What Health Care Reform Means to Your Clients (and You)

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I. Introduction

The law firm had a problem.

The health insurance premiums, already high, were increasing by 63 percent. The small firm had always paid the full cost of employee coverage, but this was simply unaffordable. Moreover, the rate hike was difficult to understand – no one in the small group had experienced any significant claims – until a representative from the insurer explained that it was primarily because of the change in the average age of the group. Earlier in the year, three younger employees had left the firm, leaving only four persons on the policy and dramatically increasing the average age of the group. Because state rating laws allow insurers to consider age in establishing small group rates, the premiums shot up more than simple medical inflation would have called for. With no better premiums available from other insurers, the group moved to the highest deductible health plan it could acquire. Moving to a large deductible plan to reduce the impact of rate increases can create a burden on lower-paid employees, a difficult economic choice many businesses and individuals have had to deal with in recent years.[1]

That was in 2008. While that scenario will persist not just for law firms but for many small groups for a few years, the health reform law which President Barack Obama signed on March 23, 2010, after a contentious and often confusing year of debate in Congress, after raucous "town hall" meetings, and even after Glenn Beck vowed to leave the United States if reform passed (he didn't), will limit the use of age factors in rating small group and individual coverage (as explained below) in 2014. That will be good news for a group similar to the one above, but the flip side of that change will bring bad news in the form of higher premiums for younger persons, since insurers need to get aggregate premiums sufficient to cover claims for all persons.

That rating restraint is only one short provision in the contents of the 2,407 page health reform bill and the companion 148 page reconciliation act.[2] Those bills will do more than simply affect what law firms and other groups and individuals pay for insurance in the future. The reform bill contains provisions in effect today (at least one was retroactive to 2009 and others to the start of 2010), and those immediate changes have impacts on a variety of legal specialties, including adoption, tax planning, employment law, elder law and other practices, with a particular impact on lawyers counseling insurers, hospitals and other health care providers.

As with all significant legislation, a good deal of the details are left to be filled in by administrative agencies – indeed, the reform bill assigns responsibilities to "the Secretary" (most often Secretary of Health and Human Services Kathleen Sebelius) no fewer than 1,051 times.[3] At this writing, only a few of those regulations have been published.[4] Still, the outlines of the requirements are clear enough from the legislation itself to provide an understanding of its major impacts.

Attorneys who regularly counsel insurers, hospitals and other health care providers likely are already deep in the weeds of these laws seeking to identify how their clients will be affected. This article is not intended for them, mentioning those provisions only briefly, but rather is intended to provide attorneys in a broader variety of practices with an insight into some of the major provisions of the law that might affect their clients, their firms, or them personally. Below I've grouped the changes by the nature of their effect (e.g., "tax effects," "coverage effects") and within those generally by year of implementation. At the same time, the reform laws are complex, further regulations are yet to be issued, and no brief attempt at summarizing the scope of the provisions can be wholly comprehensive.

II. Tax Effects

Tax credits for health insurance premiums paid by small businesses in 2010[5]

A provision giving a tax credit for health insurance premiums paid by a business will have an immediate impact on businesses with fewer than 25 full-time equivalent employees meeting certain wage and contribution requirements. To be eligible for the credit, an employer must contribute at least half the premium cost for employee-only coverage (or the equivalent spread over family coverage contributions), not counting amounts paid under a salary reduction arrangement under IRS § 125 cafeteria plans. The credit is worth up to 35 percent of the average premium in the small group market in the state where the employer offers coverage (25 percent for tax-exempt small employers, used as a credit against employment taxes).

The credits can be carried forward for up to 20 years or carried back, after 2010, for one year. Small employers will claim the credit on their tax return filed for 2010; no corresponding deduction for amounts paid by the employer for employee coverage will be allowed. Two percent shareholders of an S corporation, 5 percent owners of a small business, partners, and persons who are dependents of such persons are not counted toward the 25 employee limit, nor are credits allowed with respect to their premiums. The amount of credit will vary with the size of the employer, and is reduced as average wages increase, with phase-down percentages for ranges from 10 to 25 full-time equivalent employees and from $25,000 to $50,000 in average annual wages.

Those credits are available for four years through 2013. Beginning in 2014, with the advent of the health insurance exchanges discussed below, they will be available only for "qualified health plans" (those providing "essential minimum benefits" as determined by the Secretary of Health and Human Services) and only for coverage offered to employees through those insurance exchanges. However, the credit increases to an amount up to 50 percent (35 percent for tax-exempt employers), but is only available for a two-year period. The credits are available both to businesses already sponsoring coverage and to businesses which start to offer coverage.

Extension and expansion of adoption tax credit/adoption assistance deduction through 2011[6]

In 2001, the adoption tax credit was expanded from $5,000 to $10,000 (more for special needs children) and indexed for inflation (the amount for 2010 had risen to $12,170). That expansion was set to revert to $5,000 in 2011. Similarly, the ability to exclude from income amounts paid by an employer under an adoption assistance program followed the same

scheduled amounts. The reform bill increased the credit or deduction by $1,000 to $13,170 for 2010, the credits were made refundable, and the reversion was delayed until 2012.

Codification of the economic substance doctrine effective March 23, 2010[7]

For some tax advisors involved in corporate and partnership tax planning, entering into a transaction principally for the purpose of tax reduction had been an acceptable reason for structuring certain deals. That has not been a position with which the IRS or most courts have agreed,[8] and the health reform laws codified what had been a contested point of law: the nature of the "economic substance doctrine," the requirement that transactions have a basis other than tax avoidance to enjoy favorable tax treatment. The changes specify that a transaction must have "economic substance" for a business (other than its federal tax position), requiring that the taxpayer's economic position have changed in a meaningful way and that the taxpayer had a substantial business purpose (other than its federal tax obligation) for engaging in the transaction.

It appears that simply profiting is in itself insufficient in terms of a change in economic position; rather, if the first test is met (change in economic position) then profit potential can be considered as a substantial purpose, using a test of whether the present value of pretax profits, taking into account the transaction expenses, is substantial compared to the present value of the anticipated tax benefits. The technical explanation[9] has a lengthy discussion indicating that these provisions are not intended to apply to certain tax credit transactions traditionally recognized, such as those involved in Section 42 low-income housing, production, new markets, and rehabilitation tax credits. The technical explanation further disclaims that the intent of the provision is not to change the law, but merely to clarify and codify existing case law.

