# The Status of Montana's Health Insurance Population

**SUBMITTED BY**
Bureau of Business
and Economic Research
The University of Montana–Missoula
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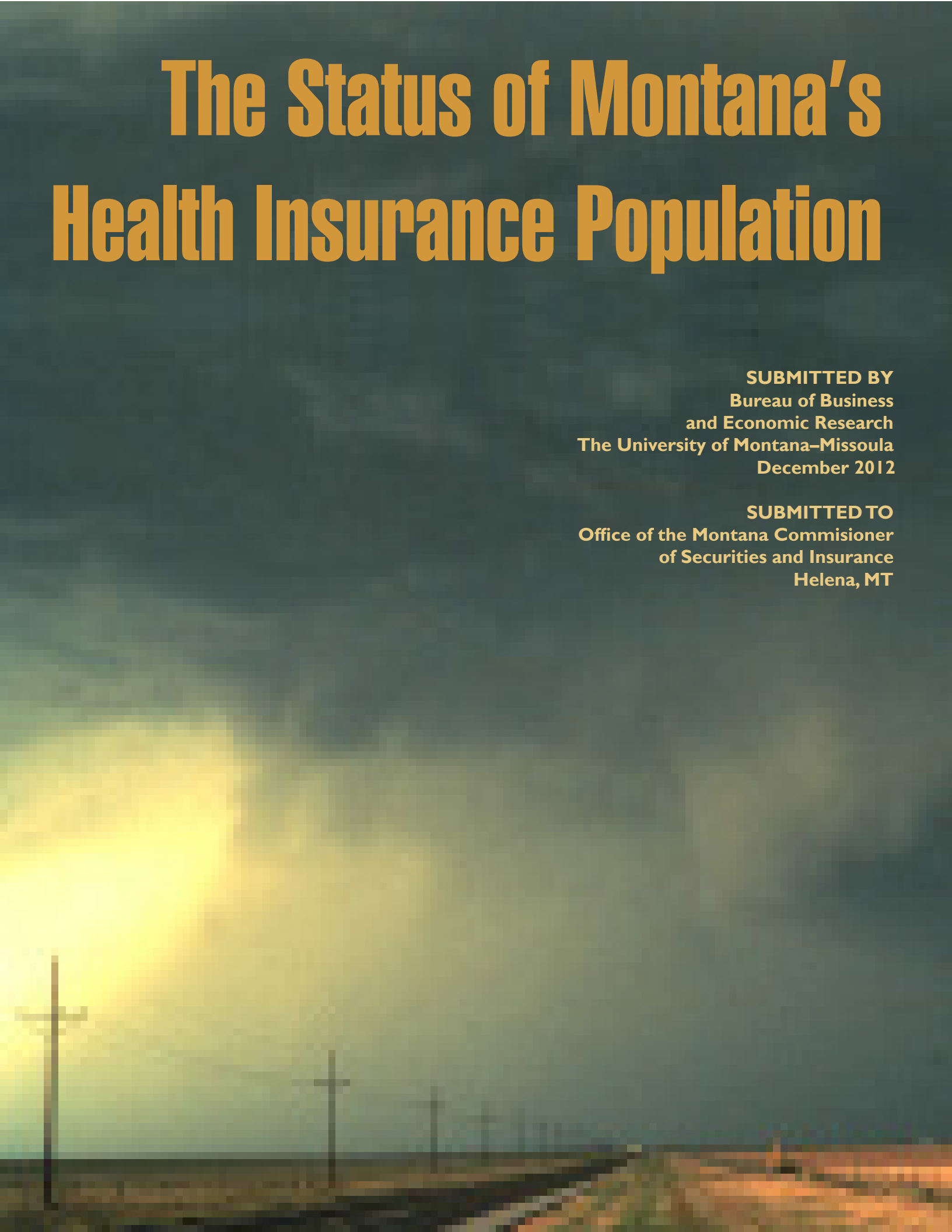

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## Executive Summary

The purpose of the 2011 Health Insurance Study is a:

- Study of the insured, underinsured and uninsured Montanans
- Estimate how the Affordable Care Act will effect Montana's insurance market
- Formal assessment of cycling.
- Study of Montana's current insurance market.

BBER conducted two surveys:

- A survey of 2,306 Montana households during September 12, 2011 through February 27, 2012 asking about their health insurance situation.
- A survey of 516 Montana employers, from July 27, 2011 through September 14, 2011 asking about health insurance as an employee benefit.

Major findings:

- Nearly one in five Montanans does not have health insurance
- Indian Health Service users account for 20 percent of Montana's uninsured population.
- Almost six in ten Montanans has commercially provided health insurance. Within this group, most obtain their health insurance through an employer.
- Among those who experienced a period last year without insurance, three-quarters were uninsured involuntarily. Reasons for lack of health insurance were many, but most notably low-wage jobs, premiums that were too expensive, or forced unemployment.
- Only 9 percent purchase their health care insurance directly through a health insurance provider.
- Three variables most influential on the ability to have health insurance coverage are highly correlated with each other: educational attainment, employment status, and income.
- More than 40 percent of those who self-report fair or poor health are uninsured; the uninsured account for only 22 percent of those who self-report excellent health. Montanans without health insurance are also less likely to report a regular health care provider.
- Medical debt in Montana is almost 2 percent of the entire state's gross domestic product in 2011, accounting for $650 million. Nearly one in four uninsured report medical debt, averaging over $9,000 per household. Medical debt among the insured is almost $4,000 per household, but less than 9 percent of households with health insurance report medical debt..
- Among the working age population, the uninsured rate increases as income relative to the federal poverty level decreases. For those with incomes 400 percent of the federal poverty level, only 10 percent do not have health care insurance. But for the working age population with incomes below 100 percent of the federal poverty level, 60 percent lacks health insurance. Uninsured rates increase to over 50 percent for those with incomes below 150 percent of the federal poverty level and between the ages of 26 to 54 years of age.
- The uninsured rate for high income earners, 400 percent of more of the FPL, is actually higher than for those with incomes down to 250 percent of the FPL. Relatively young, high income earners may choose instead to forego health insurance and save on their own for their medical needs.

- Household characteristics most likely to be associated with higher rates of uninsured status include unemployed, employed part-time, full-time student, and disabled. Uninsured householders increase as the size of the employing firm decreases.
- The most important factor determining whether health insurance is provided by an employer is the size of the firm, measured by the number of employees. For those firms with more than 50 employees, nearly all offer health insurance as a compensation and fringe benefit to their employees. For smaller employers however, those with only 1 to 5 employees, only one in four offer some kind of health coverage for their employees. The main reason given by employers that do not offer health insurance for their employees is the cost of health insurance.
- Two characteristics of employer-sponsored health insurance are waiting periods for coverage to begin and minimum hours per week work requirement. Almost half of all firms offering health insurance have a three-month waiting period, with 28 percent having a six-month waiting period. Eight in ten firms have a minimum hour work week requirement, an average of around 33 hours per week.
- It is apparent that many households are unaware of their policy premiums, deductibles, and out-of-pocket maximums. Half of all households with employer-sponsored health insurance do not know their share of the monthly insurance premium. Almost four in ten cannot reveal their deductible amounts, and one in four does not know their out-of-pocket maximum.
- When households did claim to know their monthly health insurance premium, it was well above the monthly premium reported by employers. Households report an average premium of $350, while businesses report the employee share of only $61 for employee only coverage. Even with family coverage, employers report an average premium of $162 for the employee share, still well below that reported by households.
- Almost all employer-sponsored health insurance plans required a deductible, with the average deductible around $1,600. The most common co-insurance is 80-20 for all firms except the smallest. Firms with fewer than five employees report co-insurance rates across a wide spectrum, from 0 percent to 50-50 co-insurance. A significant percentage of all employers could not reveal the co-insurance rate on their policies. Even among large employers, those with more than 50 employees, 15 percent could not state their health plan co-insurance rates.
- Comparing health insurance premiums to prior years, employers apparently absorbed some of the increase in health plan premiums. Particularly for the larger firms, those with 26 or more employees, premium costs were absorbed by half the employers. Deductibles and co-insurance remained largely unchanged, the exception is smaller firms with fewer than 5 employees where between 20 and 30 percent of these firms increased deductibles and co-insurance.
- Slightly more than 30 percent of employees eligible for their employer's health insurance plan refuse the offer of health insurance coverage. Refusal is highest among the smaller firms, with 1 to 5 employees.
- The majority of employees who refuse their employer's offer of health insurance coverage do so because they have health insurance coverage elsewhere, primarily through a spouse. Another significant percentage (20 percent) however refuses the offer due to cost.
- Only 12 percent of the insured population in Montana purchases insurance on their own, paying an average monthly premium of $525; the average deductible for direct pay health insurance ($4,600) is four times that of the employer-sponsored plan deductible. Generally, direct pay purchasers are in very good or excellent health, well educated, self-employed, or work for a small firm with less than five employees.

- The majority of direct pay purchasers (38 percent) have incomes above 400 percent of the federal poverty level. Only 20 percent have family incomes below 200 percent of the federal poverty level.
- Less than 10 percent of insured individuals in Montana are underinsured. However, a disproportionate number of direct purchase insured are underinsured, between 22 and 38 percent by the two measures used in this study. The younger workforce is less likely to be underinsured compared to older working-age adults. Only 6 percent of adults 19 to 26 years old are underinsured, compared to almost 12 percent of 27-64 year olds. But the young are less likely to be insured so any insurance at all is likely to be employer-sponsored or provided through their parents.
- BBER estimates that there are approximately 60,000 individuals with incomes less than 138 percent of the federal poverty level who presently do not have health insurance. The bubble population, those thought to have considerable risk cycling into and out of Medicaid, are those individuals with incomes around 150 percent of the federal poverty level. Expanding the Medicaid eligible population to 150 percent of the federal poverty level adds another 14,000 individuals who do not have health insurance.
- Medicaid take-up rates of 50 and 60 percent add another 37,000 to 45,000 uninsured as newly eligible Medicaid enrollees. Should the take-up rate approximate the national average, newly eligible Medicaid enrollees could add another 47,000 individuals to Montana Medicaid. How soon these newly eligible adults in fact enter Medicaid is uncertain, but it is reasonable to assume that the intensity of state efforts in outreach will be a significant determining factor. The BBER estimates that there are approximately 60,000 individuals with incomes less than 138 percent of the federal poverty level who presently do not have health insurance. The bubble population, those thought to have considerable risk cycling into and out of Medicaid, are those individuals with incomes around 150 percent of the federal poverty level. Expanding the Medicaid eligible population to 150 percent of the federal poverty level adds another 14,000 individuals who do not have health insurance.
- An in-house analysis of Medicaid data over the last three years (2008-2010), shows that only 40 percent or so of Medicaid enrollees are continuously enrolled, indicating that enrollees leave Medicaid in rather large proportions. Newly enrolled policyholders account for approximately half of the total enrolled policyholders.
- Approximately 195,000 Montanans, or 70 percent of the Federally Facilitated Exchange population, may qualify for federal subsidies and cost sharing assistance.

## Introduction

The purpose of the 2011 Health Insurance Study is a:

- Study of the insured, underinsured and uninsured Montanans
- Estimate how the Affordable Care Act will affect Montana's insurance market
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Many of the information needs to complete these tasks are only available through primary research. BBER designed two surveys to gather some of this information: a survey of businesses and a survey of households.

The surveys are designed to help policy-makers and health planners examine the efficiency, capacity, and flexibility of Montana's health insurance system to meet current needs and future demands.

The household telephone survey provides health policy-makers and planners a model of different groups of Montanans and their current insurance coverage status. The survey explores how different groups are insured and why the uninsured are not insured. A large subset of the respondents was also asked about their utilization of health services. The survey was administered from September 12, 2011 through February 27, 2012. Of the 4,662 eligible respondents contacted, 2,306 (49.5 percent) participated in the survey. This cooperation rate is considered typical for a survey of this type.

The business survey filled in gaps in our knowledge about Montana business's offering of health insurance to their employees. The data were collected by the Survey Research Center at The University of Montana-Missoula, Bureau of Business and Economic Research, from July 27, 2011 through September 14, 2011. A total of 516 interviews were completed. The overall completion rate to the 2011 Montana Employer Survey was 70 percent.

Data from the surveys were used to develop a profile of the insurance status of Montana residents. An extensive literature search was combined with these profiles to derive estimates of the effects the Affordable Care Act would have on the Montana insurance market.

## Structure of this Report

The primary purpose of Volume 1 of this report is to describe data collected by the 2011 Montana Health Insurance Surveys. Adequate description of these data requires presenting an extensive set of tables and charts throughout the report. Charts portray the data in ranges with a lower and upper bound. The mean is the midpoint of the range. Statistical differences are visually apparent when the ranges do not overlap. Analyses of the data are also presented with national comparison and potential policy implications.

The report examines seven areas in depth:

- Overall insurance coverage with some comparisons to national surveys is explored. The next section
- Details of the uninsured,
- Characteristics of those with employer-based health insurance.
- Population that purchases their health insurance directly from health insurers.
- Estimating the underinsured.
- Churning or those who have health insurance intermittently
- And, how many people may utilize a health insurance exchange.

Volume II contains the appendices. The text of the 2011 Household Health Insurance Survey may be found in Appendix I. Tables of responses to each question are also found in Appendix III, and can serve as a useful, quick-reference tool. Appendix II includes the text of the 2011 Employer Health Insurance Questionnaire, with a summary of responses in Appendix IV. Methodology of the surveys is found in Appendix V.

# The Insured, Underinsured and Uninsured in Montana

The University of Montana Bureau of Business and Economic Research (BBER) surveyed more than 2,500 households in Montana late in 2011 and early in 2012 about their health insurance status. Both land line and cell phone households were interviewed and asked questions about their health insurance status, along with demographic characteristics. BBER used a survey instrument that is an adaptation of the national survey developed and used by the State Health Access Data Assistance Center (SHADAC), School of Public Health at the University of Minnesota. In addition, BBER replicated a 2006 survey of Montana employers, with 516 firms cooperating. Methodology for these surveys can be found in Appendix V.

The following section summarizes the Bureau's survey of Montana households and employers, and where appropriate, compares our findings to nationally representative samples.

## The Uninsured and Insured

This section describes the insurance coverage status of Montana's non-institutionalized population, which includes people living outside of institutional group quarters such as nursing homes or prisons. According to the 2010 Census, 960,566 persons are considered non-institutionalized in Montana. The health care needs of persons living in institutions are not addressed since their health care needs are generally addressed within the institution, thus they fall outside the scope of the health insurance market.

A person is considered to be covered by health insurance if their health needs are paid for entirely or partially by a second party. These second parties are in turn divided into two groups: private and public health care coverage providers.

Private health insurance is health care provided through an employer or union, a plan purchased by an individual from a health insurance company, or insurance provided through TRICARE or other military health plans. In the BBER household survey, employer-sponsored health insurance is health care coverage offered through one's own or a relative's current, or former, employer or union. Direct-purchase health coverage is health care purchased directly from an insurance company by an individual or an individual's relative. TRICARE or other military health coverage is offered through health care programs for active-duty military personnel and retired members of the uniformed services, their families, and survivors. This health care coverage is included under private health insurance as it is a form of employer-based coverage.

Public health care coverage includes federal programs including Medicare, Medicaid, and other medical assistance programs, Veterans' Health (VA), children's health insurance programs, and individual state health plans. Medicare is a federal program which helps pay health care costs for people ages 65 and older, and for certain people under age 65 with long-term disabilities. Means-tested health care programs include Medicaid or any other type of government-provided health care coverage for low-income or disabled households. Healthy Montana Kids, formerly the Children's Health Insurance Program, is a state-level program providing health care to low-income children up to age 19 whose family incomes are below 250 percent of the federal poverty level and whose parents do not qualify for Medicaid. Healthy Montana Kids Plus, formerly Children's Medicaid, provides health care for children up to age 18 whose family incomes are below 133 percent of the federal poverty level. States also have

their own health insurance programs for low-income or high-risk uninsured individuals. These health plans are known by different names in different states. Finally, VA Health Care is a Department of Veterans' Affairs program that provides medical assistance to eligible veterans. For this study, those who have ever used or enrolled in VA Health Care are considered to have VA coverage.

Indian Health Service (IHS) is a health care program through which the Department of Health and Human Services provides medical assistance to eligible American Indians at IHS facilities. In addition, the IHS helps pay the cost of selected health care services provided at non-IHS facilities. Persons receiving health care through IHS are typically not considered insured since there are limitations in the scope of services and the geographical reach may also be limited.

Table 1.1 shows the health insurance status of non-institutionalized Montanans. The BBER estimates that 20 percent of Montana's non-institutionalized population is uninsured. This translates to about 195,000 uninsured persons. About 4 percent, or 39,000 persons, are covered by Indian Health Services.

### *Table 1.1: Individual Insurance Coverage by Type, Montana, 2011*

| | Number | Percent |
|---|---|---|
| Noninstitutionalized population | 969,000 | |
| Uninsured | 195,000 | 20% |
| Tribal Health Service | 39,000 | 4% |
| Insured | 774,000 | 80% |
| Medicare and VA insurance | 165,000 | 17% |
| Means tested insurance | 87,000 | 9% |
| Medicaid | 48,000 | 5% |
| CHIP | 39,000 | 4% |
| Employer-based | 475,000 | 49% |
| Direct purchase | 54,000 | 6% |
| Limited coverage | 9,000 | 1% |
| Unable to determine type | 26,000 | 3% |

Note: Numbers do not add because respondents can have more than one type of health insurance and rounding.

About 17 percent of Montanans are covered by entitlement programs, primarily Medicare. Medicare covers nearly all persons ages 65 and older. Other publicly provided insurance is means-tested, where persons are eligible for coverage if they meet certain criteria. About 87,000 persons are covered by means-tested insurance in Montana as measured by the BBER household survey. This compares to about 100,000 persons enrolled in Medicaid and about 21,000 in Healthy Montana Kids. The survey reports that about 5 percent, or about 48,000 persons are covered by Medicaid and about 39,000 are covered by Healthy Montana Kids. The lower survey number suggests that even with the cell phone sample, lower income households were not contacted. The higher Healthy Montana Kids estimate suggests there may be some confusion among respondents regarding the difference between Medicaid and Healthy Montana Kids.

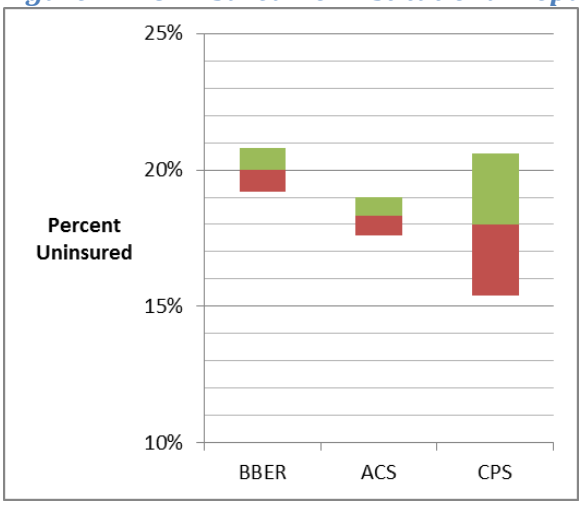
About half of Montana's residents, or 475,000 persons, are covered by employer-based health insurance including TRICARE. Another 6 percent (54,000) purchase their health insurance directly from an insurance company. Of those purchasing their own insurance, about 1 percent (9,000 persons) has only limited coverage or coverage for a specific disease. Persons with only this type of coverage are classified as uninsured.

Among the many kinds of health insurance sold today there are some products that don't provide comprehensive health insurance protection. Some examples are dread disease policies, accident-only policies, supplemental policies, discount plans, and stacked policies. Based on the BBER survey, it is apparent that over 30,000 Montanans are confused about what type of insurance coverage they have. Dread disease policies pay only for costs related to treatment for specific diseases, such as cancer. One state has banned the sale of dread disease policies, while other state insurance regulators have posted advisories cautioning consumers about the limitations of these policies. Starting in 2014, all new health insurance plans sold to individuals and small businesses, and plans sold in Montana's federally facilitated exchange, must include a range of essential health benefits.

Accident-only policies pay for care you need as a result of an accident that isn't due to illness. Accident-only policies generally aren't a good value for the consumer since a comprehensive policy will cover costs associated with accidents as well as illness. Supplemental policies, such as hospital indemnity and supplemental prescription drug policies, pays cash benefits directly to the consumer. Discount plans aren't health insurance, although consumers may wrongly consider them as such. Discount plans often have insurance like features, including a monthly premium, have a network of providers, and offer some limited coverage for a broad range of health services. Because discount plans aren't health insurance, insurance regulators often can't help. Stacked policies typically join together several limited coverage products, such as a hospital indemnity and accident-only policy or dread disease policies with a discount plan. Although the combination of plans may appear to be comprehensive health insurance coverage to the consumer, it is not.

The federal government reports two measures of health insurance coverage. These measures, along with the estimate from the BBER survey, are shown in Figure 1.1. Each estimate is shown with a corresponding confidence interval showing a lower and upper bound.

***Figure 1.1: Uninsured Noninstitutional Population, Montana, 2011***



The Census Bureau's American Community Survey (ACS) reports an uninsured rate for Montana of 18.3 percent, and the Current Population Survey (CPS-APEC) estimate is 18.3 percent. The ACS estimate is significantly different from the BBER estimate of 20 percent. The CPS estimate is not significantly different. Table 1.2 shows how the different surveys compare.

Each survey is designed for a different purpose; only the BBER survey is health insurance specific. The two U.S. Census Bureau surveys have very small subsets of data related to health insurance. Both the CPS and ACS surveys have extremely large budgets so they are able to use multiple survey modes, including personal interviews. Households without a working telephone were not interviewed by BBER. Many of these households are lower income and this may explain the lower BBER estimates for means-tested insurance.

Sample size also affects survey estimates. The CPS interviews only about 1,200 in Montana. The ACS interviews about 9,000 each year. The sample size for the BBER survey was 2,506. The data collection period and reference period for each survey also affects the estimates. The CPS-ASEC is conducted in April each year and asks about coverage in the last year. The ACS is collected continuously, and the reference period is the interview date. The BBER survey is a one-time collection effort, and the reference period is coverage in the last year.

### *Table 1.2: Comparison of Surveys with Health Insurance Estimates for Montana*

| | CPS-ASEC | ACS | BBER |
|---|---|---|---|
| **Survey Description** | The Annual Social and Economic Supplement (ASEC) to the Current Population Survey (CPS) is designed primarily to provide monthly labor force data. However, in addition, it provides supplemental data on health insurance, work experience, income, noncash benefits, and migration. | The ACS is an annual household survey designed to replace the Census 2000 sample data (i.e., the "long form") of the Decennial Census. The ACS collects detailed demographic, socioeconomic and economic information. | The BBER Household Health Insurance Survey was designed to provide estimates of health insurance coverage of Montanans. Detailed information is provided. |
| **Survey Mode** | Personal and telephone interviews | Mailout, telephone nonresponse follow-up, and personal visit nonresponse follow-up | Telephone interviews |
| **Years of Available Health Insurance Data** | 1987-present | 2008-present | 2003 and 2011 |
| **Data collection period** | February - April each year | Continuous | September 2011 - February 2012 |
| **Universe Description** | The universe is the civilian noninstitutional population of Montana living in housing units and members of the Armed Forces not living on a military base. It also includes members of the Armed Forces living in civilian housing units on a military base. | The universe is the total population, with separate housing unit (HU) and group quarters (GQ) samples. Group quarters include nursing homes, correctional facilities, military barracks, and college/university housing among others. The health insurance questions are only asked for the civilian, non-institutional population. | The universe is the civilian noninstitutional population with a working telephone, land or wieless. |
| **Sample size** | Approximately 1,200 | Approximately 9,000 | 2,506 |
| **Reference period for Health Insurance Coverage** | Any coverage during the last calendar year | Coverage at the point in time of the interview | Any coverage during the last calendar year |
| **Coverage Definitions** | Private Coverage: Employer/Union, direct purchase<br><br>Public Coverage: Medicare, Medicaid, other state programs, military related (including TRICARE and VA) | Private Coverage: Employer/Union-based, direct purchase, TRICARE and other military health care<br><br>Public Coverage: Medicare, Means-tested public coverage (e.g., Medicaid), VA Health Care | Private Coverage: Employer/Union-based, direct purchase, TRICARE and other military health care<br><br>Public Coverage: Medicare, Means-tested public coverage (e.g., Medicaid), VA Health Care |
| **Question on Health Status** | Yes | No | Yes |
| **Premiums and Employer Cost-Share** | Information on whether employer paid all, part, or none of the health insurance premium is collected. Premiums paid out-of-pocket for respondents' health insurance, and others in the household, are recorded. | The ACS does not include a question on premiums and employer cost-share | Information on whether employer paid all, part, or none of the health insurance premium is collected. Premiums paid out-of-pocket for respondents' health insurance, and others in the household, are recorded. |

A detailed analysis of the uninsured requires all three surveys. Each survey has its advantages: the CPS for its time series, the ACS for its demographic detail, and the BBER survey for its behavioral questions.

The multimode collection effort and sample size of the ACS make for a very robust estimate of health insurance coverage. The rich demographic detail from the 2011 ACS is illustrated in Table 1.3. All statistics from the ACS include those 65 years and older.

## Characteristics of the Uninsured

The most obvious demographic characteristics of the uninsured are age and sex. Between 22,000 (10.2 percent) and 28,500 (12.8 percent) of persons under 18 years of age are uninsured. Persons in this age cohort are eligible for government-sponsored health insurance programs such as Medicaid and Healthy Montana Kids if their households meet certain income thresholds. About 153,000 (plus or minus 6,000) people between 18 and 64 years of age are uninsured. This is about double the percentage of those less than 18 years old. Virtually no one over 65 years old is uninsured because they are eligible for Medicare. Males are more likely to be uninsured than females (19.5 percent vs. 17.1 percent, respectively).

