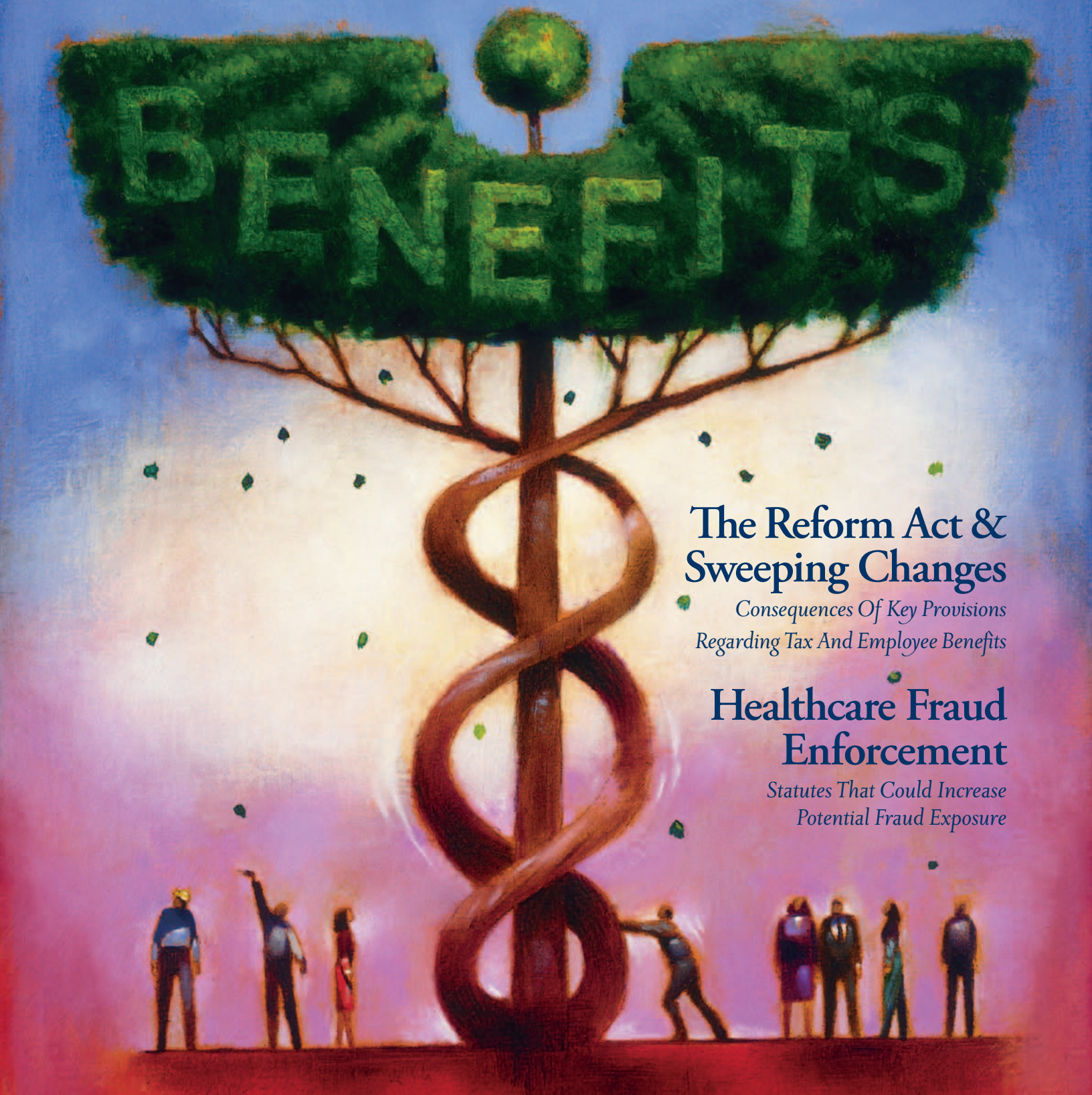
Vol. 4 No. 1 February 2011

PRO TE: *Solutio*

SOLUTIONS FOR YOU



The Reform Act & Sweeping Changes

Consequences Of Key Provisions Regarding Tax And Employee Benefits

Healthcare Fraud Enforcement

Statutes That Could Increase Potential Fraud Exposure

Dear Client:

The greatest certainty in healthcare reform seems to be the tremendous amount of uncertainty, whether related to specific provisions or to the outcome of broader legal challenges to the legislation as a whole. But, assuming reform is here to stay, the impact a number of its provisions will have on the pharmaceutical, medical device, and healthcare industries — as well as on businesses more broadly — is known already. We are devoting this issue to ways in which the 2010 Healthcare Reform Act, in conjunction with the 2010 Health Care and Education Reconciliation Act, will affect you and your business as well as to the legal challenges already in motion that seek to avoid some of those affects.

Tax and Employee Benefit Consequences of Healthcare Reform gives a non-technical nuts and bolts outline of how healthcare reform will impact most businesses, yours included. It contains a chronological summary of the changes that will take place in each of the next four years and should serve as a handy reference tool.

Governmental action against both companies and individuals alleging fraud in the healthcare area have been on the rise for some time. *Turning Up the H.E.A.T. in Healthcare Fraud Enforcement* tells you how healthcare reform will ratchet up that effort even more.

Lawsuits Challenging the 2010 Healthcare Reform Legislation outlines the principal arguments in the lawsuits challenging healthcare reform and contains a summary of the status of these cases.

Our goal in *Pro Te: Solutio* is to help educate and inform about issues that confront you every day. We hope this issue will help you prepare for some of the challenges coming to all of us through healthcare reform.

Christy D. Jones
Co-Chair — Litigation

Charles F. Johnson
Co-Chair — Business and Corporate Healthcare

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Sharing Solutions

It's human nature to share problems. But how often is someone willing to share solutions? Butler Snow wants to do just that — provide scenarios and the solutions that turned a client's anxiety into relief and even triumph. That's why we created this magazine, *Pro Te: Solutio*, which explores how real-life legal problems have been successfully solved.

That's also why we at Butler Snow redesigned and expanded our unique health-oriented industry group, now comprised of two major sections that handle business and litigation. The Pharmaceutical, Medical Device, and Healthcare Industry Group has more than 50 multi-disciplinary attorneys who provide creative solutions for the complex issues of the healthcare industry. This group includes product liability and commercial litigators; corporate, commercial, and transaction attorneys; labor and employment attorneys; intellectual property attorneys; and those experienced in government investigations.

Pro Te: Solutio is a quarterly magazine available only to the clients of Butler Snow. If you have questions or comments about its articles, you're invited to contact Christy Jones and Charles Johnson, as well as any of the attorneys listed on the last page of this publication.

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DEPARTMENTS

Every healthcare provider involved in billing federal healthcare programs knows healthcare reform is a reality. The Patient Protection and Affordable Care Act (PPACA) and the Healthcare and Education Reconciliation Act of 2010 (HCERA) were signed into law by President Obama in March 2010. What providers may not be fully aware of is the number of significant fraud changes included in both statutes that will increase potential fraud exposure for them in the months and years ahead. This article summarizes some of the most significant fraud changes included in these reform statutes.

