Montana's Health Insurance Market: Prospects for 2014 and Beyond

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Executive Summary

Passage of the Affordable Care Act (ACA) will change the way many Montanans buy health insurance. To better understand how these changes might impact Montana's health insurance markets, the Bureau of Business and Economic Research (BBER) at The University of Montana conducted an intensive survey of Montana households and businesses during 2011. This sample data, along with national and regional studies, is used to model the potential impacts of the ACA on Montana's health insurance markets.

For Montana's 195,000 uninsured, the ACA would allow many to qualify for health insurance either through the possible expansion of the Medicaid program or for advanceable premium tax credits (APTC) and cost-sharing reductions (CSR) available in the Federally Facilitated Exchange (FFE). Beginning in 2014, all Montanans, uninsured and insured, will have access to apples-to-apples comparisons of qualified health plans via the FFE consumer portal, which will make health insurance comparisons more transparent across price and quality.

The Federally Facilitated Exchange will guide qualified consumers and small employers in their purchase of health insurance plans. Qualified individuals include non-incarcerated U.S. citizens and legal immigrants who do not have access to affordable, employer-sponsored health insurance. Individuals will also qualify for health insurance plans sold in the FFE if their employer-sponsored plan has an actuarial value less than 60 percent, if the employee's share of the premium is more than 9.5 percent of their household income, or if the employer plan does not meet minimum essential coverage requirements. Small employers (those with fewer than 50 employees) may also benefit by allowing their employees to purchase health insurance in the FFE or by purchasing insurance in the Small Business Health Options Program (SHOP). In 2016, small employers are redefined to include employers with 100 or fewer employees.

For the vast majority of Montana's uninsured, health insurance is simply too expensive. Only 16,000 (8 percent) of the uninsured in Montana do not have health insurance by choice. The remaining 179,000 uninsured and many of Montana's small employers will use the Exchange as a shopping mall for affordable health insurance.

The qualified health plans sold in the FFE are required to offer essential health benefits tied to four levels of actuarial value. Actuarial value guides consumers in comparing and choosing health plans since actuarial value is a general measure of health plan generosity. Under the Bronze level of coverage, the health plan will pay 60 percent of covered benefits before the consumer's out-of-pocket limit is reached. All plans will have a statutory maximum limit for out-of-pocket expenses ($6,050 for an individual in 2014). The next level, Silver, has an actuarial value of 70 percent. The Silver Plan is the only plan where individuals who qualify may receive cost-sharing reductions. In addition, the APTC will be based on the cost of the second lowest cost plan (Silver) offered in the Exchanges. The Gold level has an actuarial value of 80 percent. The highest level,

Platinum, will pay on average 90 percent of expected medical costs before the out-of-pocket maximum limit is reached by the consumer. Catastrophic plans are available, but only to enrollees under 30 years old, or those who qualify because of non-affordability (because their share of the health care premium exceeds 8 percent of income). All individual and small employer group health plans must offer the same actuarial value tiers and follow the same essential health benefits whether they are sold inside or outside of the Exchange.

The advanceable premium tax credits, the cost-sharing reductions, and the Medicaid expansion are available to individuals based on their incomes in relation to the federal poverty level. For a family of four and based on 2012 federal poverty levels, the APTC are available on a sliding scale to those with incomes between $23,050 and $92,200. The cost-sharing reductions are limited to those with incomes up to 250 percent of the federal poverty level, or $57,625 for a family of four. The Medicaid expansion increases the maximum income threshold to 133 percent of the federal poverty level, or $30,657. With the 5 percent income offset allowed in the expansion, the income threshold for Medicaid eligibility becomes $31,809 for a family of four.

All in all, the availability of APTC and cost-sharing reductions, the potential expansion of Medicaid, guaranteed availability with no preexisting condition exclusions, and the individual mandate to purchase insurance should incentivize many Montanans to purchase health insurance who otherwise find health insurance unaffordable.

The number of Montanans who purchase health insurance in the FFE is primarily determined by the number of uninsured (195,000) and the number of individuals currently covered in the individual health insurance market (54,000). The Congressional Budget Office estimates that almost 70 percent of the Exchange population nationally will consist of the uninsured. Applying this percentage to the number of uninsured in Montana, and assuming *all* uninsured were to enter the FFE, the Exchange population could reach almost 278,000. Some of the uninsured will not enter the Exchange, so this threshold population is considered a maximum. Of these 278,000, 87,000 may qualify for the advanceable premium tax credit (available to families with incomes under 400 percent of the federal poverty level) and 55,000 may also qualify for cost-sharing reductions (available to families with incomes up to 250 percent of the federal poverty level). Should the state of Montana decide against the Medicaid expansion, another 3,000 individuals may qualify for the APTC and cost-sharing reductions available in the FFE. These 3,000 individuals are those with income levels between 100 percent and 138 percent of the federal poverty level who previously would have been eligible for the Medicaid expansion.

Several factors contribute to the potential number of subsidized individuals in the FFE. These factors include the unusually large number of uninsured in Montana, Montana's lower wages, the prominence of small employers in the state, and the proportion of private sector establishments that offer employer-provided insurance. Nationally, 44 percent of the private workforce is employed by firms with fewer than 50 employees, whereas in Montana this proportion is 63 percent. Small employers are less likely to offer

health insurance to their employees. Montana's per capita income is 88 percent of per capita income in the U.S., and 65 percent of Montana families have incomes under $75,000, or 340 percent of the federal poverty level, compared to only 59 percent nationally. The self-employed are also more prevalent in Montana than in the nation. The self-employed are also less likely to have health insurance since they do not benefit from the advantages that accrue to employer-sponsored insurance, such as guaranteed issue and nondiscrimination on the basis of health status. In Montana, three in ten employers are sole proprietors without employees, compared to two in ten nationally.

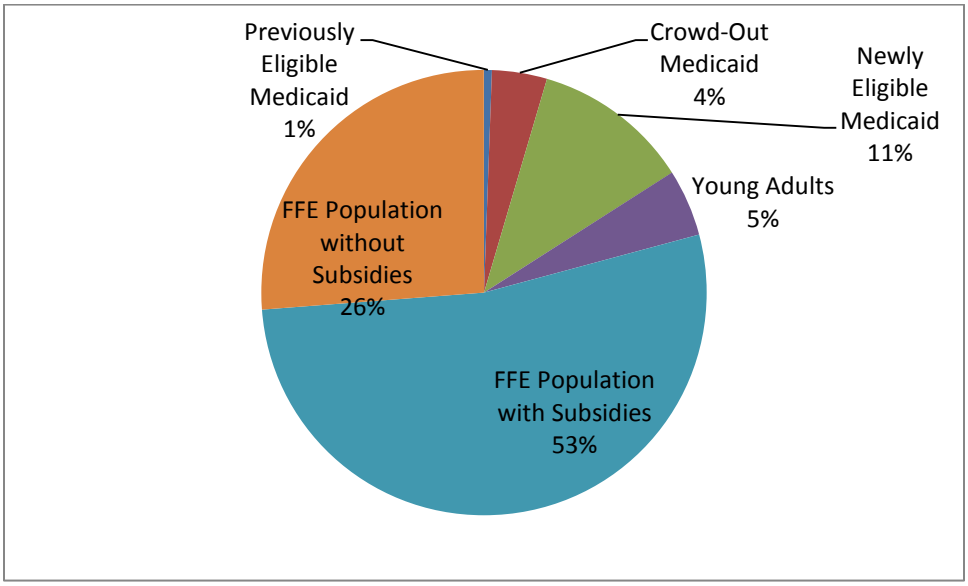
There is an inverse relationship between employer-size and health insurance coverage among Montana households. Only 10 percent of those employed by large employers (more than 100 employees) are uninsured, compared to an uninsured rate of nearly 30 percent for those employed by firms with 2 to 19 employees.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

Overall, lower-income individuals are more likely to self-report worse health than their higher-income counterparts. This is important since the APTC and cost-sharing reductions available in the FFE are tied to incomes as a percentage of the federal poverty level. Montana individuals who qualify for the Medicaid expansion self-report fair to poor health in proportions much higher than the individuals with incomes greater than 400 percent of the federal poverty level, or $92,200 for a family of four. For the uninsured in Montana whose incomes are below the Medicaid expansion threshold, over 32 percent between 30-49 years old, and 28 percent between 50-64 years old, report fair or poor health . The proportions reporting fair to poor health above 400 percent of the federal poverty level was statistically insignificant in the BBER household survey sample. Nationally, three times the number of individuals with incomes below the Medicaid expansion threshold and who are between 30-49 years of age reported fair to poor health, compared to those with incomes above 400 percent of the federal poverty level. For individuals between 50-64 years of age that are Medicaid eligible, twice the number report fair to poor health as those with incomes above 400 percent of the federal poverty level. Overall, between 11,000 and 33,000 uninsured in fair to poor health may end up in Montana's FFE.

Several provisions of the ACA may cause changes in health insurance status for Montanans, such as the availability of APTC, cost-sharing reductions, guaranteed availability, the individual mandate, the potential expansion of Medicaid, the ability of young adults to stay on their parents' insurance policies until age 26, and possible changes as individuals transition from private and employer-sponsored insurance to public insurance, primarily Medicaid. Overall, 354,000 Montanans may have a change in insurance status. Over half may enroll in the FFE for the APTC and cost-sharing reductions. This group will be comprised of the uninsured with incomes between 138 percent and 400 percent of the federal poverty level (87,000), those with private insurance with incomes under 400 percent of the federal poverty level (55,000), and individuals with employer-sponsored insurance with premiums greater than 9.5 percent of their incomes. The Medicaid expansion alone will account for 16 percent of the total number of individuals that may have a change in insurance status, with most being newly

eligible, followed by those who may be dropped from private coverage and instead enrolled in Medicaid, and a smaller percentage of individuals that previously were eligible for Medicaid, but who never enrolled in the program. Employers who drop employees from health insurance coverage, on the expectation that they will now be eligible for Medicaid, must do so for all employees, not just the Medicaid eligible.

If Montana does not expand Medicaid eligibility, 37,000 Montanans will be too rich for Medicaid and too poor for the APTC and cost-sharing reductions available in the FFE. This population therefore will most likely remain uninsured.



Among the uninsured in Montana, 160,000 could potentially gain health insurance coverage due to provisions in the ACA, including the Medicaid expansion. This still leaves 35,000 who choose to remain uninsured. Some of the uninsured may choose to remain uninsured despite the individual mandate since the penalty may be less than the cost of health care coverage, even with the APTC and cost-sharing reductions. There is no legal penalty for failing to comply with the individual mandate other than relatively small charges. Others may choose not to enroll in the Medicaid expansion simply due to the social stigma often associated with Medicaid coverage.

Certain individuals will be exempt from the individual mandate if they meet one of two opt-out criteria. One exemption from the individual mandate is if income is below the tax filing threshold for filing income taxes, currently $9,000 for an individual. The second exemption to the individual mandate is if the cost of health insurance exceeds 8 percent of their income, after taking into account the APTC available in the FFE. In Montana, 15,000 uninsured have incomes below the tax filing threshold, and are therefore exempt from the individual mandate to purchase health insurance. Another 73,000 uninsured

could possibly opt-out of purchasing health insurance since their cost of insurance, even after APTC, could exceed 8 percent of their income. This assumes that the Congressional Budget Office estimate of premiums for a Bronze Plan will be between $4,500 and $5,000 for a single policy and $12,000 and $12,500 for a family policy. Not until individual income reaches $56,000, or about 500 percent of the federal poverty level, do premium costs account for less than 8 percent of income.

Non-affordability alone is not the only way individuals can opt-out of the individual mandate. The charges for going without health insurance are relatively small. Initially the charge is only $95 per adult or one percent of income in 2014. Not until 2016 does the charge increase to $695 per adult or 2.5 percent of income, whichever is greater. For example, an individual with an income of $17,000, or 150 percent of the federal poverty level, would be expected to pay $690, or 4 percent of their income, toward the $4,500 premium. The advanceable tax premium credit would be $3,810. Should this individual decide to forego purchasing health insurance, and instead pay the penalty, they would pay just $5 more than the cost of the insurance. This concept of course ignores the peace of mind that comes with health insurance, and the fact that only 16,000 people in Montana are willingly foregoing health insurance. Nevertheless, 137,000 of Montana's 195,000 uninsured could opt-out of purchasing health insurance penalty-free. If these individuals fail to pay the penalty, the Internal Revenue Service can attempt to collect funds by reducing the amount of their tax refunds, if applicable. However, those choosing not to pay the penalty will not be subject to any criminal prosecution or fine for failing to pay.

Eligibility in both Medicaid and the Federally Facilitated Exchange will be affected by changes in income as well as family composition. As family circumstances change, there will be movement between Medicaid and the FFE and between employer-sponsored insurance and the FFE, and possibly Medicaid. Churning is the result of people moving between different types of insurance. Administratively this creates challenges since these changes in family circumstance must be closely monitored.

For example, a 2011 study examined national data to determine the frequency of income fluctuations over time among low-income adults. The study found that 24 percent of the adults in the study population experienced at least two eligibility changes within one year sufficient enough to move them in and out of the 138 percent federal poverty threshold of the Medicaid expansion. Within two years the proportion of adults with significant enough income changes to move them in and out of Medicaid increased to 39 percent. By the fourth year, only 20 percent of adults initially eligible for Medicaid would still be eligible for the program, and only 30 percent of adults eligible for the APTC in the Exchanges would be continuously eligible for the credits. The study also found that some low-income adults may have incomes low enough to exempt them altogether from the insurance mandate.

Another study in 2012 found that one-third of the people initially judged to be below the Medicaid income threshold will churn into the Exchange and be eligible for the APTC due to changes in income. For individuals and families above 400 percent of the federal poverty level ($44,680 for individuals and $92,200 for a family of four) 3 percent could

be falsely identified as eligible for the APTC at the time of application. Overall, the study found that because of changes in income, a significant percentage of families could be judged ineligible for Exchange APTC when in fact they are eligible and a much smaller percentage could be judged eligible for the APTC when in fact they are ineligible.

Insurance churn is also possible between employer-sponsored insurance (ESI) and Medicaid, and ESI and the Exchange. Whether or not employers will drop employer-sponsored health insurance and instead send their employees to the Exchanges is a topic of debate and one that has no settled conclusions. Large employers (those with 50 or more employees) will face fines for not offering coverage. However, the fines are substantially less than the cost of providing insurance. Presumably however, wages would have to increase to offset the loss of health insurance benefits and the higher tax liability that comes with higher wages. In addition, employees lose the tax exclusion of health insurance benefits. Should the employer drop employees from health insurance coverage, employees can look for insurance in the FFE beginning in 2014. Although employees won't be eligible for the tax breaks they receive with employer sponsored coverage, they may be eligible for APTC and cost-sharing reductions. Only 3 percent of the private establishments in Montana have 50 or more employees, accounting for 37 percent of total private sector employees. It is also reasonable to assume that small employers too would be pressured to increase their workforce wages. Small employers in Montana collectively employ 63 percent of total private sector employees.

The Congressional Budget Office examined numerous surveys and concluded that it is doubtful that any survey conducted prior to 2014 could provide accurate predictions of future employer decisions with respect to the ACA. As opposed to survey-based studies, modeling approaches are relatively more consistent and similar in their findings regarding employer-sponsored insurance. Studies done by the Office of the Actuary, Centers for Medicare and Medicaid Services, the Urban Institute, the Lewin Group, Rand, the Congressional Budget Office, and the Joint Committee on Taxation all predict small to modest changes in employment-based insurance. However, even given the similarity in findings, caution should be used since modeling approaches all assume modest changes in incentives and behavioral responses. The ACA is anything but a small or modest change in incentives. The changes in incentives as provided in the ACA are far-reaching and considerable in magnitude.

Certain, is that the ACA will change incentives for both employers and employees due to the Medicaid expansion, the availability of APTC and cost-sharing reductions in the Exchange, guaranteed availability in the individual market, the individual mandate, temporary tax credits available to small employers, penalties for larger employers, and the expectation by workers of higher wages should their employer drop health insurance coverage.

Montana employers that choose to abandon health insurance coverage because of the ACA will most likely be the smaller employer, with predominately lower-wage workers, who may be eligible for Medicaid or the APTC available in the FFE. Many of the smallest employers are businesses that employ only family members.

For Montana firms with higher wage workers, the advantage of obtaining health insurance in the individual exchange is negligible. Higher wage families receive smaller or no APTC, and may not qualify for any cost-sharing reductions. More importantly, higher wage families lose the tax deductions for insurance obtained through employer-sponsored insurance. In addition, the expectation of higher compensation should the employer drop health insurance coverage will push higher wage families into higher percentages of the federal poverty level, possibly high enough to eliminate any Exchange APTC and cost-sharing reductions altogether. In an analysis by the Congressional Budget Office, the tax advantaged treatment that comes with employer-sponsored insurance outweighs any benefits of buying lower cost policies in the Exchange for higher income workers. Beginning at about 300 percent of the federal poverty level, ($69,150 for a family of four) the tax subsidies associated with employer-sponsored health insurance outweigh the APTC and cost-sharing reductions available in the Exchange.

For firms contemplating dropping employer-sponsored health insurance, the advantages and disadvantages of doing so will depend on their employees' household incomes. While firms know the wages of their workers, they do not know the adjusted gross incomes of their workers' families on which the APTC and cost-sharing reductions are based.

The only consensus that can be reached from review of various modeling scenarios is that there is a tremendous amount of uncertainty about how employers will respond to the incentives and penalties of the ACA. Using data from the Medical Expenditure Panel Survey, the BBER estimates that number of lower-wage workers in Montana vulnerable to losing their employer-sponsored health insurance is between 24,000 and 41,000. These figures are based on the number of employees eligible for and enrolled in their employer's health insurance policy.

In one of the more detailed analyses of the employer response to the ACA, four different employer scenarios were examined. One scenario made the employee "whole" by subsidizing the full cost to employees of obtaining coverage in the Exchange. A second scenario examined a cost-neutral impact on the employer by subsidizing Exchange coverage without spending any more per person per year than the employer's current health plan. The third scenario provided sufficient compensation to employees in order to reduce overall net healthcare costs by 20 percent, and the fourth scenario looked at no subsidies to the employees. The analysis reached three key findings. First, there is no immediate or long-term cost advantage for employers to eliminate group health benefits. Second, it costs the employer more to make employees "whole" when shifting their coverage to the Exchange than to continue existing group health plans, and finally, if employers choose to drop health insurance, their employees suffer a significant reduction in overall compensation since employees now have to assume the incremental cost of health benefits.

Perhaps more important than the conflicting conclusions reached by many of these studies is recognition of the fact that employers must provide market value in benefits and compensation to retain and attract highly skilled workers. Particularly for mid-sized

to large firms, those most likely to provide employer-sponsored insurance, the economics of “pay or play” will depend on whether Exchange plans are more efficient than current group health plans.

Finally, several trends were already in play and pre-date passage of the ACA. These trends include increases in the employee share of health plan premiums and cost-sharing, increases in the use of account-based high-deductible health plans and consumer directed health plans, and health savings accounts.

Nationally, fewer small employers claimed the Small Employer Health Insurance Tax Credits during tax year 2010 than were eligible, according to the Government Accountability Office (GAO). According to the GAO analysis, only 4 - 12 percent of eligible small firms claimed the credit. Further, firms claiming the federal tax credit only received partial tax credits because of the full-time equivalent requirements, average wage, or state average premiums as determined by the Internal Revenue Service. In addition, the federal tax credit is reduced for those employers receiving state tax credits or state premium subsidies under Insure Montana. In Montana, this affects 701 firms using the state tax credit and 787 firms using the purchasing pool for subsidies. At this time, it is unknown whether the Montana legislature will continue to fund the Insure Montana small business tax credit and premium subsidies in 2014.

The central feature of the health reform legislation is the creation of insurance marketplaces in which individuals and small businesses can compare and purchase health plans. These Exchanges are designed to create more efficient and competitive markets for individuals and small businesses to shop for health insurance policies that are transparent on price, benefits, and quality. Whether or not these Exchanges will change the competitiveness of the health insurance industry is unknown. The health insurance industry is unique in that it can exercise market power in several ways. As purchasers of medical services, they can exercise monopsony power by extracting discounts from medical providers, possibly benefiting consumers of health care. But as sellers of health insurance, they can wield monopoly power and extract higher premiums from consumers and employers.

An examination of health insurance industry market concentration by the Kaiser Family Foundation in 2010 looked at market share based on enrollees. Based on enrollment, the market share for the largest carrier in Montana was 51 percent. Well over half of the states in the U.S. had market concentrations greater than that found in Montana. Montana’s market share (51 percent) was just under the median market share for all states, 54 percent. Alabama had the highest market concentration based on the market share of the largest insurer, 86 percent, while Wisconsin had the lowest market concentration, 21 percent.

A better measure for market concentration is the Herfindahl-Hirschman Index, which takes on a value from 0 to 10,000, where 10,000 is representative of one firm having 100 percent of the market share. Montana had a value of 3,459. Generally, values below 1,500 indicate a non-concentrated market. Values above 2,500 indicate considerable

market concentration. While Montana's index of 3,459 may seem high, 26 states had indices even higher. Wisconsin was the only state with a value less than 1,500, indicating a fairly competitive health insurance market.