Race is another demographic that has some policy implications regarding health insurance coverage. Usable data for the proportion uninsured are only available for white alone (15.9 percent +/- 0.8 percent) and American Indians (42.8 percent +/- 3.7 percent). Hispanics (25.4 percent +/- 5.1 percent) are also more likely than white non-Hispanics (15.9 percent +/- 0.8 percent) to be uninsured. Uninsured data by race includes those 65 years and older.

Educational status is an excellent indicator of insurance coverage. The more education attained, the more likely a person is to be insured. Roughly 24 percent of those with a high school education or less are uninsured, about 20 percent of those with some college are uninsured, and only about 9 percent of those with a college degree are uninsured.

Employment and work experience in the last year are also very good indicators of insurance status. About 24 percent of those in the labor force are uninsured. About 1 in 5 of employed persons is uninsured while about half of the unemployed are without insurance. About 13 percent of those outside the labor force are uninsured. Those outside the labor force include retirees, thus the much lower percentage of persons without insurance. About 17 percent of those with a full-time, year-round job in the last year were uninsured, while about 31 percent of those with a part-time or seasonal job were uninsured. Fourteen percent of those that did not work in the last year were uninsured.

Household income is a strong indicator of insurance coverage. Households with incomes well above the poverty threshold have health insurance coverage at rates far above those closer to the poverty level. Those households with incomes below $50,000 per year are about a third as likely to have health insurance as those with incomes above $50,000 per year.

### *Table: 1.3: Uninsured by Selected Demographic Characteristics, Montana, 2011*

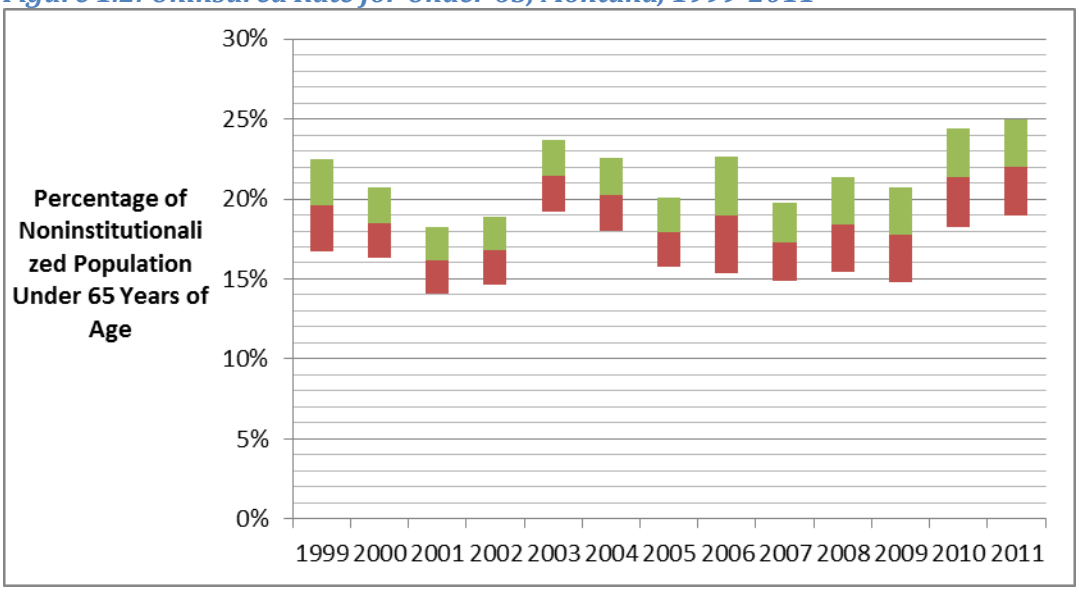
| Subject | Number | | Percent | |
|---|---|---|---|---|
| | Estimate | Margin of | Estimate | Margin of |
| Total civilian noninstitutionalized | 179,575 | +/-6,919 | 18.3% | +/-0.7 |
| AGE | | | | |
| Under 18 years | 25,562 | +/-3,006 | 11.5% | +/-1.3 |
| 18 to 64 years | 152,921 | +/-6,059 | 24.9% | +/-1.0 |
| 65 years and older | 1,092 | +/-520 | 0.7% | +/-0.4 |
| SEX | | | | |
| Male | 95,517 | +/-4,402 | 19.5% | +/-0.9 |
| Female | 84,058 | +/-4,039 | 17.1% | +/-0.8 |
| RACE AND HISPANIC OR | | | | |
| White alone | 140,074 | +/-6,996 | 15.9% | +/-0.8 |
| American Indian and Alaska | 27,759 | +/-2,493 | 42.8% | +/-3.7 |
| White alone, not Hispanic or | 137,173 | +/-6,923 | 15.9% | +/-0.8 |
| Hispanic or Latino (of any race) | 7,269 | +/-1,498 | 25.4% | +/-5.1 |
| NATIVITY AND CITIZENSHIP | | | | |
| Native born | 175,107 | +/-7,129 | 18.2% | +/-0.7 |
| Foreign born | 4,468 | +/-1,468 | 22.5% | +/-6.5 |
| Naturalized | 1,429 | +/-632 | 15.0% | +/-6.3 |
| Not a citizen | 3,039 | +/-1,240 | 29.3% | +/-9.2 |
| EDUCATIONAL ATTAINMENT | | | | |
| Civilian noninstitutionalized | 125,710 | +/-5,294 | 18.9% | +/-0.8 |
| Less than high school | 14,895 | +/-2,175 | 29.4% | +/-3.4 |
| High school graduate, GED, or | 49,196 | +/-3,460 | 24.5% | +/-1.6 |
| Some college or associate's | 44,663 | +/-3,897 | 20.0% | +/-1.5 |
| Bachelor's degree or higher | 16,956 | +/-2,195 | 8.9% | +/-1.1 |
| EMPLOYMENT STATUS | | | | |
| Civilian noninstitutionalized | 154,013 | +/-6,164 | 20.2% | +/-0.8 |
| In labor force | 121,645 | +/-5,628 | 23.7% | +/-1.1 |
| Employed | 100,219 | +/-5,264 | 21.2% | +/-1.1 |
| Unemployed | 21,426 | +/-2,483 | 54.9% | +/-4.5 |
| Not in labor force | 32,368 | +/-3,054 | 13.0% | +/-1.1 |
| WORK EXPERIENCE | | | | |
| Civilian noninstitutionalized | 154,013 | +/-6,164 | 20.2% | +/-0.8 |
| Worked full-time, year round in | 51,626 | +/-3,734 | 16.9% | +/-1.2 |
| Worked less than full-time, | 71,619 | +/-4,188 | 30.6% | +/-1.6 |
| Did not work | 30,768 | +/-2,878 | 13.8% | +/-1.2 |
| HOUSEHOLD INCOME (IN 2011 | | | | |
| Civilian household population | 177,218 | +/-6,815 | 18.3% | +/-0.7 |
| Under $25,000 | 54,899 | +/-3,924 | 27.6% | +/-1.6 |
| $25,000 to $49,999 | 65,069 | +/-5,444 | 24.8% | +/-1.7 |
| $50,000 to $74,999 | 32,111 | +/-4,187 | 15.6% | +/-1.9 |
| $75,000 to $99,999 | 12,375 | +/-2,054 | 9.1% | +/-1.5 |
| $100,000 and over | 12,764 | +/-2,605 | 7.8% | +/-1.5 |
| RATIO OF INCOME TO | | | | |
| Civilian noninstitutionalized | 178,858 | +/-6,868 | 18.4% | +/-0.7 |
| Under 1.38 of poverty threshold | 71,644 | +/-4,579 | 31.5% | +/-1.7 |
| 1.38 to 1.99 of poverty | 37,628 | +/-4,803 | 29.0% | +/-3.3 |
| 2.00 of poverty threshold and | 69,586 | +/-4,650 | 11.3% | +/-0.8 |

Source: US Census Bureau, Americand Community Survey, 2011, 1 Year Data

The population at risk for not having health insurance is under 65 years of age; those 65 years and older are usually eligible for Medicare, although not all take advantage of their eligibility.

The CPS measure is the official uninsured rate despite its large amount of error due to limited sample size. Figure 1.2 shows the percentage of Montanans under age 65 that were uninsured between 1999 and 2011. The uninsured rate ranges from a low of 16 percent in 2001 to a high of 22 percent in 2011. Other years where the rate was above 20 percent were 2003 and 2010.The margins of error are large enough that no inferences about change can be made. A possible explanation for the 2010 and 2011 increases might be that the long-term unemployed and underemployed exhausted their COBRA health benefits or simply could not afford them any longer.

*Figure 1.2: Uninsured Rate for Under 65, Montana, 1999-2011*

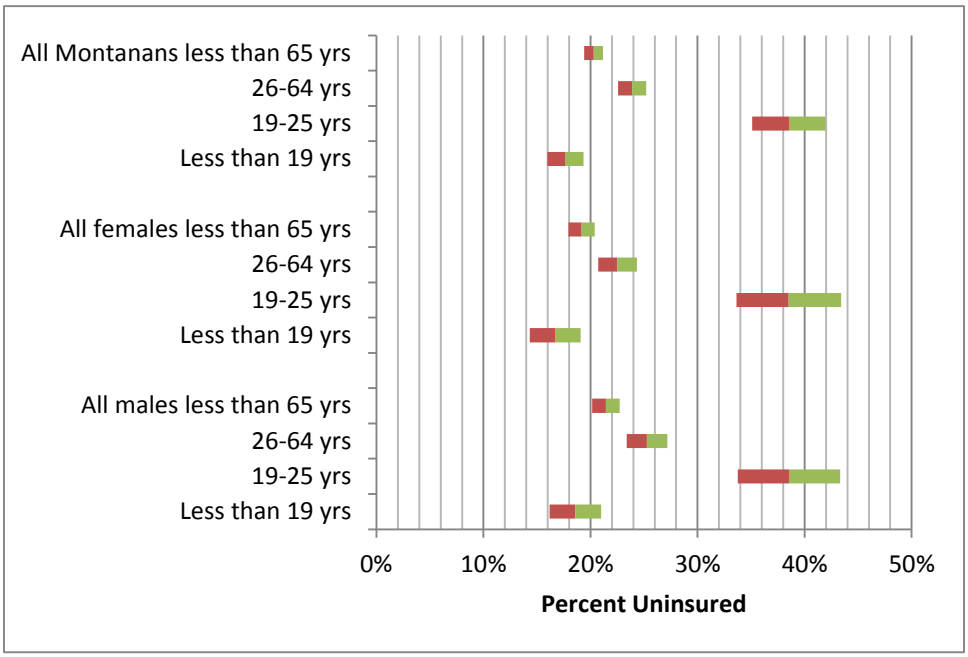



The following figures examine the demographic characteristics of the uninsured less than 65 years of age as determined from the BBER Health Insurance Survey.

Figure 1.3 shows how age and sex affect health insurance coverage as estimated by the BBER. Ranges for each demographic characteristic are shown. Age is categorized into three policy relevant groups: less than 19 years of age (eligible for Medicaid and Healthy Montana Kids), 19 to 25 years of age (coverage available on parent's health insurance as required under the Affordable Care Act), and 26 to 64 years of age (working age population).

While about 20 percent of all Montanans under the age of 65 are uninsured, between 35 and 44 percent of the 19 to 26 years of age population is uninsured. This may change as families take advantage of the ACA provision which allows adult children up to age 26 to remain on their parent's health insurance policy. Those under the age of 19 are the least likely to be without health insurance. If household income is low enough, this population is eligible for publicly provided health insurance such as Medicaid and Healthy Montana Kids.

### *Figure 1.3: Uninsured by Age and Sex, Montana, 2011*




Health status also affects whether one is insured or uninsured. The 2011 BBER Survey examined health status as well as insurance status (Figure 1.4). Nearly one in five uninsured Montana adults reports fair or poor health. A similar percentage of uninsured adults reports excellent health.

### *Figure 1.4: Health Status of the Uninsured, Montana, 2011*

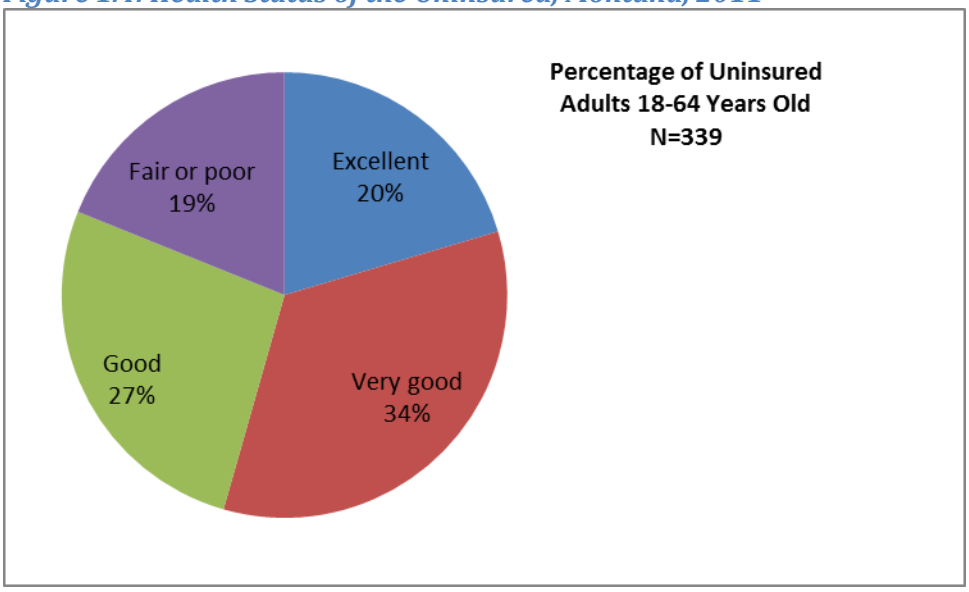
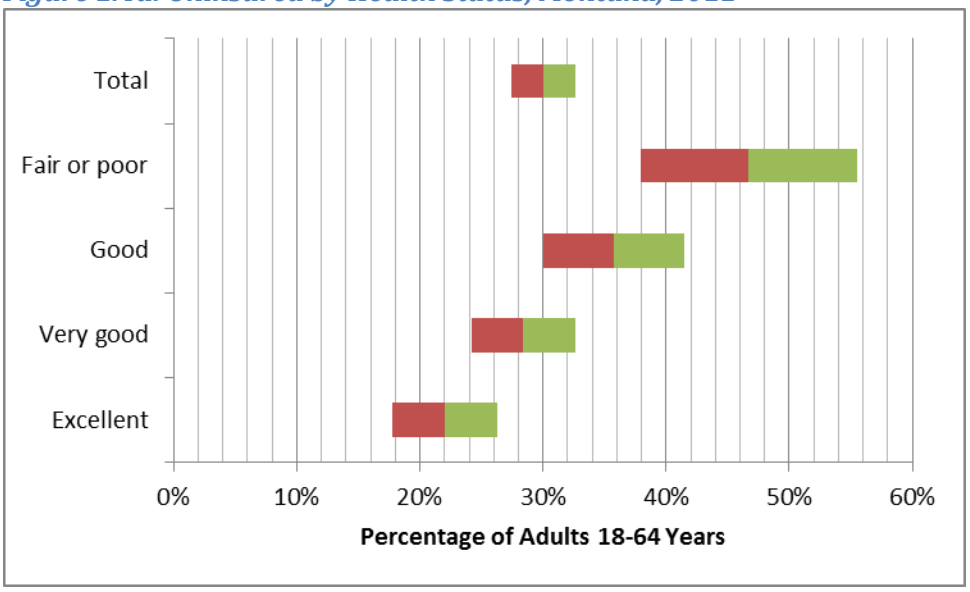


Figure 1.4a looks at health status of adults between 18 and 64 years of age in a different way. Of all Montanans reporting fair or poor health, almost half are uninsured. Of those reporting good health, about 36 percent are uninsured. The percentage of people uninsured declines as health status improves. A potential reason for the difference is that people in fair or poor health are unable to obtain insurance coverage through normal channels.

***Figure 1.4a: Uninsured by Health Status, Montana, 2011***




Given that the uninsured are more likely to self-report poor health, survey respondents were asked if they have a regular health care provider (Figure 1.5). Between 50 and 60 percent of the uninsured have a regular health care provider compared to 71 to 77 percent of the insured.

***Figure 1.5: Households with Regular Health Care Provider, Montana, 2011***

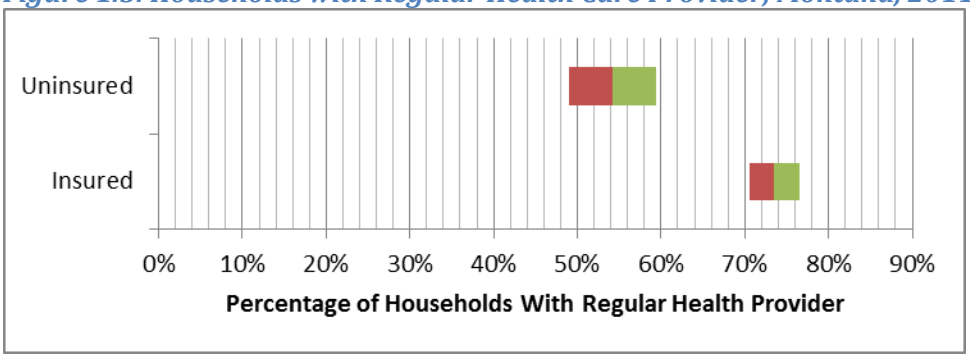
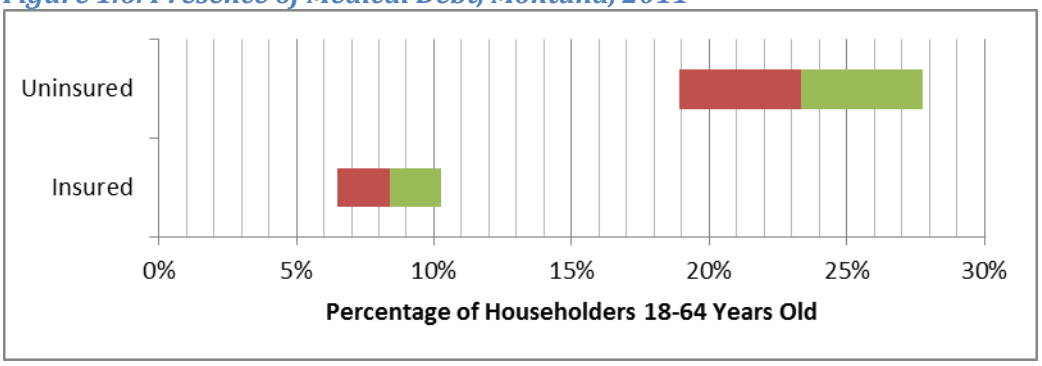


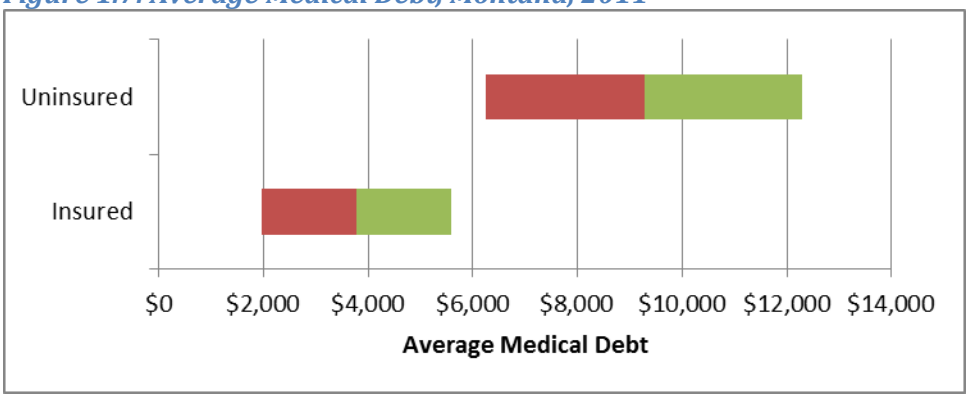

Figure 1.6 shows that the uninsured are also more likely to report medical debt in the last year. Eighteen to twenty-eight percent of uninsured households have medical debt compared to only seven to ten percent of insured households.

*Figure 1.6: Presence of Medical Debt, Montana, 2011*




More troubling is the difference between uninsured and insured household average medical debt. Average medical debt for insured households is about $3,800 compared to about $9,300 for uninsured households. The confidence intervals shown in Figure 1.7 show that this difference is significant. Total medical debt in Montana is $650 million, roughly 2 percent of the entire gross domestic product in the state during 2011. The uninsured account for nearly $416 million of this medical debt, or 64 percent of the total reported for Montana. To put the value of medical debt in perspective, medical debt is 140 percent of the gross domestic product in the Arts-Entertainment-Recreation industry and nearly 90 percent of the gross domestic product produced in durable manufacturing in the state.

*Figure 1.7: Average Medical Debt, Montana, 2011*




As previously discussed, income and age go a long way in explaining health insurance coverage. BBER calculated each household member's income relative to the Federal Poverty Level (FPL). The income ranges are based on various categories for premium assistance under the Affordable Care Act (ACA). Figure 1.8 shows how income and age relate to health insurance coverage. The basic relationship is that the lower the income, the more likely to be uninsured. However, differences appear when age is considered.

About 10 percent of those individuals 26 to 64 years of age with incomes four times the FPL are uninsured compared to with about 60 percent below the FPL. The increase in the number of uninsured follows a relatively constant rate of increase as income declines.

Those 19-25 years of age with income above 400 percent of the federal poverty level are slightly more likely to be uninsured than those with incomes 250 percent to 400 percent of the FPL. These are possibly

individuals that choose not to be insured. This age group is relatively healthy and perhaps has less perceived need for health insurance. On the other end of the income spectrum, more than 60 percent of 19 to 25 year olds with incomes less than 100 percent of the FPL are uninsured.

Children under 19 are uninsured at rates near 20 percent, with the only exception being children living in households with incomes between 133 and 150 percent of FPL. These households are too poor to afford insurance and too well-off to be eligible for publicly provided insurance.

*Figure 1.8: Uninsured by Age and Income Level, Montana, 2011*

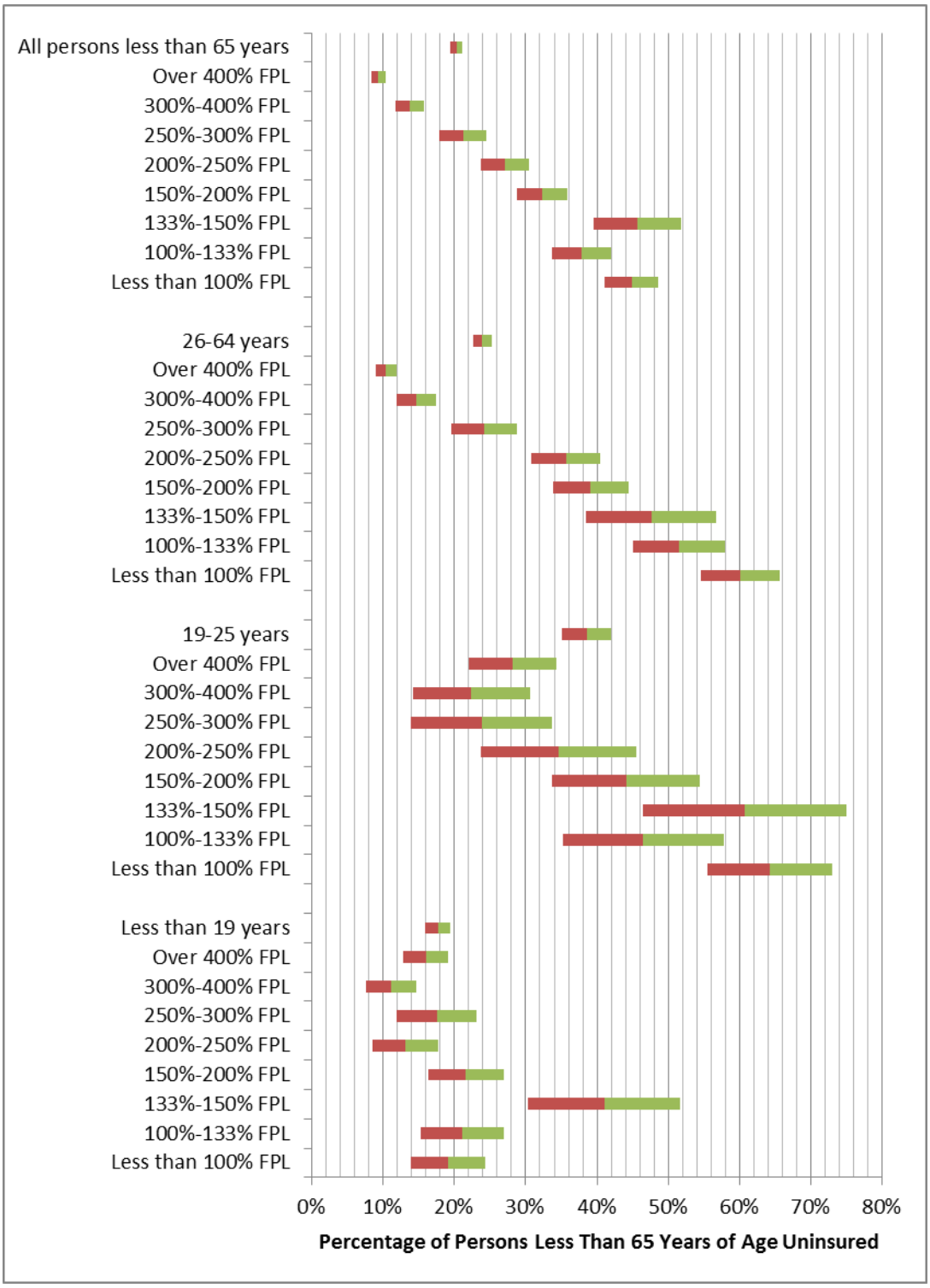


Figure 1.9 shows that BBER survey data closely replicates the relationship between education and insurance coverage found in the ACS data. Educational attainment is highly correlated with health insurance coverage. The more education a person attains, the more likely he or she is to have health insurance coverage. Figure 1.10 shows the same for employment status and insurance coverage.