A. Increased Funding for Fraud and Enforcement Efforts

The Omnibus Appropriations Act of 2009 provided for a one-time, $198 million enhancement in fraud enforcement-related spending. The 2010 federal budget adds another $311 million in funding over a two-year period, amounting to a 50% increase over the FY09 funding level. The proposed 2011 budget would add another $250 million for the DOJ/HHS joint enforcement effort known as the Health Care Fraud and Prevention Enforcement Action Team (or "HEAT").

The HEAT program was announced in May 2009 as a Cabinet-level effort by DOJ, HHS-OIG, and the Centers for Medicare and Medicaid Services (CMS) designed specifically to combat Medicare fraud. The program created strike forces across the country in cities identified as high-volume fraud locales. By the end of 2009, those strike forces had generated some 222 cases.[1] In addition to the extra funding for the HEAT program, PPACA increases funding to the Health Care Fraud and Abuse Control Program (HCFAC) for FY11 through FY20 by $10 million per year. The HCFAC Program is a funding mechanism for federal healthcare fraud enforcement efforts through dedicated healthcare fraud agent positions and attorney positions. Along with the PPACA increases, HCERA adds another $250 million to HCFAC between 2011 and 2016. Thus, the proposed overall additional spending amounts devoted to fraud and abuse enforcement efforts, if they make their way into each of the budgets in future years, could total almost $1 billion over the next 10 years.

B. Expansion of the Recovery Audit Contractor Program

Providers may be familiar already with the Recovery Audit Contractor Program (or "RAC program") which was included initially in the Medicare Modernization Act of 2003 as a demonstration project for New York, California, and Florida — and later, South Carolina, Massachusetts, and Arizona. The demonstration project lasted three years and used private recovery firms on contingent fee contracts to conduct post-payment reviews/audits. Between March 2005 and March 2008, the contractors identified some $1.03 billion in overpayments and

collected over $980 million from providers. The Tax Relief and Healthcare Act of 2006 authorized the expansion of the RAC program nationwide by January 2010. To accomplish that goal, CMS divided the country into four RAC regions and awarded contracts to four companies to implement and manage the RAC program.[2]

The healthcare reform legislation expands the RAC program to cover Medicare Parts C and D (the existing program only covered Medicare Parts A and B). Medicare Part C is the HMO/PPO version or option of Medicare, and Medicare Part D is the prescription drug program. The reform statutes also expand coverage of the program to include Medicaid. These sweeping changes in the program are to take place on a fairly short timeline, with all the additional coverage to have been in place no later than December 31, 2010. While the majority of RAC recoveries have been from inpatient hospitals, this expanded coverage will broaden significantly the circle of healthcare providers subject to the RAC audit process.

C. Overruling the Hanlester Decision on Anti-Kickback Statute Intent Requirement

In *Hanlester Network v. Shalala*, 51 F.3d 1390 (9th Circ. 1995), the Ninth Circuit ruled that the Anti-Kickback Statute's "willfully" language required the government to prove that a defendant subjectively knew that the Anti-Kickback Statute prohibited the conduct in question. This narrow reading of the statute impacted DOJ use of the statute in criminal cases, although other circuits had not read the language as narrowly.

In § 6402 of PPACA, Congress legislatively overruled *Hanlester* by including language which makes clear that the Anti-Kickback Statute does *not* require this heightened scienter standard. The statutory change resolves the split among the federal circuits and restores to federal prosecutors the ability to charge criminal violations of the Anti-Kickback Statute based on a lower evidentiary threshold. This change could also lead to increased use of the Anti-Kickback Statute generally in fraud cases.

D. Jurisdictional Changes to the False Claims Act That Benefit Relators

The majority of False Claims Act cases originate from whistleblowers, or relators, who bring actions on behalf of the government and then encourage the government to intervene in those actions. For many years, a *qui tam* relator or whistleblower plaintiff had to meet a two-part test under 31 U.S.C. § 3730(e) (4): (1) a *qui tam* plaintiff must have provided information which has not been publicly disclosed; and (2) if the information had been publicly disclosed, then the *qui tam* plaintiff/relator must have been an "original source" of the information. A large number of False Claims Act cases have been dismissed in prior years under both the public disclosure bar and the original source doctrine. PPACA significantly amends both these prongs of the False Claims Act in ways which will benefit relators, expand the potential pool of *qui tam* plaintiffs, and likely increase the number of *qui tam* cases filed.

Before these amendments, the failure of a *qui tam* plaintiff to meet the statutory requirements of the public disclosure bar and original source doctrine deprived the court of jurisdiction. PPACA changes the rules in two crucial aspects: (1) Failure to meet the public disclosure language will no longer serve as a jurisdictional bar to bringing a lawsuit, and (2) even if the *qui tam* relator completely fails to meet the public disclosure language of the statute, dismissal may be opposed by the government, in which case the False Claims Act case may proceed. Similarly, if the relator's lawsuit is based upon publicly disclosed information of which the relator is not an original source, the relator may still qualify to participate in a False Claims Act matter if he/she shares with the government "knowledge that is independent of and materially adds to the publicly disclosed allegations […]." Students of False Claims Act jurisprudence know the courts have been struggling for years with the notion of materiality. No one can predict how the courts will interpret the phrase "materially adds to the publicly disclosed allegations," but the relator/plaintiff's bar unquestionably now has a much lighter burden for initiating a False Claims Act lawsuit.

E. New Grounds for Imposing Civil Monetary Penalties

Civil monetary penalties have been an arrow in the government's fraud enforcement quiver for some time. PPACA adds new grounds for imposition of civil monetary penalties. These new grounds include:

(a) knowingly making false statements in an application, bid, or contract to participate in or enroll as a supplier or provider;

(b) failing to report or return a known overpayment;

(c) ordering or prescribing items or services during a period when the prescriber was excluded from a federal healthcare program and the person knows or should know that a claim will be made for the item or service;

(d) failing to grant HHS-OIG timely access for audits, investigations, evaluations, and the like;

(e) making false statements material to a false or fraudulent claim for payment for an item or service furnished under a federal healthcare program.

These new grounds for imposing civil monetary penalties "ratchet up" the risks involved in doing business under any federal healthcare program.

F. Mandatory Compliance Programs

Given the enhanced fraud and abuse enforcement efforts under these various amendments, it should come as no surprise that PPACA also introduced mandatory compliance programs. While the law prior to PPACA did not *require* providers to adopt formal compliance programs, healthcare lawyers have been encouraging and advising their clients for years to adopt voluntary compliance programs. Section 6004 of PPACA provides that the Secretary of HHS may now require a compliance program as a condition precedent to enrollment. No specific providers are listed in the language of the statute; rather, the Secretary of HHS is directed to establish a timeline, in consultation with HHS-OIG, for implementing mandatory compliance programs within a particular healthcare industry or supplier category.

