The State of Working Montana

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The State of Working Montana series explores the state of Montana's economy from the perspective of its workers and documents how they are faring. In this installment on health reform, and in every report in this series, our analysis goes beyond the top-level indicators that many use to evaluate the Montana economy. Instead, we focus on what matters to people who work in Montana.

In this spirit, this report examines how national health reform will help provide affordable health care for more working families.

What Health Reform Means for Montana

Each year, over 150,000 Montanans struggle to provide health insurance coverage for their families.[1] For thousands more, the cost of health insurance is making it harder and harder to meet their families' other basic needs.[2]

The health reform package recently passed by Congress may not solve all of our health care system's underlying problems, but it will bring coverage to thousands of Montana families who had been living without access to affordable health care, at relatively low cost to the state of Montana.

This edition of the State of Working Montana explains how health reform will improve access to care in Montana. While we do not cover every provision included in the bill, we have kept a sharp focus on how the bill improves affordability of insurance and access to coverage for the uninsured.

Key Findings: Expanded Coverage for Montanans under Health Reform

- 78,000 Montanans will be newly eligible for Medicaid, 42,000 of which were uninsured and 25,000 of which had non-group or other public insurance.
- 54,000 Montanans in families with jobs that don't provide health insurance will be eligible for subsidies to help purchase insurance.
- 18,000 individuals in families with self-employment, part-time employment or not working will be eligible for subsidies.
- 26,000 uninsured Montanans currently eligible for Medicaid but not enrolled may do so as a result of the new individual mandate.
- 27,000 small businesses will be eligible for subsidies to help provide insurance to their employees.
- The additional cost to the state for improving coverage for over 150,000 Montanans will be minimal. State Medicaid expenses will increase by just 3.7-6%. This cost is low relative to the increase in the number covered by Medicaid (up to a 75% increase over current enrollment).
- Millions of dollars will flow into Montana's economy through various provisions of the bill that will create jobs, income and income tax revenue.

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Current Insurance Coverage in Montana

Coverage, cost and quality of care are uneven in Montana. Many people have jobs that don't provide affordable health insurance, and many Montanans without access to affordable private insurance are ineligible for public programs like Medicaid. People who have health insurance experience a great diversity in the cost, eligibility and kinds of care covered. Others have been denied enrollment in plans because of pre-existing health conditions.

Right now, those Montanans that do have health care are covered by a few broad types of insurance options:

- Medicaid or CHIP (Children's Health Insurance Program).
- Employer sponsored insurance that usually does not cover the entire costs of premiums. [3]
- Non-group insurance (sometimes referred to as individual insurance) is purchased by individuals directly from an insurance company. Often this insurance is limited and expensive.
- Other public insurance, such as Medicare, military health benefits and Indian Health Services.
- Currently, 158,000 Montanans--almost 20% of the population--do not have any health insurance.

Table 1 shows the types of coverage for Montanans under the age of 65, compared to national averages.[4]

Table 1: Current Insurance Coverage for Nonelderly Montanans by Type of Insurance

	Medicaid or CHIP	Employer Sponsored	Non-group	Other Public	Uninsured	Total
Number	119,000	431,000	79,000	34,000	158,000	821,000
Percent	14.5%	52.5%	9.6%	4.1%	19.3%	100%
US Percent	16.8%	57.1%	6.0%	3.3%	16.8%	100%

Source: Holahan and Blumberg, 2010

Compared to the rest of the country, Montana has a high percent of people with no insurance, as well as people covered by non-group insurance. Montana also has relatively low levels of participation in Medicaid or CHIP and employer sponsored insurance.

In fact, we have the lowest rate of employer provided health insurance in the United States. Only 40.2% of employers offer health insurance to their employees in Montana, compared with 56.4% nationally.[5] Both nationally and in Montana, private insurance coverage is declining, while publicly funded health insurance has been growing.[6]

Health Reform Basics

Once fully implemented, health reform will expand coverage options for many Montanans. Key components of reform include:

- The creation of health insurance exchanges set up by the states, where individuals, families and businesses can shop for health insurance plans that are "in the interest" of buyers.[7] Private insurance will still be available outside of the exchange.

- The expansion of Medicaid to cover additional families with limited incomes.
- Subsidies for families not covered by Medicaid but for whom private insurance is unaffordable.[8]
- Important reforms of the insurance industry, including preventing insurance companies from denying coverage based on pre-existing conditions.

In addition, many Montanans will keep their current insurance provided by their employer or Medicare.