The BBER was able to update the Kaiser Family Foundation measures of market power using data provided by Leif Associates from their 2012 survey of health insurance carriers in Montana. For the individual market, the number of health insurance firms with more than 5 percent market share decreased from 3 in 2010 to 2 in 2011. The market share of the largest insurer, however, increased by 6 percentage points, or nearly 12 percent, to 57 percent of the individual market. The Herfindahl-Hirschman Index increased from 3,459 to 3,703, an increase of only 7 percent.

In the small group market, the number of health care insurers with more than 5 percent market share decreased from 5 in 2010 to 4 in 2011. The market share of the largest insurer fell in 2011, from 71 percent in 2010 to 46 percent in 2011. Because the market share of the dominant firm decreased drastically, the Herfindahl-Hirschman Index decreased as well, from 5,271 in 2010 to 3,023 in 2011. These changes indicate that the small group market is more competitive in 2011 than it was in 2010, despite a decrease in the number of health care insurers with more than 5 percent market share.

The Herfindahl-Hirschman Index for the large group market is 5,406, suggesting that the large group market in Montana is the most concentrated health insurance market compared to the individual and small group markets.

Using the other states as benchmarks to assess the relative degree of market competition in Montana's health insurance markets, Montana's individual health insurance market, although concentrated, is comparable to the degree of competition nationally. The small group health insurance market, however, is more competitive than the same market nationally. Hence, the ability of insurers to wield bargaining power in the small group market may be more limited than in the individual and large group markets. Further, Montana may be adding two more carriers to the individual market, the Montana Co-operative and a multi-state carrier. This should increase competition in a fairly concentrated market.

Perhaps the greatest threat to all Exchanges is the disproportionate enrollment of high-risk, high-cost individuals. This adverse selection could be the result of lower-risk, lower-cost individuals and employers seeking lower cost options outside the Exchanges. This then leads to the death spiral of rapidly rising costs for those left in the Exchanges. Adverse selection occurs between insurers, plan benefit designs, and even between markets. However, this is mitigated since individual and small group health insurance must follow the same rules, whether sold inside or outside the Exchanges, regarding essential health benefits, actuarial values, limitations on cost-sharing and rating reforms. For example, similar insurance products must have the same rate and be in the same risk pool inside and outside the Exchanges. Commissions must also be the same for policies sold inside and outside the Exchanges.

In Montana's Federally Facilitated Exchange, previously uninsured individuals who will be purchasing the Silver Plan will, on average, be in self-reported poorer health than their higher-income counterparts also purchasing the Silver Plan. This is primarily due to the lure of cost-sharing reductions which are available only to families below 250 percent of the federal poverty level ($57,625 for a family of four).

Some of the provisions of the ACA that mitigate the effects of adverse selection include reinsurance, risk corridors, and risk adjustment, among many other provisions and proposed new rules. Reinsurance provides funding to individual market insurers incurring high cost claims during 2014 to 2016. Reinsurance is designed to offset the claims of high-risk individuals entering the individual health insurance market once guaranteed issue is mandated in 2014. Another temporary program to deal with adverse selection is the risk corridor. Risk corridors will limit insurer losses and gains for Qualified Health Plans sold inside the Exchanges. Risk corridors are designed to mitigate inaccurate rate setting and occur only after reinsurance and risk adjustment have been applied. While reinsurance and risk corridors are temporary programs, risk adjustment is an ongoing program to protect against adverse selection between insurers. Risk adjustment applies both to the individual and small group markets inside and outside the Exchanges. Under risk adjustment, funds are transferred from health plans covering lower-risk individuals to plans that cover higher risk individuals.

Finally, this study examines how health care resources will be impacted by passage of the ACA, particularly the impact the uninsured have on ambulatory health care as they gain access to health insurance. Ambulatory health care use by the uninsured is less than that used by the insured. Some studies suggest that use of the health care system by the uninsured increases to that of the insured as they gain health insurance, while other studies indicate use increases initially above levels used by the insured then eventually returns to levels of health care utilization by the insured. Congressional Budget Office analysis assumes that the newly insured increase their use of the health care but only to levels of 75 to 90 percent of the previously insured.

The 2007 National Ambulatory Medical Care Survey shows use of the ambulatory care settings by source of payment. Compared to the uninsured, the privately insured use hospital emergency departments far less, instead relying more on primary care, medical and surgical specialty offices. Medicaid enrollees have more visits across all ambulatory health care settings when compared to the uninsured.

Approximately 65 percent of Montana's uninsured will obtain their health insurance through private coverage, while the balance (35 percent) will acquire health insurance in the Medicaid expansion, assuming the state of Montana expands Medicaid. In all, over 360,000 new visits to ambulatory care settings statewide are expected. By far the biggest increase in health care utilization will be to primary care offices.

Although BBER survey data is not statistically valid for county level analysis, data is available from the three-year estimates of the American Community Survey. Using these estimates, the demand for primary care office visits will increase by over 260,000 office

visits per year. As expected, Missoula and Yellowstone Counties will see the largest increases in the demand for primary care, over 220,000 and 296,000 office visits respectively.

Montana overall should be able to accommodate the increased demand for primary care office visits, based on the number of practicing primary care physicians and the number of office visits each can accommodate per year. Adding the increase in primary care office visits due to the uninsured acquiring insurance to existing primary care demand, primary care providers in Montana should see almost 2 million office visits per year, excluding office visits by tourists and other out-of-state patients. Based on BBER estimates, the capacity of the primary care system to accommodate this demand is almost 82,000 office visits greater than the expected demand. This is consistent with another study which showed that Montana's capacity to accommodate the added demand for primary care brought about by passage of the ACA was slightly better than the national norm. The primary care system may be more strained in certain counties however. Gallatin, Missoula and Flathead Counties may see chronic shortages of primary care providers given the projected increases in the demand for primary care as their county populations go from being uninsured to insured.

This study examined several aspects of the health insurance market, and the people most likely to be affected by passage of the ACA. While there is considerable uncertainty surrounding many aspects of the ACA, certain is the fact that the dynamics of these markets will be changed. Approximately 20 percent of Montana's civilian, non-institutionalized population will have access to more affordable health insurance either through the Federally Facilitated Exchange or the possible expansion of Medicaid. Montana's primary care system, the focus of the ACA, appears to be adequately staffed to handle the added strain put on the health care system, although certain counties may experience challenges. Understanding who Montana's uninsured are in terms of socio-demographic and health characteristics should help policy makers better prepare for the changes forthcoming from passage of the ACA.

Contents

Introduction

Montanans' access to health insurance is about to change drastically beginning in 2014. With passage of the Patient Protection and Affordable Care Act (ACA) in 2010, Montana's uninsured, that qualify, will have access to subsidized health care insurance either through the possible expansion of Medicaid or in Montana's Federally Facilitated Exchange. Others too will have access to the Exchange consumer portal which, hopefully, will enable all consumers to make apples-to- apples comparisons of qualified health plans that are price and quality transparent. Particularly for employees who don't receive health insurance coverage through large employers, a new range of options will become available.

The overall goal of the Exchange is to provide affordable health care coverage. Individuals in Montana lack health insurance not by choice, but rather because it is too expensive, particularly for Montana's low income households. The individual mandate of the ACA will only impact the 8 percent of Montana's 195,000 uninsured who voluntarily opt-out of health insurance because they are young and healthy.

It is difficult for individuals with chronic conditions to buy coverage in the individual market. The Exchanges are designed to remedy the non-affordability of health insurance policies for these individuals. Initially, individuals and small employers will use the Exchanges as a shopping mall for health insurance.

The Health Insurance Exchange

The ACA allows each state the opportunity to establish a health insurance marketplace called an Affordable Insurance Exchange ("Exchange"). Eligible individuals and small employers will be able to compare and select from qualified health plans (QHPs) for their families and their employees. Qualified Health Plans must meet actuarial value standards and provide "essential health benefits."

Exchanges will provide information to consumers to guide them in their purchase of health insurance. Health plans will initially be available to qualified individuals and small employers. Qualified individuals include non-incarcerated U.S. citizens and legal immigrants who do not have access to affordable, employer-sponsored, health insurance or whose employer offers a health plan that does not have an actuarial value of at least 60 percent, is unaffordable or does not offer "minimum essential coverage." The actuarial value measures the percentage of expected medical costs that a health plan will cover before the consumer's out-of-pocket limit is reached. The actuarial value is considered a general measure of health plan generosity. As such, it can guide consumers in comparing and choosing health plans. An employer's offer of insurance is considered affordable if the employee's share of the premium is less than 9.5 percent of household income. One problem with the criterion for affordability is that it is based on the cost of health insurance for the employee only, not the cost of covering the employee's family. This

conceivably could impede other family members' access to affordable health insurance. The Treasury Department is aware of this issue and it may be addressed later in the final rules. The health care law also provides for a Small Business Health Options Program (SHOP) Exchange for small businesses with up to 100 employees. However, states may limit the number of employees to 50 or fewer workers, prior to 2016.

States are encouraged to establish Exchanges, known as the American Health Benefit Exchange for individuals and the Small Business Health Options Program for businesses. States have the option of combining both Exchanges, or keeping them separate. States that do not establish a state-based Exchange will have a Federally Facilitated Exchange.

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

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

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

All health plans sold outside the Exchange in the individual and small employer group market must offer the same actuarial value tiers and follow the same essential health benefit benchmark.

Financial Assistance Available in the Exchange

Financial assistance to purchase health insurance in the Exchange is available to low and moderate income families who do not have an offer of affordable health insurance from their employer and who have incomes between 100 percent and 400 percent of the federal poverty level (FPL). For individuals, 100 percent of the federal poverty level in 2012 is $11,170, and for a family of four, $23,050. The 400 percent federal poverty level for individuals is $44,680, and $92,200 for a family of four. These subsidies offset premium costs and are in the form of advanceable premium tax credits (APTC). A refundable tax credit is available to individuals even if the individual does not have any tax liability. An advanceable tax credit allows a person to receive assistance at the time they purchase health insurance rather than paying the premium out-of-pocket and waiting to be reimbursed when they file their annual tax return. The advanceable premium tax credit is tied to the second lowest cost Silver plan in the Exchange and will be set on a sliding scale so that the premium contributions by families are limited to a percentage of income for specified income levels. A Silver plan is a plan that provides the essential benefits and has an actuarial value of 70 percent. A 70 percent actuarial value means that on average the health plan will pay 70 percent of the cost of covered benefits for a standard population of enrollees, until the out-of-pocket limit is reached.

As ruled by the recent Supreme Court decision on the Affordable Care Act, states now have the option of extending coverage in Medicaid to most people with incomes under 138 percent of the federal poverty level. For individuals not eligible for Medicaid, and who have incomes of at least 100 percent of the federal poverty level, APTC are available in the Exchange. People with incomes up to 250 percent of the federal poverty level are also eligible for coverage with lower deductibles and copayments, known as “cost-sharing reductions.”

The Federally Facilitated Exchange Population Eligible for Advanceable Premium Tax Credits and Cost Sharing Reductions

The Federally Facilitated Health Exchange in Montana is intended to facilitate the purchase of health insurance by individuals and small employers. Although all legal residents without access to employer-sponsored health insurance coverage may purchase their health insurance in the Federally Facilitated Exchange, sliding-scale federal credits, in the form of APTC, will be available only for individuals with incomes between 100 percent and 400 percent of the federal poverty level. These APTC are available to all residents with incomes below 400 percent of the federal poverty level, who are not Medicare or Medicaid eligible, and who do not have an affordable offer of health insurance from their employer. The APTC are tied to the premiums of the second lowest cost Silver plan to be offered in the Federally Facilitated Exchange. The APTC decrease as incomes increase. These sliding scale APTC should result in Federally Facilitated Exchange enrollees spending anywhere from 2 percent to 9.5 percent of their household income on health insurance premiums. In addition to the APTC, households with incomes up to 250 percent of the federal poverty level will be eligible for cost-sharing reductions.

For individuals, the 250 percent federal poverty level is $27,925, and for a family of four, $57,625. The APTC and cost-sharing reductions, in addition to the mandate that all individuals purchase health insurance or face a small penalty, should incentivize individuals to purchase health insurance in the Exchange.

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

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

Montana's Federally Facilitated Exchange Population

How individuals respond to the incentives and penalties of the Affordable Care Act is subject to speculation. Beginning in 2014, the uninsured that opt-out of purchasing health insurance will face penalties of $95 per year, or up to 1 percent of income, whichever is greater. Two years later, the penalty increases to $695 per year, or 2.5 percent of income, whichever is greater. A family of four with a household income of $80,000 (342 percent of the federal poverty level) would pay a penalty of approximately $2,000. On the other hand, if instead they purchase health insurance in the Federally Facilitated Exchange, they would be eligible for an advanceable premium tax credit of $4,530 toward a health care insurance policy with a premium of $12,130. The household pays $7,600 toward the premium, or 9.5 percent of their household income. The maximum out-of-pocket this family would pay is $8,333, excluding their share of the premium. The requirement for coverage can be waived for several reasons, including financial hardship or on religious grounds.

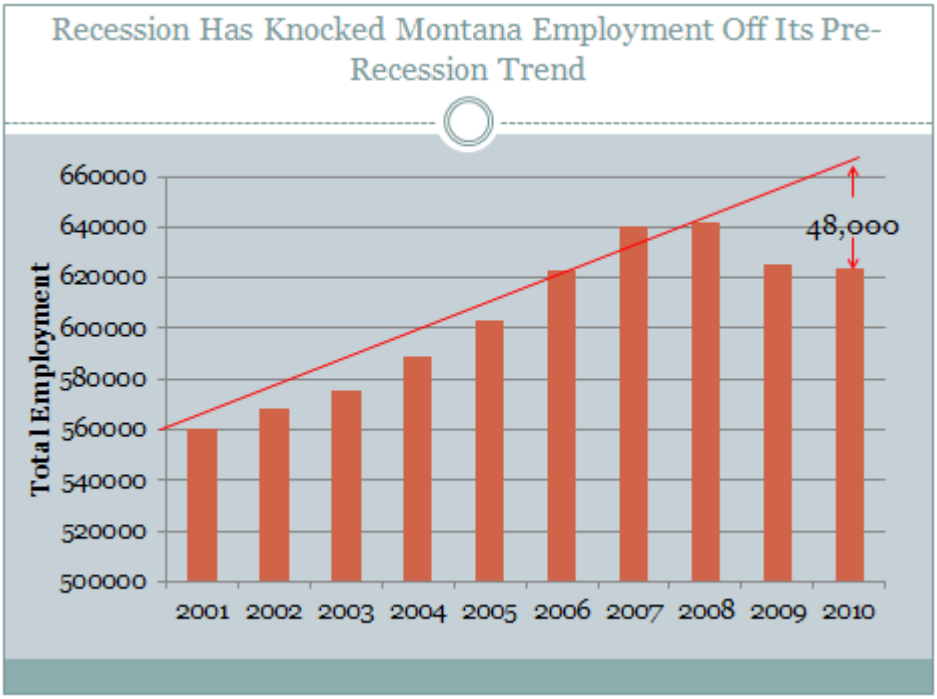
Nationally, almost 70 percent of the Exchange population is expected to come from the uninsured population. Assuming this proportion holds true for Montana, and that *all* uninsured enter the Exchange instead of paying the penalty, Montana's Federally

Facilitated Exchange (FFE) population could reach 278,000. Since not all uninsured will become insured, the Exchange population could be as low as 228,000.

Twenty percent of Montana's non-institutionalized population lacks health insurance of any kind. Eighty percent of the uninsured (156,000) have incomes below 400 percent of the federal poverty level. Approximately 35 percent (69,000) are below the threshold for the Medicaid expansion under the Affordable Care Act. Another 75,000 to 91,000 are underinsured, defined as having per person deductibles equal to or exceeding 5 percent of family income or health policy premiums that exceed 9.5 percent of family income. This would include some of the insured in the individual market (54,000).

How many Montanans end up in the Federally Facilitated Exchange is in part directly dependent on the economy and the speed by which economic recovery, and jobs, rebound in Montana. In 2010, Montana was still 48,000 jobs short of its pre-recession trend in job growth (Figure 1).

Figure 1: Employment Shortfall from Long Term Job Growth Trend, Montana



Source: BBER-UM

The potential Federally Facilitated Exchange population that will be eligible for subsidies and cost sharing is based on three independent populations; 1) the uninsured between 138 percent and 400 percent of the federal poverty level, 2) those with individual insurance, and 3) those with employer-sponsored insurance who have premiums that exceed 9.5 percent of income. Including the uninsured between 100 percent and 138 percent of the federal poverty level would add another 3,000 uninsured to the Exchange. In addition, a subset of the employer-sponsored insurance group may be small employers who choose

to use the Federally Facilitated Exchange instead of employer-sponsored insurance (discussed in a subsequent section of this report). Although the number of employees that may fall into this group is substantial, 24,000 to 41,000, we exclude them since many will be already included in the group with premiums that exceed 9.5 percent of income.

Approximately 181,000 Montanans, or two-thirds of the estimated Federally Facilitated Exchange population, may qualify for cost-sharing reductions and/or APTC. Among the uninsured only, 87,000 may qualify for APTC, while 55,000 may qualify for the cost-sharing reductions. Table 1 below summarizes the population estimates both for the Federally Facilitated Exchange and the number of people who could potentially qualify for APTC and cost-sharing reductions.

Table 1: Potential Federally Facilitated Exchange Population, Montana

Uninsured between 138% and 400% FPL	87,000
Individual Insurance and < 400% FPL	50,000
Employer-Sponsored Insurance but Premium > 9.5% Income	44,000
Total FFE Population with Subsidies and Cost Sharing	181,000
Total FFE Population	229,000 - 278,000

Source: BBER-UM

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

Montana's per capita personal income ($37,000) is 88 percent of national per capita income.[1] Montana's private sector wages are 71 percent ($33,000) of national private sector wages ($46,000).[2] In addition, 65 percent of Montana families have incomes under $75,000, or 325 percent of the federal poverty level for a family of four, compared to only 59 percent nationally.[3]

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

Small business is big business in Montana. Although the proportion of total firms with fewer than 20 employees is the same for both Montana and the U.S. (90%), the proportion of total employees employed by these firms is quite different. Small employers nationally account for only 18 percent of total employment, while Montana's

[1]U.S. Bureau of Economic Analysis.
[2]U.S. Bureau of Labor Statistics.
[3] U.S. Census Bureau.

small businesses account for 31 percent of total employment in the state.[4] The self-employed are also more prevalent in Montana. The self-employed are less likely to have health insurance since they cannot benefit from the advantages that accrue to larger risk pools. In addition, sole proprietors with no employees do not currently have access to guaranteed issue health insurance, like small employers do. Therefore, their health status may prevent them from obtaining coverage. In Montana, nearly three in ten employees are proprietors, compared to two in ten nationally.[5]

Private sector firms in Montana with 50 or fewer employees account for 63 percent of the total private sector workforce. Nationally, employers with 50 or fewer employees account for only 44 percent of the total private sector workforce.

Finally, another factor contributing to a higher proportion of Montanan's qualifying for APTC and cost-sharing reductions in the FFE is the nature of employer-sponsored insurance. Nationally, 54 percent of private U.S. firms offer health insurance to their employees, covering nearly 90 percent of private sector workers who have insurance. In Montana only 43 percent of private sector firms offer health insurance to their workers, covering almost 75 percent of total private sector workers with insurance.[6]

The Income Health Gradient in the Silver Plan

In order for Montanans to qualify for APTC and cost-sharing reductions in the FFE, they must meet certain eligibility criteria. Cost-sharing reductions under the ACA are only available to families below 250 percent of the federal poverty level, or $57,625 for a family of four who enroll in one of the Silver plans in the Exchange. Overall, individuals in the lower-income groups self-report worse health than their counterparts in higher-income groups. Self-reported health status is a widely used measure of people's health-related quality of life. There is a strong correlation between self-reported health status and mortality that has been well-documented in the literature. Hence self-reported health status is a fairly reliable measure of current health.

Table 2 indicates that previously uninsured enrollees in the Silver Plan, who are most likely to be eligible for cost-sharing subsidies, will on average be sicker than higher-income uninsured who buy in the Exchange. The percentages in parentheses represent the proportions nationally reporting fair or poor health.

[4] Statistics of U.S. Businesses, U.S. Census Bureau.
[5] U.S. Bureau of Economic Analysis.
[6] Agency for Healthcare Research and Quality.

