EXHIBIT 27
DATE 03/25/2013
HB 590

HB 590 – Implement Access Health Montana

BRIEF SUMMARY

- Access Health Montana provides access to health care for nearly 70,000 more Montanans age 19-64 (at 138% of the federal poverty level, or $31,809 for a family of four and $15,415 for a single individual). The federal government has committed 100% of the cost of benefits for the first three years, 95% in 2017, 94% in 2018, 93% in 2019 and 90% in 2020 and beyond.

- Holds providers accountable for continuous quality improvement through clear, evidence-based performance measures and care coordination. Implements the medical home model to improve care and improve cost control in the DPHHS's major health care programs and develop policies to increase primary care providers. Creates a blue ribbon panel to advise DPHHS on the medical home program.

- It provides for a streamlined application process and a modernized, more efficient eligibility determination system.

- New federal health care monies spent in Montana will increase health care and other employment creating 13,000 jobs annually and increasing Montana's GDP by $700 million annually.

- Ends insurance rate hikes due to cost-shifts caused when people who cannot afford insurance use high-cost emergency room care when they're sick, rather than visiting a doctor for preventative care.

- Makes the first increase in the proven WWAMI medical education program in over 20 years – enabling more Montana students to attend medical school.

- Increases Medicaid provider rates by 2 percent in each of the next two years to help assure the delivery of the care available through the Medicaid program.

- The bill contains a termination provision or "circuit breaker," so that as Montana partners with the federal government in expanding access to care, the state is not left funding the entire expansion should the federal government later decide not to fund its share.

DETAILED SUMMARY

SECTION 1 Legislative finding that delivery through medical homes of health care for the Medicaid and Healthy Montana Kids programs will be more efficient and effective and is in the public interest. States that health homes are exempt from collusion statutes.

SECTION 2 **Reform health plan payments/pay-for-performance** Implements the medical home to improve care and improve cost controls where providers are accountable for continuous quality improvement through clear, evidence-based performance measures and care coordination. These include uniform quality measures for coordination with hospital, ambulatory care, and behavioral health services.

SECTION 3 **Medical home blue ribbon panel** Establishes a blue ribbon panel of seven members to advise DPHHS on how to deliver high care quality and efficiency through a medical home program for Medicaid and Healthy Montana Kids. The committee must represent a diverse community, be knowledgeable about medical home delivery and quality health care, and consider public input.

SECTION 4 **Statutory appropriation** Establishes a special revenue account for the receipt of enhanced federal Medicaid matching funds to extend Medicaid eligibility coverage to meet the new standards. Federal funds will pay for 100% of the cost of coverage for newly eligible Montanans for the first three years. The federal share of this cost is reduced from 100% to 95% in 2017 and 90% in 2020 and beyond.

SECTION 5 **Standard statutory appropriation definitions.**

SECTION 6 **Eligibility determination** Amends current law to implement the new Medicaid coverage expansion and the modernized, simplified eligibility rules under a new Modified Adjusted Gross Income (MAGI) standard for the new expansion eligibility group and certain other existing eligibility groups.

SECTION 7 **Streamlined application and modernized, more efficient, accurate eligibility determination** Authorizes DPHHS to participate in a single streamlined application process for the public coverage programs administered by the DPHHS including Medicaid and Healthy Montana Kids. This process allows for application to be submitted online, on the phone, in person, or by mail, consistent with federal law.

This includes verifying customer data electronically at enrollment and renewal using modernized secure data exchanges and employing advanced technology to support increased accuracy for eligibility determination and efficient electronic data exchange.

SECTION 8-9 **Removes** out-of-date, inefficient language restricting application through local offices of public assistance to allow application online, on the phone, in person, or by mail, which is more efficient.

SECTION 10 **Appropriation** The following amounts are appropriated to the department of public health and human services:

Fiscal Year 2014 $1,892,342 General Fund $7,650,571 Federal Special Revenue Fund

Fiscal Year 2015 $3,107,521 General Fund Federal $12,580,139 Federal Special Revenue To the office of commissioner of higher education $200,000 general fund to expand the family practice residency program and $515,265 general fund for the WWAMI medical education program for the biennium.

