Wade • Goldstein • Landau • Abruzzo
A Professional Corporation
Attorneys-at-Law
61 Cassatt Avenue
Berwyn, Pennsylvania 19312
Telephone: (610) 296-1800
Fax: (610) 296-1802

Website: http://www.wadegold.com

How the Affordable Care Act Will Affect Your Practice
By Jill Garabedian, Esq., Brenda Laigaie, Esq., and Robert A. Wade, Esq.

The Patient Protection and Affordable Care Act (PPACA) is known by many names, the "Affordable Care Act," "Health Reform," and, infamously, by its detractors, "Obamacare." What is not as well known by many people, however, is how the PPACA will affect them individually and as business owners and employers. The PPACA was signed into law on March 23, 2010 by President Obama after much debate by Congress. The key provisions of the PPACA that most people are aware of are the protections for individuals with pre-existing conditions, the expansion of Medicaid exchanges, and, of course, the individual mandate, which requires adults to maintain minimum essential health insurance coverage for themselves either through an employer-sponsored plan, individual market policy, or one of the government plans (e.g., Medicaid, Medicare, TRICARE, CHIP, etc.). Following the passage of the PPACA, many cases were brought in federal court challenging the constitutionality of various provisions of the PPACA. Ultimately, the constitutionality of those certain provisions of the PPACA was brought before the Supreme Court, which recently rendered its decision upholding the PPACA as constitutional. Barring the outcome of the elections this November for Congress and the Presidency and any actions to repeal the law or portions of it, it is important for employers to understand what is now being required under the law and how the law will affect them as certain provisions go into effect in the coming years. Below are what we consider to be the top five concerns for physicians, as health care providers and employers.

Small Business Health Care Tax Credit

Small employers are not expected to be impacted as much as large employers under the PPACA. Under the law, an employer with less than 50 full-time employees (full-time defined as individuals working more than thirty hours per week) will not be subject to the much discussed employer mandate. Additionally, employers with less than 25 full-time employees and average wages of less than $50,000 per year will actually benefit from a tax credit if they meet certain standards. In order to be eligible for the tax credit, these small employers must pay at least half of the cost of health care coverage for each employee. If an employer is eligible under these requirements, it will receive a tax credit of up to 35% of the contribution made toward employees' health insurance premiums for tax years 2010-2013, which will increase to up to 50% of its contribution toward employees' health insurance premiums starting in 2014.

The actual amount of the tax credit a business may get is dependent on the number of employees and the average wages of those employees. The smaller the business, the higher the tax credit it may be eligible to receive. According to the PPACA, the amount of tax credit available to small

business owners is reduced for employers with ten or more full-time employees or with average wages of more than $25,000 per year. To calculate its credit, a business must fill out Form 8941, Credit for Small Employer Health Insurance Premiums, through the Internal Revenue Service. It is important to note that this tax credit can be applied to other tax years, either backwards or forwards. In addition, a business may also be able to claim a business expense deduction for those premiums that exceed the amount of the tax credit.

To determine if your practice qualifies as a small business under this provision, calculate your number of full-time employees by dividing the total number of hours for which wages were paid by you during a taxable year (not to exceed 2,080 for each employee) by 2,080. This number can then be rounded to the next lowest whole number. For example, let's say that a practice has paid wages on a total of 17,160 hours worked by its staff. 17,160 divided by 2,080 is equal to 8.25, therefore, under the PPACA, the practice has 8 full-time employees. While many small business owners have yet to take advantage of this tax credit, you should talk to your accountant to see if this would benefit your business.

Automatic Enrollment for Employees of Large Employers

While small employers are eligible for tax credits for offering employees health insurance, larger employers, in addition to the mandate, have other responsibilities under the PPACA. One such responsibility is automatic enrollment of certain employees in the employer health plan. Under this provision of the PPACA, an employer that offers enrollment health benefit plans and that has more than 200 full-time employees is required to automatically enroll new full-time employees in one of its plans. It also requires that current employees are continued to be enrolled in the health benefit plans that are offered by an employer. At the time of hiring, employers are required to provide notice to employees of this automatic enrollment and provide an opportunity for an employee to opt out of the automatic coverage. For larger employers, this requirement is important to be aware of and prepare for, however, at this time, employers are not expected to comply with the automatic enrollment requirements until more information is given in the final regulations to the promulgated by the Department of Labor in 2014.