The rest of this edition of the State of Working Montana will detail how certain provisions of health reform will broaden access to care in the state. Many of these provisions will not be fully in effect until 2014.[9] This analysis calculates the expansion of coverage as if it was already fully effective.

Medicaid Eligibility Expansion

Health reform expands coverage to those families with incomes below 133% of the federal poverty level (FPL),[10] which is $24,352 for a family of three (see Appendix for more detail about federal poverty levels). The expanded coverage will result in 78,671 newly eligible Montanans.

Prior to health reform implementation, eligibility for Medicaid in Montana varies dramatically based on certain characteristics of the person applying:

- Children are eligible for Medicaid at 133% of FPL or below.[11]
- Pregnant women below 150% of FPL are eligible for Medicaid.
- Children below 250% of FPL are eligible for CHIP.
- Adults with children are eligible for Medicaid below 33% of FPL.

Because children living at or below 133% of the federal poverty line are already eligible for Medicaid, the Medicaid expansion will only increase coverage for adults in the state.

Table 2 shows the current coverage (or lack thereof) for the estimated 78,671 Montanans who will be newly eligible for Medicaid. Only a small percent (15.6%) have employee-sponsored insurance, and they may remain with their current insurance. The majority of those newly eligible for Medicaid were uninsured or participated in nongroup plans.

Table 2: Montanans Newly Eligible for Medicaid

	Number	Percent of Nonelderly Population
Newly Eligible for Medicaid	78,671	9.6%
Coverage Prior to Health Reform	**Number**	**Percent of Newly Eligible**
Employee-Sponsored Insurance	12,274	15.6%
Nongroup or Other Public	24,673	31.4%
Uninsured	41,724	53.0%

Source: Holahan and Blumberg, 2010

In addition to the Montanans who are newly eligible for Medicaid, it is expected that many of those who are currently eligible for Medicaid but have not enrolled, will enroll. Currently, about 26,000

uninsured Montanans are eligible for Medicaid but are not enrolled (Table 3).[12] The individual mandate included in the reform (discussed in more detail below) may cause some of these people to enroll in Medicaid despite the fact that the penalties for not being covered are either weak or nonexistent for this population.[13] Also, research shows that when parents become eligible for Medicaid, their children, who were already eligible, often enroll too.[14]

Table 3: Montanans Currently Eligible for Medicaid, Not Enrolled

	Number	Percent of Nonelderly Population
Currently Eligible for Medicaid, Not Enrolled	48,636	5.9%
Coverage Prior to Health Reform	**Number**	**Percent of Newly Eligible**
Employee-Sponsored Insurance	16,065	33.0%
Nongroup or Other Public	6,569	13.5%*
Uninsured	26,002	53.5%

* There is an increased likelihood of estimation error because of the small sample size.
Source: Holahan and Blumberg, 2010

Subsidies to Assist with Private Insurance

Health reform also includes subsidies to help purchase health insurance for families with incomes between 133% and 400% of the federal poverty level – $24,352 and $73,240 for a family of three. Currently, 354,000 Montanans, or 43.1% of the state's population, have incomes between 133% and 400% of FPL.[15] Our state has the 3rd highest percent of population in this income range in the country.

However, not everyone in this group will be able to receive the subsidy. Anyone who already has access to affordable health care through his or her employer will not be eligible for the subsidy.[16]

In the Western US, 47.1% of individuals in this income group do not have healthcare through an employer-sponsored program.[17] Assuming the same rate holds true in Montana, we can estimate that 166,734 people in the eligible income range do not have insurance through their employer and will receive the subsidies to purchase insurance.

Additional Montanans with unaffordable employee-sponsored coverage will also be eligible for the subsidy. Montanans that do have jobs with affordable health insurance will see no change in their coverage.

Individual Mandate

Health reform also requires that everyone have health insurance, with exemptions for some groups, including people in poverty and American Indians.[18] Anyone who makes more than 400% of FPL (income over $73,240 for a family of three) will not be eligible to receive subsidies, but will be required to have health insurance.

At the moment, 256,000 Montanans, or 31.1% of the nonelderly population, have incomes above 400% of FPL. In the Western United States, 6.9% of individuals in this income range are uninsured.[19]

Assuming the same rate for Montana, approximately 17,664 people in this income range do not currently have insurance but will be required to purchase insurance or pay a fine when the reform is fully implemented.