To increase provider rates by 2% in each year of the biennium beginning July 1, 2013:

Fiscal Year 2014 $5,591,989 General Fund, $272,690 State Special Revenue, $9,902,526 Federal Special Revenue

Fiscal Year 2015 $11,309,190 General Fund, $551,273 State Special Revenue, $19,984,865 Federal Special Revenue

SECTION 11 **Standard codification instructions.**

SECTION 12 **Coordination language with HB 2.** If HB 2 contains a $200,000 appropriation to expand the family practice residency program, then the appropriation in this bill is void and vice versa.

SECTION 13 **Coordination language with HB 2.** If HB 2 contains an appropriation of $515,265 to expand the WWAMI program by 10 slots in the biennium then the appropriation in this bill is void. If HB 2 contains the less than $515,265 its appropriation is void, and if it contains more than $515,265 then the appropriation in this bill is void.

SECTION 14 **Coordination language with HB 2.** Provider rate coordination language.

SECTION 15 **Coordination language with SB 84.** If both this bill and SB 84 (Patient-Centered Medical Homes) are passed and approved then the section of SB 84 amending the Medicaid statutes would be void).

SECTION 16 **Effective dates** Sections 4, 5 and 10 are effective on July 1, 2013. The rest of the bill is effective Oct 1, 2013.

SECTION 17 **Contingent termination** Contains a termination provision, or "circuit breaker," so that the State's coverage of the expansion population ends if the federal government reduces the federal Medicaid share for the new expansion coverage group below 90%.

What does Access Health Montana do?

Access Health Montana will take advantage of the opportunity to expand and reform Montana's Medicaid program. It provides access to health care for nearly 70,000 more Montanans age 19-64 (up to 138% of the federal poverty level, or $31,809 for a family of four and $15,415 for a single individual). Federal law commits the federal government to funding 100% of the cost of benefits for the first three (2014-2016) years, 95% in 2017 through 2019 and 90% in 2020 and thereafter.

Without Access Health Montana, the uninsured whose incomes are too high to qualify for Medicaid yet too low for the tax credits and cost-sharing reductions available in Montana's federally facilitated exchange will fall into the coverage gap. Without access to Medicaid, this uninsured population will remain without health care.

Who exactly are the people who will be covered?

Veterans and their families—According to the Robert Wood Johnson Foundation and a February 2013 report by the Montana Budget and Policy Center, "Montana has the highest percentage of uninsured veterans in the nation (17.3%). Approximately 9,000 [Montana] veterans have no insurance, and about 5,000 more report having only VA health care. Military veterans and their families are among the Montanans who would benefit from the expansion of Medicaid currently being considered by the Montana Legislature. As many as 9,500 Montana veterans and their spouses would gain access to quality, affordable health care coverage if lawmakers choose to expand Medicaid."

Low-income families and adults --Right now, a family of four is eligible for Medicaid only if they earn under $13,000 a year for working families and $8,000 for families without a wage-earner. Under Access Health Montana, a family of four earning under $32,000 annually would qualify for low-cost health coverage through Medicaid.

Household Income at Federal Poverty Levels				
Percent	Household Size			
of FPL	1	2	3	4
34%	$3,798	$5,144	$6,491	$7,837
56%	$6,255	$8,473	$10,690	$12,908
100%	$11,170	$15,130	$19,090	$23,050
133%	$14,856	$20,123	$25,390	$30,657
138%	$15,415	$20,879	$26,344	$31,809
150%	$16,755	$22,695	$28,635	$34,575
200%	$22,340	$30,260	$38,180	$46,100
250%	$27,925	$37,825	$47,725	$57,625
2012 HHS Poverty Guidelines				

Despite common misperceptions, most working-age people who lack insurance are employed.[i] Often they are not offered insurance by their employers or cannot afford the health insurance that is offered. As a result of this lack of coverage, too many of Montana's workers put off needed care or risk financial ruin if they or a family member get sick.

