

# Montanans Can't Wait Any Longer For Health Care Reform

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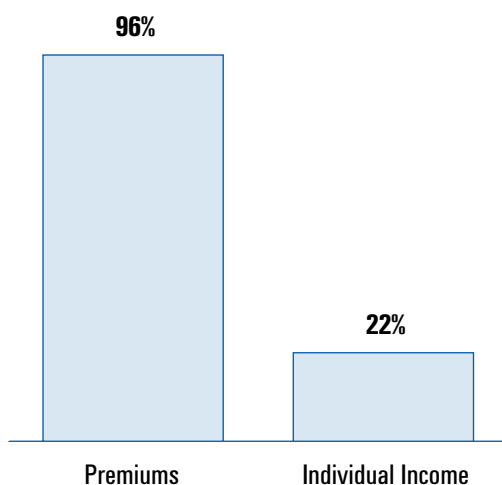
SKYROCKETING PREMIUMS and out-of-pocket medical costs are battering family budgets in Montana and making it more difficult for employers, particularly small and low-wage businesses, to provide health insurance for their workers. Health costs are rising at an unsustainable rate. Without reform, these costs threaten Montana's state and county budgets, the national economy and every American family.

Comprehensive health reform is needed to set a sustainable path for health care spending, increase the number of Americans with quality, affordable coverage, and make smart health care investments.

## Unsustainable Premium Increases Affect Families and Businesses

- Health insurance premiums for Montana working families have skyrocketed, increasing 96 percent from 2000 to 2009. During the same time, the median earnings of Montana workers increased 22 percent.<sup>1</sup>
- For family health coverage in Montana during that time, the average annual combined premium for employers and employees rose from \$6,220 to \$12,159.<sup>2</sup>
- The full cost of family employer-sponsored health insurance in Montana is projected to grow at an annual rate of 8.7 percent, compared to a 1.5 percent growth rate for income.<sup>3</sup>

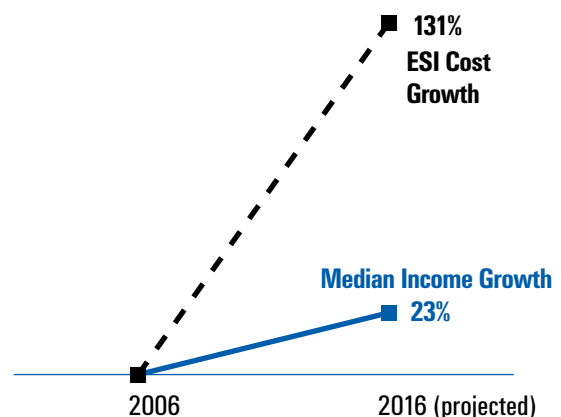
### Percentage Increase in Premiums vs Income in Montana 2000–2009



Source: Families USA, "Premiums versus Paychecks, by State, 2000 to 2009."

### Montana Employer Premiums vs Income

Cumulative growth of Montana employer sponsored insurance (ESI) premiums compared to median household income, assuming no meaningful health reforms, 2006 to 2016 (projected)



Source: New America Foundation, "The State of State Health: The Cost of Failure" (2007)

- Left unchecked, premiums will be \$25,559 in 2016—fully 52 percent of median household income.<sup>4</sup>

### **Fewer Businesses Can Afford to Offer Coverage**

- Nationally, only 59 percent of small businesses (three to 199 workers) offer their employees health benefits. This is down from 68 percent in 2000.<sup>5</sup>
- Without reform, small businesses will pay nearly \$2.4 trillion in health care costs for their workers over the next 10 years. With reform, small businesses can save as much as \$855 billion, a reduction of 36 percent—money that can be reinvested to grow their small businesses.<sup>6</sup>
- Without reform, 178,000 small business jobs will be lost in 2018 as a result of health care costs. Depending on the particular mechanism used to help small businesses meet their health care obligations, reform can preserve up to 128,000 of these jobs.<sup>7</sup>

### **More Montanans are Uninsured, Leading to Poorer Health, Higher Costs**

- One in six Montanans was uninsured in 2008, including one in five adults between the ages of 19 and 64 (123,600 people) and one in eight residents younger than 18 years old (28,200 children).<sup>8</sup>
- By 2019, without reform the number of uninsured in Montana will rise to 205,000.<sup>9</sup>

- About 62 percent of U.S. personal bankruptcies were directly related to medical bills, according to a recent report; in Montana there were 1,878 non-business bankruptcies in 2008.<sup>10,11</sup>
- Each insured family in Montana pays an extra \$2,100 per year and each individual an extra \$800 per year in health insurance premiums as a result of a “hidden tax” to cover the unreimbursed health care expenses of the uninsured.<sup>12</sup>