*Figure 1.9: Uninsured Householder by Educational Attainment, Montana, 2011*

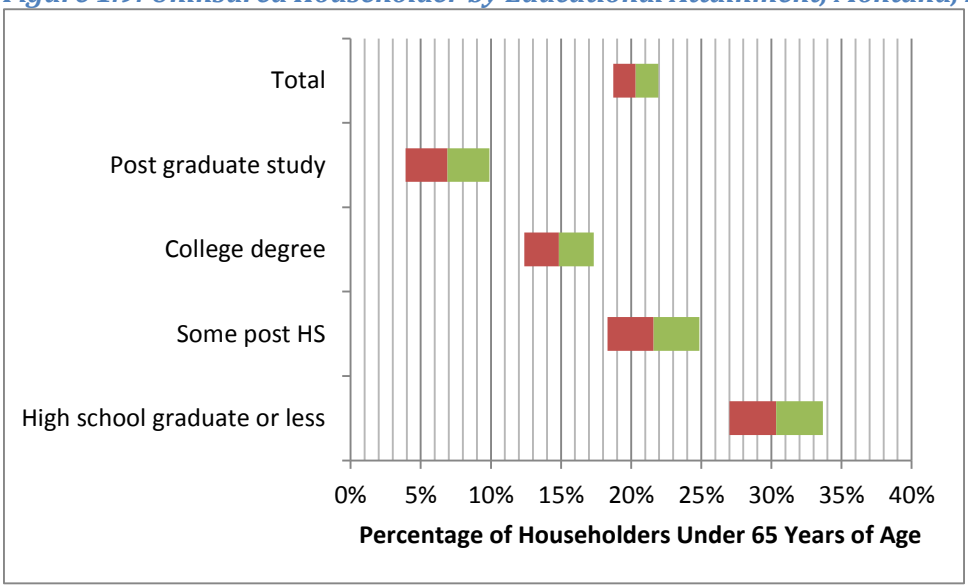
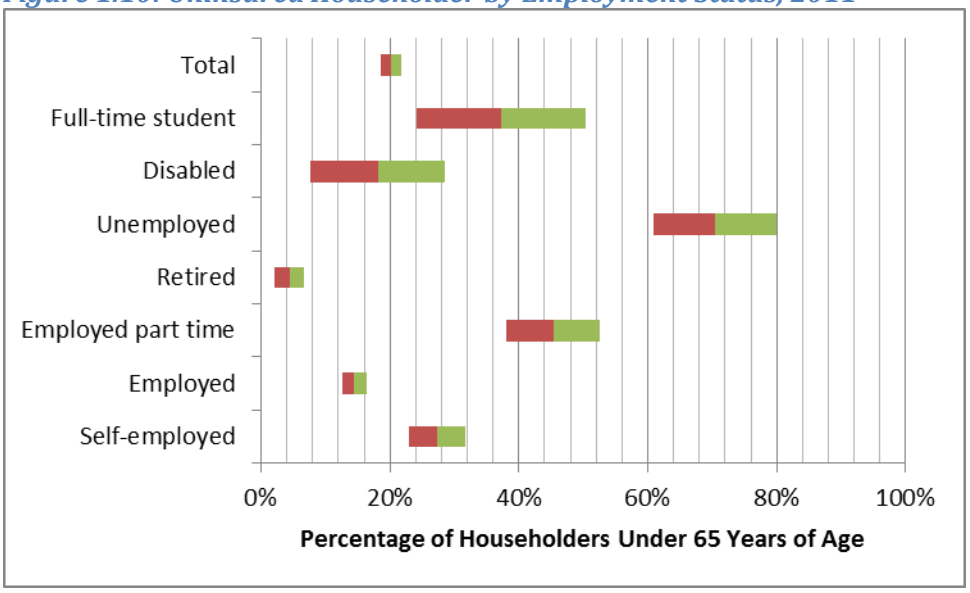


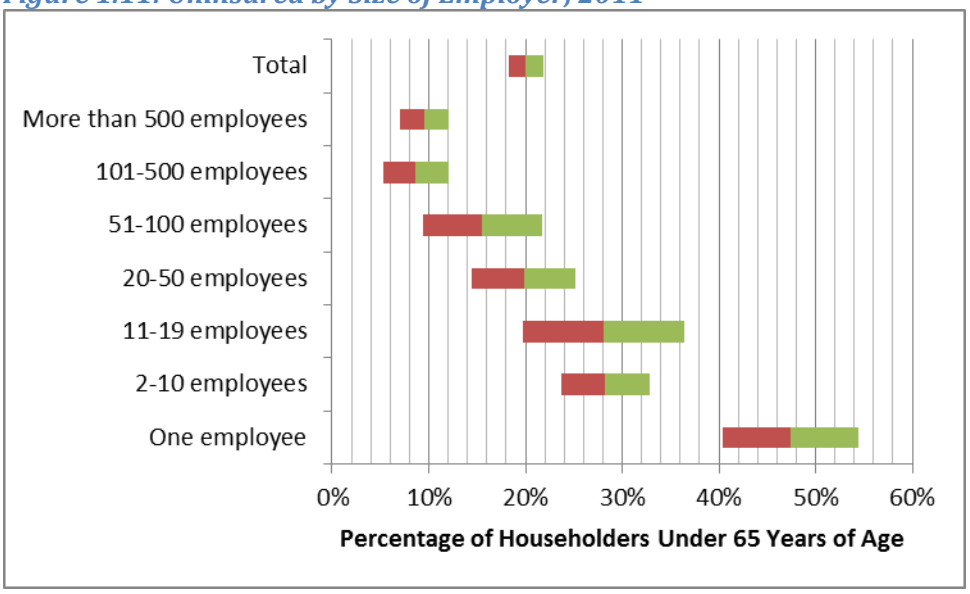

*Figure 1.10: Uninsured Householder by Employment Status, 2011*



Employer size, as measured by the number of employees, is also a determinate of the number of employees with health insurance. This is important for Montana since most Montana employers are small firms. The number of firms with fewer than 20 employees accounts for roughly 90 percent of the total number of firms both in Montana and nationally. The difference is the number of employees in these small firms. Montana employers with fewer than 20 employees account for 31 percent of the state's total employment, compared to small employers nationally that account for only 18 percent of the total employment nationally.

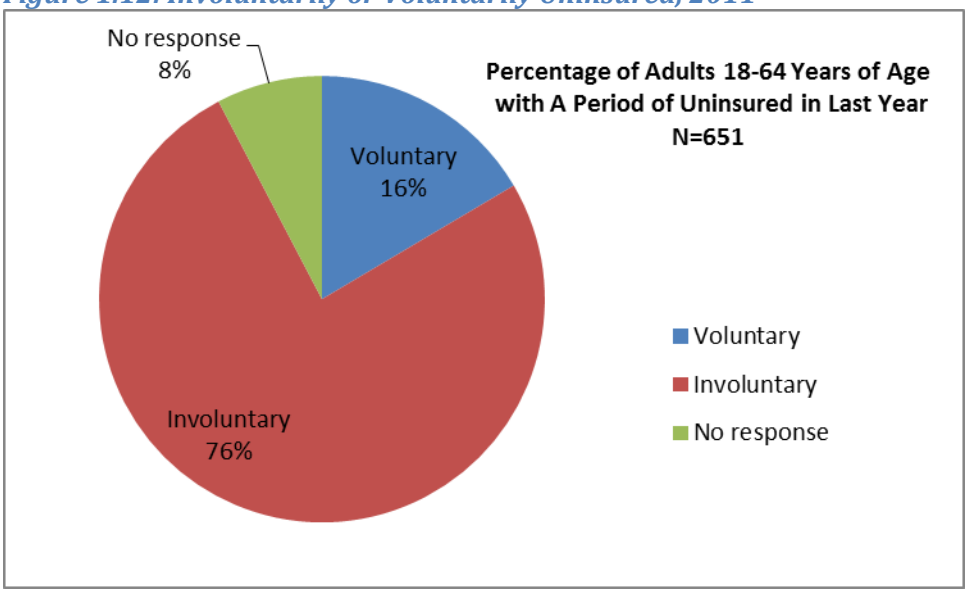
Figure 1.11 shows the relationship between employer-size and health insurance coverage for Montana householders. Only 10 percent of those employed by large employers (more than 100 employees) are uninsured, compared to an uninsured rate of nearly 30 percent for those employed by firms with 2 to 19 employees. Almost half of one-employee firms are uninsured.

***Figure 1.11: Uninsured by Size of Employer, 2011***




Among those survey respondents who reported that they were currently uninsured or experienced a period in the last year when they were uninsured, several questions were asked about why they were uninsured. The first was a general question asking whether they were uninsured voluntarily or involuntarily. Figure 1.12 shows that more than 76 percent of those experiencing a period when they were uninsured in the last year said they were uninsured involuntarily. Only 16 percent said they chose to be voluntarily uninsured. Another 8 percent did not respond.

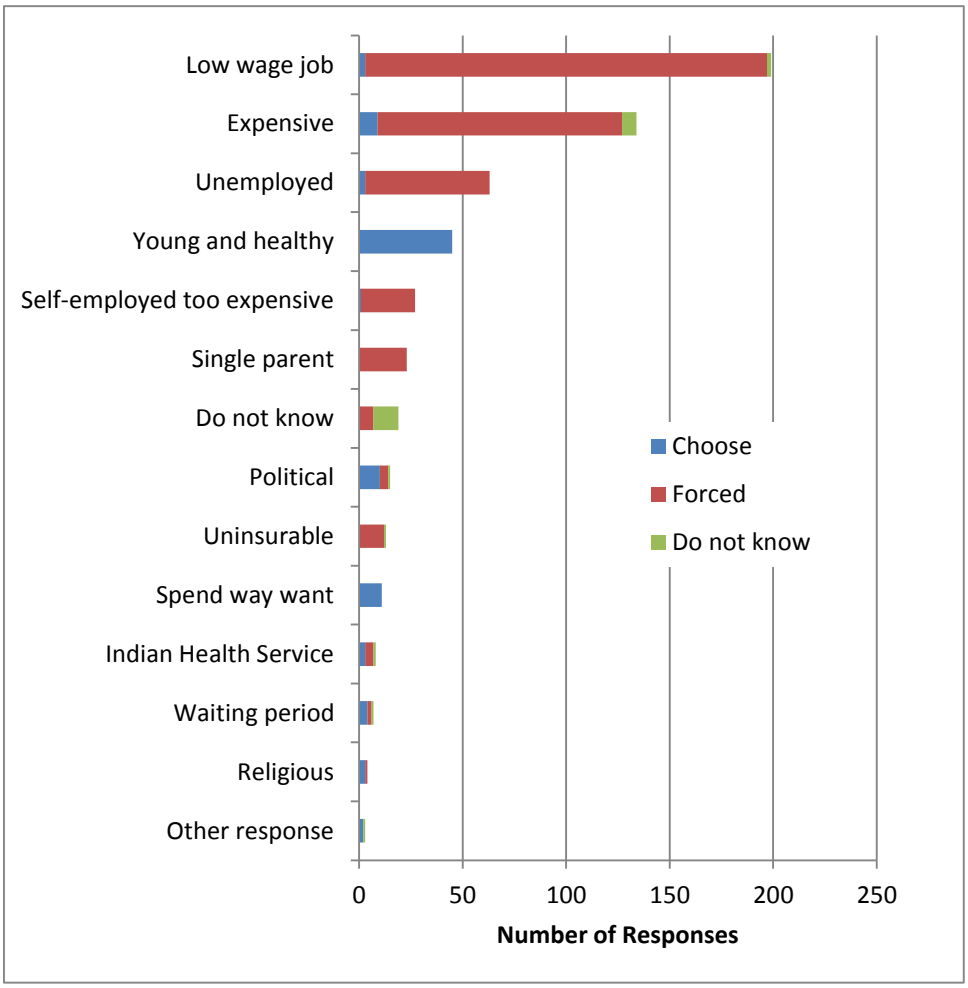
*Figure 1.12: Involuntarily or Voluntarily Uninsured, 2011*




Another question asked the respondent to tell the interviewer specifically why they are uninsured. Figure 1.13 shows why people are uninsured, whether voluntarily or involuntarily. Verbatim survey responses are presented in Appendix III.

A low-wage job is the most prevalent reason for being uninsured; 97 percent of low wage respondents reported they were involuntarily uninsured (199 total responses). The second most common factor cited as the reason for being uninsured is that "health insurance is too expensive" (134 total responses); 88 percent reported they were uninsured involuntarily. "Being unemployed" was the third most often cited factor in being uninsured (64 total responses), with all but three responses stating they were involuntarily uninsured. The "young and the invincible" represent only 45 total responses from all that were uninsured voluntarily. This response accounted for nearly half the reasons from those that chose to be uninsured.

*Figure 1.13: Reasons for Not Having Health Insurance, Montana, 2011*



The 2011 Firm Health Insurance Survey asked employers whether any of their employees are uninsured. Figure 1.14 shows the results for firms that offer health insurance and for firms that do not offer health insurance. More than 60 percent of the firms that offer health insured claim that none of their employees are uninsured. About 45 percent of the firms that do not provide health insurance reported that some of their employees were uninsured. Figure 1.15 shows the proportion of employees having health insurance by firm size. More than half the larger firms said that some of their employees were not insured.

*Figure 1.14: Firms Knowledge of Employees Uninsured Status, 2011*

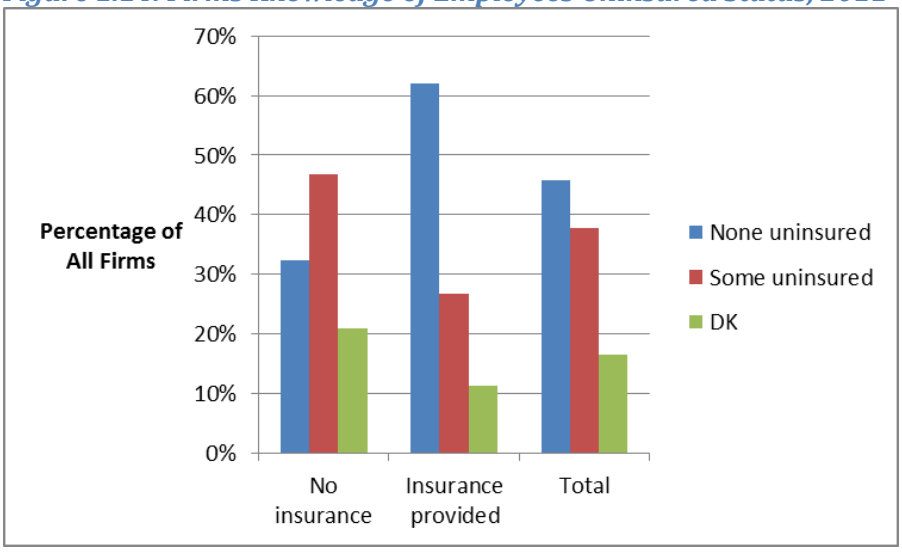



*Figure 1.15: Firms Knowledge of Employees Uninsured Status by Firm Size, 2011*

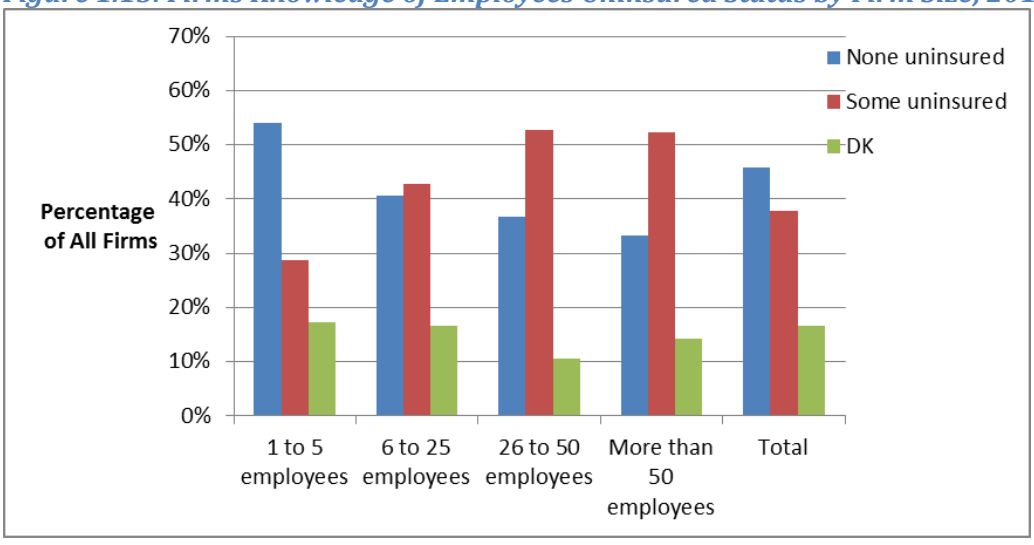
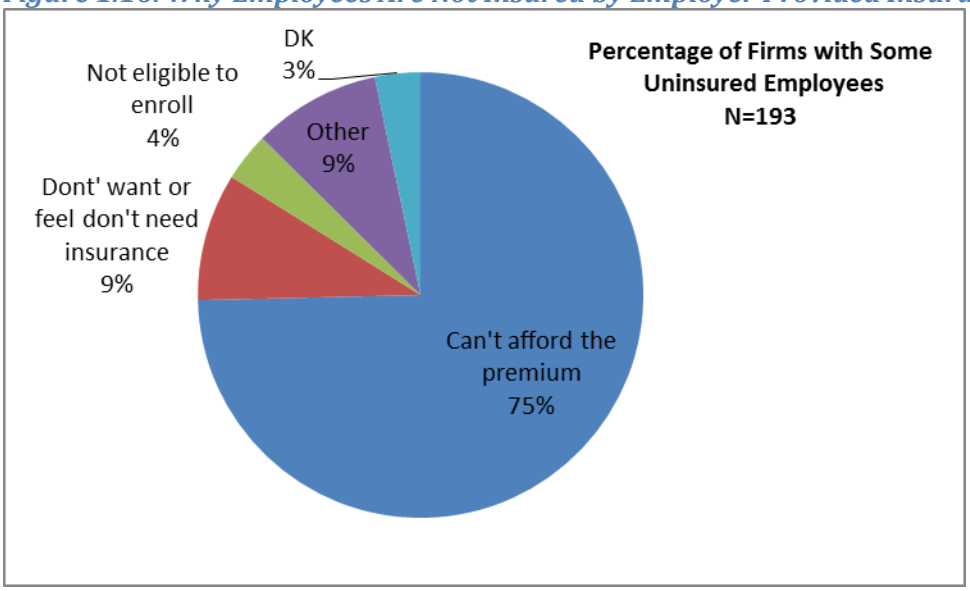


Figure 1.16 shows why employees are not insured by employer provided insurance. About three-quarters of employees not taking advantage of employer-sponsored insurance they are eligible for cannot afford the premium. Another nine percent believe they do not want or need insurance. Only four percent were ineligible for employer-sponsored insurance.

*Figure 1.16: Why Employees Are Not Insured by Employer Provided Insurance, 2011*



## Employer-Based Health Insurance

Employer-based insurance health insurance includes insurance coverage offered through one's own or someone else's current or former employer or union. Also included is TRICARE. TRICARE is health coverage offered to active-duty military personnel and retired members of the uniformed services and their dependents and survivors. Employers can purchase insurance on the open market or self-insurance if they meet criteria.

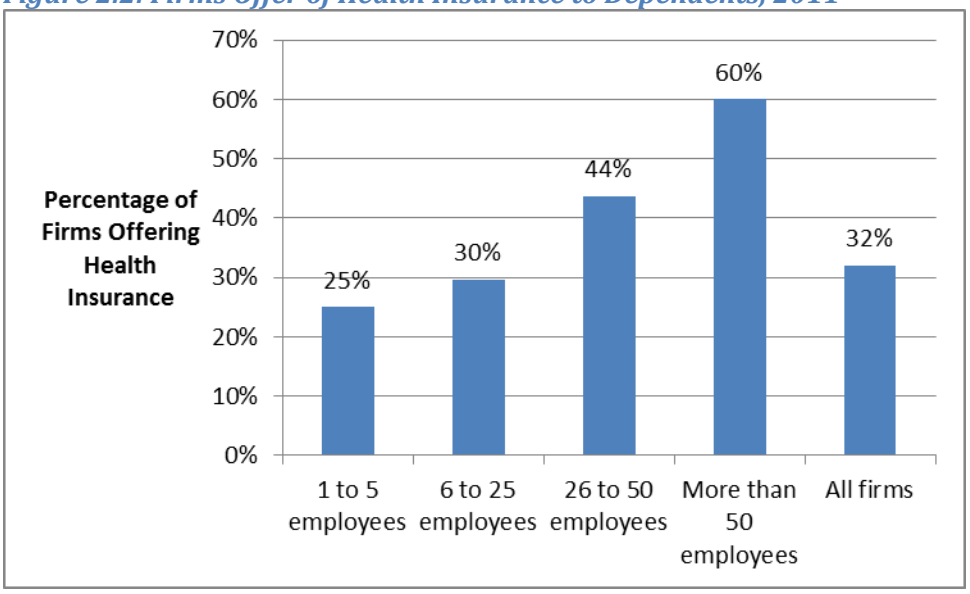
Employer-based health insurance covers nearly 80 percent of insured Montanans under age 65. About 45 percent of Montana employers provide health insurance as a benefit. This section looks at some details of employer-based insurance from the 2011 BBER Household Health Insurance Survey and 2011 BBER Firm Health Insurance Survey. Premiums, deductibles, and other characteristics such as waiting periods and work hours needed to qualify are examined. Reasons why eligible workers do not take advantage of health insurance coverage are also explored.

Firm size is an important determinant of health insurance as a benefit; the larger the firm the more likely that health insurance is an employee benefit. Nearly all firms with more than 50 employees offer health insurance to their employees. The offer rate declines to about 80 percent for firms with 26-50 employees. The margin of error is relatively large for this group as there are relatively few firms in this employee size category. Between 50 and 60 percent of firms with 6 to 25 employees provide health insurance. Only a quarter of firms with 1 to 5 employees provide health insurance.

*Figure 2.1: Firms Offering Health Insurance, Montana, 2011*

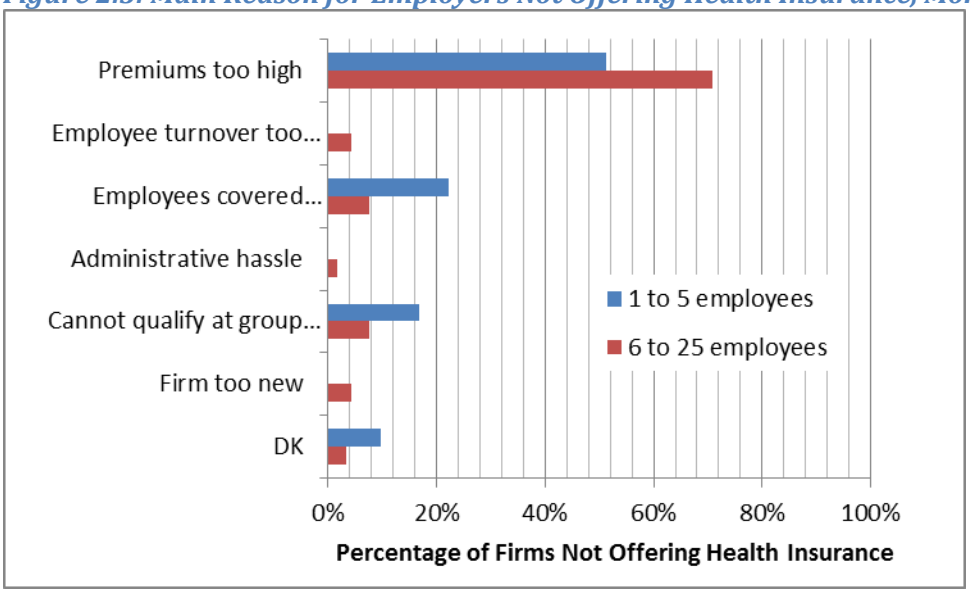

Firm size also determines health insurance coverage for employee's dependents. Figure 2.2 shows the proportion of firms offering health insurance to dependents of covered employees. Thirty-two percent of all firms offer dependent coverage. Sixty percent of large firms with more than 50 employees offer dependent coverage. The proportion offering dependent coverage declines to only 25 percent for the smallest employers offering dependent coverage.

*Figure 2.2: Firms Offer of Health Insurance to Dependents, 2011*




The main reason firms do not offer health insurance to their employees is "premiums are too high" (Figure 2.3). About 70 percent of firms with 6 to 25 employees do not offer health insurance because the premiums are too high. About half of firms with 1 to 5 employees also state that premiums are too high. Other reasons for not offering health insurance include employee turnover is too great, employees are covered under another health plan, and that the firm did not qualify for group health insurance rates. Data are not reported for larger firms because there are so few firms not offering health insurance.

