"ObamaCare": What Is in It

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House of Representative Speaker Nancy Pelosi famously said at the 2010 legislative conference for the National Association of Counties on March 9: "But we have to pass the bill so that you can find out what is in it, away from the fog of the controversy." Before the bill's passage, Rep. John Conyers (D-MI), chairman of the House Judiciary Committee, said: "I love these members, they get up and say, 'read the bill.' What good is reading the bill if it's a thousand pages long and you don't have two days and two lawyers to find out what it means after you read the bill?"

In fact, it took much longer than two days, more like a week, just to skim through the Patient Protection and Affordable Care Act ("the Act") as passed into law, which is 906 pages long in single-spaced statutory format. It would also take a whole team of lawyers just to look up the citations to previous laws. Since the Act passed, tax accountants, insurance actuaries, and others have been attempting to translate its provisions into numbers that affect their industries. Most importantly, it is actually impossible to know the ultimate impact: this is an enabling act that sets up the infrastructure for later implementation by some 159 new bureaucracies. The all-important details are not in the Act itself, but will be created by administrative agencies, insulated from the controversies in the political process—and from accountability at the ballot box.

While reading, I placed tabs, using sticky notes of five colors: green for taxation; pink for regulation; blue for legal consequences (litigation, prosecution, and penalties—administrative, civil, or criminal); peach-colored for pork or special-interest group favors; and yellow for other, such as social engineering. Of course, the classification is arbitrary, and there is significant overlap. There are no "patient protection" or "affordable care" tabs per se: these may be the desired objectives, but the machinery involves taxation, regulation, and punishment, as in the form of mandates, subsidies, and price controls. All provisions actually increase the cost of providing care, although they redistribute the burden of meeting the costs—from subscribers to insurers, patients to "providers," or one group of taxpayers to another. The key themes are redistribution of wealth, political and racial favoritism, and expansion of the welfare/surveillance state.

The following analysis is by no means exhaustive. As is apparent from the quotations of the statutory language, enormous implications may easily be hidden in a few words.

Taxation

Redistribution

The section entitled "prohibition of discrimination based on [low] salary" (p 17, §2716) prohibits requiring low-wage workers to contribute the same dollar amount or percentage of income as higher-wage workers to their health plan. This means that higher-wage workers can be required to contribute more, in absolute or relative terms. In other words, premiums can be based on wages, and if a required premium is viewed as a tax, it is a progressive or redistributive tax.

Individual Tax Credits

Complex rules for determining eligibility for refundable tax credits, reduced cost sharing, and exemptions from "individual responsibility" requirements begin on p 95. Factors include employment status, income, family size, marital status, religion, membership in an Indian tribe, whether one or more individuals in the beneficiary's family are not lawfully present (p 100), and other information that the secretary of the Department of Health and Human Services (HHS) ("the Secretary") shall prescribe. The Secretary will have to verify information in consultation with the secretary of the U.S. Treasury, the secretary of the Department of Homeland Security, and the commissioner of the Social Security Administration.

Small Employer Tax Credit

Small business owners received a postcard from the Treasury Department informing them of a 35% tax credit to employers with less than 25 full-time employees averaging less than $50,000 per year in wages (p 120, §45R). For the "three simple steps," the National Federation of Independent Business (NFIB) prepared a calculator (see www.nfib.com/issues-elections/healthcare/credit-calculators). One business owner calculated that his credit would actually be zero, and that a 35% tax credit would be available only to firms with 10 employees averaging $25,000 per year.[1]

Individual Mandate

In Subtitle F, Shared Responsibility for Healthcare, Part 1–Individual responsibility (p 124, §1501), the "requirement to maintain minimum essential coverage" begins with the constitutional rationale: The requirement is "commercial and economic in nature, and substantially affects interstate commerce…." The Act notes that without the individual mandate, many individuals would wait to purchase health insurance until they needed care—without acknowledging that this results partly from the guaranteed issue and community rating provisions of the Act.

Although Obama argued, while campaigning for the bill, that this mandate was not a tax, the Department of Justice cites the Anti-Injunction Act in its motion to dismiss a challenge brought by the state of Florida and other plaintiffs. This law restricts the courts from interfering with the government's ability to collect taxes.[2] The taxing power of Congress is another rationale claimed to support constitutionality, in case the Commerce Clause is held to be inapplicable.

