
Final Report to the Secretary

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Report to:



**Montana Department of
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EXECUTIVE SUMMARY

Prior to the receipt of the State Planning Grant (SPG), Montana had to rely on data through federal or private efforts to describe its uninsured population. In July of 2002, the Montana Department of Public Health and Human Services was awarded a planning grant from the Health Resources and Services Administration (HRSA) in order to conduct an in-depth analysis of Montana's uninsured population, obtain Montana specific data about the uninsured and develop a six-year strategic plan to provide the uninsured access to affordable health insurance coverage. This report presents the results of the project.

Governor Martz appointed a twenty member SPG Steering Committee to guide the project development and implementation. Representatives include individuals from across the state representing a cross section of key public and private stakeholders, including business and industry, minority populations, nonprofit groups, health care delivery professionals, the health insurance sector, state agencies and consumers. In addition, three work teams assisted the Department of Public Health and Human Services, the Grant Director, and the researchers in various aspects of the grant projects. Work teams supporting the project include the Data Team, the Safety Net Team, and the Coverage Options Team.

The Montana Department of Public Health and Human Services contracted with the University of Montana's Bureau of Business and Economic Research to conduct two surveys: the Montana Household and the Montana Employer Survey. These surveys were developed in consultation with the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota and with the assistance of the Data Team. The University of Montana also completed six focus groups and 30 key informant interviews.

Montana has historically had one of the higher rates of uninsurance in the nation. Depending on the source of data, current estimates of uninsurance in Montana range from 14 percent of the population to 19 percent. This report presents findings from the 2003 Montana Health Insurance Survey, the largest and most comprehensive survey on health insurance that has been conducted in Montana to date. Consistent with earlier studies, the survey finds a relatively high overall rate of uninsurance in Montana, with 19 percent of the population uninsured at the time of the survey.

Because of the way the 2003 household survey was designed, the state is able for the first time to make detailed estimates of uninsurance rates for various population groups within the state, such as rates by age or race and ethnicity. Although the overall rate of uninsurance in Montana is high, the survey finds substantial variation in uninsurance rates within various population groups:

- Young adults, particularly between the ages of 19 and 25, were more than twice as likely to be uninsured than the general population.
- Montana's American Indian populations experience uninsurance at rates that were two times higher than the statewide average.
- Insurance status also varies by income level. Montanans who have incomes below the federal poverty level are about 2 times more likely to be uninsured than the statewide average.

The 2003 Montana Household Survey on Health Insurance asked specific questions about other issues of interest to policy makers, such as medical debt, insurance affordability, and individual insurance policies and found that:

- Uninsured persons were more than 3 times as likely to have medical debt (21%) compared to those with health insurance (7%);
- Average medical debt for uninsured persons was \$2,500 or higher and represented as much as 16 percent of household income;
- Being uninsured is not voluntary, as ninety percent of the uninsured reported being unable to buy health insurance after paying for food, clothing, and shelter;
- Uninsured persons can afford to pay low monthly premiums that average about \$96 per month;
- Montana's uninsured did have coverage in the past with only 20 percent reporting no previous health insurance;
- Deductibles were high, averaging more than \$3,000 for persons with individual insurance policies; and
- Individual insurance policies take a big bite of monthly household income, ranging from 21 percent for people under 200 percent of the poverty level and 8 percent for persons more than 200 percent above the poverty level.

A key objective of the employer survey was to fill in gaps in our knowledge about Montana business offering of health insurance to their employees. Major findings for Montana employers include:

- Roughly 40 percent of small firms with 10 or fewer employees offer health insurance;
- One-third of small firms offering health insurance offer it to all employees;
- More than 90 percent of large firms with at least 100 employees offer health insurance;
- Only half of large firms offering health insurance offer it to all employees;
- High premiums were cited by 81 percent of Montana firms not offering health insurance as the major reason why they do not offer insurance;
- More than 80 percent of employers cite higher prices for hospital care, prescription drugs, physician care, and malpractice insurance as major reasons for health insurance premium increases;
- Less than 30 percent of firms not offering insurance thought they would provide insurance under a tax credit policy; and

- More than 40 percent of firms not offering insurance indicated they would ‘absolutely’ participate in a small business purchasing pool.

SECTION 1. UNINSURED INDIVIDUALS AND FAMILIES

Historically, Montana has had one of the highest rates of uninsurance in the nation. Depending on the source of data, current estimates of uninsurance in Montana range from 14 percent of the population to 19 percent. In surveys that allow for cross-state and national comparisons of uninsured rates, Montana has always ranked near the bottom in rates of health insurance coverage.

In the summer of 2002, the Montana Department of Public Health and Human Services was awarded a grant from the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services to study the issue of uninsurance in Montana. HRSA's State Planning Grant (SPG) program exists to provide support to states to conduct research and analysis of insurance coverage issues, and to provide policy options for reducing uninsurance. Montana was one of several states originally awarded grants under this program in the 2002 funding round. Although the State already had some knowledge about its uninsured population from national estimates, the HRSA grant provided an opportunity to fill in gaps in the State's knowledge about the uninsured. In particular, little detail was known about disparities in health insurance status by race and ethnicity, and little information existed about how health insurance status varies by age and income. Montana's data collection activities included a household survey, an employer survey, key informant interviews, and focus groups.

From Fall 2002 through Summer 2003, the Montana Department of Public Health and Human Services, in collaboration with the University of Montana's Bureau of Business and Economic Research conducted two surveys, the 2003 Montana Health Access Survey and the Montana Employer Survey. These surveys were designed to help fill in some major gaps in the State's knowledge about its uninsured population.

In addition to the Household and Employer Surveys, Montana's State Planning Grant was also used to conduct key informant interviews and focus groups. The Director of Community Research at the University of Montana Bureau of Business and Economic Research, conducted a series of 30 interviews statewide with "key informants" who were professionals having contact with many people who are either uninsured or at high risk of becoming uninsured. The key informants included health care providers, clinic and hospital administrators, private businesses, farmer and rancher organizations, insurance companies, community leaders and advocates.

Focus groups on health insurance were conducted among four consumer groups and two groups of employers by two professional qualitative data researchers from Montana State University-Billings and the University of Montana-Missoula. One particular goal of the consumer focus groups was to obtain qualitative information about attitudes toward, problems with, and knowledge of health insurance that is difficult to obtain in a telephone survey.

The consumer focus groups were geographically representative of rural and urban Montana, with consumer group sessions in Miles City, Billings, Polson, and Havre. Two additional focus groups were conducted: one with employers in Missoula representing professional services firms such as finance, real estate, health care, consulting, and engineering businesses; and the other with a group of Miles City employers in the hospitality sector composed of motel, casino, gas station, restaurant, and convenience store firms.

All of the SPG data collection activities have contributed to a deeper understanding of how health insurance coverage varies among different population groups in Montana, what barriers exist that prevent the uninsured from getting coverage, and how this affects their ability to access the health care system.

This chapter of the report primarily presents the statewide findings of the 2003 Montana Health Access Survey. First, it examines the overall rate of uninsurance. Next, it presents information describing the characteristics of the uninsured in Montana. Finally, it provides an analysis of potential sources of health insurance coverage for the uninsured.

1.1 What is the overall level of uninsurance in Montana?

Overall, 19 percent of Montanans, or approximately 173,000 people, were uninsured at the time of the 2003 survey. Slightly more than half (51%) of all Montanans had employer-based health insurance. Individual health insurance policies accounted for 9 percent of the state's population. Medicaid and the Children's Health Insurance Program (CHIP) accounted for 6 percent, a rate that was lowered somewhat by counting persons who were dual enrolled in Medicare and Medicaid as being Medicare insured. Medicare covered 15 percent of Montana's population. Uninsured rates for the non-elderly population are a more accurate measure of the health insurance gap in Montana than uninsured rates for the entire population since nearly everyone 65 years of age and older has health insurance through Medicare.

Because all elderly Montanans are covered by Medicare, Montana's uninsured rate is higher when the elderly are taken out of the sample and population numbers. Twenty-two percent of Montana's non-elderly population does not have any kind of health insurance—public or private. Employer-based insurance covers 58 percent of Montanans under 65 years of age compared to a national rate of 67 percent. Individual health insurance coverage is 11 percent in Montana compared to a national rate of 7 percent. Medicaid and CHIP account for 10 percent of the state's non-elderly health coverage.

1.2 What are the characteristics of the uninsured?

A profile of Montana's uninsured shows that they are most likely to

- be white (86% of the uninsured);
- be adults over 25 years of age (67 % between the ages of 26 and 64);
- have a high school education or higher (92 %);

- be single or divorced/separated (31% and 15% respectively, for a combined 46%);
- have household incomes more than twice (over 200%) of the federal poverty level (45%); and
- be self-employed or employed by someone else (77%).

High proportions of Montana's uninsured are educated and older and have income levels considerably above the federal poverty level.

Household income is a major determinant of health coverage. About 43 percent of persons in households with incomes below the 2002 federal poverty level do not have health insurance coverage. The uninsured rate drops for the next bracket of 101 to 125 percent of the federal poverty level and then increases and remains high until household income levels are more than 200 percent of the federal poverty level. Persons living in households with more than two times the poverty level have a relatively low uninsured rate of 13 percent.

Health insurance rates among Montana residents vary considerably by age. The overall uninsured rate of 19 percent for all ages is significantly exceeded by the 39 percent rate for young people between 19 and 25 years of age. The next age group of 26 to 49 year olds has a rate of 24 percent while older Montanans between 50 and 64 years of age have an insured rate of 14 percent. Montana youth 18 years old and younger have an uninsured rate of 17 percent, one of the highest uninsured rates among children in the nation.

American Indians under sixty-five years of age have a 38 percent uninsured rate compared to a rate for a combined racial group of non-elderly whites and other of 20 percent. The Indian Health Service was not considered a source of health insurance since it is not available in all areas and its availability and level of service is contingent on federal government budget decisions.

Montana's uninsured rates of 21 percent in urban areas were slightly lower than the 23 percent rate in rural areas.

Uninsured rates varied over different employment status categories. The uninsured rate for self-employed was 24 percent compared to a 19 percent rate for employed persons. Unemployed persons had an uninsured rate of 41 percent. Full time students were uninsured at a rate of 27 percent. Disabled and retired persons had uninsured rates of 12 percent.

Almost 16 percent of the 22 percent uninsured rate for non-elderly Montanans represent the hard-core uninsured that were not insured all year. Another 5.7% were intermittently insured during the past 12 months but not at the time of the interview. Intermittent with current coverage is a third group representing 3.7% of the Montana's non-elderly population. The uninsured rate for the hard-core and the two intermittent categories represent a rate of persons 25.3 percent of non-elderly Montanans who were uninsured at

some point in the past year. One in four of every non-elderly Montanans in the state lacked health insurance at some time during the year.

A summary of Montana uninsurance rates along with 95 percent confidence intervals by population group is shown in Table 1-1.

Table 1-1. Summary of Montana Uninsurance Rates by Population Group, 2003

	<u>Uninsurance rate</u>	<u>95% Confidence Interval</u>
Total population (n=2,941)	19%	17 to 20%
Age		
0-18	17%	14 to 19%
19-25	39%	34 to 45%
26-49	24%	21 to 27%
50-64	13%	10 to 16%
65+	0.5%	0.1 to 0.9%
Population under age 65 (n=2,348)	22%	20 to 23%
Race		
White & other	20%	18 to 22%
American Indian	38%	31 to 45%
Residency		
Urban	21%	18 to 23%
Rural	23%	20 to 26%
Household income as a percent of Federal poverty guidelines		
<100%	43%	35 to 50%
101-125%	34%	26 to 41%
126-150%	48%	38 to 57%
151-200%	35%	29 to 40%
Over 200%	13%	12 to 15%
Employment Status		
Self-employed	24%	20 to 28%
Employed	19%	17 to 21%
Unemployed	41%	33 to 49%
Disabled	12%	4 to 19%
Full-time student	27%	18 to 35%
Retired	12%	4 to 19%

Rates are based on a weighted sample for the state of Montana. *Upper and lower bounds are for 95% confidence interval.

1.3 What population groupings were particularly important for Montana in developing targeted coverage expansion options?

Children. Montana has a longstanding commitment to improving children's access to health insurance. Prior to the passage of CHIP, Montana established the Caring Program for Children, a public-private partnership with Blue Cross Blue Shield of Montana to provide health benefits to low-income children without insurance. Although the number of children enrolled in CHIP has increased steadily over the years, there is still room for improvement in the rate of uninsurance among Montana's children, which is currently 17% (Montana CHIP Enrollment Reports by County, 1999-2003).

Low-Income Persons with Mental Illness. Montana established the Mental Health Services Plan (MHSP) for persons with serious mental illness and emotional disturbances whose income is less than 150% FPL.