Transparency and Program Integrity

While health care providers need to be aware of the provisions of the PPACA that affect them as employers, the PPACA, as amended by the Health Care and Education Reconciliation Act of 2010, also contains over 32 sections related to fraud and abuse prevention and enforcement that apply directly to physicians. In some instances, the PPACA amends existing fraud statutes. In other instances, it creates new and complicated anti-fraud measures. This section will focus on the program integrity provisions ("Program Integrity" or "PI") of the PPACA.

The Centers for Medicare and Medicaid Services ("CMS"), through its Center for Program Integrity, has an improved and updated approach to Program Integrity. Under the National Fraud Prevention Program, CMS is using sophisticated data analysis and predictive modeling to transform its fraud prevention efforts. CMS has two concurrent approaches to its fraud prevention and detection initiatives. One approach focuses on the prevention of improper payment of claims. The other approach focuses on provider screening through the enrollment process. The goal is three fold: 1) prevent improper payment of Medicare and Medicaid claims; 2) identify bad actors and prevent them

from enrolling in the Medicare/Medicaid system; and 3) remove the bad actors from the Medicare/Medicaid system and keep them out.

CMS is not alone in its efforts. It has identified strategic partners, such as the OIG, DOJ and FBI with respect to law enforcement, as well as state and private insurers for purposes of information exchange and sharing of data. In addition, on the heels of the successful Recovery Audit Contractor (RAC) pilot program and roll-out of the full program, CMS will use Zone Program Integrity Contractors or ZPICs to assist it in finding and preventing fraud.

Implemented on or about June 30, 2011, CMS's fraud prevention system looks at provider claims' submissions on a pre-payment basis. Using predictive modeling, results are prioritized based on risk and forwarded to the ZPICs to analyze and investigate. At the conclusion of the investigation, results are made available to the Center for Program Integrity and to the law enforcement partners identified by CMS. What this means is that CMS is moving away from the "pay and chase" model and concentrating on prevention and risk assessments and, it doesn't stop there. Beyond monitoring of submitted claims, the fraud prevention system's purview extends to complaints, stolen identifications, paid investigations, and enrollment.

CMS has set three goals toward improvements in the Medicare/Medicaid enrollment process: 1) faster enrollment time; 2) user-friendly on-line enrollment; and 3) having all enrollees in the same data base with up-to-date information. In the past, CMS has reported that fraudulent providers and suppliers were able to register with stolen medical identities, provide phony addresses, re-enter the system after being revoked, and were able to stay in the local system even if revoked in the national system. The new Automated Provider Screening ("APS") system, implemented on or about December 31, 2011, allows CMS to check applicants more thoroughly. All enrollments will be housed in the national system. In addition, CMS now has the ability to check medical identities, validate locations, and check for revocations, exclusions, and felony convictions.

Using predictive modeling, the APS system will identify applications of providers that may be at high risk based on specific indicators. The APS system leverages thousands of government, public, and private resources to verify and supplement data by providers. Monitoring alerts are put into place that immediately notifies CMS when there are changes to critical eligibility requirements. The APS system also regularly re-screens all information for continued accuracy.

Unlike RACs, which are charged with identifying and correcting overpayments and underpayments in the Medicare system, ZPICs are charged with finding and preventing fraud and abuse. While RACs are paid on a contingency basis, ZPICs are paid on a fixed contracted rate with bonuses tied to quality of service and administrative action. ZPICs have the authority to conduct investigations into whether overpayments to providers were made due to fraudulent or abusive billing practices. Moreover, the ZPIC authority extends to denial of payments, recoupment of overpayments, as well as referral to the OIG, DOH or FBI. At its core, ZPICs have comprehensive technological capabilities that enable them to analyze complex data, evaluate billing trends and patterns, and detect abnormal patterns among providers when compared to other "similarly situated" providers. Given the success of the Medicare RACs and ZPICs, providers should be advised that Medicaid RACs and Medicaid Integrity Contractors (MICs) exist, have authority, and are effective.