Table 2: Income Health Gradient in Silver Plan, Montana

Family Income as Percent of Federal Poverty Level	Eligible for Exchange Credit?	Eligible for Cost Sharing Subsidy (Silver Plan Only)	Percent Reporting Fair or Poor Health, Uninsured Adults	
			30-49 Years Old	50-64 Years Old
Less than 138%	Medicaid if expanded	Medicaid, if expanded	32 (26)	28 (38)
138% - 250%	Yes	Yes	8 (16)	30 (29)
250% - 400%	Yes	No	-- (11)	-- (23)
400% +	No	No	-- (9)	-- (12)

Source: BBER-UM
---insufficient sample size
()= national data

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

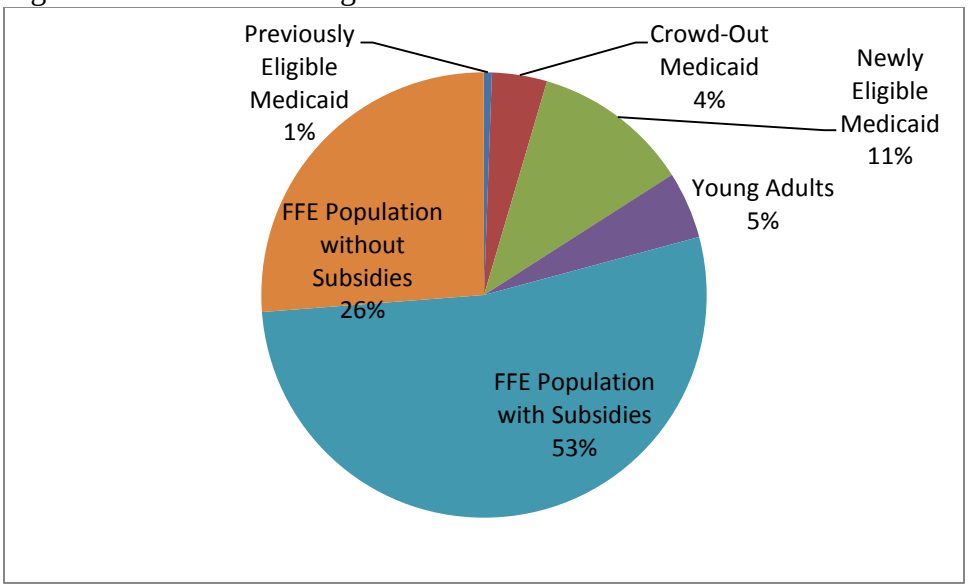
Estimated Changes in Health Insurance Status

Several provisions in the ACA may cause changes in health insurance status as individuals respond to the availability of tax credits and cost-sharing assistance, the individual mandate, the expansion of the Medicaid program, the ability for young adults to stay on their parents' insurance policies until age 26, and changes from private and employer-sponsored insurance to public insurance. Chart 2 estimates as many of these potential health insurance eligibility changes as possible.

Overall, 354,000 Montanans may experience a change in their health insurance eligibility as a result of the ACA. The Medicaid expansion will have the most dramatic impact on the number of Montanans affected by the ACA. In 2014, over 56,000 Montanans are expected to enroll in the Medicaid expansion. Three different eligibility groups will comprise the Medicaid population. Approximately 40,000 will comprise the newly eligible because of the expansion of income eligibility to 138 percent of the federal poverty level. A second eligibility group is the crowd-out population. The crowd-out population consists of individuals with private insurance that are Medicaid eligible and that now enroll in Medicaid under the expansion. The crowd-out Medicaid population who enroll in Medicaid is estimated to be around 14,000 individuals in Montana. The third eligibility group is the welcome-mat, or woodwork population. The woodwork population was eligible for Medicaid under the previous eligibility income threshold but for various reasons never enrolled in Medicaid. Under the Medicaid expansion, many are

now expected to enroll. The woodwork population is estimated to be small in Montana, only 2,000 individuals. The total Medicaid population accounts for 16 percent of the total population impacted by the ACA. The remaining population will consist of young adults who stay on the parent's health insurance policies (17,000) and the Exchange populations, including those who receive APTC and cost-sharing reductions, and those who will not receive tax credits but still purchase policies in the Federally Facilitated Exchange. Many of the new enrollees in the Exchange will enroll because of previous health status discrimination. Estimating the total Exchange population is challenging, since many of those eligible for APTC and cost-sharing reductions may not enter the Exchange at all. There is no reliable method to estimate how many of the individuals who qualify for tax credit and cost-sharing assistance will actually enter the Exchanges. In addition, the effectiveness of the consumer portal will influence how many individuals purchase insurance inside and outside the Exchanges.

Figure 2: Sources of Change in Health Insurance Status for Montanans



Source: BBER-UM

The Remaining Uninsured in Montana

Nearly 20 percent, or 195,000 non-elderly Montanans, do not have health insurance. While there may be substantial changes in the source of health insurance coverage due to provisions in the ACA, even among those who presently have health insurance, a portion of Montana's population will remain uninsured. If the Montana legislature decides to expand Medicaid coverage to individuals with incomes up to 138 percent of the federal poverty level, 56,000 uninsured, or 29 percent of the total uninsured population, are expected to actually enroll in Medicaid in 2014. Another 17,000 uninsured young adults will have health insurance by staying on their parents policies until age 26. And of the remaining uninsured, 87,000 may be enticed to enter the Federally Facilitated Exchange as the result of the individual mandate and the lure of APTC and cost-sharing reductions. In all, approximately 160,000 uninsured may gain health insurance coverage as a result of

the provisions in the Affordable Care Act. This still leaves over 35,000 who for various reasons choose to remain uninsured.

The uninsured that choose to comply with the individual mandate will impact both the number and the distribution of the newly insured. Some of the uninsured may choose to remain uninsured since the penalty may be less than the cost of coverage, even with APTC and cost-sharing reductions. There is no legal penalty other than the relatively small charges associated with failing to enroll. Some may not enroll in Medicaid simply due to the social stigma of Medicaid health coverage.

The ACA exempts individuals with incomes too low to file an income tax return, (approximately 85 percent of the federal poverty level), or who pay more than 8 percent of family income, net of premiums, for health insurance coverage. In Massachusetts, 42 percent of the state's uninsured after reform were eligible for coverage, half of whom were eligible for full subsidies. Of all those eligible for coverage, the uninsured rate is currently 4 percent.[7]

The requirement to buy health care coverage under the Affordable Care Act (ACA) is both an incentive and a penalty. Individuals and families with incomes up to 138 percent of the federal poverty level could be eligible for Medicaid assuming Montana moves forward on the expansion of the Medicaid program, now an option rather than a requirement given the Supreme Court's ruling on the ACA. Advanceable premium tax credits are available to individuals and families with incomes between 100 percent and 400 percent of the federal poverty level who purchase insurance in Montana's Federally Facilitated Exchange (FFE). Cost-sharing reductions are also available for people with incomes up to 250 percent of the federal poverty level. If Montana does not expand Medicaid, individuals with incomes between 34 percent of the federal poverty level ($3,800) and 100 percent of the federal poverty level ($11,170), as well as childless adults under 100 percent of the federal poverty level, will not have access to affordable health care coverage. These individuals will also not be eligible for tax credits or cost-sharing assistance in the Exchange.

Certain individuals will be exempt from the mandate to purchase insurance. Two such exemptions are those with incomes below the threshold requirement for filing income taxes ($9,000) or if an individual has to pay more than 8 percent of their income for health insurance, after taking into account the APTC offered in the FFE.

Opt-Out Based on Affordability

Individuals may opt-out of purchasing health insurance if premiums for the lowest cost bronze plan available in the individual market through the Exchanges, after APTC,

[7] S.K. Long, L. Phadera, and V. Lynch, "Massachusetts Health Reform in 2008: Who are the Remaining Uninsured Adults?" (University of Minnesota, State Health Access Data Assistance Center, August, 2010).

account for more than 8 percent of household income. The Congressional Budget Office estimates that premiums for Bronze plans purchased individually in 2016 would average between $4,500 and $5,000 for single policies and between $12,000 and $12,500 for family policies.

For example, an individual with an income of approximately $34,000 (300 percent of the federal poverty level) will pay $3,279 of the estimated $4,500 premium in the FFE. The government tax credit is $1,221. For this individual, the $3,279 payment required for the health insurance policy is about 9.5 percent of their income, which covers 73 percent of the total FFE premium. This same individual however could go without insurance without fear of any penalties since their share of the premium consumes more than 8 percent of their income, after taking into account the subsidy.

Figure 3 below illustrates the income thresholds where individuals could opt-out of the health insurance exchange, without incurring any of the penalties under the Affordable Care Act. Even though an individual earning less than $9,000 would qualify for Medicaid under the expansion, this person could opt-out of the program since their income is below the tax filing threshold. In Montana, this option affects almost 15,000 uninsured individuals.

At 250 percent of the federal poverty level, or $28,000, individuals may still opt-out penalty free since their responsibility for the premium exceeds 8 percent of income. Not until individual income reaches 500 percent of the federal poverty level ($56,000) do premium costs account for less than 8 percent of income. This means that nearly 73,000 Montanans could opt-out of purchasing insurance penalty free.

Nearly 45 percent of Montana's uninsured (88,000) could refuse health insurance without fear of any penalty based on the affordability criterion alone, even though many of these individuals could qualify for APTC.

Figure 3: Income Thresholds for Non-Affordability Opt-Out, Individuals

Source: BBER-UM

Opt-Out Based on Paying Penalty Instead of Purchasing Insurance

The penalty for being without health insurance starts in 2014, and is gradually increased over the following years. Initially the penalty is the greater of either $95 per adult or one percent of income. For the year 2016 and beyond, the penalty increases to $695 per adult or 2.5 percent of income, whichever is greater.

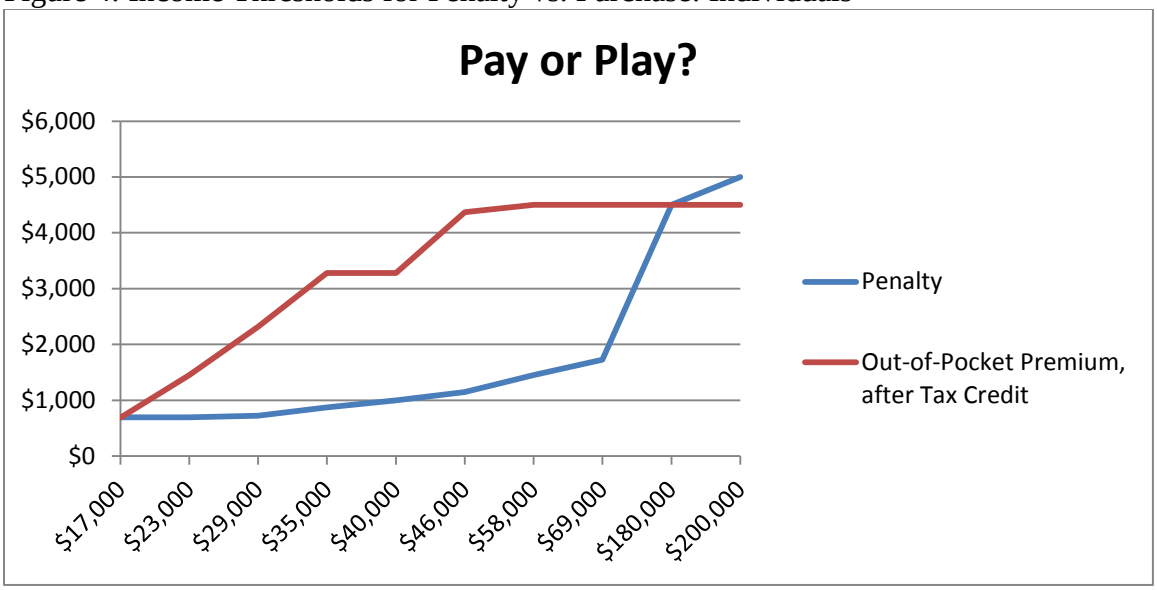
Taxpayers who are required to pay a penalty but fail to do so will receive a notice from the Internal Revenue Service (IRS) that they owe the penalty. If they still do not pay the penalty, the IRS can attempt to collect funds by reducing the amount of their tax refund in the future. However, individuals who fail to pay the penalty will not be subject to any criminal prosecution or fine for failing to pay. The Secretary cannot file notice of lien or levy on any property for a taxpayer who refuses to pay the penalty.

Applying the more stringent penalty imposed in 2016 to the cost of purchasing insurance, even with government APTC, some individuals could choose to simply pay the penalty. For example, an individual with an income at 150 percent of the federal poverty level ($17,000) may pay the penalty instead of purchasing government subsidized health insurance in the FFE. This individual qualifies for APTC and would pay approximately 4 percent of their income ($690) toward the insurance premium, with the government picking up the rest ($3,810). If instead this individual decides to forego health insurance, they would pay a $695 penalty, just $5 more than the cost of the premium. For this person the decision to purchase insurance is dependent more on the peace of mind that comes with health insurance as opposed to any penalty imposed for going without health insurance.

Not until individual incomes exceed $180,000 (1,600 percent of the federal poverty level) would the penalty exceed the expected cost of purchasing insurance ($4,500). Even for those individuals who qualify for APTC, the penalty is well below the expected out-of-pocket costs for health insurance.

The number of uninsured Montanans who could pay the penalty instead of purchasing health insurance is 122,000, 60 percent of who could also opt-out on the non-affordability criterion.

Figure 4: Income Thresholds for Penalty vs. Purchase: Individuals



Source: BBER-UM, Kaiser Family Foundation

Total Uninsured with Insurance Opt-Out in Federally Facilitated Exchange

All in all, approximately 70 percent of uninsured Montanans, or 137,000, could opt-out of purchasing insurance, even while many would qualify for APTC and cost-sharing reductions offered in the Federally Facilitated Exchange. Although nearly 70 percent of the uninsured could in fact choose to forego health insurance without paying a penalty, not many are expected to actually choose the opt-out option. Of the 195,000 uninsured in Montana, the vast majority lack health insurance due to affordability. Only 8 percent are the 'invincibles," those who are primarily young and healthy and forego health insurance simply because they feel they do not need health insurance coverage. Hence, despite the individual mandate of the ACA, most Montanans will respond to the availability of insurance options based on affordability and not the penalty of the government mandate.

Impact of Newly Insured on Health Care Resources

The utilization of health care delivery settings in Montana will be affected by the proportion of uninsured who become insured, as well as the changes in the payer mix, such as uncompensated care, self-pay, privately insured and the publicly insured. Empirical findings indicate that health care utilization by the uninsured is less than the insured.[8] The extent of the increase in health care utilization is controversial. Some studies indicate that utilization of the health care system increases to the level of the insured, while other studies suggest use increases above levels by the insured.[9] The Congressional Budget Office believes the newly insured will increase their use of the health care system by 25 to 60 percent, eventually reaching a level of utilization of only 75 to 90 percent of the previously insured.[10]

The change in the number of uninsured will have an impact on community health centers, which typically serve as safety-net health care providers for the uninsured. Massachusetts witnessed a significant increase (31 percent) in the use of safety-net facilities while the proportion of uninsured decreased by 44 percent. Half of the patients seen by Montana's community health centers in 2011 did not have insurance, and accounted for almost 400,000 clinic visits. The strain on community health centers will be felt on two levels, continued use by the uninsured and increased use by the newly insured.

[8] J. Hadley, J. Holahan, T. Coughlin, and D. Miller, "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," Health Affairs Web Exclusive, August, 2008.
[9] L. Ward, and R. Franks, "Changes in Health Care Expenditures Associated with Gaining or Losing Health Insurance," Annals of Internal Medicine, 146: 768, 2007, and J.M. McWilliams, A.M. Zaslavsky, and J.Z. Ayanian, "Use of Health Services by Previously Uninsured Medicare Beneficiaries," New England Journal of Medicine, 357: 143-153, 2007.
[10] Congressional Budget Office, Letter to Senator Evan Bayh, November 30, 2009.

Table 3 shows the incremental increase, and in some cases decrease, in the number of visits per 100 persons by health care setting and insurance status as one goes from being uninsured to insured.

Table 3: Visits to Ambulatory Care Settings, by Insurance Status

	Combined Health Care Settings	Primary Care Offices	Surgical Specialty Offices	Medical Specialty Offices	Hospital Outpatient	Emergency Department
Change in visits per 100 persons compared to Baseline						
Baseline: No Insurance	173.2	65.3	17.2	30.1	19.2	41.5
Private Insurance	+175.2	+126.7	+37.9	+31.4	-1.9	-19.0
Medicaid/CHIP	+326.5	+189.4	+15.9	+14.8	+65.7	+40.6
Medicare	+523.3	+190.9	+156.3	+146.0	+20.5	+9.5

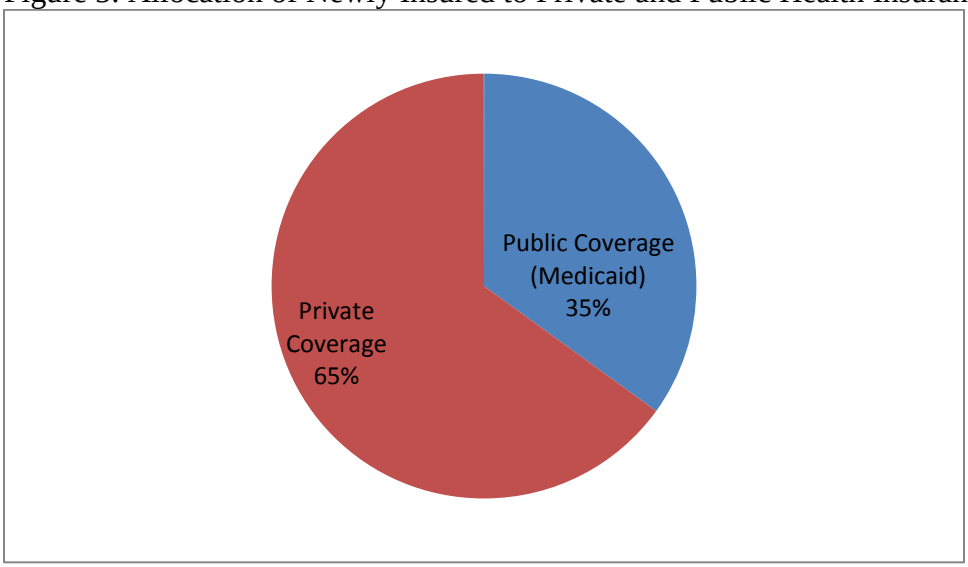
Source: National Ambulatory Medical Care Survey, 2007.

Visits per 100 persons are higher for the insured than for the uninsured for all ambulatory office settings, with one exception. The uninsured use hospital emergency departments at nearly twice the rate of the privately insured. The Medicaid population has more primary care, medical specialty, surgical specialty, hospital outpatient and hospital inpatient visits than the uninsured.

Approximately 56,000 uninsured are initially expected to enroll in the Medicaid expansion, while 17,000 young adults and nearly 87,000 uninsured obtain private health insurance coverage in the Federally Facilitated Exchange.

Applying the National Ambulatory Medical Care Survey data (2007) to the proportions of previously uninsured expected to obtain private or public health care coverage, the increase in the use of ambulatory care can be estimated. It is assumed that the uninsured increase their use of health care to that of the insured. Figure 5 depicts the expected breakdown of public and private health care coverage in the Federally Facilitated Exchange.

Figure 5: Allocation of Newly Insured to Private and Public Health Insurance Coverage



Source: BBER-UM

Table 4 presents estimates of the net change in visits to primary care offices, surgical specialty offices, medical specialty offices, hospital outpatient and hospital emergency departments in Montana that are attributable to previously uninsured obtaining health insurance coverage either through the Medicaid expansion or the Exchange.

Table 4: Incremental Increase/Decrease in Ambulatory Care Office Visits, Montana

	Primary Care Offices	Surgical Specialty Offices	Medical Specialty Offices	Hospital Outpatient Departments	Hospital Emergency Departments	Net Incremental Change
Private Coverage	131,768	39,416	32,656	-1,976	-19,760	182,104
Public Coverage	106,064	8,904	8,288	36,792	22,736	182,784
Net Incremental Change	237,832	48,320	40,944	34,816	2,976	364,888

Source: 2007 National Ambulatory Medical Care Survey, BBER-UM

In all, over 360,000 new visits to ambulatory care settings may be expected as the result of the uninsured gaining access to health care coverage. By far the biggest increase in health care utilization will be to primary care offices. As expected, visits to emergency departments will experience a decline as people gain private health insurance coverage. The privately insured use hospital emergency departments at half the rate of the uninsured. However, the Medicaid population uses the emergency department at nearly twice the rate of the uninsured. Since more of the uninsured will be on private health insurance coverage than on Medicaid coverage, the net change is negative. Nationally, many Medicaid reform efforts look at the rate of hospital emergency department use as one avenue for reducing Medicaid expenditures.

Estimating Changes in Ambulatory Use at the County Level

Three-year data from the American Community Survey is used to model the demand for health care services at the county level. Data from the BBER-UM survey of households does not allow for statistically valid analysis at the county level due to insufficient sample size.

Approximately 172,000 non-institutionalized Montanans do not have health insurance according to the three-year estimates of the American Community Survey. Exactly how many actually enroll in Medicaid or acquire private insurance is subject to debate. Regardless, however, Montana's health care delivery system will experience an unprecedented increase in the demand for all types of health care services.

Table 5 shows the rate of visits to five different ambulatory health care settings by the expected source of payment. Data is based on office-based physician practices as well as data from physicians working in Community Health Centers. Noteworthy is the low use of primary care and the high use of hospital emergency departments by the uninsured.

Table 5: Visits to Ambulatory Settings per 100 Persons, by Insurance Status

	Primary Care	Surgical Specialty	Medical Specialty	Hospital Outpatient	Hospital ED
Private Insurance	192	55.1	61.5	17.3	22.5
Medicaid/CHIP	254.7	33.1	44.9	84.9	82.1
No Insurance	65.3	17.2	30.1	19.2	41.5

Source: 2007 National Ambulatory Medical Care Survey, U.S. Department of Health and Human Services, National Center for Health Statistics

Estimating the Pre-ACA Demand for Primary Care Office Visits

To estimate the increased demand placed on Montana's ambulatory health care system, the projected change in ambulatory use as individuals go from uninsured to insured is used. Table 6 below is a slightly condensed version of Table 3,and shows the incremental change in ambulatory use by a change in insurance status from uninsured to health care coverage under Medicaid or private insurance. The Medicaid population is expected to add considerably to the demand for all types of ambulatory care settings.