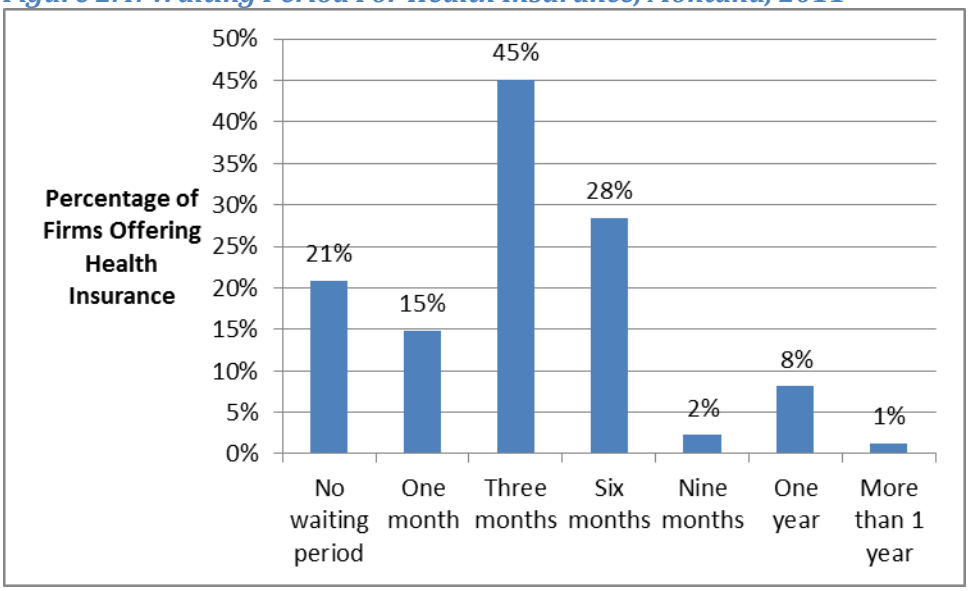
*Figure 2.3: Main Reason for Employers Not Offering Health Insurance, Montana, 2011*




Many employer-based health insurance policies have some requirements before an employee is eligible for the benefit. The 2011 Firm Health Insurance Survey asked firms what is required for an employee to become eligible for health insurance benefits. Waiting periods (Figure 2.4) are required by about 79

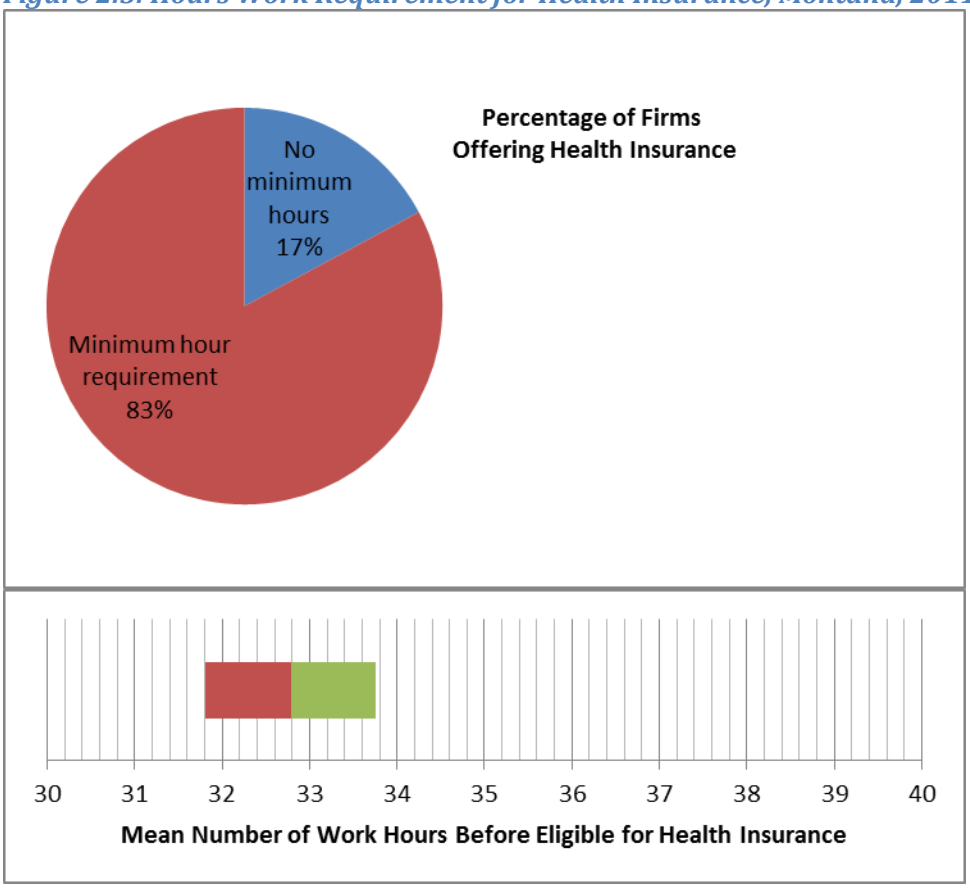
percent of Montana firms before employees can receive health insurance as a benefit. Fifteen percent of firms have a one-month wait, 45 percent have three-month waiting period, and 28 percent a six-month wait.

*Figure 2.4: Waiting Period For Health Insurance, Montana, 2011*



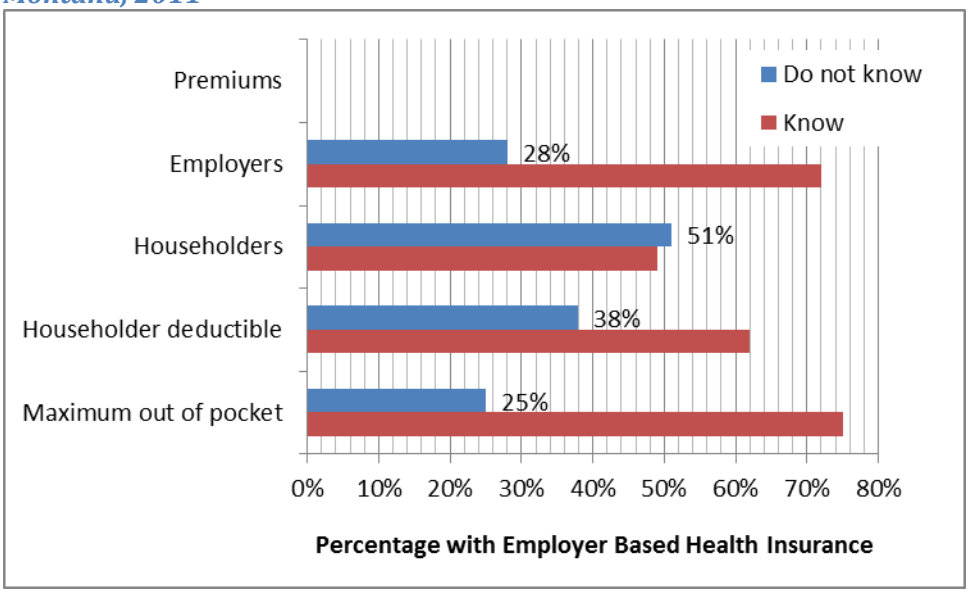

Minimum hours per week are another requirement for employer-sponsored health insurance benefits. A significant percentage of firms (83 percent) have a minimum number of hours worked as a condition for health insurance benefits (Figure 2.5). The average number of work hours required per week to receive health insurance is about 33 hours.

*Figure 2.5: Hours Work Requirement for Health Insurance, Montana, 2011*



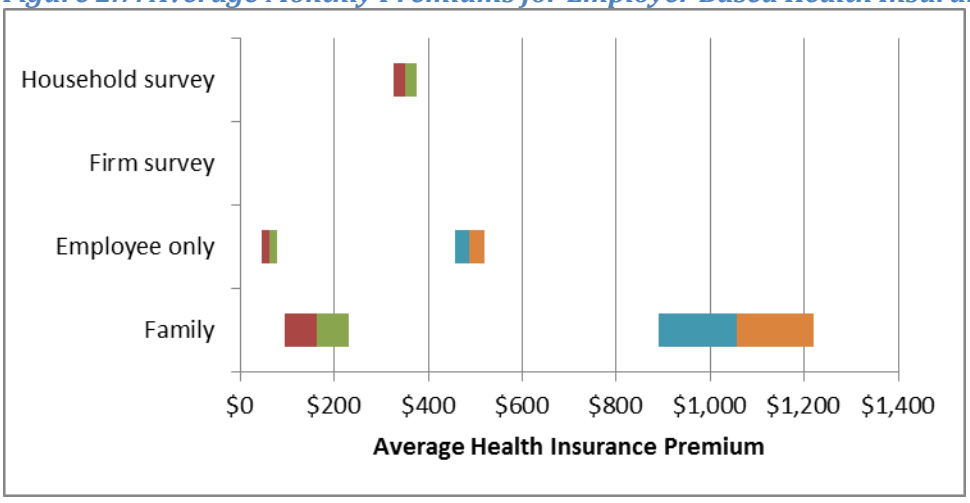

Outside of actually using health insurance benefits, premiums and deductibles are the most frequent contact most people have with health insurance. Unfortunately, a large number of respondents are unable to answer questions related to premiums and deductibles (Figure 2.6). Twenty-eight percent of firm respondents do not know what their premiums for health insurance are. Household respondents are more likely to know what their deductible is (62 percent). Much of this lack of knowledge about premiums is probably due to the complicated nature of health insurance and the way it is provided. Firm respondents are more knowledgeable because it is a major cost of employee compensation. Household respondents only contact with premiums is usually a number hidden on a pay stub. Respondents are probably more likely to know their deductible as it is more salient. It tends to hit their pocketbook more directly as they are forced to pay medical bills up to the deductible. About a quarter of households do not know if their health insurance has an annual maximum out-of-pocket.

*Figure 2.6: Knowledge of Premiums, Deductibles and Out-of Pocket, Firms and Households, Montana, 2011*



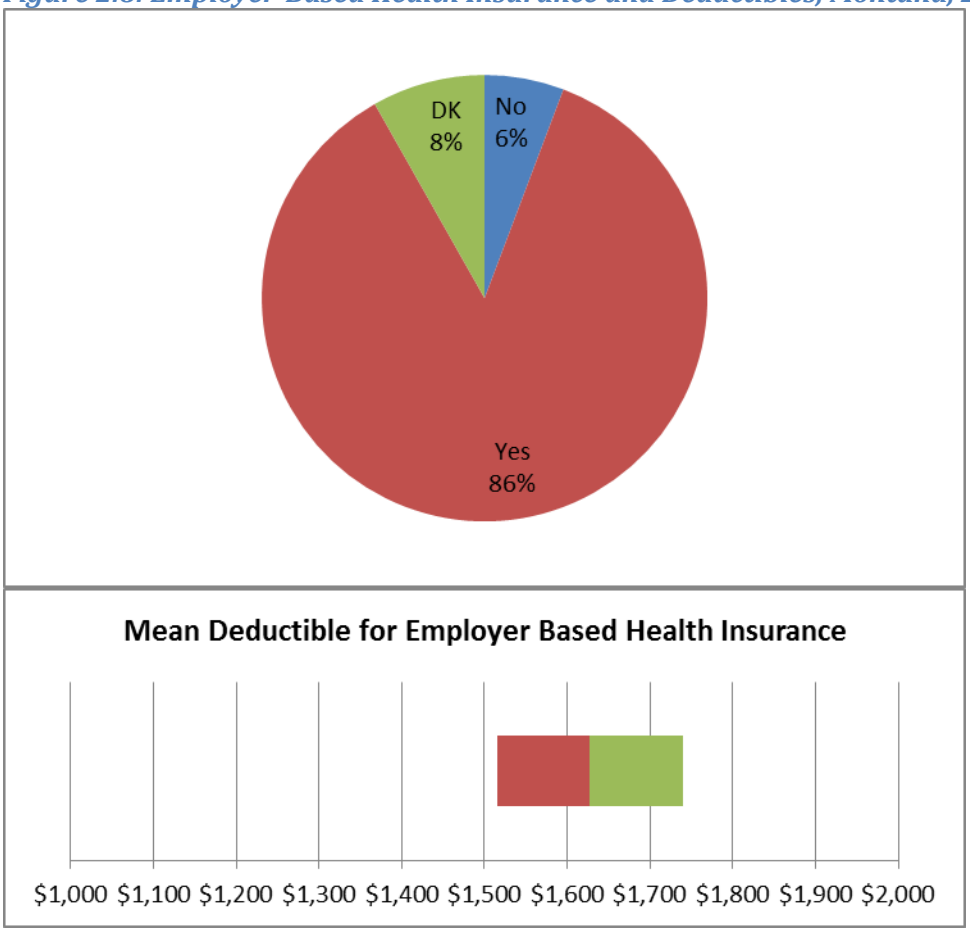

The uneven knowledge about health insurance premiums is reflected in Figure 2.7. Firms report employee contributions that are much lower than premiums reported by households. Household respondents report an average premium of about $350. Firms on the other hand report an average total premium of $488, with an employee share of $61 for an employee only policy. The firms that provide a family insurance option report a total premium of $1,055, with an employee share of $162. This apparent discrepancy in premiums shows the complicated nature of employer-based health insurance.

*Figure 2.7: Average Monthly Premiums for Employer Based Health Insurance, Montana, 2011*



Deductibles are an important factor in determining a household's medical expenses. About 86 percent of households with employer-based health insurance (Figure 2.8) report their health insurance policy requires an average deductible of $1,625.

*Figure 2.8: Employer-Based Health Insurance and Deductibles, Montana, 2011*

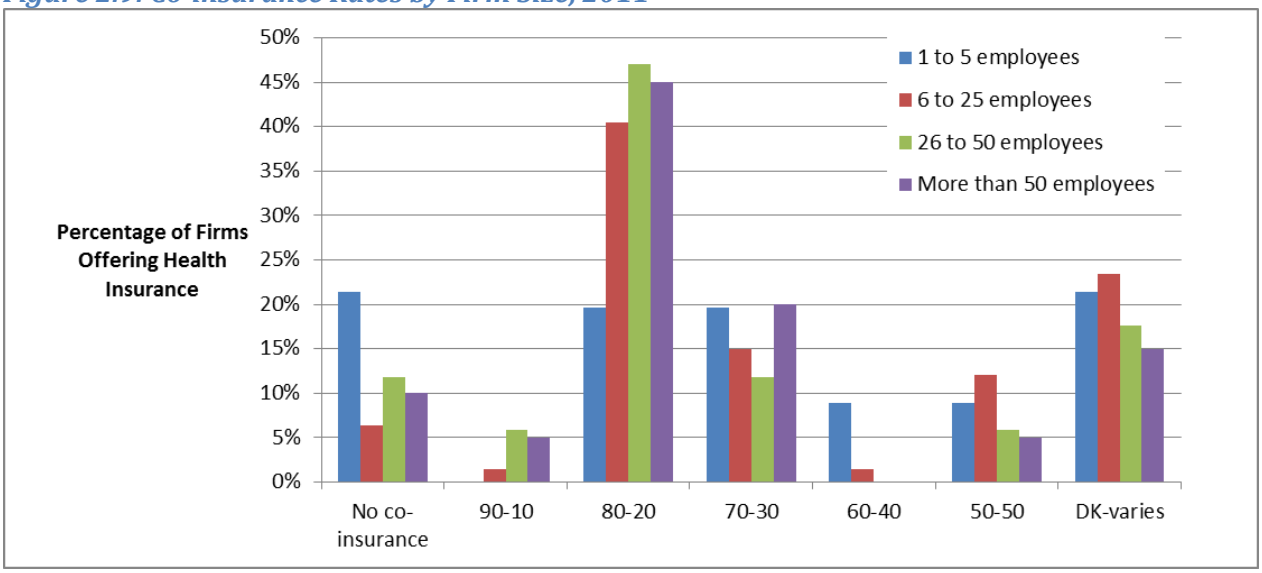



Much of today's health care debate centers on increasing the price transparency of health care to the consumer. The general belief is that consumers, particularly those with employer-sponsored health insurance, over-consume health care. While the data do not allow any assessment of over- or under-use of the health care system, it does demonstrate that consumers do not consume health care as they do other goods and services where price transparency is readily apparent. Half of all households with employer-sponsored health insurance do not know their share of the monthly insurance premium. Almost four in ten cannot reveal their deductible amounts, and one in four does not know their out-of-pocket maximum. Other studies have also shown that consumers often do not know the difference between co-pays and co-insurance. This compares to only 28 percent of employers that could not state premium, deductible, and out-of-pocket limits in their policies offered to employees. Smaller employers typically do not have human resource managers that would have full knowledge of their health insurance plans, so this result is not surprising.

The 2011 Firm Health Insurance Survey asks firms how many different health insurance policies they offer to employees. Only a few of the largest employers offer more than one. The survey asks about some other specifics of the policy each firm offers its employees. If a firm offers more than one option, the questions applied to the policy covering the most employees.

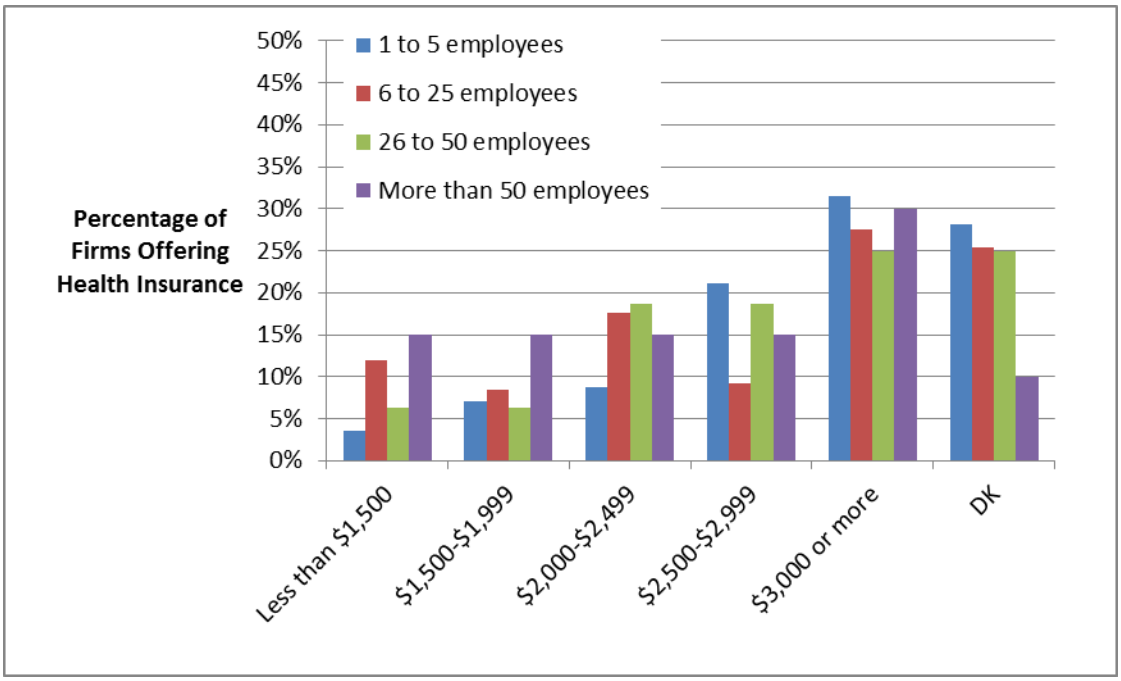
Co-insurance is an important cost-saving incentive for insurance companies and employers. If individuals are required to pay a percentage of the cost for a medical visit or procedure, they are less likely to be frivolous in their use of medical services. Figure 2.9 shows the level of co-insurance for the average policy by firm size. An 80-20 split, where the policy pays 80 percent and the covered person pays the remaining 20 percent, is the most common co-insurance for all firm sizes except the smallest firms. Small firms have many different co-insurance rates, ranging from none to 50 percent. The complicated nature of health insurance is once again illustrated by the large proportion of firm respondents that do not know their co-insurance.

*Figure 2.9: Co-insurance Rates by Firm Size, 2011*



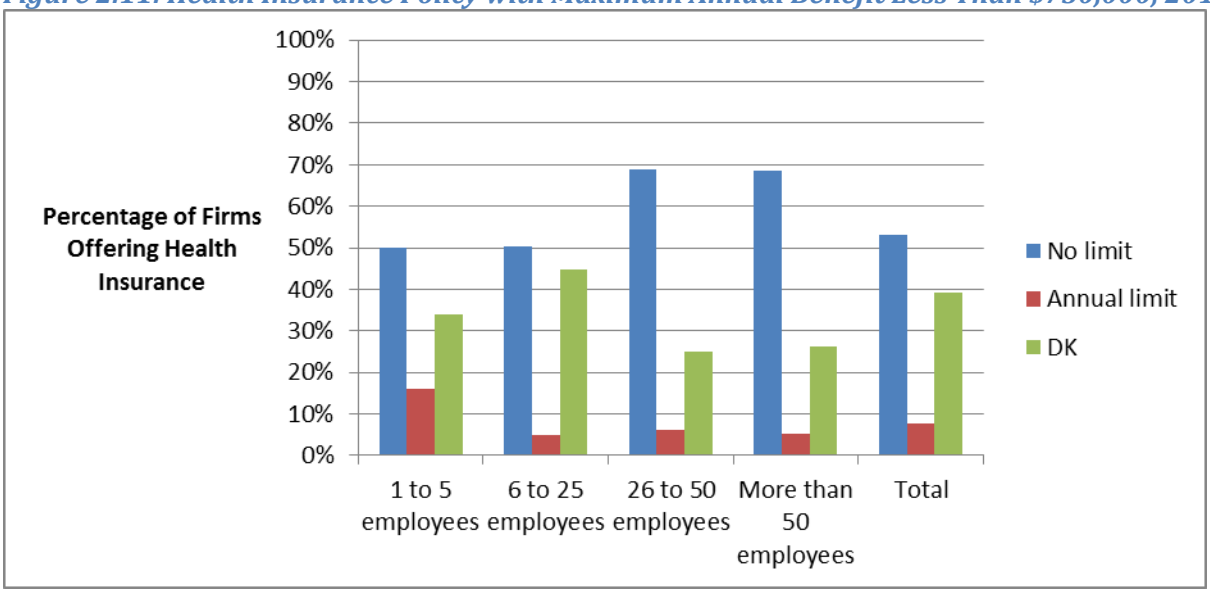

Many health insurance policies have a maximum amount that individuals pay through co-insurance before the health insurance policy pays the balance. About a quarter of firms that offer health insurance with between 6 and 50 employees (Figure 2.10) have maximum out-of-pocket payments over $3,000 per year. More than 30 percent of the smallest and largest firms' covered employees pay a maximum greater than $3,000 per year. Another 20 percent of the smaller firms' employees pay between $2,500 and $3,000 per year. A quarter of all size classes of firms except the largest do not know the maximum out-of-pocket payments required of their employees.

***Figure 2.10: Maximum Annual Out-of-Pocket Liability for an Individual, with Single Coverage, 2011***



The Affordable Care Act has several policy requirements that affect small business and the health insurance policies they provide. Starting in 2014, the Affordable Care Act will ban annual dollar limits on the value of coverage. The 2011 Firm Health Insurance Survey asks respondents if their firm's health insurance policy has an annual limit of less than $750,000 (Figure 2.11). A majority of firms report no limits, but about 15 percent of the smallest firm's policies have limits. Once again, "do not know" was a popular answer.

*Figure 2.11: Health Insurance Policy with Maximum Annual Benefit Less Than $750,000, 2011*

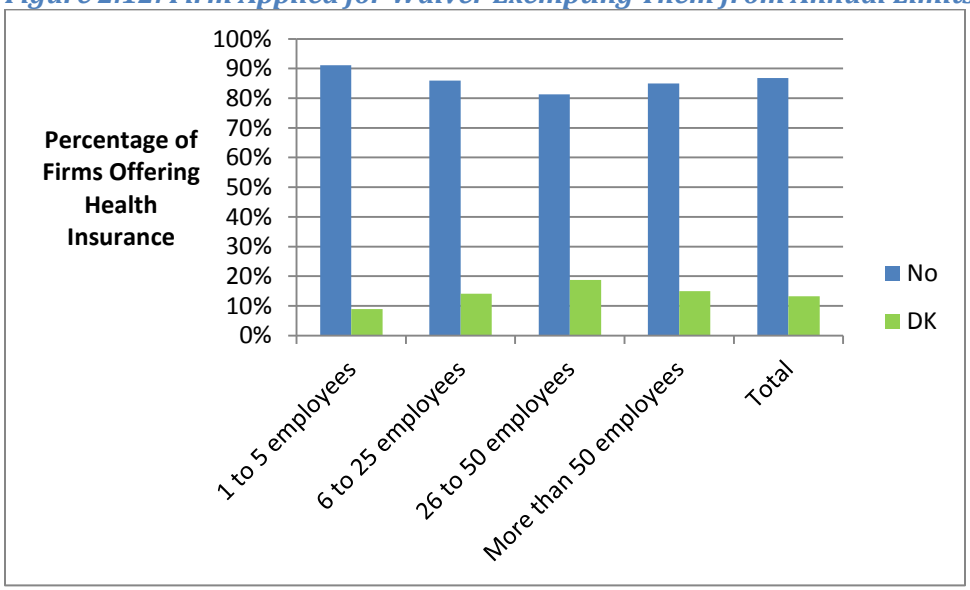



The Department of Health and Human Services announced in January of 2011 that it would stop accepting applications for waivers from the health law's minimum coverage requirements; $750,000 in 2011, $1.25 million in 2012, and $2 million in 2013. The policy became effective in September, 2011. In 2014, there will be no limits for essential benefits.

Companies that already have exemptions from the mandate can continue their mini-med plans with annual maximum coverage of $10,000. Almost all of the waivers granted (97 percent) are for health plans that are employment related. Employees most affected by the waivers are low-wage, part-time, and seasonal workers. The number of enrollees in plans with annual limits waivers is 2.1 million nationally, only about 1 percent of all Americans who have private insurance today.

The firm survey asks each firm if they applied for a waiver. Over 80 percent of firms responded negatively. "Do not know" is the response of over 10 percent of respondents in all size classes.