The provision applies to transactions entered into on and after March 23, 2010. If a transaction is found to have no economic substance under the Code provisions, deductions, and credits are disallowed and a 20 percent penalty will apply if the transaction is disclosed on the taxpayer's return (the same rate as the understatement penalty) or a 40 percent penalty if it is not disclosed. While the codification is likely to be the site of contests to clarify its meaning and application in various circumstances, the signals the law sends to the judiciary by this change and its potential penalties are likely to discourage some types of aggressive tax planning. It is worth noting that this provision and a few others in the reform laws have no relation to health care but were included to help drive federal revenues.

Extension of gross income exclusion for health coverage of adult children[10]

As a complement to coverage provisions described below allowing children to remain on a parent's coverage to age 26, the tax code was amended to allow for exclusion from gross income of the benefit of employer-provided health coverage for children under the age of 27, rather than 26, effective for the 2010 tax year. Self-employed individuals are allowed a deduction for premiums paid for such children.

W-2 reporting value of employer contributions to health coverage for 2011[11]

Beginning with tax year 2011, employers will have the option to report on W-2 forms the value of health coverage paid by the employer and will be required to report it for 2010.

Change in eligibility for coverage under HSAs, FSAs, and HRAs in 2011[12]

Today, there is a difference between medical expenses that are deductible and the kinds of medical services that can be paid from funds in a health savings account (HSA), flexible spending account (FSA), or health reimbursement arrangement (HRA). In general, the latter have broader provisions, allowing not only direct medical care and prescribed drugs and supplies to be eligible, but also encompassing self-purchased over-the-counter medicines and supplies. The reforms change the definitions beginning in 2011 for HSAs, FSAs, and HRAs to conform with the definitions used for deductions, limiting the expenditures for which these plans can be used. There is an exception for over-the-counter medications acquired with a prescription. These changes will be important in planning for contributions to such plans later this year for 2011.

Increased taxes for nonmedical distributions from HSAs and MSAs[13]

Funds in HSAs and in Archer Medical Savings Accounts (MSAs) can be used for other than qualified medical expense, subject to a surtax. In 2011, that surtax will be increased from 10 percent to 20 percent for distributions from HSAs for uses other than qualified medical expenses and from 15 percent to 20 percent for such distributions from MSAs.

SIMPLE Cafeteria Plans for employers with 100 or fewer employees available in 2011[14]

An Internal Revenue Code § 125 cafeteria plan – a plan permitting an employee to elect between taxable benefits and nontaxable qualified benefits – can lower the functional cost to employees of what would otherwise be their share of health insurance premiums or other qualified benefits by allowing for payment on a pretax basis. However, the nondiscrimination testing requirements, intended to prevent plans which favor highly compensated or key employees either with respect to the plan as a whole or with respect to specified qualified benefits, can impose a significant administrative burden on smaller employers, creating obstacles to such employers in offering § 125 plan. Effective in 2011, the reform law creates a "safe harbor" for employers of 100 or fewer employees during either of the preceding two years if the plan meets certain eligibility and contribution requirements.

In brief, the eligibility requirements mandate that all employees be eligible to participate in any of the plan benefits if they are over age 21 (or a younger age if the plan provides), worked at least 1,000 hours in the prior year, and had (if the plan requires) at least one year of service with that employer. The contribution requirement is met if (a) the employer contributes a uniform percentage of at least 2 percent of the employee's compensation for the year (regardless of whether the eligible employee chooses to make any salary reduction contribution) or (b) the value of employer-paid benefits is the lesser of (1) at least 6 percent of each eligible employee's

compensation or (2) twice the amount of the salary reduction amount for each eligible employee who is not a highly compensated employee or a key employee (as defined in the Internal Revenue Code) and who participates in the plan. In essence, an employer can contribute an equal amount to all employees, whether participating or not, the employer can provide a minimum value of paid benefits, or the employer can match salary reduction amounts of nonhighly compensated, nonkey employees.

1099s for payments to corporations[15]

The obligation for a business to generate a form 1099 when it makes payments to another person currently does not require such information reporting to the IRS when payments are made to a corporation. Beginning in 2012, payments of $600 or more made to a corporation will also require generation of a 1099.

Elimination of deduction of expenses allocable to retiree drug coverage[16]

To encourage employers to continue to provide drug coverage to retirees when the Medicare Part D drug benefit became available, Congress provided for payment of subsidies to employers electing to participate, covering about 28 percent of the cost of retiree drug coverage. That subsidy was excludable (deductible) from such employers' incomes. Beginning in 2013, it will be nondeductible.

Additional taxes on high-income taxpayers in 2013[17]

For tax years 2013 and thereafter, a new 3.8 percent Medicare contributions surtax will be applied on unearned income, i.e., the lesser of (a) net investment income or (b) the excess of modified adjusted gross income (adjusted gross increased by the amount excluded from income as foreign earned income less deductions attributable to such income) over a threshold amount of $200,000 for single taxpayers, $250,000 for joint filers, $125,000 for married taxpayers filing separately, and approximately $11,200 for estates and trusts (or undistributed net investment income, if less). Charitable remainder trusts and charitable lead trusts are exempted from the surtax. In addition, the law increases the FICA tax (currently at 1.45 percent) by 0.9 percent on earned income for individuals of more than $200,000 per year and married couples of more than $250,000 per year.[18]

Limitations on FSA contributions[19]

For tax years beginning in 2013, the reforms will limit the amount of contributions one may make to a flexible spending account plan to $2,500, a decrease from the current $5,000 limit. After 2013, the limit will be indexed to the consumer price index general component.

Raising the threshold for itemized medical deductions.[20]

Currently, medical expenses are deductible only to the extent they exceed 7.5 percent of adjusted gross income. Beginning with 2013, that threshold increases to 10 percent of adjusted gross income.

Penalties for individuals failing to hold coverage or for large employers failing to contribute adequately towards premiums[21]

One of the key aims of the health reform law is to assure persons that they could acquire health insurance without being rejected by insurers because of existing health conditions, or being subject to underwriting restrictions, such as waiting periods or exclusionary riders, related to those conditions. The requirements on insurers to achieve that objective are discussed below. To avoid insurers being saddled with a large number of persons buying coverage only when they have a known medical need – to avoid insurers having to sell insurance "after the house is on fire" – Congress created incentives in the form of penalties for individuals to purchase coverage and for large employers to contribute to premiums. Those penalties are effective beginning in 2014 as follows:

- The law imposes a penalty on U.S. citizens who fail to maintain minimum qualified health insurance coverage. The penalty in 2014 will be the greater of 1 percent of household income or $95, in 2015 the greater of $325 or 2 percent of household income, and in 2016 and thereafter, the greater of $695 or 2.5 percent of taxable income, not to exceed the national average premium for the lowest-cost qualified plan. The penalties apply only to persons with incomes over a threshold level – $9,500 for single taxpayers, $18,700 for married persons filing jointly, $3,650 for married persons filing separately, and $12,000 for head of household status. Also exempted from the penalties are persons who cannot find a premium that is less than 8 percent of their income.