Employer Mandate

Part II of Subtitle F, beginning on p 134, concerns the employer's part of the "shared responsibility." The treatment of employers under the law depends on the number of employees. Hiring the 201st, 101st, or 51st employee has significant implications. Rules for counting the

number of employees are given on pp 53-54, §1304. The rules are quite complex and concern not only the provision of coverage, but for "large" employers (more than 200 full-time workers) include extensive reporting requirements.

More than two-thirds of companies, and 80% of small businesses, could be forced to change their current coverage because it is so easy to lose the "grandfathered" status of existing plans. Even businesses that offer "correct" coverage may not escape penalties, as they will have to pay penalties up to $3,000 for every employee who receives a subsidy because his contribution is deemed unaffordable (exceeding 8% of his income). As many as one-third of employers could face these penalties, which amount to an additional tax on employment.[3]

Expansion of Medicaid

Medicaid coverage is extended to those whose income does not exceed 133% of the poverty line (p 153, Title II, Subtitle A, §2001). The "Cornhusker Kickback," reportedly used to buy the vote of Sen. Ben Nelson of Nebraska, is extended to all 50 states (p 154). Federal funding for medical assistance for individuals newly eligible under the mandate will be 100% from January 1, 2014, until December 31, 2016. After this, the amount of federal subsidies seems to depend on whether the state qualifies as "an expansion state."

A special adjustment to the Federal Medical Assistance Percentage (FMAP) is made for certain states recovering from a major disaster. Louisiana, owing to Hurricane Katrina, appears to be the only state meeting the definition (p 156, §2006), hence the appellation "Louisiana Purchase," believed to be the price of the vote of Sen. Mary Landrieu of Louisiana.

Of the 32 million people who are expected to gain benefits because of the Act, 16 million will result from the expansion of Medicaid and the Children's Health Insurance Program (CHIP). "The fate of health care reform depends on the fate of Medicaid," writes Sara Rosenbaum, J.D, of the George Washington University Medical Center.[4] States that are challenging the Act in federal district court in Florida argue that Congress has essentially hijacked the Medicaid program, forcing states to become unwilling partners in an unlawful legislative scheme.[4]

In addition to the direct tax implications from expanding Medicaid, states lose premium taxes when people lose their private coverage and are forced into Medicaid. These taxes contributed some $6.5 billion to state budgets in 2008; in Nevada, they funded one-third of Medicaid.[5]

Taxes on Medical Items and Insurance Benefits

Presidential promises notwithstanding, many explicit taxes in the Act will affect middle and low-income individuals. The 40% tax on excess "Cadillac" benefits, assuming anybody will still want them in lieu of higher wages, is estimated to hit 12% of workers at the outset but by 2018 will likely include many of today's average plans as the threshold is indexed to general inflation rather than medical cost inflation.[3]

Taxes on the sick are increased by limiting the itemized deduction for medical expenses to the amount that exceeds 10%, rather than 7.5% of adjusted gross income (p 750, §9013). By the time this is fully implemented, the Joint Committee on Taxation estimates it will affect 14.8 million taxpayers, 14.7 million of whom earn less than $200,000 a year.[6] Half of those taking advantage of this deduction earn less than $50,000 a year.[7]

Then there are taxes on prescription drugs, medical devices from CT scanners to surgical scissors, insurers, and tanning beds whether used for medical or cosmetic purposes. These taxes could cost the typical family of four with job-based coverage an additional $1,000 a year in higher premiums.[3]

Billions of Additional Tax Forms

Because of the "Expansion of Information Reporting Requirements," (p 737, §9006), businesses will have to issue a form 1099 to any entity with which it does more than $600 worth of business in a year, including corporations. This includes rent, fuel, office supplies, new or used cars, package delivery services, and lunch—not just non-wage income to unincorporated independent contractors. As an unrelated "pay for" in the Act, the provision is estimated to increase revenue by $1.7 billion a year. Rep. Dan Lungren (R-CA) introduced H.R. 5141 to repeal this costly accounting nightmare.[8]

Tax on Investment Income

Starting in 2013, the 3.8% Medicare tax will be applied to capital gains and investment income if an individual's total gross income exceeds $200,000 or a couple's exceeds $250,000. Middle-class people would be subject to this tax even if they were "rich" for only one day: the day they sold their house and bought a new one.[9]

The Effect of Inflation

If inflation hits 10%, the $100,000 a year earner gets to the $200,000 threshold in 7.5 years.[10] The threshold for additional taxes is not indexed for inflation—an additional incentive for government to debase the currency.

