is through partial capitation. In particular, the PPACA authorizes HHS to use partial capitation payments or any other method “that the Secretary determines will improve the quality and efficiency of items and services provided.”24 HHS also has the discretion to limit the partial capitation model to ACOs that are highly integrated systems of care as well as capable of assuming risk.25

**Fraud and Abuse Laws**

Structuring an ACO and distributing bonus payments among providers present difficult legal issues. ACOs that are successful enough to earn incentive bonuses or that receive partial capitation must find a mechanism to distribute the bonuses or partial capitation to participating providers in a manner that provides incentives for qualifying behavior but at the same time does not violate federal and state laws relating to patient referrals. Three key bodies of law are implicated by these payment arrangements:

- The federal Medicare-Medicaid anti-kickback statute26 and state anti-kickback statutes.27
- Federal and state self-referral laws, such as the federal Stark Law28 and the California Physician Ownership and Referral Act (PORA).29
- The federal Civil Monetary Penalties (CMP) statute,30 which prohibits payments by hospitals to physicians to reduce or limit care.

The Office of Inspector General at HHS (OIG) has issued substantial guidance regarding how the federal antikickback laws and the CMP statute may be implicated in efforts to reduce hospital costs. Some “gainsharing”31 programs—similar in spirit to the incentive payments that will be made to ACOs—have been allowed under the existing laws. The OIG initially took a very negative position on gainsharing in 1999.32 Nevertheless, beginning in 2001, the OIG through its process of issuing advisory opinions has opened a narrow window of approval for gainsharing plans.33 The OIG’s guidance with respect to gainsharing arrangements between hospitals and physicians indicates that these arrangements are not per se prohibited but do implicate the CMP statute and the antikickback laws. As a result, counsel for providers must analyze the facts and circumstances of each arrangement.

In contrast, the OIG has offered little guidance regarding how gainsharing programs operate with federal self-referral laws, such as the Stark Law, or PORA. The Stark Law generally prohibits physician referrals for “designated health services”34 to an entity with which the physician has a direct or indirect financial relationship if those services may be reimbursed by Medicare.35 It contains no express exception for gainsharing or incentive payment programs, and no guidance from the Centers for Medicare and Medicaid Services (CMS) has been forthcoming to explain under what conditions these programs can successfully operate without violating the Stark Law. Therefore, any shared savings program must be structured so that it fits within existing Stark exceptions—even though doing so may limit the ability of an ACO to recognize specific providers for their contributions to cost savings and higher quality care.

Similarly, neither the OIG nor other officials have offered significant guidance on how the state antikickback statute would be applied in the ACO context. However, with substantial similarities between the federal and California antikickback laws, state providers and their counsel should consider adopting many of the safeguards identified in the OIG’s gainsharing opinions.

Congress recognized that an ACO program necessarily implicates the federal anti-kickback law, the Stark Law, and CMP laws. As a result, the PPACA gives authority to HHS to waive any or all of these statutes for the purpose of implementing the ACO program.36 Whether HHS will use this authority to grant blanket waivers for all ACOs, establish regulations permitting limited waivers if certain conditions are met, or waive these laws only on a case-by-case basis, is not clear.

Providers and their counsel should note the dueling policy issues implicated by antikickback laws, which are concerned about overutilization, and the CMP statute, which addresses underutilization. The result is that ACOs, like all providers, must deliver exactly the right amount of care, no more and no less, to navigate between these two areas of concern.

The method that an ACO uses to select participating physicians will be an important consideration in determining whether it is operating within legal parameters. California courts have developed a body of
Still, courts in future cases may find that Potvin does not apply to ACOs. They may do so for a variety of reasons, including, for example, the fact that the number of Medicare patients in an ACO in a particular area may not be sufficient to prevent a provider from practicing his or her profession. Additionally, a court may find that the PPACA’s ACO provisions reflect a congressional desire to preempt contrary state law, including Potvin.

Antitrust Issues

ACOs also potentially raise issues under the antitrust laws. This is because ACOs may include among their members individuals and entities-affiliating under various alternative models. These affiliations may lead to allegations that the ACOs are monopolizing physician markets with or without the participation of hospitals and other providers. In addition, ACOs could become involved in scenarios that may raise the specter of antitrust liability.