Medically Uninsurable Individuals. In 1985, Montana established the Montana Comprehensive Health Association (MCHA) to provide access to health insurance to Montana residents who are either medically uninsurable or cannot obtain insurance as a standard risk. The MCHA Association Plan is the traditional high-risk plan available to Montana residents who have been rejected or offered a restrictive rider by two insurers within the last six months or have certain specified major illnesses. The MCHA Portability Plan is available to Montana Residents leaving insured or self-insured creditable group coverage.

In December 2003, Montana was one of 16 states to receive a federal grant from the Department of Health and Human Services to provide health insurance to uninsurable state residents through MCHA. MCHA, which currently insures more than 3,000 residents, will add the \$638,228 grant to its \$14 million annual services budget.

Native Americans. Native Americans make up the largest proportion of Montana's non-White population and have the highest rates of uninsurance (38%). The needs of uninsured Native Americans were considered within each of the future coverage expansion options.

1.4 What is affordable coverage? How much are the uninsured willing to pay?

Health insurance cost impacts on household budgets were explored through several questions in the household survey. Montanans were asked if they could afford a monthly premium and how much could they afford to pay for that monthly premium. Eighty-one percent of the respondents indicated that they could afford a monthly premium. Ninety-six dollars (\$96) was the average amount indicated as affordable.

Health insurance premium costs can dramatically impact household budgets, taking away income/money for other, non-health purchases. Individual insurance premiums for lower income households (below 200 percent of poverty) represent, on average, 21 percent of

their household income. The budget impact of insurance premiums is considerably lower for higher income households, representing about 8 percent of monthly household income.

Focus group comments noted the high costs of individual insurance premiums. Self-employed persons such as ranchers and small business owners cited high premium costs as a real burden for their individual insurance coverage.

1.5 Why do uninsured individuals and families not participate in public programs for which they are eligible?

Insurance and healthcare cost impacts on households are especially burdensome in a low-income state like Montana. The predominance of low income working households makes the availability of public health programs especially important. Qualitative data from focus discussion groups supplements some of the quantitative information on Medicaid and CHIP enrollment presented earlier.

The Medicaid focus group included a person with 2 kids, no insurance, and earning too much money to qualify for Medicaid. Several focus group members experienced applying to the CHIP program but being just above the income eligibility cutoff. Another person worked for a doctor that limited the number of Medicaid patients. One focus group participant thought that CHIP was a great program initially but was dismayed at the yearly cuts she saw happening in the program. Another consumer had problems with CHIP because certain doctors would not accept it.

The Montana Comprehensive Health Association (MCHA) and COBRA (extension of health insurance benefits after losing a job) are two policy options designed to alleviate a lack of health insurance. Comments on MCHA indicted that it was too expensive and that the annual limit for benefits could be exhausted with one major health event such as a person's asthma attack requiring emergency care in Great Falls. The cost of health insurance under COBRA was too high for some people. And there was a strong consensus that once a person lost his or her job there should be some way that person could afford to keep their insurance.

1.6 Why do uninsured individuals and families disenroll from public programs?

Although our survey research did not directly address this question, one of the key informants reported that sometimes people on Medicaid who are temporarily working have their wages arbitrarily annualized and are consequently disenrolled from the program. The participant commented that it takes forever to straighten out the problem and get these individuals back on Medicaid.

Studies of Medicaid beneficiaries suggest that one of the reasons individuals and families disenroll from public programs is that they fail to comply with complicated reporting requirements (Ross & Ku, 2002). In the wake of budget shortfalls, some states have actually used complicated enrollment procedures as a strategy to limit their Medicaid

enrollment. Examples of these strategies include: having short enrollment periods; having renewal requirements such as face-to-face interviews, and income or residency verification; and, not using joint Medicaid/SCHIP enrollment forms (Ross & Cox, 2003). A number of studies have found that many public program enrollees lose their health coverage because they are unable to complete complicated forms, because their paperwork gets lost in the mail, or because overloaded State administrative systems do not process their paperwork correctly (Ross & Ku, 2002).

Over the last decade, most states have made progress in eliminating administrative complexities and obstacles that diminish continued participation in public programs. Key strategies used in states for simplifying Medicaid and SCHIP renewal procedures are listed below in Table 1-2. More recently, select states have rescinded some of these simplifications as a way to curb enrollment growth and meet budget targets (Ross & Cox, 2003). The State of Montana has implemented many, but not all, of the simplified renewal procedures used in other states for select enrollee groups, and has maintained this progress despite the tight fiscal environment.

Table 1-2: Use of Select Strategies for Simplifying Renewal Procedures in Montana

Use of Simplified Renewal Procedures in Montana	Montanan Enrollee Groups		
	Children in Medicaid	Children in SCHIP	Medicaid for Parents
12-month renewal	✓	✓	
12-month continuous eligibility		✓	
No face-to-face interview at renewal	✓	✓	✓
No income verification required at renewal		✓	
Individual NOT required to be uninsured for specified period prior to re-enrolling	✓	3 month wait period	✓
Joint Medicaid/SCHIP renewal form			

Source: Ross & Cox, 2003. Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2003.

1.7 Why do uninsured individuals and families not participate in employer-sponsored coverage for which they are eligible?

Montana employers were asked reasons why their eligible employees did not use the health insurance coverage offered. Sixty five percent of the employers thought or knew that their employees were covered by another plan. Five percent of the employers said that their employees not using the firm's coverage were employees who thought they did not need insurance. Twenty-eight percent of the employers responding to this question cited high premium costs and the affordability of insurance as the major reason some of their workers did not use the firm's health insurance plan.

1.8 Do workers want their employers to play a role in providing insurance or would some other method be preferable?

Key informant interviews suggest that people feel expansion of health insurance programs should come through the private sector. People would much rather have coverage through their employer than accept it as charity from the government.

Other research suggests that many employees take advantage of employer-sponsored coverage when it is offered. According to research by Fronstin (2001), 83 percent of workers who are offered employer-sponsored insurance decide to take it. While the share of the health insurance premium paid by employees can vary from zero to 100 percent, on average workers pay 14 percent of the cost of individual coverage and 27 percent of the cost of family coverage (Kaiser-HRET, 2000). Employer-sponsored coverage provides the most affordable source of health insurance available to many workers.

Comments from focus group participants suggest that individually purchased insurance is costly for families. Premiums for individually purchased plans may represent as much as 21 percent of a family's monthly income.

1.9 How likely are individuals to be influenced by: Availability of subsidies? Tax credits or other incentives?

Tax credit proposals to assist lower-income persons to obtain health insurance have strong bipartisan support although there are questions about their effectiveness. The recent bipartisan Relief, Equity, Access and Coverage for Health would provide tax credits of \$1,000 for individuals and \$2,500 for families without access to employer-sponsored insurance. Increased coverage for these individuals and families would presumably be through individual insurance markets, a result that would restrict the policy objective of increased coverage according to the Center for Studying Health System Change (Policy Brief #41, July 2001, www.hschange.org).

Individual insurance premiums are typically more expensive than group insurance rates for all age groups with the exception of young, healthy males. It would take significant tax credits to make individual insurance premiums affordable, particularly in view of the Montana Household Survey data on affordable monthly premiums.

There are also some national data illustrating the magnitude of tax credits necessary to bring more persons into private insurance markets. National estimates (Lewin Group) of health insurance premiums and coverage rate show that a 1 percent reduction in premiums would increase coverage by .2 percent. This means that a 50 percent reduction in premiums through tax credits would increase coverage by 10 percent. Assuming the national estimates apply to Montana this would represent an increase of 55,000 more persons insured out of the state's uninsured population of 171,000 persons.

The estimated, increased coverage for 55,000 more Montanans does not allow for risk selection for those who would go through individual insurance markets. If a

disproportionate number of sick or older people with health problems become insured through private insurance, particularly individual insurance, the cost of coverage will increase and healthy people will look elsewhere for a better deal. Insurers may offset the loss of healthy customers by offering low-premium plans with high deductibles, less comprehensive packages and restricted choice of providers.

One recent study of individual market rates and tax credits finds those insurance markets most favorable to young, healthy males (Commonwealth Fund, pub. # 527, May 2002, www.cmwf.org). Recognition of much higher individual insurance rates for healthy 55 year olds points to the persistence of affordability problems whereby even with a \$1,500 tax credit, low income 55 year old persons would pay one-fourth or more of the income toward health insurance in order to receive benefits close to those prevailing in employer plans.

The employer survey asked Montana employers about the option of purchasing pools. The idea of a small business purchasing pool arrangement was viewed more favorably by Montana employers than was the option of a buy-in to the state employee insurance program.

Policy analysis conducted by the State Health Access Data Assistance Center (SHADAC) under Montana's SPG suggests that given the experience of other states in developing and sustaining purchasing pools, and the unique barriers faced by a frontier state like Montana, it is unlikely that this policy strategy alone will result in significant progress toward helping residents access affordable health insurance. As part of a broader health care reform agenda, or if coupled with other initiatives such as small employer tax incentives, further efforts and investments in the development of purchasing pools may be worthwhile. Because previous efforts in Montana to initiate group health care purchasing cooperatives have had limited success, the discussion of new efforts to develop small-employer purchasing pools should include: possible state investments in the pools; employer mandates or incentives; individual or small employer tax credits; and combined state purchasing group strategies.

Comment [k1]: I wouldn't include this because it is somewhat different from our conclusion on the purchasing pool issue brief. I Included something from this.

1.10 What other barriers besides affordability prevent the purchase of health insurance?

Complexity of policy and coverage information. One of the barriers to coverage that focus group participants identified was the complexity of policy and coverage information. It takes effort for employers and consumers to sift through and make sense of the health plan options available to them. Employers reported using independent insurance agents or administrators to find information on health insurance options while consumers reported using the internet, the newspaper, and insurance agents.

Difficulty applying for public coverage. Key informant interviews revealed that the application process for public coverage overwhelms some individuals. Convenience of the application and re-consideration process poses challenges for many applicants. The

distances to county offices in rural areas are burdensome and some offices are crowded and unappealing especially to people with children.

The compartmentalization of public programs leads to a lack of coordination among programs. This renders the process of accessing assistance very difficult, especially for families in crisis. Some interviewees said that most departments are still on a steep learning curve to create a more seamless service delivery system with multiple points of entry.

Stigma associated with charity care. Another reason for non-participation in public coverage programs is that sometimes families view those programs as charity which their strong work ethic and pride do not allow them to accept. Although some key informants felt the stigma of being on a public program was not a big problem, some rural families felt even having to go into a county office was an embarrassment.

Lack of awareness. Focus group participants reported that younger people do not always see the importance of health coverage. Correspondingly, younger focus group participants were more likely to be willing to go without coverage and “take a chance.”

Declines in employer offerings. Although employers cited cost as the number one reason for not offering coverage, employers also indicated that high turnover and employees’ having access to coverage through a spouse or partner were also reasons for employers not offering health insurance.

Farming and ranching communities. Key informants identified the following problems that are specific to people in farming and ranching:

- distance/access to providers;
- high assets disqualifying them from public insurance, even if their income qualified them;
- perception that, traditionally, farmers and ranchers have looked after their own and would not ask for help;
- perception that the public insurance programs were “charity”;
- no ability to pool;
- having Workers Compensation confused with having private insurance; and
- mobility of seasonal farm workers prevented them from accessing county-based programs.

Seasonal and migrant farm workers. Key informant interviews revealed that seasonal and migrant farm workers seldom have any type of health insurance and are at the low end of the wage scale. By law, seasonal and migrant farm workers are considered contractual employees. If any dispute arises between employer and employee there is seldom any written, signed agreement as much business in the agricultural community is conducted verbally. This leaves the worker at a disadvantage in trying to settle any wage dispute and may contribute to a family’s poverty, which contributes to them being unable to access health care.

1.11 How are the uninsured getting their medical needs met?

The majority of focus group participants reported that they don't use medical services because they simply can't afford it. In the groups of consumers, this was true not only for people without insurance coverage, but also for those few individuals who have health insurance coverage, as well. Those with insurance cited large deductibles, reduced allowable expenses, reduced percent of cost covered through insurance, pre-existing condition clauses that preclude coverage, and the other complexities of coverage that leave too much still owed by the individual consumer. Those without insurance who do access medical care use the following general providers: Deering Clinic, Walk-in Clinics, the ER, and physicians who are flexible about payment terms and allow people to pay what they can afford each month.

1.12 What are the features of an adequate, bare bones benefit package?

When key informants were asked what constitutes a "bare bones" health insurance policy the overwhelming number of responses included mental health and dental coverage. However, the amount people should pay and the extent of the coverage fell on a continuum. Those who daily serve people from low-income communities who are on Medicaid had the strongest opinions about the lack of mental health benefits. The amount of time that it takes the state mental health system to determine eligibility was mentioned as a barrier to participation as by the time the determination is made the provider may no longer be able to find the patient to initiate services. The delay can mean the difference between getting the patient needed services and potentially deflecting a crisis, or not getting services with the patient ending up in high-cost hospitalization or in the justice system.