Regulation

Regulations that Outlaw True Insurance

There can be no lifetime limits on coverage (p 13, §2711), and annual limits are also restricted. Actuaries need to know the risk of incurring a loss and the dollar value of the loss. Casualty insurance places a replacement value on your car or house, and liability coverage places a limit on the amount of payout. Health insurance, in contrast, will have to be open ended and virtually unlimited—except of course by the solvency of the insurer or the government, or the rulings of a de facto rationing board.

The prohibition on rescissions (p 13, §2712) meets a popular demand, although it may not represent much change from the status quo. It has generally been illegal to cancel a policy just because a claim is made, although it was and still is legal to cancel it if the insured has committed fraud or made an intentional misrepresentation of material fact.

"Fair health insurance premiums" (p 37, §2701) are redistributional, and overcharge low-risk individuals. There is guaranteed issue (p 36) and a form of community rating: Variation of premiums by age is limited, and they may not be based on health status (except for smoking).

"Quality" and "Efficiency"

"Ensuring the quality of care" (p 17, §2717) requires implementation of quality reporting, activities to reduce medical errors through the use of "best clinical practices," "evidence-based medicine," and "health information technology." It encourages the use of new structures such as medical homes and thus discourages traditional independent forms of practice. The Secretary is given the authority (p 18) to develop and impose "appropriate penalties" for noncompliance.

The goal "Improving the Quality and Efficiency of Healthcare" (p 235, Title III) is to be achieved through "Transforming the Health Care Delivery System" and its payment mechanism. Specifics include "linking payment to quality outcomes under the Medicare program," measuring Medicare spending per beneficiary, and improving the Physician Quality Reporting System (p 245, §3002). The Secretary is to establish appropriate measures of quality (p 256), apply a payment modifier in a manner that promotes systems-based care (p 257), and integrate quality reporting with requirements for "meaningful use" of electronic health records (p 247).

Thus, the academics' wish list for dictating acceptable medical practices is to be imposed from above, and the Physician Quality Reporting Initiative (PQRI), which originated in the 2006 Tax Relief and Health Care Act and has been tinkered with for several years, is to expand. The process is reminiscent of what occurred with the "pilot program" of diagnosis-related groups (DRGs), which was inflicted on hospitals nationwide without any apparent effort to analyze its effect on medical outcomes.[11]

In one of about 13 such provisions in the Act, the Secretary's establishment of methodology for determining an "episode of care" is insulated from administrative or judicial review (p 249).

A key part of the Secretary's national strategy to improve healthcare quality (p 260, §3011) is to "reduce health disparities across health disparity populations…and geographic areas." Thus "quality" may be defined by equality, with the implication that while some may receive more or better care, others may receive less or worse care, depending on where they live and what population subgroup they belong to.

The Interagency Working Group on Health Care Quality (p 262, §3012) includes senior-level representatives of agencies A through X, with A being the Department of HHS and X being any other federal agencies and departments with activities relating to improving healthcare quality and safety, as determined by the President. In between are the Coast Guard, the Department of Education, the Federal Bureau of Prisons, and 19 others.

The payment models to be tested (p 272) as replacements for fee-for-service include varying payments to physicians according to adherence to appropriate criteria for ordering services. One redistributive mechanism is the accountable care organization (ACO), which "shall have a formal legal structure that would allow the organization to receive and distribute payments for shared savings…to participating providers and services and suppliers" (p 278)—and thus collectivize responsibility for denying care.

Insurance Mandates

Cost sharing for "preventive services" is prohibited (p. 33, §2713). This is likely to increase the demand for screening by low-risk patients who don't value the service enough to pay for it, without necessarily bringing in high-risk patients who could benefit most. Increased short-term spending is assured; long-term savings are speculative.

Limits on insurers' spending on "administration," called "ensuring that consumers receive value for their premium payments" (p 19) could put many insurers, especially smaller ones, out of business. Few, if any, high-deductible plans, which are required for patients with health savings accounts (HSAs), can meet the minimum 80% medical-loss ratio.[3] The Secretary has the power to adjust requirements and may "use this flexibility to err on the side of ensuring that disruption and the accompanying political fallout are minimal until the exchanges are in place in January 2014."[12]

The Act puts the cost of "quality improvements" in the same category as "clinical services," not of administrative functions. The definition of "medical costs" has become the topic of heated debate.[12]

