The New Health Care Law: Montana's First Steps

by Gregg Davis and Jerry Furniss

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Editor's note: This article is the first in a series of articles about key legislative health care reforms. Look for articles in future issues about proposed state insurance exchanges and related penalties for non-participation, mandated minimum policy coverages, as well as choices and types of care options for Montana consumers.

The health care legislation signed into law on March 23, 2010, is slated to change the health care marketplace gradually through numerous provisions affecting individuals, employers, health care providers, and the insurance industry. While the major provisions of the legislation won't kick in until 2014, many provisions take effect during the next six months. Three of these provisions are already out of the starting gate: tax credits for small employers offering health insurance to their employees; the closing of the "donut hole" for Medicare Part D enrollees; and the creation of a state high-risk pool for individuals who have been without health care insurance for at least six months.

Small Business Tax Credits for Employers Offering Health Insurance

Small businesses and tax-exempt organizations that provide employee-sponsored health insurance now qualify for a special tax credit if they meet certain requirements. This new, federally mandated tax credit does not impact Montana's existing state tax credit (or premium subsidy) available to Montana employers under the Insure Montana program (see sidebar). The first phase of the credit covers the period 2010 through 2013, with the second phase beginning in 2014, when the tax credit increases but will only be available for two more years. The tax credit is applied to income earned this year and will be filed on 2011 income tax returns.

Businesses with fewer than 50 employees are exempt from the health insurance mandates of the legislation. For Montana, this means that 97 percent of the state's establishments with at least 32 percent of the state's total employment are exempt from the mandate to offer health insurance to their employees. However, employers who choose to offer health insurance voluntarily may now qualify for a tax credit of up to 35 percent of the premium paid by the employer, subject to the conditions that the employer pays at least 50 percent of the total health insurance premium for the employee and has fewer than 25 full-time equivalent (FTE) employees with average wages less than $50,000 per employee. The full tax credit is limited to employers with 10 or fewer FTE employees and with average annual wages of $25,000 or less, excluding both the time and wages of the business owner. The amount of the employer's premium payment that counts for purposes of the credit is capped by the premium payment the employer would have made for an average premium for single coverage in Montana, or $4,772. The Internal Revenue Service website (www.irs.gov) walks the employer through the process of qualifying for and applying for the small business tax credit.

But as with many aspects of the legislation, more questions than answers remain until the U.S. Department of Health and Human Services issues its regulations and rules specific to each provision of the legislation.

Exactly how many small businesses in Montana are currently offering health insurance is unknown. The Internal Revenue Service sent out more than 26,000 postcard notices to Montana businesses that may qualify for the credit. Using national data on the proportion of employers offering employee-sponsored health insurance and based only on the number of business establishments with fewer than 10 employees, employers in Montana who qualify for the full tax credit could be as high as 7,400 businesses. But among these 7,400 businesses, the number of businesses with average wages below $25,000 is uncertain.

The industries in Montana most likely to qualify for the small business health care tax credit are retail trade, information services, real estate rental and leasing, education services, arts/entertainment/recreation services, and accommodation/food services. However, average wages in these industries are precariously close to the $25,000 threshold of the new health care bill.

Insure Montana and the New Federal Employer Tax Credit:

How Do These Programs Relate?