1.13 How should underinsured be defined? How many of those defined as "insured" are underinsured?

Key informants did not agree on a definition of "underinsured," in fact the answers were very diverse and often indicated the interviewees' professional situation or ideological viewpoint. It is interesting to note that 19 interviewees thought having a catastrophic plan was being underinsured, but only 3 thought that a catastrophic plan constituted a minimum "bare bones" insurance policy. One owner of a private company said he was "embarrassed" that all he could offer was a catastrophic plan – even though it covered his family also.

The proportion of the population with medical debt (i.e., unpaid medical bills) is another indicator of underinsurance. Eleven percent of all non-elderly Montanans had medical debt in the past 12 months. There were differences by insurance status with 7 percent of insured Montanans having medical debt and more than 3 times that percent or 21 percent of uninsured persons with medical debt. Public health insurance coverage did not eliminate the impact of medical debt on low-income households. Fifteen percent of the publicly insured did not have medical debt.

Average debt was high for every insurance coverage category. Montanans with medical debt had, on average, \$2,546 in unpaid medical bills over the past 12 months. Average debt was slightly smaller for persons with health insurance (\$2,506) and increased to a level of \$2,700 for persons without health insurance. Publicly insured individuals had the highest average medical debt with a value of \$2,828.

SECTION 2. SUMMARY OF FINDINGS: EMPLOYER-BASED COVERAGE

This section documents Montana's research activities related to employer-based coverage. The 2003 Montana Business Insurance Survey was a stratified random telephone survey of businesses located in Montana covered by unemployment insurance. The data were collected by the Survey Research Center at The University of Montana-Missoula, Bureau of Business and Economic research from March 2003 to May 2003.

A key objective of the survey was to fill in gaps in our knowledge about Montana business offering of health insurance to their employees. The survey sampling methodology was designed to obtain a higher number of completed interviews from smaller businesses because most Montana businesses have fewer than 10 employees. In order to achieve these goals, the survey was conducted as a stratified random sample, where the strata were business size.

2.1 What are the characteristics of firms that do not offer coverage, as compared to firms that do?

Firm size by the number of employees was the major determinant for the offering of job-based health insurance in Montana. Fifty nine percent of Montana firms with 10 or fewer employees did not offer health insurance. There was not much difference in insurance offer rates when the small firm cutoff of 10 or fewer employees was subdivided into firms with 1 to 5 employees, 63 percent of whom did not offer insurance, and firms with 6 to 10 employees where 48 percent of the firms in this size group did not offer insurance.

The percent of firms not offering insurance decreased to 29 percent for firms with 11 to 19 employees and continued to drop as firm size increased. More than 95 percent of firms with more than 100 employees offered health insurance and 100 percent of very large employers of 500 or more workers offered health insurance.

Not all workers in a firm were offered insurance no matter how large the firm. Small firms offered coverage to a portion of their employees. Large firms offered insurance to a higher proportion of their work force although not necessarily to their entire work force.

Thirty percent of firms with 10 or fewer employees offered insurance to all employees, a rate that increased to 53 percent for firms with 11 to 20 employees. The proportion of firms offering insurance to all employees remained at about 50 percent for firms up through those with more than 100 employees. Even large firms with 200 or 500 or more employees had a high offer rate approaching 100 percent but the insurance was not offered to all employees.

2.2 What influences the employer's decision about whether or not to offer coverage? What are the primary reasons employers give for electing not to provide coverage?

Employer costs of health insurance premiums were cited by employers as the major reason for not offering health insurance. Eighty one percent of the firms responding to this question thought premiums were too high and prevented firms from offering insurance. Six percent thought high turnover was a major determinant of Montana firms not offering health insurance coverage, and another 9 percent thought that employees were covered by another plan—perhaps that of their spouse or partner—and therefore did not need to be offered insurance.

2.3 How do employers make decisions about the health insurance they will offer to their employees? What factors go into their decisions regarding premium contributions, benefit package, and other features of the coverage?

Employers repeatedly stated that they want to offer health insurance as a benefit so they can recruit and retain good employees. The importance of being able to get health insurance was often a deciding factor about which jobs people take. One larger employer said that it is often the first question asked in an interview of a potential employee.

Although Montana's employer survey did not address this question directly, results from the Employer Health Benefits Survey (2003) suggest that in response to increasing cost pressures, employers have been turning to alternative benefit designs such as offering a plan with a high deductible (Kaiser/HRET 2003). Employers have also expressed interest in consumer-driven health plans that combine a high deductible plan with a health savings account.

Mandated Health Insurance Benefits

Montana's employers are also affected by mandated health insurance benefit regulations. Both state and federal law require certain insurance products to provide certain health care benefits. These benefits can be found in the form of certain forms of medical or health care services, access to certain kinds of providers, and provisions relating to the insurance product itself. There is a great debate about the benefit to mandated benefits. There is a cost reflected in insurance premiums, but there is also a benefit to the individuals receiving certain levels of coverage and perhaps to society itself ensuring that coverage for certain health needs is available. Mandates do not universally apply, however. Some apply only to individual policies, some to group policies. Self-insured plans generally do not have to offer the benefit, but the State of Montana employee coverage plans, for example, do provide the same benefits mandated to private insurance.

State-specific mandates range from requirements to cover specific diagnostic or treatment services, statutes that require health plans to cover services by particular types of providers, or laws to extend benefits to certain populations.

A. Service mandates

- Coverage for outpatient self-management training and education for treatment of diabetes
- Coverage for adopted children from time of placement (if natural children are covered)
- Coverage for treatment of inborn errors of metabolism
- Coverage for mammography examinations
- Coverage for minimum hospital stay following childbirth
- Postmastectomy care
- Coverage for reconstructive breast surgery after mastectomy
- Coverage for spouse or dependents of peace officer, game warden, and firefighters
- Benefits for home health care

B. Provider mandates (if services are covered)

- Coverage required for services provided by physician assistants-certified
- Independent chiropractic physical examination or utilization review of records
- OB/GYN's as primary care physicians
- Self-referral must be permitted
- Payment of covered services provided by certified advance practice registered nurses
- Coverage for Naturopaths
- Coverage for Physical Therapists
- Cover dentists for covered medical health care or services
- Nurse specialists

C. Other related provisions that could be considered "mandates"

- Freedom of choice of providers (only if offer benefits and benefit is mandated): physician, physician assistant-certified, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, acupuncturist, naturopathic physician, physical therapist, advanced practice registered nurse within scope and limitations of practice
- Gender nondiscrimination (how maternity is mandated)
- Portability or conversion provisions:
 - Creditable coverage/COBRA
 - Conversion on termination of eligibility
 - Conversion
 - Preexisting conditions
 - Guaranteed renewability

2.4 What would be the likely response of employers to an economic downturn or continued increases in costs?

Study findings indicate that many employers have dropped coverage due to the downturn in our economy and increases in premiums. Most uninsured Montanans previously had insurance coverage. More than half, 56 percent, indicated they had previously been covered by employers, 12 percent had individual coverage, and another 9 percent had coverage through a public program. Only 20 percent of the uninsured had never had previous health insurance. Focus group comments corroborated some of these patterns. Some participants indicated they used to have health insurance on the job but it was dropped when coverage became too expensive to their employer. Other participants indicated that their employers offered health insurance when business conditions were good, with a subsequent dropping of coverage when business conditions were bad (see Focus Group Report).

2.5 What employer and employee groups are most susceptible to crowd-out?

Administrators in the key informant interviews were asked to comment on crowd-out but there is no mention of their responses to this question in the key informant report.

2.6 How likely are employers who do not offer coverage to be influenced by: Expansion/development of purchasing alliances? Individual or employer subsidies? Additional tax incentives?

Two purchasing pool policy options of small business purchasing pools and buy-in to state employee insurance program were offered to employers during the survey interview session. Reaction to these two policy options was varied. A small percentage of firms not offering health insurance would still not offer insurance under either one of the two purchasing alternatives. Other responses were dependent on learning more about the alternatives and on the cost arrangements of the alternatives.

The strongest, unequivocal response of ‘absolute’ participation was in response to the idea of the small business purchasing pool, with 40 percent of the firms not offering insurance saying they would participate. A smaller 19 percent expressed willingness to participate with a buy-in to a state employee insurance program.

Employer reactions to tax credits for health insurance premiums were qualified by credits with a sunset provision whereby the tax credits would be in effect for five years versus an unlimited time for the credit (no sunset). They were offered several choices for responses. Sixteen percent of the firms not currently offering insurance said they would not offer health insurance even if the tax credit policy option were offered. A similar percent said they did not know what their reaction would be to a tax credit.

Employers were offered different levels of tax credits with choices between the forty to sixty percent. The percent of employers who would offer health insurance increased slightly when the proposed tax credit increased from 40 to 50 to 60 percent although it

was neither a systematic nor strong response. A small percent of employers still did not know what their insurance offer response would be under these different tax credit allowance rates.

In the key informant interviews, the question about how likely businesses would be to be influenced by subsidies, tax credits or other incentives was universally answered by those in private industry with a very qualified “maybe,” with the observation that incentives would probably not be large enough or would not be useful to all businesses who needed them. For some owners of small businesses the question about being offered tax credits or subsidies would be very welcomed only if it didn’t raise taxes in other areas.

2.7 What other alternatives might be available to motivate employers not now providing or contributing to coverage?

This question was not specifically addressed in Montana’s data collection activities. However, having more insurance products available to choose from could potentially motivate more employers to provide coverage. Lack of competition in the Montana insurance market is seen as a primary reason that more insurance products are not available. Key informant interviews revealed employers understood that the small size of the state’s market would never attract the competition among insurance companies that exists in larger markets. Another aspect of Montana’s population size that was identified as affecting health insurance is the lack of any type of large Health Maintenance Organization or Preferred Provider Organization. Another comment on lack of competition pointed to the unregulated nature of competition and that companies are allowed to come into the state and offer good prices to healthy groups and can avoid having to cover the high risk, older pools.

Blue Cross and Blue Shield of Montana was identified by all who mentioned lack of competition in the health care market. Sometimes the comments were negative but mostly they reflected an understanding of the Montana health care market that precluded many national carriers being interested in coming into the state. One interviewee pointed out that even if Blue Cross keeps 20 cents out of every dollar for their overhead, that still leaves eighty cents locked into the cost of health care.

SECTION 3. SUMMARY OF FINDINGS: HEALTH CARE MARKETPLACE

This section documents activities related to Montana's health care marketplace.

3.1 How adequate are existing insurance products for persons of different income levels or persons with pre-existing conditions? How did you define adequate?

None of the committees was willing to define 'adequate'. Given that Montana has only two Montana-based insurance companies (Blue Cross and New West), the researchers only identified that there are different insurance products, based on income and pre-existing conditions. Researchers posted information and access to their individual web sites, so people would have the information.

3.2 What is the variation in benefits among non-group, small group, large group and self-insured plans?

This issue was not addressed by the SPG.

3.3 How prevalent are self-insured firms in Montana? What impact does that have in Montana's marketplace?

This issue was not addressed by the SPG.

3.4 What impact does Montana have as a purchaser of health care (e.g., Medicaid, SCHIP and State employees)?

Given the economic challenges of the State of Montana, the Governor's Office and the 2003 Legislature directed the Department of Public Health and Human Services (DPHHS) to convene a task force to examine the public programs. The results of the Public Health Redesign Committee are available at www.dphhs.state.mt.us.

3.5 What impact would current market trends and the current regulatory environment have on various models for universal coverage? What changes would need to be made in current regulations?

This issue was not addressed by the SPG.

3.6 How would universal coverage affect the financial status of health plans and providers?

This issue was not addressed by the SPG.

3.7 How did the planning process take safety net providers into account?

As part of the State Planning Grant process, a Safety Net Team--including representation from a variety of safety net providers, consumers, and state agency representatives--

developed an analysis of Montana's Safety Net, its strengths and weaknesses, as well as a strategic plan that was presented to the SPG Steering Committee.

3.8 How would utilization change with universal coverage?

This issue was not addressed by the SPG.

3.9 Did you consider the experience of other States with regard to: Expansions of public coverage? Public/private partnerships? Incentives for employers to offer coverage? Regulation of the marketplace?

The Steering Committee invited representatives from SHADAC, the State Coverage Initiative and a representative of the Utah Department of Health to provide information regarding the various experiences of other states in efforts to increase coverage rates. In addition, the three members of the Steering Committee are participating in the Public Health/Medicaid Re-Design Project, which has as its goal to develop strategies toward a sustainable, stable health care system. The recommendation to pursue a HIFA waiver is based in part on the experience of other states.