Price Controls

The Secretary, along with individual states, shall establish a process for annual review of "unreasonable premium increases" (p 21, §2794). To help the states cope with the additional burden, $250 million in grants will be appropriated over 5 years. There is as yet no regulatory definition for "unreasonable" and no federal authority to deny rate increases. Further legislation that would establish a national health insurance rate authority to set limits on premiums has been proposed by Sen. Dianne Feinstein.[13]

Eligibility

In the guise of "administrative simplification" (p 28, §1104), transaction standards will enable "to the extent feasible and appropriate," the "determination of an individual's eligibility and financial responsibility for specific services prior to or at the point of care." In addition, it will require timely status reporting that supports a "transparent *claims and denial management* process" [emphasis added]. This implies that access to services will by no means be universal, but rather contingent on eligibility. It looks as though this sets up a process for denying the services themselves, not just the claims afterwards.

Health plan certification (p 31) will require very extensive data and information systems for electronic funds transfers and a determination of eligibility for the plan, enrollment and disenrollment, health plan premium payments, and "referral certification and authorization."

With reference to the threat of "death panels," it seems reassuring that the Secretary shall "ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individual's age or expected length of life or the individuals present or predicted disability, degree of medical dependency, or quality of life" (p 46). The term "essential benefits," however, is subject to definition, and individual wishes, to manipulation.

Insurance "Exchanges"

The centerpiece of "reform" is the Health Insurance Benefit Exchange. By 2014, all states are supposed to establish one or more exchanges, or else default to a national exchange. The exchanges would serve as clearinghouses through which consumers could purchase plans meeting minimum federal requirements, as well as all state mandates. Individuals or small businesses could buy a plan through an exchange; individuals receiving a tax subsidy or credit would be required to do so. After 2017, states have the option of expanding the exchanges to large employers.[3] In nearly every way, the Act mirrors the Massachusetts model, the Commonwealth Connector. Some suspect that a delay in guidelines for the state programs might be purposeful, and will cause more states to default.[14]

High-risk pools are supposed to help bridge the gap between now and the establishment of exchanges. More than 20 states have rejected the federal pools. Minnesota's Governor Tom Pawlenty cited concerns about "federal bureaucracy with centralized decision-making."[15] Then there's the cost: $5 billion was allocated, but cost is expected to be $15 billion by 2013. John Graham of the Pacific Research Institute called the $5 billion a "gateway drug" to "a complete federal takeover of our access to medical services," and applauded the wisdom of states that refused it.[16]

"Comparative Effectiveness Research" and Rationing

The goals of "patient-centered outcomes research" (p 609, §6301) are to determine the "effect on national expenditures associated with a healthcare treatment, strategy, or health conditions" and to reduce "practice variation and health disparities." Although the section on "limitations on certain uses of comparative clinical effectiveness research" (p 622, §1182) provides that the Secretary shall not use these findings to determine coverage in a manner that "treats extending the life of an elderly, disabled, or terminally ill individual as of lower value than extending the life of an individual who is younger, nondisabled, or not terminally ill," the next paragraph says this prohibition is not be construed as preventing the Secretary from using evidence to determine coverage based on a comparison of the difference in effectiveness of alternative treatments in extending an individual's life due to the individual's age, disability, or terminal illness. The actual meaning of this will probably be defined by the regulations that are to come.

"Fixes" to Medicare's Administrative Pricing System

Medicare has a complex scheme for varying payments by region, which is supposed to reflect varying costs and bring about fairness. See, for example, "extension of the work geographic index floor and revisions of the practice expense geographic adjustment under the Medicare physician fee schedule" (p 298, §3102). Perceived inequity in payment to hospitals and physicians in Oregon was supposedly corrected in order to obtain the vote of Rep. Peter DeFazio of Oregon. But the centralized, inherently arbitrary scheme remains in place.

Medicare disproportionate share hospital (DSH) payments for uncompensated care are "improved" (p 314, §3133), and the estimates that the Secretary makes for implementing them are not subject to administrative or judicial review (p 315).

The Independent Medicare Advisory Board

The heart of the effort to control Medicare spending is the Independent Medicare Advisory Board (IMAB) (p 371, §3403). The purpose of this section is to reduce the per capita growth rate in Medicare spending by (1) requiring the chief actuary of the Center for Medicare and Medicaid Services (CMS) to project spending growth; (2) requiring the IMAB to develop and submit a proposal containing recommendations to reduce the per capita growth rate if the projected spending exceeds the target; and (3) "by requiring the Secretary to implement such proposals unless Congress enacts legislation pursuant to this section." Thus it appears that by failing to act, Congress is delegating its authority to the Secretary.