- The law also imposes a nondeductible penalty on large employers (generally those with 50 or more full-time employees) who do not meet certain contribution and coverage requirements. The penalty applies to a large employer when any full-time employee enrolls in a health insurance exchange and receives a premium assistance tax credit or cost-sharing. A penalty of $166.67 per month ($2,000 per year) per employee, based on the number of employees in excess of 30, applies to an employer in such a circumstance who fails to offer full-time employees the opportunity to enroll in a "minimum essential coverage plan" sponsored by the employer. If the employer offers such coverage but any employee is nonetheless enrolled through a health insurance exchange and receives a credit, a penalty of $250 per month ($3,000 per year) per employee enrolled in the exchange applies, not to exceed $166.67 per month per employee times the total number of full-time employees.[22] While that sounds like a complex approach, the concept underlying it is to encourage employers to offer coverage and to make an adequate contribution towards employee coverage so that employees elect to enroll in the employer's program.

III. Coverage Issues

Young adults can remain on parents' coverage[23]

Beginning with plan years six months after the effective date of the reform law (beginning September 23, 2010), children not otherwise eligible for employer-sponsored coverage will be able to stay on a parent's health plan to age 26. For many persons, the effective date of this provision will be January 1, 2011, because many plans operate on a calendar year basis. The U.S. Department of Health and Human Services (HHS) issued proposed regulations on May 13, 2010, explaining that access to coverage is available for unmarried and for married adult children (but not the spouses or children of such married children) and that the child need not be dependent for tax purposes, need not be a student, and need not be living at home.[24]

Several insurers have agreed to implement the change early, although the details may vary from one insurer to another.[25] Otherwise, eligible adult children not currently on a policy will be able to be added during a special open enrollment following the start of the plan year after September 23, 2010. Any premium due because of adding them would enjoy the same tax treatment as parental premiums and benefits received would not be taxable. In addition, if employers wish to allow coverage through age 26, changes in the tax code allow premiums and benefits to be treated in the same fashion as they are for the employee up to age 27. Nothing in the regulations or the law limits how insurers may charge for such additional coverage, including requiring higher premiums for children with severe health conditions.[26]

No unfair rescissions of coverage[27]

Beginning six months from the effective date of the reform law, insurers are banned from rescinding coverage except with regard to individuals who performed an act or practice that constitutes fraud or making of an intentional misrepresentation of a material fact in applying for coverage.

No lifetime benefit caps[28]

Beginning six months after enactment, group health plans (group insurance and self-insured plans) and individual insurance may not impose lifetime limits on the dollar value of benefits or set restricted annual limits on the dollar value of essential health benefits as determined by the Secretary of HHS. In 2014, annual limits will be banned entirely. These changes likely will eliminate a category of relatively low-priced insurance policies that insurers have sold in recent years such as those providing a very low lifetime limit on benefits or limited benefits for specified services, such as office visits, accidents, x-rays, and other services.

Access to coverage (high-risk pool)[29]

Although Kansas currently has a high-risk pool as a resource for otherwise uninsurable persons, that pool involves a six-month waiting period and premiums that are capped at 130 percent of comparable individual coverage.[30] Beginning 90 days from enactment of the reform law, each state must develop a high-risk pool for persons who have been uninsured for at least six months and who have a condition that prevents them from acquiring coverage in normal insurance markets. If a state does not develop such a pool, a pool run by the federal government will be available for citizens of that state.[31] The pool coverage may not impose any limitations on preexisting conditions and must cover, on average, 65 percent of medical costs and limit out-of-pocket spending to that allowed for an HSA, or $5,950 for individual policies and $11,000 for family policies.

Premiums will be based on market prices for similar coverage but may not vary based on age by more than a factor of 4 (that is, the price for older persons may not be more than four times the price for younger persons). Because the enrollees will be less healthy – more expensive – than persons covered in the ordinary individual market, the premiums are subsidized by federal appropriations. The high risk pool is temporary. When insurance exchanges come into being in 2014, the requirement to maintain high risk pools goes away, because (as explained below) insurers and health insurance exchanges will not be permitted to exclude persons based on health and will be subject to rating rules that eliminate health status as a factor.

First dollar coverage for preventive services[32]

Cost sharing (deductibles and copayments) for proven preventive care services, which will be identified by the Secretary of HHS, will be eliminated for new plans commencing six months after the effective date of the law. Although high deductible health plans provided as a part of a health savings account already may provide such coverage for preventive services, there exist today catastrophic coverages which subject all services to significant deductibles before benefits are available for any such services; these requirements may result in the elimination of such coverages in the future.

Reinsurance for employers covering retirees[33]

To be available within 90 days of enactment (June 23, 2010), employers providing insurance to retirees ages 55 to 64 (including coverage of a spouse, surviving spouse, and dependents) will receive up to 80 percent of costs for health benefits between $15,000 and $90,000. These amounts will be adjusted in future years by the medical component of the consumer price index. Plans must use these proceeds to lower health costs for enrollees (e.g., premium contributions, copayments, deductibles, etc.) The program terminates in 2014 when such persons will be eligible to acquire coverage through health insurance exchanges. Five billion dollars has been allocated for the program, and if that is exhausted, the program will end sooner.

Payments will be made to employer-sponsored health plans, and employers with either self-insured benefits or group health insurance are eligible. Because the proceeds must be used to lower premiums, deductibles or copayments, the amounts received are excludable from gross income. Employer health plans will have to submit an application to HHS along with documentation of paid claims for early retirees to receive the assistance. In addition, to be eligible, such employer health plans will have to implement programs aimed at generating cost savings for plan participants with chronic, high-cost conditions. Employers will likely have to secure paid claims data and other assistance from their insurers or claims administrators to complete the process.

