BREAKING BARRIERS

Improving Health Insurance Enrollment and Access to Health Care in Montana

April 2015

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MONTANA ORGANIZING PROJECT

Indian People's Action

ALLIANCE FOR A JUST SOCIETY

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As of April 10, 2015 the State Senate and state House of Representatives had voted in favor of Medicaid legislation that would extend coverage to an estimated 27,000 to 40,000 Montanans. Observers predict that the bill will reach the desk of Governor Steve Bullock and be signed into law.

AFTER MUCH DELAY AND DEBATE, MONTANA IS MOVING TOWARD EXPANSION OF MEDICAID, to date the key barrier to increasing health coverage among the state's uninsured residents. As of April 10, the State Senate and state House of Representatives had voted in favor of Medicaid legislation that would extend coverage to an estimated 27,000 to 40,000 Montanans. Observers predict that the bill will reach the desk of Governor Steve Bullock and be signed into law.

This development represents an important advance in the effort to secure quality, affordable health care for all Montanans. However, standing alone, the Medicaid expansion bill will not remove all barriers to coverage and care experienced by Montanans. Removing these barriers will require further action on the part of Montana legislators and policymakers.

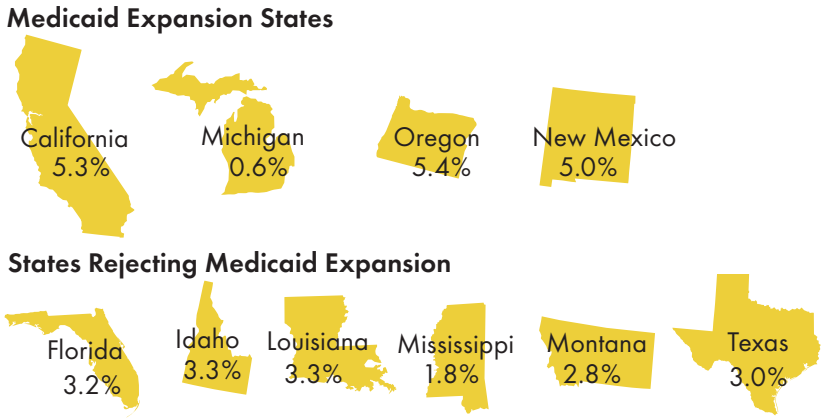
The Medicaid expansion making its way through the Legislature comes with a number of cost-sharing requirements that will present obstacles to coverage and care for low-income Montanans. The legislation requires monthly premiums, which will both limit the number of people able to enroll and also result in disenrollment for some who are unable to maintain monthly payments. Those who do obtain coverage will encounter additional copayments when they seek certain health services. As important as Medicaid expansion is, these cost requirements limit its potential to guarantee coverage and care for those eligible.

Furthermore, Medicaid expansion accounts for one of multiple measures to expand access to coverage and care under the recent health reform legislation, the Affordable Care Act (ACA). The ACA also introduced a marketplace for the purchase of health insurance, with subsidies available for many purchasers, and other patient-protection provisions. The ACA's success in Montana depends not only on the number of people able to enroll in coverage but also on their ability to use that coverage to get needed health care. On both counts, there exist a number of obstacles, particularly for Montana's communities of color and in rural areas.

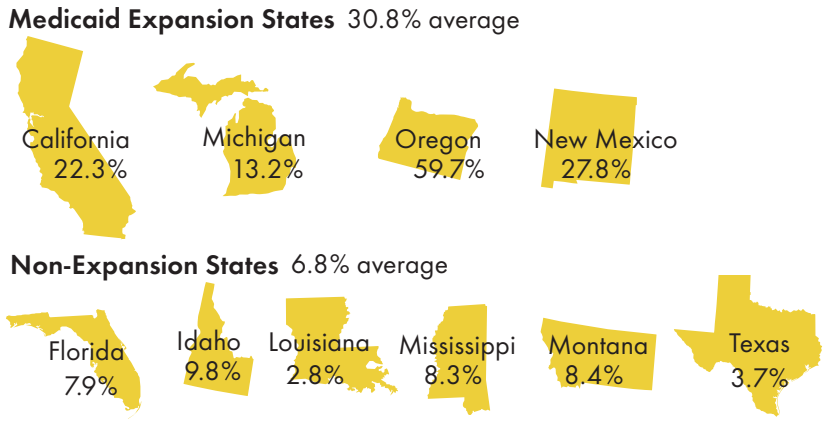
This report, part of a 10-state study, reviews Montana's enrollment efforts and consumers' attempts to access health care in the state's low-income communities, contrasting enrollment efforts and access to care in white and Native American communities. The methodology includes key actor interviews with Montana-based navigators, policy and health care professionals, and advocates, as well as 115 surveys with low-income community residents at food pantries, health clinics, and homeless service centers across the state. The report compares and contrasts the enrollment and "coverage-to-care" trends shown through the interviews and surveys to reported Montana outcomes and, when appropriate, to national trends. Analyses of these results serve as the basis for the report's recommendations.