WHILE THE LAW PRIOR TO PPACA DID NOT REQUIRE PROVIDERS TO ADOPT FORMAL COMPLIANCE PROGRAMS, HEALTHCARE LAWYERS HAVE BEEN ENCOURAGING AND ADVISING THEIR CLIENTS FOR YEARS TO ADOPT VOLUNTARY COMPLIANCE PROGRAMS.

CIVIL MONETARY PENALTIES HAVE BEEN AN ARROW IN THE GOVERNMENT'S FRAUD ENFORCEMENT QUIVER FOR SOME TIME.

PPACA ADDS NEW GROUNDS FOR IMPOSITION OF CIVIL MONETARY PENALTIES.

As these guidelines are developed in future months and years, healthcare providers will be well advised to make known to the Secretary of HHS and to the Inspector General the terms and conditions providers believe are appropriate and necessary.

G. Changes to the Stark Law and the New Self-Referral Disclosure Protocol

1. New Freedom of Choice Rules for In-Office Ancillary Services

Subject to various exceptions or safe harbors, the Stark Law prohibits a physician from referring a Medicare or Medicaid beneficiary to an entity in which the referring physician, or members of his/her immediate family, have a financial relationship.[3] Unlike the Anti-Kickback Statute, which applies to anyone providing services or supplies under a federal healthcare program, the Stark Law is addressed to physicians only.

The so-called In-Office Ancillary Services (or "IOAS") exception is one of the major exceptions to the Stark Law. It allows individual physicians in solo practice and in physician practice groups to self-refer patients for most designated health services if they meet certain additional requirements relating to who performs the service, the location of services, and the billing. Section 6003 of PPACA adds a new "Freedom of Choice" notification requirement for certain imaging services when a physician or practice group is seeking this "in-office" protection under the IOAS exception.

Here's how the statutory amendment works: (1) The physician must inform a patient, in writing, that the patient may obtain the designated health service (DHS) from another entity *outside* the physician's office or *outside* the referring physician's group practice. (2) The amendment applies to MRI, CT scans and PET scans, and to "any other DHS specified under [42 U.S.C. § 1395nn](h)(6)(D) that the Secretary determines appropriate." This reference to § (h)(6)(D) is to radiology services. (3) The amendment requires the referring physician to provide a written list of other physicians, durable medical equipment providers, or other suppliers who furnish the imaging service in the area where the beneficiary resides. (4) The Secretary may use rulemaking to impose similar Freedom of Choice requirements on referrals of other designated imaging services such as radiology services and ultrasound. (5) The Freedom of Choice notices are not required to comply with other Stark Law exceptions or for in-office services other than the imaging services designated by PPACA. (6) CMS will promulgate regulations to implement this new requirement.

2. Limits on Physician-Owned Hospitals

Another Stark Law exception amended by PPACA is the so-called "whole hospital" exception. This exception allows physicians to refer for designated health services to hospitals owned, in whole or in part, by the referring physician or an immediate family member, so long as the physician's ownership interest is in the entire (or "whole") hospital and not in merely a distinct part or department of the hospital. Stark also permits physician referrals to "rural" hospitals where substantially all of the designated health services furnished by the entity are furnished to individuals residing in a rural area. Section 6001 of PPACA essentially prevents the formation of new physician-owned hospitals, limits service expansions at existing physician-owned hospitals, and freezes the amount of physician ownership in existing hospitals as of March 23, 2010, the effective date of PPACA (*i.e.*, physicians may not acquire greater ownership interests in hospitals than what they already owned as of March 23, 2010). The language effectively prohibits physician ownership in any hospital that does not have a Medicare provider agreement in effect as of December 31, 2010. CMS may grandfather-in existing hospitals with provider agreements in place as of that date. The reform statute requires written annual reports to HHS regarding the identity of owners and ownership interests (and these reports will be posted on an HHS website). These new physician-ownership limitation rules are also extended to physician ownership of rural hospitals. CMS is to promulgate regulations on these physician-ownership amendments by January 1, 2012.

3. A New Stark Self-Referral Disclosure Protocol

In 2009, HHS-OIG announced that its Self-Disclosure Protocol used by providers to report technical (and, often, unintentional) violations of various federal healthcare fraud and abuse laws was *not* available for use in disclosing Stark Law violations. This gap left providers with potential Stark issues in a quandary about how to approach the government in these circumstances, since Stark has some of the harshest penalties provisions — imposing a requirement that *all* payments for designated health services paid in violation of Stark are to be refunded to the government in addition to a $15,000 civil monetary penalty for *each* designated health service provided in violation of Stark.

In response to provider concerns, Congress added § 6409 to PPACA, which obligated the Secretary of HHS to develop and implement a disclosure protocol for actual and potential Stark violations within six months of the enactment of PPACA. CMS was instructed to publish the new Self-Referral Disclosure Protocol on its website within six months, with instructions to providers on how to access and use it. Right on schedule, the new Protocol was announced and appeared on the CMS website on September 23, 2010. The Protocol makes clear, as set forth in § 6409(a)(2) of PPACA, that it is separate and distinct from the existing CMS advisory opinion process used to determine whether a Stark violation exists.

The Protocol is not as clearly written as it might have been, and it appears to be limited solely to Stark issues, adhering specifically to the statutory language that mandated it. This means the new Protocol cannot be used for Anti-Kickback Statute issues or for other voluntary disclosures to the government. Too, while earlier voluntary disclosures might have generated a discounted fine for Stark violations, this new Protocol merely provides that CMS "may consider" reducing the amounts "otherwise owed" based upon five factors: (1) the nature and extent of the improper or illegal practice; (2) the timeliness of the self-disclosure; (3) the cooperation in providing additional information related to the disclosure; (4) the litigation risk associated with the matter disclosed; and (5) the financial position of the disclosing party.

H. Criminal Enhancements Included in the Reform Statutes

When Congress enacted the original HIPAA statute in 2003, it gave DOJ significant enhanced criminal authority in combating healthcare fraud (including the new healthcare fraud statute at 18 U.S.C. § 1347 and the ability to issue administrative subpoenas known as authorized investigative demands under 18 U.S.C. § 3486). PPACA adds even more criminal healthcare fraud tools for DOJ to use, including:

(1) The U.S. Sentencing Commission is directed to update the Sentencing Guidelines to increase offense levels by 20-50% for crimes involving losses of more than $1 million;

(2) The definition of "healthcare fraud offense" under 18 U.S.C. § 24 is broadened to include Anti-Kickback Statute violations; Food, Drug and Cosmetic Act violations, and even certain ERISA reporting violations;

(3) PPACA provides DOJ with subpoena authority for investigations conducted pursuant to the Civil Rights of Institutionalized Persons Act (42 U.S.C. § 1997, *et seq.*), giving the government authority to seek to protect residents of nursing homes, mental health facilities, and similar institutions;

(4) PPACA amends the obstruction of justice statute, 18 U.S.C. § 1510, to provide that obstruction of criminal investigations involving HIPAA administrative subpoenas is treated the same as obstruction of investigations involving grand jury subpoenas; and,

(5) All of these offenses now become predicates for asset forfeiture proceedings and qualify as specified unlawful activities for money laundering charges. The separate healthcare obstruction of justice statute (18 U.S.C. § 1518) is extended to include these new offenses, and PPACA authorizes the use of administrative subpoenas in such investigations.