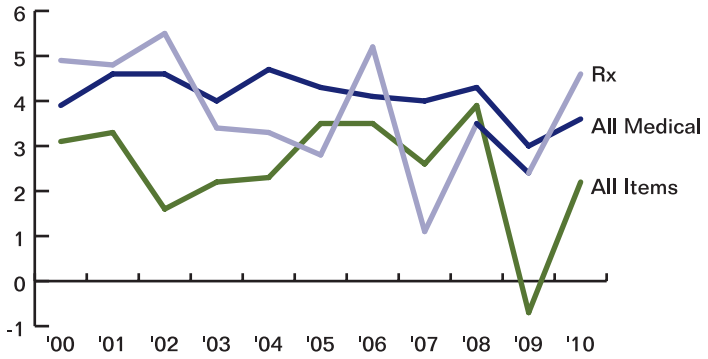
Insure Montana presently helps nearly 1,600 Montana employers cover more than 8,000 employees with group health coverage by providing either a tax credit or premium subsidy, thereby reducing the cost of coverage for small businesses. The Insure Montana tax credit is for qualifying employers who already cover employees, and the subsidy is for qualifying employers who initiate new coverage for their employees. The newly enacted federal tax credit for employers providing health insurance to employees does not impact the existing Insure Montana tax credit (or premium subsidy) program. Employers may be eligible for both. However, because the federal tax credit is based on the cost of providing health care to employees, to the extent that a Montana employer's health care costs are reduced by participating in Insure Montana, the employer's federal tax credit may be somewhat diminished.

For example, if a Montana employer spends $40,000 on health care for employees and receives a tax credit from the state of $12,000, the employer's cost of providing care is reduced from $40,000 to $28,000. The federal tax credit is calculated as a percentage of the cost of care ($28,000), as reduced by the state tax credit. Therefore, the 35 percent federal tax credit would be calculated on the employer's cost of care of $28,000 instead of $40,000.

The Donut Hole

Seven years ago, Congress passed legislation creating today what is known as Part D of Medicare. Part D prescription drug plans are privately provided as a free-standing drug plan or through Medicare Advantage Plans. Although benefits vary from plan to plan, Part D coverage basically subsidizes all enrollees after they meet their Part D deductibles, usually around $310 per year. Enrollees are also obligated to monthly premiums, which in 2010 averaged $39 per month. After meeting the deductible, Part D enrollees are responsible for only 25 percent of their drug costs. But when enrollees spend $2,830 for their share of drug costs, plus their deductibles, they hit the "donut hole." Once in the hole, co-insurance

Figure 1
Annual April 2000 to April 2010 Price Changes



Source: Bureau of Business and Economic Research, The University of Montana.

goes from 25 percent to 100 percent, making the individual completely responsible for all drug costs, hence the name "donut hole." After they spend $6,440 per year for drugs, enrollees are then eligible for catastrophic drug coverage. Under this coverage, the co-insurance goes from 100 percent to only 5 percent. This gap in coverage, or the donut hole, affects more than 3.5 million seniors, or 15 percent of the Part D Medicare population nationally. This excludes those who in fact do hit the coverage gap but otherwise qualify for government subsidies (such as through Medicaid eligibility) because of their low-income or disability status.

Prescription drug coverage is important for the elderly. Among the 65-plus age cohort, nearly 90 percent have prescription drug expenses each year. And prescription drug prices continue to climb, relative to general inflation rates. Figure 1 compares annual price changes for prescription drugs to medical inflation and overall economy-wide inflation over the past 10 years. Aside from the year-to-year volatility evident, prescription drug prices continue to outpace general inflation, and in some years, medical inflation as well. Also, the trend for prescription drug plans is to gravitate away from fixed-dollar co-pays for cost sharing to co-insurance. Because co-insurance is a percentage of the drug's cost, as prescription drug prices increase, so does the out-of-pocket prescription drug expense.

Recent changes to Medicare's Low-Income Subsidy Program, also known as LIS or "Extra Help," may also help low-income Montana Medicare beneficiaries by limiting their prescription drug expenses. Medicare beneficiaries with incomes below $16,245 per year (or $21,855 if married) and bank accounts, stocks and bonds with values up to $12,510 ($25,010 if married) will pay lower prices for generic and brand-name drugs. In addition, Medicare beneficiaries in Montana with incomes less than $21,660 ($29,140 if married) may qualify with Big Sky Rx for premium assistance. Big Sky Rx is a State Pharmaceutical Assistance Program (SPAP) funded by the tax on tobacco products that may pay up to $37.55 per month toward the Part D premium. Regardless, for seniors on fixed incomes, prescription drug prices continually erode their buying power.