ENROLLMENT

Reduction in Percentage of Uninsured Residents November 2013-April 2014[5]



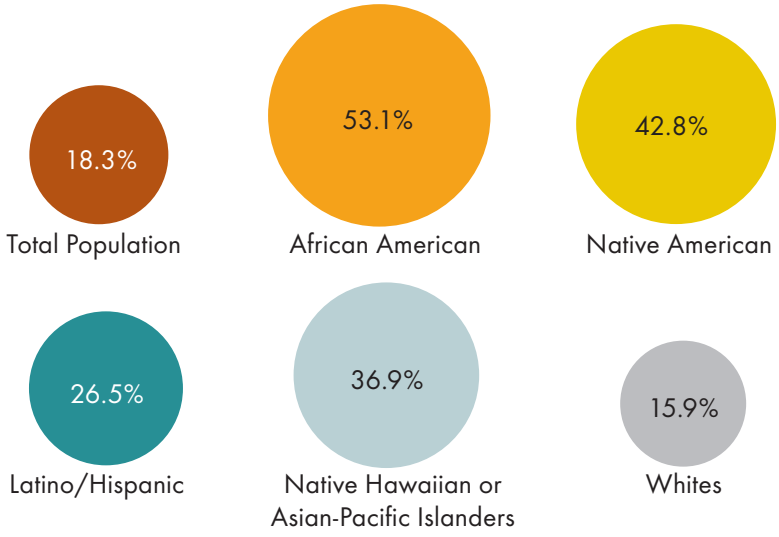
Percentage Medicaid and CHIP enrollment increase from 2013 pre-enrollment to August 2014[6]



At 6.5 percent of the population, Native Americans are Montana's largest minority population; they are also uninsured at a very high rate, 42.8 percent. Whites, by contrast, constitute 87 percent of the state's population and are less than one-fifth as likely (15.9 percent) to be uninsured.

Montana Uninsured Rates, by Race/Ethnicity

Percent uninsured in 2011



Racial/Ethnic Groups' Share of the Montana Population and of ACA Marketplace Enrollees in Montana

Race/Ethnicity	Percent of state population	Percent of marketplace enrollees in Montana (through April 2014)[7]
African American	0.6%	0.3%
Native American	6.5%	1.7%
Latino/Hispanic	3.3%	1.9%
Native Hawaiian or Asian-Pacific Islander	0.9%	1.2%
White	87%	93.3%

The Gallup-Healthways Well-Being Index shows that by mid-2014 the percentage of Montana's residents who were uninsured had decreased from 20.7 percent to 17.9 percent. Medicaid and CHIP enrollment increased by 8.4 percent, 1.6 percentage points more than the average among other states in this study that rejected Medicaid expansion, but still a full 22.4 percentage points below the 30.8 percent average increase in the Medicaid expansion states studied.

At 6.5 percent of the population, Native Americans are Montana's largest minority population; they are also uninsured at a very high rate, 42.8 percent. Whites, by contrast, constitute 87 percent of the state's population and are less than one-fifth as likely (15.9 percent) to be uninsured. People of color overall in Montana are uninsured at a rate of 38.6 percent, approximately double the rate for whites. One would assume, therefore, that resources would be directed to reach the populations with the greatest need for medical insurance, but outcomes suggest that this was not the case. Enrollment data through April 2014 shows that in comparison to their percentage of the state population, African Americans, Native Americans, and Latinos enrolled

through the marketplace at rates lower than their percentages of the state's population, while whites and Native Hawaiians/Asian-Pacific Islanders enrolled at higher percentages. These general outcomes suggest a basic question: did the first round of ACA enrollment in Montana lessen or exacerbate racial inequities in health? While it is too early for a definitive answer, examining trends in both enrollment and access to care for whites and Native Americans can offer some preliminary conclusions.