I. Conclusion

The healthcare fraud and abuse landscape has changed significantly as a result of the passage of both PPACA and HCERA. Not only has the scope of potential conduct subject to prosecution been broadened, but also the scope of potential liability under the False Claims Act has been expanded and the number of potential whistleblowers/relators bringing False Claims Act cases has been increased significantly. All healthcare providers must pay close attention to these changes in the coming months, as DOJ and HHS-OIG undoubtedly will be turning up the heat — through their new HEAT strike forces — on the entire healthcare industry.

[1] Thus far, HEAT strike forces have been formed in Miami, Tampa Bay, Los Angeles, Dallas, Houston, Detroit, and Brooklyn, with the most recent task force having been created in Baton Rouge, Louisiana. For more information on the HEAT strike forces, take a look at the website <www.stopmedicarefraud.gov>.

[2] *See generally*, <www.cms.hhs.gov/RAC>.

[3] *See generally*, 42 U.S.C. § 1395nn.

Written *by* Bob Anderson

CASE LAW

LAWSUITS CHALLENGING THE 2010 HEALTHCARE REFORM LEGISLATION

Less than one year after passage, the Patient Protection and Affordable Care Act ("PPACA"; "Act")[1] — part of the Obama Administration's healthcare reform legislation signed into law on March 23, 2010[2] — already is the subject of numerous legal challenges. The following is a summary of the pending cases.

As of this writing,[3] twenty-one lawsuits[4] have been filed challenging the constitutionality of the PPACA. With some variation, the lawsuits generally challenge the Act on one or more of the following bases: (i) the Act is an unlawful expansion of Congress's power to regulate interstate commerce in violation of the Commerce Clause, Art. I, § 8; (ii) the individual health insurance mandate is an unapportioned direct tax on the people, in violation of the Direct Tax prohibition, Art. I, § 9; (iii) certain aspects of the passage of the legislation violated the Constitution's guarantee of a republican form of government, Art. IV, § 4; (iv) the Act infringes upon individuals' religious beliefs in violation of the First Amendment; (v) the Act's individual insurance mandate constitutes an unreasonable seizure in violation of the Fourth Amendment; (vi) the Act takes private property for public use and deprives individuals of property without due process of law, in violation of the Fifth Amendment Takings Clause and the Due Process Clause; (vii) the Act infringes upon the unenumerated rights retained in the people in violation of the Ninth Amendment; (viii) the Act commandeers state government, mandates compensation that states must pay to elected officials, and forces the states to impose a tax increase in violation of the Tenth Amendment; and (ix) the Act violates the Fourteenth Amendment guarantees of due process and equal protection.

The Cases

Florida v. United States Department of Health & Human Services, pending in the Northern District of Florida, Cause No. 3:10cv00091, before Judge Roger Vinson. Among the Plaintiffs are the Attorneys General of 26 states.

Allegation: The Act's mandate that individuals pay a penalty if they do not have health insurance is unconstitutional under the First, Fifth, Ninth, and Tenth Amendments.

Status: In a significant ruling, on January 31, 2011, Judge Vinson granted summary judgment for the Plaintiffs, holding that the individual mandate is an unconstitutional expansion of Congress's Commerce Clause and Necessary and Proper Clause powers. Judge Vinson went further and held that because the individual mandate is not severable from the operation of the rest of the reform legislation, the entire Act is unconstitutional.

Virginia v. Sebelius, pending in the Eastern District of Virginia, Cause No. 3:10cv00188, before Judge Henry E. Hudson.

Allegation: The Act's individual health insurance mandate is an unconstitutional exercise of Congress's Commerce Clause power.

Status: On December 13, 2010, the court granted the Commonwealth's summary judgment motion, holding that the individual insurance mandate is unconstitutional.[5]

Liberty University Inc. v. Geithner, pending in the Western District of Virginia, Cause No. 6:10cv00015, before Judge Norman Moon.

Allegation: The Act favors one religion over another and violates the Constitution's guarantee of a republican form of government. The suit also challenges the Act's use of public funds for abortions.

Status: The Defendants' motion to dismiss was granted on November 30, 2010. The Plaintiffs have appealed that ruling to the Fourth Circuit Court of Appeals.

Thomas More Law Center v. President of the United States, pending in the Eastern District of Michigan, Cause No. 2:10cv11156, before Judge George Caram Steeh.

Allegation: This case is essentially a preliminary injunction action to prevent enforcement of the Act. The action is based on Commerce Clause and First Amendment challenges.

Status: The preliminary injunction was denied, and two counts were dismissed in October. The Plaintiffs have appealed to the Sixth Circuit Court of Appeals.

New Jersey Physicians Inc. v. Obama, pending in the District of New Jersey, Cause No. 2:10cv01489, before Judge Susan Wigenton.

Allegation: The Act's individual mandate and penalty provisions exceed the federal government's power, and the Act is not a valid exercise of Congress's Commerce Clause power.

Status: A motion to dismiss is pending.

Bellow v. United States Department of Health and Human Services, pending in the Eastern District of Texas, Cause No. 1:10cv00165, before Judge Ron Clark.

Allegation: Congress exceeded its power in passing the Act; the Act is an unconstitutional encroachment on Fourth Amendment privacy rights; and the Act is a violation of Article I's prohibition on direct taxation.

Status: The *pro se* Plaintiff submitted letters to the court regarding the Defendants' failure to answer. Otherwise, the case is stagnant.

Association of American Physicians & Surgeons Inc. v. Sebelius, pending in the District of Columbia, Cause No. 1:10cv00499, before Judge Richard Leon.

Allegation: The Act is an unconstitutional limitation on healthcare professionals' choices regarding Medicaid and Social Security.

Status: A motion to dismiss is pending.

Walters v. Holder, pending in the Southern District of Mississippi, Cause No. 2:10cv00076, before Judge Keith Starrett.

Allegation: The Act's individual health insurance mandate provisions violate the Fifth, Tenth, and Fourteenth Amendments.

Status: A motion to dismiss is pending.

Calvey v. Obama, pending in the Western District of Oklahoma, Cause No. 5:10cv00353, before Judge David Russell.

Allegation: The forced funding of abortions violates the First and Fifth Amendments.

Status: The court has issued summonses, but no answer to the complaint has been filed.

Shreeve v. Obama, pending in the Eastern District of Tennessee, Cause No. 1:10cv00071, before Judge Curtis Collier.

Allegation: The Act is an unconstitutional exercise of power in violation of the Tenth Amendment.

Status: The court granted the Defendants' motion to dismiss, finding the 29,000 plus Plaintiffs lacked standing. The Plaintiffs plan to re-file in another court.