Table 6: Incremental Change in Ambulatory Care by Setting and Insurance Status

incremental increase in office use per 100 persons					
uninsured to…	Primary Care	Surgical Specialty	Medical Specialty	Hospital Outpatient	Hospital ED
Private Insurance	126.7	37.9	31.4	-1.9	-19
Medicaid/CHIP	189.4	15.9	14.8	65.7	40.6

Source: BBER calculations

Data from the American Community Survey three year estimates, 2009-2011, is combined with the estimated visits to primary care offices by type of insurance coverage from the 2007 National Ambulatory Medical Care Survey to estimate the *current* demand

for primary care, along with other ambulatory care services, including surgical specialty offices, medical specialty offices, hospital outpatient and hospital emergency department visits.

Many medical communities serve as regional trade centers. Hence, estimating demand for medical care based only on county residents will understate true demand. In estimating the existing demand for primary care office visits for the state as a whole, this problem is reduced since Montana residents seldom leave the state for primary care services. Also excluded in this analysis is the increase in primary demand due to visitors, primarily tourists, who through mishaps end up in the offices of Montana primary care providers. Additional study would be needed to include this population in the demand for primary care.

Table 7 summarizes the demand for primary care office visits for Montana and also for the major population centers in Montana. The estimate for Montana is different from Table 4 since the data below is based on a different data source, the American Community Survey three-year estimates of uninsured.

Table 7: Estimated Visits for Primary Care, Montana and Select Counties, Pre-ACA

	Source of Expected Payment						Total PC Office Visit Demand
	ESI	Private Insurance	Medicare	Medicaid/CHIP	Uninsured	Unknown	
Montana	742,310	295,037	415,287	141,863	94,653	47,382	1,736,533
Cascade	57,145	19,173	35,625	13,201	7,520	4,589	137,253
Flathead	64,414	26,243	36,229	9,989	12,281	4,015	153,171
Gallatin	78,021	34,120	23,278	5,901	8,279	4,664	154,264
Lewis & Clark	61,198	15,759	25,354	6,581	4,202	2,504	115,598
Missoula	89,937	33,335	36,019	14,480	12,871	3,298	189,939
Ravalli	26,003	13,709	23,627	7,733	4,088	488	75,647
Silver Bow	27,199	8,963	16,448	7,488	3,185	317	63,599
Yellowstone	120,837	37,503	58,811	22,182	15,857	5,302	260,492

ESI is employer sponsored insurance
Source: 2007 National Ambulatory Medical Care Survey, American Community Survey, BBER-UM

The eight trade center counties above account for two-thirds of the total statewide demand for primary care services.

Estimated Increase in the Demand for Primary Care Office Visits

The number of uninsured in Montana will decline due to the lure of APTC and cost-sharing reductions in the Federally Facilitated Exchange, the individual mandate to have insurance, guaranteed issue in the individual market, and the Medicaid expansion. In this analysis, utilization rates for primary care office visits are assumed to reach the levels of utilization reported in the ambulatory medical care survey. All "uninsured" are also assumed to obtain health insurance in the first year. Certainly not all uninsured will purchase insurance; even Medicare doesn't have a 100 percent participation rate. Participation rates in Medicaid also vary significantly, from 43 percent of the eligible population in Louisiana to 83 percent in Massachusetts. Nationally, participation rates for Medicaid are 63 percent of the eligible population.

According to the American Community Survey, nearly 68,000 Montanans are uninsured and Medicaid eligible, leaving an estimated 104,000 uninsured who do not qualify for the Medicaid expansion. While the number of Medicaid eligible uninsured is consistent with BBER-UM survey estimates, the number of uninsured is lower than BBER-UM estimates. But when margins of error are factored in, the American Community Survey estimate is within 90 percent of the BBER-UM estimate. American Community Survey data is used here since it can provide estimates of the number of uninsured eligible for Medicaid at the county level.

Assuming all Medicaid eligible participate in the Medicaid expansion and the remaining uninsured purchase private health insurance, an additional 261,000 primary care office visits are expected statewide (Table 8).

Table 8: Estimated Increase/Decrease in Demand for Primary Care Services, Montana

	Primary Care	Surgical Specialty	Medical Specialty	Hospital Outpatient	Hospital ED	Total Office Visits
Private Coverage	131,768	39,416	32,656	(1,976)	(19,760)	182,104
Medicaid Coverage	128,792	10,812	10,064	44,676	27,608	221,952
Total Change	260,560	50,228	42,720	42,700	7,848	404,056

Source: National Ambulatory Medical Care Survey, American Community Survey, BBER-UM

The decline in office visits for hospital outpatient and hospital emergency department visits is the result of the uninsured using these services less as they acquire health insurance. By far, the greatest impact is on the demand for primary care office visits. Adding the incremental increases for primary care to existing demand provides a snapshot of the total anticipated demand for primary care office visits (Table 9).

Table 9: Total Estimated Demand for Primary Care Services, Montana and Select Counties

County	Total Additional PC Office Visits	Total Demand for PC Office Visits
Montana	260,560	1,997,093
Cascade	17,854	155,107
Flathead	28,252	181,423
Gallatin	18,631	172,895
Lewis & Clark	9,424	125,022
Missoula	30,745	220,684
Ravalli	11,300	86,947
Silver Bow	7,482	71,081
Yellowstone	35,736	296,228

Source: BBER-UM

Primary Care Capacity

The capacity of the primary care system to accommodate additional demand may be modeled by the number of primary care practitioners and the number of office visits primary care providers can offer each year. A study by Davis, Roberts, and White (2009) found 495 practicing primary care physicians in Montana. This number includes Family Practice, Internal Medicine, and Pediatric practitioners. Other studies contrast drastically with this number, and range from 629 primary care providers (Stenseth 2009) to 862 primary care providers (Rivard 2009).

The U.S. Department of Health and Human Services uses a guideline of 4,200 office visits per year for primary care physicians, much lower than the American Medical Association guideline of 5,400 office visits per year for family practitioners. The lower threshold is used in this analysis. Table 10 presents estimates of the available supply of primary care services in the state and select counties. By comparing primary care capacity to estimated total demand, the ability of the primary care system to accommodate the increased demand for primary care services can be assessed.

Table 10: Estimated Primary Care Capacity and Primary Care Demand, Montana and Select Counties, Total Office Visits

Locale	Primary Care Supply	Primary Care Demand	Visits/Year: Shortage (-) Surplus (+)
Montana	2,079,000	1,997,093	+81,907
Cascade	163,800	155,107	+8,693
Flathead	176,400	181,423	-5,023
Gallatin	71,400	172,895	-101,495
Lewis & Clark	147,000	125,022	+21,978
Missoula	201,600	220,684	-19,084
Ravalli	58,800	86,947	-28,147
Silver Bow	71,400	71,081	+319
Yellowstone	508,200	296,228	+211,972

Source: BBER-UM

Major medical markets, such as Missoula, Great Falls, and Billings, serve areas well beyond the county boundaries. Although primary care is usually delivered locally, it is reasonable to assume that primary care demand is still underestimated to a considerable degree. More illustrative perhaps are the counties with low surpluses of primary care capacity, or in some, shortages of primary care capacity. Gallatin County, in particular, appears to have a severe shortage of primary care capacity given the additional burdens to be placed on their providers. Some of the burden could be minimized thorough the use of mid-level practitioners, including nurse practitioners and physician assistants.

Absent in this analysis is the role that payment to the provider serves in seeing certain payer mixes, particularly Medicaid. As payments fall to the marginal cost of providing services to these patients, doctors will have limited options. Some may decrease the number of Medicaid patients seen, some may simply retire earlier. Many primary care physicians are now employed by local hospitals and federally funded clinics. Hospitals and these clinics receive higher payments from government sources than an independent physician receives for the same services. How this trend affects overall costs is not apparent, but it does provide some support to help keep primary care physicians in Montana communities.

Sources of Insurance Churn

The Affordable Care Act will extend health insurance coverage through the expansion of Medicaid and by offering subsidized health insurance to families with incomes up to 400 percent of the federal poverty level in the Federally Facilitated Exchange in 2014. Eligibility in both Medicaid and the Federally Facilitated Exchange is affected by changes in income as well as family composition. In the Exchange, advanceable premium tax credits are determined by a linear sliding scale percentage of the taxpayer's household income and the premium of the second lowest cost benchmark Silver plan. The ACA specifies applicable percentages that, when multiplied by the taxpayer's household income, determines the taxpayer's share of the premium for a benchmark health plan.

This required share is subtracted from the adjusted monthly premium of the benchmark plan to determine the premium assistance amount. The percentage is computed first by determining the percentage that the taxpayer's income bears to the federal poverty level for the family's household size. The federal poverty line percentage is then compared to the six income categories and increases in a linear manner.

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

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

Medicaid and Exchange Insurance Churn

An in-house analysis of Medicaid data over the last three years, (2008-2010) indicates that only 40 percent or so of Medicaid enrollees are continuously enrolled, indicating that enrollees leave Medicaid in rather large proportions. Newly enrolled policy holders account for approximately half of the total enrolled policy holders. Research shows that nationally 43 percent of newly enrolled adults in Medicaid have a disruption in coverage within a year. Churning is the result of people moving into and out of Medicaid as the result of changing income and/or family size. Nationally, the average adult is enrolled in Medicaid for 2/3 of the year. Approximately 35 percent of all adults with family incomes below 200 percent of the federal poverty level will experience a move from Medicaid to the Exchange or from the Exchange to Medicaid within six months. Within one year, 50 percent will experience a move from Medicaid to the Exchange or vice versa.

Changes in income or family status may trigger disruptions in plan and provider coverage, as well as a financial obligation to repay some or all of the subsidies received in the Exchange. Consumers who have accepted APTC, failed to report changes in their household income, and have adjusted gross incomes over 400 percent of the federal poverty level at the end of the tax year, will be required to pay-back all of the APTC. Consumers receiving the APTC will be periodically prompted to report any changes in their household income. If they do report changes in income, their APTC will be adjusted to avoid "pay-back" at the end of the tax year. Also, consumers who are near the 400 percent poverty level threshold and know their income may increase can choose to claim their tax credit at the end of the year, instead of monthly.

Monitoring income changes is important. Research shows that disruptions in health insurance coverage adversely affect access, as well as increase administrative costs.

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

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

Table 11: Policy Options to Mitigate Medicaid and Exchange Churn

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

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

A follow-up study by Hwang, Rosenbaum, and Sommers (June 2012) analyzed data from the 2008 panel of the Survey of Income and Program Participation and found that churn between Medicaid and the Exchanges could be reduced by 4 percent simply by increasing the Medicaid eligibility threshold to 200 percent of the federal poverty level. Not only would the rate of churn be reduced somewhat, but low-income families would be less likely to be subject to recouping of federal tax credits. The authors note, however, that churning rates would still remain high, and that mitigating steps such as offering the same

health plans in both Medicaid and the Exchanges, and implementing policies to facilitate smooth transitions between programs, would still be needed.

Another potential source of churn is the manner in which APTC and cost-sharing reductions are tied to income levels under the ACA. The income basis for advanced premium tax credits and cost-sharing reductions is modified adjusted gross income using the applicant's most recent federal tax year. This presents challenges to properly determining eligibility since, for many Exchange enrollees, income tax filings from several years prior to enrollment may be used for eligibility determination. Income fluctuations are common among lower income individuals. This may lead to over-subsidizing some, while under-subsidizing others.

In a study by Graves (2012) one-third of people initially judged to be below the Medicaid income threshold will "churn" into the Exchange and be eligible for tax credits.[11] An additional 12 percent of the Exchange eligible population would be incorrectly judged to be ineligible for the tax credits. For individuals and families above 400 percent of the federal poverty level, approximately 3 percent could falsely be identified as eligible for tax credits at the time of application. The final result is that a significant percentage of families may be judged ineligible for the Exchange tax credits when in fact they are eligible, and a much smaller percentage could be judged eligible for the tax credits when in fact they are ineligible, all due to changes in income at the time of application.

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

Employer-Sponsored Insurance Churn

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

Whether or not employers drop employer-sponsored insurance for any kind of alternative is first a matter of why firms offer health insurance at all. Many workers prefer some of

[11] John Graves, "Better Methods Will Be Needed to Project Incomes to Estimate Eligibility for Subsidies in Health Exchanges," Health Affairs, Number 2, 2012.

their compensation in the form of health benefits. Health insurance benefits when provided by the employer are not subject to income or payroll taxes. Employer - sponsored insurance is also beneficial for many employees since, prior to 2014, the individual market was more expensive or unavailable for unhealthy or older workers. Employers also may decide to provide coverage simply because it is an expectation in their industry.

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

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

The Urban Institute has found generally favorable impacts on small firms and their workers as a result of provisions in the ACA. Using their Health Insurance Policy Simulation Model (HIPSM), the Urban Institute modeled the cost of providing health insurance coverage through the options available in the ACA with any penalties firms could face if they employed 50 or more employees, for not offering health insurance, or offering unaffordable health insurance to their employees. Overall, they found that premium costs for small firms would decline by nearly 9 percent as the result of the ACA, primarily though reduced marketing and administrative costs. Further, the savings to small firms would be heavily concentrated among those with fewer than 50 employees. Offer-rates would increase by 10 percent among small firms under the ACA, since it would be less expensive for small firms to offer coverage to their employees. For firms with fewer than 10 employees, offer rates increase from 35 percent pre-ACA to 40 percent post ACA, an increase of 14 percent. Key to this finding, however, is the assumption that small firms would apply for the tax subsidies available to firms with fewer than 25 employees. Empirically, the number of small firms nationally actually applying for the federal tax credit has been disappointing.

Among firms with 50 to 99 employees, the Urban Institute found almost no change in the number of employees covered by employer-sponsored insurance due to the provisions of the ACA.

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

Quite different results were reported by McKinsey and Company in their 2011 survey of 1,300 employers. Nearly half of the employers surveyed say they will definitely or probably pursue alternatives to employer-sponsored insurance after the Exchanges take effect in 2014. Dropping health insurance coverage all together is only one of the options, another option is providing health insurance as a defined contribution benefit. Over 30 percent stated they will definitely or probably drop coverage after 2014.

Avalere Health (2011) predicts employer-sponsored health insurance will remain fairly stable after the Exchanges are implemented in 2014 with large employers continuing to offer health insurance.

As evident in the studies discussed above, whether or not employers drop employer-sponsored insurance is based on employer surveys and/or modeling approaches. Problems emerge with respect to both approaches. First, with employer surveys, there are conflicting findings. In a survey conducted by Mercer, 9 percent of the firms with more than 500 employees state they are likely to drop ESI after 2014.[12] McKinsey and Company report 30 percent are likely to drop coverage, and the proportion increased to more than 50 percent among those firms with a high level of awareness of the ACA's provisions.[13] Another survey by the International Foundation of Employee Benefit Plans found that up to 3 percent planned to eliminate ESI for active employees.[14] Locton found that 19 percent of the employers surveyed were considering dropping ESI.[15]

According to the Congressional Budget Office (CBO), it is doubtful that any survey conducted prior to 2014 can provide accurate predictions of future employer decisions since responses to surveys basically have no consequences, do not require detailed analysis, and are usually based on very limited or uncertain information about the ACA and the future market for health insurance.

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[12]"Employers Accelerate Efforts to Bring Health Care Costs Under Control," November 16, 2011, www.mercer.com/press-releases/1434885.
[13]"How U.S. Health Care Reform Will Affect Employee Benefits," McKinsey Quarterly, June, 2011.
[14]"New Survey Examines Employer Reactions to Health Care Reform One Year Later," June, 2011.
[15] "Health Reform Challenges Employers' Ability to Control Costs, Maintain Robust Plans, Survey Show," June, 2011.

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

Employer Responses in Montana

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

1. In 2014, workers with family incomes below 138 percent of the federal poverty level will be eligible for Medicaid coverage, with little or no deductibles and co-pays. For a family of four, the projected threshold for 138 percent of the federal poverty level is $33,000 by 2014.
2. Workers with incomes between 138 percent and 400 percent of the federal poverty level will be eligible for tax credits if their employers do not offer health insurance coverage, or if the employer health plan is unaffordable, or if the health plan is below 60 percent in actuarial value. Families with incomes of 150 percent are responsible for only 4 percent of the cost of the second lowest cost Silver plan, while families with incomes of 400 percent of the federal poverty level will pay 90.5 percent of the cost of the second lowest cost Silver plan.
3. For larger firms with a mix of lower and higher income workers, not all employees will be eligible for Medicaid, CHIP, or Exchange subsidies if their employer does not offer coverage. Further, it is unlikely firms will offer coverage only to higher paid workers since nondiscrimination provisions in the Internal Revenue Code and the Public Health Service Act prohibit excluding certain groups from health insurance benefits.
4. There should be greater demand for health insurance since individuals face penalties for non-compliance. This should increase the incentive for employers to offer health insurance in order to attract and retain qualified workers.
5. At least until 2016, smaller employers can qualify for federal tax credits.
6. The ACA does not require businesses to provide health insurance to their employees. But for larger firms, those with more than 50 employees, and who employ 37 percent of the Montana workforce, penalties are imposed if any of their employees receives a subsidy in the exchange, regardless of whether the firm offers coverage or not. For firms offering coverage, the penalty is imposed if the actuarial value is less than 60 percent or if an employee has to pay more than 9.5 percent of family income for the employer coverage.
7. For employers who do choose to drop employer-sponsored insurance, employees will expect cash compensation in the form of higher wages, which will be taxed.

There are reasons, however, to support the possibility that some firms will abandon employer-sponsored insurance. Workers can purchase health insurance in the individual Exchange beginning in 2014, which could reflect lower premiums since it is designed to be a competitive marketplace. Firms with workers whose family incomes are 400 percent of the federal poverty level or less qualify for substantial premium tax credits, and cost sharing assistance. For firms employing more than 50 employees, the penalties that firms will face are significantly smaller than the cost of providing insurance, particularly since the first 30 employees will be excluded from the penalty. Finally, for smaller employers, the federal tax credits available are temporary, and the application process somewhat complex.

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

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

Further complicating the analysis is the premium to be charged in the Exchange relative to the premiums that employers will face in the group market. The CBO expects the premium for the second lowest cost Silver plan to be about 80 percent of the premium employers now pay for employer-sponsored health insurance in the group market. The differential is primarily due to employer-sponsored plans that nationally have an actuarial value of 85 percent while Silver plans are required to have actuarial values of only 70 percent. This lower actuarial value for Silver plans will also increase expected out-of-pocket spending for people in the Exchange relative to employer-sponsored plans. Out-of-pocket spending for Silver plan beneficiaries is expected to be 50 percent of the out-of-pocket spending by employer-sponsored health insurance beneficiaries after taking into account the government premium tax credits.

All taken together, the illustration below demonstrates the relationship between employer-sponsored incentives relative to the incentives provided to families in the Exchange for a family of four, and based on 2012 federal poverty levels. Tax credits for employer-sponsored insurance include the employee's marginal federal and state tax

rates, the employee's share of social security taxes (up to the limit of $110,100), and Medicare taxes.

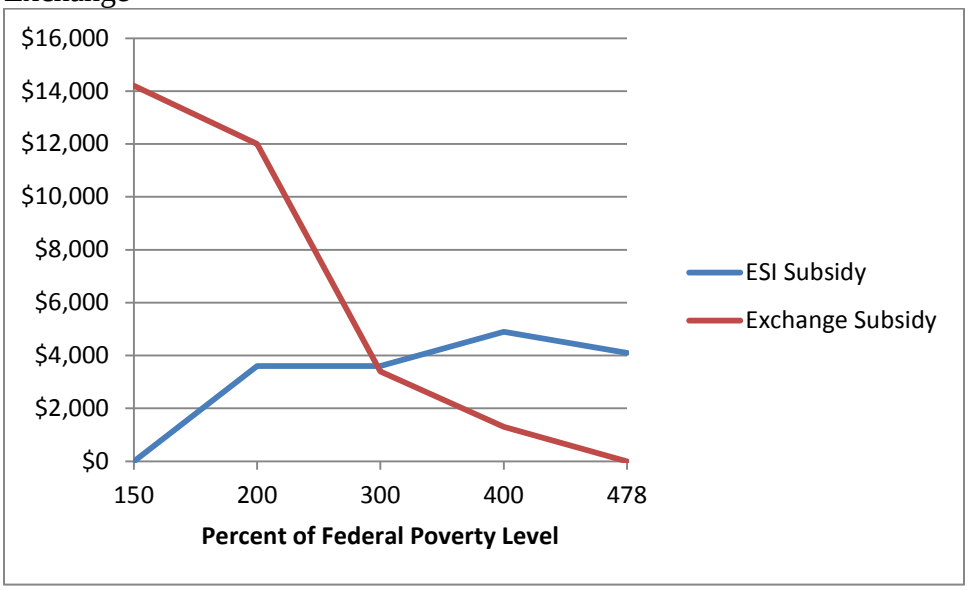
Table 12: Cost of Exchange Insurance Coverage Relative to Employer-Sponsored Insurance, by Percent of the Federal Poverty Level

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

Source: Congressional Budget Office

Using the federal poverty levels above and the premium and out-of-pocket costs expected under the ACA, it is readily apparent that firms with lower wage workers would stand to gain by buying insurance in the Exchange. However this analysis ignores the impact of increased compensation to the employee, which could conceivably move workers into higher poverty level thresholds, reducing if not eliminating the premium tax credits available in the Exchange. Noticeable however is that for higher income workers, the tax advantaged treatment of employer-sponsored insurance outweighs any benefits of buying lower cost policies in the Exchange. The analysis below suggests that at approximately 300 percent of the federal poverty level, the tax subsidies associated with employer-sponsored insurance outweigh the subsidies available in the Exchange (Figure 5).