MEDICAL COVERAGE, BY RACE

Do you have medical coverage?

* *Percentages for the state of Montana includes responses from respondents of all racial/ethnic groups*

Did you get medical coverage in the last 12 months?

Race/Ethnicity	Percentage Yes
All MT Respondents	**67.7%**
Native American or Alaska Native	50.0%
White	75.0%

The proportion of survey respondents with medical coverage (26.1 percent) is the lowest of any of the 10 states we surveyed for this study and the 14.3 percent of Native Americans covered was the lowest percentage of any ethnic group. Of those who had coverage, three-fourths of whites and half of Native American respondents got coverage in the last 12 months. What accounts for this low rate of insurance?

The Kaiser Family Foundation estimates that "40,000 uninsured adults (22 percent of the uninsured in the state) who would have been eligible for Medicaid if the state expanded fall into the coverage gap [ineligible for Medicaid absent expansion but with incomes too low for a subsidy to buy insurance]." These adults are all below the poverty line and thus have very limited incomes. Because they do not gain an affordable coverage option under the ACA, they are most likely to remain uninsured."[8] Rhiannon Simon of Planned Parenthood Montana explains: "Because there is no Medicaid expansion, navigators see a lot of people that they have to turn away. There is a gap, people don't make enough to get help and affordability has been very difficult for people. Also, a lot of people were seeking help and then realized they couldn't get it because there was no expansion. Many people who had this experience blame the ACA, not the state, which has hurt public opinion of the program."[9]

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And the rules are not the same for all Indian people. Some tribes, like the Little Shell Tribe, are state-recognized but not federally recognized, so their members can get the Native American exemption in the ACA marketplace but they cannot get the same plans as a federally recognized tribal member.

As for Native American enrollment, according to a 2012 report by the University of Montana's Bureau of Business and Economic Research, Indian Health Service (IHS) users account for 20 percent of Montana's uninsured population.[10] Tressie White, Assistant Director of the Helena Indian Alliance, which manages the Leo Pocha Health Clinic explains that "the enrollment process for Indian people is different. For instance, our clinic is involved in the enrollment process all year long. Over the past few years we have increased the percentage of people that we see who are insured to almost 60 percent. But it has taken a lot of education and urging. Initially many people wanted to stick with Indian Health Service because that is what they know. And the rules are not the same for all Indian people. Some tribes, like the Little Shell Tribe, are state-recognized but not federally recognized, so their members can get the Native American exemption in the ACA marketplace but they cannot get the same plans as a federally recognized tribal member. If a person is a member of a federally recognized tribe and their income is between 100 and 300 percent of the federal poverty level they can get a plan that has no co-pay and no deductible. They get 100 percent care fully paid for. Unfortunately none of the navigator funds went to any of the five urban Indian clinics in the state and many of the ACA navigators are not familiar with the programs available to Indian people."[11]

Geography also played a role in the sparse enrollment numbers of Native Americans. According to Montana state Senator Christine Kaufmann, "No navigator grants were given to Native entities, though IHS and urban Indian clinics now have developed a network of certified application counselors (CACs). Sometimes they would get calls from people who were 100 miles away from the nearest clinic or navigator; this distance combined with technology issues was a big problem. CACs or navigators often drove long distances to get to people to sign them up. Only around 600 Native people enrolled in ACA coverage in Montana."[12] The U.S. Department of Health and Human Services (HHS) reports the actual number as 521.[13]

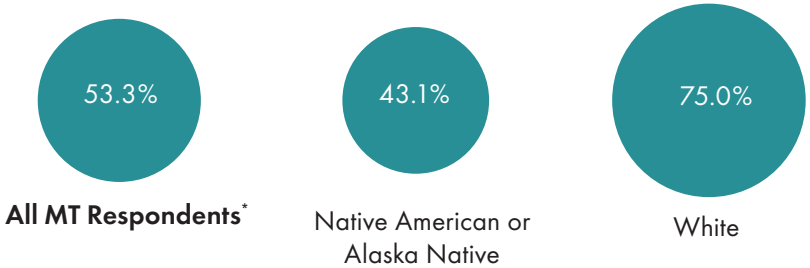
ELECTRONIC ACCESS

Do you have an email address?