Here are some examples of people who would be eligible for Access Health Montana. These figures represent a full 40-hour work week.

Occupations that would make a family eligible for health care with Access Health Montana	
Occupation	**Average Annual Wages**

Dishwashers	$17,830
Child Care Workers	$18,380
Waiters and Waitresses	$18,650
Laundry and Dry-Cleaning Workers	$19,420
Hotel, Motel, and Resort Desk Clerks	$19,550
Home Health Aides	$20,510
Lifeguards, Ski Patrol, and Other Recreational Protective Service Workers	$20,540
Restaurant Cooks	$20,800
Teacher Assistants	$22,160
Nursing Aides, Orderlies, and Attendants	$23,650
Retail Salespersons	$24,620
Farm Workers & Laborers, Crop, Nursery & Greenhouse	$24,680
Preschool Teachers, (Except Special Education)	$24,700
Security Guards	$25,300
Source: Department of Labor and Industry, Occupational Employment Statistics, 2010 As presented by the Montana Budget & Policy Center online here.	

What are the costs of implementing the program?

The net cost of implementing the Medicaid expansion, including additional administrative costs, is approximately $5 million for FY 2014-2015.

How does it impact Montana business?

Core Montana industries like tourism, construction, and ranching will have the most workers that will benefit from Access Health Montana.

Workplaces with the Most Uninsured Workers Who Could Gain Medicaid Coverage in 2014	
Total Uninsured Workers in Montana under 138% of Federal Poverty Level	43,640
Industries with Most Uninsured Workers under 138% of FPL in MT	
Restaurants and Other Food Service	6,690
Construction	4,550
Recreation and Gambling (casinos, ski resorts, etc.)	2,190
Animal Production (ranching, poultry farming, etc.)	1,700
Nursing Care Homes	1,590
Grocery Stores	1,560
Hotels and Motels	1,540
Child Day Care Services	1,270
Business Support Services (call centers, mail services, etc.)	1,020

Dry-Cleaning and Laundry Services	1,010

Source: Analysis of the 2011 American Community Survey. Adults are those aged 19 through 64. Workers are those who have worked within the past year. The ten industries above are those with the largest number of uninsured citizen workers in the Medicaid expansion income-eligibility range in Montana. All figures are rounded to the nearest ten workers. As presented by the Montana Budget & Policy Center online here.

What do we know about the lack of access to health care in Montana?

Individual insurance plans are very expensive. For an individual to find an insurance plan on the private market that is comparable to the essential benefits plan it would cost anywhere from $450-800 per month depending on age, health history and deductible.

Under the Affordable Care Act, Montanans will be able to use the health care "exchange" marketplace. This means there will be one coordinated system for individuals and families to learn if they are eligible for Medicaid or Healthy Montana Kids or whether they can get a break on the cost for private insurance. The exchange will be designed to simplify the process of finding health insurance by making it easy to compare plans and to get-a plan that meets basic quality standards.

What are the risks associated with not implementing Access Health Montana?

- It will be more difficult to keep the doors open to Montana's hospitals in rural and urban communities– federal payments for uncompensated care shrink as a result of new federal laws. Montana hospitals in communities across the state could lose over $18 million in Medicaid Disproportionate Share Hospital payments over the next seven years alone. [ii]
- It will be more difficult to hold the line on health insurance premium increases – and prevent an uncompensated care cost-shift to private-sector premiums
- On average, hospitals, community providers and physicians in Montana provided over $400 million a year in uncompensated care. Hospitals accounted for 60% of the total. Medicaid expansion would provide coverage for over 70,000 people, significantly reducing this cost.

If the legislature doesn't pass Access Health Montana, how will it impact Montana's economy?

- If Montana doesn't pass Access Health Montana, it means a **$700 million annual loss** to Montana's future Gross Domestic Product.[iii]
- The expansion of Medicaid will result in $5.0 to $8.7 billion in additional value-added GDP over the next eight years, with over $9 billion of additional economic output. [iv]
- The expansion of Medicaid would add an additional 1.7% to Montana's GDP for the next eight years. The 1.7% addition would roughly double our expected GDP growth rates for the next several years.
- The increased GDP and labor income would result in an additional $441 million in state and local tax collections.