Small Business Subsidies

The reform also provides subsidies for small businesses (fewer than 25 employees) to purchase health insurance for their employees. The subsidies will help pay up to half of the employer's contribution to employee premiums. Any business that participates in this program must have fewer than 25 employees and average annual wages less than $50,000. Montana has 27,734 businesses that have fewer than 25 employees, accounting for 126,420 employees.[20] Currently these businesses represent 80% of businesses in Montana and only 29% offer health insurance to their employees.

Fees for Large Employers

Health reform also includes fines for employers with 50 or more employees who don't sponsor affordable insurance for employees. Any business with at least 50 employees must pay a fee if their full-time employees utilize the individual subsidies (discussed above) to buy health insurance. The fee varies according to whether or not the firm offers any coverage.

If a large company does not offer coverage, the fee is $2,000 per full-time employee, but the first 30 employees are exempt. If the firm does offer coverage, the fee is $3,000 for each full-time employee who receives a subsidy to purchase insurance in the exchange or $2,000 for every full-time employee, whichever is less.[21]

Only 5,614 private companies in Montana have 50 or more employees, and 96.2% of these employers offer health insurance to their employees.[22] Consequently, only about 213 employers in Montana will face penalties if they don't provide health insurance to their employees. Additional firms may face fees if they do not provide affordable plans and employees utilize the subsidies available to purchase insurance through the exchange.

Improvements to Indian Health Services

The federal government is obligated to provide health care to American Indians. This obligation was agreed to in exchange for land and resources in the 18th century. To help fulfill this obligation, the Indian Health Services (IHS) was created.

However, IHS has historically been severely underfunded. Legislation to improve the provision of healthcare to American Indians expired in 2002. Since then, numerous critics have described IHS as outdated, suffering from a lack of elder and long-term care, cancer screenings, and sufficient providers to meet demand.[23]

Health reform promises to help reverse course on these shortcomings and improve access to health care for American Indians.

First, the reform package permanently reauthorizes the legislation that improved how native communities receive health care. This will fill in some of the gaps in care created by the expiration of the legislation in 2002.

Second, thousands of American Indian adults in Montana will be newly eligible for Medicaid under the expanded coverage. Montana has approximately 15,000 American Indians between the ages of 18 and 64 who live below 133% of FPL and are either currently eligible or will be newly eligible for Medicaid.[24] Medicaid coverage will expand health care options for these Montanans. American

Indian Medicaid enrollees may seek care from facilities outside of IHS under reform. In addition, Medicaid serves as primary insurance, which means that IHS will receive reimbursements when it provides care to a Medicaid enrollee, freeing up IHS funds for other purposes. IHS will effectively receive increased funding through this reimbursement, allowing them to improve their core services.

Third, prior to the reform bill, IHS was not authorized to provide cancer screenings, except mammograms. Under health reform, IHS's ability to provide preventative care, including cancer screening, will be expanded. The new reforms will also substantially expand the elder and long-term care options across Indian Country.

Health Reform Assistance for the Uninsured

Based on the improvements described above, the 158,000 Montanans who are currently uninsured will have many ways to receive health insurance when the reform provisions are fully implemented in 2014:

- 42,000 will be newly eligible for Medicaid.
- 26,000 who are currently eligible for, but not yet enrolled in, Medicaid may decide to enroll.
- 54,000 in families with jobs that don't provide health care will be eligible for subsidies to help pay for coverage.
- 18,000 individuals in families with self-employment, part-time employment or not working will be eligible for subsidies.
- 19,000 will be ineligible for Medicaid or a subsidy, but may use the exchange to purchase insurance.[25]

Additional Benefits to the State

Besides the large expansion in coverage, many other parts of health reform will bring millions of dollars into the Montana economy, often to areas of the state that need economic development and job creation the most.

While all of the bill's benefits to the state are too numerous to list, here are a few examples:

- Funding to help residents in Libby recover from asbestos-related diseases. Health reform provides $25 million through 2014 and $20 million for every five-year period thereafter to screen people for asbestos-related illness. Anyone who tests positive for asbestos exposure will be eligible for Medicare coverage, regardless of age.
- Increased Medicare reimbursements to hospitals in frontier states (Montana, North Dakota, South Dakota, Utah and Wyoming).
- Federal funding for employers (including state and local governments) who incur insurance costs for early retirees who are not yet eligible for Medicare.
- Additional grants to clinics that provide care to medically underserved populations and schools.
- By the summer of 2010, $16 million in federal funds will be available to fund an expansion of the high-risk pool that offers insurance to individuals who have been without health insurance and have a preexisting condition.
- Grants for physicians and nurses who provide care to rural or underserved communities.
- Federal subsidies to individuals and businesses to buy health insurance (discussed in detail above).