Race/Ethnicity	Percentage Yes
All MT Respondents	**61.8%**
Native American or Alaska Native	67.1%
White	50.0%

Do you have Internet access at home?

Percent Yes



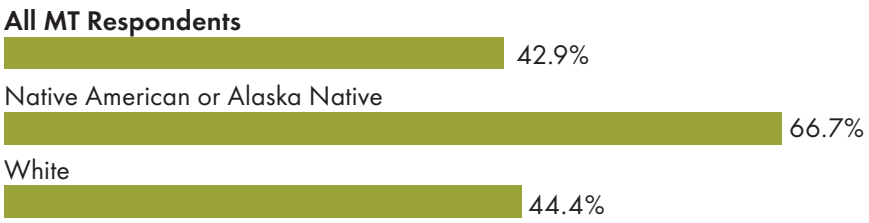
Did anybody help you enroll?

Race/Ethnicity	Percentage Yes
All MT Respondents	**47.6%**
Native American or Alaska Native	33.3%
White	44.4%

Percentage of respondents who reported difficulties with enrollment

(Difficulties included electronic problems with enrollment, language issues, amount of time the enrollment process took, complicated medical or insurance terms, other)

Percentage of respondents who reported difficulty



Two-thirds of Native Americans and half of whites reported having an email address, a necessary prerequisite to electronic enrollment. Three-quarters of white respondents, compared to 43.1 percent of Native American respondents, had Internet access at home. Electronic access was a key component to successful enrollment. As former legislator Christine Kaufmann, who directs the navigator program for the Montana Primary Care Association, points out, "The issue with healthcare.gov functionality was the second biggest barrier to getting insurance, next to the rejection of Medicaid expansion." "There isn't wifi in all rural areas," explains navigator Rhiannon Simon. "Planned Parenthood has invested in hot spots to work around this but wasted time in the beginning driving to rural areas who thought they had Internet but didn't. Issues with healthcare.gov have also been a problem. Many people would drive all the way to find a navigator and the system would go down so they couldn't get signed up. It was hard to get people to persevere through the rough start of healthcare.gov."[14] One interviewee reported that her brother-in-law spent many hours trying to get through the broken website (healthcare.gov) and was pretty discouraged. "So it took a lot to get him to try again. But, once he was able to finally get through the process he discovered that he falls in the Medicaid gap."[15]

The obstacles to ACA enrollment were not necessarily all Internet-related; some were related to staffing. For instance, former legislator Teresa Henry, who currently teaches nursing at Montana State University, notes that "there's still a lack of awareness, both in the community and at the federal level, among the people who have been hired to staff the assistance phone line. An application tech from Partnership Health said that sometimes they will call the federal marketplace with an issue and will reach someone who doesn't know the answer; they will be told to call back in hopes that they will get someone who does know."[16] Almost half of our survey respondents had help with

"My wife and I are in the 'medigap.' We have two kids covered under Healthy Montana Kids but when we tried to apply for ourselves through Healthcare.gov, the plans were unaffordable."

enrollment (47.6 percent), yet two-thirds of Native American respondents and more than four of ten whites reported one or more difficulties with enrollment. Comments to surveyors included: "The whole process took too long." "I filled out the Medicaid application in September [this comment was made in December 2014] and have followed up and they say they are still getting to it. I am waiting for a determination, a verdict." "My wife and I are in the 'medigap.' We have two kids covered under Healthy Montana Kids but when we tried to apply for ourselves through Healthcare.gov, the plans were unaffordable."[17]

Many of the new health plans are pretty complicated; do you know which services are included in your coverage and which you'll have to pay extra for?

Race/Ethnicity	Percentage Yes
All MT Respondents	**62.1%**
Native American or Alaska Native	60.0%
White	69.2%

When you enrolled in a health plan, were you informed that financial support was available for low-income people?

