SJR 35: HEALTH CARE
Selected Elements of the Final Federal Health Care Legislation

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The following table highlights selected provisions of the final health care reform legislation approved by Congress in March 2010. The elements are contained in H.R. 3590, passed by the Senate in December 2009 and the House in March 2010; H.R. 4872, the reconciliation bill approved by both chambers in March 2010; and the manager's amendment to H.R. 4872.

	Final Federal Health Care Legislation
Individual Insurance Mandate	• **Effective in 2014**: All eligible individuals must have health insurance that meets minimum coverage requirements • Exemptions: Financial hardship, Native Americans, religious objections, and individuals who are either incarcerated, without coverage for less than three months, for whom the lowest cost plan exceeds 8% of their income, or who have incomes below the tax filing threshold. In 2009, the threshold was $9,350 for single filers and $18,700 for couples.
Penalties for Individuals	• **Effective in 2014**: Penalties for failure to obtain insurance coverage • Penalty is the greater of $695 per year (up to a maximum of three times that amount, or $2,085, per family) or 2.5% of household income • Penalty is phased in as follows: a flat fee of $95 per person in 2014, $325 in 2015, and $695 in 2016 or 1% of taxable income in 2014, 2% in 2015, and 2.5% in 2016. After 2016, penalty increases by the cost-of-living adjustment.
Subsidies for Individuals	• **Effective in 2014**: To offset the costs of buying insurance, refundable and advanceable premium credits will be available for individuals and families who buy insurance through a state health insurance exchange if they have incomes between 133% and 400% of the federal poverty level • Amount that qualifying individuals must contribute to their premiums ranges from 2% of income for people at or below 133% of poverty to 9.5% of income for those between 300% and 400% of poverty • Cost-sharing subsidies available to reduce the amount of annual out-of-pocket costs for people who are between 100% and 400% of poverty • Employees offered coverage through their jobs are ineligible for tax credits if they purchase a policy through the exchange unless the actuarial value of the employer's plan is less than 60% or the employee share of the premium exceeds 9.5% of income • Legal immigrants who are barred from enrolling in Medicaid during their first five years in the United States are eligible for premium credits • Verification of income and citizenship status required for determining eligibility for premium credits

Topic	Final Federal Health Care Legislation
Employer Insurance Provisions	• **In general**: Employers not required to offer insurance • **Effective in 2014**: Firms employing 50 or more workers must pay a fee if at least one full-time employee receives a premium tax credit for obtaining insurance in the state insurance exchange • The fee varies depending on whether the firm offers insurance coverage. Firms that don't offer coverage must pay $2,000 per full-time employee, but the first 30 employees are exempt from the calculation. Firms that offer coverage must pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full-time employee. • Employers that offer coverage must provide employees with a voucher if the employee has an income that is less than 400% of poverty, the employee's share of the premium for the employer plan is more than 8% but less than 9.8% of the employee's income, and the employee opts to buy insurance through the exchange. The voucher must equal the amount the employer would have paid for the employee's coverage and must be used to offset the premium costs for the exchange-purchased plan. • Employers with 200 or more employees must enroll employees into plans they offer; employees may opt out
Tax Credits for Employers	• **Effective immediately**: Employers with 25 or fewer employees and average wages below $50,000 qualify for tax credits if they offer insurance coverage and pay a portion of the employee's premium • **Effective in tax years 2010-2013**: Credits of up to 35% of the employer's contribution are available if the employer contributes at least 50% of the premium cost or 50% of a benchmark premium • Tax-exempt businesses may receive up to 35% of their contribution toward employees' premiums until 2013 • **Effective in 2014 and late**r: Credits of up to 50% of the employer's premium costs are available for two years for eligible small businesses that buy insurance through the state exchange and pay at least 50% of the employee's total premium costs • The full tax credit is available to employers with 10 or fewer employees and average annual wages of less than $25,000; credit phases out as firm size and average wage increases • Tax-exempt businesses may receive up to 25% of their contribution toward employees' premiums in 2014 and later • **Effective in 2010**: A $5 billion reinsurance program will reimburse employers who provide insurance coverage to retirees over age 55 but under age 65. The program will reimburse 80% of claims of $15,000 to $90,000 and will terminate Jan. 1, 2014.
Medicaid Expansion	• **Effective immediately**: States must maintain current Medicaid eligibility guidelines until 2014 or lose federal matching funds • **Effective in 2014**: Medicaid coverage expanded to childless, nondisabled adults; eligibility limit for all Medicaid-covered individuals set at 133% of poverty • Income disregards eliminated; income eligibility measured by modified adjusted gross income • Newly eligible adults will receive a benchmark benefit package that covers essential health benefits, as defined by the federal government • Federal government pays the full costs of the expansion for the first three years • **Effective in 2017**: States begin sharing in the costs of the expansion as follows: 5% in 2107, 6% in 2018, 7% in 2019, and 10% in 2020 and beyond