Goudy-Bachman v. United States Department of Health & Human Services, pending in the Middle District of Pennsylvania, Cause No. 1:10cv00763, before Judge Chris Conner.

Allegation: The Act's individual health insurance mandate/penalty provisions violate the Takings Clause of the Fifth Amendment.

Status: A motion to dismiss is pending.

Peterson v. Obama, pending in the District of New Hampshire, Cause No. 1:10cv00170, before Judge Joseph Laplante.

Allegation: The Act violates the Fifth, Ninth, and Tenth Amendments, and the passage of the Act was unconstitutional.

Status: A motion to dismiss is pending.

United States Citizens Ass'n v. Obama, pending in the Northern District of Ohio, Cause No. 5:10cv01065, before Judge David Dowd, Jr.

Allegation: The Act violates the First, Third, Fourth, Fifth, and Ninth Amendments by requiring individuals to purchase a good or service.

Status: The Defendants' motion to dismiss was denied.

Baldwin v. Sebelius, pending in the Southern District of California, Cause No. 3:10cv01033, before Judge Dana Sabraw.

Allegation: The Act is an unconstitutional exercise of Congress's Commerce Clause power; violates the right to privacy; is a direct tax; was passed unconstitutionally in that it originated in the Senate; unconstitutionally expands federal power; discriminates on the basis of gender; is unconstitutionally vague regarding the funding of abortions; and the Defendant Kathleen Sebelius has already failed to comply with the Act.

Status: The Defendants' motion to dismiss was granted. An appeal is pending in the Ninth Circuit Court of Appeals. Plaintiffs attempted an unconventional direct appeal to the United States Supreme Court, which was denied.

Physician Hospitals of America v. Sebelius, pending in the Eastern District of Texas, Cause No. 6:10cv00277, before Judge Michael Schneider.

Allegation: The Act discriminates against physician-owned hospitals in favor of hospitals owned by non-physician individuals.

Status: A motion for summary judgment is pending, and the trial setting of December 9, 2010, was cancelled.

Mead v. Holder, pending in the District of Columbia, Cause No. 1:10cv00950, before Judge Gladys Kessler.

Allegation: The Act's requirement for individuals to purchase health insurance violates individual religious beliefs and is a violation of the Religious Freedom Restoration Act of 1993.

Status: Both a motion to dismiss and a motion for summary judgment are pending.

Kinder v. Department of Treasury, pending in the Eastern District of Missouri, Cause No. 1:10cv00101, before Judge Rodney Sippel.

Allegation: The Act violates the First, Fifth, Tenth, and Fourteenth Amendments and is an unconstitutional exercise of Congress's Commerce Clause powers.

Status: The Defendant's answer is due by January 15, 2011.

Sissel v. United States Department of Health & Human Services, pending in the District of Columbia, Cause No. 1:10cv01263, before Judge Richard Leon.

Allegation: The Act violates the Commerce Clause.

Status: A November 15, 2010, motion to dismiss is pending.

Coons v. Geithner, pending in the District of Arizona, Cause No. 2:10cv01714, before Judge Murray Snow.

Allegation: The Act violates the Fourth, Fifth, Ninth, and Tenth Amendments.

Status: A motion for preliminary injunction to stop enforcement of the Act is pending.

Independent American Party of Nevada v. Obama, pending in the District of Nevada, Cause No. 2:10cv01477, before Judge James Mahan.

Allegation: This class action lawsuit challenges almost every aspect of the PPACA and includes a Thirteenth Amendment challenge alleging that the Act constitutes involuntary servitude.

Status: No answer has been filed.

Purpura v. Sebelius, pending in the District of New Jersey, Cause No. 3:10cv04814, before Judge Freda Wolfson.

Allegation: The bill was illegally signed, and the Act itself illegally expands government.

Status: A motion for a temporary restraining order and preliminary injunction was denied. An answer is due to be filed soon.

[1] Patient Protection and Affordable Care Act, Pub. L. No. 111-148. Available at <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/content-detail.html>. March 23, 2010. Last accessed Jan. 13, 2011.

[2] *Id.*

[3] The inevitable delay in the printing of this article may have caused some information to become outdated. Please contact us if you would like more up-to-date information on these lawsuits.

[4] The Attorney General-elect of Oklahoma recently announced his intention to file a lawsuit challenging the PPACA. *See* CNN Wire Staff. "Oklahoma to Challenge Health Care Law." *CNN Politics*. Available at <http://articles.cnn.com/2011-01-07/politics/oklahoma.health.care_1_health-care-overhaul-individual-mandate-oklahoma-voters?_s=PM:POLITICS>. Jan. 7, 2011. Last accessed Jan. 13, 2011.

[5] This ruling solidifies that the individual insurance mandate will be the focus of these lawsuits going forward. *See* Amy Goldstein. "Mandatory Health Insurance Now Law's Central Villain." *Washington Post*. Available at <http://www.washingtonpost.com/wp-dyn/content/article/2010/12/14/AR2010121407704.html>. Dec. 14, 2010. Last accessed Jan. 13, 2011.

Written by John Dollarhide

Tax and Employee Benefit CONSEQUENCES of Healthcare Reform

Popular media coverage of "healthcare reform" has focused largely on how individual consumers might be affected. Less attention has been given to what the legislation means for businesses — and not just businesses in healthcare-related industries. The 2010 Healthcare Reform Act (Patient Protection and Affordable Care Act[1] or PPACA), in conjunction with the Health Care and Education Reconciliation Act[2] ("Reconciliation Act") contains significant tax and employee benefit changes. Many of these provisions are phased in over several years, so their full impact is yet to be felt. This article examines a few of the key provisions contained in this new legislation.

I. Tax Changes

The tax changes found in the new legislation focus on the universal health insurance coverage mandate and revenue raisers, some health-related and others not. Certain changes are expected to have the greatest impact.

A. Beginning in 2011

Beginning in 2011, a fee will be levied against drug manufacturers and importers based on market share. The total fee assessed for 2011 will be $2.5 billion and will gradually increase until it peaks in 2018 at $4.1 billion. In 2019, the fee will decrease to $2.8 billion and will remain constant thereafter.[3]

B. Beginning in 2013

1. Federal Sales Tax on Sales of "Medical Devices"

Manufacturers and importers of medical devices will be taxed 2.3% of the sales price of any "taxable medical device" intended for humans.[4] This tax will not apply to medical devices the IRS determines are of a type "generally purchased by the general public at retail for individual use" such as eyeglasses, contact lenses, and hearing aids.[5]

2. Loss of Deduction for Retiree Prescription Drug Plans

The Reform Act not only imposes additional fees and taxes but also reduces or eliminates certain deductions. Currently, employers are entitled to an income tax deduction for the cost of providing a prescription drug plan to retirees even though they receive a tax-free Medicare Part D subsidy from the federal government. Under the new legislation, the amount allowed as a deduction for retiree prescription drug expenses will be reduced by the amount of the tax-free subsidy payments received.[6]