To address these Program Integrity provisions, having an active compliance program is mandatory as well as practical. If a compliance plan is used effectively, it will assist in identifying and

preventing mistakes that could lead to refunding money to payors, interruptions of payments – or worse. In addition, providers need to stay on top of fraud alerts, advisory opinions, and bulletins. Although not law, these publications give guidance and are instructive. Providers should also know the issues identified by the OIG in its work plan as well as the areas identified by CMS as high risk. Through professional organizations and societies, providers should be aware of changes to existing laws as well as the passage of new laws and regulations that impact on their area of practice.

Revenue Offset Provisions

The cost to the federal government for the PPACA, either as direct payments to cover previously uninsured populations or in the form of various tax incentives to individuals and employers to provide or acquire coverage, is currently estimated by the Congressional Budget Office to be in excess of $1 trillion over the next ten years. Someone has to pay for that or the country's current debt concerns will likely be aggravated to the kinds of crises we're seeing in the European Union. However, the PPACA has that covered by introducing a number of "revenue offset provisions" (*i.e*., taxes). In fact, according to the CBO, after all the dust settles, including reductions in Medicare spending and the various taxes, the net result should be revenue neutral.

The good news for ophthalmic practices is that most provisions are likely to have a direct impact on the economics of reimbursement. The biggest concern comes not from the PPACA but rather from the legislative mandate from the late 1990's to reign in Medicare Spending generally by linking the Physician Conversion Factor of Medicare Physician Fee Schedule to a "Sustainable Growth Rate" (SGR). Faced with stiff opposition from physician groups, Congress has annually postponed implementation of the SGR, to the point now, that, if implemented, ophthalmologists would face across the board Medicare reimbursement cuts of 25%.

As noted above, the PPACA is really not expected to have a significant impact in how small businesses offer benefits to their employees—i.e., those that have fewer than 50 full-time employees. Most single specialty ophthalmic practices simply are not going to have much to worry about in terms of direct impact on their operations or the taxes and fees associated employment. Larger groups that have more than 50 full-time employees, also as noted above, have some changes ahead and will find their employment costs rising indirectly or directly—but again, with large groups, most are already providing coverage to their employees in a manner that will not change.

That said, health insurance premiums will be increasing—and employers of all sizes will feel that as will employees who pay for a portion of the cost. An excise tax on insurance companies will go into effect. Nationally, the impact on that will amount to roughly $6 billion, per year. The insurance companies will **eat** some of that, but much of it will be passed on to consumers in the form of increased premium costs. Employers picking up the cost, or a portion, will see their expenses rise accordingly. For companies, like Papa John's, they'll be able to pass along some of the costs to their employees and some to the customer in the form of a higher cost to enjoy their product. For ophthalmologist, though, who are limited by negotiated or mandated fee schedules, there are only two pockets those costs can be taken from—the employer's and the employees'. Spread across all the folks who participate in, and buy health insurance, the impact is likely to be minimal on a per person basis, maybe $20.00 per person per year. Add in other inflationary pressures, and even small increases begin to hurt.

Unless a practice offers tanning services (a 10% excise tax to discourage the use of tanning beds because of their link to skin cancer), the next biggest "revenue offset" (tax) event looming on the

horizon, is going to be felt by ophthalmologists personally. Individuals with wages in excess of $200,000, and couples whose combined wages exceed $250,000 will pay a .9% Medicare tax on wages in excess of those thresholds. In addition, there will be an additional 3.8% tax on investment income. These taxes are set to go into effect next year.

In addition, next year, the annual limits on contributions to Flexible Spending Accounts ("FSA's") will be cut back from $5,000 to $2,500. Most people didn't take full advantage of those contribution limits, with the average employee setting aside only $1,400 per year. That said, higher paid ophthalmologists, who took advantage of the FSA's full contribution limits will lose a $2,500 tax benefit, with a real cost of up to $950-$1,000 depending on their tax bracket.

After that, the next tax event doesn't come into play until 2018, when insurance companies that offer "Cadillac" health care coverage will be subject to a 40% excise tax above a certain benefits threshold. Technically, the tax will be imposed on insurers, but, once again, the cost will get passed down the line in the form of increased premiums, or more likely, in the limiting of the kinds of benefits available. The annual premium cost threshold for a "Cadillac" plan is $10,200 for an individual and $27,500 for a family. Not too many plans would be affected currently, and the threshold is going to be linked to inflation—but since premium costs have exceeded inflation by a substantial percentage every year, by the time 2018 rolls around, it may become a real issue.