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CHIP	• **Effective immediately**: States must maintain current Children's Health Insurance Program (CHIP) eligibility levels through 2019 or lose federal funds • CHIP benefit packages and cost-sharing rules will continue as under current law • **Effective in 2014**: CHIP-eligible children who cannot enroll in the program because of enrollment caps will be eligible for tax credits for buying insurance through the exchanges • **Effective in 2015**: States will receive an increase of 23 percentage points in the CHIP matching rate, up to a cap of 100%
Health Insurance Exchanges	• **By 2014**: States must establish a health insurance exchange through which individuals and small businesses (up to 100 employees) may buy insurance coverage • Each exchange must offer at least two multi-state plans that meet the federally established coverage requirements and that have separate risk pools • Exchanges must maintain a customer service call center and establish procedures for enrollment and for determining eligibility for tax credits • American Indians with incomes at or below 300% of poverty are exempt from any cost-sharing requirements of policies sold through the exchange • **Effective in 2016**: States may form compacts to allow for purchase of individual policies across state lines; insurers in the compact would be subject only to the coverage laws of the state where the policy is written or issued • **Effective in 2017**: States may allow businesses with more than 100 employees to buy coverage through the exchange
Insurance Market Reforms	• **Effective in 2010**: No denial of coverage for children with pre-existing conditions; no lifetime limits on coverage for individual or group health plans; no restrictive annual limits on coverage; no rescission of coverage except in cases of fraud; children may remain on a parent's policy up to age 26 regardless of marital status; process established to review insurer premium increases • **Effective in 2011**: Insurers must provide rebates to consumers if they fail to spend a certain percentage of premium dollars on health care costs. The percentage is set at 85% for plans in the large group market and 80% for plans in the individual and small group markets. • **Effective in 2014**: Guaranteed issue and renewability; no exclusions for pre-existing conditions for any individuals; no annual limits on benefits; premiums may vary based on age (3:1 ratio), tobacco use (1.5:1 ratio), family composition, and geographic location; waiting period for coverage limited to 90 days; deductibles in the small group market limited to $2,000 for individuals and $4,000 for families, with some exceptions • **Exceptions**: Existing individual and group plans will not need to meet many of the benefit and insurance reform requirements until 2014 but must, in 2010, extend dependent coverage to adult children up to age 26, prohibit rescission of coverage, and eliminate waiting periods in excess of 90 days for coverage

	Final Federal Health Care Legislation
Benefit Plans	• **Effective in 2010:** New plans in the private market must cover preventive care with no deductibles or cost-sharing requirements; requirement will apply to all plans in 2018 • **Effective in 2014**: All plans offered in the exchange and in the individual and small group markets outside of the exchange must offer at least the essential health benefit package developed by the federal government. The plan must offer a comprehensive set of services, have an actuarial value of at least 60%, and limit annual cost-sharing to the current Health Savings Account limits of $5,950 for individuals and $11,900 for families. • Plans offered in the exchange and in the individual and small group markets must offer four benefit options with actuarial values ranging from 60% to 90% • Grandfathered individual and employer-sponsored plans would be exempt from offering the essential health benefits package • "Catastrophic" policy available, in the individual market only, to young adults under the age of 30 who want a less expensive policy that covers only major medical costs; policy must cover preventive services and three primary care visits
State Role	• **Effective in 2010**: States must establish an ombudsman office to act as a consumer advocate and may establish a high-risk pool meeting federal guidelines. State high-risk pools will share in federal funds available for covering individuals with pre-existing conditions. If a state high-risk pool is not created by July 1, residents are covered by a federal plan. • **By 2104**: States must establish health insurance exchanges • **Effective in 2017 and beyond**: States must pay a portion of the costs of expanding Medicaid coverage, starting at 5% of the additional costs in 2017 and increasing gradually to 10% in 2020 and beyond
Alternative to Private Insurance	• **Effective July 1, 2013**: A nonprofit, member-run insurance company (co-op) may be created and may receive federal loans for startup costs and federal grants to meet state solvency requirements • The cooperative may not be an existing organization that was providing insurance on July 16, 2009, or affiliated with such an organization and may not be sponsored by a governmental entity of any type
Workforce Issues	• **Effective in 2010:** More flexibility for the types of locations where medical residents can train; additional federal incentives — including scholarships, loans, and loan repayments — available to increase the workforce supply and support primary care training; appointment of a Workforce Advisory Committee to develop a national workforce strategy • **Effective in 2011**: Primary care providers and general surgeons in shortage areas will receive 10% Medicare bonus payments for 5 years; residency slots for primary care training will be created by redistributing unused slots, with priority given to states with the lowest resident physician-to-population ratios • **Effective in 2013 and 2014**: Increase in Medicaid reimbursement rates to 100% of the Medicare rate for primary care physicians. The federal government will fund the cost of the increase.