Figure 5: Tax Subsidies with Employer-Sponsored Insurance Compared to Subsidies in Exchange



Source: Congressional Budget Office, BBER-UM

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

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

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

Another way of estimating the working population more vulnerable to losing employer-sponsored insurance is to again use MEPS data to look at the number of employees

working at establishment that offer health insurance and working in establishments that have at least 50 percent of their labor force earning less than $11.50 per hour, or $24,000 per year (104 percent of the federal poverty level for a family of four).

Table 12: Low Wage Employees, Montana

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

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

There are fewer than 350,000 employees in Montana working in the private sector. The private sector includes the self-employed with employees, and the incorporated self-employed without employees. Of the approximately 350,000 employees, about 74 percent work in establishments that offer health insurance, but only 56 percent are eligible for the health insurance. Ineligibility is often due to hours worked and/or length of time with the employer. Of the 335,000 private sector employees, 45 percent are eligible and enrolled in the firm's health insurance plan. For private sector employees who work in firms with over 50 percent of the workforce earning less than $11.50 per hour, only 20 percent are eligible and enrolled in their employer's health insurance plan. This provides some insight as to the lower threshold (24,000) of the number of employees who could end up in the Exchange as employers drop coverage. Following a similar methodology using the MEPS data, the upper bound could be as high as 41,000. Notice, however, the large margins of error of nearly 25 and 19 percent, respectively, for the lower and upper bounds.

Table 13: Workforce Vulnerable to Losing Employer-Sponsored Insurance

Estimated Number of Workforce Vulnerable to Losing Employer-Sponsored Insurance	
Lower Threshold	24,000 $\pm$ 5,749
Upper Threshold	41,000 $\pm$ 7,820

Source: BBER-UM, Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality.

Rand Health modeled the impact of the ACA on employer-sponsored insurance in Montana. While they caution that there is considerable uncertainty surrounding their estimate, they predict 18,000 workers in Montana will end up in the Exchange that previously had employer-sponsored insurance. Rand predicts that the nature of employer-sponsored insurance will change only slightly under the ACA, and that small employers are the most likely to look for health care coverage in the Exchange. Rand

attributes this stability in the employer-sponsored market to factors that will increase the demand for employer-sponsored insurance more than offsetting factors which could decrease the demand for employer-sponsored insurance. Specifically, the individual mandate and the employer penalties for not offering coverage will outweigh the decrease in demand for employer-sponsored coverage due to individual market Exchange tax credits available to lower-income workers.

Finally, a significant proportion of workers with employer-sponsored health insurance coverage will not qualify for Medicaid, CHIP, or the Exchange premium tax credits. Although the median household income for Montana families with four members is 300 percent of the federal poverty level, several factors will limit the number of households qualifying for Medicaid, CHIP, and the Exchange premium tax credits. Families with workers in the household tend to have higher incomes than families without workers. Second, family income is expected to increase faster than the federal poverty level, since poverty levels are indexed to the consumer price index for all urban consumers. Finally, higher-income workers are more likely than lower-income workers to work for a firm that offers health insurance, and are more likely to take up health insurance coverage when offered. Nationally, full-time year-round workers with family incomes above 200 percent of the federal poverty level, 90 percent are covered by private insurance.[16]

The ACA does not mandate an employer to provide health insurance to its employees. In 2014, however, the ACA does impose certain penalties on large employers. Employers with at least 50 full-time equivalents (FTEs) that do not provide coverage may be subject to penalties if at least one of their full-time employees receives a premium tax credit in the Exchange. Large employers can exclude the first 30 workers before the penalty is imposed.

Requirements and Penalties for Employers with at Least 50 Full-Time Employees Offering Health Insurance

For employers who offer health insurance to their employees, an employer will not be treated as meeting ACA requirements if at least one full-time employee receives premium credits in an Exchange plan. An employee may be eligible for individual market premium tax credits if the employee's required contribution for the premium exceeds 9.5 percent of the employee's household income or if the employer's health plan has an actuarial value less than 60 percent. Firms with more than 200 full-time employees that offer coverage will automatically enroll new full-time employees in a plan. Automatic enrollment programs will be required to include adequate notice and the opportunity for an employee to opt out.

[16] William Carroll and G. Edward Miller, Health Insurance Status of Full-Time Workers by Demographic and Employer Characteristics, 2008, Statistical Brief No. 317.

Requirements and Penalties for Employers Not Offering Health Insurance with at Least 50 Full-Time Employees

A firm with at least 50 FTEs that chooses not to offer health insurance to its full-time employees will be subject to penalties if any of its full-time employees receive premium credits in the Exchange. These firms will pay a penalty based on the number of employees receiving the tax credit (minus 30) for any applicable month. Employers who do not provide health insurance coverage must also file a return stating that they do not offer coverage, the number of full-time employees, and other information required by the Secretary. These firms must also provide notice to their employees about the existence of the Exchange, including a description of the services provided by the Exchange.

Employer Pay or Play in the Federally Facilitated Exchange

The share of employers offering health insurance has generally declined over the last decade. There has been considerable research since passage of the ACA in 2010 on whether employers may drop coverage all together, instead opting to either "pay" the penalty for dropping group health benefits to employees or "play" by continuing to offer employer provided benefits.

In addition, a Cadillac Tax will be imposed in 2018. This will require employers to pay a 40 percent excise tax on the value of total health care premiums in excess of specified threshold amounts. Benefits subject to the tax include employer and employee contributions to medical and pharmacy benefits, Flexible Spending Accounts, employer contributions to Health Savings Accounts or Health Reimbursement Arrangements, and benefits received at worksite clinics. Stand-alone dental and vision coverage is not subject to the tax.

For employers, the issue becomes whether to continue offering health insurance benefits despite the current trend of 6 percent or more annual insurance premium hikes or eliminate benefits altogether and pay the penalty of $2,000 for each employee. Truven Health Analytics (2012) analyzed four benefit design scenarios for 33 large employers with a workforce of 933,000 employees. The industries represented were diverse, and included university, pharmaceutical, retail, financial, and manufacturing industries. The four benefit design scenarios modeled all eliminate employee group health coverage but differ in the employer approach to saving on health care costs. The four scenarios modeled are:

1. Make the employees "whole" by subsidizing the full cost to employees of obtaining coverage in the Exchange,
2. A "cost-neutral impact" on employers by subsidizing Exchange coverage without spending any more per person per year than the employer's current health plan,
3. Provide sufficient additional compensation to employees in order to reduce overall net employer healthcare costs by 20 percent, and
4. No subsidies to employees to purchase their own health care insurance.

The analysis yielded three key findings. First, there is no immediate or long-term cost advantage for employers to eliminate group health benefits. Second, it will cost employers more to make employees "whole" when shifting their health care coverage to an Exchange than to continue existing group health plans. Finally, if employers eliminate group health plans, their employees will suffer a significant reduction in overall compensation since employees now have to assume the incremental costs of health benefits and increased tax obligations on their wages.

Under the "make employees whole" scenario, employers would face significant net cost increases that could drive their healthcare costs from $8,483 per employee per year (PEPY) to over $17,000 PEPY to account for health care purchased in the Exchange, a $2,000 penalty per employee, $1,403 in additional wages to offset payroll and income taxes, and $799 for lost time benefits (short-term disability, long-term disability, workers' compensation, incidental absence, and productivity). The spike in costs comes without a price break for employees, since their expenses would stay the same with or without group health coverage, roughly $4,000 per year in 2020.

In the cost-neutral scenario, the employer eliminates group health benefits but provides additional compensation so that the move to Exchange based benefits is cost-neutral to the employer. Taking into account the benefit design, net premium, out-of-pocket, and tax differences, a significant cost-shift to employees takes place. Employers would have to provide an additional $5,684, or 67 percent of current health plan costs, in salary to compensate for eliminating group health plans. But this still leaves the employee short of their annual $10,000+ healthcare cost burden in premium and out-of-pocket obligations.

The third scenario examined the impact of eliminating group health coverage and instead provides additional compensation to employees to obtain a 20 percent PEPY savings relative to net health costs. Similar to the previous scenario, employees again bear a significant cost shift. Even though employers obtain significant savings even after paying the fines, the remaining costs fall on their employees since they would now pay at least $10,000 more than the traditional plan copay.

Under the final scenario, employees bear the full brunt of the employer decision to drop health insurance. While employer costs fall considerably, even after paying the fine, employees pay the full cost of at least $16,000 in annual healthcare costs, or $13,000 more than they would pay in a continued group coverage scenario.

Perhaps more important than the numeric estimates in these studies is recognition of the fact that employers must provide market value, in benefits and compensation, to retain skilled workers. The potential penalties and the stigma attached to those penalties, along with the net gain most employees would need to receive in their compensation packages to make up for lost health benefits should be of sufficient merit to discourage most employers from dropping health benefits. Particularly for midsize and large employers, those most likely to offer health insurance, the economics of pay or play will depend on

whether the Exchange offers plans that are as efficient as or even more efficient than existing group health plans.

In a comprehensive review of 27studies examining the potential impact of the ACA on employer decisions to offer health insurance, The Congressional Budget Office (CBO) found that micro-simulation models generally predict little change in the prevalence of employer sponsored coverage, while results of employer surveys varied more widely. Variation in the micro-simulation studies is a function of the assumptions about employer and employee decision making, the time periods used for study, and compliance with the individual mandate. Variation in employer surveys is a function of sampling techniques, number and types of employers, and how survey questions were framed.

Micro-simulation models systematically estimate the combined effect of multiple provisions in the legislation based on previous research and empirical data. These models all rely on many assumptions and the impact of past policy choices to drive the model, which may not be predictive of the impact of future policy changes. Further, there is very little information with which to assess the validity of the projections. Although the experiences in Massachusetts are often used as a benchmark for modeling the ACA, several exceptions are noteworthy. Self-insured employers are not subject to penalties in Massachusetts. Under the ACA the self-insured are subject to penalties. Employer penalties are different as well, creating different incentives for employers to offer health insurance. Finally, Massachusetts had one of the highest insured rates in the country, so that comparing Massachusetts's experience to Montana with nearly 20 percent of its non-institutionalized population uninsured could be problematic. Massachusetts also has many more large employers who already provide health insurance coverage to their employees.

Several trends in employer-sponsored health plans were already in play and pre-date passage of the ACA. These trends include increases in the employee share of health plan premiums and cost sharing and increases in the use of account-based health plans, such as high-deductible health plans (HDHP) and consumer directed health plans (CDHP), and health savings accounts (HSA).

The Small Employer Tax Credit

Nationally, fewer small employers claimed the Small Employer Health Insurance Tax Credits during tax year 2010 than were eligible, according to a report released in May, 2012, by the Government Accountability Office (GAO). Depending on the number of eligible firms who could claim the credit, only 4 percent to 12 percent, actually claimed the federal tax credit. Further, most claims were limited to partial rather than the full tax credit because of the full time equivalent requirements, average wage, or base premiums that were limited by a state set premium average. Factors thought to limit the number of small firms applying for the credit were that few small firms offer health insurance, the credit was not large enough to incentivize employers to begin offering insurance, the credits were calculated based on complex rules on full-time equivalents (FTE) and average wages, and the time needed to calculate the credit was simply not worth the

employer's time. The necessary form to compute the credit, Form 8941, initially didn't have all the required steps to properly determine the tax credit. And in Montana specifically, the full tax credit was limited to the average premium as determined by the Internal Revenue Service, $4,923 for a single plan and $10,789 for a family plan. Based on BBER-UM survey data, employers paid on average 88 percent of the single plan premium. The single coverage amount for Montana is limited to 88 percent of $4,923, or the state average premiums for small group markets as determined by the Internal Revenue Service. Hence, employers in Montana are limited to $4,332 (88 percent of $4,923) for the full tax credit. However, employers paid $5,124 for single plan coverage or $792 over the IRS limit. Further "deincentivizing" small employers from taking advantage of the federal tax credit is the fact that the credit is reduced for those employers receiving state tax credits or state premium subsidies. In Montana, this affects 701 firms taking advantage of the state tax credit and another 787 firms using the purchasing pool for subsidies. It is not known whether or not the Montana legislature will continue to fund the Insure Montana small business tax credit and premium subsidies in 2014.

Market Power in the Exchanges

The central feature of the federal health care reform legislation is the creation of insurance marketplaces in which individuals and small businesses can compare and purchase health plans. These "Exchanges" serve as a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparisons of available health insurance plans based on price, benefits and services, and quality. Exchanges will increase the pool of health plan participants, reduce transactions costs, and increase transparency. Exchanges are designed to create a more efficient and competitive market for individuals and small employers.

There are certain required functions of the insurance exchange that states that choose to create a state-based Exchange must comply with as a result of the federal reform legislation. These include:

- Provide an individual and small group insurance portal, either individually or combined,
- Provide standardized actuarial plan options (Bronze, Silver, Gold, Platinum),
- Provide cost calculators and toll-free call center support to exchange users,
- Collect information for the individual mandate affordability exemption,
- Determine eligibility for and enroll qualified applicants in public programs,
- For Exchange applicants with household incomes between 100 and 400 percent of the federal poverty level, determine eligibility for sliding scale premium tax credits and cost-sharing reductions,

- Facilitate advance payments of premium tax credits by the Department of Treasury to insurers,
- Operate a consumer assistance program,
- Report user and employer data to Department of Treasury, and
- Generate sufficient revenue to be self-sustaining by 2015.

While there is no state flexibility with respect to the requirements above, there is considerable flexibility for states that choose to operate their own Exchanges, including governance and organizational structure. In addition, states have flexibility in two key policy areas; how selective an Exchange will be in qualifying health plans and how adverse selection will be avoided.

With respect to the former, states must determine how selective they will be in choosing plans for the Exchange. As an "active purchaser" states may choose only the highest-performing health plans for the Exchange. Still others may select health plans according to premium costs, plans that score well on various measures of health care quality, and other strategic priorities. Two factors that should be considered are:

1. Size of the Exchange
2. Composition of the marketplace

An Exchange with a relatively large slice of the individual insurance market will attract more insurers and provide more bargaining power for the state. The BBER-UM estimates that as many as 278,000 Montanans may end up in Montana's Federally Facilitated Exchange, of which two-thirds may qualify for cost-sharing reductions and and/or APTC. According to the Congressional Budget Office (CBO), the adults in the Exchange will be of worse health but have fewer diagnosed chronic conditions than the current privately-insured population. Despite the fact that adults in the exchange will be of poorer health, their average medical spending is not expected to be significantly different than that of adults with employer-sponsored insurance or adults purchasing insurance in the non-group market.

Unless many of the uninsured opt-out of the individual mandate and instead pay the penalty, or opt-out on affordability, the size of the Exchange should encourage health insurer participation. However, the relatively low thresholds that define affordability and the small penalties attached to non-compliance could reduce the size of the Exchange considerably. The potential number of Montanans who could opt- out on health insurance coverage altogether based on either affordability or simply by paying the penalty instead is 137,000, or half of the individual market Exchange population, and 70 percent of the uninsured.

Beginning in 2014, health care insurers will offer products with more comparable benefits and cost-sharing to all individuals without regard to pre-existing health conditions. Federally Facilitated Exchanges require insurers to provide policies to individuals and small businesses in an open and transparent environment. It is hoped that this environment will facilitate and promote health insurance purchases by people who otherwise do not have health insurance. Key to the success of the Exchanges is the level

of competition among insurers, which in theory, should moderate premiums in the health insurance market. The federal government too will gain through lower premium payments to low and moderate income households.

Whether or not states become active or passive purchasers in the Exchange is also influenced by the degree of market competition. In states with highly concentrated health insurance markets, countervailing forces are evident in this decision. As an active purchaser, states will decide who's in and who's out in the health insurance Exchange. Conceivably then, a state could use its power as an active purchaser to leverage the power of just a few health insurance carriers. On the other hand, when just a few insurers control the health insurance market, excluding even one will decrease the competition within the Exchange and, potentially, offset any gains in reducing the number of uninsured and reducing health care premiums. State decisions on rate review may also be influenced by the degree of market power. A more aggressive rate review process may be in order in states with highly concentrated insurance markets.

Ideally the competitiveness of health provider markets should also be addressed, since costs are the primary driver behind health insurance premiums. While health insurers with considerable market power may command higher premiums for their policies, they may also be able to negotiate greater discounts from health care providers.

The insurance industry exercises market power in two ways. When sellers exercise market power it is called monopoly power, when buyers exercise market power it is called monopsony power. Health insurers are buyers of medical services (from providers) and sellers of health insurance (to consumers and employers), so health insurers can raise both monopoly and monopsony concerns.

Another aspect of market power is the ability to maintain substantial barriers to entry for new firms. In the health insurance market, these barriers include provider networks as well as the ability to establish brand awareness among consumers.

Market Power in Montana's Health Insurance Industry, 2010

Insurance market concentration can be measured in a number of ways. Market concentration can be measured by the market share of the largest insurer based on enrollees. It takes on a value from 0 (no market) to 100 (one producer). A second measure, the Concentration Ratio, measures market concentration by calculating the market share of the top four producers. It too takes on a value from 0 to 100. A third measure, the Herfindahl-Hirschman Index (HHI), serves as the analytical foundation for federal antitrust merger guidelines. The HHI is calculated by summing the square of the market share of all producers. It takes on a value from 0 (no market concentration) to 10,000 (one producer).

According to an analysis by the Kaiser Family Foundation, Montana had three carriers with more than a 5 percent market share in the individual market in 2010. Nationally the median number of carriers with more than 5 percent market share was 4. Based on enrollment, the market share for the largest carrier in Montana was 51 percent. Well over

half of the states (including the District of Columbia) had market concentrations greater than that found in Montana. Montana's market share was just under the median market share for the nation, or 54 percent. Alabama had the highest market concentration based on the market share of the largest insurer, 86 percent, while Wisconsin had the lowest market concentration, 21 percent.

A better measure for market concentration is the Herfindahl-Hirschman Index. The index takes a theoretical range of 0 to 10,000. A value closer to zero indicates a more competitive market, while a value of 10,000 would represent one firm with 100 percent of market share. In the individual market, Montana has a HHI value of 3,459. As a rule of thumb, values below 1,500 indicate an un-concentrated market. Values above 2,500, however, indicate a highly concentrated market. While Montana's threshold value of 3,459 may seem high, 26 states have even more concentrated health insurance markets. Wisconsin is the only state with an index less than 1,500, indicating a competitive health insurance market. While the dominant firm controls 21 percent of the individual market, there are 6 carriers with more than 5 percent market share in Wisconsin.

The small group market is generally characterized by a similar level of competition as the individual market. The median market share captured by the largest carrier in Montana was 51 percent, compared to 54 percent in the individual market in 2010. Twenty-six states and the District of Columbia had small group markets with a single insurer accounting for more than half the small group market. In Montana, the largest insurer, again based on the number of enrollees, accounted for 71 percent of the small group market. The median HHI for the small group market is 3,595, slightly below the HHI for the individual market, 3,761. Three-fourths of the states have HHI that exceed 2,500, indicating little competition in the health insurance markets for a considerable number of states. The HHI for Montana in the small group market is 5,271, well above the national median 3,595. However, the number of carriers with market shares of more than 5 percent is 5 in the small group market, above the national median of 4. So despite a relatively high HHI in the small group market, the potential for competition exists.

Market Power in Montana's Health Care Industry, 2011

Leif Associates conducted a survey of Montana health insurance carriers in the spring of 2012, which allows us to update the market concentration indices to 2011 as well as expand the indices for associations and the large group market. Around 204,000 covered lives were insured by Montana's health care insurance industry. Excluded are the self-insured, which account for as many as 70,000 individuals.

For the individual market, the number of health insurance firms with more than 5 percent market share decreased from 3 to 2, but the market share of the largest insurer increased by 6 percentage points, or by nearly 12 percent, to 57 percent of the individual market. The HHI increased as well, from 3,459 to 3,703, an increase of only 7 percent.

In the small group market, the number of health care insurers with more than 5 percent market share again decreased from 5 to 4. The market share of the largest health care insurer, however, fell in 2011, from 71 percent in 2010 to 46 percent in 2011, a decrease

of 35 percent. Because the market share of the dominant firm decreased drastically, the HHI decreased as well, from 5,271 in 2010 to 3,023 in 2011, a 43 percent decrease in just one year. These indices suggest that the small group market is more competitive in 2011 than it was in 2010, despite a decrease in the number of health care insurers with more than a 5 percent market share.