In Montana, seniors account for 14 percent of the state's population. In 2006, Medicare beneficiaries with known drug coverage totaled over 135,000 in Montana. Assuming that 15 percent of this population hits the donut hole, more than 20,000 Montana seniors are spending in excess of $3,000 per year for prescription drugs. (Recall that incurring the deductible of $310 plus out-of-pocket expenditures of $2,830 places the senior in the donut hole.) And nationally, females are hit even harder with prescription drug expenses, spending almost 25 percent more than their male counterparts for prescription drugs. But beginning this summer, seniors reaching the donut hole will receive a one-time $250 rebate check to help with prescription drug expenses. Then beginning in January of next year, seniors will receive 50 percent drug discounts for brand name drugs once they hit the donut hole. These discounts are part of the deal made between the government and the pharmaceutical industry, which agreed to almost $85 billion in discounts, fees, and rebates. Beginning in 2013, the government will offer subsidies for seniors who reach the coverage gap, with subsidies starting at 2.5 percent and increasing to 25 percent by 2020. By 2020, industry discounts negotiated with the pharmaceutical companies, along with government subsidies, will bring the co-insurance for seniors down to 25 percent for brand name drugs. For generic drugs, typically offered at a fraction of their name brand counterparts, government subsidies begin in 2011, until the co-insurance for generic drugs is likewise 25 percent by 2020. In effect, as co-insurance stabilizes at 25 percent, the coverage gap disappears in 2020.

High Risk Pools To Cover The Uninsurable

The new reform legislation allocated $5 billion to create high-risk health insurance pools for those presently without health insurance and uninsurable because of pre-existing medical conditions. These new pools may be administered by the states, or, if a state opts out, the federal government will administer the pool for that state. A majority of the states, including Montana, have chosen the funding (potentially up to $16 million for Montana) and will administer the pools. These new high-risk pools are in addition to any existing state high-risk pool (which Montana already has), and will end when the state insurance exchanges are in place in 2014. The concept is to provide a stop-gap measure by covering the uninsurable until they can receive insurance through the state exchanges, which cannot impose pre-existing conditions restrictions on the insured. Between 5.6 million and 7 million individuals may qualify for the coverage, but the funding may only be sufficient to provide coverage for as few as 200,000 uninsureds (Merlis, 2010). It will be critical for state regulators to create innovative plans that will meet the requirements in order to stretch the coverage dollars.

Montana is one of 35 states that have a state high-risk pool for uninsurable individuals. This new federal funding and pool will not replace or substitute for Montana's existing high-risk pool, known as the Montana Comprehensive Health Association (MCHA). Montana has chosen to have the MCHA oversee this federal pool, and the applications for enrollment in Montana's version of the plan – the Montana Affordable Care Plan (MAC Plan) – are now available. (For a comparison of the MCHA and the new Federal High Risk Health Pool, see the sidebar below.)

Federal law limits the premiums for the program to no more than private insurers would charge healthy individuals in the same market. Based on that rate, the rules allow rating modifications based on age, family type (individual versus family), tobacco usage, and geography. For example, the highest rate differential based on age cannot exceed four times the lowest rate. And, while plan benefits are not specified by state law, plans would have to cover at least 65 percent of an enrollee's medical cost (not counting premium cost), and the enrollee's out-of-pocket costs for medical care is capped at the level specified for high-deductible health plans linked to Health Savings Accounts, which is $5,950 for individuals ($11,900 for families) in 2010. Unlike state risk pools, plans developed under the federal mandate will not have a pre-existing condition period, which may provide a significant benefit to new enrollees. Federal law requires that to be eligible for participation an individual must be a U.S. citizen, have a pre-existing medical condition, and have been uninsured for at least six months prior to enrollment. Because of limited funding, enrollment in the MAC Plan will likewise

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MCHA Vs. Federal High Risk Pool (MAC Plan)

Montana's high-risk health pool, the Montana Comprehensive Health Association (MCHA), provides coverage to well over 3,000 Montanans who would otherwise be uninsurable. Unlike the current MCHA plans, Montana's newly created high-risk pool plan, called the Montana Affordable Care Plan (MAC Plan), will not contain a 12-month pre-existing condition period. This means that under the MAC Plan, an enrollee would be immediately covered for a pre-existing condition, whereas under an MCHA plan, the enrollee would not be covered for that same pre-existing condition for the first 12 months of coverage.