Nondiscrimination in group health plans[34]

New group health plans established six months or later after the effective date of the legislation will be prohibited from discriminating in eligibility rules in favor of the highly compensated. Although the group quota requirements of many insurers effectively require participation by most employees not having coverage elsewhere, it has not been unusual for some employers to have differing benefits available for different classes of employees, reserving the richer plans (and higher contribution levels) for more highly paid employees. The legislation specifically provides that a plan will not be considered discriminatory if it provides higher levels of contributions to lower-paid employees (some employers have provided what amounts to graduated employee contributions, increasing with pay levels).[35]

New rights to external review of denied claims[36]

Most states (including Kansas)[37] have laws that create a right to external review by an independent entity of claims denied under a health insurance contract on the grounds of lack of medical necessity or because the service was determined to be experimental or investigational. For plan years beginnig on or after July 1, 2011, health insurers and group health plans (including self-insured plans) will be required to make available both an internal review process and a process for independent external review of denied claims following a model of the National Association of Insurance Commissioners. The result of that external review, if exercised, will be binding.

Reducing the coverage gap for Medicare Part D (drug coverage) enrollees

Medicare beneficiaries are eligible to enroll, subject to payment of additional premiums, in prescription drug plans underwritten by private insurance companies but subsidized by the federal government. The benefit structure currently includes a coverage gap – the "doughnut hole" – after initial benefits during which enrollees are exposed to a potential personal out-of-pocket expense ranging from $2,700 to $6,154 in drug costs. Enrollees who acquire prescription drugs subject to this coverage gap will receive a $250 rebate for 2010.[38] In 2011, a 50 percent discount on brand-name drugs acquired while in the coverage gap will reduce the impact of that gap, and additional discounts on both brand-name and generic drugs will be phased in until the coverage gap is completely eliminated in 2020.[39]

Rebates from insurers for excessive administrative costs and profits[40]

Beginning in 2011, health insurers will be required to spend 80 percent of premiums collected in the individual and small group markets and 85 percent of premiums collected in the large group market on medical services. Insurers not meeting those standards will be required to provide rebates to insureds for excessive premiums. The law directs the National Association of Insurance Commissioners to develop uniform definitions for insurer reporting of costs for medical services, and the Secretary of HHS is tasked with oversight and enforcement of the law.

Medicare advantage program changes

Beginning in 2012, the reform law changes the amount of government payments to privately-operated Medicare plans ("Medicare Advantage" plans) to bring them closer to costs under traditional Medicare,[41] thus affecting premiums enrollees must pay. The reform law also prohibits such plans, beginning in 2011, from having higher cost sharing requirements than traditional Medicare for chemotherapy, renal dialysis and other services, placing them on a more equal competitive footing with traditional Medicare.[42]

Government-administered long-term care insurance[43]

The reform measure includes provisions for a voluntary insurance program, to be administered by the federal government, providing coverage for community living services and institutional (long-term facility) care for persons who become functionally or cognitively disabled and require long-term care services when unable to perform activities of daily living. The provision is known as the Community Living Assistance Services and Supports program, or CLASS Act. The law calls for cash benefits to purchase nonmedical services and supports needed to maintain residence in the community of the insured (example services include adult day care, assistive technology, home modifications, personal assistance services, accessible transportation, and homemaker services) as well as payments when institutional care is necessary.

The level of benefits is to be based on the degree of disability, but may average no less than $50 per day. In modeling the program, a $75 per day benefit was widely anticipated.[44] While that amount is not enough to cover the full cost of such care, it would offset a substantial amount of such costs. In addition, since Medicaid would be secondary to the benefits of such a program, it would ease the burden on Medicaid as well. The CLASS benefits are to be financed by self-sustaining voluntary premiums paid by those electing to enroll, estimated at an average of $123 per month[45] (the rates will vary depending on age). Payroll deduction options will be available, and if an employer is participating, persons will be automatically enrolled unless they opt out. While it is expected that enrollment will begin in 2013, one must have paid premiums for five years and have worked for at least three of those five years before benefits are available.[46]

2014 rules encouraging enrollment in coverage (the so-called "mandate")[47]

Starting in 2014, all U.S. citizens and legal residents (with income-related exceptions) will be required to have minimum essential coverage or pay a penalty.[48] The Secretary of HHS will develop regulations specifying the contents of "minimum essential coverage." The penalty is graduated over three years, beginning as the greater of $95 per person or 1 percent of income in 2014, increasing to $325 per person or 2 percent in 2015, to $625 and 2.5 percent in 2016, and indexed thereafter for inflation. The obligation will be monitored through reporting on tax returns (as well as matching required information reporting by insurers) and will be enforced by the IRS as a required payment in addition to taxes. The IRS will be entitled to withhold refunds to enforce the penalty but many of its traditional enforcement tools will not apply (underpayment penalties and interest, levies, and seizure of assets, for ex-

ample). The penalties are significantly less than the actual cost of maintaining coverage – the average cost of an individual policy providing single coverage in 2009 was $2,985 per year, with a range from $1,350 for persons under 18 to $5,755 for persons age 60-64.[49]

Making insurance affordable through advance tax credits[50]

The law creates premium assistance tax credits designed to assure that low-income persons do not spend more than a specified percentage of income on medical insurance premiums. Those credits first become available in 2014. Persons with household incomes between 100 percent and 400 percent of the federal poverty level will be eligible for those credits, which will be payable in advance. The tax credits will assure that such persons at the lower end of this scale spend no more than 2 percent of income for premiums and that persons at the upper end spend no more than 9.5 percent. Such assistance may only be used to purchase coverage through a health insurance exchange.

Limits on cost sharing for low-income individuals[51]

Starting in 2014, the law creates limits on out-of-pocket costs related to the same household income thresholds that determine eligibility for advance tax credits. For persons at the lower end of the scale the reform law limits cost-sharing to one-third of health savings account limits ($1,983 for individuals, $3,967 for families) and ranges up to two-thirds of the HSA limits for persons at the upper end of that scale.

Guaranteed availability of health insurance beginning in 2014[52]

Beginning in 2014, insurers will be prohibited from rejecting any person from coverage, although insurers will be permitted to limit enrollment dates to open enrollment periods. This guaranteed-issuance requirement is a reciprocal of the requirement that individuals hold coverage or pay a penalty. Insurers could not be required to accept anyone who sought coverage if they could not get a broad cross-section of the healthy and those needing care, and to get such a broad cross-section, some disincentive to not enrolling in coverage was necessary.[53] As noted above, upon the 2014 effective date of this guaranteed-issue requirement, the need for a separate high risk pool for persons who would be rejected because of existing health conditions will be moot, and the high risk pools will be eliminated.