The Sherman Act generally prohibits contracts, combinations, and conspiracies that restrain trade, and it also prohibits monopolization and attempts or conspiracies to monopolize. The Clayton Act prohibits joint ventures or consolidations that may substantially lessen competition or tend to create a monopoly. The Federal Trade Commission Act prohibits any “unfair methods of competition,” including not only violations of the Sherman and Clayton Acts but also other restraints of trade. The federal antitrust laws are enforced by the Federal Trade Commission (FTC) and the Department of Justice (DOJ), although there are technical differences in their enforcement powers. California has its own comparable antitrust law, the Cartwright Act, which includes provisions very similar to parts of the Sherman and Clayton Acts.

In 1996, the DOJ and the FTC issued their joint Statements of Enforcement Policy in Health Care, in which they analyzed certain common activities in the healthcare field under federal antitrust law. The statements included one addressing physician joint ventures and another discussing multiprovider networks. These two provide guidance on the view of the DOJ and FTC regarding the affiliation and operation of certain physician organizations and multiprovider organizations that may be applicable to ACOs. The statements identified key areas under which a physician joint venture could qualify for “safety zone” protection. To avoid characterization of joint sales as price fixing, the joint venture participants must either share substantial financial risk or be sufficiently clinically integrated. The DOJ and the FTC justify the safety zone based on their view that joint ventures provide efficiencies that are likely to benefit consumers.

The FTC also has issued a number of advisory opinions that have further illuminated the discussion in the joint statements. In particular, the FTC has given more guidance on what constitutes clinical integration. In 2007, the FTC issued an advisory opinion to the Greater Rochester Independent Practice Association, Inc., concerning a proposal under which GRIPA would negotiate contracts, including price terms, with payers on behalf of its physician members. The FTC approved of the GRIPA program, noting that GRIPA was sufficiently clinically integrated to justify joint sales of physician services.

Whether these advisories will be found applicable to particular ACOs is unclear. However, courts may find that the creation of ACOs by Congress indicates the desire to exempt these specific entities from some or all of the general federal antitrust standards. Similarly, the new ACO concept could be deemed to reflect a congressional desire to preempt the field regarding any contrary state laws, including state antitrust rules. Moreover, California has enacted a number of statutes meant to encourage what may be considered an analogous restrictive provider group—namely, the preferred provider organization. These laws protect not only insurers but also groups of providers who join together to contract with insurers. At least one court has found that these laws exempted a group of providers from antitrust laws when the providers combined for the purpose of entering into an exclusive arrangement with a healthcare insurer.

Tax-Exempt Entities

Hospitals that are organized as tax-exempt entities under Internal Revenue Code Section 501(c)(3) should be careful about the distribution of incentive payments among participating providers. If the entity that receives a bonus payment—such as a hospital or a medical foundation—is a tax-exempt entity, it will be subject to the IRS prohibitions against inurement and private benefit. At a minimum, these prohibitions require that payments to nonexempt entities, including physicians, be based on fair market value. Determining fair market value for a bonus distribution from an ACO may be a difficult proposition when the physicians are being rewarded for controlling or reducing utilization, not necessarily for providing services.

The IRS has provided some guidance for similar arrangements, including an Information Letter issued in 2002 regarding a CMS demonstration program for bundled payments to hospitals and staff physicians. The IRS determined that tax-exempt hospitals were not prohibited from making incentive payments to physicians. Further, the IRS...
provided a list of relevant factors that must be considered in determining whether an arrangement has violated the private inurement or private benefit doctrines.56

ACOs and their counsel may find more IRS guidance for tax-exempt entities in the manner in which the IRS previously treated physician-hospital joint ventures. The typical ACO arrangement involving a tax-exempt hospital and its affiliated physicians would fit within the IRS’s broad definition of joint venture. The governance and operational controls in the organizing documents of the entity or in the contractual arrangement for a contractual joint venture will be the most important elements for properly structuring a joint venture to protect a hospital’s tax-exempt status and to guard against intermediate sanctions being levied against the hospital. A tax-exempt hospital will also need to consider whether the formation of an ACO will result in unrelated business income.57

Given that an ACO will be responsible for the cost of care of Medicare patients assigned to it, and will influence, if not directly control, the volume and type of services provided to its assigned beneficiaries, it could be liable in the event of an adverse patient outcome. For example, if a patient did not receive a diagnostic test that could have detected a serious ailment, the patient’s lawyer likely will claim that this inaction was due to the ACO’s financial incentive program, which had the effect of denying necessary care. These types of claims have become fairly common in the context of commercial managed care. Managed care plans often compensate primary care physicians and other providers through fixed payment systems, such as capitation. As a result, the providers have a strong financial incentive to provide as little care to the members as possible.