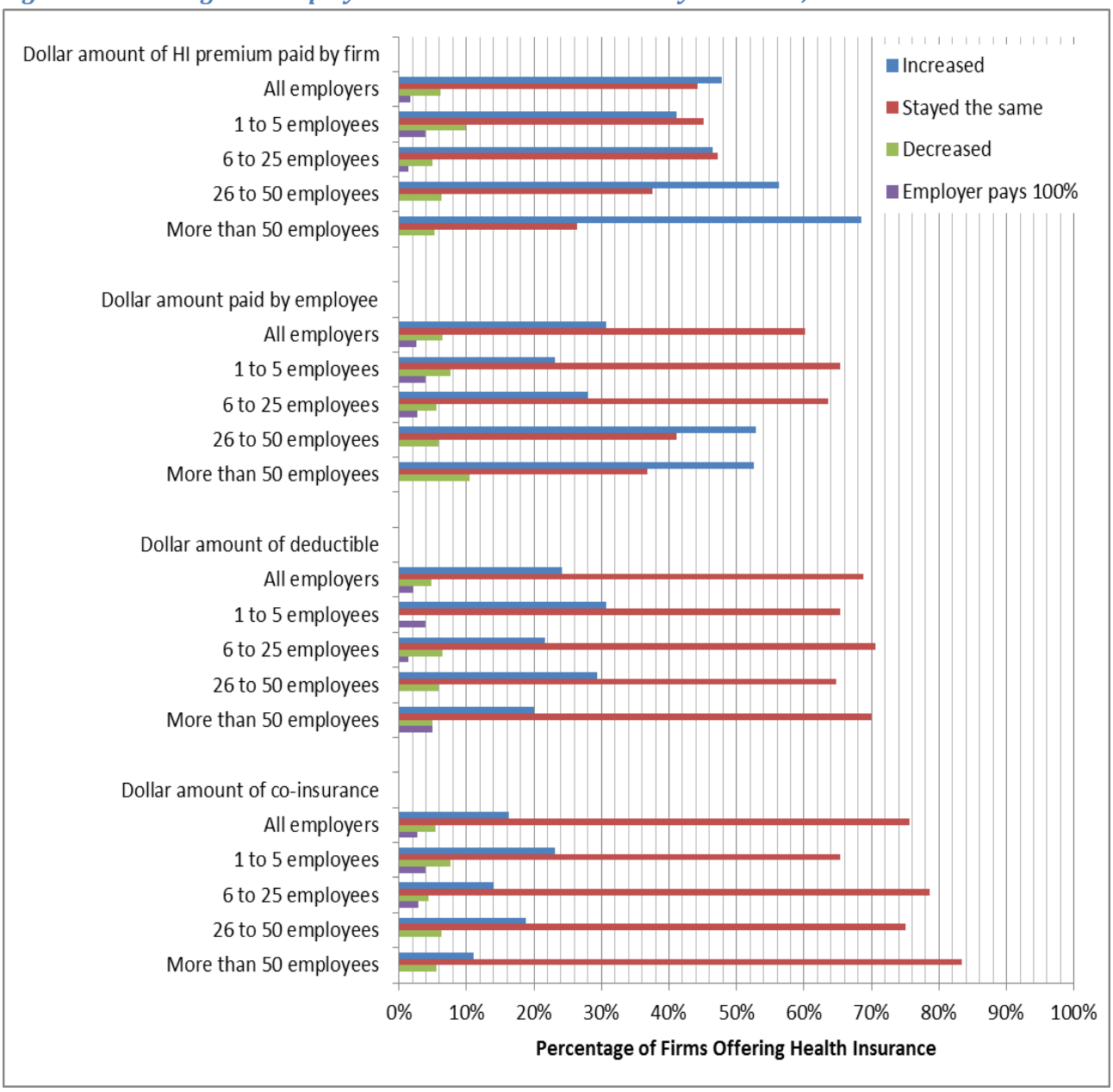
*Figure 2.12: Firm Applied for Waiver Exempting Them from Annual Limits of ACA, 2011*




Four common business strategies exist to help defray the cost of providing health insurance as a benefit to their employees. These responses are shown in Figure 2.13; changes to the premium paid by the employer, changes to the premium paid by the employee, changes to the deductible, and changes in the co-insurance. Once again there are differences among the different firm employee sizes. There is little change in the dollar amount of both the deductible and the co-insurance amounts. If any change is made it is an increase.

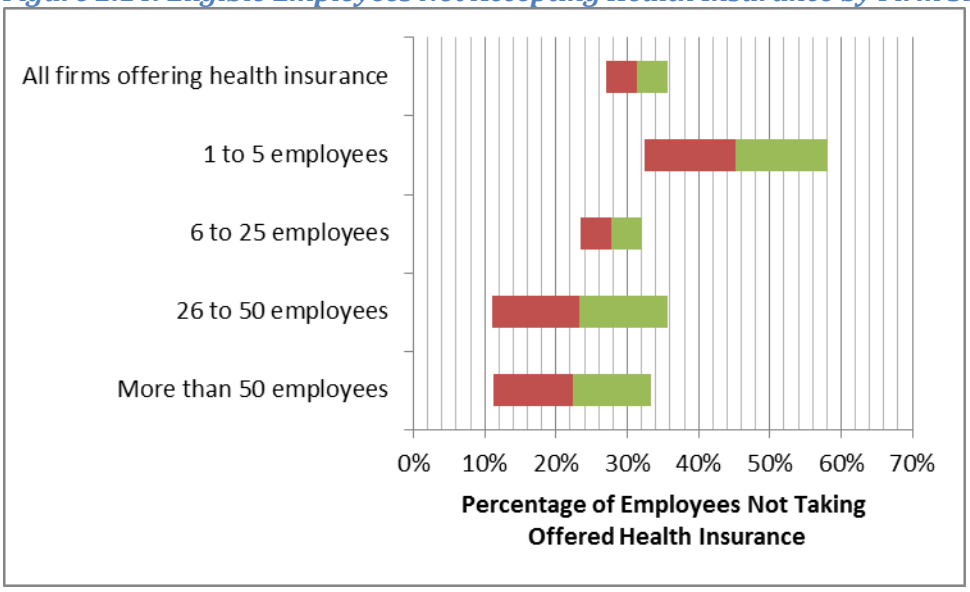
The premiums paid by the company increased for a majority of firms with 26 or more employees. Almost 70 percent of the large firms saw increases; about 55 percent of those with 26 to 50 employees had premium increases. More than 40 percent of the smaller firms had increases in their total premiums. The data show that firms tried to keep premium increases from employees. Only half of the larger firms (those with 26 or more employees) increased the premiums for employees.

*Figure 2.13: Changes in Employer-Based Health Insurance by Firm Size, 2011*



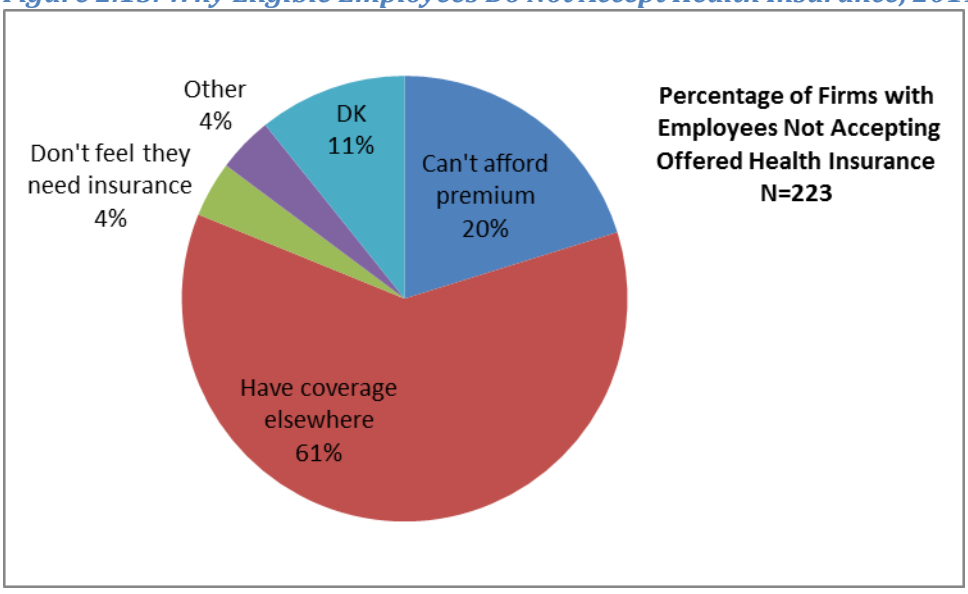
Even though employers offer health insurance as benefits, some employees do not take advantage of the benefits. Figure 2.14 shows the proportion of employees that do not take advantage of their health insurance benefit, according to the 2011 Firm Health Insurance Survey. Between 27 and 36 percent of employees do not utilize their health insurance benefit. Once again firm size is a determining factor. Between 32 and 58 percent of employees from the smallest firms do not accept health insurance. The large number of firms in the 6 to 25 employee range allows for a tighter confidence interval, 24 to 32 percent of employees refuse health insurance coverage. Between 12 and 36 percent of employees from the larger firms do not accept health insurance.

*Figure 2.14: Eligible Employees Not Accepting Health Insurance by Firm Size, 2011*



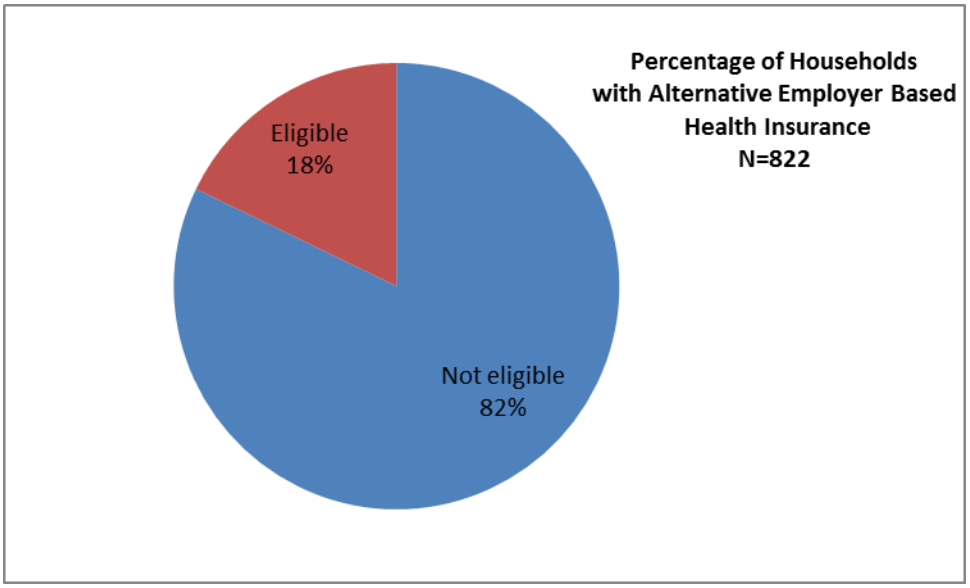

With around 30 percent of eligible employees refusing health insurance as an employee benefit, firms were asked why their employees refuse coverage (Figure 2.15). Sixty-one percent said their employees have coverage elsewhere. Another 20 percent said their employees could not afford the premium.

*Figure 2.15: Why Eligible Employees Do Not Accept Health Insurance, 2011*



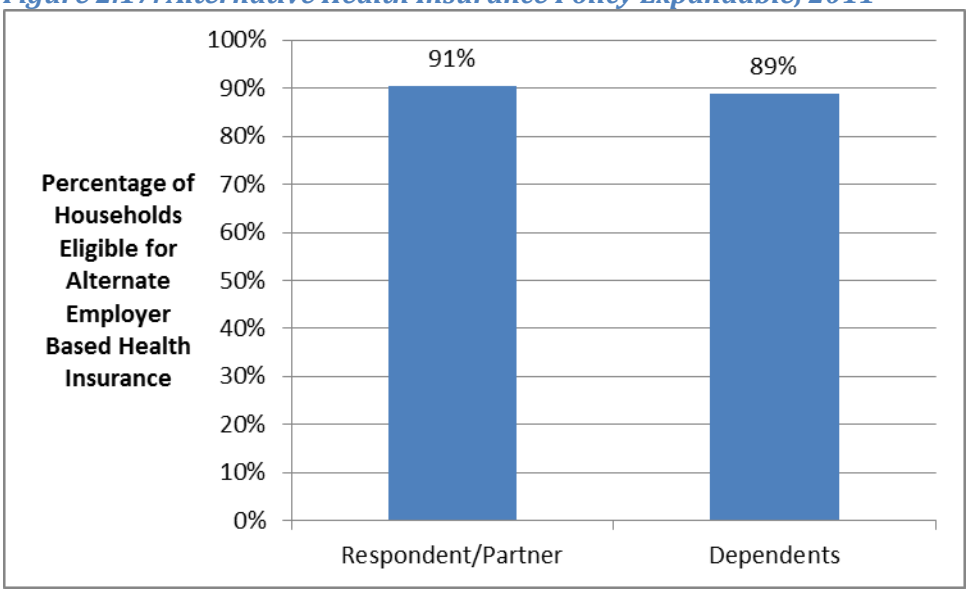
Employees eligible for but not utilizing health insurance benefits were also investigated in the 2011 Household Health Insurance Survey. Married respondents were asked about the availability of employer-based health insurance though their own work or their partner's work. Figure 2.16 shows that 82 percent are not eligible for alternative employer-sponsored health insurance due to minimum weekly hour requirements, part-time employment, and other non-identified reasons. Eighteen percent are eligible for their partner's health insurance benefit.

### *Figure 2.16: Alternative Employer-Based Health Insurance for Eligible Household Member, 2011*



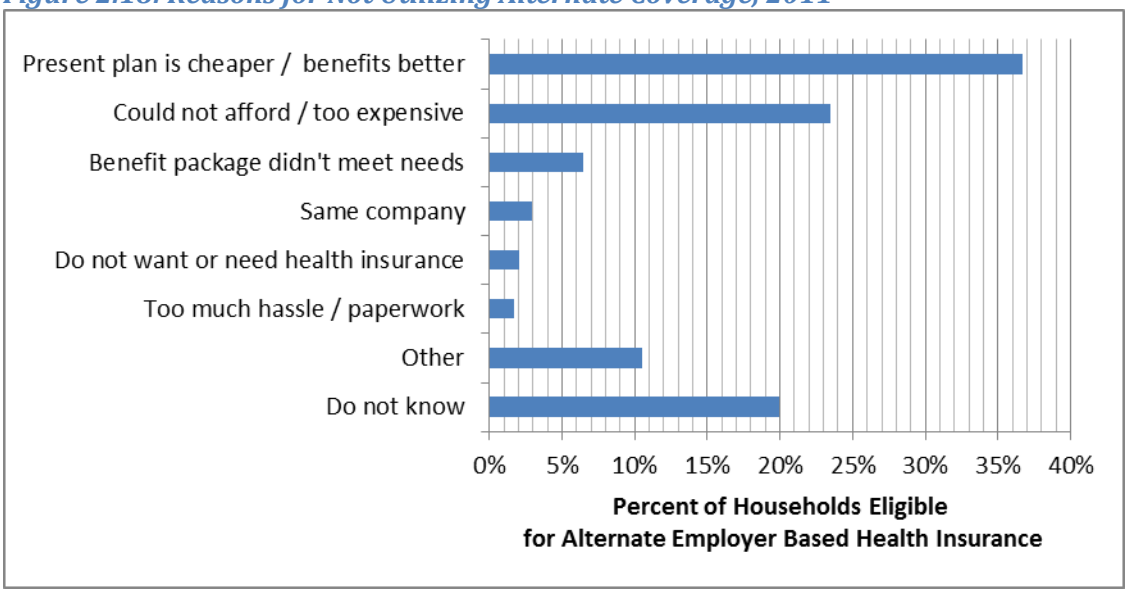

Those that are eligible were then asked if the policy could also be used to cover the respondent's partner and dependents (Figure 2.17). Ninety-one percent are expandable to the respondent/partner and 89 percent to other dependents.

*Figure 2.17: Alternative Health Insurance Policy Expandable, 2011*




Respondents were also asked why they did not take advantage of the alternative coverage. Just over 35 percent of respondents say their present health insurance plan is better than that of their partner. About 23 percent said they could not afford it. Less than 10 percent of respondents mentioned "did not meet needs," "worked at same company," "do not need or want." About 20 percent could not easily give a reason.

*Figure 2.18: Reasons for Not Utilizing Alternate Coverage, 2011*

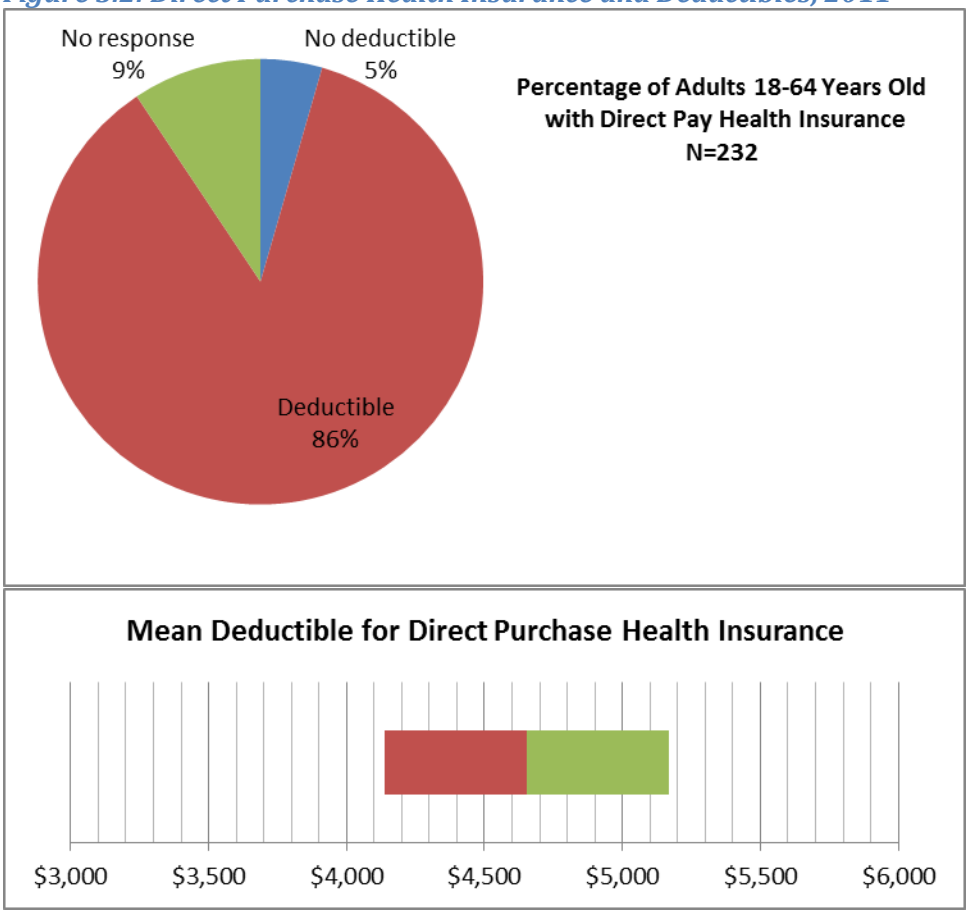


## Direct Purchase Health Coverage

Direct purchase health coverage is bought directly from an insurance company by an individual or an individual's relative. About 6 percent (54,000) of Montanans purchase their health insurance directly from health insurers. These policy holders pay an average monthly premium of between $470 and $591 (Figure 3.1). Like employer-based health insurance, about 86 percent of direct purchase policy holders are required to pay a deductible (Figure 3.2). Deductibles for direct purchase health insurance average about $4,600 per year. That is nearly three times the average deductible required by employer- based health insurance policies.

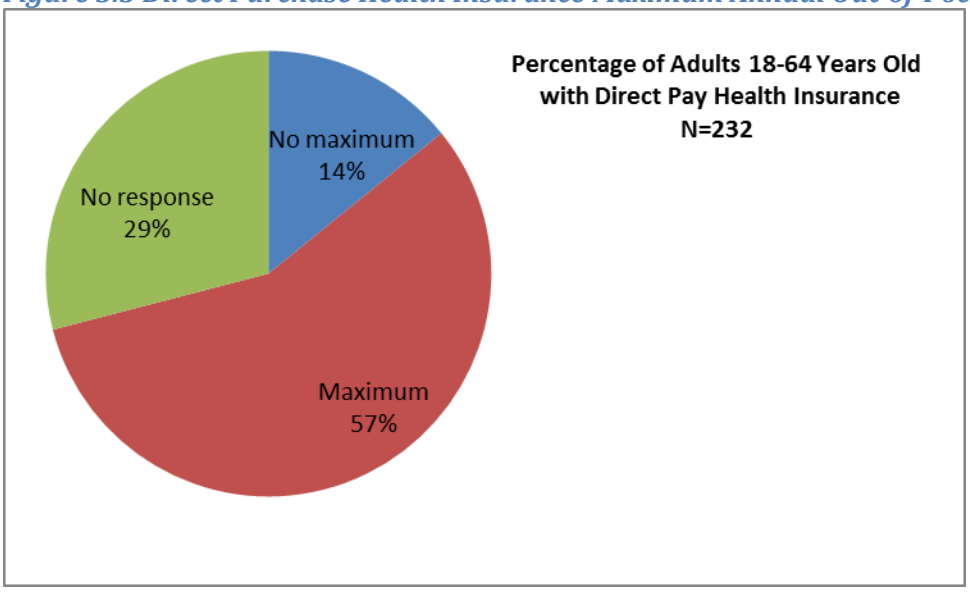
*Figure 3.1: Mean Monthly Premium for Direct Purchase Health Insurance, 2011*


*Figure 3.2: Direct Purchase Health Insurance and Deductibles, 2011*



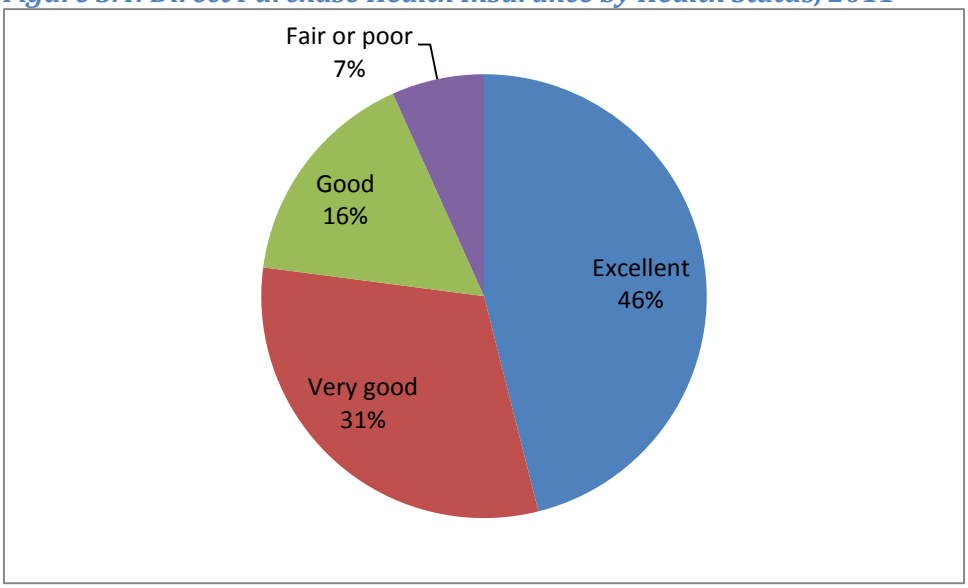
Maximum out of pocket limits are efforts to protect consumers from catastrophic medical bills. Respondents with direct purchase health insurance were asked whether their policy has a maximum out-of-pocket (Figure 3.3). Only 57 percent said their policy has a maximum out-of-pocket. More revealing was the 29 percent that did not know, demonstrating the intricacies of the insurance system.

*Figure 3.3 Direct Purchase Health Insurance Maximum Annual Out-of-Pocket, 2011*



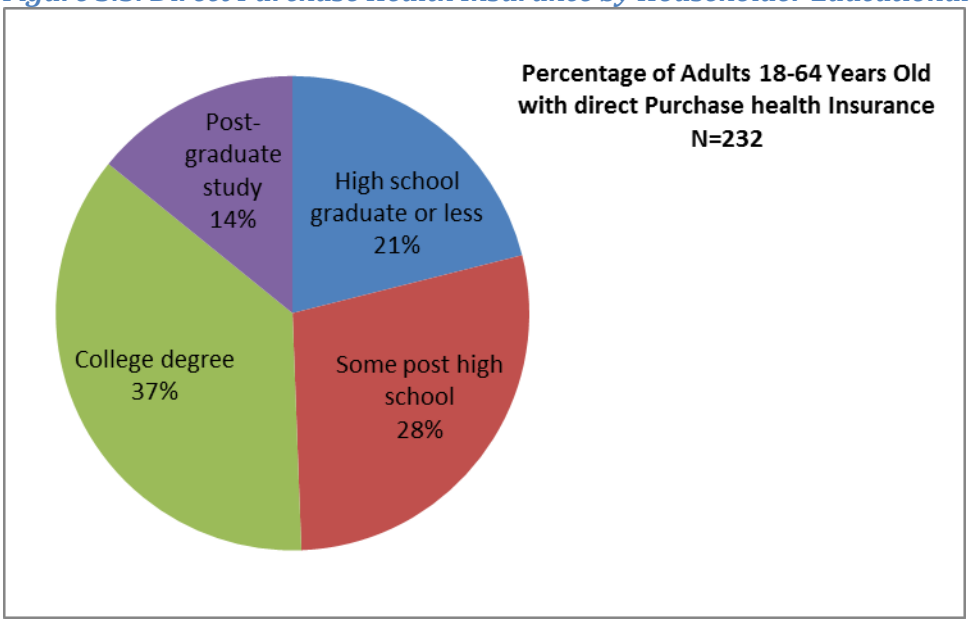

The demographic characteristics of direct purchase health insurance users are shown in the next four charts (Figures 3.4, 3.5, 3.6, 3.7). Direct purchase policy holders are in very good or excellent health; only 23 percent report good, fair, or poor health. Persons with poorer health may have difficulty obtaining affordable health insurance in the open market.

*Figure 3.4: Direct Purchase Health Insurance by Health Status, 2011*



Householders with direct purchase health insurance are relatively well-educated. About half of direct purchase policy holders have at least a college degree, another quarter some post high school.

*Figure 3.5: Direct Purchase Health Insurance by Householder Educational Attainment, 2011*




Over half of direct purchase health insurance policy holders are self-employed. The self-employed do not have other alternatives for health insurance. Another 24 percent are employed full time and nine percent are employed part time. Those that are employed by someone else work predominately for small firms with less than 10 employees.