3. Surtax on Investment Income of High-Income Taxpayers

As a revenue raiser, a surtax will be imposed on the investment income of high-income taxpayers. This tax will be a 3.8% Medicare contribution tax and will be imposed on the net investment income of certain individuals, estates, and trusts with income above specified thresholds. For individuals, the tax is 3.8% multiplied by the lesser of either net investment income or adjusted gross income in excess of $200,000 for single filers or $250,000 for joint filers. Net investment income includes interest, dividends, royalties, rents, and net gain from the disposition of investment assets. The surtax is subject to individual estimated income tax payment requirements and is not deductible for income tax purposes.[7]

C. Beginning in 2014

1. Industry-wide Fee on Health Insurance Providers

An industry-wide fee will be levied against health insurance providers with net premium income from health insurance of more than $25 million. For purposes of this fee, health

insurance does not include coverage for a specified disease or illness only, hospital indemnity or other fixed indemnity insurance, insurance for long-term care, or Medicare supplemental health insurance. This fee, which will be apportioned based on net premiums received during the preceding year, will be $8 billion in 2014. The fee gradually increases to $14.3 billion in 2018. Thereafter, the fee will be indexed for premium growth.[8]

2. Employer Group Health Insurance Mandate

A "pay-or-play" tax will be imposed on employers that fail to provide affordable coverage to employees. (*See section* II.E.1.) This provision applies to employers with an average of fifty full-time employees during the preceding calendar year and who are not offering "minimum essential coverage." For purposes of determining whether an employer has fifty employees, business entities under common control must aggregate employees. "Minimum essential coverage" is a plan where the employer covers at least 60% of the costs under the plan and employee costs do not exceed 9.5% of household income. The monthly penalty is one-twelfth of $2,000 multiplied by the number of employees in excess of thirty.[9]

D. Beginning in 2018

A 40% excise tax will be imposed on "coverage providers" for the cost of the employer-sponsored health coverage to employees that exceeds $10,200 for single coverage and $27,500 for family coverage. These plans are often referred to as "Cadillac" plans. For purposes of this tax, "coverage providers" include the health insurer for fully-insured plans, employers making the contributions for health savings accounts (HSA) or Archer medical savings accounts (MSA) contributions, and the person administering the plan for self-insured plans or flexible spending accounts (FSA).[10]

II. New Employer-Sponsored Group Health Plan Requirements

Applicability and Grandfathered Plan Exclusion

Employer-sponsored group health plans (GHPs) subject to the Reform Act include both private and governmental GHPs, whether insured or self-insured. Those GHPs in existence on March 23, 2010, are "grandfathered" (the "if-you-like-your-current-coverage-you-can-keep-it" provision) and are thus eligible for the *limited* grandfathered GHP exclusion (GPE).[11] While the scope of the GPE appears extremely broad on its face, the regulations promulgated by the affected federal agencies — Department of Labor/Employee Benefits Security Administration, Internal Revenue Service, and Department of Health and Human Services ("Agencies") — severely limit what can and cannot be done in plan redesign and still maintain eligibility for GPE status.[12]

Employees covered under a GHP qualifying for the GPE still satisfy the employee's individual responsibility requirement, even if the GHP provides less coverage than required under the new legislation.[13] (*See section* I.C.1.) Additionally, new employees hired after March 23, 2010, and their dependents can still be covered under a GHP eligible for the GPE.[14] Furthermore, dependents of an employee covered by an eligible GHP may be added to the employee's coverage after March 23, 2010.[15] Theoretically, those GHPs that can maintain GPE status should be able to achieve a permanent exemption from certain provisions of the Reform Act targeted at GHPs. However, the Administration has indicated that it expects that most GHPs will lose the GPE by 2014 and that the GPE might be temporary anyway.

While the GPE is a significant and pervasive concept in the Reform Act, it is nevertheless not all-inclusive. Since it is only available for certain requirements of the Reform Act and not for others, the significance of a particular requirement to a GHP must be considered in light of its availability. The new GHP requirements are outlined below, by their effective date.[16] Those requirements for which the GPE is available are designated with the parenthetical "(GPE)."

A. Beginning in 2010

1. Automatic Enrollment

The Reform Act requires that employers with more than two hundred employees automatically enroll eligible employees in their GHP unless an employee opts out pursuant to a required opt-out notice.[17] Since this requirement has no stated effective date, the effective date technically was the date of enactment. However, compliance is being delayed by the Agencies until regulations are issued.[18]

The following provisions are effective for GHPs with plan years beginning after September 23, 2010.

2. Annual & Lifetime Limits

No lifetime limits or annual limits on "essential health benefits" are allowed.[19] "Essential health benefits" is to be defined by Department of Health and Human Services regulations.

3. Retroactive Rescissions

Retroactive cancellation of coverage is prohibited except for fraud or intentional misrepresentation of material facts, and then only with prior written notice.[20]

4. Pre-Existing Condition Exclusions

Through 2013, there are to be no pre-existing condition exclusions for employees under age 19 or dependents under age 19.[21] Beginning January 1, 2014, there are to be no pre-existing condition exclusions for any employees or dependents irrespective of age.[22]

5. Coverage of Children to Age 26 (Limited GPE)

GHPs offering dependent coverage must also permit coverage of children until their twenty-sixth birthdays. The child does not have to be a student or a tax-dependent of the employee and can be married. The child can be included on the parent's plan even if coverage is available under that child's own employer's group health plan (if coverage is available under a plan sponsored by an employer other than a parent's employer, a limited GPE is available only until January 1, 2014).[23] A HIPAA special enrollment period is required for any such children who have already ceased to be covered but are now re-eligible.[24] GHPs are not required to cover the child's spouse or children.[25] If the covered child has not reached the age of twenty-seven before the end of the year, the value of coverage is excluded from the employee's income for the entire year for tax purposes, and benefits are excluded from the child's income for tax purposes.[26]

6. Preventive Care — First-Dollar Coverage (GPE)

GHPs are to provide first-dollar coverage, *i.e.* no cost-sharing, for certain types of preventative care including certain well-child, adolescent, and female care, as well as certain immunizations.[27]

7. Nondiscriminatory Insured Plans (GPE)

There also can be no discrimination in favor of highly-compensated employees by insured GHPs, similar to the previously existing nondiscrimination rules for self-insured GHPs.[28] The IRS, though, has announced delayed enforcement of this requirement until after implementing regulations are issued.[29]

8. Claims Appeals/External Review Procedures (GPE)

New benefit appeals procedures allow claimants to present evidence and oral testimony as part of the appeal and require continued coverage during the appeals process.[30] GHPs will have to provide an external review process as part of the review procedures for denied claims.[31] Written notice of these new rights must be provided.[32]

9. Patient Protections (GPE)

GHPs must now include a number of new patient protection features. For instance, if enrollees are required by their GHP to designate a primary-care provider, certain types of enrollees may designate certain types of providers as their primary-care provider, *i.e.* pediatricians for children and OB/GYNs for women.[33] In addition, there can be no preauthorization or increased cost-sharing required for emergency services, and no preauthorization or referral can be required for OB/GYN care.[34]

B. Beginning 2011

1. Reimbursement of OTC Drugs

Effective January 1, 2011, there can be no reimbursement for over-the-counter medicine (except insulin) by an FSA, health

reimbursement accounts (HRA), HSA, or MSA without a prescription.[35]

2. Form W-2 Requirements

Beginning with 2011 W-2s, employers must report the aggregate value of employer-sponsored GHP coverage (solely for informational purposes) for the benefit of the covered employee. The IRS has announced that compliance will not be required until 2012 W-2s are issued.[36]

C. Beginning March 23, 2012

1. Benefits Summary

A new summary of benefits and coverage of no more than four pages, separate from the summary plan description already required by ERISA must be provided to applicants and enrollees in GHPs both at initial and annual enrollment.[37] The style, content, and even format of this new summary will be specified in regulations.