The proposal shall include recommendations that "will result in a net reduction in total Medicare program spending…." However, "the proposal shall not include any recommendation to ration healthcare, raise revenues or Medicare beneficiary premiums…, increase Medicare beneficiary cost-sharing, including deductibles, coinsurance, and copayments, or otherwise restrict benefits or modify eligibility criteria." So how shall the objective be achieved—other than by reducing payments for services? And how shall this provision be characterized, other than as an extension of the sustained growth rate (SGR) concept to all expenditures?

The Act spells out the procedure to be followed for Congress to consider the proposals submitted by the IMAB (p 377), and it attempts to bind future Congresses: "It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report…that would repeal or otherwise change the recommendations of the board if that change would fail to satisfy the requirements [above]" (p 378). Additionally, "it shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report that would repeal or otherwise change this subsection." This prohibition could be waived or suspended in the Senate only by affirmative vote of three-fifths of the members.

For the first time in Medicare history, the chief actuary called the projections in the Medicare Trustee's report "implausible" and encouraged consideration of an "illustrative alternate" report. This report concludes that if the Act is implemented as written, 25% of hospitals, skilled nursing facilities, and home health agencies would be unprofitable by 2030, and 40% by 2050.[17]

Provider Enrollment

The Medicare, Medicaid, and CHIP Program Integrity Provision (p 629, §6401) includes screening of providers and suppliers, a provisional period of enhanced oversight, the imposition of temporary enrollment moratoria, and the establishment of compliance programs. These procedures are supposed to go into effect not later than 180 days after enactment. The Secretary will determine the level of screening required according to the risk of fraud, waste, and abuse. It may include a criminal background check, fingerprinting, unscheduled and unannounced site visits, and database checks. In order to be screened, each provider will have to pay $200 in 2010 ($500 for institutional providers), with increases in subsequent years based on the percentage change in the Consumer Price Index. Current providers will have to pay a fee for revalidation of enrollment two years after the date of enactment. New providers will be subjected to prepayment review and payment caps for up to a year following enrollment.

Any application for enrollment or revalidation must disclose any current or previous affiliation (directly or indirectly) with a provider or supplier that has uncollected debt, has been or is subject to a payment suspension under a federal healthcare program, has been excluded from participation under the program, or has had its billing privileges denied or revoked. If the Secretary believes any previous affiliation poses an undue risk of fraud, waste, or abuse, the Secretary may deny the application. The Secretary also has the authority to make "any necessary adjustments to payments" to a provider in order to satisfy any past-due obligations.

The Secretary may impose a temporary moratorium on the enrollment of new providers of services and suppliers, if she determines that such a moratorium is necessary to prevent or combat fraud, waste, or abuse. Such a moratorium is not subject to judicial review. She may also impose a numerical cap for providers or suppliers that she identifies as being at high risk for fraud, waste, or abuse.

No later than January 1, 2011, the Secretary shall promulgate a regulation requiring that all providers who qualify for a national provider identifier (NPI) include it in all applications for enrollment or claims for payment (p 638).

Must All Physicians Who Serve Medicare Patients Enroll?

A section that could be the equivalent of requiring a federal license to practice medicine, at least if a physician ever sees a Medicare beneficiary, is titled "Physicians Who Order Items or Services Required to be Medicare-Enrolled Physicians or Eligible Professionals" (p 650, §6405). This definitely concerns durable medical equipment and home health services, but the Secretary may extend (and has extended) the requirement to all other categories of items or services under title XVIII of the Social Security Act (Medicare).

Legal Consequences

Penalties on Insurers

The Secretary's standards for notifying beneficiaries of coverage or changing coverage will preempt any state standards (p 16). Entities shall be subject to a fine of $1,000 for each failure, and such a failure with respect to each enrollee shall constitute a separate offense. This is a regulatory cost, likely to subject beneficiaries to more "notifications," while providing a way to levy arbitrarily heavy fines on a disfavored insurer.

For plans failing to meet extensive reporting standards, the Secretary *shall* assess a penalty fee against a health plan in the amount of $1 per covered life per day until certification is complete (p 35). In addition, there are fees of up to $40 per covered life under the plan if the plan knowingly provides inaccurate or incomplete information.