These additional dollars will flow through the economy creating jobs, income and income tax revenue in Montana, thus enhancing the state's ability to afford the costs of expanding coverage.

Costs to the State

In exchange for expanded coverage and additional dollars flowing to the state, Montana will be expected to cover a small amount of the costs of extended Medicaid coverage.

Medicaid is a partnership between states and the federal government. In Montana, the federal government currently contributes over two-thirds of the costs.[26] For anyone who was already eligible for Medicaid, the same cost sharing arrangement will apply under health reform. For people newly eligible under health reform, the federal government will cover 100% of the costs for the first three years (2014-2016) and 90% permanently.[27]

According to the Kaiser Commission on Medicaid and the Uninsured, Montana is expected to pay 3.7% to 5.7% more for Medicaid between 2014 and 2019.[28] This relatively small additional cost will cover up to 75% more Montanans than are currently covered.[29]

The Montana Department of Public Health and Human Services (DPHHS) anticipates it will spend an additional $173 million to fund the changes in Medicaid and CHIP for 2014-2019.[30] This reflects a 6% increase over what the state would have spent on Medicaid without reform.

DPHHS' estimate is higher than the Kaiser Commission because it assumes a much higher participation rate by newly eligible adults (80-95%) than other studies.[31] The Congressional Budget Office (CBO) assumed a 57% participation rate, based on current participation rates and the lack of penalties for this income group.[32] The Kaiser Commission estimates are based on a range starting with the CBO participation rate of 57% and extending to a 75% rate if states enhance outreach efforts.[33]

According to each analysis, the cost to expand coverage to a large number of Montanans is very low, and other health-related costs for the state are expected to decline due to health reform as well.

State and local budgets will see lower costs for uncompensated care, which happens when a public health care facility treats a patient who is uninsured. These facilities include chemical dependency centers, veterans' homes, and mental health hospital and care centers. Health reform's efforts to lower health care costs may also help state and local governments' cover health care for legislators, teachers, prison populations, children in foster care and public safety officers.

Conclusion

Health reform will not solve all of our health care system's challenges. Costs, access, and the quality of health care are still likely to vary greatly, but it would be a mistake to overlook the coverage the reform will provide to the far too many Montanans currently struggling to keep themselves and their families healthy without health insurance.

Expanding Medicaid coverage will bring much needed relief to families struggling to make ends meet and will keep the costs of uncompensated emergency room care down. Subsidies will provide relief to even more Montanans who don't have access to affordable insurance. Small businesses in Montana will also get assistance providing health insurance for their employees. Some of the misguided policies and underfunding for Indian Health Services that created massive gaps in care will be reversed.

The effects of these expansions could control costs for an even greater number of Montanans, all at a very reasonable cost to the state. Health reform does not signal the end of Montana's health care challenges, but it does represent a step in the right direction toward delivering quality affordable health care for all Montanans.

Endnotes

1. The Henry J. Kaiser Family Foundation, *Montana: Kaiser State Health Facts*. At http://www.statehealthfacts.org/profileglance.jsp?rgn=28 (accessed 06/04/2010).
2. Montana Budget and Policy Center, *The State of Working Montana*, February 2010, pp. 9-10.
3. Employer sponsored plans includes plans sponsored by public employers such as school districts, fire departments, and local, state and federal governments.
4. The elderly population is eligible for Medicare for which eligibility will not change under health reform.
5. Agency for Healthcare Research and Quality. 2008. Medical expenditure panel survey. http://www.meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp?regionid=86&year=2008 (accessed 4/19/2010).
6. *The State of Working Montana*, Montana Budget and Policy Center, February 2010, pp. 9-10.
7. Patient protection and affordable care act. In. 2010. P.L. 111-148.
8. Subsidies will only be available to purchase insurance through the exchanges.
9. For more information about the phase in schedule of provisions see O'Connell, Sue. 2010. *SJR 34: Health care: Selected elements of the final federal health care legislation*. http://www.leg.mt.gov/content/For-Legislators/sjr35-reform-summary-april2010.pdf (accessed 4/29/2010).
10. The Federal Poverty Level (FPL) is currently $18,310 for a family of three. http://aspe.hhs.gov/poverty/09extension.shtml
11. Medicaid and CHIP for children in Montana fall under the Healthy Montana Kids program.
12. Holahan, John and Linda Blumberg. 2010. *How would states be affected by health reform: Timely analysis of immediate health policy issues*. Washington DC: Urban Institute.
13. The penalties are zero for those below 100% of FPL.
14. Dubay, Lisa and Genevieve Kenney. 2003. Expanding public health insurance to parents: Effects on children's coverage. *Health Services Research* 38, no. 5: 1283-1302.
15. Holahan, John and Linda Blumberg. 2010. *How would states be affected by health reform: Timely analysis of immediate health policy issues*. Washington DC: Urban Institute.
16. Affordable means that the employee contribution does not exceed 9.5 percent of their income. Patient protection and affordable care act. In. 2010. P.L. 111-148, Health care and education reconciliation act of 2010. In. 2010. P.L. 111-152.
17. Holahan, John and Linda Blumberg. 2010. *How would states by affected by health reform: Timely analysis of immediate health policy issues*. Washington DC: Urban Institute.
18. Kaiser Family Foundation. 2010. *Summary of new health reform law*.
19. Holahan, John and Linda Blumberg. 2010. How would states by affected by health reform: Timely analysis of immediate health policy issues. Washington DC: Urban Institute.