Medicare Savings Programs and Accountable Care Organizations ("ACO's")

Probably the most ballyhooed provisions of the PPACA, from the perspective of health care providers, have been those dealing with the opportunities to share in Medicare Cost Savings through the creation of what are known as Accountable Care Organizations ("ACO's"). Essentially, Medicare will provide opportunities for physicians, hospitals and other care providers to join forces to share in any savings achieved by meeting various standards and goals—lowering hospital readmissions, for example.

So, ACO's are the next "BIG THING" for ophthalmologists, right? Everyone needs to be in one or they will eventually find their market share eroded and end up selling to a hospital or working as an employee of an HMO. Not so.

In fact, as things now stand, at least in the short-term and, indeed, for the foreseeable future, most ophthalmologists, unless they are already part of a multi-specialty group with a large primary care component or already integrated into physician hospital organization dominated by primary care, the most we expect in the way of ACO involvement for ophthalmology in the near future is the possibility of contracting to provide ophthalmic services on a fee for service basis.

Complacency, unfortunately, is not allowed. It is important to know a little about ACO's because they do point the way, and continue trends for how medical practices in general have been under pressure to integrate these past 15-20 years—trends that will only continue.

So, what exactly, is an ACO? The answer is that it can take on a number of different shapes, sizes and organizational structures. They can be corporations, LLCs, limited partnerships, and even "joint ventures" built around contracts. The federal government doesn't really care what legal form an ACO takes. They can be comprised of physicians, physicians and hospitals, or physician hospitals and other entities as long as there is a heavy representation of primary care physicians (family practice, internal medicine, pediatrics and OB-GYN). And, the federal government has begun to loosen up,

somewhat, the laws and regulations that often get in the way of less formal and integrated affiliations. Anti-trust concerns as well as anti-kickback and tax rules have been, or are being, relaxed to allow for the kind of organizational formation that might have been stopped because of such concerns. The key thing is, though, ACO's must be set up with the intention of, eventually accepting risk. There are two "tracks" ACO's can follow to get to the place of sharing risk. They can either start sharing risk (and, of course, rewards) right from the start—meaning that if their population of Medicare beneficiaries does not produce the kinds of cost savings the government is looking for, they share those "losses" with the government and Medicare. Of course, if the PPACA achieves cost savings, they share in the savings.

For ACO's that aren't ready to assume risk sharing, they can, for the first three years of the ACO program accept only the "upside" potential and share in the cost savings while not accepting any "downside". The upside is smaller than for groups willing to share in the risk, but proceeding in this manner allows groups to get used to the idea, and get a track record before taking on risks.

Each ACO will be required to report on 33 measures of patient care, patient safety, preventive care and at risk populations.

Where things get very complicated, though (you mean it's not already), from a patient's perspective, all this will be seamless. They do not, unlike a traditional HMO with risk contracts, sign up or get assigned to a particular doctor. Medicare maintains its freedom of choice. In fact, patients are assigned after the fact based, essentially, on who they see as their primary physician during the relevant time period. Primary care physicians will have to select one PPACA, and one only, if they are going to participate. However, since ophthalmologist' services are not considered primary care, they won't have to choose just one PPACA. They can be associated with many—or none at all. To the extent patients had freedom of choice before to select their ophthalmologist, they'll continue to have that choice. That said, over time, the pressure will mount on ophthalmologists to be willing to either provide discounted services to ACO's, or, more likely in the mean time, to be able to prove that one's results are better and less costly than others'. But that is not really any different than the situation currently. Pressures continue to grow to be able to demonstrate that groups are continuously moving to improve patient outcomes at lower costs, which requires investment of capital in electronic health records hardware and software, the development of better protocols and more accurate and precise outcomes measurement. And, those kinds of investments generally are better spread across multiple providers—generally speaking groups with adequate numbers and fairly deep integration.

The bottom line is that, for ophthalmologists, there is no rush to jump on board any ACO, but to recognize the trend is, and has been, one of more and more integration and a willingness to be willing to provide data and, ultimately be willing to share in cost savings and, in downside risk—because as Medicare begins to push groups in this direction, it will only be a matter of time before the commercial payors will follow suit and as they have done in the past, eventually overtake what the federal government does.