2. Notice of Material Modifications

A new notice of material modifications, separate from the summary of material modifications already required by ERISA, must be provided at least sixty days *before* the effective date of a material modification in coverage.[38]

3. Quality Report (GPE)

The GHP must annually file a quality report with the Department of Health and Human Services, reporting any plan design changes intended to improve outcomes, reduce hospital readmissions, reduce medical error, implement wellness programs, etc.[39] The effective date for this reporting requirement is to be in accordance with regulations required to be published by March 23, 2012; the actual effective date could be earlier.

D. Beginning in 2013

1. FSA Limitations

Effective January 1, 2013, FSA salary reductions are limited to $2,500 per year. This is to be indexed to the consumer price index beginning in 2014.[40]

2. Exchange Notice (GPE)

Effective March 1, 2013, employers must provide written notice to their employees, at hiring, of the availability of state exchanges and of the employee's right to purchase healthcare coverage through such an exchange. This notice must also inform the employee that he or she may be eligible for a subsidy through the exchange if the employer's share of the GHP benefit cost is less than 60% of the cost of the individual plan and that, if the employee purchases coverage through an exchange without an employer-provided voucher, the employee will lose the employer's contribution for health benefits.[41]

E. Beginning in 2014

The Reform Act requires the states to establish health insurance exchanges by January 1, 2014. These exchanges are generally designed to provide affordable health coverage to people not covered under a GHP sponsored by an employer. Smaller employers, *i.e.* those with one hundred or fewer employees (states have the option to limit this to fifty employees), and individuals may purchase coverage through required state exchanges.[42]

1. Minimum Essential Coverage

While the Reform Act does not mandate that any specific benefits be provided, effective January 1, 2014, employer-sponsored GHPs must nevertheless offer "minimum essential coverage" in conjunction with the establishment of the exchanges.[43] "Minimum essential coverage" is to be defined in regulations.

2. Pay-or-Play Penalty

Employers are not required to offer any health coverage. If they do not offer "minimum essential coverage" or the coverage offered is "unaffordable," though, they will be subject to the "pay-or-play" penalty, effective January 1, 2014.[44] (*See section* I.C.2.)

3. Reporting Coverage

If an employer does not offer "minimum essential coverage" to full-time employees and their dependents, the employer must confirm that such coverage is not offered and file a variety of other information in order to permit the assessment of the "pay-or-play" penalty against the employer.[45]

4. Free Choice Vouchers

Employers that pay part of the GHP coverage cost must issue "free choice" vouchers to "qualified employees."[46] These vouchers permit employees to purchase coverage through an exchange instead of their employer's GHP.[47] If the employee chooses to participate in the exchange, the employer pays the redeemed voucher amount to the exchange, which must be the amount the employer would have contributed to its GHP, to the exchange.[48] (If the employer contributes different amounts for different coverage options, the voucher amount must be the maximum employer contribution available to the employee.) The exchange pays any excess to the employee. These vouchers are excluded from the employee's income to the extent they are used for healthcare and also are deductible by the employer.[49]

A "qualified employee" is an employee (1) whose household income is less than 400% of the Federal poverty level (400% of the federal poverty level was $88,000 in 2010 for a family of 4), (2) whose required contribution under the GHP is between 8% and 9.8%[50] of his or her household income, and (3) who does not participate in the employer's GHP.[51]

5. Expiration of Limited Exclusions

For Plan Years Beginning (PYB) after January 1, 2014, the limited GPE for restricted annual limits and for coverage for children until age 26 who have coverage available under a plan sponsored by an employer other than an employer of their parents will no longer be available. The limitation on the pre-existing condition exclusion for covered individuals age 19 and older expires as well. There may also be no waiting periods in excess of ninety days.[52]

6. HIPAA Wellness Program Incentives (GPE)

Under the HIPAA wellness program regulations, the permissible incentive for satisfaction of a health standard increases from 20% to 30% (or as much as 50% by regulation) effective January 1, 2014.[53] However, existing EEOC issues under the Americans With Disabilities Act continue.

7. Cost-sharing Limits (GPE)

Effective for PYB after January 1, 2014, out-of-pocket expenses cannot exceed HSA coverage amounts (currently $5,950 for individuals and $11,900 for families), and deductibles cannot exceed $2,000 for single coverage and $4,000 for family coverage, as indexed.[54]

8. Clinical Trials Coverage (GPE)

Effective for PYB January 1, 2014, GHPs must cover the routine costs of participation in certain approved clinical trials relating to life-threatening diseases.[55]

Conclusion

The Reform Act creates sweeping changes throughout many sectors of the U.S. economy, targeting both businesses and individuals. While many of these benefit mandates and notice and reporting requirements have already taken or will soon take effect, the country is still awaiting regulations to aid in the implementation not only of certain currently effective provisions but also of many others soon to take effect. The true impact of the Reform Act on the healthcare payor system will not really begin to be felt until sometime in 2013, as GHPs prepare for the January 1, 2014, effective date of the state exchanges and coverage mandates.

[1] Pub. L. No. 111-148 (2010).

[2] Pub. L. No. 111-152 (2010).

[3] PPACA, Pub. L. No. 111-148, § 9008 (2010), as amended by HCERA, Pub. L. No. 111-152, § 1404 (2010).

[4] A taxable medical device is defined in Section 201(h) of the Federal Food, Drug, and Cosmetic Act as "an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, which is (1) recognized in the official National Formulary, or the United States Pharmacopeia, or any supplement to them, (2) intended to affect the structure or any function of the body of man or other animals, and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of its primary intended purposes."

[5] Code § 4191, as added by HCERA, Pub. L. No. 111-152, § 1405 (2010).

[6] PPACA, Pub. L. No. 111-148, § 9012 (2010), as amended by HCERA, Pub. L. No. 111-152, § 1407 (2010).

[7] Code § 1411, as added by HCERA, Pub. L. No. 111-152, § 1402 (2010).

[8] PPACA, Pub. L. No. 111-148, § 9010 (2010), as amended by PPACA, Pub. L. No. 111-148, § 10905 (2010), as further amended by HCERA, Pub. L. No. 111-152, § 1406 (2010).

