Montana State Planning Grant
A Big Sky Opportunity to
Expand Health Insurance Coverage

Interim Report

Submitted to
Health Resources and Services Administration (HRSA)
U.S. Department of Health and Human services

September 2003

Executive Summary

Prior to the receipt of the State Planning Grant (SPG), Montana has had to rely on data through federal or private efforts to describe our 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 implement provide the uninsured access to affordable health insurance coverage.

This interim report highlights the results of the first twelve months of the grant 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 key public and private stakeholders from across the state, 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. The work teams include: Data Team, 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 Survey 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 the Data Team. The University of Montana also completed six Focus Groups and 30 Key Informant Interviews. Preliminary data on the results of the two surveys was presented to the SPG Steering Committee at their September 2003 meeting.

The SPG grant proposal identified an eight-person Safety Net team to begin meeting in the fall of 2002. A Special Session of the Montana Legislature was called in August 2002 to address significant budget shortfalls. Budget cuts were made within the Montana Medicaid program and state agency programs in order to maintain a balanced budget. The SPG Safety Net team was expanded to include statewide representation from a variety of providers, consumers, and state agency representatives. This work team met between November 2003 and May 2003 and developed a Safety Net analysis and strategic plan that was presented to the SPG Steering Committee.

The Coverage Options team has been reviewing the preliminary data from the University of Montana, along with other information from states who have expanded coverage to the uninsured. In addition we are working with SHADAC, who is providing further data analysis and comparison options in relation to other states. The results of SHADAC's research are slated to be presented to our SPG Steering Committee and Coverage Options team in December 2003.

The grant extension awarded by HRSA will allow the Steering Committee to continue to review the data, analyze options and develop our strategic plan.

Section 1. Summary of Findings: Uninsured Individuals and Families

1.1 What is the overall level of uninsurance in your State?

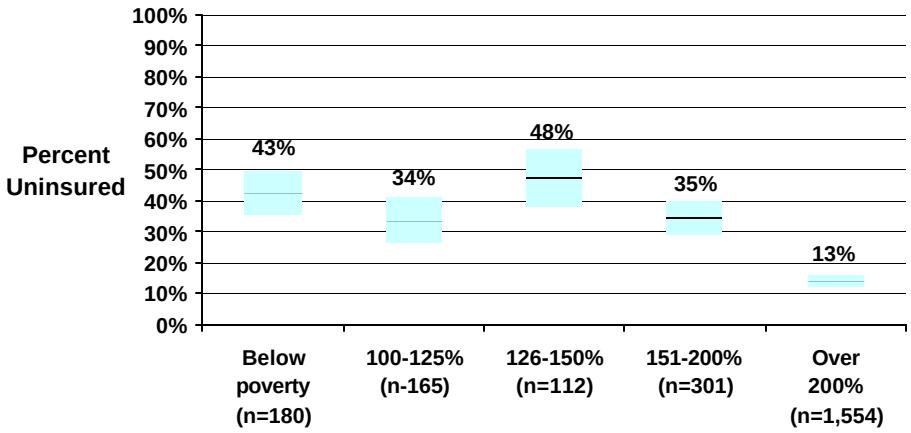
Overall, 19% of Montanans, or approximately 173,000 people were uninsured at the time of the 2003 survey.

1.2 What are the characteristics of the uninsured?

Income

Household income levels are a major determinant of health coverage. Lower income households, as shown in Figure 1, have higher rates of uninsurance. About 43 percent of persons in households with income below the 2002 federal poverty level ($18,100 for a family of four) do not have health insurance coverage. The uninsured rate drops for the next poverty bracket of 101 to 125 percent 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.

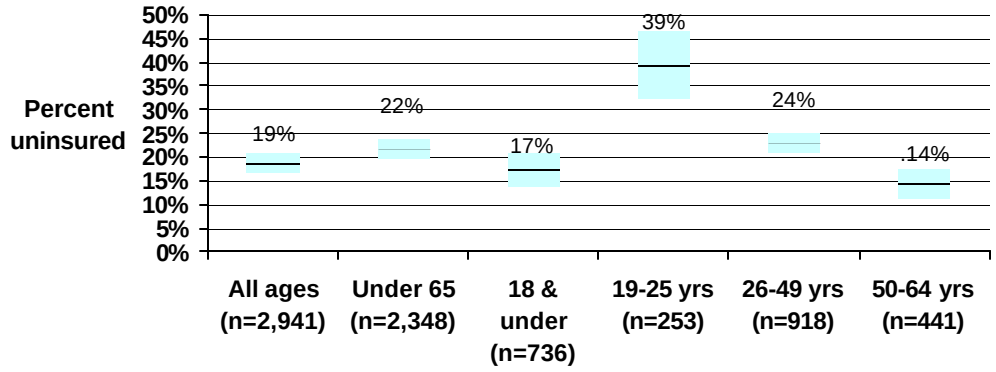
Figure 1.1 Uninsured Rate by Income As a Percent of Poverty, Montana Residents 0-64 years old, 2003



Age

Health insurance rates by age show considerable variation (Figure 1.2). The overall uninsured rate for all ages of 19 percent 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 uninsured rate of 14 percent. Montana youth 18 years old and younger have an uninsured rate of 17 percent, one of the highest children uninsured rates in the nation.