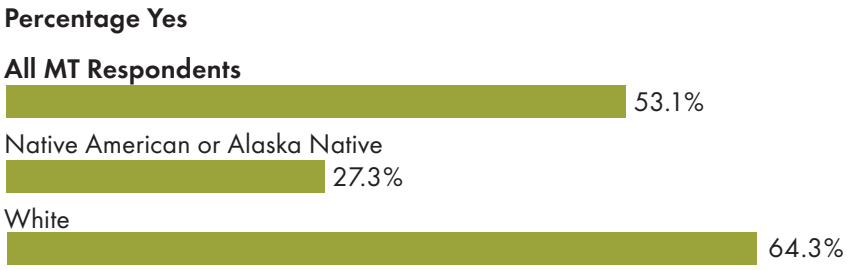
Sixty-nine percent of white respondents and 60 percent of Native Americans reported they knew which services were included in their plan. However, fewer than 10 percent of Native Americans were informed about the availability of financial support for low-income people, compared with 64.3 percent of white respondents. These findings are consistent with those of a 2012 University of Montana study finding that "many households are unaware of their policy premiums, deductibles, and out-of-pocket maximums. Almost four in ten cannot reveal their deductible amounts, and one in four does not know their out-of-pocket maximum.[18]" Said one interviewee, "Health insurance literacy is an issue – people don't understand why they need it, then when they get in the process they have too many options and don't know what to choose. Even when asked, navigators can't tell people which plan to choose."[19] Lack of familiarity with insurance options, coupled with confusing information, particularly about costs, is an ongoing barrier to increased enrollment, particularly for Native Americans but for all uninsured Montanans. One successful enrollee reported that she and her husband were able to enroll in coverage that costs them half of what they were paying Blue Cross/Blue Shield each month just to cover her. It was the first time in her husband's 60 years that he has had coverage. Other survey respondents reported negative

experiences. For example, one said, "I tried for insurance in 2014 but the premium was too high. I decided it would be better to pay the $94 fine than to pay monthly premiums that I couldn't afford. The website is very difficult to navigate. I have not tried for 2015 for the same reason. I cannot afford the premium."[20]

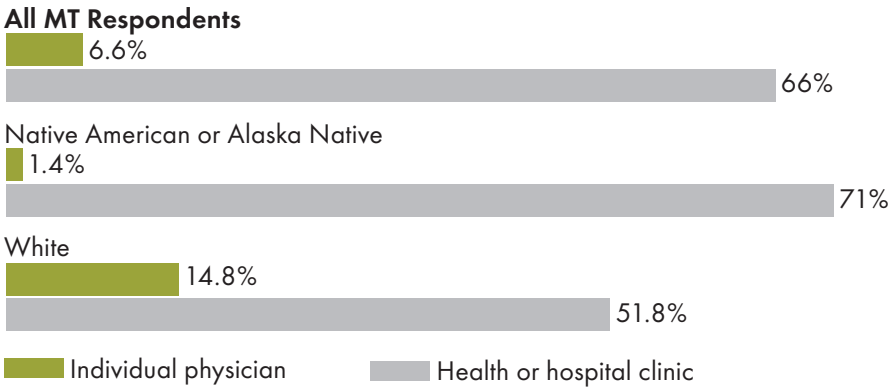
FROM COVERAGE TO CARE

Beyond the enrollment question, insurance coverage does not necessarily translate into quality care, which includes access to providers, a relationship with a personal doctor, and access to both medication and other forms of treatment. Although the ACA infrastructure is still developing, in this section we examine some key issues related to access and treatment.

A personal doctor (also called primary care provider) is the one you would regularly see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?



Where do you go for your primary health care needs?



Race/Ethnicity	No regular place to go
All MT Respondents	**17.0%**
Native American or Alaska Native	18.8%
White	14.8%

"I tried for insurance in 2014 but the premium was too high. I decided it would be better to pay the $94 fine than to pay monthly premiums that I couldn't afford. The website is very difficult to navigate. I have not tried for 2015 for the same reason. I cannot afford the premium."

One respondent whose family has insurance reported that they can afford treatment for only one family member at a time. The respondent's wife, who has had a tumor in her upper sinus cavity, has been the priority and the respondent himself hasn't seen a doctor for over 15 years.