The survey of Montana health care insurers also allows for the calculation of market power in the large group market. The number of health insurers with more than 5 percent market share is 3, with the largest health insurer capturing 71 percent of the market, based on enrollment. The HHI is 5,406, suggesting that the large group market is more concentrated than the individual and small group markets.

The health insurance market for associations is also concentrated. Only 3 health insurers have market share greater than 5 percent, with the largest insurer having 78 percent of the Association market. The HHI is 6,220, suggesting it is the most concentrated insurance market in Montana. The table below shows the number of health insurers with more than a 5 percent market share, the corresponding market share of the largest insurer, and the HHI for the individual, small group, large group and association health insurance markets in Montana during 2011.

Table 14: Market Power Measures in Montana's Health Insurance Markets, 2011

	Number Insurers with > 5 Percent Market Share	Market Share of Largest Insurer	U.S. Median	Herfindahl-Hirschman Index	U.S. Median
Individual	2	57%	54%	3,703	3,761
Small Group	4	46%	51%	3,023	3,595
Large Group	3	71%	NA	5,406	NA
Association	3	78%	NA	6,220	NA

Source: Leif Associates, BBER-UM.

Using the U.S. for benchmarks to assess the relative degree of market competition in Montana's health insurance markets, Montana's individual insurance market (HHI = 3,703), although concentrated, is comparable to the degree of competition nationally (HHI = 3,761). Two new insurers may be added to the individual market in Montana over the course of the next year, so the degree of market concentration may fall.

The small group market however is relatively less concentrated than the same market nationally. Hence the ability of insurers to wield bargaining power in the Exchange may be more limited than in the individual and large group markets.

Adverse Selection

One threat facing Exchanges is the disproportionate enrollment of high-risk, high-cost individuals. This could result from lower-risk individuals and employers seeking lower

cost options outside the Exchange. At the extreme, this could lead to the death spiral of rapidly rising costs for those left in the Exchange. Adverse selection can occur among insurers, between plan benefit designs, and between markets. Adverse selection can occur in all three ways in the Exchanges beginning in 2014. This is mitigated by the fact that individual and small group health insurance must follow the same rules, whether sold inside or out of the Exchanges, for essential health benefits, actuarial value levels, cost-sharing limitations, and rating reforms, including the use of a single risk pool. The same or similar insurance product must have the same rate, both inside and outside the Exchanges. Producer commissions must be the same also, inside and outside the Exchanges.

Since consumers will have a choice between two markets, the Exchange and a traditional health insurance market outside the Exchange, the federal regulations governing these markets are designed to avoid making the Exchange the state's high-risk pool. The problem is less acute for employer-provided plans. In employer group insurance, adverse selection is minimized since employees seldom refuse coverage regardless of health status, due to insurer participation requirements and the non-taxability of employee benefits.

The ACA contains several provisions to minimize adverse selection in the individual market Exchange. Some of the provisions are:

1. The individual mandate to encourage larger numbers of healthy people to participate in the insurance markets,
2. Prohibitions against charging higher premiums based on health status or pre-existing conditions,
3. Entices participation in the Exchange by offering tax credits for individuals and small businesses,
4. Requires health plans to cover the same defined "essential health benefits" and apply the same out-of-pocket limits for plans offered both inside and outside the Exchange,
5. Requires insurers with plans inside and outside the Exchange to combine individuals into one "community rated" risk pool ,
6. Requires insurers to charge the same premium for a qualified health plan outside and inside the Exchange,
7. Insurers are not allowed to use marketing practices that discourage sicker enrollees or encourage healthier enrollees to purchase their plans,
8. Insurers must offer at least one Gold and one Silver plan in order to participate in the Exchange since Bronze and catastrophic plans will attract younger and healthier enrollees, and
9. Creates three risk spreading mechanisms to make the insurance market more predictable, stable and less risky for insurers. A three year reinsurance program and risk corridor program, along with a permanent and ongoing risk adjustment program, are designed to compensate insurers who enroll higher-cost enrollees.

Still, some risk of adverse selection exists against the Exchange. Insurers may choose to sell plans outside the Exchange only and offer much less expensive options, even though they cannot sell policies below the Bronze level of coverage. One exception is catastrophic coverage for eligible individuals under the age of 30 years old. This would attract primarily younger and healthier enrollees since these plans would have much higher cost-sharing and lower premiums.

The experiences of two states serve to illustrate how adverse selection is addressed by states with up and running Exchanges. The Massachusetts Health Connector mirrors the federal reform legislation in its approach to minimize adverse selection. State legislation has the individual mandate, an Exchange with subsidized coverage, risk pooled across the Exchange and outside market, and homogeneity in the products offered inside and outside of the Exchange. Massachusetts also experienced adverse selection when enrollment periods were not restricted. Starting in 2012, only one open enrollment period is offered to reduce the number of people purchasing health insurance only when they expect to have significant health expenses. While limiting the potential for adverse selection, restricting enrollment to only one period requires an aggressive outreach and education program to avoid the possibility of those needing insurance remaining uninsured.

The Utah Health Exchange piloted in 2010 requires premiums to be the same inside and outside of the Exchange, standardized rating practices, and prospective and retrospective risk adjustment for health plans offered in the Exchange to compensate health plans enrolling sicker and higher cost enrollees.

Avenues for Adverse Selection in 2014

There are numerous avenues for adverse selection to occur in a health insurance market that contains an Exchange of some sort. One potential problem for any Federally Facilitated Exchange is the possibility that it could become a high risk pool should sicker than average enrollees obtain their coverage in the Exchange. Cost-sharing reductions are available only to families below 250 percent of the federal poverty level and only for those who enroll in a Silver plan. Native American populations do not have any cost-sharing up to 300 percent ($69,150 for a family of four).

Overall, lower-income groups are less healthy than their higher-income counterparts. The incentive to purchase the Silver plan level of coverage (70 percent actuarial value) is the cost-sharing available to lower-income individuals. As discussed earlier, based on BBER-UM survey results, previously uninsured individuals who will be purchasing the Silver plan will on average be sicker than the higher-income counterparts who also purchase the Silver plan. Upon examination of the proportion of individuals reporting fair to poor health in the population eligible for cost-sharing (below 250 percent of the FPL) to the higher income thresholds (above 250 percent of FPL), it is readily apparent that significantly higher proportions of lower-income individuals report fair to poor health.

Federal regulations proposed in November 2012 limit adverse selection in the individual market overall by allowing insurers outside the Exchanges to use the same open enrollment periods that apply to individual market coverage sold through the Exchanges.

Another source of adverse selection is the extensiveness of the provider network. Older and sicker enrollees are most likely to be more concerned with the adequacy of the provider network than younger and healthier consumers. States will have to ensure that plans in and out of the Exchange are similar in terms of the robustness of network providers. The ACA requires network adequacy for health plans sold both inside and outside the Exchanges.

The federal reform legislation requires that insurers must treat all non-grandfathered health plans sold in the individual market as a single risk pool and all health plans sold in the small group market as a single risk pool. This is true only for plans sold by the same insurer. Risk adjustment is available as a permanent mechanism to address the possibility that adverse selection could occur between insurers participating in the Exchange and insurers operating outside the Exchange. Grandfathered plans could increase the possibility of adverse selection since these plan participants are removed from the risk pool. However, the number of grandfathered plans in existence is not expected to be significant by the start of the exchanges in 2014. Leif Associates found that grandfathered plans in 2011 accounted for only 15 percent of the health insurance market.

Differences in commission fees inside and outside the Exchanges could push enrollees toward the market that best serves the interests of the insurers. These differentials would have to be eliminated in order to level the playing fields between plans in and outside the Exchange. Federal regulations proposed in November 2012 currently address this potential discrepancy by requiring commission fees to be the same in and outside the Exchange.

Despite efforts in the ACA to minimize adverse selection by requiring essential health benefits and Exchange plans to offer specified actuarial tiers, insurers could be able to discourage sicker populations from purchasing their policies through benefit design. Individuals and employers will base insurance decisions on the price of coverage and the benefits they expect to use. Individuals could purchase lower levels of coverage while healthy and move to more comprehensive coverage when sick during open enrollment periods. However, the Federally Facilitated Exchange has plans to implement software that detects and eliminates discriminatory benefit designs.

Reinsurance will provide funding to individual market insurers that incur high cost claims for the period 2014 -2016, although the largest distributions will occur in the first year. All insurers and third party administrators on behalf of group health plans must contribute funding to the reinsurance program. This program is designed to offset the claims of high risk individuals who enter the individual health insurance market once guaranteed issue is required in 2014. Another temporary program, risk corridors, limits insurer losses as well as gains for Qualified Health Plans (QHP) sold in the Exchanges. Risk corridors are meant to protect against inaccurate rate setting, and occurs only after

risk adjustment and reinsurance have been applied. Risk adjustment is an ongoing program to protect against adverse selection between insurers. Risk adjustment occurs for both the individual and small group markets inside and outside the Exchanges and transfers funds from plans covering lower risk individuals to plans that cover higher risk individuals.

Conclusion

Passage of the Affordable Care Act in 2010 represents one of the single most significant changes to the delivery of health care in the U.S. For Montanans, access to affordable health care should change drastically beginning in 2014. Twenty percent of Montana's non-institutionalized population, or 195,000, do not have health insurance of any kind. For most of these uninsured, the major obstacle to health insurance is its affordability. Only 8 percent of the uninsured in Montana lack health insurance by choice.

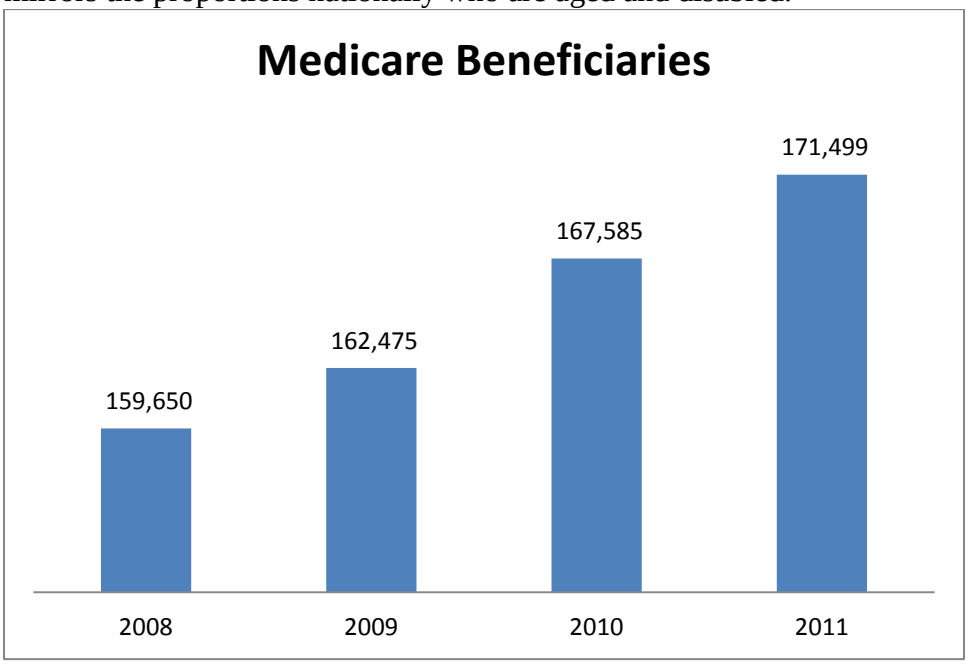
Modeling the impact of the ACA at the national level is subject to limitations since the provisions of the reform bill have large and far-reaching consequences for consumers, employers, employees, medical providers, and health insurers. The ACA will change incentives on many fronts, and modeling these changes in consumer, provider, and employer behavior is well beyond the use of traditional models. Extending the models to statewide impacts is even more perilous since much of the behavioral response information needed is simply not available.

This report has attempted to use "best practice" methods for examining the health insurance market in Montana and assessing the impact, particularly of the Federally Facilitated Exchange, on the uninsured, employers, and medical providers. The BBER-UM has tried to tailor its analysis as much as possible to the circumstances in Montana by relying on primary data collected in the household and business surveys during 2011. Nevertheless, much is still unknown, and the dynamics of the ACA as it unfolds will likely lead to changes along the way.

Appendix 1

Medicare

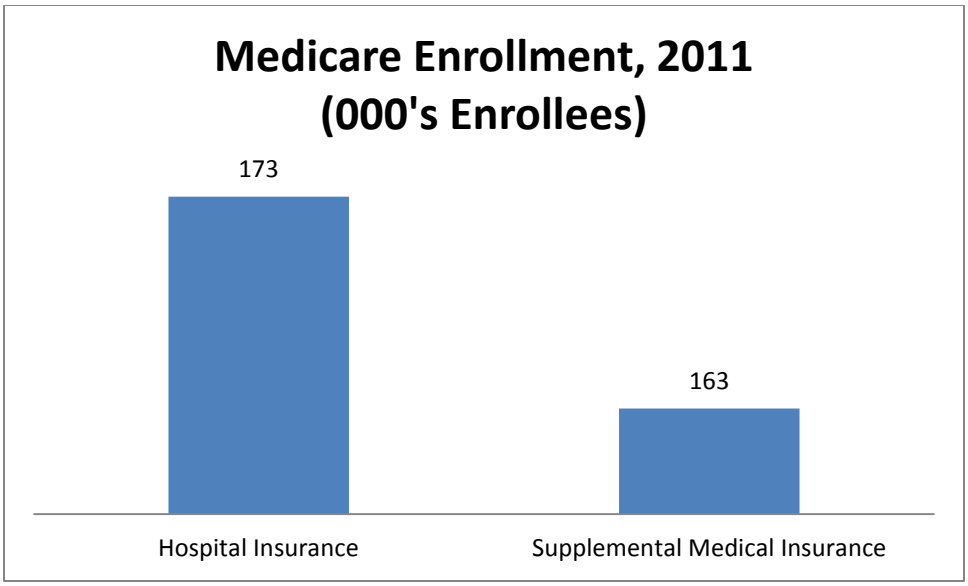
In July, 2011, there were 173,661 Montanans enrolled in Medicare. The Kaiser Family Foundation analysis of Medicare enrollees in March of 2011 reports slightly fewer beneficiaries, 171,499. Eight in ten enrollees are aged, with the remainder disabled. This mirrors the proportions nationally who are aged and disabled.



Source: Mathematica Policy Research, Kaiser Family Foundation

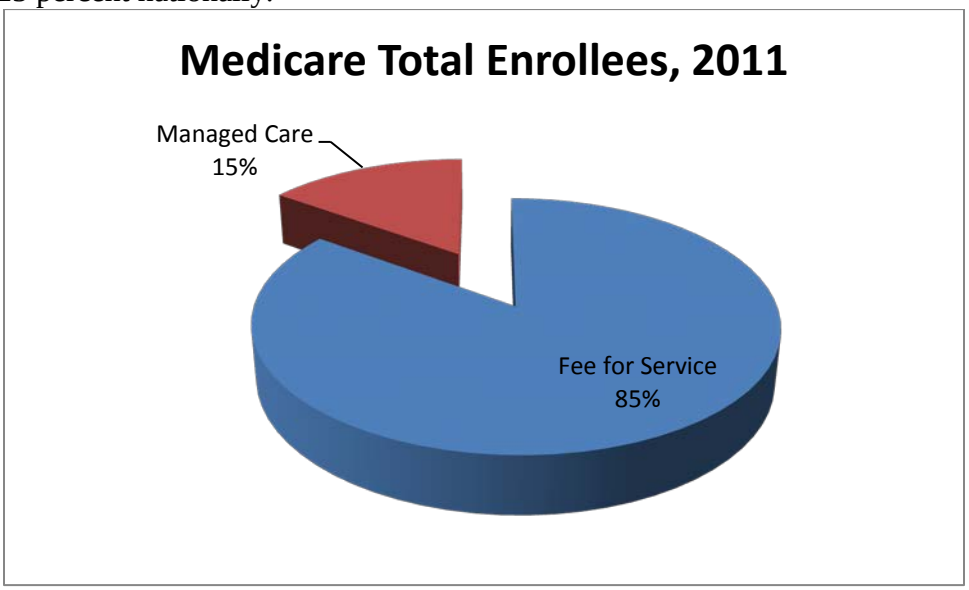
The average annual growth in Medicare beneficiaries from 2008 to 2011 is 2.5 percent.

Nine in ten Medicare beneficiaries also have Medicare Part B (Supplementary Medical Insurance) in addition to Part A (Hospital Insurance).

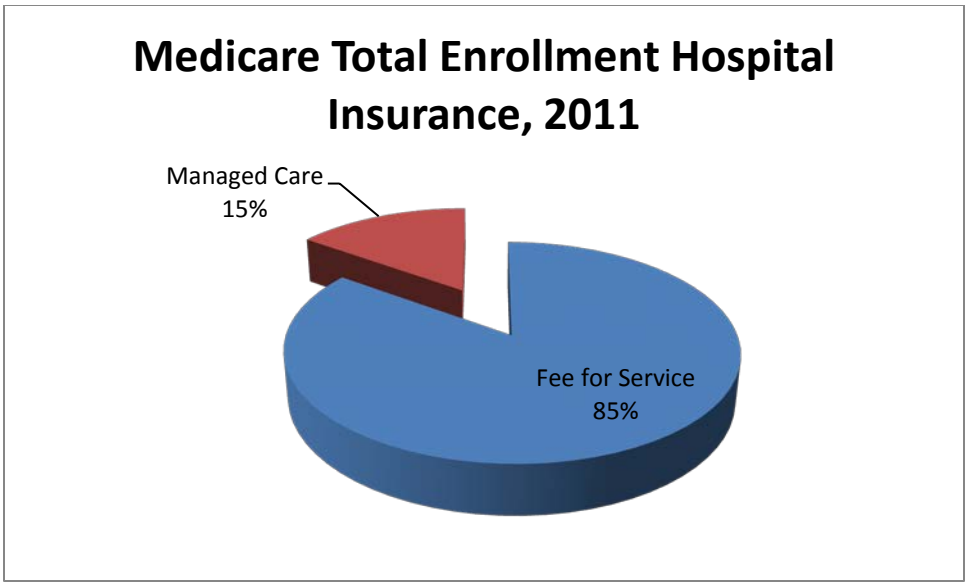


Source: Medicare and Medicaid Research Review, 2012 Statistical Supplement

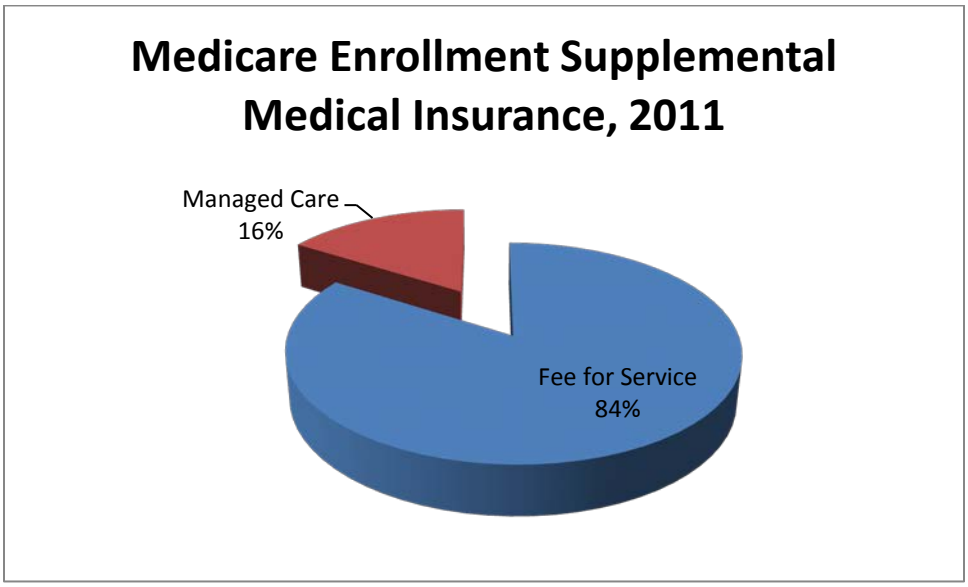
Fifteen percent of Medicare beneficiaries are on managed care plans, while the vast majority is on fee-for-service plans. For hospital insurance and supplementary medical insurance, the proportions on managed care plans remain the same. Compared to the proportions of national Medicare beneficiaries on managed care plans, Montanans are significantly less likely to be on managed care plans, 15 percent in Montana compared to 25 percent nationally.