SECTION 4. OPTIONS AND PROGRESS IN EXPANDING COVERAGE

The purpose of this section is to provide specific details about the policy options selected by the State. A number of States have not reached a consensus on a coverage expansion strategy and are not yet in a position to answer the questions included in this section. These States should answer questions 4.1 through 4.15 as applicable, but should focus primarily on questions 4.16, 4.18, and 4.19.

4.1 Which coverage expansion options were selected by the State (e.g., family coverage through SCHIP, Medicaid Section 1115, Medicaid Section 1931, employer buy-in programs, tax credits for employers or individuals, etc.)?

For the past two years, a statewide cross section of public and private leaders appointed to the SPG Steering Committee by the Governor of Montana, Judy Martz, guided the development, implementation, and identification of policy recommendations. In addition, three work groups addressing data, safety net issues, and coverage options reviewed resources, analyzed data, and identified feasible solutions. These work groups were comprised of health care insurers and providers, advocates for low-income individuals, Indian Health Services staff, senior citizens, legislators, and business representatives.

The vision produced by Montana's SPG Steering Committee has the following goals: provide affordable health care coverage for all Montanans; strengthen the health care safety net across Montana; and reduce, by 2010, Montana's uninsured rate by 50%, with an emphasis on covering children. Recognizing that no one solution will erase the problem of the uninsured in Montana, the SPG Steering Committee developed a strategic plan for implementing a variety of coverage options that will provide affordable health insurance coverage and strengthen the health care safety net between 2004 and 2010. The strategic plan focuses on expanding existing programs, maintaining public-private partnerships, and enacting legislation to maintain as well as create new programs to reduce the number of uninsured persons in the state.

The remainder of this section presents summary and detailed information on the various policy recommendations coming out of the data collection and analysis, policy development, and consensus building activities made possible under Montana's SPG.

Summary of Recommendations to Increase Health Insurance Coverage in Montana

Montana's state planning process yielded policy recommendations that can be organized into four categories: (1) proposals that would not have a significant fiscal impact on the state; (2) proposals that would require new state legislation and/or new state dollars; (3) proposals that would require legislation and/or a state funding mechanism; and (4) public health redesign committee recommendations. These recommendations are summarized below.

Proposals Without Significant Fiscal Impact on the State

- A. *Associations.* Encourage associations and groups to explore the benefits of purchasing pools, given the legislative changes made in the 2003 Legislative session.
- B. *University System.* Recommend that the Commissioner of Higher Education, Board of regents and the University/Community College system develop consistent internal policies and procedures to require proof of existing insurance coverage (parents or employers) or require students to purchase health insurance offered through the University system.
- C. *Health Literacy.* Educate the public in the benefits of health insurance coverage by promoting health literacy and the value of maintaining one's health. Improve health promotion with consumers and employers, and promote preventive health curriculums within the education system.

Proposals Requiring New State Legislation And/Or New State Dollars

- D. *Safety Net Providers.* Recognize and support safety net providers (Community Health Centers, FQHC, Urban Indian Clinics, etc.) as a vital component of the health care delivery system. Support recommendations to enhance safety net providers' ability to operate throughout the state. Recommendation includes a request for funding.
- E. *Tax Credits.* Continue to pursue tax credit options for low-income individuals with family incomes less than 175% FPL and employers with fewer than 5 employees who do not have any employees earning more than \$150,000 per year. Continue to pursue tax credit incentives at 50% employer level and for individuals at 175% Federal Poverty Level (as introduced in 2003 Legislative Session). Explore capping available tax credits at maximum of \$10 million per year.
- F. *Health Care Costs.* Explore the feasibility of reducing cost drivers such as mandated benefits, utilization, and administrative complexities. Creative approaches should include consideration of basic benefit designs, care management programs, benefit limits and caps, cost sharing by consumers, and streamlining of applications and paperwork related to healthcare coverage.
- G. *Employer-Sponsored Coverage.* Pursue development of legislative proposals that encourage employer-sponsored health care plans like the currently available individual-only plans such as Blue Care or the New West Bridge Plan.

Proposals Requiring Ongoing Legislation And State Funding Mechanisms

- H. *Enroll Children Currently Eligible for Public Programs.* Enroll children currently eligible for Medicaid and CHIP (at or below 150% FPL).

- I. *Expand CHIP*. Expand CHIP coverage for uninsured children up to 200% FPL, in graduated increments (165%, 185%, 200% FPL). Institute increased cost-sharing for children from 151% to 200% FPL.
- J. *Support the Montana Comprehensive Health Association (MCHA)*. Maintain and increase the Montana Comprehensive Health Association (MCHA) high-risk pool availability of coverage through:
 - Ensuring enrollment for those currently eligible.
 - Maintaining or increasing the low-income premium assistance state subsidy established by the 2003 Legislature
 - Explore the possibility of expanding the current premium assistance program for eligible individuals from 150% to 200% FPL.
 - Continue participation in the Trade Adjustment Assistance (TAA) and consider support for TAA expansion.
- K. *Prescription Benefit*. Explore a prescription benefit for adults at or below 200% FPL who are between ages 62 to 64 and who have applied for disability benefits.

Other Recommendations to the Public Health Redesign Project (Not Mentioned Above)

- L. *Address Enrollment Issues and Promote Outreach*. Identify individuals who are currently eligible for existing programs but who are not enrolled in Medicaid or CHIP. Document and track enrollment barriers. Continue collaboration with groups to enroll eligible Native Americans in Medicaid and/or CHIP. Resume outreach to potentially eligible Medicaid and CHIP children.
- M. *Support Development of a Health Insurance Flexibility Act (HIFA) Waiver*. The waiver would allow expansion of health care coverage, on a graduated basis, to uninsured Montanans. Several options were identified, including:
 - Insure parents and guardians of publicly-insured children. At a minimum, insure parents/guardians at or below 100% FPL. Alternatively, expand Medicaid to cover parents/guardians between 101% and 150% FPL.
 - Provide coverage to Mental Health Service Plan recipients and/or low-income working adults.
 - Consider a premium assistance program or a basic medical plan, which may have limits, exclusions, and/or capped coverage for certain services.
 - Explore a modified self-directed program (similar to a Home & Community Based Waiver) that would provide the consumer with capped basic benefits and where the consumer shares an increasing responsibility for their own health care.

Detailed Recommendations

Montana's state planning process identified target populations; support and rationale; administrative issues; cost; funding sources; and implementation steps for each of the state's recommended coverage options. For information addressing questions 4.2 through 4.17, please refer to the detailed recommendations provided below.

Proposals Without Significant Fiscal Impact on the State

- A. Encourage Associations and groups to explore the benefit of purchasing pools, given changes made in the 2003 Legislative session.

Target Population:	Groups of 51 or more eligible individuals
Support/Rationale:	<p>The 2003 Legislative Session, in House Bill 104, lowered the number of eligible individuals needed to form a purchasing pool from 1000 to 51. This recommendation offers new coverage or makes continuing coverage affordable. The 2003 Montana Household and Employer Survey identified that 77% of Montana's uninsured are employed. The survey found that sixty percent of the State's uninsured are either self-employed or work for a small business with ten or fewer employees.</p> <p>Recently two Associations announced the availability of an insurance plan. The Montana Nonprofit Association (MNA), after over a year of study and analysis, partnered with New West Health Services, to offer lower cost health care insurance through an Association plan. This plan includes coverage for single employee nonprofit groups. Montana Chamber Choices (MCC) is available to small employers with 2 to 50 employees who are members of a local chamber or the State Chamber. MCC, in association with Blue Cross Blue Shield of Montana, offers three standard health insurance options.</p>
Administrative Issues:	Staff resources from within Association(s) associated with research of potential plans, projections of take-up rates; benefit design and other related start-up activities
Cost:	No state funding involved
Funding Sources:	Employer and employee
Implementation:	<ul style="list-style-type: none">• Encourage current Associations to poll their members to identify the number of uninsured and facilitate opportunities to train members about available options.• Encourage the Chamber of Commerce and MNA to track the take-up rate with their respective association plans.• Provide outreach and employer education to other Associations by the State Auditor, Chamber of Commerce, National Federation of Independent Business (NFIB), the Montana Society of Association Executives.

- B. Encourage the Commissioner of Higher Education, Board of Regents and the University/Community College system to develop consistent internal policies and procedures requiring proof of existing insurance coverage (parents or employers), or requiring students to purchase health insurance offered through the University System.

Target Population:	Uninsured and between the ages of 18-26, at a minimum. The requirements may provide an avenue for insurance coverage for those full-time students over the age of 26. 18% of undergraduates at the University of Montana are age 25 or older. The University of Montana and Montana State University had a total enrollment of approximately 25,000 students, with over 19,000 students considered full-time. Almost 82% of the students attend school on a full time basis. Assumption: One half of the full-time students are covered by their
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	parents' policies (9,500); one-quarter purchase insurance or is covered through University Plan, employer or spouse (4,750). This recommendation could potentially reduce the uninsured by more than 4,750 post-secondary students.
Support/Rationale:	The Montana Household survey findings identified that 39% of people between the ages of 19-25 are uninsured (32,000 individuals). The uninsurance rate for those between the ages of 26-49 is 24% (75,000 individuals). Montana State University (Bozeman and Billings campus) and the University of Montana (Missoula) campus have existing internal policies and procedures to require proof of insurance for students carrying twelve or more credits. The premium cost for students purchasing the University policy is approximately \$400 per semester.
Administrative Issues:	Consistency in implementation and enforcement
Cost:	No state cost
Funding Sources:	N/A
Implementation:	Implementation of statewide policy by Commissioner of Higher Education and Board of Regents.

- C. Educate the public in the benefits of health insurance coverage by promoting health literacy and the value of maintaining one's health. Promote preventive health with consumers and employers (e.g., wise pharmacy) and within education curricula (e.g., consumer education, general life skills, driver's education, etc.)

Target Population:	All Montanans
Support/Rationale:	<p>The Montana Household Survey and the Employer Survey identified increased health care costs and health insurance affordability as critical issues for Montanans. Health literacy is defined by Healthy People 2010 as "the degree to which people can obtain, process and understand basic health information and services they need in order to make health decisions." Health literacy is about the entire process of exchanging healthcare information. The National Academy on an Aging Society reports that "over 90 million adults with low health literacy skills have limited ability to read and understand the instructions contained on prescriptions or medicine bottles, appointment slips, informed consent documents, insurance forms, and health education materials...the estimated additional health care expenditures due to low health literacy skills are about \$73 billion in 1998 health care dollars."</p> <p>Promoting health literacy provides formal and informal avenues of targeting all ages of the uninsured across Montana. Surgeon General Richard Carmona, at the 2003 Governor's Health Care Summit in Billings stated, "Health Literacy can save lives, save money and improve the health care and well-being of millions of Americans."</p>
Administrative Issues:	Coordinating efforts, especially given the rural nature of our state. Developing collaborative partnerships to share information and the message.
Cost:	Unknown
Funding Sources:	Explore grant applications from foundations (e.g., Robert Wood Johnson Foundation) as well as the Federal government
Implementation:	<ul style="list-style-type: none"> Promote health wellness through state agency collaboration. DPHHS would continue to be primary coordinator and would partner with other state

	<p>agencies (e.g., Commerce, Labor, Insurance Commissioner, OPI, University System) and the private sector.</p> <ul style="list-style-type: none"> • Explore existing technology avenues in Montana to enhance opportunities to deliver the message of health literacy (e.g., telecommunications, web sites, Public Service Announcements, etc.) • Promote role of Advisory Council on Work Life Wellness. • Encourage the development of curriculums in primary and secondary education settings (e.g., health classes, life skill classes) through the Office of Public Instruction. • Promote health screenings through Montana Hospital Association and Community Health Fairs. • Continue to collaborate with the 32 Public Health Advisory Councils. • Promote media literacy with Montana Broadcasters, Montana Newspaper Association, School of Journalism. • Partner with organizations that interact with the uninsured, working poor, and underinsured. • Explore the “211” concept (i.e., regional or statewide telephone access to health care information). • Collaborate with Montana safety net providers. • Develop outreach strategy with AARP/Montana Senior Citizen Association. • Develop outreach strategy for families and young children via Head Start and early childhood program.
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Proposals Requiring New State Legislation And/Or New State Dollars

- D. Recognize and support the safety net (e.g., Community Health Centers, FQHCs, Urban Indian Clinics, etc.) as a vital component of the health care delivery system. Support recommendations to enhance safety net providers’ ability to operate throughout the state.