An ACA goal is to link patients with personal doctors. However, just over half of our survey respondents have a personal doctor (53.1 percent) and whites report having doctors at more than twice the rate of Native Americans. This disparity is consistent with responses to our question about where respondents go for primary care: only 1.4 percent of Native American respondents said they go to an individual physician. Similarly, 18.8 percent of Native American respondents have no regular place to go for medical care; for whites the percentage was 14.8 percent.

Do you use the Internet for any of the following: to communicate with your insurance company, health care provider, schedule appointments with your doctor, or find out information about your health plan?

Respondents with health coverage who use the Internet for health communication

Not including copayments, have you ever had to pay extra for doctor visits or medicines that your plan doesn't cover?

Race/Ethnicity	Percentage Yes
All MT Respondents	**63.3%**
Native American or Alaska Native	60.0%
White	57.1%

Consistent with our earlier findings on home Internet access, over half of white respondents (53.9 percent) used the Internet for health care communications, compared to 18.2 percent of Native Americans. And, consistent with the limited information about financial support documented in the enrollment section of this report, six of ten Native Americans and 57.1 percent of white respondents had to pay extra for medical care or medicines. One respondent whose family has insurance reported that they can afford treatment for only one family member at a time. The respondent's wife, who has had a tumor in her upper sinus cavity, has been the priority and the respondent himself hasn't seen a doctor for over 15 years. Another respondent reported that in the last five weeks of 2014 he went to the local clinic for a skin rash. The pharmacist filling his prescription told him he had no drug coverage as his health insurance had been discontinued effective Nov 30, 2014. He's still trying to sort this out but can't access the website because he has problems with his password.[21]

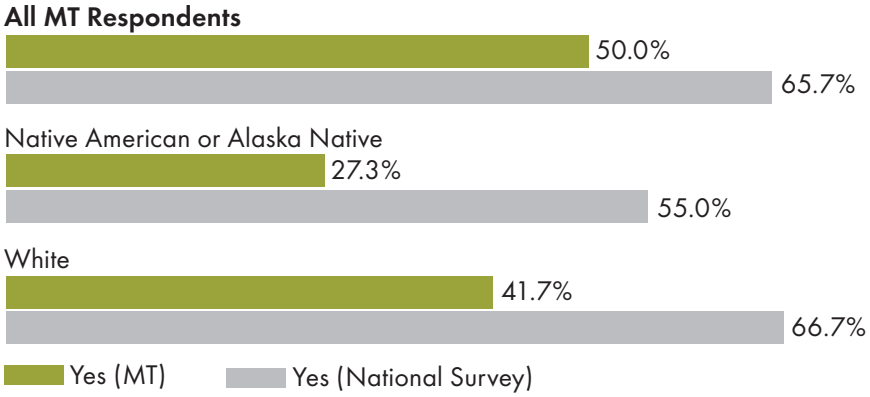
How long does it take you to travel to your health care provider?

Race/Ethnicity	More than 1.5 hrs
All MT Respondents	**25.0%**
Native American or Alaska Native	27.3%
White	28.6%

When was the last time you saw your doctor or health care provider?

Percentage more than a year ago

In the last 6 months, did a doctor or other health provider order a blood test, x-ray or other test for you?



Travel time to health care providers was an obstacle to care for a significant portion of our survey respondents, more than a quarter of whom (27.3 percent of Native Americans and 28.6 percent of whites) reported having to travel more than 1.5 hours to see their health care provider. Long travel times may contribute to the high percentages of whites (29.6 percent) and Native Americans (51.9 percent) who have not seen a health provider in more than a year. However, the percentage of Native American respondents (27.3 percent) who had blood test, x-rays or other tests in the last year was half the national average for Native Americans (55 percent), while the percentage of white respondents (41.7 percent) who had tests ordered was and more than a third lower than the national average for whites (66.7 percent). The gap between whites and Native Americans was also larger in Montana (14.4 percentage points) than nationally (11.7 percentage points).

In the last 6 months, when you tried to get an appointment for care you needed right away, how long did you usually have to wait between trying to get an appointment and actually seeing someone?