Penalties for Failure to Maintain Coverage

Although the mandate is called a tax for purposes of arguing the constitutionality of the Act, the Act itself refers to a "penalty" imposed for every month without acceptable coverage (p 1265, §5000A). The amount depends upon one's modified gross income and family size, and will be indexed by cost of living adjustments. It begins in 2014 and ramps up quickly to a minimum of $2,085 for a family of four in 2016, with a maximum of 2.5% of annual income—still much less than the cost of "minimum essential coverage."

Curiously, the Act provides that criminal penalties are waived for failure to pay the penalty (p 131), and "the Secretary shall not file notice of lien" or levy any property by reason of failure to pay. However, IRS Deputy Commissioner Steven Miller has said that the IRS may withhold tax refunds from noncompliant individuals. The IRS could, notes Michael Tanner of the Cato Institute, apply part of a person's regular tax payments toward the mandate penalty, and then punish him for failure to pay regular taxes in full.[3]

Although employer penalties might be considered a tax, the Act calls them an "assessable penalty," which is not tax deductible (p 137).

Enhanced Civil Monetary Penalties

A civil monetary penalty of $50,000 is set for each false statement or misrepresentation of a material fact by any individual or entity on any application, agreement, bid, or contract to participate or enroll (pp 639-640). The penalty also applies to anyone who orders or prescribes an item of service during a period in which the person was excluded from a federal healthcare program, if he knows or should know that a claim will be submitted under such a program.

The $50,000 penalty also applies to any false record or statement material to a claim (p 652, §6408), presumably including any statement in the medical record used to document the service as well as on the claim itself.

Physicians must keep documentation related to referrals for items at high risk of waste and abuse, such as durable medical equipment or home health service (p 651, §6406). The penalty for failure to maintain and provide access on request of the Secretary to this documentation is $15,000 for each day of the failure to permit access, as well as revocation of enrollment for a period of not more than one year for each act. The effective date for this section is for acts committed on or after January 1, 2010 (p 654), although the Act was not passed until Mar 23, 2010.

Enhanced Power for Law Enforcement

The Act confers increased testimonial subpoena authority (p 641).

The government's burden of proof for healthcare fraud is reduced. Section 1128B of the Social Security Act (42 U.S.C 1320a-7b) is amended by adding: "With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section." If there is a "credible allegation of fraud," the Secretary has the authority to suspend payments pending an investigation. Potentially, this could stop most of a physician's cash flow for an indefinite period of time upon mere suspicion that a fraud may have occurred.

Enhanced Reporting and Self-incrimination

Even as Congress created a new program of gargantuan size and complexity, it recognized that since 1990 the Government Accountability Office (GAO) has designated Medicare a high-risk program "because its vast size and complexity make it vulnerable to fraud, waste, and abuse." In addition to strike forces, more rigorous screening provisions, and other law enforcement efforts, the Act apparently adopts the goal enunciated by James Sheehan, Medicaid's inspector general in New York: "to compel organizations to police their own activities. It shifts the burden to the provider to be vigilant about the legality of activities or potentially pay a price for not doing so."[18] For example, a provider that does not report an overpayment from Medicare or Medicaid and repay within 60 days is liable under the False Claims Act (p 637). Another such provision is requiring public disclosure of payments and other "transfers of value" to providers from manufacturers.[18]

Harsher Sentences

Federal sentencing guidelines will be revised to provide that the aggregate dollar amount of fraudulent bills submitted to the government healthcare program (not the amount paid) shall constitute prima facie evidence of the amount of the intended loss by the defendant (p 888, §10606). The U.S. Sentencing Commission shall ensure that the federal sentencing guidelines and policy statements "reflect the serious harms associated with healthcare fraud and the need for aggressive appropriate law enforcement action to prevent such fraud; and provide increased penalties for persons convicted of healthcare fraud offenses "in appropriate circumstances" (p 889).

Special-Interest Group Favors

Smoking Cessation Privileged

While healthy individuals cannot benefit from lower premiums, all who participate in certain favored "wellness" programs may be rewarded—as well as those offering the programs. The cost of a smoking cessation program is reimbursed (p 39), whether or not the individual quits smoking. Steven Schroeder, former president and CEO of the Robert Wood Johnson Foundation (RWJF), the most prominent promoter of such programs (and tax-funded support thereof), implicitly admits that they don't work very well. The prevalence of smoking has barely budged in recent years: It was 20.8% in 2006, 19.8% in 2007, and 20.6% in 2008. Schroeder makes a case for continued funding of tobacco cessation programs, claiming that "by assuming that the tobacco war has been won, we risk consigning millions of Americans to premature death."[19]