### **Lack of Competition Among Health Insurers Raises Costs, Limits Choices**

- Consolidation in the insurance industry means that employers, particularly small businesses, have fewer insurance choices and less power in bargaining to negotiate a plan for workers. Freedom from genuine competition allows Montana insurers to reap oversized profits and raise premiums with impunity.<sup>13,14</sup>
- Blue Cross and Blue Shield of Montana, the state’s biggest health insurer, controls 75 percent of the statewide commercial market. Together with New West Health Services, they hold 85 percent of the market.<sup>15</sup>
- The negative effects of consolidation in Montana are most conspicuous when viewed at the local level. In the Great Falls area, for example, Blue Cross and Blue Shield of Montana controls 95 percent of the market, including self-funded employer-sponsored health plans.<sup>16</sup>

## Montana Insurance Market Consolidation by Metro Area, 2007<sup>17</sup>

Metro Area	Health Insurer With Largest Market Share	Market Share %	Health Insurer With No. 2 Market Share	Market Share %	Combined Market Share % of Top Two Insurers
Billings	Blue Cross and Blue Shield of Montana	74	New West Health Services	10	84
Great Falls	Blue Cross and Blue Shield of Montana	95	Great West (One Health)	3	98
Missoula	Blue Cross and Blue Shield of Montana	90	New West Health Services	7	97

Source: American Medical Association, "Competition in health insurance: A comprehensive study of U.S. markets: 2007 update."

### Without Reform, Health Costs of Insured and Uninsured Montanans Projected to Double by 2019

- Reducing health care cost growth is key to our fiscal health. "Done correctly, health care reform can genuinely slow the growth rate of health care costs and thus put us on a path to greatly reduced budget deficits in the long run," said Christina D. Romer, chairwoman of the White House Council of Economic Advisers. "Dealing with the looming budget deficits through effective health care reform is

not simply the best way to go, it is likely the only way."<sup>18</sup>

- Failing to act will stress state budgets. By 2019, the number of people in Montana without insurance will increase from 159,000 to 205,000, according to the Urban Institute and the Robert Wood Johnson Foundation.<sup>19</sup>
- The state will face an increased burden that it cannot afford while thousands of families and business will face crippling medical costs and the prospect of medical bankruptcies, according to the Urban/Johnson report.<sup>20</sup>

### Without Reform, Health Costs of Insured and Uninsured Montanans Projected to Double by 2019

Projected Aggregate Health Spending in Montana Under Current Law, Non-Elderly Population (dollar figures in millions)

	2009	2014	2019	Percent change 2009-2019
Uncompensated Care	\$186	\$274	\$405	118
Employer Premium Spending	1,172	1,634	2,196	87

Source: Robert Wood Johnson Foundation, "The Cost of Failure to Enact Health Reform: Implications for States," September 2009.

## Racial and Ethnic Health Disparities Persist in Montana

- No one has more at stake in the battle over health reform than the 103 million people of color in the U.S.,<sup>21</sup> including the 117,000 in Montana.<sup>22</sup>
- For people of color in Montana and nationwide, life is shorter, chronic illness more prevalent and disability more common. These are predictable side-effects of a health care system that provides these communities in Montana with narrower opportunities for regular health services, fewer treatment options and lower-quality care.
- In Montana, 20 percent of Latina women received no early prenatal care, compared with 14 percent for whites.<sup>23</sup>
- In Montana, almost 10 percent of Latino adults have been diagnosed with diabetes—a rate that is more than 30 percent higher than whites.<sup>24</sup>

### Montana Racial and Ethnic Disparities and Performance on Key Health Indicators

Commonwealth Fund rankings show increasing cost pressures and deterioration in access across the U.S., together with geographic disparities in performance, underscore the urgent need for comprehensive national reforms to ensure access, change the trajectory of costs and enhance value.

HEALTH INDICATORS	STATE RANKING (out of 50 states plus District of Columbia)
Percent of nonelderly adults (18-64) insured	36
Percent of children ages 19-35 months received all recommended doses of five key vaccines	47
Percent of children with both a medical and dental preventive care visit in the past year	47
Percent of adults with a usual source of care	47
Infant mortality, deaths per 1,000 live births	30
Suicide deaths per 100,000 population	51
Percent of nonelderly adults (ages 18-64) limited in any activities because of physical, mental or emotional problems	37
Percent of at-risk adults have not visited a doctor for routine checkup in the past two years	41
Percent of adults age 50 and older did not receive recommended screening and preventative care	49

Source: Commonwealth Fund. "State Scorecard Data Tables," October, 2009.

## MONTANA CAN'T WAIT FOR HEALTH REFORM

The aim of health care reform is to improve access to quality health care services in every corner of Montana and the nation in a way that does not add to, and begins to lower, the cost burden on middle-income families. Through reform, we must slow the growth in health insurance premiums, extend coverage to the sixteen percent of Montanans who are uninsured, inject competition into highly concentrated and anti-competitive insurance markets, reduce racial and ethnic disparities in access to care and health outcomes, and strengthen the economy of Montana and the nation. Given the tremendous burden our dysfunctional health care system places on Montana families and businesses, Montana and the nation cannot wait any longer for health care reform.