Source: Mathematica Policy Research, Kaiser Family Foundation



Source: Mathematica Policy Research, Kaiser Family Foundation



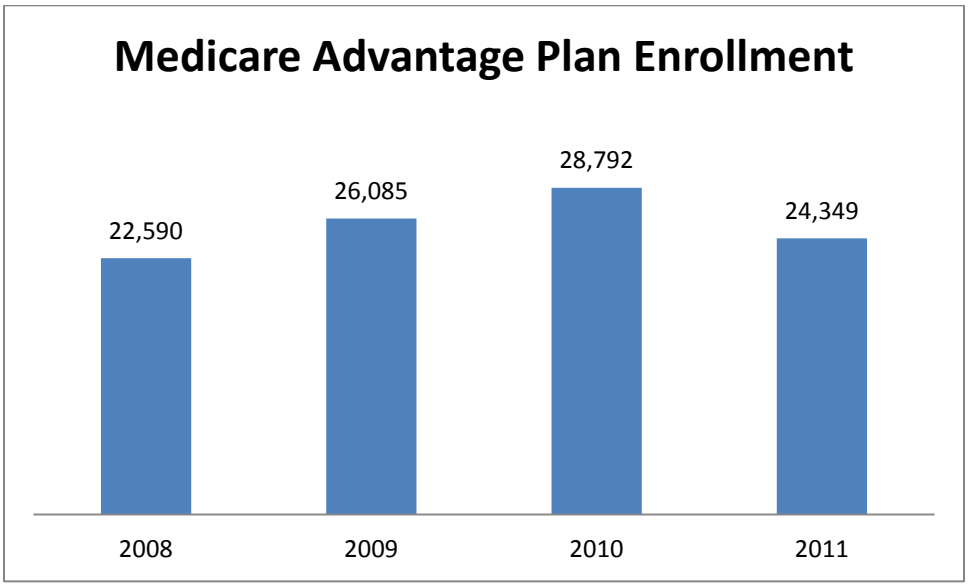
Source: Mathematica Policy Research, Kaiser Family Foundation

Medicare Part C

Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are offered by private companies approved by Medicare. Under a Medicare Advantage Plan, beneficiaries have Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage from the Medicare Advantage Plan rather than original Medicare. Each Medicare Advantage Plan can charge different out-of-pocket costs and have different rules for how beneficiaries receive medical services, and these rules can change each year.

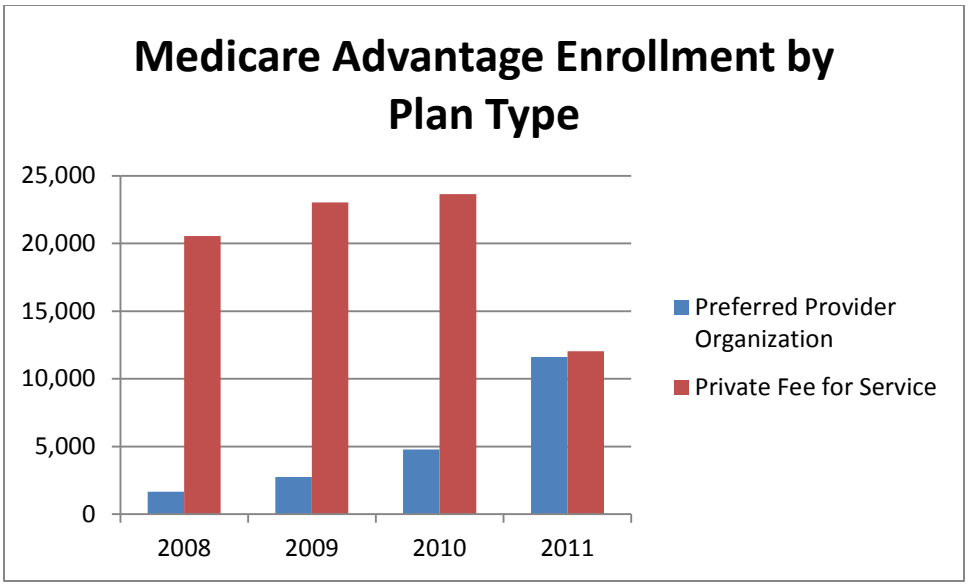
There are different types of Medicare Advantage Plans, including Health Maintenance Organizations (HMO's), Preferred Provider Organizations (PPO's), Private Fee-for-Service Plans (PFFS's), and Special Needs Plans (SNP's). In some states, less common types of Medicare Advantage Plans may be available, such as HMO Point of Service Plans (HMOPOS) which allow beneficiaries to receive some services out-of-network at a higher cost, and Medical Savings Account (MSA) Plans, where high deductibles are combined with a bank account.

Medigap policies (Medicare Supplement Health Insurance) are more standardized, and must follow Federal and state laws. Medigap policies costs may differ widely, and generally, the only difference between Medigap policies sold by different insurance companies is the cost.



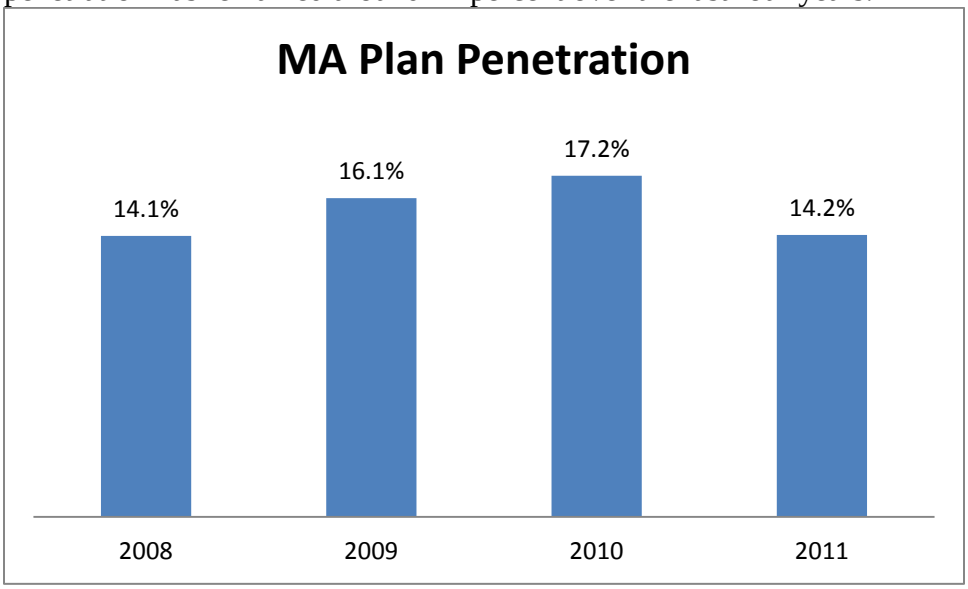
Source: Mathematica Policy Research, Kaiser Family Foundation

In 2011, over 24,000 Montanans were enrolled in a Medicare Advantage plan, down slightly from the previous year's enrollment. By far, the largest enrollment was in private fee-for-service plans until 2011. In 2011, fee-for-service plans had a 50 percent drop in enrollment while preferred provider organization enrollment experienced a 150 percent increase.



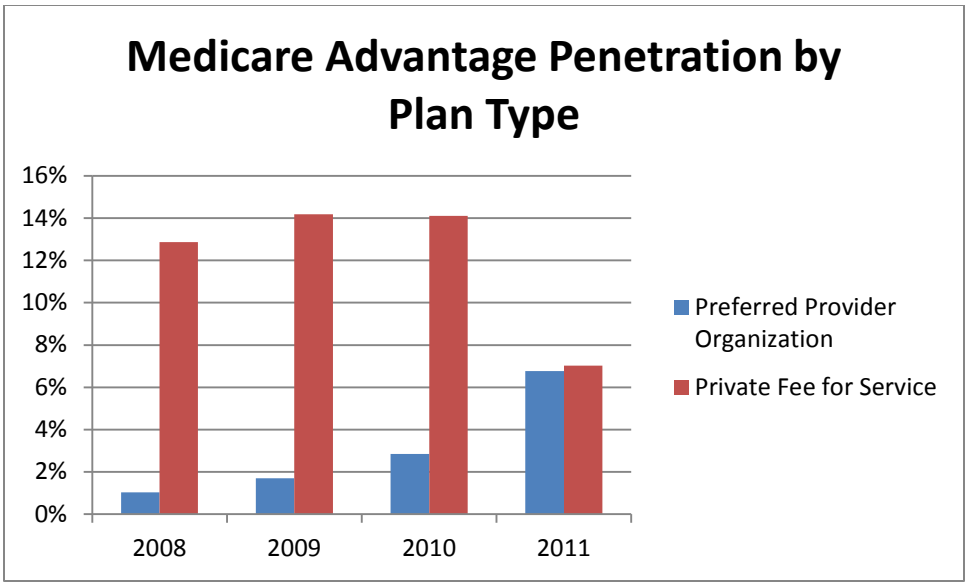
Source: Mathematica Policy Research, Kaiser Family Foundation

Plan penetration is defined as the number of Medicare Advantage Plan (Part C) enrollees expressed as a share of total Medicare beneficiaries. Medicare Advantage Plan penetration has remained around 14 percent over the last four years.



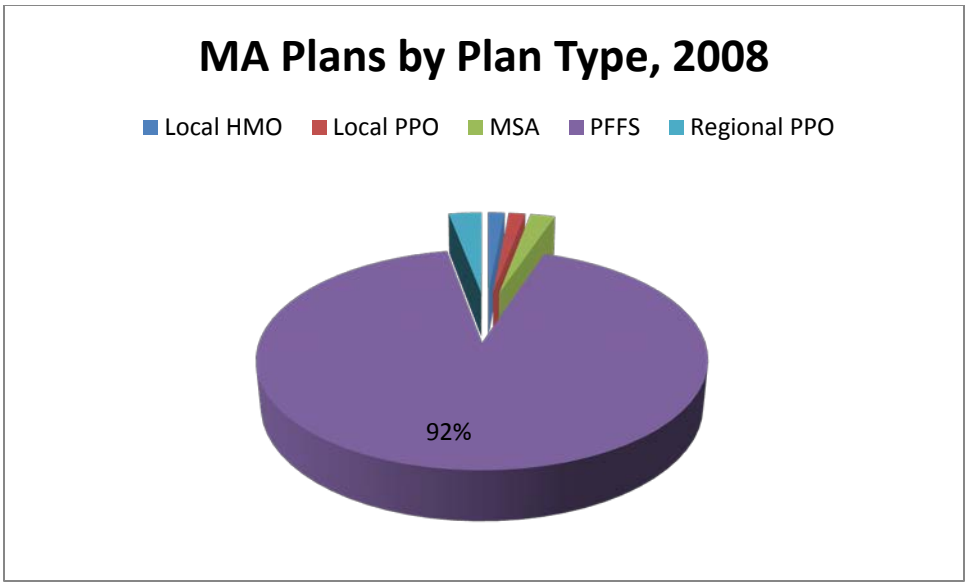
Source: Mathematica Policy Research, Kaiser Family Foundation

Private Fee-for-Service Medicare Advantage Plans were dominant until 2010. Thereafter, Medicare Plan Penetration for Preferred Provider Organizations and Private Fee-for-Service Plans became more equally split among Medicare enrollees.



Source: Mathematica Policy Research, Kaiser Family Foundation

The next six charts depict the changes in Medicare Advantage plan types offered in 2008, 2010, and 2011in Montana. Of interest is the emergence of local and regional Preferred Provider Organizations and the decline in fee-for-service plans. In 2008, five different plan types were evident in Montana with a majority of the plans offered being private fee-for-service plans. Private Fee-for-Service Plans (PFFS) are private health plans that pay providers directly for the services they provide to Medicare beneficiaries using the same payment rates that apply in the traditional Medicare program. These plans do not coordinate care. However, PFFS are part of the Medicare Advantage program and receive capitated payments from the Centers of Medicare and Medicaid Services. Local HMO, Local PPO, MSA, and Regional PPO's collectively represented less than 10 percent of the plans offered.



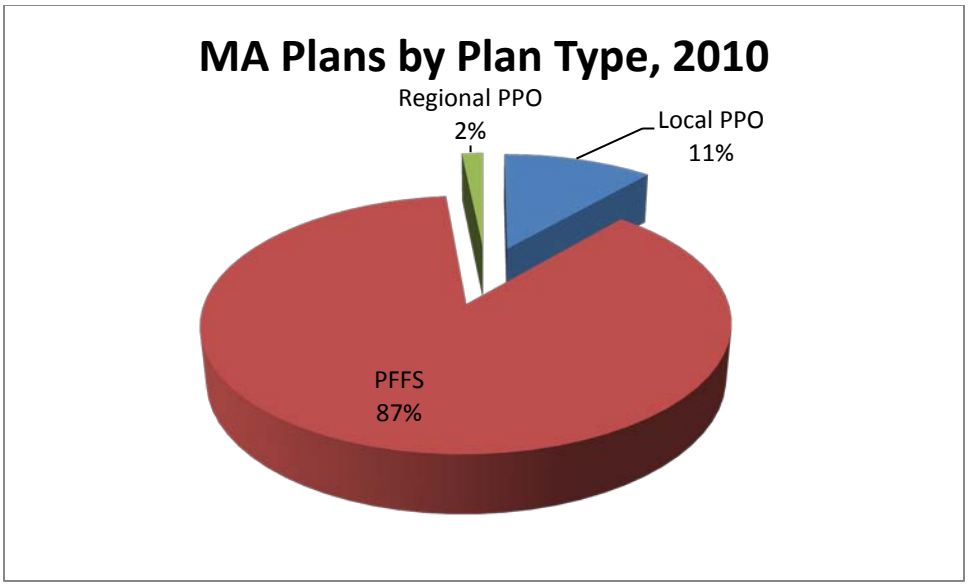
Source: Mathematica Policy Research, Kaiser Family Foundation

Local HMO plans are plans with defined networks of providers that beneficiaries must patronize in order to receive medical services. Local HMOs serve specific geographic areas usually consisting of a service area defined by several aggregated counties.

Local PPOs are Local Preferred Provider Organizations. Local PPOs are network based plans that serve specific geographic areas similar to Local HMO plans. Local PPOs however are generally more flexible in provider choice as long as the provider is in the defined network. Beneficiaries may use out-of-network providers, but out-of-pocket costs will be higher for out-of-network providers.

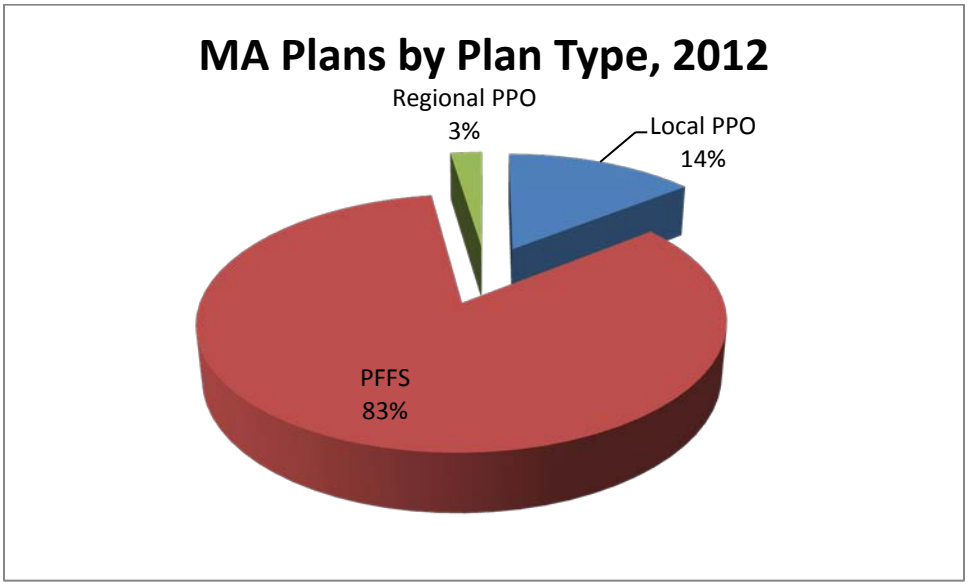
MSA Plans are Medical Savings Account Plans. These plans combine a high deductible with the ability to use bank account deposits made by Medicare (usually less than the deductible).

Regional Preferred Provider Organizations (PPO) are plans that serve large areas defined by 26 regions, including one or more states. RPPOs offer the same plan with the same benefits and premiums across the entire region served. RPPOs are structured to integrate cost sharing across Part A and Part B benefits and include out-of-pocket limits.



Source: Mathematica Policy Research, Kaiser Family Foundation

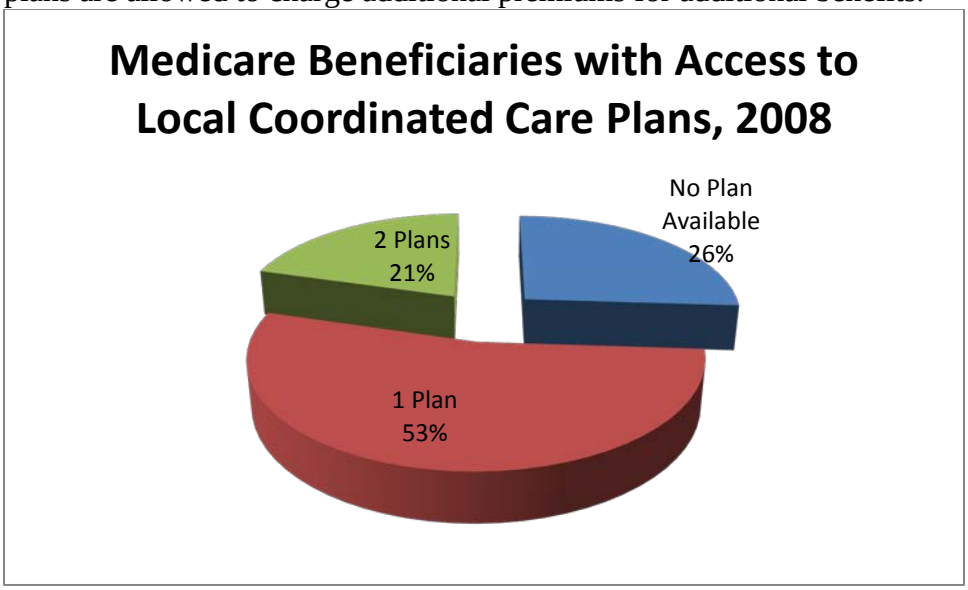
Beginning in 2010, local HMO plans and MSA plans had disappeared from the Montana market. Local PPO plans in particular increased 250 percent from 2008; two Local PPOs plans existed in 2008, increasing to 7 by 2010.



Source: Mathematica Policy Research, Kaiser Family Foundation

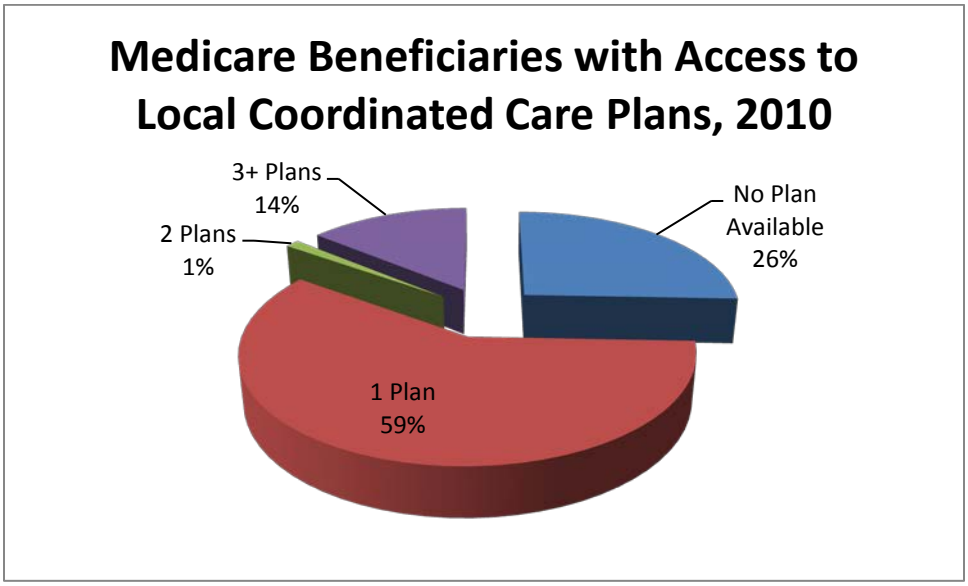
Local PPO plan percentage increased in 2011 over 2010, although the number of Local PPO plans decreased by one. This is attributable to the fact that 20 fewer Medicare Advantage Plans were offered in 2011 when compared to 2010. Private Fee-for-Service Plans totaled 35 in 2011, compared to 54 in 2010 and 125 in 2008.

Local Coordinated Care Plans (CCPs) refer to Medicare Advantage Plans that coordinate care for members, and include provider-sponsored organizations and preferred provider organizations. Generally, CCP enrollees must use plan providers to get coverage for their medical care or pay more for their care if they go to out-of-network providers. Private plans are allowed to charge additional premiums for additional benefits.

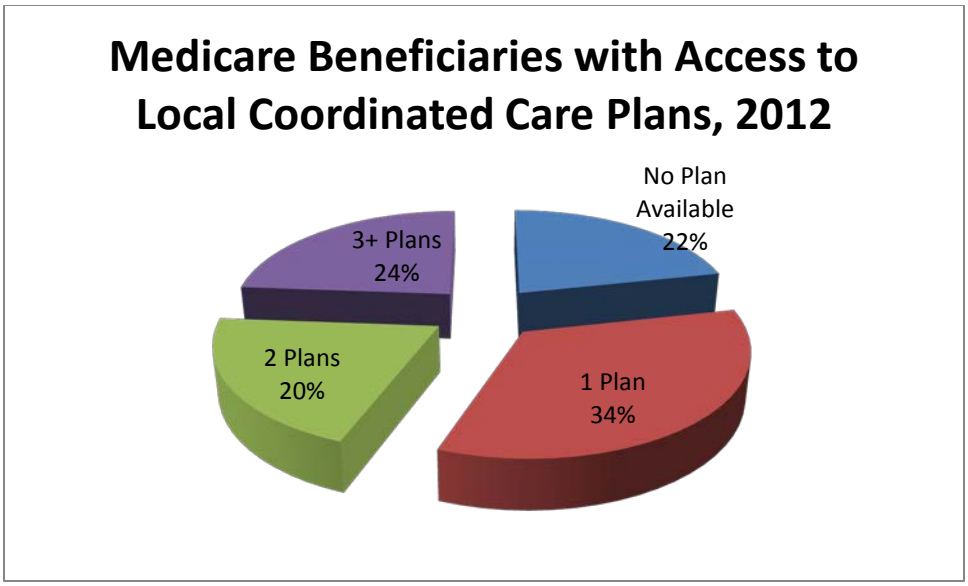


Source: Mathematica Policy Research, Kaiser Family Foundation

In 2008, the majority of Medicare Advantage enrollees had access to only one CCP. By 2012, 24 percent Medicare beneficiaries had access to 3 or more CCPs.