Since the federal high-risk pool requires that an individual be uninsured for at least six months prior to enrollment, individuals presently in the MCHA's plans are not eligible for enrollment in the federal high risk health pool. Individuals would need to be without insurance for six months prior to enrollment. This situation is a temporary stop gap measure that will resolve in 2014 when the federal high risk pool is phased out and the state health insurance exchanges become operational.

MCHA (existing state high risk pool)	MAC Plan (new federal high risk pool)
Qualifying for Coverage - must have specified illnesses or be rejected or offered restricted rider by two insurers within the last six months	Qualifying for Coverage- must have a pre-existing condition (as defined by the feds) and have been uninsured for the last six months
Deductibles - plans have wide range of deductibles ranging from $1,000 to $10,000	Deductibles- not specified by federal law (Montana's plan has a $2,500 deductible)
Annual Out-of-Pocket Cost Limits - varies from $4,000 to $15,000, depending on the policy selected	Annual Out-of-Pocket Cost Limits - maximum for individual plans is $5,950 under federal law (Montana's plan has annual maximum out-of-pocket limits of $5,950)
Pre-existing Conditions Limits - coverage is not provided for the first 12 months for pre-existing conditions	Pre-existing Conditions Limits- Federal law prohibits coverage restrictions on the basis of pre-existing conditions
Rates - base rates may range up to 200% of private sector "market" rates for similar plans; presently average across all plans approximately 135% of market rates; rate differentials are tied to age	Rates - federal law requires base rates to be equal to 100% of private sector "market" rates for similar plans; Montana rates are based on 100% of private sector market rates as required; rate differentials are tied to age, similar to MCHA plans
Plans are individual plans; family plans are not offered. Each family member must qualify and pay premium	Like MCHA, plans are individual plans; family plans are not offered. Each family member must qualify and pay premium
Low-Income Subsidies - provided for under Montana law	Low-Income Subsidies - not provided for under federal law
Covered Insureds- 3000 +	Covered Insureds - first year target of 100 insureds; maximum of 400 insureds

Timeline for Health Reform Implementation: Overview

Reform will unfold incrementally. Although some major elements of reform begin in 2010, others will be implemented over the course of several years. In 2014, the most substantial changes—including shared responsibility for coverage, expansion of Medicaid, insurance exchanges, and creation of an essential benefits package—will take effect.

Early retirees: A temporary reinsurance program will help offset the costs of expensive premiums for employers providing retiree health benefits.

Access to care: Funding will be increased by $11 billion over five years for community health centers and the National Health Services Corps to serve more low-income and uninsured people.

Small-business tax credits: Small businesses (25 or fewer employees and average wages under $50,000) that offer health care benefits will be eligible for tax credits of up to 35 percent of their premium costs for two years.

Coverage for young adults: Parents will be able to keep their children on their health policies until they turn 26.

"Donut hole" rebates: Medicare will provide $250 rebates to beneficiaries who hit the Part D prescription drug coverage gap known as the "donut hole."

Benefit disclosure: Employers will be required to disclose the value of benefits provided for each employee's health insurance coverage on the employee's W-2 forms.

New payment and delivery approaches: A new Center for Medicare and Medicaid Innovation will test reforms that reward providers for quality of care rather than volume of services. Medicare will increase payment for primary care physicians by 10 percent for primary care services.

CLASS Act: A national, voluntary insurance program for purchasing community living assistance services and support (CLASS) will be established. All working adults will be automatically enrolled—unless they opt out—through payroll deductions that, after five years, will qualify them for monthly payments toward services to help them stay at home should they become disabled.