	Final Federal Health Care Legislation
Revenue Sources	• **Effective July 1, 2010**: Imposes a tax of 10% on indoor tanning services • **Effective 2011**: Increases to 20% the tax on withdrawals from Health Savings Accounts (HSAs) or Archer Medical Savings Accounts (MSAs) for non-medical expenses, from 10% and 15%, respectively; excludes costs of over-the-counter, non-prescribed drugs from being reimbursed through a health Flexible Spending Account (FSA) or Health Reimbursement Arrangement (HRAs) or on a tax-free basis through an HSA or Archer MSA; imposes an annual fee of $2.5 billion on pharmaceutical manufacturers, increasing annually to $4.1 billion in 2018 and reverting to $2.8 billion in 2019 and beyond • **Effective 2013**: Imposes a tax of 2.3% on the sale of taxable medical devices; limits contributions to medical FSAs to $2,500 a year, increased annually by the cost of living; increases the threshold for itemized deduction of unreimbursed medical expenses from 7.5% of adjusted gross income to 10%; increases the Medicare Part A tax rate on wages from 1.45% to 2.35% on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly and imposes a 3.8% tax on unearned income for higher-income taxpayers • **Effective 2014**: Imposes a tax on individuals who don't have insurance coverage; imposes an annual fee of $8 billion on the health insurance sector, increasing annually until it reaches $14.3 billion in 2018 and then increasing in subsequent years by the rate of premium growth • **Effective 2018**: Imposes a tax of 40% on insurance companies that offer employer-sponsored plans with an aggregate value higher than $10,200 for individual coverage and $27,500 for family coverage; the tax is imposed on the value of the plan that exceeds the threshold amount. The aggregate value includes reimbursements under a medical FSA or HRA, employer contributions to an HSA, and coverage for supplementary health insurance coverage, excluding dental and vision coverage.

Sources: Compiled from Kaiser Family Foundation and National Conference of State Legislatures materials.

Implications of Selected Provisions for Montana

While the federal legislation affects all states, some provisions apply only to Montana or a selected group of rural states, including:

- designated funding to assist Libby residents with diseases stemming from their exposure to asbestos at the W.R. Grace and Co. vermiculite operation. The bill provides $25 million through 2014 and $20 million for every five-year period after that to screen people for asbestos-related diseases. It also will expand Medicare coverage regardless of age to those who test positive if they meet the residency requirements, and it establishes a pilot project to pay for asbestos-related disease care that's not covered by Medicare.

- an increase in the Medicare minimum "area wage index" for hospitals located in a frontier state. The bill defines a frontier state as one in which at least 50% of the counties have fewer than 6 people per square mile. Montana, North Dakota, South Dakota, Utah, and Wyoming qualify for this provision, which will increase Medicare reimbursements to the state's largest hospitals.

In addition, Northern Montana Hospital in Havre will benefit from a one-year extension of the Rural Community Hospital Demonstration Program, which reimburses small rural hospitals at cost for their services. About a dozen hospitals in eight states are currently involved in the demonstration project.

2009 FEDERAL POVERTY LEVEL GUIDELINES

	Gross Yearly Income							
Family Size	**approx 33%**	**100%**	**133%**	**150%**	**175%**	**250%**	**300%**	**400%**
1	$3,576	$10,830	$14,404	$16,245	$18,953	$27,075	$32,490	$43,320
2	$4,704	$14,570	$19,378	$21,855	$25,498	$36,425	$43,710	$58,280
3	$5,892	$18,310	$24,352	$27,465	$32,043	$45,775	$54,930	$73,240
4	$7,092	$22,050	$29,327	$33,075	$38,588	$55,125	$66,150	$88,200
5	$8,280	$25,790	$34,301	$38,685	$45,133	$64,475	$77,370	$103,160
6	$9,468	$29,530	$39,275	$44,295	$51,678	$73,825	$88,590	$118,120
7	$10,668	$33,270	$44,249	$44,905	$58,223	$83,175	$99,810	$133,080
8	$11,844	$37,010	$49,223	$55,515	$64,768	$92,525	$111,030	$148,040

ELIGIBILITY LEVELS: STATE PROGRAMS AND FEDERAL REFORM PROPOSALS

Montana Programs	**% of FPL**
Medicaid	
Adults with children	~33%
Children through age 18	133%
Pregnant women	150%
Healthy Montana Kids	250%
MCHA premium assistance	150%

Federal Health Care Legislation	**% of FPL**
Medicaid Expansion	133%
Low-Income Subsidies	400%