*Figure 3.6: Direct Purchase Health Insurance by Householder Employment Status, 2011*

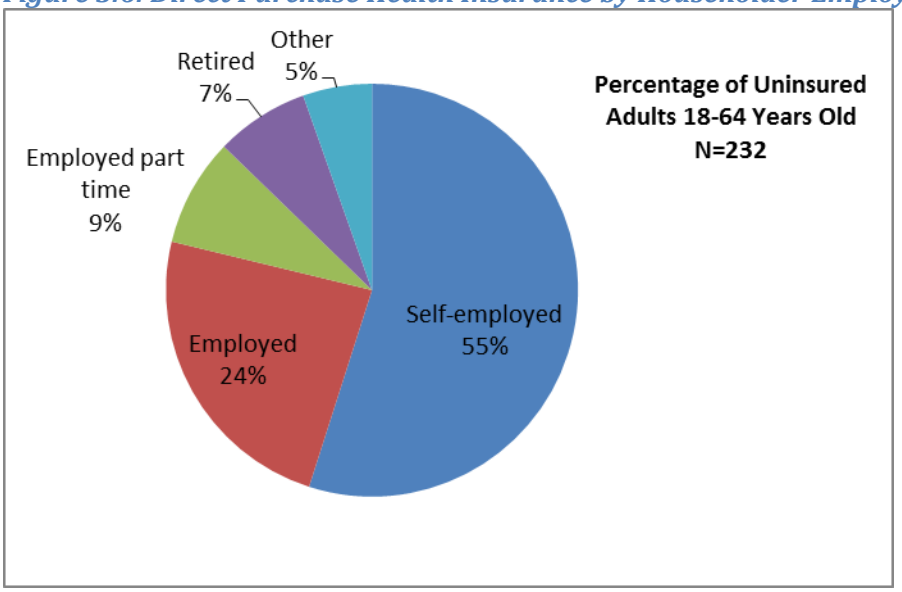
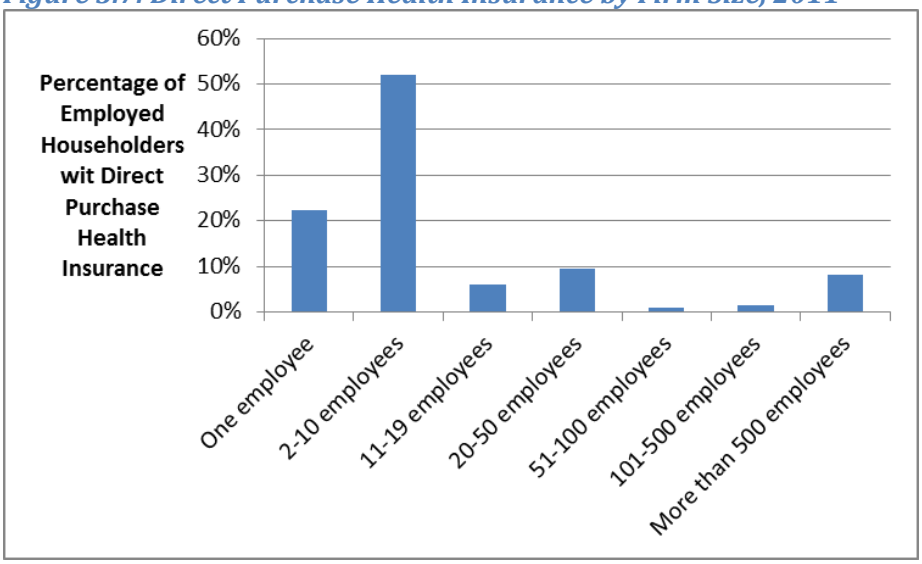
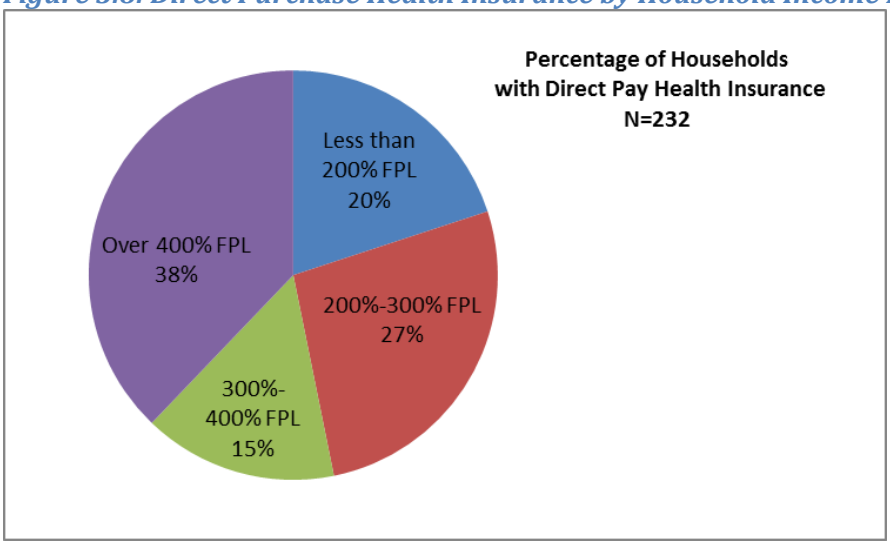


*Figure 3.7: Direct Purchase Health Insurance by Firm Size, 2011*




The majority of direct purchase health insurance policy holders have incomes above three times the federal poverty level (FPL). About a quarter have household incomes between two and three times the FPL and another 20 percent below 200 percent of the FPL.

*Figure 3.8: Direct Purchase Health Insurance by Household Income Level, 2011*



## The Underinsured in Montana

While defining the uninsured is fairly straightforward, the appropriate criteria for defining the underinsured are not as obvious. Almost all definitions use some form of out-of-pocket spending, but apply these thresholds against different benchmarks. Some of the various measures used in the literature to define and quantify the number of underinsured include out-of-pocket spending over $2,000 per family member, out-of-pocket spending, inclusive of health insurance premiums, greater than 40 percent of family income, and the amount of family income after health care spending in relation to the federal poverty level.

One of the more illustrative examples of the dynamics of the underinsured population is the 2007 Commonwealth Fund Biennial Health Insurance Survey. The survey looks at changes in the uninsured and underinsured 19 to 64 years of age adult population. Survey respondents who have health insurance are classified as underinsured if they met at least one of three indicators of financial risk relative to family income: out-of-pocket health care spending exceeding 10 percent of family income, out-of-pocket spending on health care that is 5 percent or more of family income for families with incomes below 200 percent of the federal poverty level, and deductibles that are 5 percent or more of family income.

The Commonwealth Fund Biennial Health Insurance Survey compares results from 2003 to 2007 and finds that:

- There was a slight decline in the proportion of non-elderly adults having health insurance all year (72 percent);
- The underinsured population meeting at least one of the three financial risk criteria increased 60 percent, with underinsured rates for families below 200 percent of the federal poverty level increasing nearly three-fold;
- The rates of underinsurance increased among all three measures;
- The number of underinsured as defined by deductibles of 5 percent or more of family income increased two-fold from 2003;
- Including the uninsured, 42 percent of the adult non-elderly population had either no health insurance or inadequate health insurance in 2007, up from 35 percent in 2003;
- Seventy-two percent of families under 200 percent of the federal poverty level were either uninsured or underinsured, compared to only 22 percent for higher income families; and
- Although underinsurance rates for lower-income families are three times higher than underinsurance rates for higher income families, the underinsurance rate increased most among the higher income families.

The risk factors most associated with underinsurance are age, (50-64 years), family income less than 300 percent of the federal poverty level, health insurance that was purchased in the individual market or from public sources, low wage jobs, and employment at smaller firms.

The number of underinsured in Montana may be understated due to a reverse moral hazard. In a study done by Jean Marie Abraham, Thomas DeLeire, and Anne Beeson Royalty (Health Services Research, June 2010, 45(3):806-24) the rate of underinsurance among households employed by small firms was found to be underestimated by 20 percent. The authors found that small-firm households reduce both their utilization and spending on health care in response to the higher cost-sharing they face through a

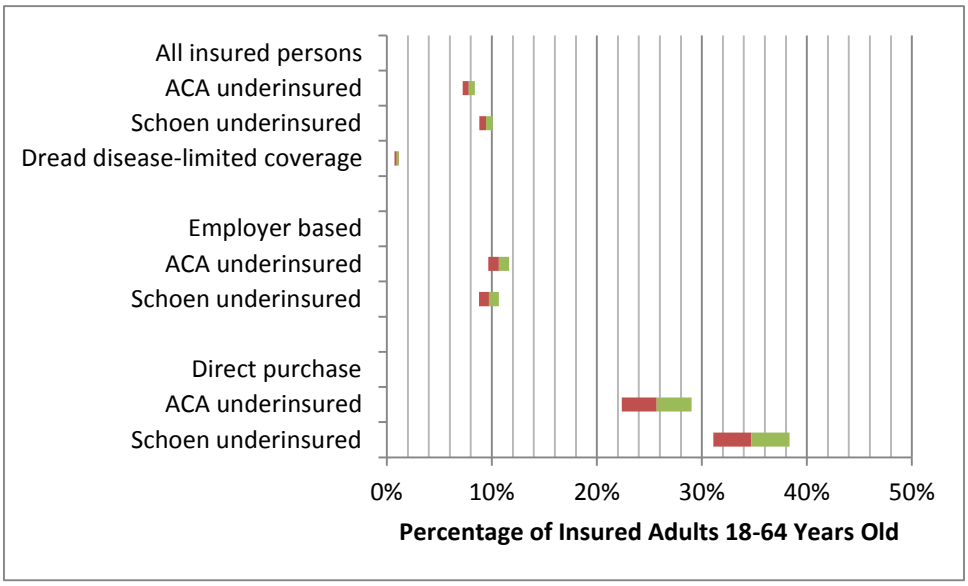
"reverse" moral hazard effect. Households working at small firms have less generous health insurance on average than households working for larger firms. As a result, smaller-firm households reduce their spending on health care, making any threshold measures using out-of-pocket spending as a proportion of income less reliable as a measure of underinsurance. Adjusting for this moral hazard effect increases the rate of underinsurance among households that work at smaller firms and decreases the rate of underinsurance for households employed by larger firms. Unfortunately, the data required to make this adjustment at the state level do not exist.

One of the more landmark studies of underinsurance rates was done by Cathy Schoen, Michelle M. Doty, Ruth H. Robertson, and Sara R. Collins (Health Affairs, 2011). The authors used three indicators of financial risk compared to family income to define the underinsured: family out-of-pocket expenses that exceed 10 percent of income, medical expenses that exceed 5 percent of income for families under 200 percent of the federal poverty level, and per person deductibles that are equal to or exceed 5 percent of income. All three measures exclude health insurance premiums paid to the insurer. One downfall to this approach is missing the healthy who have insurance with caps or benefit limits who otherwise may have been underinsured had they been sick, and the 5 percent and 10 percent thresholds for out-of-pocket expenses could capture some higher income households who otherwise have sufficient income and assets to cover their medical expenses.

BBER uses two approaches to estimate the number of underinsured in Montana. The household survey has information on deductibles and family income. Using per person deductibles that equaled or exceeded 5 percent of family income as the underinsured threshold, an estimated 91,000 Montana households qualify as underinsured. Using a slightly different benchmark for underinsured as specified in the Affordable Care Act (ACA), 75,000 Montanans are underinsured when defined by premiums that exceed 9.5 percent of adjusted gross income. This represent between 7 percent and 8 percent of the total insured population in Montana.

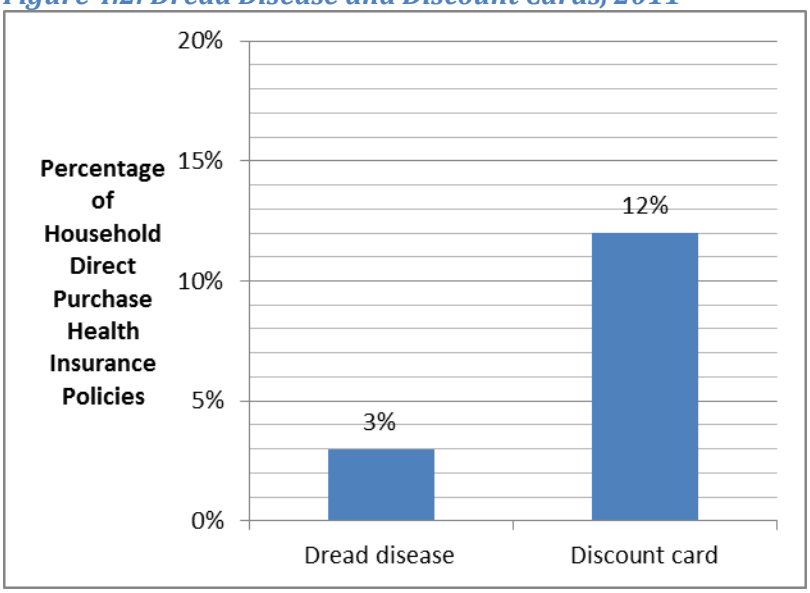
Figure 4.1 shows that only a small percentage of insured individuals in Montana are underinsured (less than 10 percent); however, a disproportionate number of those with direct purchase health insurance policy are underinsured. Between 22 and 29 percent of those with direct policies are underinsured as defined by the ACA. The Schoen definition of underinsured results in a higher number of underinsured, between 31 and 38 percent.

*Figure 4.1: Percentage of Underinsured, Montana, 2011*




Policies directed at specific diseases such as cancer and so-called discount cards are a concern of regulators. These policies make up a very small portion of direct purchase health insurance (Figure 4.2). Respondents of the 2011 Household Health Insurance Survey self-report that about 3 percent of direct purchase health insurance could be classified as dread disease policies directed a specific disease. About 12 percent of respondents with direct purchase health insurance report their policy is for discounted treatment. If a respondent reports only a dread disease or discount card for health insurance coverage, BBER classifies them as uninsured.

*Figure 4.2: Dread Disease and Discount Cards, 2011*



Even though the proportion of underinsured individuals is relatively small, the number of persons affected is substantial (Figure 4.3). Using the ACA definition of underinsured, between 70,000 and 80,000 persons are underinsured. About 50,000 are insured under employer-based health insurance and 20,000 are insured by direct purchase. The Schoen definition suggests that about 85,000 to 95,000 people are underinsured. Employer-based health insurance insures between 40,000 and 50,000 and direct purchase insurance covers between 25,000 and 35,000 individuals. The numbers do not add exactly as post-stratification weights affect each subset differently. The broader based measures give an upper bound of the number of underinsured.

*Figure 4.3: Number of Underinsured, Montana, 2011*

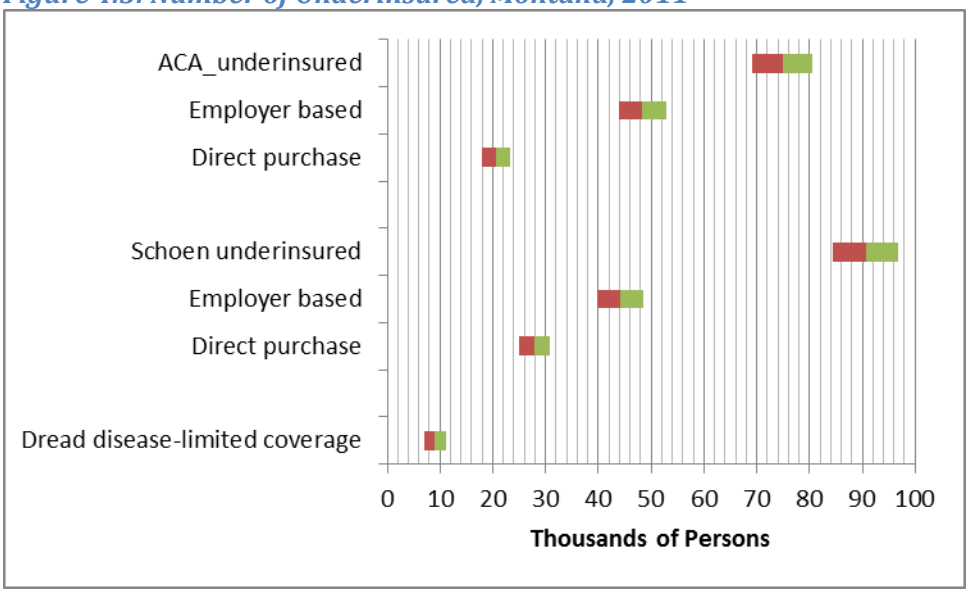



Figure 4.4 shows there is little difference in the health status of the underinsured. Figure 4.5 shows that younger people are less likely to be underinsured. They are also less likely to be insured at all, so any insurance is likely to be employer-based or provided by their parents.

*Figure 4.4: Underinsured by Health Status, Montana, 2011*

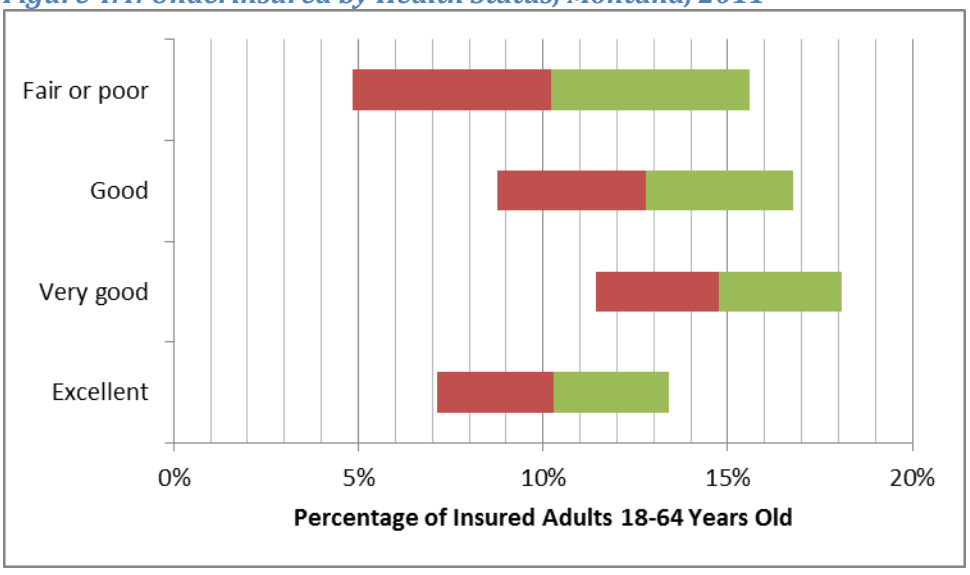
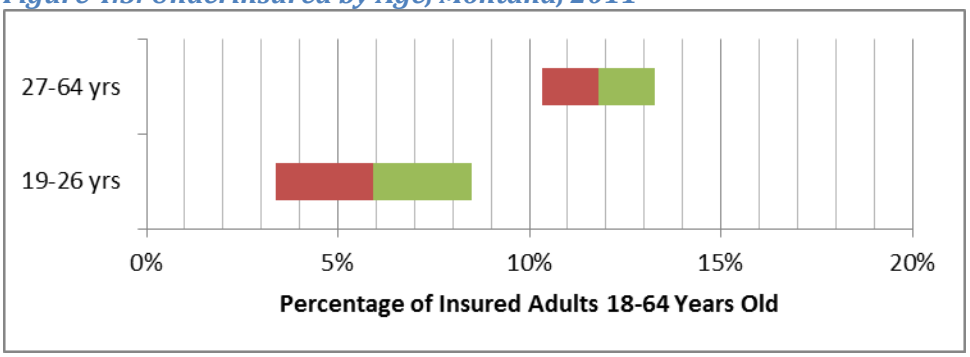


*Figure 4.5: Underinsured by Age, Montana, 2011*




## Summary

Nearly one in five Montanans does not have health insurance, considerably above the proportion nationally. This is particularly noteworthy since the state has a disproportionate share of its population Medicare eligible and with veteran status, and hence, eligible for government-provided health care. Because users of Indian Health Services typically have limited health services and geographically divergent access to healthcare, IHS users are considered uninsured as well, consistent with other measures of uninsured populations. HIS users account for 20 percent of Montana's uninsured population. Almost six in ten Montanans has commercially provided health insurance. Within this group, most all obtain their health insurance through an employer.

Among those who experienced a period last year without insurance, three-quarters were uninsured involuntarily. Reasons for lack of health insurance were many, but most notably low-wage jobs, premiums that were too expensive, or forced unemployment.

Similar to the health insurance status of the non-institutionalized population nationally, nearly 50 percent of the state's population has employer-sponsored insurance, including TRICARE, the health insurance plan for veterans and their families. Only 9 percent purchase their health care insurance directly through a health insurance provider. Females in Montana are more likely to be uninsured, representing a significant barrier to the health care marketplace.

Three variables most influential on the ability to have health insurance coverage are highly correlated with each other: educational attainment, employment status, and income. The impact of the recent recession nationally, and to different severity levels in Montana counties, has placed additional strains on the ability of the state population to afford and access health care services. Charitable care has increased considerably in Montana hospitals and elsewhere, reflecting the decreased economic status for many Montanans. Households with incomes below $50,000 per year, or 224 percent of the federal poverty level in 2011, are a third as likely to have health insurance coverage as families with incomes above $50,000 per year.

More than 40 percent of those who self-report fair or poor health are uninsured; the uninsured account for only 22 percent of those who self-report excellent health. Montanans without health insurance are also less likely to report a regular health care provider.

Medical debt in Montana is almost 2 percent of the entire state's gross domestic product in 2011, accounting for $650 million. Nearly one in four uninsured report medical debt, averaging over $9,000 per household. Medical debt among the insured is almost $4,000 per household, but less than 9 percent of households with health insurance report medical debt. Total medical debt in Montana is 1.5 times the gross domestic product of the arts/entertainment-and recreation industry in Montana.

Although the rate of uninsured increases inversely with income in relation to the federal poverty level, variations in uninsured rates exist depending on age cohorts. Among the working age population, the uninsured rate increases as income relative to the federal poverty level decreases. For those with incomes 400 percent of the federal poverty level, only 10 percent do not have health care insurance. But for the working age population with incomes below 100 percent of the federal poverty level, 60 percent lacks health insurance. Uninsured rates increase to over 50 percent for those with incomes below 150 percent of the federal poverty level and between the ages of 26 to 54 years of age.

While the relationship between income as a percent of the federal poverty and the uninsured rate is almost linearly inverse for the working age population, that is, the rate of uninsured increases as income as a percent of the federal poverty level decreases, this isn't the case for the 19 to 25 years of age demographic. As income falls as a percent of the federal poverty level, the uninsured rate falls too until income is 250 percent to 300 percent of the federal poverty level. The uninsured rate for high income earners, 400 percent of more of the FPL, is actually higher than for those with incomes down to 250 percent of the FPL. Relatively young, high income earners may choose instead to forego health insurance and save on their own for their medical needs.

Household characteristics most likely to be associated with higher rates of uninsured status include unemployed, employed part-time, full-time student, and disabled. Uninsured householders increase as the size of the employing firm decreases. Only 10 percent of uninsured households work at firms with more than 100 employees, while the proportion uninsured increases to 30 percent if the wage earner works at a firm with 2 to 19 employees. Half of the self-employed are uninsured. This is particularly important for Montana in that the proportion of total employment that is self-employed is higher than the proportion nationally, 22 and 28 percent respectively.

For those with health insurance in Montana, employer-sponsored health insurance is the predominate method for health insurance coverage. While only 45 percent of Montana employers offer health insurance as a benefit, nearly 80 percent of Montana's insured are covered. The most important factor determining whether health insurance is provided by an employer is the size of the firm, measured by the number of employees. For those firms with more than 50 employees, nearly all offer health insurance as a compensation and fringe benefit to their employees. For smaller employers however, those with only 1 to 5 employees, only one in four offer some kind of health coverage for their employees. The main reason given by employers that do not offer health insurance for their employees is the cost of health insurance.

Although 45 percent of all firms offer health insurance coverage to their employees, only 32 percent provide coverage for their employee's dependents. As expected, the larger the firm when measured by the number of employees the more likely health insurance options exist for employee dependents.

Two characteristics of employer-sponsored health insurance are waiting periods for coverage to begin and minimum hours per week work requirement. Almost half of all firms offering health insurance have

a three-month waiting period, with 28 percent having a six-month waiting period. Eight in ten firms have a minimum hour work week requirement, an average of around 33 hours per week.

It is apparent that many households are unaware of their policy premiums, deductibles, and out-of-pocket maximums. Much of today's health care debate centers on increasing the price transparency of health care to the consumer. The general belief is that consumers, particularly those with employer-sponsored health insurance, over-consume health care. While the data do not allow any assessment of over- or under-use of the health care system, it does demonstrate that consumers do not consume health care as they do other goods and services where price transparency is readily apparent. Half of all households with employer-sponsored health insurance do not know their share of the monthly insurance premium. Almost four in ten cannot reveal their deductible amounts, and one in four does not know their out-of-pocket maximum. Other studies have also shown that consumers often do not know the difference between co-pays and co-insurance. This compares to only 28 percent of employers that could not state premium, deductible, and out-of-pocket limits in their policies offered to employees. Smaller employers typically do not have human resource managers that would have full knowledge of their health insurance plans, so this result is not surprising.

When households did claim to know their monthly health insurance premium, it was well above the monthly premium reported by employers. Households report an average premium of $350, while businesses report the employee share of only $61 for employee only coverage. Even with family coverage, employers report an average premium of $162 for the employee share, still well below that reported by households.

Almost all employer-sponsored health insurance plans required a deductible, with the average deductible around $1,600. The most common co-insurance is 80-20 for all firms except the smallest. Firms with fewer than five employees report co-insurance rates across a wide spectrum, from 0 percent to 50-50 co-insurance. A significant percentage of all employers could not reveal the co-insurance rate on their policies. Even among large employers, those with more than 50 employees, 15 percent could not state their health plan co-insurance rates.

Rising health care costs can be passed along to the employer and employee in four ways. Premiums can be passed along, deductibles can be increased, and co-insurance rates can change. Co-pays can also increase, but was not assessed in the employer survey.