Target Population:	Uninsured, under-insured and low-income residents. Currently, fourteen rural communities are interested in pursuing grants to be designated as Community Health Centers (Kalispell, Plains, Miles City, Lewistown, Baker, Ekalaka, Fort Benton, White Sulphur Springs, Cut Bank, Shelby, Hamilton, Townsend, Sheridan, and Conrad).
Support/Rationale:	<p>Within the development of the five year strategic plan, it is not feasible to achieve a 100% uninsured rate in Montana, therefore the on-going development of primary and preventive health care access is critical. Uninsured, under-insured and low-income Montanans are served by a significant number of safety net health care providers across the State. Safety net services are part of the fabric of providing health care to all Montanans, especially given Montana’s frontier designation.</p> <p>The U.S. Public Health Act provides federal funds to three major programs in Montana: (1) Community Health Centers; (2) Migrant Health Centers; and (3) Homeless Programs. Montana is currently served by eleven Community Health Centers in fifteen different communities across Montana. The Montana Migrant Program, headquartered out of Billings, also provides seasonal services in nine sites across the state. The Homeless program, based out of Billings, provides satellite services in three communities. In addition, since 1998, through the Rural</p>

	<p>Hospital Flexibility Program, 35 Montana communities have received designation as Critical Access Hospitals. With the cost-based reimbursement (Medicaid and Medicare), many rural communities were able to maintain health care access for uninsured, under-insured, and low-income Montanans.</p> <p>Based on 2002 data, approximately 75% of the people who used Community Health Center services had incomes below 100% of the federal poverty level. In addition, approximately 15% of those served were privately insured; just over 20% had Medicaid and/or Medicare coverage. Community Health Centers provide primary and preventive care to the uninsured across the state. Supporting the development of additional Community Health Centers will provide additional health care access as well as bolster economic development opportunities for our smaller communities. The Montana Primary Care Association has identified more than \$8 million dollars in direct federal grant dollars coming to local Montana communities as a result of the existing grants. Ongoing services are supported by a variety of funding sources including, but not limited to, patient fees, donations, Medicaid and Medicare payments, contracts, private insurance, etc. A minimum of \$300,000 yearly is provided to communities through these grant funds.</p> <p>Health care services to Native Americans are provided through Indian Health Services and Urban Indian Clinics, tribal facilities and other safety net providers. Funding for health care services to those Native Americans who are Medicaid eligible and receive services directly from Indian Health Services or tribal facilities are paid with 100% federal funds. As identified in the 2004 Public Health Redesign report, "...100% federal reimbursement is only available for those services allowable under the Montana's approved Medicaid State Plan."</p>
Administrative Issues:	Technical support is necessary to support the small, rural communities in completing the federal grant applications.
Cost:	<p>State funding options to assist small rural communities in their grant applications for various federal programs, for example:</p> <ul style="list-style-type: none"> • \$50,000 yearly appropriation to provide five communities with start-up funds to initiate and complete the grant process • Equal contributions by the state and communities
Funding Sources:	Tobacco Initiative dollars, Community Block Grant dollars, and/or state funding
Implementation:	<ul style="list-style-type: none"> • Primary Care Bureau of DPHHS to identify health care professional shortage areas and related program placement of health care professionals in programs like the National Health Service Corp. • Montana Primary Care Association to provide technical assistance to the rural communities in its CHC grant applications. • Montana Hospital Association (MHA)—an association of Montana health care providers—to provide technical assistance to rural communities and to rural hospitals applying for designation as Critical Access Hospitals.

- E. Increase the affordability of health care insurance and expand health insurance options in the private market by providing tax incentives to low-income individuals and small employers. Continue to pursue tax credit of 50% for employers and individuals (as introduced in 2003 Legislative Session through HB 204 and HB 216).

Target Population:	Low-income individuals with family incomes less than 175% FPL and employers with fewer than 5 employees who do not have any employees earning more than \$150,000 per year.
Support/Rationale:	Tax relief proposals fill the coverage gap that exists between poor children and parents who are eligible for Medicaid and the Children's Health Insurance Plan (CHIP), as well as those who do not have access to or who cannot afford to purchase employer-sponsored insurance. The 2003 Montana Employer Survey, conducted by the University of Montana, identified that 56% of uninsured Montanans work for small businesses with ten or fewer employees. 48% of employers not currently offering health insurance coverage would do so with a tax credit of 50% or more. Further, close to sixty per cent of small businesses with ten or fewer employees do not offer health insurance. Eighty-one percent of Montana firms not offering health insurance cite high premiums as the major reason why they do not offer insurance.
Administrative Issues:	Refundable tax credits utilize existing administrative systems and require less coordination and verification of coverage with employers. The Fiscal Notes for HB 204 and HB 216 identified at minimum increased workloads for the Department of Revenue and the State Auditor's Offices (e.g., credit payments, eligibility and outreach activities). SHADAC Issue Brief #2 identifies additional advantages and disadvantages.
Cost:	<p>Fiscal Notes for HB 204 and HB 216 identified anticipated costs. With the tax credit model, the State bears one-half of the cost. A Pilot Program identified in HB 204, based on a sample take-up projection of 12,700 individual credit and small group credits, projected costs at \$19 M for each year of the biennium.</p> <p>HB 216 identified 38,997 income tax returns with combined incomes of less than 175% FPL. The tax rate for eligible individuals using the medical insurance deduction is estimated to be 3.65%. The net reduction in revenue is \$20M in FY 2004 and \$41M in FY 2005. Both legislative proposals would also require additional FTEs within state government.</p>
Funding Sources:	One of the intended uses of the revenue generated by a proposed tobacco tax increase is targeted to new tax credits or to fund new programs to assist small businesses with the costs of providing health insurance benefits to employees. The issue of sustainability for small businesses is critical to the future of this proposal.
Implementation:	<ul style="list-style-type: none"> • Legislation would be required. • The Montana Department of Labor is encouraged to add questions to their survey of employers regarding health insurance, in order to track progress we have made in reducing the number of uninsured.

- F. Explore the feasibility of reducing cost drivers such as mandated benefits, utilization and administrative complexity. Approaches should include consideration of basic benefit designs, care management programs, benefit limits and caps, cost sharing by consumers, and streamlining of applications and paperwork related to healthcare coverage.

Target Population:	General population
Support/Rationale:	This private sector recommendation would require additional study and analysis.

	<p>The 2002 Colorado Health Care Cost Study may provide comparative information. If the hypothesis is correct and alternatives can be identified, this recommendation may benefit small businesses that do not offer health insurance.</p> <p>As identified in the Montana Household and Employer Survey, eighty one percent of Montana firms not offering health insurance cite high premiums as the major reason why they do not offer insurance. Further, close to sixty per cent of small businesses with ten or fewer employees do not offer health insurance.</p>
Administrative Issues:	Some of the current cost drivers are based on federal laws.
Cost:	Unknown at this time
Funding Sources:	Pursue additional HRSA grant funds or request state funding via an interim legislative study.
Implementation:	A Legislative Interim Study and/or other resources would be needed for a study/analysis of cost drivers.

- G. Develop legislative proposals that create more health insurance options to serve individuals who are uninsured. Pursue development of legislative proposals that encourage group sponsored health care plans like the individual-only plans from Blue Care or the New West Bridge Plan.

Target Population:	Young adults, especially those who are turning 19 and are no longer eligible for Medicaid or CHIP; adults ages 19-26 who are not enrolled in post-secondary schools; and adults working for small businesses who do not offer health insurance.
Support/Rationale:	<p>Employers are very interested in an affordable alternative to traditional health insurance plans. While a limited benefit plan is not considered optimal, it offers a considerable improvement over the absence of health care coverage for thousands of individuals. Such a plan also provides a broader base for cost sharing across a group that is not currently participating.</p> <p>The safety net that currently exists to cover the uninsured places the cost on the shoulders of individuals obtaining care and providers. Under a limited plan design, costs may be modified by insurers who have the capability to direct care, offer care management, and negotiate reimbursement on behalf of covered members.</p> <p>Currently there are only two programs in Montana that specifically address the uninsured. Blue Care, a product offered by Blue Cross Blue Shield, offers a low premium benefit for uninsured individuals and families. The basic benefit package includes primary care, emergency room, pharmacy and hospitalization. Maximum benefits are capped.</p> <p>The 2003 Legislative Session, in HB 384, provided avenues for a demonstration project to provide limited health care services to uninsured Montanans. The current demonstration project, sponsored by New West Health Plan, provides insurance to uninsured Montanans under the age of 65 and not on Medicare, who have been uninsured for the previous six months and live within a 30-mile radius of Billings or Helena. The provisions within HB 384 allow the demonstration</p>

	project to exclude some of the services that are a mandated requirement of health insurance plans. The New West Health Plan includes access to primary and specialist care in the office setting, basic lab and x-ray, generic prescription medication, mental health and other outpatient therapies. It does not provide services for emergency room and inpatient hospitalization. While enrollment is currently quite low, only 50% of the enrollees have utilized services in the first quarter. This demonstrates the cost sharing opportunity that exists in such a plan.
Administrative Issues:	Flexibility in Legislation, as evidenced by HB 384
Cost:	No state cost
Funding Sources:	Private Insurance Companies
Implementation:	<ul style="list-style-type: none"> • Legislation would be required for this private sector recommendation. • The State Auditor's office would review and study the annual reports on the Bridge Program, the pilot project created by the 2003 Legislative session, as submitted by New West Health Plan. • HB 384, the legislation enabling plans such as New West's Bridge Plan, sunsets in 2009.

Proposals Requiring Ongoing Legislation And State Funding Mechanisms

H. Enroll those currently eligible for Medicaid and the Children's Health Insurance Plan (CHIP).

Target Population:	Uninsured, eligible children for Medicaid and CHIP (below 150% FPL). DPHHS estimates that an additional 7,000 children could be covered by Medicaid and that an additional 15,000 children could be covered by CHIP.
Support/Rationale:	Covering the most needy has been a consistent theme identified by the various committees of the State Planning Grant. The Montana Household Survey identified that approximately 22,000 children in Montana are uninsured and living in households with annual gross incomes below 150% FPL. The current CHIP eligibility income limit is at or below 150% FPL.
Administrative Issues:	The program is currently operational. Additional staff will be needed to address the workload associated with increased enrollment.
Cost:	Assuming an 85% take-up rate, the cost to the State to cover those currently eligible for Medicaid would be \$3.5 M and \$4 M for CHIP. The annual state cost to insure a child under Medicaid is \$590.35; the annual state cost to insure a child under CHIP is \$311.60.
Funding Sources:	State and Federal dollars; donations to CHIP program
Implementation:	<ul style="list-style-type: none"> • Address funding needs through HB 2 in order to assure general fund appropriations for the state share for Medicaid and CHIP. • Fund DPHHS staff and associated costs to develop and maintain outreach efforts to educate parents about the program. • Document and track barriers of those who do not apply for programs for which they are eligible. • Continue collaborating with Tribal Health and DPHHS to enroll Native

	Americans in Medicaid and/or CHIP if eligible.
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- I. Expand CHIP to cover children up to 200% FPL. Potentially, expand program in graduated increments: children up to 165% FPL, 185% FPL, and 200% FPL. Institute increased cost sharing for children between 151% and 200% FPL.

Target Population:	<p>A total target population of 13,900 children would be served. The 2003 Montana Household Survey identified 13,900 uninsured, eligible children below 200% FPL. If graduated increments are implemented, the following numbers of children could be served:</p> <ul style="list-style-type: none"> • An additional 2,700 children up to 165% FPL • An additional 4,700 children up to 185% FPL • An additional 6,500 children up to 200% FPL <p>In proposing an incremental approach to serving more children, it is the goal of the State Planning Grant to attain a 3% uninsured rate among Montana children.</p>
Support/Rationale:	The Montana Household Survey findings identified approximately 13,900 children in Montana who are uninsured and living in households with annual gross incomes between 151% and 200% FPL. The current CHIP income limit is 150% FPL.
Administrative Issues:	The program is currently operational. Additional staff will be needed to address the workload associated with increased enrollment. CHIP coverage cannot be expanded to children within this income range until all the children living at or below 150% FPL are covered.
Cost:	<p>CHIP contracts with an insurance plan for medical benefits. Total cost per year per child for medical benefits, dental services, eyeglasses, and state administration is \$1,639.99, of which the state share is \$311.60. Assuming an 85% take-up rate, 11,815 children between 151% and 200% FPL would be covered. The total annual cost would be \$19,360,082, of which the state share is \$3,808,128.</p> <ul style="list-style-type: none"> • Year 2: Serve 2,295 up to 165%, state share of cost is \$715,122 • Year 3: Serve 6,290 up to 185%, state share of cost is \$1,959,964 • Year 4: Serve 9,265 up to 200%, state share of cost is \$2,886,974 • Year 5: Serve 11,815 up to 200%, state share of cost is \$3,681,532 <p>Cost sharing for this group can be increased up to a 5% of annual gross household income. Increased cost sharing would mitigate the premium for the medical benefit and reduce the costs to the state listed above. Maximum annual cost sharing amounts for each income group are listed below:</p> <ul style="list-style-type: none"> • Up to 165% FPL, \$702 (\$58 per month) • Up to 185% FPL, \$772 (\$64 per month) • Up to 200% FPL, \$865 (\$72 per month)
Funding Sources:	State and Federal dollars; donations to CHIP program
Implementation:	<ul style="list-style-type: none"> • Address funding needs through HB 2 in order to assure general fund appropriations for the state share for Medicaid and CHIP. • Request a change in statute to increase CHIP income level from a maximum

	<p>of 150% FPL to 200% FPL.</p> <ul style="list-style-type: none"> • Implement administrative changes in order to serve uninsured children at determined Federal Poverty Level. • Implement cost sharing, if approved. Note there is no cost sharing at 100% FPL. The cost sharing is limited to 5% of the gross family income. Co-payments currently exist for the children between 101% and 150% FPL.
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- J. Maintain or increase availability of coverage through the Montana Comprehensive Health Association (MCHA) high-risk pool. Ensure enrollment for all those currently eligible; maintain or increase the low-income premium assistance state subsidy established by the 2003 Legislature; explore the possibility of expanding the current premium assistance program for eligible individuals from 150% Federal Poverty Level to 200% Federal Poverty Level; and continue or expand participation in the Trade Adjustment Assistance Act (TAA).