2010

2011

High-risk pool: People with pre-existing conditions who have been uninsured for at least six months will have access to affordable insurance through a temporary, subsidized high-risk pool. Premiums will be based on the average health status of a standard population. Annual out-of-pocket costs will be capped at $5,950 for individuals and $11,900 for families.

Protection for children: Insurers can no longer deny health coverage to children with pre-existing conditions or exclude their conditions from coverage.

Preventive care: All new group and individual health plans will be required to provide free preventive care for proven preventive services. In 2011, Medicare also will provide free preventive care.

Annual review of premium increases: Health insurers will be required to submit justification for unreasonable premium increases to the federal and relevant state governments before they take effect, and to report the share of premiums spent on nonmedical costs.

New insurance rules: Insurance companies will be banned from rescinding people's coverage when they get sick, and from imposing lifetime caps on coverage. Restrictions will be placed on annual limits.

Pharmaceutical manufacturer fee: An annual, nondeductible fee will be imposed on pharmaceutical companies' and importers' branded drugs, based on market share.

OTC drug reimbursement restrictions: Over-the-counter drugs not prescribed by a doctor will no longer be reimbursable through flexible spending accounts or health reimbursement arrangements, or on a tax-free basis in health savings accounts.

Physician quality reporting: Medicare will launch a Physician Compare website where beneficiaries can compare measures of physician quality and patient experience.

"Donut hole" discounts: Medicare beneficiaries in the Part D prescription drug coverage "donut hole" will receive 50 percent discounts on all brand-name drugs. By 2020, the "donut hole" coverage gap will be closed.

Premium share spending: Health plans in the large-group market that spend less than 85 percent of their premiums on medical care, and plans in the small-group and individual markets that spend less than 80 percent on medical care, will be required to offer rebates to enrollees.

2012

Medicare value-based purchasing: Medicare will reward hospitals that provide higher quality or better patient outcomes.

2013

Administrative simplification: Health insurers must follow administrative simplification standards for electronic exchange of health information to reduce paperwork and administrative costs.

Flexible spending limits: Contributions to flexible spending accounts (FSAs) will be limited to $2,500 a year, indexed to the Consumer Price Index (CPI).

2014

Shared responsibility for coverage: Individuals will be required to carry health insurance, and employers with 50 or more workers will be required to offer health benefits or be subject to a fine of $2,000 per employee (not counting the first 30 employees) if any worker receives governmental assistance with premiums through the insurance exchanges.

Insurance industry fee: Insurers will pay an annual fee, based on market share, to help pay for reform.

New rules for insurers: Insurers will be banned from restricting coverage or basing premiums on health status. Annual, in addition to lifetime, limits on benefits are banned.

Premium subsidies: Premium and cost-sharing assistance on a sliding scale will make coverage affordable for families with annual incomes between $30,000 and $88,000 that buy plans through the exchanges.

Medicare managed care plans: Four- and five-star Medicare private plans will receive 5 percent bonuses as a reward for providing better clinical quality and patient experiences.

Insurance exchanges: New state-based marketplaces will offer small businesses and people without employer coverage a choice of affordable health plans that meet new essential benefit standards.

Essential benefits package: The Department of Health and Human Services will establish an essential standard benefits package for policies sold in the exchanges and individual and small-group markets with a choice among tiers of plans (bronze, silver, gold, and platinum) that have different levels of cost-sharing.

Independent payment advisory board: A new independent payment advisory board within the executive branch will work to identify areas of waste and federal budget savings in Medicare. The board's recommendations must not ration care, raise taxes, or change Medicare benefits, eligibility, or cost-sharing.

Medicaid expansion: Medicaid eligibility will be expanded to all legal residents with incomes up to 133 percent of the federal poverty level. Currently, states have different—and in many cases very low—eligibility thresholds, and most states do not cover adults without children.

2018

High-cost insurance plans: Insurers will face a 40 percent excise tax on policies with premiums over $10,200 for individuals or $27,500 for family coverage.