Comparing health insurance premiums to prior years, employers apparently absorbed some of the increase in health plan premiums. Particularly for the larger firms, those with 26 or more employees, premium costs were absorbed by half the employers. Deductibles and co-insurance remained largely unchanged, the exception is smaller firms with fewer than 5 employees where between 20 and 30 percent of these firms increased deductibles and co-insurance.

Slightly more than 30 percent of employees eligible for their employer's health insurance plan refuse the offer of health insurance coverage. Refusal is highest among the smaller firms, with 1 to 5 employees. More than 40 percent of the employees working at firms with 1-5 employees that offer health insurance coverage refuse the offer. Recall that only 25 percent of these employers offer such coverage. Given that only 32,000 employees work at these firms, the number refusing coverage would be quite low. Assuming 1.6 employees per firm, based on 2009 data from the Statistics of U.S. Businesses, Census Bureau, fewer than 3,300 employees refuse coverage at these small firms. For Montana's largest firms

who offer health insurance coverage to their employees, approximately two in ten refuse the offer of health insurance coverage.

The majority of employees who refuse their employer's offer of health insurance coverage do so because they have health insurance coverage elsewhere, primarily through a spouse. Another significant percentage (20 percent) however refuses the offer due to cost.

Only 12 percent of the insured population in Montana purchases insurance on their own, paying an average monthly premium of $525. Unlike their counterparts who purchase health insurance through an employer-sponsored plan, the average deductible for direct pay health insurance ($4,600) is four times that of the employer-sponsored plan deductible. Generally, direct pay purchasers are in very good or excellent health, well educated, self-employed, or work for a small firm with less than five employees.

The majority of direct pay purchasers (38 percent) have incomes above 400 percent of the federal poverty level. Only 20 percent have family incomes below 200 percent of the federal poverty level.

There are several ways to estimate the number of underinsured in Montana, all of which use some form of out-of-pocket spending on health care relative to family income, per family member, or in relation to the federal poverty level, to name a few. From 2003 to 2007, the number of underinsured by almost all measures increased across all income categories, but the rate of underinsured increased most among higher income families.

The risk factors most associated with underinsured are 50 to 64 years of age, family incomes less than 300 percent of the federal poverty level, insurance purchased in the individual market or obtained from public sources, low-wage jobs, and employment at smaller firms. For Montana, these risk factors put a considerable proportion of the population at risk.

Two methods are used to estimate the number of underinsured in Montana. A person is considered underinsured if per person deductibles equal or exceed 5 percent of family income. Using this measure, between 85,000 and 95,000 are underinsured. A second measure of the underinsured uses premium contributions that exceed 9.5 percent of adjusted gross income. This is a measure used in the Affordable Care Act to define non-affordability. This measure suggests that between 70,000 and 80,000 persons are underinsured.

Less than 10 percent of insured individuals in Montana are underinsured. However, a disproportionate number of direct purchase insured are underinsured, between 22 and 38 percent by the two measures used in this study. The younger workforce is less likely to be underinsured compared to older working-age adults. Only 6 percent of adults 19 to 26 years old are underinsured, compared to almost 12 percent of 27-64 year olds. But the young are less likely to be insured so any insurance at all is likely to be employer-sponsored or provided through their parents.

## The Medicaid Expansion

One important aspect of the Affordable Care Act of 2010 is the expansion of Medicaid insurance coverage to an estimated 32 million Americans who account for half of the total uninsured population. Beginning in January 2014, non-elderly adults with incomes up to 133 percent of the federal poverty level ($30,657 for a family of four in 2012) will be newly eligible for Medicaid. With the additional 5 percent income offset, newly Medicaid eligible will have incomes below $32,000. Confounding this expansion is not all Medicaid eligible individuals enroll. Participation in Medicaid (take-up rate) varies significantly across states, and has been found to be lower in the states with the most Medicaid eligible adults.

The national Medicaid take-up rate is around 63 percent of newly eligible adults. In Montana, the take-up rate has been estimated to be much lower, 50 to 60 percent of newly eligible adults. This is important since childless adults are expected to comprise the majority of newly eligible individuals after 2014. Comparing the individuals newly eligible for Medicaid because of the expansion to those currently eligible, the take-up rates for newly eligible adults is somewhat uncertain for two reasons. Individuals eligible for Medicaid because of the expansion under the ACA will receive a more restrictive set of benefits, or benchmark coverage, compared to those already in traditional Medicaid. This benchmark coverage should lower the take-up rate for individuals now eligible for Medicaid. Offsetting this affect however, the ACA eliminates the asset test for eligibility for newly eligible adults. Removing the asset test lowers a barrier to enrollment, so the take-up rate could be higher for newly eligible adults.

The Kaiser Family Foundation in May 2012 estimated the newly eligible Medicaid population by state according to two different take-up rate scenarios. For adults with incomes below 133 percent of the federal poverty rate and assuming take-up rates of 57 percent contrasted to 75 percent, total new enrollees into Montana Medicaid by 2019 are 38,000 and 57,000, respectively.

The BBER estimates that there are approximately 60,000 individuals with incomes less than 138 percent of the federal poverty level who presently do not have health insurance. The bubble population, those thought to have considerable risk cycling into and out of Medicaid, are those individuals with incomes around 150 percent of the federal poverty level. Expanding the Medicaid eligible population to 150 percent of the federal poverty level adds another 14,000 individuals who do not have health insurance.

Medicaid take-up rates of 50 and 60 percent add another 37,000 to 45,000 uninsured as newly eligible Medicaid enrollees. Should the take-up rate approximate the national average, newly eligible Medicaid enrollees could add another 47,000 individuals to Montana Medicaid. How soon these newly eligible adults in fact enter Medicaid is uncertain, but it is reasonable to assume that the intensity of state efforts in outreach will be a significant determining factor.

## The Health Insurance Exchange

The Affordable Care Act allows each state the opportunity to establish a health insurance marketplace called an Affordable Insurance Exchange ("Exchange"). Eligible individuals and small employers will be able to compare and select from qualified health plans (QHPs) for their families and their employees that meet benefit design, consumer protection, and other standards.

Exchanges will provide information to consumers to guide them in their purchase of health insurance. Health plans will initially be available to qualified individuals and employers. Qualified individuals include non-incarcerated U.S. citizens and legal immigrants who do not have access to affordable employer sponsored health insurance or whose employer offers a health plan that does not have an actuarial value of at least 60 percent. The actuarial value measures the percentage of expected medical costs that a health plan will cover. It is considered a general summary measure of health plan generosity. As such, it can guide consumers in choosing health plans by providing information on covered benefits. An employer's offer of insurance is considered affordable if the employee's share of the premium is less than 9.5 percent of household income. One problem with the criterion for affordability is that it is based on the cost of health insurance for the employee only, not the cost of covering the employee's family. This conceivably could impede other family members' access to affordable health care insurance. The health care law also provides for a Small Business Health Options Program (SHOP) Exchange for small businesses with up to 100 employees. However, states may limit the number of employees to 50 or fewer workers prior to 2016.

States are required by law to establish Exchanges, the American Health Benefit Exchange for individuals and the Small Business Health Options Program for businesses. States have the option of combining both Exchanges, or keeping them separate.

In Montana, the Exchange will be a Federally Facilitated Exchange. The Affordable Care Act directs the Secretary of the Department of Health and Human Services to establish and operate a Federally Facilitated Exchange (FFE) in any state that did not elect to do so. However, states do have the option of entering into a partnership with an FFE. Under a State Partnership model, a state may administer plan management functions, in-person consumer assistance functions, or both. In non-Partnership FFE States, FFEs will perform these functions.

Funding to establish the Exchanges will be available until January 2015. Thereafter, states must ensure that the Exchange is self-sustaining by charging assessment or user fees to participating health insurance issuers or by other means of generating funds.

Qualified health plans in the Exchange are required to offer uniform benefits tied to four levels of value. The four levels of coverage vary depending on how much the insurer pays. Under the Bronze level of coverage, the health plan will pay 60 percent of the covered benefits for a standard population. Under the next level, Silver benefits are actuarially equivalent to 70 percent of full value. The next level, Gold, benefits are actuarially equivalent to 80 percent of full value, and under the last level, Platinum, benefits are actuarially equivalent to 90 percent of the full value. Qualified health insurers must offer at least one plan at the Silver level and one plan at the Gold level. Plans may also offer catastrophic coverage to enrollees under 30 years of age or those who otherwise would be exempt from the requirement to purchase coverage because the premium exceeds 8 percent of income. These plans will offer less coverage but at a lower premium.

### Subsidies Available in the Exchange

Subsidies to purchase health insurance in the Exchange are available to low and moderate income families who do not have an offer of affordable health insurance from their employer and who have incomes between 100 percent and 400 percent of the federal poverty level (FPL). These subsidies are to offset premium costs and are in the form of refundable and advanceable tax credits. A refundable tax credit is one that is available to individuals even if the individual does not have any tax liability. An advanceable tax credit allows a person to receive assistance at the time they purchase health insurance rather than paying the premium out-of-pocket and waiting to be reimbursed when they file their annual tax return. . The premium subsidies are tied to the second lowest cost Silver plan in the Exchange and will be set on a sliding scale so that the premium contributions by families are limited to percentages of income for specified income levels. A silver plan is a plan that provides the essential benefits and has an actuarial value of 70 percent. A 70 percent actuarial value means that on average the health plan will pay 70 percent of the cost of covered benefits for a standard population of enrollees.

As revised by the recent Supreme Court decision on the Affordable Care Act, states now have the option of extending coverage in Medicaid to most people with incomes under 138 percent of the federal poverty level. For individuals not eligible for Medicaid premium subsidies are available in the Exchange. People with incomes up to 250 percent of the FPL are also eligible for coverage with lower deductibles and copayments.

## Insurance Coverage Churn

The Affordable care Act will extend health insurance coverage through the expansion of Medicaid and by offering subsidized health insurance to families with incomes up to 400 percent of the federal poverty level in the federally facilitated exchange in 2014. Eligibility in both Medicaid and the subsidized federally facilitated exchange is affected by changes in income as well as family composition. In the exchange, subsidies are determined by a linear sliding scale percentage of the taxpayer's household income and the premium of the second lowest cost benchmark silver plan. The ACA specifies applicable percentages that when multiplied by the taxpayer's household income determines the taxpayer's share of the premium for a benchmark health plan. This required share is subtracted from the adjusted monthly premium of the benchmark plan to determine the premium assistance amount. The percentage is computed first by determining the percentage that the taxpayer's income bears to the federal poverty level for the family's household size. The federal poverty line percentage is then compared to the six income categories and increases on a sliding scale in a linear manner.

For example, if a household's income is 275 percent of the federal poverty level for 2012, or $63,388, the percentage of the premium the household is responsible for is between 8.05 percent and 9.5 percent, based on the applicable percentages for poverty levels between 250 percent and 300 percent. Since this household's income is halfway between 250 and 300 percent, the applicable percentage is 8.78 percent, which is halfway between the initial percentage (8.05 percent) and the final percentage (9.5 percent) for households with incomes between the 200 and 300 percent threshold levels of poverty.

For taxable years beginning after December 2014, the percentages used to compute the subsidy may be adjusted to reflect rates of premium growth relative to income growth. Historically, premium growth has outpaced income growth. But for the taxable years after December 31, 2018, the percentages may be adjusted to reflect rates of premium growth relative to general inflation, or the Consumer Price Index.

An in-house analysis of Medicaid data over the last three years (2008-2010), shows that only 40 percent or so of Medicaid enrollees are continuously enrolled, indicating that enrollees leave Medicaid in rather large proportions. Newly enrolled policyholders account for approximately half of the total enrolled policyholders. Research shows that throughout the nation 43 percent of newly enrolled adults in Medicaid have disruptions in coverage within a year. Churning is the result of people moving into and out of Medicaid as the result of changing income and/or family size. Nationally, the average adult is enrolled in Medicaid for two-thirds of the year. Approximately 35 percent of all adults with family incomes below 200 percent of the federal poverty level will experience a move from Medicaid to the exchange or from the exchange to Medicaid within six months. Within one year, 50 percent will experience a move from Medicaid to the exchange or vice versa.

Changes in income or family status may trigger disruptions in plan and provider coverage, as well as a financial obligation to repay some or all of the subsidies received in the exchange. Further, research shows that disruptions in health insurance coverage adversely affect access, as well as increases administrative costs.

In a study by Benjamin Sommers and Sara Rosenbaum published in Health Affairs (2011), national data was used to determine the frequency of income fluctuations over time among low-income adults. These income fluctuations would lead to changes in health insurance between Medicaid and insurance policies sold in the exchange. Risk factors were also identified.

Sommers and Rosenbaum found that a significant number of families will experience income changes sufficient enough to move them across the "Medicaid-exchange market divide." Nearly 24 percent of the adults studied experienced at least two eligibility changes within one year sufficient enough to move them in and out of the 138 percent of poverty level Medicaid-exchange divide. Within two years, 39 percent would have experienced at least two income eligibility changes. By the end of four years, less than one-in-five adults initially eligible for Medicaid will have been continuously eligible, and only three-in-ten adults eligible for subsidies in the exchange would have been continuously eligible. Also possible is that some low-income adults may have incomes low enough to exempt them from the insurance mandate altogether. Income changes were most prevalent for young adults and the more educated. The authors identify several policy options to mitigate churn. These options are summarized below.

***Table 5.1: Policy Options to Mitigate Churn***

| Policy Objective | Possible Strategies |
|---|---|
| Reduce frequency of eligibility changes | Guaranteed eligibility periods with annual redetermination periods |
| Support services | Use real time reporting of income changes, clarify that changes in income and family status will change premium eligibility in exchange, extend Medicaid time period coverage or make exchange plans retroactive |
| Mitigate coverage differences between Medicaid and exchange plans | Ensure conformance of Medicaid benchmark coverage to essential benefits in exchange |
| Align markets and provider networks | Certify products to operate in both Medicaid and exchange |
| Monitor access and quality of care | Programs to assess underservice, continuity of care |

See "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges," Benjamin Sommers and Sara Rosenbaum, Health Affairs, February 2011.

A follow-up study by Ann Hwang, Sara Rosenbaum, and Benjamin Sommers (Health Affairs, June 2012) analyzed data from the 2008 panel of the Survey of Income and Program Participation and found that churn between low-income people between Medicaid and the exchanges could be reduced by 4 percent simply by increasing the Medicaid eligibility threshold to 200 percent of the federal poverty level from 138 percent of the federal poverty level. Not only would the rate of churn be reduced somewhat, low-income families would be less likely to be subject to recouping of federal tax credits. The authors note however that churning rates would still remain high, and that mitigating steps such as offering the same health plans in both Medicaid and the exchanges, and implementing policies to facilitate smooth transitions between programs, would still be needed.

Another potential source of churn is the way credits and cost-sharing subsidies are tied to income levels under the ACA. The income basis for advance credits and cost-sharing subsidies is modified adjusted gross income using the applicant's most recent federal tax year. This presents challenges to properly determining eligibility since for many exchange enrollees income tax filings from several years prior to enrollment may be used for eligibility determination. Income fluctuations are common among lower income individuals. This may lead to over-subsidizing some, under-subsidizing others. Medicaid eligibility under the ACA will use one month of current income instead of annual modified adjusted income. In a study by Graves (John Graves, "Better Methods Will Be Needed to Project Incomes to Estimate Eligibility for Subsidies in Health Exchanges," Health Affairs, Number 2, 2012) one-third of people initially judged to be below the Medicaid income threshold will "churn" into the Exchange and be eligible for subsidies. An additional 12 percent of the Exchange eligible population would be incorrectly judged to be ineligible for the subsidies. For individuals and families above 400 percent of the federal poverty level, approximately 3 percent could falsely be eligible for tax credits at the time of application. The final result is that a significant percentage of families may be judged ineligible for the Exchange subsidies when in fact they are eligible, and a much smaller percentage judged could be eligible for the subsidies when in fact they are ineligible, all due to changes in income at the time of application.

Massachusetts has studied the churn between its subsidized insurance market (Commonwealth Care) and its Medicaid program (MassHealth). Both MassHealth and CommCare have similar plan offerings and provider networks. But as individuals transition from MassHealth to CommCare, 43 percent were not enrolled after 90 days, compared to only 4 percent of those transitioning from CommCare to MassHealth.

Aside from the churn likely between Medicaid and families receiving tax credits in the exchange, churn is also possible between those with employer-sponsored insurance (ESI) and the exchange. Individuals not eligible for minimum essential coverage under an employer group health plan are able to purchase health insurance in the exchange. An individual is eligible for minimum essential coverage only if the group health plan is affordable and provides a minimum actuarial value. Employees who are offered such coverage from an employer are not eligible for the premium tax credit in the exchange. However, an employee who is enrolled in an eligible employer-sponsored health plan is not eligible for the premium tax credit even if the plan is unaffordable or does not provide minimum actuarial value. The affordability test for the premium tax credit is based on the cost of self-only coverage. The employer-sponsored health plan is affordable if the required contribution by the employee for a self-only plan does not exceed 9.5 percent of the taxpayer's household income.

Whether or not employers drop employer-sponsored insurance for any kind of alternative is first a matter of why firms offer health insurance at all. Many workers prefer some of their compensation in the form of health benefits. Health insurance benefits when provided by the employer are not subject to income or payroll taxes. Employer-sponsored insurance is also beneficial for many employees since the individual market can be expensive for unhealthy or older workers. Employers also may decide to provide coverage simply because it is an expectation in their industry.

Whether or not employers will drop employer-sponsored health insurance and instead send their employees to the health exchanges is a topic of debate. While larger employers, those with 50 or more employees, would face fines for not providing coverage, those fees would be substantially less than the cost of providing health insurance. Presumably however, wages would have to increase to offset the loss of health insurance benefits, mitigating some of the advantage for employers to end employer-sponsored health insurance coverage. This would be true too for smaller employers who presently offer health insurance benefits.

Several components of the ACA are likely to affect the health insurance decisions of small firms. Small firms are more likely to benefit from the Medicaid expansion and the introduction of the federally facilitated exchange in 2014. By expanding Medicaid eligibility to 138 percent of the federal poverty level ($31,809 for a family of four in 2012) and offering tax credits for health coverage in the exchange to families with household incomes up to 400 percent of the federal poverty level ($92,200), low-income workers are expected to benefit.

The Urban Institute has found however generally favorable impacts on small firms and their workers as a result of provisions in the ACA. Using their Health Insurance Policy Simulation Model (HIPSM), the Urban Institute modeled the cost of providing health insurance coverage through the options available in the ACA with any penalties firms could face if they employed 50 or more employees, or for not offering health insurance or offering unaffordable health insurance to their employees. Overall, they found that small firm costs would decline by nearly 9 percent as the result of the ACA, primarily though reduced marketing and administrative costs. Further, the savings to small firms would be heavily concentrated among those with fewer than 50 employees. Offer rates would increase by 10 percent

among small firms under the ACA, since it would be less expensive for small firms to offer coverage to their employees. For firms with fewer than 10 employees, offer rates pre ACA go from 35 percent to 40 percent post ACA, an increase in the rate for offering insurance of 14 percent. Key to this finding however is the assumption that small firms would apply for the tax subsidies available to firms with fewer than 25 employees. Nationally, the number of small firms claiming this credit has been dismal at best.

Among firms with 50 to 99 employees, the Urban Institute found almost no change in the number of employees covered by employer-sponsored insurance. A possible exception however in employer-sponsored health insurance coverage is some employers with lower income workers may find it cost disadvantageous given the assessments for firms with more than 50 workers.

The May 2011 Lockton Employer Health Reform Survey found that 18 percent say they will consider terminating group health insurance coverage. But also in the survey were several responses on why employers would continue to provide employer-sponsored health insurance. Almost nine in ten employers that responded to the survey stated that they will continue to use health insurance benefits as an attraction and retention tool, 30 percent expressed concern that employees would have to pay considerably more for health insurance if instead they turned to the exchange for coverage, and 26 percent did not wish to deal with the penalties if they terminated coverage. Locton estimates that employees would face premium hikes of 79 to 125 percent if they lose employer coverage and instead purchase coverage in the exchange.

Quite different results were reported by McKinsey and Company in their 2011 survey of 1,300 employers. Nearly half of the employers surveyed say they will definitely or probably pursue alternatives to ESI after the exchanges take effect in 2014. Dropping health insurance coverage all together is only one of the options, the others include providing health insurance as a defined contribution model, or offering it only to certain individuals. Over 30 percent state they will definitely or probably drop coverage after 2014.

Avalere Health released a study in June, 2011 that predicts employer-sponsored health insurance will remain fairly stable after the exchanges are implemented in 2014. Large employers, whose employment exceeds that of smaller firms, will continue to offer health insurance, while smaller employers may begin offering health insurance via the exchanges.

As evident in the discussion above, whether or not employers drop employer-sponsored insurance is estimated based on employer surveys and/or modeling approaches. Problems emerge with respect to both approaches. First, with employer surveys, there are conflicting findings. In a survey conducted by Mercer, 9 percent of the firms surveyed, those with more than 500 employees, stated they were likely to drop employer-sponsored insurance after 2014. ("Employers Accelerate Efforts to Bring Health Care Costs Under Control," November 16, 2011, www.mercer.com/press-releases/1434885.) McKinsey and Company, discussed earlier, reported 30 percent were likely to drop coverage, and the proportion increased to more than 50 percent among those firms with a high level of awareness of the ACA's provisions. ("How U.S. Health Care Reform Will Affect Employee Benefits," McKinsey Quarterly, June, 2011.) Another survey by the International Foundation of Employee Benefit Plans found that up to 3 percent planned to eliminate ESI for active employees. ("New Survey Examines Employer Reactions to Health Care Reform One Year Later," June, 2011, http://www.ifebp.org/AboutUs/PressRoom/Releases/pr_060811.htm). A survey by Locton found that 19 percent of the employers surveyed were considering dropping ESI. ("Health Reform Challenges

Employers' Ability to Control Costs, Maintain Robust Plans, Survey Show," June, 2011, www.locton.com/Resource_/PageResource/MKT/Employer%20Health%20Reform%20Survey%20Results%202011--FINAL.pdf.) But according to the Congressional Budget Office, it is doubtful that any survey conducted prior to 2014 can provide accurate predictions of future employer decisions since responses to surveys basically have no consequences, do not require detailed analysis, and are usually based on very limited or uncertain information about the ACA and the future market for health insurance.

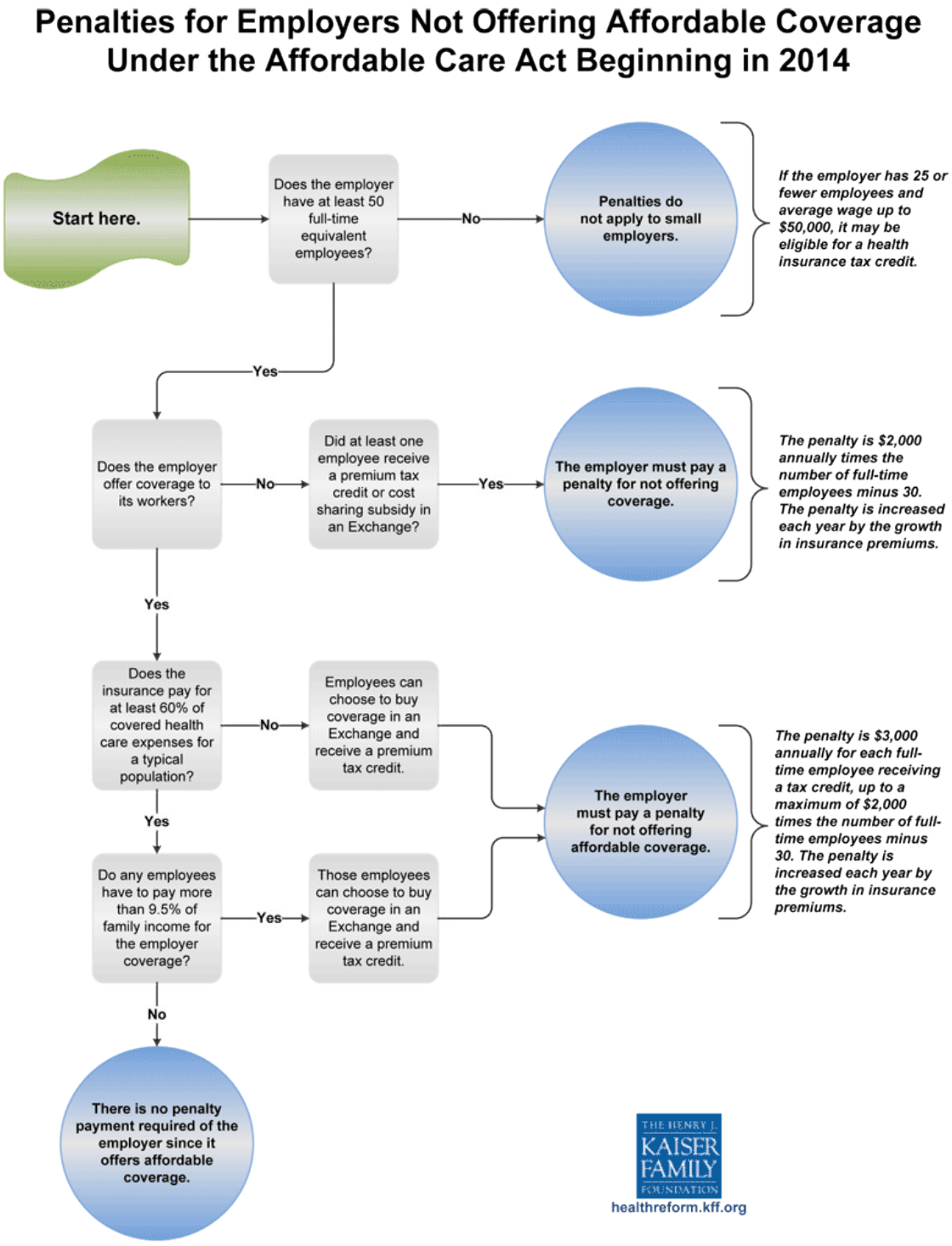
Modeling approaches to employer reactions to the ACA are relatively more consistent and similar in findings. Studies by the Office of the Actuary, Centers for Medicare and Medicaid Services, the Urban Institute, The Lewin Group, Rand, and the Congressional Budget Office and Joint Committee on Taxation all predict small to modest changes in employment based insurance. But despite similar conclusions, models of the health insurance market face considerable challenges. These models generally predict changes in behavioral responses to small or modest changes in incentives. The changes in incentives under the ACA however are wide and considerable in magnitude.