Target Population:	<p>MCHA offers subsidized insurance policies to eligible Montana residents who are considered uninsurable due to medical conditions or who are eligible for HIPAA Portability coverage. Currently MCHA serves</p> <ul style="list-style-type: none"> • 1,400 individuals through a traditional plan • 1,680 individuals through a portability plan • 180 individuals through the MCHA premium assistance program <p>The MCHA premium assistance program provides an additional premium subsidy for persons with qualifying conditions and a family income at or below 150% FPL. The 2003 Legislature certified the MCHA Portability Plan as a coverage option for persons eligible via the TAA. 3,500-4,000 individuals would be targeted by this proposal.</p>
Support/Rationale:	<p>Created by the 1985 Legislature, Montana's high-risk pool (MCHA) provides access to health care coverage to Montanans who are otherwise considered uninsurable due to existing medical conditions. If coverage were not offered to these individuals, providers would be faced with increased charity care and uncompensated care costs. Individuals served by this program have been rejected for health insurance coverage or have been offered a policy with a rider excluding a primary health condition. The 1997 Montana Legislature created a new MCHA plan to comply with HIPAA. This act requires that individuals who lose employer group coverage be guaranteed access to individual coverage with credit for pre-existing medical conditions.</p>
Administrative Issues:	<p>The MCHA Board directs the program, and Blue Cross and Blue Shield of Montana administers the plan.</p>
Cost:	<p>Together with federal HRSA grant funds, a legislative appropriation of \$1,150,000 for the current biennium helps to fund the low-income Premium Assistance program.</p> <p>Premiums paid by program participants and assessments on health premiums in Montana fund MCHA's traditional and portability coverage. MCHA was also awarded a federal Trade Adjustment Assistance Act (TAA) grant of \$638,228 to help offset health care expenses in calendar year 2004.</p> <p>As identified in the Montana Household Survey, uninsured individuals can only afford to pay low monthly premiums. Yet the cost of premiums is a major factor for most individuals who have pre-existing medical conditions or who have lost</p>

	<p>their health insurance coverage. The State Planning Grant recommends that the MCHA Board consider a benefit redesign for low-income individuals.</p> <p>Premium assistance for an additional 3,000 individuals would amount to more than \$20M for individuals not receiving the additional premium assistance. In that current premiums cover about 60% of costs, \$8M would have to be covered elsewhere, since assessment are capped.</p>
Funding Sources:	Unknown at this time
Implementation:	<p>Legislature:</p> <ul style="list-style-type: none"> Continue subsidy of MCHA and the premium assistance, established by the 2003 Session. <p>MCHA Board/State Auditor:</p> <ul style="list-style-type: none"> Continue to pursue federal funding sources where applicable. Ensure sustainability of current MCHA program. Continue to explore expansion of the MCHA assessment base to provide MCHA sustainability into the future. Continue current outreach including: requesting that all insurance agents provide MCHA to those who do not qualify for other plans; public service announcements; Health Fairs, etc. Identify a means to document current barriers regarding affordability of coverage. Continue to review and monitor the health status responses to the Behavioral Risk Factor Surveillance Survey (BRFSS) conducted annually by the Department of Public Health and Human Services (DPHHS) to help identify approximate numbers of persons with health risk factors and/or pre-existing conditions. Continue Annual Report to Legislature and State Auditor's Office regarding enrollment and access issues to ensure funding sources. <p>Department of Labor:</p> <ul style="list-style-type: none"> Develop and maintain outreach to potentially eligible persons. Continue to pursue federal funding sources (e.g., TAA).

- K. Explore a prescription drug benefit for adults between the ages of 62 and 64 with incomes up to 200% FPL who have applied for disability coverage and have a two-year waiting period.

Target Population:	Uninsured and underinsured adults. The total number of Montanans between the ages of 62 and 64 is 22,684 (2000 Census Data). No more than half are assumed to be at or below 200%FPL (or 11,342 individuals).
Support/Rationale:	The cost of prescription drugs is a significant cost driver. Nationwide prescription costs have been increasing as much as 20% to 30% per year. Moreover, prescription services may delay or obviate the need for inpatient services and thereby prevent more expensive care.
Administrative Issues:	Several prescription drug proposals were introduced in the 2003 Legislative Session. The eligibility requirements identified in SB 474 were complicated.

	The program would not go into effect until January 2005. Eligibility system enhancements would be required if this program were to be administered by DPHHS. .
Cost:	The fiscal note for SB 473 identified state special revenue (generated from an application fee), state and federal dollars in order to establish and maintain the program.
Funding Sources:	Based on previous legislation, funds would include state general funds, state special revenue, federal funds and prescription rebate fees. A portion of the proposed tobacco tax increase would also help to fund a state prescription drug program.
Implementation:	<ul style="list-style-type: none"> • In the interim, until the program is funded, provide outreach regarding Patient Assistance and prescription discount programs offered by pharmaceutical companies. Use the Information and Assistance program within the ten Area Agencies on Aging. • Explore the use of preferred drug lists as a way to control the high cost of drugs. • Review the evidence-based research (e.g., Oregon approach). • Provide education and consultation on the wise use of prescriptions (e.g., PharmAssist program). • Review Rx programs offered in the District of Columbia, Idaho, Alaska, Indiana, Vermont, Minnesota, Maine and Hawaii. • Request FDA approval for importation of drugs from Canada.

Other Recommendations to the Public Health Redesign Project (Not Mentioned Above)

L. Address enrollment issues and promote outreach

Target Population:	Uninsured, eligible children for Medicaid and CHIP (below 150% FPL). DPHHS estimates that an additional 7,000 children could be covered by Medicaid and that an additional 15,000 children could be covered by CHIP. See also recommendation H.
Support/Rationale:	Covering the most needy has been a consistent theme identified by the committees of the State Planning Grant.
Administrative Issues:	The program is currently operational. Additional staff may be needed to address increased volume associated with application process etc.
Cost:	To Be Determined
Funding Sources:	State and Federal dollars, donations to CHIP program
Implementation:	DPHHS should continue to pursue waiver options. The waiver could carve out dollars through refinancing which would specifically address outreach efforts, which would result in increased enrollment in Medicaid and/or CHIP.

M. *Support Development of a Health Insurance Flexibility Act (HIFA) Waiver.* The waiver would allow expansion of health care coverage, on a graduated basis, to uninsured Montanans.

Target Population:	<p>Several options were identified, including:</p> <ul style="list-style-type: none"> • Insure parents and guardians of publicly-insured children. At a minimum, insure parents/guardians at or below 100% FPL. Alternatively, expand Medicaid to cover parents/guardians between 101% and 150% FPL. • Provide coverage to Mental Health Service Plan recipients and/or low-income working adults. • Consider a premium assistance program or a basic medical plan, which may have limits, exclusions, and/or capped coverage for certain services. • Explore a modified self-directed program (similar to a Home & Community Based Waiver) that would provide the consumer with capped basic benefits and where the consumer shares an increasing responsibility for their own health care. <p>The SPG Coverage Options Committee recommends covering the parents of publicly insured children. At minimum, the goal would be to provide coverage for parents under 150% Federal Poverty Level.</p> <p>Based on the March 2004 enrollment of 10,770 children in CHIP, there are 5,385 families with children covered by the CHIP program. Statistics maintained by the Montana CHIP program indicates 6,998 parents (or 76%) are uninsured. Health insurance statistics regarding parents of Medicaid children are not available.</p> <p>76% of the parents of CHIP children are between the ages of 26-49. The Montana Household survey identifies an uninsured rate of 38% for those between the ages of 19 and 26 and 24% uninsured rate for those between the ages of 26-49. Providing health care to parents would help reduce the uninsured rate in Montana.</p> <p>The Mental Health Services Plan serves over 4,000 individuals annually. At a minimum, at least 90% of these individuals do not have health insurance.</p> <p>The waiver proposal would need to include a determination of the populations to include in the waiver, the implementation date and the coverage benefits offered.</p>
Support/Rationale:	<p>Based on the 2003 Montana Household Survey, statistics indicated that although 70% of the parents are employed, only 7% have employer-sponsored health insurance. The policy implication deduced from this information would indicate that no single approach would be effective in providing coverage for parents.</p> <p>Insuring parents, however, has been determined to be a positive strategy because the absence of health insurance can have serious consequences for the entire family. National studies and analyses, as identified in the Montana Issue Brief, reinforce that increasing access to health insurance would be keep working parents healthy and would assure that their children would access on-going health care and preventive services as needed.</p> <p>The development of the self-directed concept improves access, reduces bureaucratic complexities and promotes health literacy.</p>
Administrative Issues:	<p>The baseline information identified by the State Planning Grant has been beneficial. DPHHS will need to determine further issues if they move forward with the HIFA waiver option (and determine whether a full benefit or a limited benefit is offered to parents).</p>

Cost:	<p>The Department prepared a very rough estimate by using the number of Poverty Child (PC) and Poverty Six (PS) household cases covered and assuming an average of one parent per household. This roughly takes into account those PC and PS cases with no parent and those with two parents present. Anecdotal information identifies most cases are single parent households. Using this method, the rough estimate would add 11,813 adults, based upon February 2004 caseload figures. There may be some duplication in this due to households with children in both PC and PS programs. Again, exact figures would require an ad hoc report from TEAMS.</p> <p>Making the assumption that this count of 11,813 is the number of adults Montana could reasonably expect to cover under Medicaid, the cost would be:</p> <p>Cost of Medicaid coverage for Parents of Medicaid eligible children - using a premium assistance plan.</p> <table><tr><th></th><th>Individual Cost Per Month</th><th>Individual Cost Per Year</th><th>Total Cost Per Year</th><th>Estimated General Fund Cost</th></tr><tr><td>Blue Care Plan A (est.)</td><td>\$80</td><td>\$960</td><td>\$11,340,480</td><td>\$3,126,570</td></tr><tr><td>New West Bridge Plan (est.)</td><td>\$66</td><td>\$792</td><td>\$9,355,896</td><td>\$2,579,420</td></tr><tr><td>State Employee Health Plan</td><td>\$365</td><td>\$4,380</td><td>\$51,740,940</td><td>\$14,264,977</td></tr><tr><td>MCHA Average Mkt Rate (age 42)</td><td>\$324</td><td>\$3,888</td><td>\$45,931,779</td><td>\$12,663,391</td></tr></table>		Individual Cost Per Month	Individual Cost Per Year	Total Cost Per Year	Estimated General Fund Cost	Blue Care Plan A (est.)	\$80	\$960	\$11,340,480	\$3,126,570	New West Bridge Plan (est.)	\$66	\$792	\$9,355,896	\$2,579,420	State Employee Health Plan	\$365	\$4,380	\$51,740,940	\$14,264,977	MCHA Average Mkt Rate (age 42)	\$324	\$3,888	\$45,931,779	\$12,663,391
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Funding Sources:	State and Federal dollars																									
Implementation:	<p>DPHHS should continue to pursue waiver options. Through the waiver, a benefit design will need to be identified. Moreover, given the five year term of the waiver, provisions could be made to provide an employer premium assistance program at some point during the life of the waiver.</p> <p>Legislative approval and an associated appropriation will be necessary in order to pursue the waiver option.</p>																									

Recently DPHHS announced they will ask the 2005 Legislature to approve waiver options in order to initially cover approximately 8000 uninsured children and low-income adults. Under the proposed waiver, the Children's Health Insurance Program (CHIP) could add 5,000 children to the program. In addition, it is estimated that 3000 people currently enrolled in the Mental Health Services Plan would be eligible for a primary-care health insurance plan.