RWJF owns more than 42 million shares of Johnson & Johnson stock, valued at more than $2.2 billion. J&J profits from the sale of Nicoderm and Nicorette, and has cornered the marked on over-the-counter nicotine replacement products, which show a 98.4% failure rate for long-term quitting.[20]

Priorities

The listing of favored "wellness and prevention" programs (p 18 and numerous other locations) and "chronic conditions" (p 203) reflects the priorities of reform advocates such as RWJF, which have

for decades used grants to promote the funneling of legislative subsidies to entities that engage in certain activities. These prominently include smoking cessation, weight management, stress management, and chronic conditions. Working at, but never solving such problems could be a lucrative long-term program for stakeholders, diverting resources from the care of the sick.

Abortion Coverage

The wording related to abortion coverage (p 50, §1303) is artful and complex. Public funding is prohibited for some abortions, but allowed for others. Community health centers may provide abortions, and may receive federal funds, but the funds must be segregated. In any insurance exchange, the Secretary shall assure that there is at least one plan that provides coverage of abortion and at least one plan that does not (p 52). The federal premium subsidies are not to be used to bear the insurance risk for abortions—although money, of course, is fungible.

Grantees for Reporting and Payment Mechanisms

"Eligible entities" (p 265), which have been hovering around since the Clinton Task Force on Healthcare Reform and before, are in line for grants and contracts to develop the measurements, guidelines, and payment models, and provide the certified health information technology.

Expansion of Public, Contraction of Private Sector

Spending for federally qualified ("community") health centers is slated to increase from $3.0 billion in 2010 to $8.3 billion dollars for fiscal year 2015 (p 559, §5601). It is expected that the percentage of the U.S. population served by such health centers will increase from about 5% to 10%.[3] In these centers, the federal government assumes liability for alleged malpractice. As injured patients would have to sue the federal government, malpractice litigation is discouraged. Physicians employed there do not need to purchase professional liability insurance, giving them a significant competitive advantage over private physicians, who must collect sufficient revenue from patients to cover the cost of this insurance.

As the Act expands federally owned facilities, further restrictions are placed upon physician-owned facilities, in Title VI, Transparency and Program Integrity, Subtitle A, Physician Ownership and Other Transparency (p 566, §6001). A reported 60 physician-owned hospitals, which had promised to offer an innovative alternative to big corporate and nonprofit facilities, are virtually destroyed, and another 200 already-existing facilities may be put out of business by the Act. This is considered a victory for the American Hospital Association, the sixth biggest lobbyist in Washington, D.C.[21]

Social Engineering, Ethical Issues, and Other Considerations

Marriage Penalty

Requiring inclusion of "children" up to age 26 in parents' coverage—*unless* married (p. 14, §2714)—is one example of a marriage penalty. Another is that the income threshold for subjecting couples to extra taxes is not double that for individuals, but only $50,000 higher.

Multiculturalism

Appeals processes (p 19, §2719) must provide enrollees information that is "culturally and linguistically appropriate."

In developing a "healthcare career pathway" (p 471), "cultural competency," health literacy, and dealing with "health disparity populations" must be included in the curriculum.

To be eligible for Mental and Behavioral Health Education and Training Grants (p 508, §5306), an applicant shall demonstrate "participation in the institution's programs of individuals and groups from different racial, ethnic, cultural, geographic, religious, linguistic, and class backgrounds, and different genders and sexual orientations." Any internships will have to prioritize "cultural and linguistic competency."

Social Leveling

"Nondiscrimination in healthcare" (p 42, §2706) prohibits better pay for better qualified personnel. It does, however, allow the Secretary or a health plan to establish varying reimbursement rates based on compliance with quality or performance measures. Thus, all providers acting within their "scope of practice" will be paid at the same rate, whether a nurse practitioner, primary-care physician, or fellowship-trained specialist.

"End-of-Life" Treatment

Individuals or institutions refusing to participate in "assisted suicide, euthanasia, or mercy killing" may not be discriminated against by government, entities receiving federal financial assistance under this Act, or health plans created under this Act (p 141, §1533). This protection, however, explicitly does not apply to or affect "any limitation relating to—(1) the withholding or withdrawing of medical treatment or medical care; (2) the withholding or withdrawing of nutrition or hydration; (3) abortion, or (4) the use of any item for the purpose of alleviating pain even if such use may increase the risk of death as long as such an item is not furnished with the purpose of causing, or the purpose of assisting in causing, death, for any reason."