20. Agency for Healthcare Research and Quality. 2008. *Medical expenditure panel survey*. http://www.meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp?regionid=86&year=2008 (accessed 4/19/2010).

21. O'Connell, Sue. 2010. *SJR 34: Health care: Selected elements of the final federal health care legislation*. http://www.leg.mt.gov/content/For-Legislators/sjr35-reform-summary-april2010.pdf (accessed 4/29/2010).

22. Agency for Healthcare Research and Quality. 2008. *Medical expenditure panel survey*. http://www.meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp?regionid=86&year=2008 (accessed 4/19/2010).

23. James, Cara, Karyn Schwartz and Julia Berndt. 2009. *A Profile of American Indians and Alaska Natives and Their Health Coverage* The Henry J. Kaiser Foundation.

24. 2005-2007 American Community Survey (includes individuals who self identify as American Indian alone or in combination with some other race).

25. _____. 2010. *How would states be affected by health reform: Timely analysis of immediate health policy issues*. Washington DC: Urban Institute. Note: The breakdown of numbers provided by type of coverage or assistance doesn't add to the total of uninsured Montanans due to rounding.

26. The FMAP for 2010 was increased by the American Recovery and Reinvestment Act to 77.99%. This increase has been extended through December 31, 2010, at which time it will revert to 67.42%. Center for Medicaid and State Operations. 2010. *Revised clawback calculations*. https://www.cms.gov/smdl/downloads/SMD10004.pdf (accessed 4/19/2010); Kaiser Family Foundation. 2010. *State health facts*. www.statehealthfacts.org (accessed 4/30/2010).

27. The federal government will pay 100% for the first three years (2014-2016) and the federal support will phase down to 90% for 2017-2020.

28. Holahan, John and Irene Headen. 2010. *Medicaid coverage and spending in health reform: National and state-by-state results for adults at or below 133% fpl*. Washington DC: The Henry J. Kaiser Family Foundation.

29. _____. 2010. *Medicaid coverage and spending in health reform: National and state-by-state results for adults at or below 133% FPL*. Washington DC: The Henry J. Kaiser Family Foundation.

30. Montana Department of Health and Human Services. 2010. *Montana and major components of federal healthcare reform*. Helena.

31. _____. 2010. *Montana and major components of federal healthcare reform*. Helena.

32. Congressional Budget Office. 2009. *Spending and enrollment detail for CBO's March 2009 baseline: Medicaid*. Washington DC.

33. Holahan, John and Irene Headen. 2010. *Medicaid coverage and spending in health reform: National and state-by-state results for adults at or below 133% fpl*. Washington DC: The Henry J. Kaiser Family Foundation.

Appendix

Income by Percent of Federal Poverty Level and Family Size						
Family Size	Percent of the Federal Poverty Level					
	33%	100%	133%	150%	250%	400%
1	$3,576	$10,830	$14,404	$16,245	$27,075	$43,320
2	$4,704	$14,570	$19,378	$21,855	$36,425	$58,280
3	$5,892	$18,310	$24,352	$27,465	$45,775	$73,240
4	$7,092	$22,050	$29,327	$33,075	$55,125	$88,200
5	$8,280	$25,790	$34,301	$38,685	$64,475	$103,160
6	$9,468	$29,530	$39,275	$44,295	$73,825	$118,120
7	$10,668	$33,270	$44,249	$44,905	$83,175	$133,080
8	$11,844	$37,010	$49,223	$55,515	$92,525	$148,040