SECTION 5. CONSENSUS BUILDING STRATEGY

5.1 What was the governance structure used in the planning process and how effective was it as a decision-making structure? How were key State agencies identified and involved? How were key constituencies (e.g., providers, employers, and advocacy group) incorporated into the governance design? How were key State officials in the executive and legislative branches involved in the process?

The Governor appointed a twenty member Steering Committee to guide the activities of the grant, including project development, implementation, and identification of recommendations. Committee members included public and private sector leaders from all regions of the state, and represented business and industry, minority populations, nonprofit groups, health care delivery professionals, the health insurance sector, state agencies, and health care consumers.

Three work groups (data, safety net, and coverage options) were also formed to review resources, analyze data, and identify feasible solutions. Individuals involved in committee work included health care insurers, providers, advocates for low-income individuals, Indian Health Services staff, senior citizens, state legislators, and representatives from the business community and Chamber of Commerce.

5.2 What methods were used to obtain input from the public and key constituencies (e.g., town hall meetings, policy forums, focus groups, or citizen surveys)?

Information and input was gathered from a variety of sources. The Bureau of Business and Economic Research from the University of Montana and the State Health Access Data Assistance Center from the University of Minnesota partnered to develop and conduct the Montana Household Survey and Montana Employer Survey, the largest and most comprehensive surveys on health insurance in the state's history. The University of Montana also completed six focus groups and 30 key informant interviews.

To supplement the findings of the surveys, the University of Montana completed six focus groups and 30 key informant interviews. The state also held one statewide meeting using videoconferencing technology to obtain input from the public and various constituencies.

5.3 What other activities were conducted to build public awareness and support (e.g., advertising, brochures, Web site development)?

The Governor's Office assisted the SPG project team in coordinating all of the communication efforts regarding the study of the uninsured and policy work toward expanding health care coverage for Montana's uninsured population. A communication

plan guided efforts to make the public aware of the grant. Prior to the implementation of the household survey, a press release was sent to all Montana daily and weekly newspapers, including Native American newspapers, and association newsletters (Montana Medical Association, Montana Office of Rural Health, the Montana Hospital Association, Partners for Health, etc.) Steering Committee members prepared editorial comments for public radio stations and television interviews regarding the surveys.

After the Governor was briefed on the results of the surveys, additional press releases were issued. Issues facing the uninsured were discussed during the 2002 Governor's Health Care Summit. Representatives of the State Planning Grant Steering Committee were involved in the organization of the 2003 Governor's Health Care Summit, which included a panel discussion regarding the uninsured.

Information from the Steering Committee and the three work teams was published on the Department of Public Health and Human Services website. This information includes meeting dates, minutes, survey findings, power point presentations, as well as links to other national and state resources for the uninsured. Many consumers from across the state have used the website to request information.

In addition, the website address was used in all of the SPG quarterly updates, summary grant updates, and information articles provided to association newsletters and related mailings. The preliminary results of the Household Survey were released during a statewide videoconference meeting in March of 2003.

Representatives of the State Planning Grant Steering Committee and our work teams participated in the March 2002 and May 2003 Robert Wood Johnson Covering the Uninsured Week planning committee and events. This collaboration included providing informational updates on the grant via handouts, panel presentations, presentations to high school students, etc.

Data from the Household Survey were important to various communities in their applications for Community Health Center Funding. In addition, Montana's Healthy Mothers, Healthy Babies program used the results of the survey in its efforts to make families aware of the CHIP program.

5.4 How has this planning effort affected the policy environment? Describe the current policy environment in the State and the likelihood that the coverage expansion proposals will be undertaken in full.

The receipt of this grant provided the state with an opportunity to continue policy discussions that took place during the 2002 and 2003 Governor's Health Care Summit, as well as during earlier efforts to expand health care access. SPG activities over the past two years have brought together a diverse group of stakeholders to work toward defining a common vision. The individuals and groups involved in the SPG effort have articulated the shared goals of: providing affordable health care coverage for all Montanans;

strengthening the health care safety net across the state; and reducing (by 2010) the state's uninsured rate by 50% with an emphasis on covering children. These goals have gained visibility with state policy makers, key constituencies, and the public at large.

In order to achieve the goals envisioned, the SPG process identified an incremental approach to reducing the number of uninsured and promoting health among residents over the next six years. The strategies combine various approaches in public, employer-based, and individual health care markets, and have various fiscal implications for state and federal governments. Certain recommendations would require no additional funding, but others would involve new state dollars or longer-term funding mechanisms.

Much like other states, the downturn of the economy has had a dramatic effect on Montana's budget. Limitations on spending present significant obstacles. Resources to address health insurance coverage needs will surely compete with other highly visible priorities, such as education, corrections, economic development, and emergency preparedness, in future legislative sessions.

Nevertheless, the SPG planning effort has helped to mobilize a certain political consensus around the overall goal of increasing access to health insurance coverage. To the extent that health care continues to be high on the public's agenda, certain SPG recommendations may have a high likelihood of approval in the Legislature in upcoming sessions. Additional revenue sources may also be found to finance initiatives for uninsured Montanans. For example, the Insurance Commissioner, the Joint Subcommittee on Health Care and Health Insurance and other groups continue to pursue a proposal to increase the tobacco tax and utilize interest from the Tobacco Settlement Trust Fund for this purpose.

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES

6.1 How important was State-specific data to the decision-making process? Did more detailed information on uninsurance within specific subgroups of the State population help identify or clarify the most appropriate coverage expansion alternatives? How important was the qualitative research in identifying stakeholder issues and facilitating program design?

The State-specific data was crucial to the development of policy options to increase coverage among the uninsured. The 2003 Household Survey allowed Montana for the first time to make detailed estimates of uninsurance rates for various population groups within the state, such as rates by age or race and ethnicity. The Employer Survey filled in gaps in our knowledge about Montana businesses' offering of health insurance to their employees. The key informant interviews and focus groups helped to provide a more comprehensive picture of Montana's uninsured.

All of the SPG data collection activities have contributed to a deeper understanding of how health insurance coverage varies among different population groups in Montana, what barriers exist that prevent the uninsured from getting coverage, and how this affects their ability to access the health care system.

6.2 Which of the data collection activities were the most effective relative to resources expended in conducting the work?

The household and employer surveys yielded the most information relative to resources expended. It was helpful to use local vendors, to facilitate communication and project oversight. Establishing relationships with local vendors also helped to build the State's infrastructure for addressing health policy questions.

6.3 What (if any) data collection activities were originally proposed or contemplated that were not conducted? What were the reasons (e.g., excessive cost or methodological difficulties)?

Data activities were completed as originally proposed.

6.4 What strategies were effective in improving data collection? How did they make a difference (e.g., increasing response rates)?

One of the most important strategies identified within the SPG process was the use of a state-based vendor with experience in survey methodologies. The University of Montana Bureau of Business and Economic Research has been conducting statewide surveys for over 40 years. It is likely that their credibility accounted for the very high response rates on both the Household and Employer surveys.

6.5 What additional data collection activities are needed and why? What questions of significant policy relevance were left unanswered by the research conducted under the HRSA grant? Does the State have plans to conduct that research?

One of the coverage expansion policies Montana is considering is to insure parents of children on Medicaid and/or SCHIP. Although the household survey collected income and asset information, it was not specific enough to allow for the modeling of this kind of parent coverage expansion or other targeted strategies for low-income families. The state does not have plans to conduct this research at this time.

6.6 What organizational or operational lessons were learned during the course of the grant? Has the State proposed changes in the structure of health care programs or their coordination as a result of the HRSA planning effort?

Two key recommendations to structurally redesign public health care programs were made to members of Montana's Public Health Redesign Project by the SPG Steering Committee. These included addressing enrollment issues for individuals currently eligible for existing programs but who are not enrolled in Medicaid or CHIP, and supporting the development of a HIFA Waiver to allow a graduated expansion of health care coverage to uninsured Montanans. Both of these recommendations are discussed in greater detail in Section 4 of this report.

6.7 What key lessons about our insurance market and employer community resulted from the HRSA planning effort? How have the health plans responded to the proposed expansion mechanisms? What were your key lessons in how to work most effectively with the employer community in your State?

Data was collected from the employer community through our Employer Survey and data from the insurance market was collected via key informant interviews. Representatives from the insurance market and the employer community were also on the SPG Steering Committee. One of the key lessons we learned was the importance of having this representation when exploring policy options. When the Steering Committee explored the possibility of small business purchasing pools, these representatives shared their insights into why this option was not feasible for the State of Montana.

6.8 What are the key recommendations that your State can provide other States regarding the policy planning process?

Involve as much representation as possible from both the private and public sector and keep the general public informed throughout the grant process.

6.9 How did your State's political and economic environment change during the course of your grant?

The political and economic environment during the course of the grant was very challenging, especially given the fiscal cuts the State and Legislature were faced with making.

6.10 How did your project goals change during the grant period?

Goals did not change, as researchers focused on getting the survey results and incorporating those findings into their final recommendations.

6.11 What will be the next steps of this effort once the grant comes to a close?

The State will pursue the federal waiver in order to provide a primary care health insurance plan for individuals using the Mental Health Service Plan and will add 5,000 children to the Children's Health Insurance Plan program.

All of the grant documents have been collated and sent to the DPHHS Director's Office to be housed for future reference and sharing with State officials and public sector partners. The final report and recommendations will be printed and distributed statewide. In addition, this report will be maintained on the DPHHS web site.

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

7.1 What coverage expansion options selected require Federal waiver authority or other changes in Federal law (e.g., SCHIP regulations, ERISA)?

Several coverage expansion options as recommended by the SPG Steering Committee would require Federal waiver authority under HIFA. The waiver would allow expansion of health care coverage, on a graduated basis, to uninsured Montanans. Several coverage options were identified, including:

- Insuring parents and guardians of publicly-insured children. At a minimum, insuring parents/guardians at or below 100% FPL. Alternatively, expanding Medicaid to cover parents/guardians between 101% and 150% FPL.
- Providing coverage to Mental Health Service Plan recipients and/or low-income working adults.
- Considering a premium assistance program or a basic medical plan, which may have limits, exclusions, and/or capped coverage for certain services.
- Exploring a modified self-directed program (similar to a Home & Community Based Waiver) that would provide the consumer with capped basic benefits and where the consumer shares an increasing responsibility for their own health care.

7.2 What coverage expansion options not selected require changes in Federal law? What specific Federal actions would be required to implement those options, and why should the Federal government make those changes?

None of the coverage options considered in Montana would require changes in Federal law.

7.3 What additional support should the Federal government provide in terms of surveys or other efforts to identify the uninsured in States?

The level of detail provided by state-level surveys is very useful for state policymaking. However, the usefulness of cross-sectional data is limited. A consistent source of funding for routine surveys of health coverage in the states would provide a better source of data for program development, implementation and evaluation.

7.4 What additional research should be conducted (either by the federal government, foundations, or other organizations) to assist in identifying the uninsured or developing coverage expansion programs?

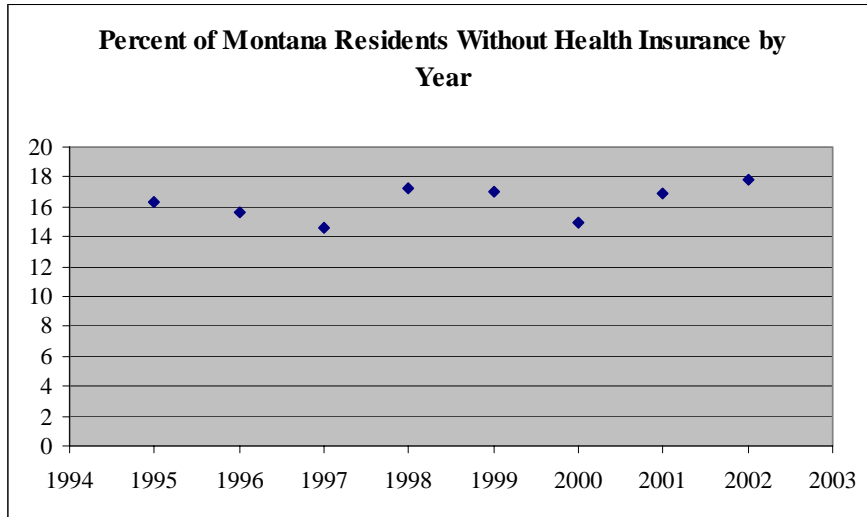
Once the research has been conducted, rural states like Montana need dollars for staffing in order to implement and follow-up on the recommendations.