Rating rules in the individual and small group markets[54]

As the scenario introducing this article indicates, in 2014 a provision becomes effective that will have important effects, favorable to some and unfavorable to others, limiting how insurers may develop rates in the individual and small group markets. Insurers will be prohibited from charging the oldest individuals, or small groups with persons with older average ages, more than three times the amount charged the youngest such individuals or groups. By comparison, insurers today may have age ratios of 1:7 or higher.[55] While that will mean lower premiums for older persons, it will mean higher premiums for younger persons. In addition to this restriction, individual and small group rates may not take health status (other than tobacco use) into consideration in rate development, and may only use as additional factors geographic rating area and family composition. Today, other factors, including group size, group claims experience, industry classification, and (in the individual market) health status, all influence rates in these market segments.[56]

Limits on deductibles and cost-sharing[57]

Starting in 2014, deductibles in the small group market will be limited to $2,000 for individuals or $4,000 for families (with the additional requirement of first-dollar coverage of preventive services). In addition, annual cost sharing (deductibles and copayments combined) will be limited to the HSA limits in effect.

Health insurance exchange[58]

The reform legislation creates state-based health exchanges (the "American Health Benefit Exchanges and the Small Business Health Options Program (SHOP) Exchanges), to be available beginning in 2014. Exchanges can be thought of as an insurance "shopping mall" in which persons can select the insurer and the benefit plan of their individual choice whether enrolling as an individual or as an employee of a participating employer.

The exchanges will be administered by a governmental unit or a nonprofit organization. Individuals and employers of up to 100 employees (prior to 2016, states have the option of limiting that to employers of up to 50 employees) can purchase minimum essential insurance through the exchanges. Those persons and employers receiving premium assistance or tax credits must acquire coverage through the exchanges. States are authorized to use a single exchange for both the individual and small group markets (and by 2017, can expand availability of the exchanges to larger employers).

Health insurance exchanges embody several theories. One is that by creating a central market in which price, quality, and other information can be accessed by consumers, a more competitive insurance market will result.[59] Another underpinning is that exchanges will create a market of insurance purchasers of such significance that insurers have to offer rates (in essence, reduce their administrative costs and profit margins) to a level similar to those charged to large groups. A third element of exchanges is that they allow consumers, including employees accessing coverage through the exchange, to have a choice of insurance carriers and plans, and to acquire coverage which is portable – which can be carried from one place of employment to another, rather than depending on the insurance carrier and coverage selected by an employer.[60]

The coverages available in an exchange would be sold by existing health insurers meeting qualifications established by HHS and the exchanges. The same underwriting limitations and rating restrictions (guaranteed issuance, limited rating factors) applicable to insurers selling coverage in the individual and small group markets would also apply to coverage sold through the exchanges. Each exchange must offer at least two plans available on a multi-state basis and at least one plan that provides no coverage for abortion other than coverage permitted by federal law. States can enter into regional compacts creating multi-state exchanges or can allow more than one exchange if each serves a distinct, separate geographical area.

The Secretary of HHS will set up and operate an exchange in any state that fails to establish one.

Other features of exchanges include:

- Availability of four benefit levels – The Secretary of HHS will define uniform benefit packages ("essential minimum coverage") which must include ambulatory patient services, emergency services, hospital services, maternity and newborn care, mental health services, substance abuse services, prescription drugs, rehabilitation services, ease management services, and pediatric services including oral and vision care. Four levels of coverage must be available: Bronze (the plan would provide 60 percent of actuarial value of plan benefits), Silver (70 percent), Gold (80 percent) and Platinum (90 percent). All plans in an exchange must offer at least one Silver plan and one Gold plan. Plans may also offer programs of catastrophic benefits, with deductibles at the HSA level but initial coverage for preventive services and three primary care visits per year to persons (a) either under age 30 or (b) who are exempt from the requirement to hold coverage or pay a penalty because the cost of coverage would exceed 8 percent of their income. States can also create a "Basic Health Plan" for persons with incomes between 133 percent and 200 percent of the federal poverty level to be available as an alternative to such persons receiving premium subsidies to purchase coverage through the exchange.

- Exchanges will certify insurers allowed to offer coverage in an exchange and will monitor (but not regulate) premium increases.

- Exchanges will make public ratings of health plans based on quality and price, and will require plans to make public information on claim payment policies, financial information, enrollment date, denied claim data cost sharing requirements, out-of-network payment obligations of enrollees and other information.

- Exchanges will require the use of a uniform enrollment form by participating insurers.

- Exchanges will operate a toll-free consumer assistance hotline and a website allowing persons to obtain standardized comparative information about health plans offered by participating insurers.

- Importantly, exchanges will administer subsidies for individuals, including "free choice" vouchers described below.

Free choice vouchers[61]

To assure that affordable coverage is available to employees who would not qualify for Medicaid but for whom employee contributions for an employer plan pose a burden, the act provides that beginning in 2014, employers that offer minimum essential coverage to employees and pay any part of the premium must also provide a "free choice voucher" to employees for whom the required employee contribution would exceed 8 percent, but not exceed 9.8 percent, of household income.

The free choice voucher would be valued at the employer contribution level, and could be used by the employee in an exchange to pay premiums for a plan the employee acquires through the exchange as an alternative to the employer plan, with the employee paying for any difference between the value of the voucher and the premium. The vouchers do not count as taxable income to the employee, are used in determining any additional premium subsidy the employee gets in the form of tax credits, and are deductible by the employer. The underlying need for an employer to know not just an employee's wage base but the household income of the employee is worth noting in this element of the law.