How much money is coming to the state of Montana if we expand?

This bill brings $6.5 billion in new federal funds to Montana, keeps Montana tax dollars in Montana and will create more than 13,000 new jobs.

- It will keep working Montanans in jobs – most uninsured Montanans work and connecting them to coverage means keeping them in jobs, including many who provide health care services to others.
- Jobs trump politics –the Affordable Care Act, it is the law of the land. Sending Montanans' money to other states will jeopardize Montana's ability to be competitive especially in the health care industry.

How much will the state of Montana have to pay?

This chart represents the state share as a percentage of the cost of covering newly eligible Montanans.

FMAP
Montana State Share Percentage

State Fiscal Year	New Adults Under Reform
FY 2014	0.0%
FY 2015	0.0%
FY 2016	0.0%
FY 2017	2.5%
FY 2018	5.5%
FY 2019	6.5%
FY 2020	8.5%
FY 2021	10.0%
FY 2022	10.0%
FY 2023	10.0%

What about the health exchange and Medicaid?

- The federally facilitated exchange will set up a single streamlined application for private insurance and affordability programs including Medicaid, Healthy Montana Kids (CHIP), tax credits and cost-sharing reductions that can be submitted online, on the phone, in person, or by mail.
- Customer data will be verified electronically at enrollment and renewal using modernized secure data exchanges to support real time (to the greatest extent possible) and increased accuracy for eligibility determination and efficient electronic data exchange.

- The exchange will notify Montanans if they are eligible for Medicaid, tax credits, or payment subsidies.

What types of subsidies are available to people buying health insurance on the exchange?

Access Health Montana extends coverage by Medicaid to most people with incomes under 138% of poverty. For people with somewhat higher incomes (up to 400% of poverty), the ACA provides tax credits that reduce premium costs. People with incomes up to 250% of poverty also are eligible for reduced cost sharing (e.g., coverage with lower deductibles and copayments) paid for by the federal government. The premium tax credits and cost-sharing assistance will begin in 2014. [v]

Who is eligible for premium tax credits under the exchange?

Citizens and legal residents in families with incomes between 100% and 400% of poverty who purchase coverage through a health insurance exchange are eligible for a tax credit to reduce the cost of coverage. In states without expanded Medicaid coverage, people with incomes less than 100% of poverty will not be eligible for exchange subsidies, while those with incomes at or above poverty will be.[vi](See graph on page 1)

Why can't people who don't have healthcare just get it through the exchange?

The exchange is a website tool where people will be able to shop for insurance options. Financial help is available for some people, however, only those who earn between 100-400% of the federal poverty level will be able to receive a subsidy to buy care on the exchange. Those under 100% of poverty (50,000 Montanans) would not receive a subsidy to help purchase healthcare on the exchange. That means that we leave behind 50,000 of the 70,000 people who would be eligible under the expansion. The 50,000 would be the most vulnerable population of adults who are often working and uninsured and cannot purchase health coverage.

Why not just expand Medicaid to the 50,000 people who can't get help through subsidies to purchase health care on the exchange?

States do not have the option to expand Medicaid only to those who earn up to 100% of the FPL and still have the coverage paid for with 100% federal funding. If Montana chose to expand to a lower eligibility level than provided for by federal law, the state would have to pay for the entire expansion with the current state match of 34% (federal match of approximately 66%).

FMAP
Montana State Share Percentage

State Fiscal Year	New Adults Under Reform
FY 2014	0.0%
FY 2015	0.0%
FY 2016	0.0%
FY 2017	2.5%
FY 2018	5.5%
FY 2019	6.5%
FY 2020	8.5%
FY 2021	10.0%

This would be very expensive. It is estimated that this would cost an additional $45 million in state general funds for 2014, an additional $117 million in state general fund in 2015, and an additional $148 million in state general fund every year after that. All this extra cost would cover 20,000 fewer people because instead of paying the percentage of coverage from the chart to the left, Montana would be paying 34% of the cost of benefits.