Apparently, physicians are protected against retaliation for declining to perform what is recognized as euthanasia, but not for refusing to ensure death by abortion, overmedication, or withdrawal of fluid, nutrition, or medical care. This provision also may contradict other provisions of the Act that seem to protect those who decline to participate in abortion (p 53).

Immediately following is a provision (p 141, §1554) that the Secretary shall not promulgate any regulation that "creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care." Apparently, the Secretary defines "unreasonable" and "appropriate," and could define it to preclude any barrier to abortion. The prohibition apparently does not apply to health plans, which could perform the unpopular rationing functions.

Family Life

Enhanced surveillance of child rearing will begin with "at risk" populations (p 216, §2951), including smokers, drug abusers, low achievers, and members of the military or veterans. This includes home visits with extensive data collection on health-related measures, expansively defined to include poverty, school readiness, and crime.

The Secretary is encouraged to be concerned about postpartum depression (p 226, §2952), and the director of the National Institute of Mental Health may conduct a longitudinal 10-year study of "the relative mental health consequences for women of resolving a pregnancy (intended and unintended) in various ways, including carrying the pregnancy to term and parenting the child, carrying the pregnancy to term and placing the child for adoption, miscarriage, and having an abortion."

Personal Responsibility Education grants to states (p 229, §2953) are to help achieve goals for reducing pregnancy rates and birth rates in youth populations. Sex education materials must be "medically accurate and complete," which means "verified or supported by the

weight of research conducted in compliance with accepted scientific methods and published in peer reviewed journals, where applicable; or comprising information that leading professional organizations and agencies with relevant expertise in the field recognize as accurate, objective, and complete."

School-based health centers will take over much of the family's responsibility for health, providing "comprehensive health assessments"; diagnosis and treatment of minor, acute, and chronic medical conditions; mental health and substance use disorder assessment; crisis intervention; counseling; and referral to emergency psychiatric care, community support programs, inpatient care, and outpatient programs. Health professionals in the centers will abide by parental consent and notification laws—as long as they are not inconsistent with federal law.

Social Transformation

The section on "Creating Healthier Communities" (p 446, §4201), establishes the rationale and infrastructure for a fundamental transformation involving redistribution of wealth and changing the basic culture of communities through Community Transformation Grants. There is to be "a detailed plan that includes the policy, environmental, programmatic, and as appropriate, infrastructure changes needed to promote healthy living and reduce racial and ethnic disparities," including "social, economic, and geographic determinants of health."

National Servitude

Student loans will be contingent upon a 10-year commitment to practice in underserved areas (p 488). Funding for the National Health Service Corps increases from about $320 million in fiscal year 2010 to $1.1 billion in fiscal year 2015 (p 494, §5207). A Ready Reserve Corps will be established (p 496, §5210), which shall "be available and ready for involuntary calls to active duty during national emergencies and public health crises, similar to the uniformed service reserve personnel." They are also to be available for "backfilling critical positions left vacant during the deployment of active duty commission corps members, as well as for deployment to respond to public health emergencies, both foreign and domestic, and to be available for service assignment in isolated, hardship, and medically underserved communities."

Conclusions

This analysis can only hit the highlights of a massive program, whose details are yet to be written in regulations. Only about one-third of the Act's provisions would fit on a chart prepared by minority members of the Joint Economic Committee led by Rep. Kevin Brady (R-TX) and Sen. Sam Brownback (R-KS).[22]

Enactment of ObamaCare has been called "a historic moment in U.S. social policy." Elenora E. Connors, J.D., M.P.H., and Lawrence O. Gostin, J.D., of Georgetown University Law Center write that: "Like Medicare and Social Security, which were highly contested before enactment, national health insurance reform hopefully will, in time, become part of accepted social structures."[23] Nevertheless, the program may be designed to fail.

"In case you didn't notice," writes Philip Jenkins, "all the actuarial assumptions that have kept the insurance system afloat for some 300 years just got repealed." The more egregious the failure, the louder the demands for an ever-larger state mechanism, he observes. "Failure is a terrible thing to waste."[24]

Implementation is not a fait accompli. Already there are bills to repeal at least sections of the Act, promises by many congressional candidates to repeal or defund it, and lawsuits to enjoin it.[25, 26] States are signaling reluctance to accept costly and intrusive new programs, even to the extent of turning down federal funds. The leap in regulatory requirements and the increasing criminalization of medicine may finally lead to an exodus of large numbers of physicians—into truly private medicine.

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