Figure 1.2 Montana Uninsured Rate by Age,



Gender

50% males and 50% females represented the uninsured in our survey.

Family Composition

The household composition results of the survey were:

31% - single	9% - living with a partner
45% - married	15% - divorced/widowed/separated

Health Status

Information is still being reviewed.

Employment Status

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.

A large majority of uninsured Montanans is employed. Twenty-six percent of the uninsured were self-employed and 51 percent by someone else (for uninsured children, these statistics refer to the primary wage earner in the family). A high percent of employed Montanans without insurance were in permanent jobs (84%) and were employed by small employers of 10 or fewer employees (56%). Industries with high proportions of the uninsured included agriculture, construction, government, hospitality services such as motels, casinos, convenience stores, and gas stations, other services such as personal and repair businesses, and retail trade.

Availability of private coverage

Slightly more than half (51%) of all Montanans had employer-based health insurance. Individual health insurance policies accounted for nine percent of the state's population. Uninsured rates for the non-elderly population are a more accurate measure of the health

insurance gap in Montana since nearly everyone 65 years of age and older has health insurance through Medicare.

Availability of public coverage

Medicaid and CHIP account for 10 percent of the state's non-elderly health coverage. Medicare covered 15 percent of Montana's population. See Figure 1.3 for a summary of insurance coverage by type.

Figure 1.3 Insurance Coverage by Type for Non –Elderly (under 65 years of age) Montana Residents, 2003

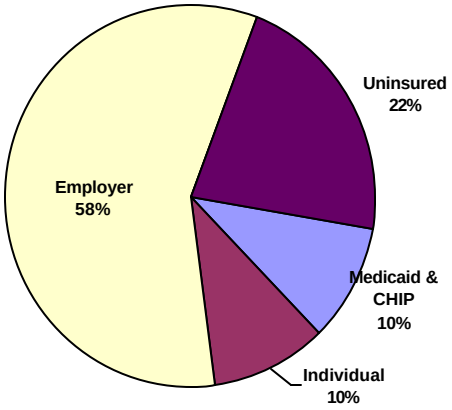
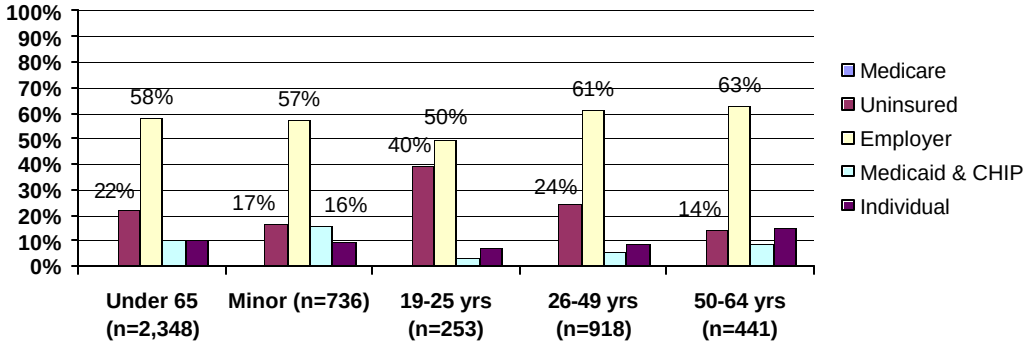


Figure 1.4 Insurance Coverage by Type, Montana, 2003



Race/Ethnicity

Montana's American Indian populations experience uninsurance at much higher rates that were two times higher compared to the statewide average. Uninsured American Indians represent about 24,000 of the 173,000 uninsured Montanans.

Immigration Status – This question was not evaluated.