Percentage over two weeks

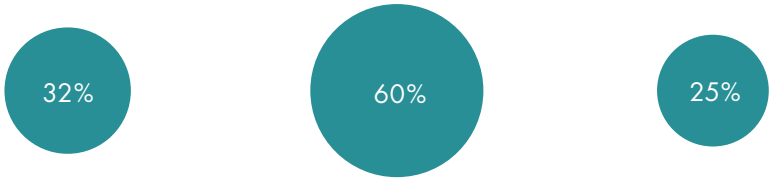
All MT Respondents*

Native American or Alaska Native

White

In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed it?

Percentage sometimes or never



All MT Respondents*

Native American or Alaska Native

White

Half of Native American respondents reported having to wait over two weeks to get an urgent health care appointment compared with 10 percent of white respondents. One-fourth of white respondents, compared with 60 percent of Native Americans, reported that they "sometimes or never" got health care as soon as they thought they needed it.

SUMMARY OF FINDINGS

ENROLLMENT

Medicaid expansion has been the largest political barrier to enrollment in Montana. The Gallup-Healthways Well-Being Index shows that, although by August 2014 by April 2014 the proportion of uninsured residents declined by 2.8 percent, to 17.9 percent, Montanans are still uninsured at the sixth highest rate in the country. With an estimated 70,000 low-income people in the coverage gap, the single biggest barrier to enrolling low-income people has been delay in expanding Medicaid. In his 2015 State of Tribal Nations address Gerald Gray, Chairman of the Little Shell Tribe of Chippewa Indians, cited Montana Department of Public Health and Human Services data that found whites in Montana live, on average, 20 years longer than Native Americans. Urging Montana legislators to expand Medicaid, Gray said "people's lives literally depend on it."[22]

Significant percentages of all respondents reported one or more difficulties with the enrollment process: 66.7 percent of Native American respondents and 44.4 percent of white respondents reported difficulties.

Enrollment data reflects racial disparities. Whites comprise 87 percent of the state's population and 93.3 percent of those enrolled through the marketplace. Latinos make up 3.3 percent of the state population but account for only 1.9 percent of those enrolled through the marketplace, with one in four Latinos uninsured. Even more dramatically, the Native American community is 7 percent of the state's population but only 1.7 percent of marketplace enrollees, with an uninsured rate of 42.8 percent. A number of factors account for these outcomes:

The digital divide, evidenced by the fact that white survey respondents communicate electronically with insurers or health providers at almost three times the rate of Native Americans. And, although Native American respondents were more likely than whites to have an email address (67.1 percent versus 50.0 percent), they were significantly less likely to have Internet access at home (75 percent for whites versus 43.1 percent for Native Americans).

Cultural barriers: Cultural barriers for Native American residents may include a historic and ongoing relationship to Indian Health Services and a mistrust of the ACA, compounded by a lack of enrollment resources for certified application counselors (CACs). In addition, lack of familiarity with culturally-specific insurance and medical terms constitutes a significant enrollment obstacle.

Information gaps. Significantly, only 9.1 percent of Native American respondents knew about financial support available to low-income families, versus 64.3 percent of whites, while more than 30 percent of whites and 40 percent of Native Americans did not know which services were included in their coverage and which were not.

FROM COVERAGE TO CARE

Although enrollment differences were significant, racial differences in health access were even more substantial:

- 27.3 percent of Native Americans versus 64.3 percent of whites reported having a personal doctor;
- 18.8 percent of Native American respondents versus 14.8 percent of whites reported having no medical home;
- 51.9 percent of Native American respondents versus 29.6 percent of whites had not seen a health provider in over a year;
- 50 percent of Native American respondents versus 10 percent of whites waited over two weeks for urgent care.

To improve enrollment and care options in Montana, we recommend the following:

SAFEGUARDING ACCESS TO HEALTH INSURANCE

Increase both the number of people with insurance and federal funding for health coverage by expanding Medicaid.

Target for enrollment low-income residents already enrolled in income-based programs. The state should immediately increase low-income health insurance enrollment by automatically enrolling in Medicaid people who already receive need-based benefits like SNAP (food stamps), Supplemental Security Income (SSI), WIC, or free or reduced-price school meals, as well as people released from incarceration with no immediate source of income or assets.