[9] Code § 4980H, as added by PPACA, Pub. L. No. 111-148, § 1513 (2010), as amended by PPACA, Pub. L. No. 111-148, § 10106 (2010), as further amended by HCERA, Pub. L. No. 111-152, § 103 (2010).

[10] Code § 4980I, as added by PPACA, Pub. L. No. 111-148, § 9001 (2010), as amended by PPACA, Pub. L. No. 111-148, § 10901 (2010), as further amended by HCERA, Pub. L. No. 111-152, § 1401 (2010).

[11] PPACA, Pub. L. No. 111-148, § 1251(e) (2010).

[12] 75 F.R. 116 (06/17/10).

[13] PPACA, Pub. L. No. 111-148, § 1251(a)(1) (2010).

[14] PPACA, Pub. L. No. 111-148, § 1251(c) (2010); Treas. Reg. § 54.9815-1251T(b)(1); DOL Reg. § 2590.715-1251(b)(1); HHS Reg. § 147.140(b)(1).

[15] PPACA, Pub. L. No. 111-148, § 1251(b) (2010); Treas. Reg. § 54.9815-1251T(a)(4); DOL Reg. § 2590.715-1251(a)(4); HHS Reg. § 147.140(a)(4).

[16] While the Agencies have struggled valiantly to issue timely regulatory and sub-regulatory guidance in advance of the effective dates of the provisions which have already become effective, there are still significant gaps in the regulatory scheme, leaving many questions unanswered. Additional regulations and sub-regulatory guidance should answer many of these questions. Future regulations will also determine the effective dates of certain statutory provisions, since several of such provisions either have effective dates coinciding with the issuance of regulations or are not being enforced by the Agencies until the issuance of regulations. In the meantime, where a statutory provision becomes effective without adequate regulatory guidance, the Agencies have indicated that good faith compliance, based upon a reasonable interpretation of the statute, should be undertaken.

[17] FLSA § 18A, as added by PPACA, Pub. L. No. 111-148, § 1511 (2010).

[18] FLSA § 18A, as added by PPACA, Pub. L. No. 111-148, § 1511 (2010).

[19] PHSA § 2711, as added by PPACA, Pub. L. No. 111-148, §§ 1001(5) and 10101(a) (2010).

[20] PHSA § 2712, as added by PPACA, Pub. L. No. 111-148, § 1001(5) (2010).

[21] PPACA, Pub. L. No. 111-148, § 10103(e)(2) (2010); Treas. Reg. § 54.9815-2704T(b)(2); DOL Reg. § 2590.715-2704(b)(2); HHS Reg. § 147.108(b)(2).

[22] PHSA § 2704, as amended by PPACA, Pub. L. No. 111-148 (2010), as amended by HCERA, Pub. L. No. 111-152 (2010).

[23] PHSA § 2704(a), as amended by the PPACA, Pub. L. No. 111-148, § 1201 (2010).

[24] Interim Final Rules Relating to Dependent Coverage of Children to Age 26 under PPACA, 26 CFR Parts 54 and 602; 29 CFR Part 2590; 45 CFR Parts 144, 146, and 147; 75 Fed. Reg. 27121 (May 13, 2010).

[25] Interim Finals Rules Relating to Dependent Coverage of Children to Age 26 Under PPACA, 26 CFR Parts 54 and 602; 29 CFR Part 2590; 45 CFR Parts 144, 146, and 147, 75 Fed. Reg. 27121 (May 13, 2010).

[26] Code § 105. *See also* IRS Notice 2010-38, 2010-20 I.R.B. 682.

[27] PHSA § 2713, as added by PPACA, Pub. L. No. 111-148 (2010).

[28] PHSA § 2716, as added and amended by PPACA, Pub. L. No. 111-148 (2010).

[29] IRS Notice 2011-1, 2011 I.R.B. (12/22/2010).

[30] PHSA § 2719(a)(1)(C), as added by PPACA, Pub. L. No. 111-148 (2010).

[31] PHSA § 2719(b), as added by PPACA, Pub. L. No. 111-148 (2010).

[32] PHSA § 2719(a)(1)(B), as added by PPACA, Pub. L. No. 111-148 (2010).

[33] PHSA § 2719A(a), as added by PPACA, Pub. L. No. 111-148 (2010); Treas. Reg. § 54.9815-2719AT(a)(1)(i); DOL Reg. § 2590.715-2719A(a)(1)(i); HHS Reg. § 147.138(a)(1)(i).

[34] PHSA § 2719A(d), as added by PPACA; Treas. Reg. § 54.9815-2719AT(d); DOL Reg. § 2590.715-2719A(d); HHS Reg. § 147.138(d).

[35] Code § 106(f), as added by PPACA, Pub. L. No. 111-148 (2010).

[36] PPACA, Pub. L. No. 111-148 § 9002 (2010).

[37] PHSA § 2715(a), as added by PPACA, Pub. L. No. 111-148 (2010).

[38] PHSA § 2715(d)(4), as added by PPACA, Pub. L. No. 111-148 (2010).

[39] PHSA § 2717, as added by PPACA, Pub. L. No. 111-148 (2010).

[40] Code § 125(i), as amended by PPACA, Pub. L. No. 111-148 (2010) and HCERA, Pub. L. No. 111-152 (2010).

[41] FLSA § 18B, as added by PPACA, Pub. L. No. 111-148 (2010).

[42] PPACA, Pub. L. No. 111-148, § 1312(f) (2010).

[43] Code § 4980H(a), as added by PPACA, Pub. L. No. 111-148 (2010) and amended by HCERA, Pub. L. No. 111-148 (2010).

[44] Code § 4980, as added by PPACA, Pub. L. No. 111-148 (2010) and amended by HCERA, Pub. L. No. 111-152 (2010).

[45] Code § 6056, as added by PPACA, Pub. L. No. 111-148 (2010).

[46] PPACA, Pub. L. No. 111-148, § 10108(a) (2010).

[47] PPACA, Pub. L. No. 111-148, § 10108(d)(2) (2010).

[48] PPACA, Pub. L. No. 111-148, § 10108(d)(1)(A) (2010).

[49] Code § 162(a), as amended by PPACA, Pub. L. No. 111-148, § 10108(g)(1) (2010).

[50] This rate is inconsistent with similar exchange limitations of 9.5%, and it is felt that this discrepancy is incorrect and will be corrected.

[51] PPACA, Pub. L. No. 111-148, § 10108(c)(1) (2010).

[52] PHSA § 2708, as added by PPACA, Pub. L. No. 111-148 (2010).

[53] PHSA § 2705(j), as amended by PPACA, Pub. L. No. 111-148 (2010).

[54] PPACA, Pub. L. No. 111-148, § 1302(c)(1).

[55] PHSA § 2709(a)(1), as added by PPACA, Pub. L. No. 111-148 (2010).

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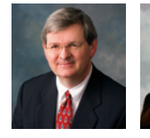

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