Geographic location

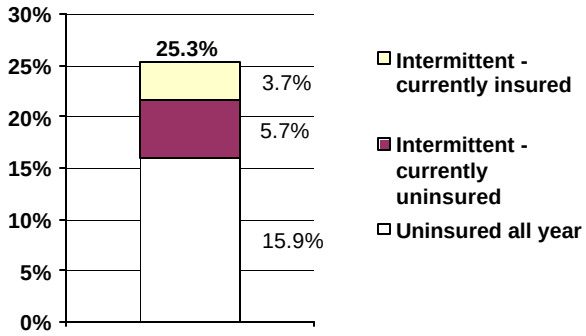
Montana's uninsured rates of 21 percent in urban areas were slightly lower than the 23 percent rate in rural areas.

Duration of uninsurance

Rates of uninsured in this report are point in time estimates from telephone calls during the first 5 months of 2003. Persons reported their insurance status at the time of the phone call as well as insurance status over the past year. It is possible to estimate transitions between insured and uninsured from this information since it is possible to identify respondents who did not have insurance during the past 12 months, those who were uninsured at the time of the interview but were covered at some point during the past 12 months, and those who were covered but did not have insurance at some point during the past 12 months.

These different measures for Montana's non-elderly population are shown in Figure 1.5. Almost 16 percent of the 22 percent uninsured rate for non-elderly Montanans represent the long term 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 long term 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 Montanan in the state lacked health insurance at some time during the year.

Figure 1.5 Montana Uninsurance Rates in 2003 Using Alternative Definitions (n=2941)



1.3 Summarizing the information provided above, what population groups were particularly important for your State in developing targeted coverage expansion options?

The Coverage Options Team is identifying these groups.

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

Ninety percent of the uninsured said the lack of health insurance was forced or due to lack of a budget for insurance after paying for the basic life necessities such as food, clothing, and housing. This response pattern was reinforced by comments and discussions of focus group participants who cited high monthly premiums as beyond their monthly income.

Health insurance cost impacts on household budgets were explored through several questions on the household survey. Eighty one percent of the respondents indicated they could afford a monthly premium of ninety-six ($96).

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

The summary report of the Focus Group study identifies some qualitative data of why people do not participate in public programs. See www.dphhs.mt.us (Health Policy Division/uninsured). The Coverage Options team is continuing to evaluate this study.

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

The summary report of the Focus Group study identifies some qualitative data of why people disenroll from public programs. . See www.dphhs.mt.us (Health Policy Division/uninsured). The Coverage Options team is continuing to evaluate this study.

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

The high premium cost and affordability were two reasons for not participating.

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

The Coverage Options team is evaluating this information.

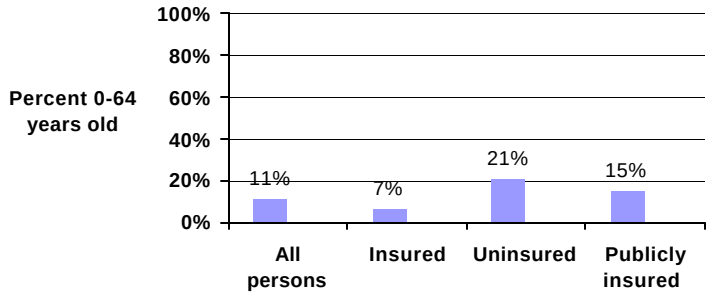
1.9 How likely are individuals to be influenced by:
Availability of subsidies?
Tax credits or other incentives?

SHADAC is assisting the Steering Committee and the Coverage Options Team in evaluating this information.

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

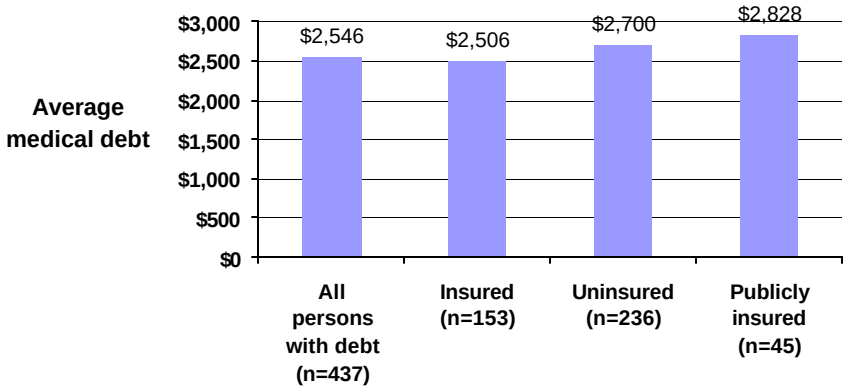
Eleven percent of all non-elderly Montanans had medical debt in the past 12 months. There were differences by insurance status with 7 percent of insured Montanans having medical debt and more than 3 times that percent or 21 percent of uninsured persons with medical debt. Public health insurance coverage did not eliminate the impact of medical debt on low-income households. Fifteen percent of the publicly insured did have medical debt.