To address this potential liability, counsel should advise providers to form the ACO as a separate legal entity with limited liability, such as a limited liability corporation or partnership. Even though an ACO formed in this way may still be found liable, the reach of the liability most likely would not extend to the individual participants, except for those directly involved in an inappropriate treatment decision. Nonetheless, ACOs should purchase liability insurance.

Whether ACOs will be successful or universally adopted remains a question. What is certain, however, is that fundamental change in the healthcare delivery program is necessary if Medicare costs are to be constrained. Consequently, if ACOs are not initially successful in containing costs, Congress will no doubt amend the law regarding the structure of ACOs.

If ACOs are successful, similar programs are bound to be adopted by commercial
health plans and perhaps the Medi-Cal program. ACOs that have successfully negotiated a contract with the Medicare program will be well positioned to contract with private payors. In time, ACOs may become major players in the healthcare market—establishing standards for clinical care, influencing the referral of patients, and controlling the distribution of healthcare dollars. If ACOs become more dominant, primary care physicians, who will be an essential part of any ACO network, may assume a more important role in the delivery system. Specialists may find the marketplace more competitive as pressure intensifies to decrease the utilization of specialty services and costs.

Of course, no one can truly predict what scenarios will materialize. They will depend on a variety of factors, including whether the ACO model fulfills the expectations of Congress, the regulations adopted by HHS for the implementation of the program, and the amount of the bonuses ultimately provided by the Medicare program.

2 PPACA §§3022 and 10307 call for the addition of a new §1899 to Title XVIII of the Social Security Act (to be codified at 42 U.S.C. §1395jjj).
4 Knox-Keene Health Care Service Plan Act, HEALTH & SAFETY CODE §§1340 et seq.
7 Social Security Act §1899(b)(1).
8 Business and Professions Code §2400 provides, in pertinent part, that “corporations and other artificial legal entities shall have no professional rights, privileges or powers.”
9 Social Security Act §1899(b)(2)(D).
10 Social Security Act §1899(c).
12 Social Security Act §1899(b)(2)(H).
13 Social Security Act §1899(b)(2)(B).
15 Social Security Act §1899(d)(1)(A).
16 Social Security Act §1899(d)(1)(A).
17 Id.
20 Social Security Act §1899(d)(2).
21 Id.
22 Social Security Act §1899(d)(3).
23 Social Security Act §1899(d)(2).
24 Social Security Act §1899(d)(3); see also Social Security Act §1899(d)(2)(A).
26 42 U.S.C. §1320a-7b(b).
27 See, e.g., BUS. & PROF. CODE §650; WELF. & INST. CODE §14107.2.
29 Physician Ownership and Referral Act, BUS. & PROF. CODE §§650.01, 650.02.
30 Civil Monetary Penalties (CMP) statute, 42 U.S.C. §1320a-7(a)(5).
31 “Gainsharing” refers to programs that encourage

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32 Department of Health and Human Services, Office of the Inspector General (OIG), Special Advisory Bulletin, Gainsharing Arrangements and CMPs for Hospital Payments to Physicians to Reduce or Limit Services to Beneficiaries (July 1999).

33 See OIG Advisory Opinion 01-01 (Jan. 11, 2001); OIG Advisory Opinion 07-21 (Dec. 28, 2007).

34 See 42 U.S.C. §1395nn(h)(6). These include clinical laboratory services, radiology services, physical therapy services, occupational therapy services, durable medical equipment and supplies, prosthetic devices and supplies, outpatient prescription drugs, and inpatient and outpatient hospital services.


36 Social Security Act §1899(f).


38 Id. at 1071.

39 See MedPac 2009 Report, supra note 3. MedPac noted, “The ACO bonus structure would create incentives for building systems, and systems would come with enhanced market power.” Id. at 55-56. Further, MedPac explained, “One danger is that physician groups consolidate into larger entities and use this negotiating power to increase prices charged to private insurers. There would need to be some protections for the privately insured patients when their insurers negotiate with large, dominant integrated providers.” Id. at 56.