This chart represents the state share as a percentage of the cost of covering newly eligible Montanans.

Why don't we use all this federal money to pay for "buying in" coverage for those who earn 100-138% on the exchange to be subsidized –isn't it all the same federal money?

The federal government has not committed to paying the enhanced FMAP (100% of the cost of coverage) to states that expand Medicaid only to those who earn up to 100% of the FPL. If Montana chose to expand to a lower eligibility level than provided for by federal law, the state would have to pay for the entire expansion with the current state match of 34% (federal match of approximately 66%).

There is no confirmation from the federal government or anyone else that an Arkansas proposal to use Medicaid dollars to purchase private coverage on the exchange while still receiving 100% of the cost of coverage from the federal government has or will be approved. Premiums for private insurance for this eligible group typically cost much more than Medicaid would cost (approximately $9,000 per individual per year v. Medicaid @ $6,000/individual per year).

Will the federal funds used for Access Health Montana increase our tax burden?

No. The federal funding for the coverage comes from the cuts to or elimination of other federal government programs such as payment to hospitals for the Disproportionate Share Hospital payments and from a reform in Medicare Fee for Service rates. These payments go to hospitals that care for a high proportion of low income Americans. The estimated total federal savings is $741 billion and the estimated cost for the federal share of the extending Medicaid coverage is $643 billion. There is no additional stress on the federal government's budget. [vii]

What do we do when we have to pay the 90/10 split in 2020?

A number of programs now funded by state tax dollars could be shifted to the new coverage program — saving millions of dollars a year in state spending.

What about those who believe Medicaid should be reformed?

Access Health Montana includes several reform measures:

Reforms the eligibility process: This bill provides for a streamlined application process and a more efficient eligibility determination and payment system for the new Medicaid coverage expansion and some other existing coverage groups.

- Reforms the eligibility process with modernized, simplified eligibility rules under a new Modified Adjusted Gross Income (MAGI) standard.

- Offers a single streamlined application for all insurance affordability programs including Medicaid, Healthy Montana Kids, tax credits and cost-sharing reductions that can be submitted online, on the phone, in person, or by mail.
- Verifies customer data electronically at enrollment and renewal using modernized secure data exchanges.
- Employs advanced technology to support real time (to the greatest extent possible) and increased accuracy for eligibility determination and efficient electronic data exchange.

Reform health plan payments/pay-for-performance:

- Implements a medical home where providers are accountable for continuous quality improvement through clear performance measures and care coordination.
- Blue Ribbon Panel-- Establishes a blue ribbon panel of seven members to advise the DPHHS on how to deliver health care with high quality and efficiency through a medical home program for Medicaid and Healthy Montana Kids.
- This investment trains more health care professionals who will then be available for preventive and personal care.
- It increases payments to providers for care that was previously uncompensated. This reduced the cost shift to people with private insurance.
- DPHHS will reform the Medicaid claims payment system to replace a 35-year-old system that uses outdated technology that is time consuming and costly to maintain.

How does the medical home model in HB 590 differ from the patient-centered medical home bill, SB 84?

In a medical home model, primary care and other services is usually delivered through a team of appropriate professionals including nurses, mental health professionals, care managers, pharmacists, licensed addiction counselors, nurse practitioners, physician assistants and physicians. It emphasizes building a relationship with the patient and coordinating care to help the patient seek primary and other health care at the most appropriate place--at the clinic rather than the emergency room. Senate Bill 84 would provide that payers have common, aligned measures of quality and outcome and includes language intended to address collusion concerns with the Patient Centered Medical Home model. The HB 590 medical home model differs from SB84 in that it will serve as a health home for special populations in addition to the general service population, e.g. populations that share specific health and medical treatment needs.

Providers say that they don't get paid enough now to take care of Medicaid patients. Why would they want to see more?