Figure 1.6 Montana Residents 0-64 Years Old with Medical Debt, 2003 (n=2,251)



Average dollar amounts of medical debt are shown in Figure 1.7. 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.

Figure 1.7 Average Medical Debt for Non-elderly Montanans, 2003



1.11 How are the uninsured getting their medical needs met?

The Coverage Options team is studying this issue.

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

The Coverage Options Team is studying this issue.

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

The Coverage Options Team is addressing this issue.

Section 2. Summary of Findings: Employer-based Coverage

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

According to the Montana Employer Survey, firm size by the number of employees was the major determinant for offering job-based health insurance in Montana. Fifty-nine percent of Montana firms with ten or fewer employees did not offer health insurance. See Table 2.1 There was some difference in insurance offer rates when the small firm cutoff of ten or fewer employees was subdivided into firms with one to five employees (64% of whom did not offer insurance) and firms with six to ten employees, where 48% of the firms in this size group did not offer insurance.

Employer size

Table 2.1: Montana Firms Offering Health Insurance, 2003

	Percent offering Health Insurance		
Firm Size (# employees)	**No Insurance**	**Certain Employees**	**All Employees**
1 to 5	63%	9.4%	27.5%
6 to 10	47.7%	15.4%	36.9%
11 to 20	28.1%	18.8%	53.1%
20 to 100	20.1%	34.4%	45.5%
More than 100	3.9%	47.4%	48.7%

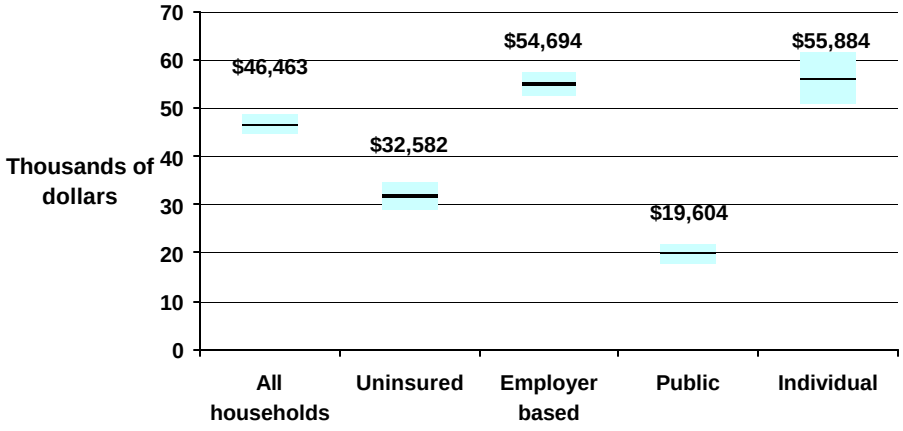
More than 95% of firms with more than 100 employees offered health insurance and 100% of very large employers of 500 or more offered health insurance.

Industry Sector – This information will be summarized in the final report.

Employee income brackets

Employer based insurance coverage varied by household size and by average income. Persons in households of 2, 3 and 4 persons were more likely to be covered on the jobs with coverage rates varying from 61.1% to 59.7% to 64.1%. Average household income was higher for persons covered by individual insurance and by employed based insurance.

Figure 2.2 Insurance Coverage by Household Income (under 65 years of age) Montana Residents, 2003



The survey results found the average number of hours per week requirement for

insurance coverage was 30 hours. The average number of months waiting period before becoming eligible for the employer's health coverage plan was four months.

Geographic location - This information will be included in the final report.

Other(s) This information will be included in the final report.

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?

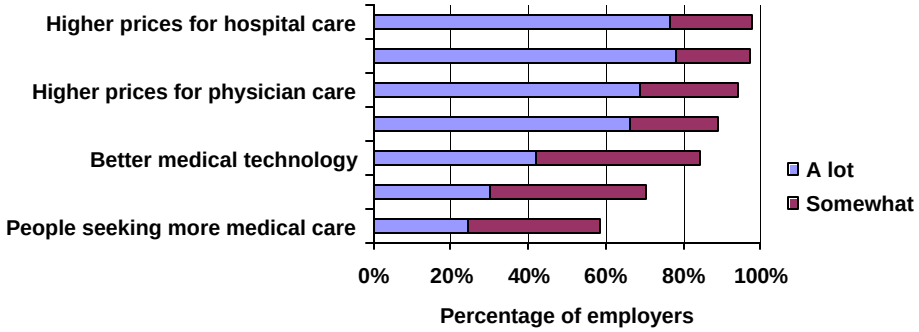
Employer costs of health insurance premiums were cited as the major reason that employers identified as to why they either did not offer or thought firms did not offer health insurance. Eighty one percent of the firms responding to this question thought premiums were too high and prevented firms from 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 health insurance they will offer to their employees? What factors go into their decisions regarding premium contributions, benefit packages, and other features of the coverage?