Source: Mathematica Policy Research, Kaiser Family Foundation



Source: Mathematica Policy Research, Kaiser Family Foundation

Average monthly payment rates for Medicare Advantage Plans are shown below. The payment rates are weighted by Medicare Advantage enrollees in HMO, local PPO, PFFS, and PSO contracts in each county. Medicare Advantage payment rates reflect base county rates for Aged Medicare beneficiaries and do not reflect the actual payments to Medicare Advantage Plans. Actual payments to Medicare Advantage Plans are typically weighted based on health status, age, gender, working status, Medicaid eligibility, and institutionalized status of each Medicare enrollee.

	2005	2006	2007	2008	2009	2010	2011	Average Annual Percent Change
Local MA Benchmark	$591.91	$620.36	$662.36	$699.02	$726.15	$731.43	$731.37	3.6

Source: Mathematica Policy Research, Kaiser Family Foundation

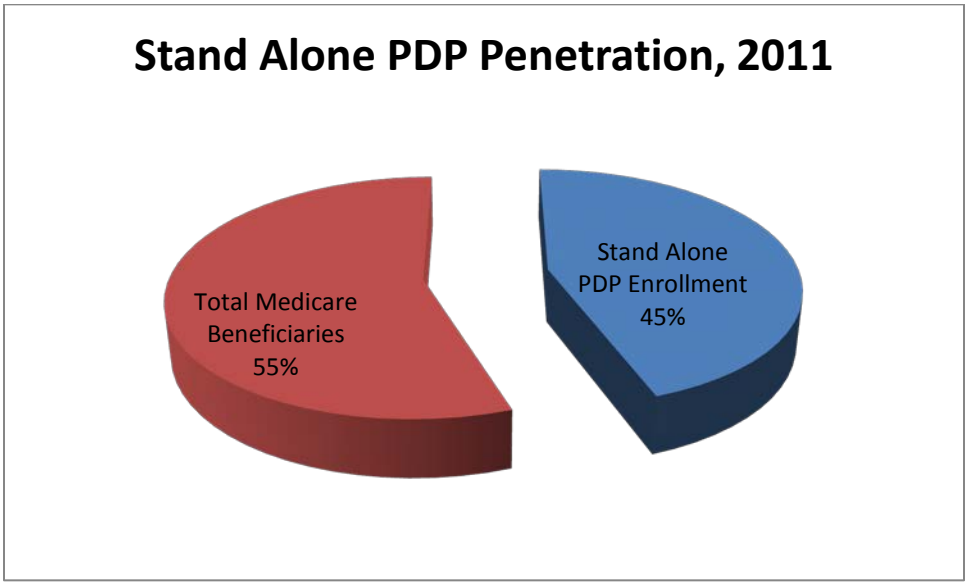
The Centers for Medicare and Medicaid Services (CMS) grades Medicare Advantage Plans using a star rating system from one to five. One star plans have poor performance, and five star plans have excellent performance. In Montana, Medicare Advantage contracts with four or more stars were non-existent. Medicare Advantage contracts are contracts that private health plans have with CMS to offer health care coverage to Medicare beneficiaries in a certain geographical area, usually one to ten counties. A single MA contract may consist of multiple plans or benefit packages.

Medicare Advantage average star ratings were 2.8 in 2008 and 3.4 in 2011, representing a 21 percent increase in overall performance.

Medicare Part D

Medicare beneficiaries usually get prescription drug coverage (Part D) through their Medicare Advantage Plans. In some types of plans that do not offer coverage, beneficiaries can join a Medicare Prescription Drug Plan. Medicare enrollees can't have prescription drug coverage through both a Medicare Advantage Plan and a Medicare Prescription Drug Plan. Should an enrollee in a Medicare Advantage Plan with prescription drug coverage inadvertently enroll in a Medicare Prescription Drug Plan, they would be automatically disenrolled from the Medicare Advantage Plan and returned to original Medicare.

Prescription Drug Plans (PDPs) are sometimes referred to as stand-alone prescription drug plans. These are private plans that contract with Medicare to provide coverage for prescription drugs only. Beneficiaries who enroll in a PDP continue to have access to all other Medicare benefits through the original, fee-for-service program. In 2011, almost 77,000 Montanans had stand-alone PDPs, resulting in a 46 percent stand-alone PDP penetration rate. The penetration rate excludes employer-only prescription drug contracts.



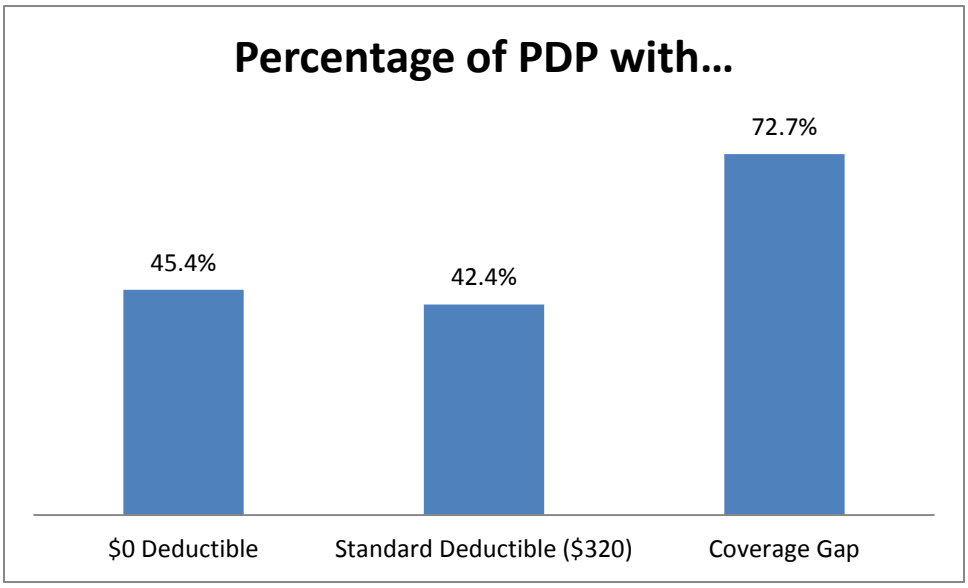
Source: Mathematica Policy Research, Kaiser Family Foundation

The maximum premium for a PDP in 2011 was $107, with the minimum premium available being $15.

Source: Mathematica Policy Research, Kaiser Family Foundation

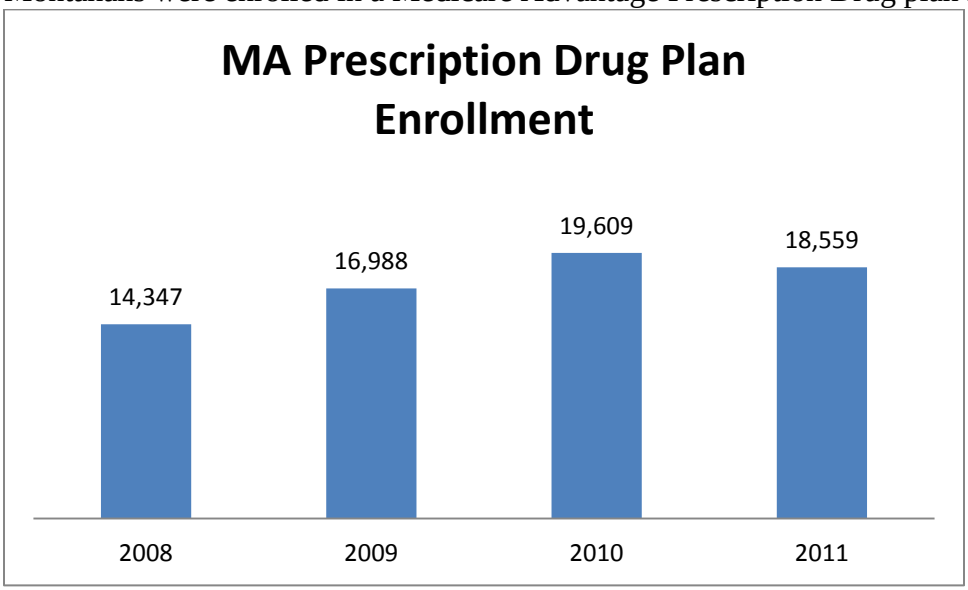
The chart below shows the number of prescription drug plans with a $0 deductible, standard deductible, and the percentage of prescription drug plans with a coverage gap. Standard deductibles went from $250 in 2006 to $320 in 2012, representing a 28 percent increase over the six-year period. Deductibles have increased at an annual average rate of 4 percent from 2006 to 2012.

Prescription drug plans with a coverage gap refers to the gap in benefits in which Part D enrollees are required to pay the full cost of their prescription drugs until they qualify for catastrophic coverage. Nearly three-quarters of prescription drug plans in Montana had coverage gaps.



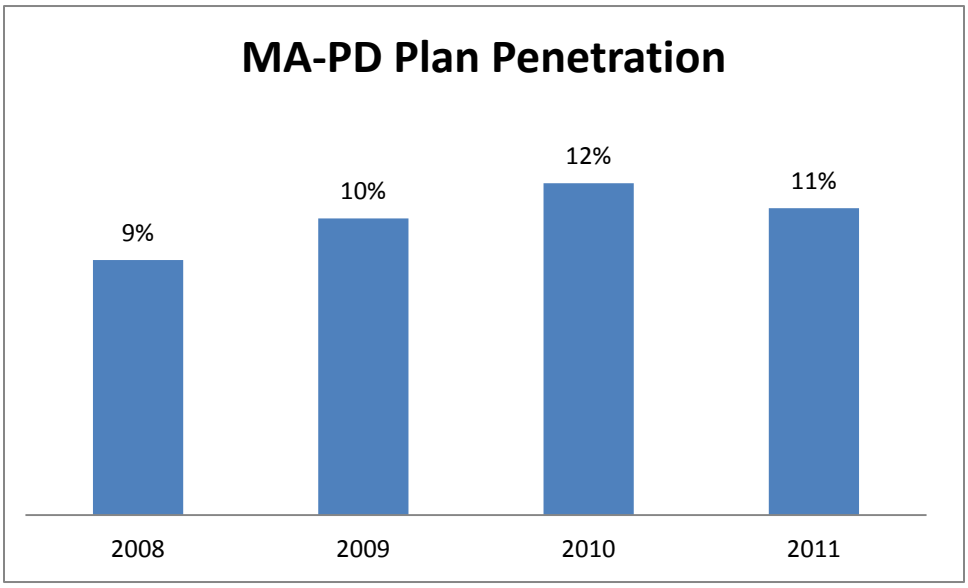
Source: Mathematica Policy Research, Kaiser Family Foundation

MA-PD Plans are Medicare Advantage-Prescription Drug Plans. Almost 19,000 Montanans were enrolled in a Medicare Advantage Prescription Drug plan in 2011.



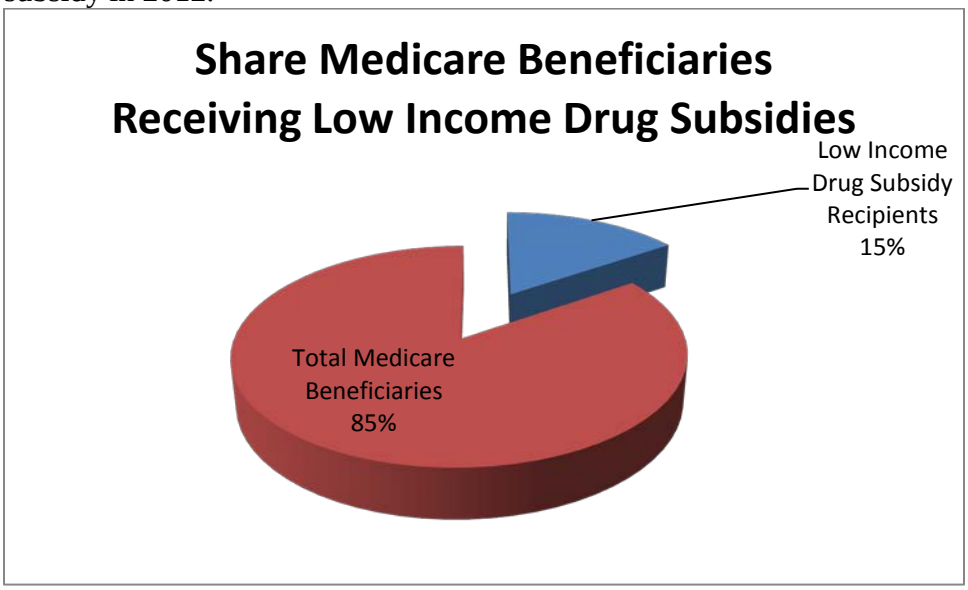
Source: Mathematica Policy Research, Kaiser Family Foundation

Medicare Advantage Prescription Drug Plan penetration is calculated by dividing the number of prescription drug plan enrollees by the number of Medicare enrollees in Montana. As seen below, penetration rates have stabilized in 2011, after increasing during the 2008 to 2010 period. Plan enrollment in 2006 was only half of total plan enrollment in 2008 (not shown).



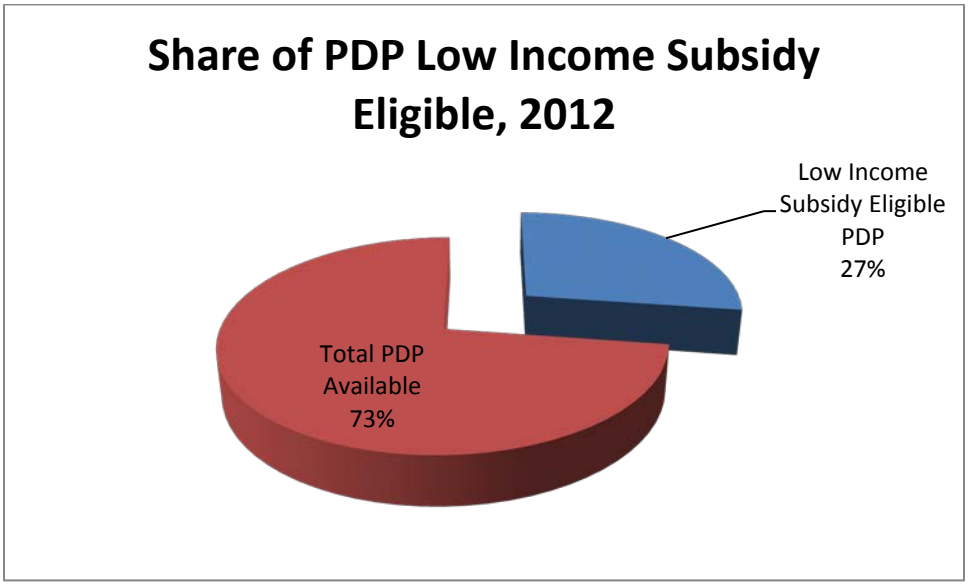
Source: Mathematica Policy Research, Kaiser Family Foundation

Part D Low-Income subsidy, also referred to as the low-income benchmark premium amount, is the maximum level of premium assistance Medicare will provide for qualifying low-income beneficiaries. A beneficiary who is enrolled in a PDP with a premium that is higher than the low-income subsidy amount is responsible for the balance. Fifteen percent of Medicare beneficiaries qualified for the low-income drug subsidy in 2012.



Source: Mathematica Policy Research, Kaiser Family Foundation

Nine of the thirty-three PDPs available in Montana in 2012 were low-income subsidy eligible.



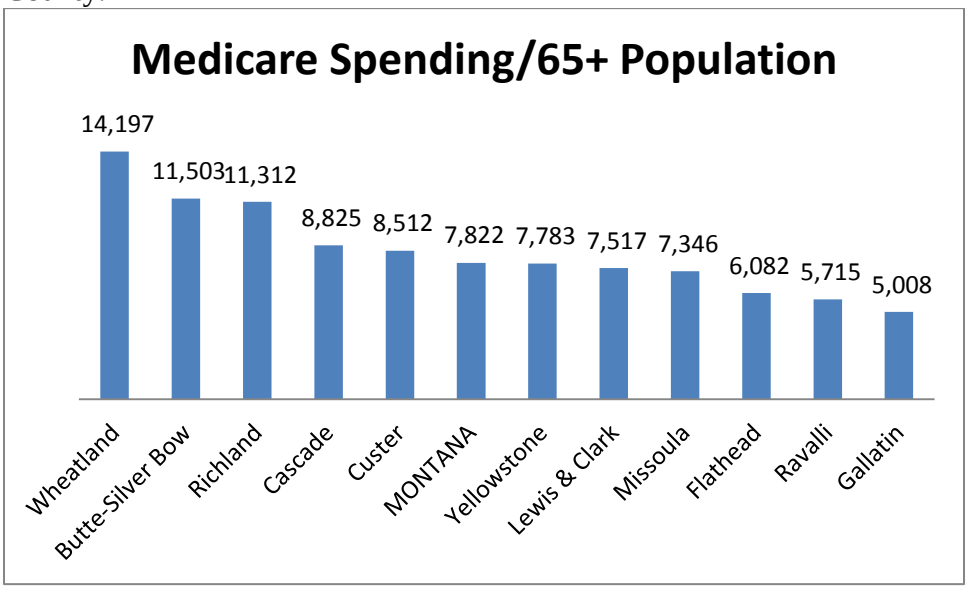
Source: Mathematica Policy Research, Kaiser Family Foundation

Summary

Medicare will continue to play an important part in Montana's health care delivery system. Medicare comprises almost 20 percent of Montana's personal health care spending. Further, Medicare represents 30 percent of all personal health care spending for hospital care, 20 percent of all physician and clinical care, 39 percent of home health care, 20 percent of nursing home care, 33 percent of durable medical equipment health care spending, and 24 percent of all prescription drug spending in the state of Montana.

Montana's reliance on Medicare spending will increase as well. Montana's aged population is proportionately higher than the aged population nationally. For many counties, reliance on Medicare is important since a high proportion of their population is 65 years old or older.

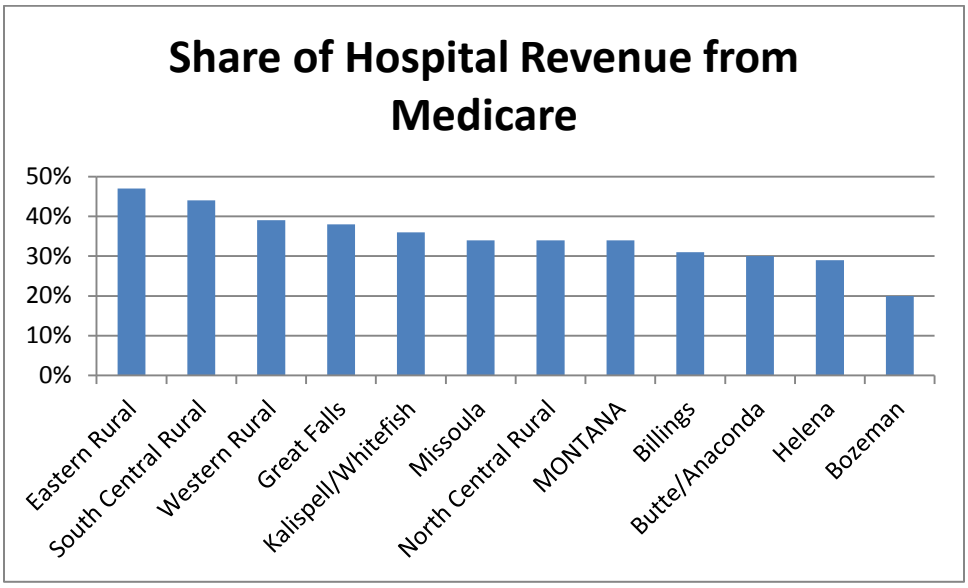
The relative importance of Medicare spending per aged adult varies by county. The graph below examines Medicare spending per aged adult for select counties. Medicare spending per aged adult is almost three times higher in Wheatland County than it is for Gallatin County.



Source: CMS, Census Bureau, BBER calculations

Medicare spending in Montana, Parts A, B, and D support over 21,000 jobs in Montana and generate an additional $1.1 billion in labor income. Although many of these jobs are in health care, other sectors of the economy benefit as well as the ripple effects of health care spending spreads throughout the economy.

Hospitals alone employ over 3 percent of the state's total employees. Reliance on Medicare for their revenues varies from county to county. Most of the rural areas in Montana, where many of Montana's elderly reside, rely on Medicare for their hospital revenues.



Source: Unpublished, Certificate of Need, BBER calculations