Provider provisions payments

The reform law contains a variety of provisions dealing with Medicare payments, and a thorough description of those is not possible in this article. As a centerpiece of the reform, the law establishes an Independent Payment Advisory Board, modeled on the military base closure commission, which would be required to submit recommendations to achieve spending reductions beginning in 2014 unless growth in Medicare per capita spending is at or below a specified rate. The Secretary of HHS is required to implement those recommendations unless Congress enacts legislation achieving the same level of savings.[62]

The law also includes a variety of specific payment changes, including reductions in the index used to update payments for hospital services beginning this year, and for home health agencies, skilled nursing facilities and other Medicare institutional providers in 2012.[63] Other payment changes include reductions in payments made to hospitals serving a large number of Medicaid and uninsured persons (disproportionate share hospitals) beginning in 2014.[64]

The reform law also provides a 10 percent bonus payment to primary care physicians and nurse practitioners beginning in 2011 if at least 60 percent of their services were for primary care, and a 10 percent bonus to general surgeons practicing in health professional shortage areas.[65] The law also schedules general reductions (no more than 1 percent in 2013, 2 percent in 2014, and 3 percent in 2015 and thereafter) in amounts otherwise payable to hospitals (other than critical access hospitals) to account for payment otherwise occurring for preventable readmissions, and a reduction by 1 percent beginning in 2015 for hospital-acquired infections.[66]

The law authorizes some innovative programs. These include a pilot program to pay a bundled amount for an episode of care for inpatient and outpatient services rather than paying for each service separately,[67] payment arrangements to providers organized as Accountable Care Organizations allowing them to share in cost savings they achieve,[68] and a program to encourage at-home care of high-need Medicare beneficiaries by allowing teams of health care professionals to share savings from reduced hospitalizations coupled with improved outcomes and patient satisfaction.[69]

The reform law also contains various provisions addressing quality, and incentives related to quality. These include payment programs for hospitals based on performance measures

beginning in 2012, with a requirement for developing similar plans for skilled nursing facilities, home health agencies, and ambulatory nursing facilities. There are also provisions for incentive payments to physicians for quality reporting through 2014,[70] coupled with a mandatory physician quality reporting program beginning in 2015.[71]

Changes to Antikickback Act and False Claims Act, obligation to return overpayments

Today, physicians and hospitals are prohibited by the Antikickback Act from furnishing a thing of value to another if any purpose was to induce referrals.[72] Because the Antikickback Act containing these provisions includes criminal penalties, it is strictly construed and proof of intent to induce a referral is required.[73] In addition, the False Claims Act, making it a crime to present the government with a false claim, has frequently been invoked against health care providers with respect to Medicare payments.[74]

The reform law includes an obligation for a health care provider to report and return known overpayments within 60 days, and provides that a known overpayment not returned is an obligation (a claim, in essence) under the False Claims Act.[75] The reform law separately provides that a kickback also constitutes a false claim under that Act.[76] Finally, addressing the enforcement of the Antikickback Act in all circumstances, the reform law provides that a person need not have actual knowledge of the provisions of the Antikickback Act or a specific intent to commit a violation of it to be liable.[77]

Time for submission of Medicare claims[78]

The time allowed for submission of Medicare claims is reduced in the law from three years to one year.

Charitable hospital obligations[79]

The law creates both action and reporting criteria for charitable hospitals. Charitable hospitals are required to engage in a community health needs assessment, to have a written financial assistance policy, not to charge persons eligible for financial assistance more than is generally billed to insured persons, not to engage in extraordinary collection efforts before determining whether a patient is eligible for financial assistance, and to undergo a mandatory review of their tax exemption every three years. Charitable hospitals are also subject to a special tax beginning in 2011 (regardless of whether they retain their tax exemption) for failure to meet the requirements applicable to charitable hospitals set out in the law.

Physician interests in facilities

Concern that physician ownership of specialty hospitals (e.g., heart hospitals, spine hospitals, etc.) resulted in unnecessary admissions caused Medicare to impose a moratorium on payments to new physician-owned specialty facilities for a period running from late 2003 through early 2005.[80] The reform law prohibits expansion or new creation of physician-owned hospitals (not restricted to specialty hospitals), requires reporting on the identity and extent of current physician ownership, prohibits increases in percentages of current ownership, requires physician-owners referring patients to hospitals in which they have an interest to disclose that interest, and requires hospitals to disclose physician ownership interests on websites and in public advertising.[81]

In addition, beginning with the effective date of the act, the law creates an obligation for physicians with an ownership interest in an MRI, CT, PET, or other designated services to inform a patient, when referring that patient for such service, of that interest and to advise the patient that the service may be obtained from another place, providing the patient with a list of suppliers of the service.[82]

IV. Other Provisions

Demonstration programs for alternatives to medical malpractice litigation[83]

The act provides for the Secretary of HHS to award grants to states that develop demonstration programs allowing for alternatives to malpractice litigation. The alternative resolution procedures must be voluntary and the participants informed of the effect of them and of their alternatives.

Elder Justice Act[84]

The law contains the Elder Justice Act, addressing adult abuse, neglect or exploitation by a caregiver, including both volunteers and those working for pay (and encompassing family members who provide compensated or uncompensated supportive services to an elder). The Elder Justice Act provides grants to states for elder justice programs, to create elder justice forensic centers, to support long-term care ombudsman programs and adult protective services, and to create incentives and programs to enhance training, recruitment, and retention of staff providing direct long-term care. The Elder Justice Act also creates an elder justice coordinating council and an advisory board to provide recommendations on improving the quality of long-term care and other elder care elements.

Employers to provide lactation facilities[85]

The reform law requires employers to provide reasonable break times for an employee to express breast milk for a nursing child for one year after the child is born and to provide a place shielded from view and intrusion by others. An employer does not have to compensate for that time (other than compensation an employer might provide for regularly-provided breaks). The requirements do not apply to employers of fewer than 50 employees if doing so would create a substantial hardship on the employer in terms of facilities, staffing, or other factors.

Excise tax on tanning services in 2010[86]

A 10 percent excise tax will be levied on indoor tanning services (those services using UV lamps) effective July 1, 2010. This tax replaced a proposed tax on cosmetic surgery.

Nutritional labeling in chain restaurants[87]

Chain restaurants will be required, pursuant to regulations to be issued within one year of the effective date of the act, to provide nutritional labeling (nutrient and caloric content) of standard menu items as well as suggested daily caloric intake on menus or with posted prices, and with each item at a salad bar.

V. Not a Conclusion

The Patient Protection and Affordable Care Act is so comprehensive and so broad in its reach that an exhaustive description of all elements that might be of interest to any given attorney or anyone interested in health care financing as a policy matter would be well beyond the limitations of this article. The article has not even touched on the provisions of the law regarding significant Medicaid expansion, for instance, or on those provisions regarding health information technology, the website the Secretary of HHS will have available in the summer of 2010 to allow persons to be aware of existing health insurance alternatives, the authorization for nonprofit cooperative health insurance plans in the exchanges, additional support for maternal and child health services, support for community health centers, nursing home quality, transparency and accountability, requirements on insurers when emergency services are obtained from a provider not contracting with that insurer, and other elements, each of significance. In addition, clarification of and implementation of many aspects of the law through the publication of regulations, particularly HHS regulations, is occurring regularly and will continue unabated during the next three years at least.