APPENDIX I: BASELINE INFORMATION

Population

According to the US Census Bureau, the 2001 population estimate for the state of Montana is 904,433 persons (US Census 2004a).

Number and percentage of uninsured (current and trend)



(CDC 2004)

Average age of population

Persons under 5 years old, percent, 2000	6.1%
Persons under 18 years old, percent, 2000	25.5%
Persons 65 years old and over, percent, 2000	13.4%

(US Census 2004a)

Percent of population living in poverty (<100% FPL)

Persons below poverty, percent, 1999	14.6%
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(US Census 2004a)

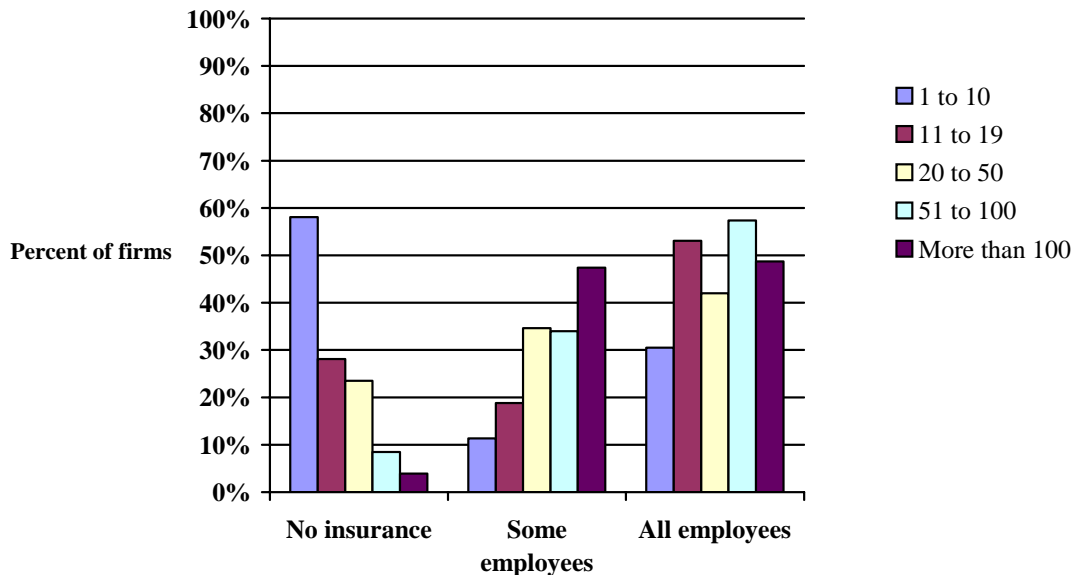
Primary industries

Industry	Number of Employees	Number of Establishments
Total	301,460	32,294
Forestry, fishing, hunting, and agriculture support	1,616	390
Mining	4,486	268
Utilities	2,825	220
Construction	18,607	3,958
Manufacturing	20,759	1,226
Wholesale trade	14,766	1,523
Retail trade	52,917	5,179
Transportation & warehousing	9,674	1,117
Information	8,811	647
Finance & insurance	13,987	1,685
Real estate & rental & leasing	4,813	1,345
Professional, scientific & technical services	16,191	2,707
Management of companies & enterprises	2,359	108
Admin, support, waste mgt, remediation services	12,340	1,289
Educational services	4,927	263
Health care and social assistance	49,761	2,887
Arts, entertainment & recreation	7,402	866
Accommodation & food services	39,599	3,148
Other services (except public administration)	14,520	3,008
Auxiliaries (exc corporate, subsidiary & regional mgt)	678	57
Unclassified establishments	422	403

(US Census 2004b)

Number and percent of employers offering coverage

The following graph depicts the percent of Montana firms who offer coverage to none, some or all of their employees by firm size. The data for the chart comes from the 2003 Montana Employer Survey (n=520).



Number and percent of self-insured firms

The table below shows the percent of private sector establishments that offer health insurance and self-insure at least one plan, by firm size. The data presented are from the 1999 Medical Expenditure Panel Survey, Insurance Component.

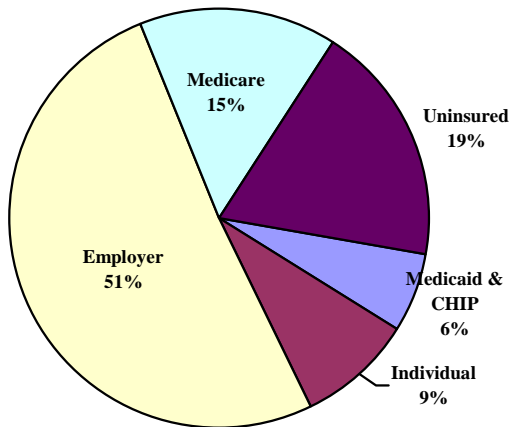
Firm Size	Percent that Self-Insure
Total	23.2%
Less than 100 employees	10.6%
100-499 employees	24.3%
500 or more employees	75%
Less than 50 employees	9.5%
50 or more employees	55.6%

(AHRQ 1999)

Payer mix

The following chart shows Montana residents' insurance coverage by type. These results are based on the 2003 Montana Household Survey.

Insurance Coverage by Type, Montana, 2003 (n=2,941)



Provider competition

According to the latest data provided by Health Resources and Services Administration (HRSA) State Profiles, Montana currently has about 181 active primary care physicians per 100,000 people, which is below the estimated average of 198 in the US. To help supplement the health care workforce, physician assistants, nurse practitioners and registered nurses (RNs) are available. There are about 15 physician assistants and 812 RNs per 100,000 people compared to the US average of 10 and 782 respectively. Montana has a strong safety net of community health clinics and hospitals for providing care to the low-income uninsured as well.

Insurance market reforms

The following paragraphs highlight the insurance market reforms initiated in Montana since 1991.

1991 – Limited Benefit Disability Insurance – Legislative proposal to allow marketing of a basic benefit package to uninsured employer groups. As an incentive, a tax credit was proposed for up to ten employees with a graduated credit of up to \$25 if the employer pays at least 50% of the health insurance cost. Basic plan provides maternity and newborn, well-child up to age two, a limited psychiatric and substance abuse benefit and hospital services. This was also a pay-or-play proposal, which did not make it, plus four new mandates and three health insurance regulatory expansions.

1993 - Montana Health Care Authority (HCA) – Legislative mandate to develop a comprehensive statewide health care reform strategy to provide all Montanans with improved access to high quality, affordable health care. The HCA was required to submit a single payer plan and a regulated multiple-payer system. A third alternative, a market-based sequential health care reform package was added. Due to financial constraints and lack of political consensus, plan was not funded.

SB 285 Small Group Reform – In addition to creation of the Health Care Authority, SB 285 also instituted the following small group reform provisions: establishment of classes of business with certain restrictions placed on rating; reasonable disclosure; guaranteed renewal except for premium non-payment; establishment of a minimum of two plans - a basic and a standard; limits preexisting waiting periods; regulates enrollment uniformity and contribution participation requirements; establishes small employer carrier reinsurance program.

1995 – Health Care Advisory Council (HCAC) replaces Health Care Authority. The Legislature charged the HCAC with monitoring and evaluating incremental and market-based approaches for health care reform.

Health Information Network – Legislature directed the development of a central database of healthcare resource, cost and quality information to increase access, promote cost containment and improve quality. The 1997 Legislature did not fund continuation of either of these projects.

Group Purchasing Cooperative – Legislatively authorized. Only one purchasing pool has been formed and its functions have changed considerably over time.

Caring Program for Children – Legislature provided state funding for this 1992-public/private partnership with Blue Cross Blue Shield of Montana, which targets low-income uninsured children.

Mental Health Access Program – Legislature authorized state funding for mental health services for non-Medicaid low-income individuals with serious mental illnesses/children with emotional disturbances.

Small Group Reform, round II and the Small Employer Health Insurance Availability Act, Individual Market Reform – comparability provisions added; Uniform Benefit Plan, a lower-cost, catastrophic plan added; clarification that association plans must comply with guarantee issue; portability of preexisting waiting period carried to individual coverage. MCHA benefits were expanded.

Medicaid Managed Care – allowed a new category of licensure for managed care plans called Managed Care Community Networks that could be established by providers only.

Premium Deductibility - allowed individual income tax deduction for 1/2 of premium payments for health insurance.

Medical Savings Accounts – tax exemption for contributions up to \$3000 deposited into a MSA Account.

1997 – Managed Care Network Adequacy and Quality Assurance Act – Legislative initiative to protect the rights of individuals enrolled in managed care plans. The Act improved access to emergency services and set standards for network adequacy and quality assurance, which, to date, are rare throughout the United States.

Montana HIPAA Implementation – All group business – prevention of “job lock”, no discrimination on health status; preexisting condition look-back 6 months, credit for prior creditable coverage, small group reforms expanded to groups of 2 – 50; MCHA expansion for Portability – addition of coverage availability.

Premium Deductibility moved to 100%, MSAs amended and six additional insurance mandates or regulatory provisions applied

2003 – HB 216 – Tax Credit for Small Businesses and Individuals Pilot. The 2003 Legislature, based on a recommendation from the SJR 22 Committee, considered a bill to allow advanceable, refundable tax credits to small businesses and lower-income individuals. Died in House Tax Committee.

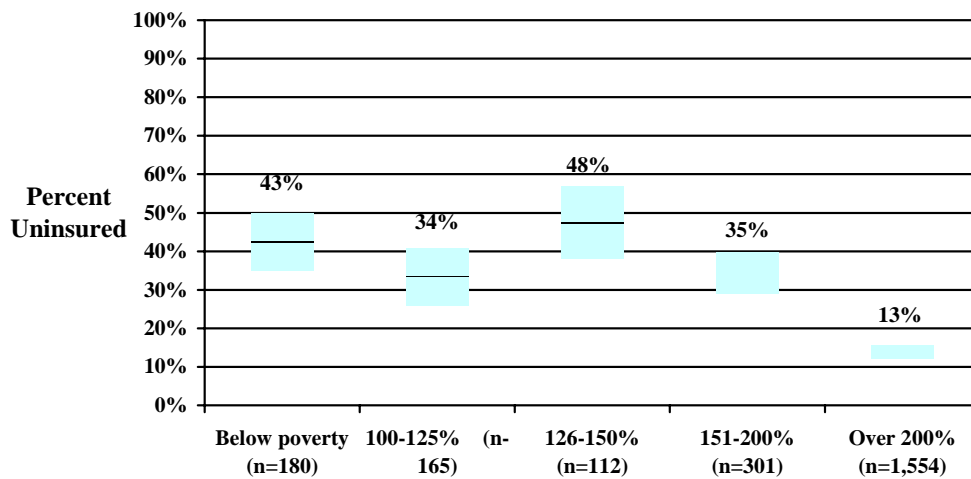
HB 104 – Revise laws for insurance purchasing pools. Lowered the number of eligible individuals needed to form a purchasing pool from 1000 to 51.

HB 384 – Limited health benefit plans for uninsured individuals. Adopted by the legislature, this bill allows health insurers to conduct demonstration projects issuing limited benefit plans, including a plan covering only outpatient care. First state funding to subsidize premiums for low-income individuals buying MCHA high-risk pool coverage. In response to I-146, the legislature appropriated \$1,350,000 for the biennium to the MCHA to continue the premium subsidy program begun in 2002 through a federal grant.

Eligibility for existing coverage programs (Medicaid/SCHIP/other)

The chart below depicts the uninsured rate by income as a percent of poverty for Montana residents ages zero to 64 years. The Medicaid income eligibility level for low-income pregnant women and children under six years in Montana is 133% of the Federal Poverty Guidelines (FPG). The income eligibility level for SCHIP is 150% FPG. The data presented below suggest that there are several uninsured Montana residents who appear to be eligible for public coverage.

Uninsured Rate by Income As a Percent of Poverty, Montana Residents 0-64 Years Old, 2003



Use of Federal Waivers

Montana applied for a Medicaid Section 1115 waiver in October 2003. This waiver would provide a limited Medicaid benefit package of optional services for Medicaid-eligible adults aged 21-64 who are not pregnant or disabled. This is a continuation of the same limited Medicaid benefit package provided under the authority of Montana's welfare reform waiver in 1996.

Montana also utilizes home and community-based waivers for the provision of long-term care services to the aged and disabled.

APPENDIX II: LINKS TO RESEARCH FINDINGS AND METHODOLOGIES

State of Montana Department of Public Health and Human Services:

<http://www.dphhs.state.mt.us>

Montana State Planning Grant for the Uninsured:

<http://www.dphhs.state.mt.us/hpsd/uninsured/index.htm>

Montana State Planning Grant Survey Information:

<http://www.dphhs.state.mt.us/hpsd/uninsured/survey.htm>

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