Allocate resources to Tribes and Urban Indian Health Centers to hire and train more certified application counselors (CACs) and accelerate enrollment in Native American communities.

Simplify the insurance-shopping experience and keep provider information current. The state should simplify print and electronic descriptions of plans and benefits, especially deductibles, co-pays, preventive services available at no cost, and the significance of providers being in- or out-of-network, making costs transparent and ensuring easy comparison of services available with no co-pay. It should also require plans to continually update information about which providers are in their networks.

Make faster decisions on enrollment applications. The state should require decisions on ACA and Medicaid applications within two weeks of filing.

MOVING CONSUMERS FROM COVERAGE TO CARE

Expand and extend the role of community health outreach workers. Many enrollees are new to health insurance coverage. Not only are they unfamiliar with medical terminology, they have had little interaction with the medical system or the insurance system and may need both an introduction and an acclimation. Navigators and certified application counselors are in an ideal position to perform this role. The state should extend the role of outreach workers to encompass teaching new enrollees how to use insurance coverage and recruiting enrollees to participate in marketplace-sponsored evening and weekend clinics focusing on health education, specific mobile services (exams, immunizations, etc.), and access to different medical modalities (e.g., acupuncture, chiropractic care).

Address racial health disparities. Montana should enforce ACA statutory provisions that require insurers to act to reduce racial disparities and continually monitor implementation of insurers' disparity-reduction plans and programs, especially outreach and outcomes. The state should impose penalties, including exclusion from the exchange, against plans that do not succeed in reducing disparities within established target timeframes.

Require plans to include in their networks at least one full-time primary care provider for every 2,000 patients and ensure that enrollees are able to make appointments with their primary care providers within 10 business days of seeking an appointment, as do California and Washington.

Require that new enrollees have the opportunity for a free physical exam and appropriate screening tests within 60 days of enrollment.

Require plans to adopt geographic access standards ensuring that, for at least 90 percent of enrollees, primary care providers are available within 10 miles or 30 minutes average driving or public transit time and specialists within 45 miles or one hour, whichever is less, as New Jersey does (N.J. Admin. Code § 11:24A–4.10). Vermont imposes similar requirements. Enrollees who live farther from providers should be offered free transportation.

Reinforce the ACA-mandated women's right to no-cost "well-woman preventive" care by ensuring that all plans available through the marketplace include reproductive health care services, including all FDA-approved forms of contraception.

Expand and standardize preventive services, ensuring that non-grandfathered plans offer preventive services (yearly check-ups, immunizations, counseling, and screenings) at *no out-of-pocket cost* and penalize plans in which fewer than 70 percent of enrollees receive these services.

Require plans to track health outcomes, disaggregated by race, ethnicity, primary language, tribal designation, gender, disability, and sexual orientation.

BUILDING AN INFRASTRUCTURE TO PROMOTE PREVENTIVE HEALTH CARE

Offer incentives to plans that adopt a broad view of health benefits and tackle underlying social determinants of health. Montana is a state with 15.2 percent of its residents living in poverty. Insurance is one step toward better health, but in order to address the prevalence of chronic diseases, the state must encourage innovation and experimentation to address the underlying causes of poor health—particularly in low-income rural communities.

Expand medical-legal partnerships as an avenue toward the broad array of issues that lead to poor health in low-income communities (e.g., mold in housing, domestic violence). While three-quarters of states and seven of the 10 states studied already have at least one such partnership, through which medical and legal professionals collaborate to look holistically at barriers to health and wellness and work jointly to remove the barriers, the partnerships already in place cannot begin to meet the need.

Invest in school-based health centers. Seek funds from HHS' Health Resources and Services Administration or use state funds to expand school-based health centers, especially in medically-underserved communities (where 23.7 percent of Montana residents reside) to mitigate the lack of other health care options (Section 4101 of the ACA, 42 U.S.C. § 280h-4).

ENDNOTES

1. Whitney, Eric, Medicaid's Western Push Hits Montana, NPR (Jan. 6, 2015), accessed at: http://www.npr.org/blogs/health/2015/01/06/375315937/medicaid-s-western-push-hits-montana.

2. Interview with AJS staff, June 2014.

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