44 Bus. & Prof. Code §§16700-16770.


46 Id.

47 Id.


49 Id.

50 Ins. Code §10133 (allowing an insurer to contract with any provider to become a preferred provider); Health & Safety Code §1373.9 (requiring an insurer to consider other providers wishing to become preferred providers only if the insurer’s existing preferred providers do not adequately serve the relevant geographic area).

51 The California Legislature enacted three virtually identical statutes stating the intent “that the formation of groups and combinations of providers and purchasing groups for the purpose of creating efficient-sized contracting units be recognized as the creation of a new product within the health care marketplace, and be subject, therefore, only to those antitrust prohibitions applicable to the conduct of other presumptively legitimate enterprises.” See Bus. & Prof. Code §16770 (g); Ins. Code §10133.6; Health & Safety Code §1342.6.

52 Lori Rubenstein Physical Therapy, Inc. v. PTPN, Inc., 148 Cal. App. 4th 1130 (2007) (affirming demurrer to excluded physical therapist’s antitrust complaint against Blue Cross and its exclusive physical therapy provider on grounds that California Legislature expressly authorized preferred provider organizations).

53 I.R.C. §501(c)(3).


56 Id.

57 Treas. Reg. §1.513-1.
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Minor’s Counsel in 2010

ON FRIDAY AND SATURDAY, OCTOBER 15 AND 16, the Los Angeles County Bar Association will host a minor’s counsel training program. Attendance will provide the necessary MCLE hours to meet the educational and training requirements of Rule 5.242 of the California Rules of Court. Those who are new to the minor’s counsel arena will need to attend Friday and Saturday. Those who have already completed the 12-hour program will need to attend Friday afternoon (after the lunch break) and Saturday.

Speakers will include Marjorie S. Steinberg (supervising judge of the Family Law Departments), Commissioner Michael J. Convey, Judge Scott M. Gordon, Judge Thomas Trent Lewis, Commissioner Steff Padilla, and several prominent attorneys. This program will cover the law, practice pointers from the bench, child interview techniques, important security considerations, and what minor’s counsel can do in high-conflict cases.

The program will take place at the Los Angeles County Bar Association, 1055 West 7th Street, 27th floor, Downtown. Parking is available at 1055 West 7th and nearby parking lots. On-site registration will begin at 8 A.M. on Friday, with the program beginning at 8:30 on Friday and 8 on Saturday. The program ends at 4:30 P.M. on both days. The registration code number is 011011. The prices below include meals and are for those who have not completed the previous 12 hours of the minor’s counsel program.

$305—CLE+PLUS member
$395—nonprofit attorneys
$400—Small and Solo Division, Family Law Section member
$495—LACBA member
$725—all others
12 CLE hours

The Marijuana Ballot Measure and What It Means for Real Estate Lawyers

On Tuesday, October 26, the Real Property Section and the Land Use Planning and Environmental Subsection will present a program on the current state of the law on city authority to regulate marijuana distribution facilities. The presenters will highlight issues of importance to real estate attorneys handling landlord/tenant, liability, and regulatory compliance issues related to dispensaries. Speaker Jeffrey Dunn was the lead attorney in the two California Court of Appeal decisions establishing municipal land use authority to regulate marijuana distribution facilities, and speaker Asha Greenberg leads the efforts of the city of Los Angeles to regulate and close illegal marijuana dispensaries.

The program will take place at the Los Angeles County Bar Association, 1055 West 7th Street, 27th floor, Downtown. Parking is available at 1055 West 7th and nearby parking lots. On-site registration will begin at noon, with the program continuing from 12:30 to 1:30 P.M. The registration code number is 011040. The prices below include the meal.

$20—CLE+PLUS member
$45—Real Property Section member
$55—Other LACBA members
$65—all others
1 CLE hour

The Future of Big Law

On Thursday, October 7, the Association will host the Corporate Law Departments, Litigation, and Business and Corporations Law Sections in a panel discussion about how the recent economic turmoil and a host of other market forces are affecting large law firms. The panel—Jerry Coben, Stuart A. Forsyth, Rex S. Heinke, John Page, Fram Virjee—includes large law firm partners, general counsel, and experts in the industry. They will address some of the challenges facing large law firms now. Topics will include alternative billing arrangements, pressures on the firm structure, outsourcing, and the need to balance quality with efficiency.

