The New Health Care System

President Obama's signing of the reconciliation health care bill on March 30 signaled the end of a legislative process to reform health care that lasted over a year and involved a series of legislative steps. In the end, the president signed into law two separate pieces of legislation: the Senate comprehensive health care legislation on March 23 and the reconciliation bill with fixes requested by House Democrats on March 30. Below is an outline of the major provisions in the bill that associations need to know; keep in mind the regulatory process will provide further details on many of these items.

Insurance Market Changes

The insurance market reforms, maybe the most well-known reforms in the legislation, are spread out over four years. The following is a timeline of implementation for the major reforms:

- 2010 – Insurance companies will be required to cover children with preexisting conditions. Congress will create and fund a high-risk insurance pool to offer insurance to those adults who do not have coverage due to a preexisting condition. This insurance pool will exist as a bridge for the uninsured without coverage due to preexisting conditions until 2014, when insurers will no longer be able to refuse coverage due to preexisting conditions. Dependents will be allowed to remain on their parent or guardian's insurance plan until age 26

- 2014 – Insurance companies will now be prohibited from denying coverage due to preexisting conditions. Also, insurers will be prohibited from charging higher rates to different populations except on the basis of age, geography, and family size.

New Insurance Mandates

By 2014, all citizens are required to have health insurance and to report it on their federal tax filings. The penalty for failing to carry insurance gradually increases beginning in 2014 to $695 for individuals and $2,085 for families by 2016.

Businesses with more than 50 full-time employees are also required to provide "credible and affordable" health insurance to their employees. If an employer with more than 50 employees *does not offer credible coverage* (defined as paying at least 60% of employees' premiums) and has at least one employee in the Exchange, then the employer must pay a fine for every employee, regardless of whether that employee is in the Exchange. The penalty per employee for a company that does not offer insurance would $2,000 per employee. However, the first 30 FTE would not count in calculating the penalty, and businesses would be permitted to count part-time workers' time as "full-time equivalents".

If that same employer offers credible coverage, but has at least one employee who is receiving insurance from the Exchange (which they can enter if their employer is not covering at least 60% of their premiums

or their costs exceed 9.8% of their income) then the employer must pay the lesser of $3,000 for each employee in the Exchange or $750 for every employee, regardless of how they receive their insurance.

For example, Employer Z has 55 employees, does not offer credible coverage to any of its employees and one of their low-income employees receives insurance from an Exchange. Employer Z must now pay a fine of $2,000 for every employee. However, it would only pay the fine for 25 of its employees (first 30 of its 55 employees are exempt), so its total fine would be $50,000 annually. The next year, Employer Z offers "credible insurance coverage" to every employee, but one employee spends 10% of their income on their insurance costs. This person can enter the Exchange to receive insurance, and Employer Z must now pay a $3,000 fine for that employee (which is less than paying a $750 fine for each employee).

Insurance Exchanges

By 2014, each state must create its own health insurance Exchange, and the federal government would only get involved if the state failed to create an Exchange. The purpose of the exchange is to offer the self-employed and small businesses the same kind of health care system federal employees receive – one where a multitude of health care providers and plans are offered. The definition of who would be eligible to participate would also be set by the individual states. One option for the states would be the creation of Small business Health Option Program (SHOP) plans, which would be open to small businesses under 100 employees and the individually insured. Associations and other membership organizations could serve as "navigators" in these programs to guide eligible members to the Exchange.

All state Exchanges, however, would have a series of common requirements. All plans in an Exchange would use the same enrollment form, and every insurance company must list their plans' benefits in the same manner to allow for easy comparison by the consumer. States may apply for a waiver to form "compacts" with other states to permit cross-state sale of health insurance, essentially creating regional exchanges.

The federal government would also provide a series of financial supports to low-income Americans who receive insurance through the Exchange. A refundable tax credit would be made available to participants between 100 and 400% of the federal poverty level on a sliding scale.

The bill also created the "Consumer Operated and Oriented Plan" program, or Co-ops. Co-ops would be state and regional nonprofit organizations whose sole purpose would be to create a health insurance plan for members of the co-op. The nonprofit could not have been an insurance provider before a specific date and all profits must be used to lower insurance premiums.

Insurance Standardization Measures

Insurance providers are required to create and use standardized forms for common paperwork like claim reimbursement and plan enrollment. Congress will also provide grants to states to create a healthcare ombudsman, whose role is to assist residents with their insurance paperwork.

Small Employer Provisions

All employers with fewer than 50 employees would be exempt from penalties for not providing insurance. To help small employers provide coverage for their employees, employers who offer coverage and have

25 or fewer employees that have an average salary of $50,000 would be eligible for a tax credit for three years. Small nonprofits that qualified would take the credit against their payroll tax, a provision that ASAE and the nonprofit community argued would help nonprofits continue to offer insurance to employees.

- For 2010 through 2013, eligible employers will receive a small business credit for up to 35 percent of their contribution toward the employee's health insurance premium. Tax-exempt small businesses are eligible for tax credits of up to 25 percent of their contribution.

- In 2014 and later, eligible employers who purchase coverage through the Exchange can receive a tax credit for two years of up to 50 percent of their contribution. Tax-exempt small businesses are eligible for tax credits of up to 35 percent of their contribution.

Changes to Pre-Tax Accounts

Beginning in 2011, the maximum contribution to a flexible spending account is reduced to $2,500 annually (down from $5,000).

Revenue Raising Provisions

Both health care bills contained a number of "pay-fors" to offset the cost of the overall changes to the health care system. The Medicare Hospital Insurance tax will be increased for individuals making over $200,000 and couples over $250,000 by 0.9%. A new excise tax of 40% on insurance companies or plan administrators with an annual premium of over $10,200 for single coverage and $27,500 for family coverage will be collected beginning in 2018. The excise plans are indexed for inflation beginning in 2020 and exclude dental and vision benefits. In addition, there is a new tax equal to 3.8% of an individual or family's total unearned income from interest, dividends, annuities, royalties, or rents. The combined tax is anticipated to raise $210.2 billion over a ten year period.

Specific industries are also targeted to raise revenue for health care reform. An annual fee of $3.85 billion would be imposed on the pharmaceutical manufacturing sector beginning in 2011 and be allocated by market share, exempting small companies. Medical device manufacturers are also required to pay an excise tax on medical device sales equal to 2.9% of the price of a device. Finally, health insurance providers would pay an annual fee beginning in 2014 that would gradually increase to $12.2 billion for 2017 and beyond.

Specific Profession Benefits

In order to boost the number of medical professionals in underserved areas, the bills allow for both repayment programs and tax incentives for medical practitioners and specialist in these areas. Loan programs would also be created to decrease the nursing shortage, as well as steer more pediatric doctors to underserved areas. The government would also create new support for workforce training programs in areas like public health dentistry, geriatrics, and mental/behavioral health.