At a minimum, the Patient Protection and Affordable Care Act will affect the health insurance plans of law firms both this year and in the future, and likely will have impacts on the clients of and practices of nearly all lawyers in some fashion.[88] ■

About the Author

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ENDNOTES

1. The example is taken from the experience of the law firm with which the author is associated. Its health plan included health savings accounts and the firm increased its contribution to those accounts substantially when moving to the higher deductible.

2. H.R. 3590, the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and H.R. 4872, the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152. Throughout, citations to the former are to Pub. L. No. 111-148 sections, and to the latter are to section numbers of the Reconciliation Act. The sections of these laws frequently amend existing laws, such as the Social Security Act, the Public Health Services Act, and the Internal Revenue Code. For brevity's sake, the sections of those existing laws which are amended are not always identified in the following footnotes unless doing so did not result in a complex footnote.

3. Transcript: *Health on the Hill*, Kaiser Health News (April 26, 2010), http://www.kaiserhealthnews.org/Stories/2010/April/26/Health-On-The-Hill-Transcript.aspx.

4. *See, e.g.*, Group Health Plans and Health Insurance Issuers Providing Dependent Coverage of Children to Age 26 Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 27141-01 (May 13, 2010); Early Retiree Insurance Program, 75 Fed. Reg. 24450-01 (May 5, 2010).

5. Pub. L. No. 111-148 § 1421, 124 Stat. 119, 237-42.

6. *Id.* § 10909, 124 Stat. 119, 1021-24.

7. Reconciliation Act § 1409.

8. *See, e.g., ACM P'ship v. Comm'r*, 157 F.3d 231 (3d Cir. 1998), *cert. denied,* 526 U.S. 1017 (1999).

9. Joint Committee on Taxation, Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," as Amended, in Combination With the "Patient Protection and Affordable Care Act" (March 21, 2010), *available at* http://www.jct.gov/publications.

10. Reconciliation Act § 1004.

11. Pub. L. No. 111-148 § 9002, 124 Stat. 119, 853-54. The IRS has announced that such inclusion will be optional in 2011, but mandatory beginning in 2012. http://www.irs.gov/pub/irs-drop/n-2010-69.pdf.

12. *Id.* § 9003, 124 Stat. 119, 854.

13. *Id.* § 9004, 124 Stat. 119, 854-55.

14. *Id.* § 9022, 124 Stat. 119, 855.

15. *Id.* § 9006, 124 Stat. 119, 874-77.

16. *Id.* § 9012, 124 Stat. 119, 855.

17. Reconciliation Act § 1402.

18. *Id.* § 9015, 124 Stat. 119, 871-72.

19. *Id.* § 9005, 124 Stat. 119, 854-55.

20. *Id.* § 9013, 124 Stat. 119, 868.

21. *Id.* § 1501, 124 Stat. 119, 242-49.

22. *Id.* § 1513, 124 Stat. 119, 253-56.

23. *Id.* § 1001, 124 Stat. 119, 132, adding new § 2714 to the Public Health Service Act. The exception to the obligation to cover children to age 26 if they have other employer-sponsored coverage available to them applies only to existing employer health plans, and those will be obligated to provide coverage without regard to the offer of other employer coverage beginning in 2014. Individual policies renewed after and new employer health plans established after September 23, 2010, must make the coverage available without regard to the availability of employer-sponsored coverage for such child.

24. Group Health Plans and Health Insurance Issuers Providing Dependent Coverage of Children to Age 26 Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 27141-01 (May 13, 2010).

25. U.S. Department of Health and Human Services, Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Families and Businesses, *available at* http://www.hhs.gov/ociio/regulations/adult_child_fact_sheet.html (last visited May 20, 2010).

26. *Id.*

27. Pub. L. No. 111-148 § 1001, 124 Stat. 119, 131, adding new § 2712 to the Public Health Service Act.

28. *Id.* § 1001, 124 Stat. 119, 131, adding new § 2711 to the Public Health Service Act.

29. *Id.* § 1101, 124 Stat. 119, 141-43.

30. K.S.A. 40-2117 *et seq*. According to a report of the Government Accountability Office, the premiums in Kansas for persons in the high risk pool are 130 percent of the market rate, although the law would permit premiums to be up to 150 percent of that rate, K.S.A. 40-2119(c)(4), GAO-09-730R, Health Insurance: Enrollment, Benefits, Funding, and Other Characteristics of State High-Risk Health Insurance Pools, at 17, (July 22, 2009), *available at* http://www.gao.gov (enter GAO-09-730R in the search box).

31. Kansas has elected to have a state-run pool rather than rely on the federal fallback. Letter from Sandy Praeger, Insurance Commissioner, to Kathleen Sebelius, Secretary of HHS, *available at* http://www.ksinsurance.org/consumers/healthreform/HHS--High_Risk_Pool_letter.pdf.

32. Pub. L. No. 111-148 § 1001, 124 Stat. 119, 131-32, adding new § 2713 to the Public Health Service Act. This requirement and certain other requirements do not apply to "grandfathered" health plans (plans without significant changes in coverage or employee cost sharing) until plan years beginning in 2014. 26 C.F.R. 2590.

(Continued on next page)

33. *Id.* § 1102, 124 Stat. 119, 143-145. The Secretary of HHS published proposed regulations relating to early retiree reinsurance on May 5, 2010. Early Retiree Insurance Program, 75 Fed. Reg. 24450-01.

34. There is currently some difference of opinion over what constitutes a "new" health plan, i.e., whether an employer that changes carriers or that adopts a different benefit structure has adopted a new health plan or whether that employer has simply modified an existing plan.

35. Pub. L. No. 111-148 § 1001, 124 Stat. 119, 135, adding new § 2716 to the Public Health Service Act.

36. *Id.* § 1001, 124 Stat. 119, 137-38, adding new § 2719 to the Public Health Service Act. Interim regulations governing such appeals appear at 45 C.F.R 147.136. For a discussion of state constitutional issues regarding statutes creating external review processes, which are binding on an insurer, *see* William Pitsenberger, "*Sez Who?" State Constitutional Concerns with External Review Laws and the Resulting Conundrum Posed by Rush Prudential HMO v. Moran*, 15 Conn. Ins. L.J. 85 (2008-2009).

37. K.S.A. 40-22a13 *et seq*.

38. Pub. L. No. 111-148 § 3301, 124 Stat. 119, 467-68, amending § 1860D-2(b) of the Social Security Act.

39. *Id.* § 3301, 124 Stat. 119, 461-462, adding new § 1860D-43 to the Social Security Act.