## Endnotes

<sup>1</sup>Families USA, “Premiums versus Paychecks, by State, 2000 to 2009.” Accessed at <http://www.familiesusa.org/assets/pdfs/premium-increases-2000-to-2009.pdf>.

<sup>2</sup>Ibid.

<sup>3</sup>New America Foundation, “The State of State Health: The Cost of Failure (2007),” Accessed at <http://statehealth.newamerica.net/>.

<sup>4</sup>Ibid.

<sup>5</sup>Kaiser Family Foundation, “Employer Health Benefits 2009 Survey.” Accessed at <http://ehbs.kff.org>.

<sup>6</sup>Small Business Majority, “The economic impact of healthcare reform on small business,” 2009. Accessed at [http://www.smallbusinessmajority.org/pdfs/SBM-economic\\_impact\\_061009.pdf](http://www.smallbusinessmajority.org/pdfs/SBM-economic_impact_061009.pdf).

<sup>7</sup>Ibid.

<sup>8</sup>Kaiser Family Foundation, “Montana: Health Insurance Status.” Accessed at <http://www.statehealthfacts.org/profilecat.jsp?rgn=28&cat=3>.

<sup>9</sup>Robert Wood Johnson Foundation, “The Cost of Failure to Enact Health Reform: Implications for States,” October 2009. Accessed at <http://www.rwjf.org/files/research/49148.pdf>.

<sup>10</sup>David Himmelstein, et al., “Medical Bankruptcy in the United States, 2007: Results of a National Study,” *The American Journal of Medicine*, 2009. Accessed at [http://pnhp.org/new\\_bankruptcy\\_study/Bankruptcy-2009.pdf](http://pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf).

<sup>11</sup>U.S. Bankruptcy Courts, “Table F2: Business and Nonbusiness Bankruptcy Cases Commenced, by Chapter of the Bankruptcy Code: During the Twelve Month Period Ending Dec. 31 2008.” Accessed at <http://www.uscourts.gov/bnkrpctystats/statistics.htm>.

<sup>12</sup>Center for American Progress Action Fund, “The Cost Shift from the Uninsured,” March 24, 2009. Accessed at [http://www.americanprogressaction.org/issues/2009/03/pdf/cost\\_shift.pdf](http://www.americanprogressaction.org/issues/2009/03/pdf/cost_shift.pdf).

<sup>13</sup>James Robinson, “Consolidation and the Transformation of Competition in Health Insurance,” *Health Affairs*, 23, No. 6, 2004. Accessed at <http://content.healthaffairs.org/cgi/content/full/23/6/11>.

<sup>14</sup>Stephen Foreman, “Proposed Consolidation of Highmark and Independence Blue Cross,” July 2008. Accessed at <http://www.ins.state.pa.us/ins/lib/ins/highmark-ibc/0943.pdf>.

<sup>15</sup>AMA data in this report are based on combined enrollment in preferred provider organizations (PPOs) and health maintenance organizations (HMOs) in states and metropolitan statistical areas (MSAs) as defined by the U.S. Census Bureau. The AMA calculates market share by dividing an insurer's enrollment in a given product by the total enrollment across all insurers in a market multiplied by 100. Total enrollment is for commercial products only, including self-insured employer-sponsored PPO plans and individual coverage, and does not include Medicare, Medicaid, or Children's Health Insurance Program enrollments. Self-insured employer plans refer to PPOs only. Accessed at <http://www.ama-assn.org/go/competition2007>.

<sup>16</sup>American Medical Association, “Competition in health insurance: A comprehensive study of U.S. Markets: 2007 update.” Accessed at <http://www.ama-assn.org/go/competition2007>.

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<sup>18</sup>Christina D. Romer, “Health Care Reform and the Budget Deficit,” October 26, 2009. Accessed at <http://www.whitehouse.gov/files/documents/HealthCareDeficit.pdf>.

<sup>19</sup>Robert Wood Johnson Foundation, “The Cost of Failure to Enact Health Reform: Implications for States,” October 2009. Accessed at <http://www.rwjf.org/files/research/49148.pdf>.

<sup>20</sup>Robert Wood Johnson Foundation, “The Cost of Failure to Enact Health Reform: Implications for States,” October 2009. Accessed at <http://www.rwjf.org/files/research/49148.pdf>.

<sup>21</sup>US Census Bureau, “USA QuickFacts,” 2008. Accessed at <http://quickfacts.census.gov/qfd/states/00000.html>.

<sup>22</sup>US Census Bureau, “USA QuickFacts,” 2008. Accessed at <http://quickfacts.census.gov/qfd/states/00000.html>.

<sup>23</sup>Cara James, et al., “Putting Women's Health Care Disparities on the Map: Examining Racial and Ethnic Disparities at the State Level,” Kaiser Family Foundation, June 2009. Accessed at <http://www.kff.org/minorityhealth/upload/7886.pdf>.

<sup>24</sup>Department of Health and Human Services, Office of Public Health and Science, Office of Women's Health. Quick Health Data Online, 2008.