The reform part of this bill is just as important as the expansion part. Health care must be delivered in a new way that improves access for the patient—including better health and cost containment. The bill allows for new models of reimbursement for team care, care coordination and other ideas that improve the care of the patient. The bill also includes increases in Medicaid provider rates by two percent in

each of the next two years to help assure the delivery of the care available through the Medicaid program.

The improvement in Medicaid also comes with a long-overdue federal investment in primary care—the most significant in the last 40 years. The federal government through innovation projects is testing models that repurpose health care services by looking at team care, care coordination, and investing in the health care workforce. The investment trains more doctors and nurses who will then be available to patients and families for preventive and personal care[viii]. It also increases payments to primary care providers so more providers will be able to make more time available to Medicaid patients.[ix]

States that do not expand Medicaid will begin to lose doctors and other health professionals to states that do expand. Physicians prefer to practice in areas that are economically more stable where people have health coverage.

Why don't we wait two years and improve the system then expand?

- This opportunity for 100% federal funds is only good for the first three years. If we do not do this now (in 2013) we are missing an historic opportunity which will have serious impacts on our communities. Without Access Health Montana, the uninsured whose incomes are too high to qualify for Medicaid yet too low for the tax credits and cost-sharing reductions available in Montana's Federally Facilitated Exchange will fall into the coverage gap.
- Without the expansion of Medicaid many Montanans will remain without health care.
- If we wait, we'll miss out on the opportunity to create thousands of new jobs. New federal health care monies spent in Montana will increase health care and other employment creating 5,000 jobs the first year and 13,000 jobs annually after that. This will provide stability for many small community hospitals, clinics and private offices because now they will be getting paid for much of the care that they did previously as charity care. This will make Montana more competitive for doctors and other health care providers to want to come and practice in our state knowing that most Montanans will have health coverage.

Is the state prepared to handle the newly eligible population?

The Montana Department of Health and Human Services recently successfully implemented a large eligibility expansion of the Healthy Montana Kids program. About 30,000 children were added to the program, demonstrating the state's ability to implement an expansion and providing experience to make this opportunity a success.

Montana has an advantage over many states that will be extending Medicaid eligibility. We are in the process of launching new, next generation eligibility and payment systems for a more modern, efficient and accurate process. Because the systems are integrated with other income-determined assistance programs such as the Supplemental Nutrition Assistance Program (SNAP) and Temporary Aid for Needy Families (TANF), we can identify the vast majority of the newly-eligible clients and know how to contact them.

What about fighting fraud and abuse or overutilization?

- By extending Medicaid coverage, we extend Montana's nationally recognized fraud prevention reforms to more Montanans. The fraud prevention measures Montana has adopted must be extended to encompass more Montana claims. For example, our new claims processing system incorporates a highly adaptable fraud and abuse detection system for the ongoing, retrospective, comprehensive analysis of Medicaid data for the detection of potential provider and client fraud, abuse, or unusual utilization (e.g. doctor shopping for drugs).

- Montana has also joined with Utah and other states in a contract with a Recovery Audit Contractor in December 2012 for the analysis of health care claims. The contractor uses analytics and technology to identify aberrant billing of services, based on historical data and algorithms.

- Other reforms include enhanced screenings and enrollment requirements, increased data sharing across government, expanded overpayment recovery efforts and greater oversight of private insurance abuses.[x]

What about putting in disincentives for people who constantly over utilize the system?

Montana currently restricts people who over use the system to one provider and one pharmacy. We also operate a 24-hour nurse hotline. We are committed to exploring other methods such as care coordinators that create a relationship with those with chronic diseases such as alcohol dependency, mental illness and other social factors that create barriers to a healthy lifestyle. Access Health Montana allows for a variety of models to be implemented.

What about Montana's tribal communities?

Despite having a legal right to health care as part of longstanding government to government responsibilities, treaties and laws, many American Indians still lack access to health coverage. Indian Health Service is part of the responsibility but an extension of that responsibility is the new opportunity to make quality health care more available through the new federal funding available through Access Health Montana. Up to 19,547 American Indians in Montana would be eligible to be newly enrolled in the Access Health Montana.