The program will take place at the Los Angeles County Bar Association, 1055 West 7th Street, 27th floor, Downtown. Parking is available at 1055 West 7th and nearby parking lots. On-site registration will begin at 5:30 P.M., with the program continuing from 6 to 7:30. The registration code number is 010933. The prices below include the meal.

$25—CLE+PLUS member
$55—LACBA member
$85—all others
1.5 CLE hour
Can Judges Fix American Healthcare?

WHILE MOST ADVANCED COUNTRIES have a single-payer healthcare system with guaranteed care, American hospitals negotiate with many private insurance companies. As a result, the cost of a procedure can vary widely based on which insurance company pays for it. Hospitals are required to make their basic charges available to the public, but these prices usually bear no relationship to what insurance companies negotiate. The California Court of Appeal for the Fourth District recently issued a pair of decisions on whether this system is fair to the uninsured. One case holds, in effect, that an uninsured patient may be entitled to be treated as if he or she were insured. The other case does not. Both cases involve the same hospital.

In recent years, a host of lawsuits have made the claim that it is unfair for hospitals to charge their uninsured patients more for services and procedures than what insurance companies pay. Nearly all of these cases have failed. A judge in New York who heard such a case reasoned that plaintiffs were seeking a political solution in a judicial forum: “Plaintiffs here have lost their way; they need to consult a map or a compass or a Constitution because Plaintiffs have come to the judicial branch for relief that may only be granted by the legislative branch.”

In the two California decisions involving the same hospital, the facts are similar, but an allegation concerning the patient's “expectation” is all that was needed to permit one of the cases to proceed beyond the pleadings. In Durell v. Sharp Healthcare,2 the court affirmed the sustaining of a demurrer to a claim that it is unfair for a hospital to charge an uninsured patient more than what an insured patient pays. On the same day, in Hale v. Sharp Healthcare,3 the same panel partially reversed the same trial court's sustaining of a demurrer. In both cases, an uninsured patient sought healthcare and signed an admission form promising to pay the “customary charge” or “regular rates.” In both cases the patient filed a class action under California’s unfair competition law.

Pleading for Fairness

The court concluded that Durell failed to plead “actual reliance.” But in Hale, the court deemed that there had been reliance that was based on a claimed expectation: “The [complaint] alleges...at the time of signing the contract, she was expecting to be charged “regular rates.””4 The court offered no factual basis to explain why this expectation was reasonable.

The hospital argued that the patient could not have relied on the admission agreement before coming to the hospital. But the court theorized, “It is possible, however, for a person who has arrived at the hospital to rely on the Admission Agreement in deciding whether to proceed with treatment.”5 Based on the “expectation” and an assumption about what was “possible,” Hale concludes that the unfair competition claim was adequately pleaded.

Hale endorses talismanic pleading, in which charmed words—such as “expecting”—suffice to allege the required elements. The Hale court also misunderstood that these suits are not about fraud. The actual beef of uninsured plaintiffs is not that they were misled but that they were charged more than what insurers negotiated. No one can believe that had the plaintiffs been handed the price list as they entered the hospital they would have turned around and left. These cases are not about truthful advertising; they are about a medical insurance system that plaintiffs think is substantively unfair.

It is. Not even Senator Mitch McConnell thinks the American health insurance system is equitable. But should airlines be forbidden to charge passengers different prices and stores not be permitted to offer discounts?

If Hale must be charged the same as someone who has paid insurance premiums, why pay the premiums? Under Hale, anyone who “expected” to pay less than what he or she was billed can require a hospital to treat persons who are not similarly situated as if they were. As the judge in the New York case pointed out, the reform of complex social policies is a matter for democracy, not the courts. Hale disregards precedent that cautions courts not to tread beyond their authority and expertise.6

One wishes to help uninsured patients caught between sickness and financial ruin. But Hale upends a system that, however flawed, supports millions of insurance agreements, each of which defines and protects expectations far more justified—and bargained for—than the “expectancy” pleaded by Hale. Hale is an anomaly that promulgates a superficial rule for pleading reliance and fails to recognize the limits of judicial competence.

4 Id. at 1385 (italics in original).
5 Id. at 1386.

Bruce G. Iwasaki is a business litigation partner at Lim, Ruger & Kim in Los Angeles.
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