Source: The Commonwealth Fund.

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be limited, and waiting lists will likely be required. If federal funds are exhausted, MAC Plan insureds are eligible to move to one of the MCHA's regular plans but must pay the full premium for the particular MCHA plan chosen.

Other Provisions: Dependent Coverage for Adult Children up to Age 26

Not all provisions of the reform legislation scheduled to take effect in September will in fact take effect in September. Language in the legislation for the more immediate reform areas has as the effective dates "six months after enactment, or September 2010." But, per the legislation, the measures need not take effect until the new health plan year begins. For example, many parents sighed with relief that legislation allowed their 25-year-old adult children to remain on their policy as long as the young adults were not offered a plan at their place of work. And although two of the largest insurance companies stepped up to the plate and included this coverage effective immediately, many employers have not. For those employers who have not voluntarily offered the extended coverage, the mandate will not take place until the new plan year of the applicable policy. Therefore, the timing of the extension of coverage of those dependents up to 26 years of age depends on each policy's plan year and renewal date.

According to a Commonwealth Fund survey, almost half (45 percent) of those between 19 and 29 years of age were uninsured for at least part of 2009 (Nicholson and Collins, 2009). For Montana, this could mean more than 60,000 uninsured young adults. For those between the ages of 20 and 26, nearly 37,000 may have been uninsured at one point during 2009. Because of the health care law change which allows more young adults to be insured under their parents' family health care plans, these newly insured young adults may put a strain on the health care system.

To the extent the newly eligible young adults are now seeking coverage where none existed before, the impact on insurers can be fairly significant. For example, the National Bureau of Economic Research estimates that for every 10 percent increase in health care coverage for the young uninsured, visits to emergency rooms and in-patient hospitalizations could increase by 4 percent and 6 percent respectively (Anderson et al., 2010). Increases in the demand for primary care are certain to increase as well, placing added demands on an already existing shortage of primary care providers.

One factor that might lessen the impact of this new federal provision on Montana insurers and providers is the fact that, in 2007, Montana joined half of the states and bumped the mandatory continuation of coverage for dependents up to age 25. For over two years, many Montanans up to age 25 have already had the choice to be covered under their parents' health plans. What makes an analysis of the impact of the federal law on Montana difficult is the fact that Montana's rules are somewhat different than the new federal law. For example, Montana's existing rule does require the child to be unmarried, whereas the new federal mandate allows both married and unmarried to be eligible, assuming the other dependency requirements are met. Additionally, the federal mandate applies to private individual and group plans as well as self-funded employer health plans, whereas Montana's rule only mandates extension of coverage to private insurers, but not self-funded employer plans. And, even though not required by Montana law, some of the self-funded employer health plans in Montana already voluntarily extended benefits to dependents up to age 25. As a result, health coverage became available to many, but not all, older dependents of Montana insureds already. Consequently, much, but not all, of the impact of the recent federal mandate on Montana insurers and providers may have already been felt.

Conclusion

There is little dispute that the present trend in health care costs is unsustainable. There is no shortage of opinion, however, on whether the new health care overhaul will indeed "bend the cost curve." But separating fact from opinion is not an easy task. For Montana, health care reform is particularly important. Our state devotes nearly 9 percent of its Gross State Product to health care, a proportion that is exceeded in only eight other states. Success of the new reform will be measured incrementally for years to come as different components of the law become reality. The small business tax credit, the state's high risk insurance pool, the Medicare Part D prescription drug fix, and the extension of insurance for adults up to age 26 are four of the first implemented components that will provide a well-monitored litmus test on how well the health law is implemented and the results that follow.

It's been said that the moderation of the health care overhaul law created its complexities. Trying to guess the rules, regulations, legislative modifications, and lawsuits forthcoming, along with the behavioral responses of individuals, firms, and providers, is a complex process with unparalleled precedent.❑

Gregg Davis is the Bureau's director of health care industry research. Jerry Furniss is a professor in The University of Montana School of Business Administration.

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