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.

Employers' concerns over health insurance premium costs and increased premiums were examined through the views on health insurance premium increases in 2003 (Figure 2.3). Higher prices for basic medical services such as hospital care; prescription drugs, and physician care were the most frequently cited factors for higher premiums in the view of Montana employers. Malpractice insurance costs were another factor thought to be driving higher insurance premiums. Better medical technology, higher insurance company profits and higher healthcare utilization by consumers were three factors also cited although with a lower frequency by employers.

Figure 2.3: Montana Employer Views on Health Insurance Premium Increases in 2003 (n=520)



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

This question was not addressed in our survey.

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

This question was not addressed in our survey.

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?

Policy options for increasing employer based insurance coverage were examined in the employer survey. Montana employers not offering health insurance were asked about their reaction to tax credits that would offset a portion of the health insurance premiums for their workers. They were also questioned about attitudes and reaction to buy ins into large, public health insurance plans like the state employees' plan with eligibility confined to low-income employees. More detailed analysis of policy options will be conducted by the State Health Access Data Assistance Center located in the University of Minnesota School of Public Health.

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

This question will be addressed in the final report.

Section 3. Summary of Findings: Health Care Marketplace

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

This question will be addressed in the final report.

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

To date, we have not addressed this question

3.3 *How prevalent are self-insured firms in your State? What impact does that have in the State's marketplace*?

This question will be addressed in the final report.

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

This question will be addressed in the final report.

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

To date, we have not addressed this question

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

To date, we have not addressed this question.

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. (The Safety Net report will be included with our final report).

3.8 How would utilization change with universal coverage?

To date, we have not addressed this question

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 the 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 addition, the three members of the Steering Committee are participating in the Public Health/Medicaid Re-design project.

Section 4. Options for Expanding Coverage

The Coverage Options team is evaluating various options and awaiting the presentation of the three Issue Briefs by SHADAC.

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 groups) 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 members to guide the activities of the grant. Representatives included key public and private stakeholders from all regions of the state. Membership included Legislative representatives, the Insurance Commissioner, health care consumers, Native American representation, insurance companies, the State Chamber of Commerce and the National Federation of Independent Business, safety net providers, community organizations and state agencies dealing with health and insurance.

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 across the state. The University of Montana conducted two surveys: the Montana Household Survey and the Montana Employer Survey. To date, one statewide meeting has been held via the statewide videoconference. In addition, six focus groups were held and thirty individuals were interviewed for the Key Informant report.

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 State Planning Grant in coordinating all of the communications efforts regarding our study of the uninsured and work towards expanding health care coverage for Montana's uninsured population. In addition, our communication plan helped direct our efforts to make the public aware of the grant project. Prior to the implementation of the Household Survey, a press release was sent to all Montana daily and weekly newspapers, including the 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 the Montana NPR Radio Stations and television interviews regarding the surveys.

Additional press releases were issued after briefing updates on the survey results were held with the Governor. Issues facing the uninsured were discussed during the 2002 Governor's Health Care Summit. Representatives of the State Planning Grant Steering Committee are involved in the organization of the 2003 Governor's Health Care Summit. Plans are underway to include a panel discussion regarding the uninsured at the September 2003 Health Care Summit.

Information from Steering Committee and the three work teams was published on the Department of Public Health and Human Services web site. The information on the web site includes meeting dates, minutes, survey findings, power point presentations, Montana and national resources for the uninsured. Many consumers from across the state have also used the web site to submit information and/or request information as a result of being uninsured.

In addition, the web site address was used in all of the SPG quarterly updates; summary grant updates and information articles provided to various Association newsletters and related mailings. During a statewide videoconference meeting, the preliminary results of our Household survey were released in early March

Representatives of the State Planning Grant Steering Committee and our work teams participated in the March 2002 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.

The preliminary data of our Household survey was important to various communities in their applications for Community Health Center funding. In addition Montana's Healthy Mothers, Healthy Babies, in their late summer outreach to make families aware of the CHIP program, used the preliminary survey results.

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.

This question will be addressed in the Final Report.

Section 6. Lessons Learned and Recommendations to States

These questions will be addressed in the Final Report.

Section 7. Recommendations to the Federal Government

These questions will be addressed in the Final Report.