In considering how Montana employers may respond to incentives under the ACA and whether they would drop ESI for their employees, several factors must be considered.

The ACA will change incentives for both employees and employers. These incentives are:

1. In 2014, workers with family incomes below 138 percent of the federal poverty level will be eligible for Medicaid coverage, with little or no deductibles and co-pays. For a family of four, this is projected to be around $33,000 in 2014. This level is $31,809 today.
2. Workers with incomes above 138 percent but up to 400 percent of the federal poverty level will be eligible for significant subsides if their employers do not offer coverage or the employer health insurance is unaffordable or below 60 percent in actuarial value. Families with incomes of 150 percent are responsible for only 4 percent of the cost of the second lowest cost silver plan, while families with incomes of 400 percent of the federal poverty level will pay only 90.5 percent of the cost of the second lowest cost silver plan.
3. For larger firms with a mix of lower and higher income workers, not all employees will be eligible for Medicaid, CHIP, or exchange subsidies if their employer does not offer coverage. Further, it is unlikely firms will offer coverage only to higher paid workers since nondiscrimination provisions in the Internal Revenue Code and the Public Health Service Act discourage excluding certain groups from health insurance benefits.
4. There should be greater demand for health insurance since individuals face penalties for non-compliance. This should increase the incentive for employers to offer health insurance.
5. At least until 2016, smaller employers can qualify for federal tax credits. To date, however, the number of eligible firms applying for this credit has been dismal at best.
6. The ACA does not require businesses to provide health insurance to their employees. But for larger firms, those with more than 50 employees, and who employ a majority of the Montana workforce, penalties are imposed if any of its employees receives a subsidy in the exchange, regardless of whether the firm offers coverage or not. For firms offering coverage, the penalty is imposed if the actuarial value is less than 60 percent or if an employee has to pay more than 9.5 percent of family income for the employer coverage. The Kaiser Foundation provides a quick schematic on the employer penalties imposed, and is presented below.
7. For employers who do choose to drop employer-sponsored insurance, employees will expect cash compensation in the form of higher wages.

*Figure 5.1:*


Penalties for Employers Not Offering Affordable Coverage Under the Affordable Care Act Beginning in 2014
Start here.
Does the employer have at least 50 full-time equivalent employees?
No
Penalties do not apply to small employers.
If the employer has 25 or fewer employees and average wage up to $50,000, it may be eligible for a health insurance tax credit.
Yes
Does the employer offer coverage to its workers?
No
Did at least one employee receive a premium tax credit or cost sharing subsidy in an Exchange?
Yes
The employer must pay a penalty for not offering coverage.
The penalty is $2,000 annually times the number of full-time employees minus 30. The penalty is increased each year by the growth in insurance premiums.
Yes
Does the insurance pay for at least 60% of covered health care expenses for a typical population?
No
Employees can choose to buy coverage in an Exchange and receive a premium tax credit.
Yes
Do any employees have to pay more than 9.5% of family income for the employer coverage?
Yes
Those employees can choose to buy coverage in an Exchange and receive a premium tax credit.
The employer must pay a penalty for not offering affordable coverage.
The penalty is $3,000 annually for each full-time employee receiving a tax credit, up to a maximum of $2,000 times the number of full-time employees minus 30. The penalty is increased each year by the growth in insurance premiums.
No
There is no penalty payment required of the employer since it offers affordable coverage.
THE HENRY J. KAISER FAMILY FOUNDATION
healthreform.kff.org

There are reasons, however, to support the possibility that firms will abandon employer-sponsored insurance. These reasons include:

1. Workers can purchase health insurance in the exchange beginning in 2014, which could reflect lower premiums since it is designed to be a competitive marketplace.
2. Firms with workers whose family incomes are 400 percent of the federal poverty level or less qualify for substantial premium subsidies and cost-sharing assistance.
3. For firms employing more than 50 employees, the penalties firms will face are significantly smaller than the cost of providing insurance, particularly since the first 30 employees may be excluded from the penalty.
4. For smaller employers, the tax credits available are temporary, time consuming, and burdensome.

Central, however, to whether firms will drop employer-sponsored insurance is the proportion of its employees who will be eligible for Medicaid and CHIP, or the exchange subsidies relative to the employer's workforce as a whole. Employers must weigh the value of the tax exclusion benefit for employer-sponsored health insurance that is available to all employees against the value of the exchange subsidies, including Medicaid and CHIP that will be available to some of the employees. *The Montana businesses that choose not to offer health insurance coverage because of the ACA will most likely be the smaller employers and employers with predominately lower-wage workers who will be eligible for Medicaid, CHIP, and the exchange subsidies.*

For firms with higher wage workers, the advantages of obtaining health insurance in the exchange are negligible since higher wage families will receive smaller subsidies, but more importantly, lose the larger tax subsidies for insurance obtained through their employer due to the tax advantaged treatment of benefits. In addition, the increased compensation likely to follow should a firm drop its employer-sponsored health insurance will push families into higher percentages of the federal poverty level, reducing the exchange subsidies or possible eliminating them altogether.

Further complicating the analysis is the premium to be charged in the exchange relative to the premiums employers will face in the group market. The Congressional Budget Office expects the premium for the second lowest cost plan (silver plan) to be about 80 percent of the premium employers will pay for employer-sponsored health insurance in the group market. The differential is primarily due to employer-sponsored plans will have an actuarial value of 85 percent compared while silver plans are required to have actuarial values of only 70 percent. This lower actuarial value for silver plans will also increase expected out-of-pocket spending for people in the exchange relative to employer-sponsored plans. Out-of-pocket spending for silver plan beneficiaries is expected to be 50 percent of the out-of-pocket spending by employer-sponsored health insurance beneficiaries before taking into account the government subsidies.

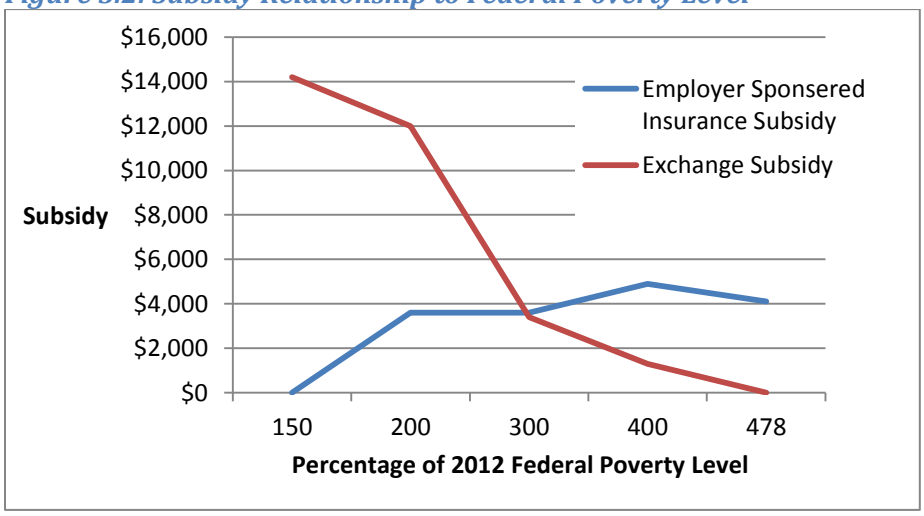
All taken together, the illustration below demonstrates the relationship between employer-sponsored incentives relative to the incentives provided to families in the exchange for a family of four, and based on 2012 federal poverty levels. Tax subsidies for employer-sponsored insurance include the employee's marginal federal and state tax rates, the employee's share of social security taxes (up to the limit of $110,100), and Medicare taxes.

*Table 5.2: Comparison of Employer-Based and Exchange Health Insurance Incentives*

| Modified Adjusted Gross Income | Percentage of 2012 Federal Poverty Level | | | | |
|---|---|---|---|---|---|
| | 150 ($35,000) | 200 ($46,000) | 300 ($69,000) | 400 ($92,000) | 478 ($110,000) |
| Employer-Sponsored Insurance (Premium = $12,600, out-of-pocket = $3,200) | | | | | |
| Average Marginal Tax Rate | 28.0 | 28.5 | 28.9 | 39.1 | 32.9 |
| Average federal and State Subsidies | $3,500 | $3,600 | $3,600 | $4,900 | 4,100 |
| Total Cost, including after tax premium and out-of-pocket costs | $6,700 | $6,800 | $6,800 | $8,100 | $7,300 |
| Exchange Coverage (Premium = $10,000, out-of-pocket = $6,400) | | | | | |
| Percentage of income required for second-lowest cost silver plan | 4.0 ($1,400) | 6.3 ($2,900) | 9.5 ($6,600) | 9.5 ($8,700) | 100.0 ($10,000) |
| Premium subsidy | $8,600 | $7,100 | $3,400 | $1,300 | $0 |
| Cost-sharing subsidies | $5,600 | $4,900 | $0 | $0 | $0 |
| Total Cost | $2,200 | $4,400 | $6,600 | $8,700 | $10,000 |
| Cost of Exchange Coverage – Cost of ESI | -$4,500 | -$2,400 | -$200 | $600 | $2,700 |

Using the federal poverty levels above and the premium and out-of-pocket costs expected under the ACA, it is readily apparent that firms with lower wage workers would stand to gain by buying insurance in the exchange. However, this analysis ignores the impact of increased compensation to the employee, which could conceivably move them into higher poverty level thresholds, reducing if not eliminating the premium subsidies available in the exchange. Obvious however is that for higher income families, the tax advantaged treatment of employer-sponsored insurance outweighs any benefits of buying lower cost policies in the exchange. The analysis above suggests that at approximately 300 percent of the federal poverty level the tax subsidies associated with employer-sponsored insurance outweigh the subsidies available in the exchange.

*Figure 5.2: Subsidy Relationship to Federal Poverty Level*



For firms contemplating dropping employer-sponsored insurance, the advantages and disadvantages of doing so will depend on the distribution of employee incomes. Unknown to the firm, however, is the families' adjusted gross incomes. Smaller firms would forego the tax advantages of employer-sponsored insurance, in addition to any tax credits they make take advantage of. Larger firms would face penalties should they forego employer-sponsored insurance and have a significant number of employees qualify for tax subsidies in the exchange.

The only consensus that can be gleaned from the literature review of various modeling scenarios is that there is a tremendous amount of uncertainty about how employers and employees will respond to the incentives and disincentives of the ACA. Where change is most likely to occur is in smaller firms with low-wage employees.

The number of low-wage workers in Montana is unknown. According to the Medical Expenditure Panel Survey (MEPS), Agency for Healthcare Research and Quality, in 2010 the number of private sector employees in Montana was 334,772. Of these 334,772 private sector employees, approximately 22 percent (74,000) were working for firms with fewer than 10 employees. Total private sector employees working for firms with fewer than 24 workers totaled 36 percent of total private sector workers, or approximately 122,000 workers. However, a majority of Montana's private sector workers (184,000) are employed by firms with more than 50 employees and therefore subject to the provisions of the ACA. The remainder, 151,000 workers, works for firms that are exempt from the requirements of the ACA, and are the most vulnerable to losing employer-sponsored health insurance.

Another way of estimating the working population more vulnerable to losing employer-sponsored insurance is to again use MEPS data to look at the number of employees working at establishment that offer health insurance and working in establishments that have at least 50 percent of their labor force earning less than $11.50 per hour, or $24,000 per year (110 percent of the 2010 federal poverty level for a family of four).

### *Table 5.3: Working Population Vulnerable to Losing Employer-Based Health Insurance from Medical Expenditure Panel Survey*

| Employee Classification | Total Number | Working at Establishments with >50% Low Wage |
|---|---|---|
| Private Sector | 334,772 | 113,521 |
| In establishments that offer health insurance | 246,727 | 62,323 |
| Eligible for health insurance in establishments that offer health insurance | 186,526 | 35,399 |
| Eligible and enrolled in health insurance in establishments that offer health insurance | 150,153 | 23,399 |

Source: Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality

There are just fewer than 350,000 employees in Montana working in the private sector. The private sector includes the self-employed with employees and the incorporated self-employed without employees. Of these 350,000 employees, about 74 percent work in establishments that offer health insurance, but only 56 percent are eligible for the health insurance. Ineligibility is often due to hours

worked and/or length of time with the employer. Of the 335,000 private sector employees, 45 percent are eligible and enrolled in the firm's health insurance plan. For private sector employees who work in firms with over 50 percent of the workforce earning less than $11.50 per hour, only 24,000 are eligible and enrolled in their employer's health insurance plan. This provides some insight as to the lower threshold of the number of employees who could end up in the exchange as employers drop coverage. The upper bound is most likely around 41,000, the number of workers who are employed by firms with fewer than 50 employees and who are eligible for and are enrolled in their firm's health insurance plan.

***Table 5.4: Working Population Vulnerable to Losing Employer-Based Health Insurance***

| | |
|---|---|
| Lower Threshold | 24,000 ± 5,749 |
| Upper Threshold | 41,000 ± 7,820 |

Source: Bureau of Business and Economic Research and Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality.

Rand Health used their Comprehensive Assessment of Reform Efforts (COMPARE) model to estimate the impact of the ACA on employer-sponsored insurance. Although Rand states there is considerable uncertainty surrounding their estimate, they predict 18,000 workers will end up in the exchange that previously had employer-sponsored insurance. Rand predicts that the nature of employer-sponsored insurance will change only slightly under the ACA, and that small employers are the most likely to opt for coverage in the exchange. Rand attributes this stability in the employer-sponsored market to factors that will increase the demand for employer-sponsored insurance more than offsetting the factor which may decrease it. Specifically, the individual mandate and the employer penalties for not offering coverage will outweigh the decrease in demand for employer-sponsored coverage due to exchange subsidies available to lower-income workers.

Finally, a significant proportion of workers with employer-sponsored health insurance coverage will not qualify for Medicaid, CHIP, or the exchange subsidies. Although the median household income for Montana families with four members is 300 percent of the federal poverty level, several factors will limit the number of households qualifying for Medicaid, CHIP, and the exchange subsidies. Families with workers in the household tend to have higher incomes than families without workers. Second, family income is expected to increase faster than the federal poverty level, since poverty levels are indexed to the consumer price index for all urban consumers. Finally, higher-income workers are more likely than lower-income workers to work for a firm that offers health insurance, and are more likely to take up health insurance coverage when offered. For full-time year-round workers with family incomes above 200 percent of the federal poverty level, 90 percent are covered by private insurance. (see William Carroll and G. Edward Miller, Health Insurance Status of Full-Time Workers by Demographic and Employer Characteristics, 2008, Statistical Brief No. 317, http://www.meps.ahrq.gov/mepsweb/data_files/publications/st317/stat317.pdf.)

## Health Status of Enrollees in Silver Plan

Cost-sharing subsidies under the ACA are only available to families below 250 percent of the federal poverty level, or $57,625 for a family of four and who enroll in one of the silver plans in the exchange. Overall, individuals in the lower-income groups tend to be in worse health than their counterparts in higher-income groups. Self-reported health status is a widely used measure of people's health-related quality of life. There is a strong correlation between self-reported health status and mortality that has been well documented in the literature. Hence self-reported health status is a reliable measure of current health.

Table 5.5 below indicates that previously uninsured enrollees in the Silver plan who are most likely to be eligible for cost-sharing subsidies will on average be sicker than higher-income uninsured who buy in the Exchange.

### *Table 5.5: Health Status of Potential Exchange Silver Plan Enrollees*

| Family Income % of FPL | Eligible for Exchange Credit? | Eligible for Cost Sharing Subsidy (if in Silver Plan) | Fair or Poor Health, Uninsured Adults | |
|---|---|---|---|---|
| | | | 30-49 Years Old | 50-64 Years Old |
| < 138% | Medicaid | Medicaid | 32% | 28% |
| 138% - 250% | Yes | Yes | 8% | 30% |
| 250% - 400% | Yes | No | 0% | 0% |
| 400%+ | No | No | 0% | 0% |

Source: Bureau of Business and Economic Research, 2011 Household Health Insurance Survey.

The Robert Johnson Wood Foundation used data from the Behavioral Risk Factor Surveillance System (BRFSS) to estimate the proportion of the 18+ population living in households that report fair or poor health. Based on BRFSS data over a seven year period, approximately 13 percent (± 6 percent) of the population living in households in Montana report they are in fair or poor health. This is well above the national average of 10 percent. Applying the percentage of adults in Montana reporting fair or poor health to the three-year estimates for the Montana civilian population living in households that are uninsured, between 11,000 and 33,000 uninsured who are in fair or poor health may end up in the Exchange.

## The Federally Facilitated Exchange Population Eligible for Subsidies and Cost Sharing

The Federally Facilitated Health Exchange in Montana is intended to facilitate the purchase of health insurance by individuals and small employers. Although all legal residents may purchase their health insurance in the Federally Facilitated Exchange, sliding-scale federal subsidies, in the form of tax credits, will be available only for individuals with incomes between 138 percent and 400 percent of the federal poverty level. These subsidies are available to all residents with incomes below 400 percent of the federal poverty level, who are not Medicare or Medicaid eligible, and who do not have an affordable offer of health insurance from their employer. The federal premium subsidies are tied to the premiums of the second lowest cost silver plan to be offered in the Federally Facilitated Exchange. The subsidies decrease as incomes increase. These sliding-scale subsidies should result in Federally Facilitated Exchange enrollees spending anywhere from 4 percent to 9.5 percent of their household income on

health insurance premiums. In addition to health insurance premium subsidies, households with incomes less than 250 percent of the federal poverty level will receive subsidies for the cost-sharing component of their health insurance policy. These subsidies, along with the mandate that all individuals purchase health insurance or face a small penalty, will incentivize individuals to purchase health insurance in the Exchange.

The Congressional Budget Office estimates that 81 percent of individuals purchasing their own coverage in the Exchanges by 2019 will receive subsidies. This projected 2019 exchange population is relatively older, less educated, lower income, and more racially diverse than current privately-insured populations. The adults projected to be in the Exchange will be of worse health but have fewer diagnosed chronic conditions than the currently privately-insured populations, according to CBO estimates. Despite the fact that as the uninsured gain health insurance coverage medical spending may increase by up to 25-60 percent, the average annual medical expenditures for adults in the Exchanges is not expected to be significantly different than that of the current adult population with employer-sponsored insurance or the current population purchasing health insurance in the non-group markets.

The Congressional Budget Office projects the 2019 Health Insurance Exchange population to consist of five distinct groups. The vast majority of the Exchange population will consist of the previously uninsured (67 percent). Around 15 percent will consist of individuals who lose their employer-sponsored health insurance, followed by 8 percent who lose their Medicaid coverage because their income is above 138 percent of the federal poverty level. The remaining Exchange population is expected to consist of individuals who transition from non-Exchange non-group insurance and those who previously had employer-sponsored insurance but paid a family premium above 9.5 percent of total family income.

## Montana's Federally Facilitated Exchange Population

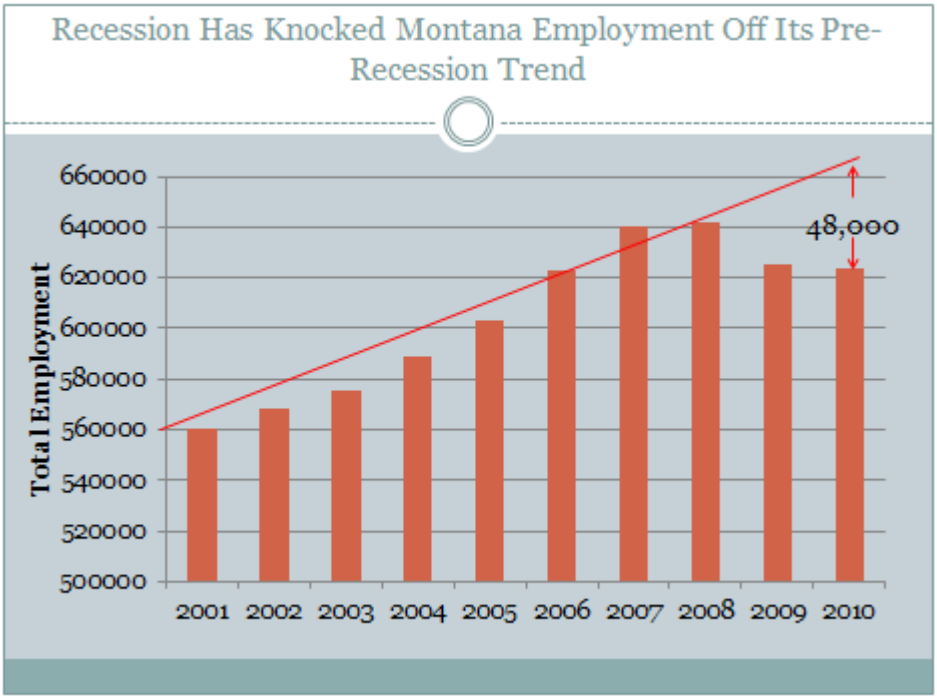
How individuals respond to the incentives and penalties of the Affordable Care Act is subject to speculation. Beginning in 2014, the uninsured that opt out of purchasing health insurance will face penalties of $95 per year, or up to 1 percent of income, whichever is greater. Two years later, the penalty increases to $695 per year, or 2.5 percent of income, whichever is greater. The requirement for coverage can be waived for several reasons, including financial hardship or on religious grounds.

Nationally, almost 70 percent of the exchange population is expected to come from the uninsured population. Assuming this proportion holds true for Montana, and that all uninsured enter the exchange instead of paying the penalty, Montana's Federally Facilitated Exchange (FFE) population could reach 278,000.

Twenty percent of Montana's non-institutionalized population lacks health insurance of any kind. Eighty percent of the uninsured (156,000) have incomes below 400 percent of the federal poverty level. Approximately 30 percent (60,000) are below the threshold for the Medicaid expansion under the Affordable Care Act. Another 75,000 to 91,000 are underinsured, defined as having per person deductibles equal to or exceeding 5 percent of family income or health policy premiums that exceed 9.5 percent of family income.

How many Montanans end up in the Federally Facilitated Exchange is in part directly dependent on the economy and the speed by which economic recovery, and jobs, rebound in Montana. In 2010, Montana was still 48,000 jobs short of its pre-recession trend in job growth.

*Figure 5.3:*




Source: Bureau of Business and Economic Research.

BBER estimates the potential Federally Facilitated Exchange population that will be eligible for subsidies and cost sharing based on three independent populations; the uninsured between 138 percent and 400 percent of the federal poverty level, those with individual insurance, and those with employer-sponsored insurance who have premiums that exceed 9.5 percent of income. In addition, a subset of the employer-sponsored insurance group may be small employers who choose to use the Federally Facilitated Exchange instead of employer-sponsored insurance. Although the number of employees that may fall into this group is substantial, 24,000 to 41,000, we exclude them since many will be already included in the group with premiums that exceed 9.5 percent of income.

Approximately 195,000 Montanans, or 70 percent of the Federally Facilitated Exchange population, may qualify for federal subsidies and cost sharing assistance. The table below summarizes the population estimates both for the Federally Facilitated Exchange and the number of people who could potentially qualify for subsidy and cost-sharing assistance.

*Table 5.6: Estimated Population in Federally Facilitated Health Insurance Exchange*

| | |
|---|---|
| Uninsured between 138% and 400% FPL | 96,000 |
| Individual Insurance and < 400% FPL | 55,000 |
| Employer-Sponsored Insurance but Premium > 9.5% Income | 44,000 |
| Total FFE Population with Subsidies and Cost Sharing | 195,000 |
| Total FFE Population | 278,000 |

Source: Bureau of Business and Economic Research, 2011 Household Health Insurance Survey.

The main factors driving the number of subsidized individuals in the FFE are Montana's relatively low wages, the uninsured rate, the preponderance of small employers, and the proportion of private sector establishments that offer employer-sponsored insurance.

Montana's per capita personal income ($37,000) is 88 percent of national per capita income (Bureau of Economic Analysis, 2010 data). Montana's private sector wages are 71 percent ($33,000) of the national average wage rate, $46,000 (Bureau of Labor Statistics, 2010 data). In addition, 6 in 10 Montana families have incomes under $75,000, or 340 percent of the federal poverty level for a family of four, compared to only 59 percent nationally (U.S. Census Bureau, 2010).

With respect to the number of people without health insurance, Montana is well above the proportion nationally. Just over 20 percent of Montana's non-institutionalized population is living without health insurance compared to just over 17 percent nationally.

Small business is big business in Montana. Although the proportion of total firms with fewer than 20 employees is the same for both Montana and the U.S. (90%), the proportion of total employees employed by these firms is quite different. Small employers nationally, those with fewer than 20 employees, employ only 18 percent of total employment, while Montana's small businesses employ 31 percent of total employment in the state. (Statistics of U.S. Businesses, U.S. Census Bureau, 2009 data). The self-employed are also more prevalent in Montana. The self-employed are less likely to have health insurance since they cannot benefit from the advantages that accrue to larger risk pools. In Montana, nearly three in ten employees are proprietors, compared to two in ten nationally. (Bureau of Economic Analysis, 2010 data).

Finally, another factor contributing to a higher proportion of Montanan's qualifying for subsidies in the FFE is the nature of employer-sponsored insurance. Nationally, 54 percent of private U.S. firms offer health insurance to their employees, covering nearly nine in ten private sector workers who have insurance. In Montana however only 43 percent of private sector firms offer health insurance to their workers, covering almost three-fourths of total private sector workers with insurance. (Agency of Healthcare Research and Quality, 2010 data).