40. *Id.* § 10101(f), 124 Stat. 119, 885-86, adding new § 2718(c) to the Public Health Service Act.

41. *Id.* § 3201, 124 Stat. 119, 442-54, amending § 1853(j) of the Social Security Act.

42. *Id.* § 3202, 124 Stat. 119, 454-55, amending § 1852(a)(1)(B) of the Social Security Act.

43. *Id.* § 8001 and 8002, 124 Stat. 119, 828-46, adding new §§ 3201-10 to the Public Health Service Act.

44. *Id.*

45. Kaiser Family Foundation, The Community Living Assistance Services and Support Act Issue Brief, http://www.kff.org/healthreform/7996.cfm (last visited May 20, 2010).

46. *Id*.

47. Pub. L. No. 111-148 § 1501, 124 Stat. 119, 242-49, adding new § 5000A to the Internal Revenue Code.

48. This provision is at the heart of constitutional challenges to the health reform law with opponents asserting that there is no power under the Commerce Clause for the federal government to require a person to buy insurance. *See, e.g., Thomas More Law Center et al. v. Obama et al.*, __ F. Supp. 2d __, 2010 WL 3952805 (E.D. Mich. 2010) (dismissing request for injunction); *Virginia ex rel. Cuccinelli v. Sebelius*, 702 F. Supp 2d 598 (E.D. Va. 2010) (denying government motion to dismiss request for injunction); *Florida ex rel. McCollum v. U.S. Dept. of Health and Human Services*, __F. Supp. 2d__, 2010 WL 4010119 (N.D. Fla. 2010) (denying government motion to dismiss request for injunction).

49. America's Health Insurance Plans, Individual Health Insurance 2009, http://www.ahipresearch.org/pdfs/2009IndividualMarketSurveyFinalReport.pdf (last visited May 20, 2010).

50. Pub. L. No. 111-148 §§ 1401, 1411 and 1412, 124 Stat. 119, 213-20, 224-33, as amended by §10104 of Pub. L. No. 111-148, 124 Stat. 119, 904, and further amended by § 1001 of the Reconciliation Act, adding new § 36B to the Internal Revenue Code.

51. *Id.*

52. *Id.* § 1201, 124 Stat. 119, 156, adding new § 2702 to the Public Health Service Act.

53. *Id.* § 1501, 124 Stat. 119, 242-44, expressing the Congressional rationale for the requirement for coverage or payment of a penalty.

54. *Id.* § 1201, 124 Stat. 119, 155-56, adding new § 2701 to the Public Health Service Act.

55. Mark A. Hall, *The Competitive Impact of Small Group Health Insurance Reform Laws*, 32 U. Mich. J.L. Reform, 685, 693-94 (1999).

56. John V. Jacobi, *The Ends of Health Insurance*, 30 U.C. Davis L. Rev. 311, 374 (1997).

57. Pub. L. No. 111-148 § 1302(c), 124 Stat. 119, 165-167.

58. *Id.* §§ 1311-1312, 124 Stat. 119, 173-84.

59. The Commonwealth Fund, *Health Insurance Exchanges in Health Care Reform: Legal and Policy Issues*, http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/Dec/Health-Insurance-Exchanges-in-Health-Care-Reform-Legal-and-Policy-Issues.aspx (last visited May 6, 2010).

60. *Id.*

61. Pub. L. No. 111-148, § 10108, 124 Stat. 119, 912-14.

62. *Id.* §3 403, 124 Stat. 119, 489-507, adding new § 1899A to the Social Security Act.

63. *Id.* § 3401, 124 Stat. 119, 480-88.

64. *Id.* § 3133, 124 Stat. 119, 399-409, as amended by Pub. L. No. 111-148 § 10316, 124 Stat. 119, 946-947 and by § 1104 of the Reconciliation Act.

65. *Id.* § 5501, 124 Stat. 119, 399-404, as amended by Pub. L. No. 111-148 § 10501, 124 Stat. 119, 993.

66. *Id.* 8 § 3025, 124 Stat. 119, 408-13 (readmissions) and *id.* § 3008, 124 Stat. 119, 376-78 (hospital-acquired infections).

67. *Id.* § 3023, 124 Stat. 119, 399-404, as amended by Pub. L. No. 111-148 § 10308, 124 Stat. 119, 941-42.

68. *Id.* § 3022, 124 Stat. 119, 395-99, as amended by 111-148 § 10307, 124 Stat. 119, 940-941.

69. *Id.* § 3024, 124 Stat. 119, 404-08.

70. *Id.* §§ 3001, 3004-3007, 124 Stat. 119, 352-64, 368-76.

71. *Id.* § 3002, 124 Stat. 119, 364-66.

72. 42 U.S.C. § 1320a-7b(b); *United States v. Greber*, 760 F.2d 68, 69 (3d Cir. 1985).

73. *Hanlester Network v. Shalala*, 51 F.3d 1390, 1397-98 (9th Cir. 1995).

74. 31 U.S.C. § 3729 *et seq*.

75. *Id.* § 6402, 124 Stat. 119, 753-63.

76. *Id*.

77. *Id*.

78. *Id.* § 6404, 124 Stat. 119, 765-68.

79. *Id.* § 9007, 124 Stat. 119, 855-59, as amended by *Id.* § 10903, 124 Stat. 119, 1016.

80. 2005 Health Law Handbook § 7:32 (Alice Gosfield, ed., 2005).

81. Pub. L. No. 111-148 § 6001-6002, 124 Stat. 119, 684-96.

82. *Id.* § 6003, 124 Stat. 119, 697.

83. *Id.* § 10607, 124 Stat. 119, 1009-14.

84. *Id.* § 6701-6703, 124 Stat. 119, 782-804.

85. *Id.* § 4207, 124 Stat. 119, 577-78.

86. *Id.* § 10907, 124 Stat. 119, 1020.

87. *Id.* § 4205, 124 Stat. 119, 573-76.

88. For attorneys who wish to keep abreast of new regulations or discussions about the impact of health reform, there are a number of institutions which provide e-mail alerts and newsletters they might consider subscribing to, including those of HHS (www.healthreform.gov), the Kaiser Family Foundation (www.kff.org), and the Commonwealth Fund (www.commonwealthfund.org). In addition, the websites of the Kansas Insurance Commissioner (www.ksinsurance.org), and of the Kansas Health Policy Authority (www.khpa.ks.gov) are regularly updated with information about local reform implementation issues.