Don't Montana's tribal communities already have the Indian Health Service?

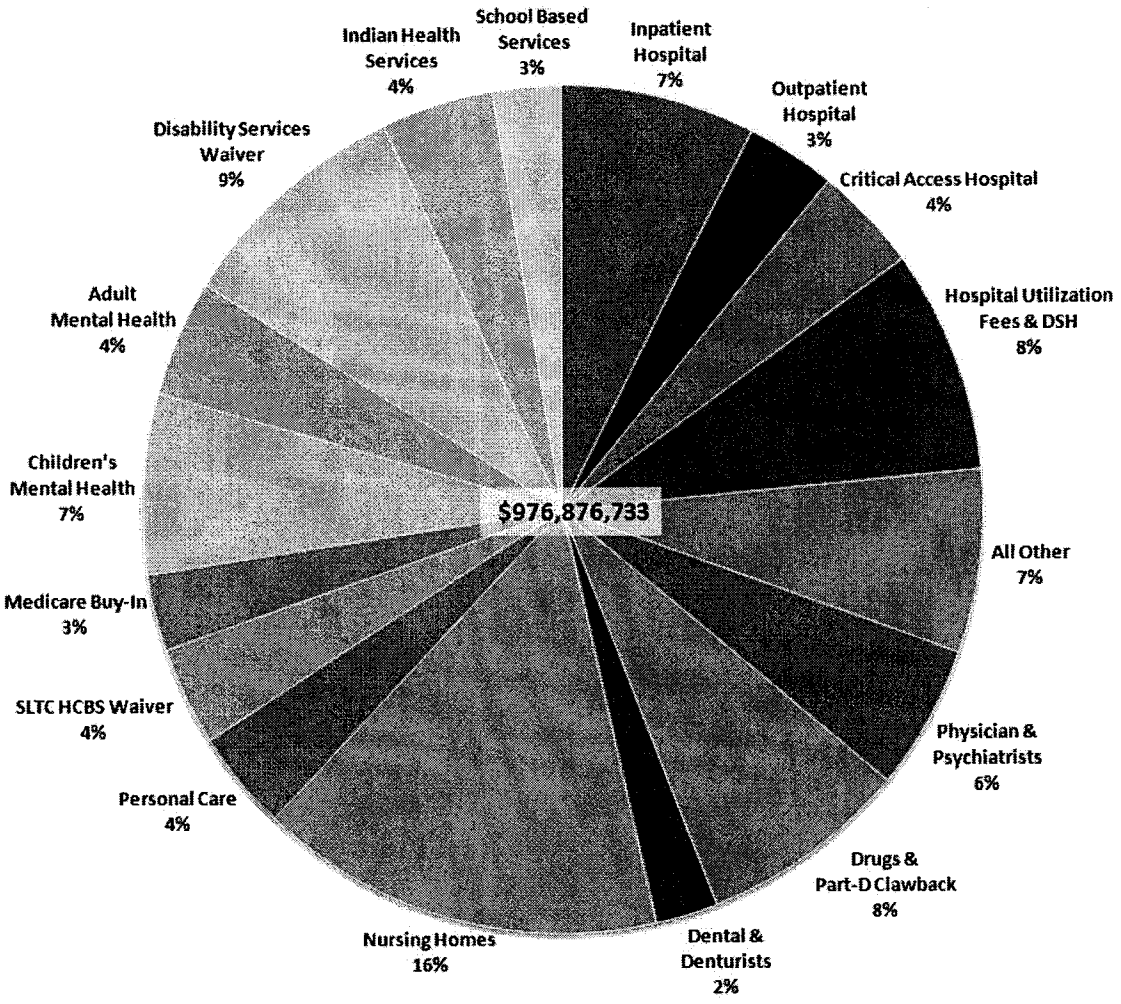
Montana IHS facilities are located in reservations, making them inaccessible to those who reside off reservation. If Indian people have access to IHS, they can still go to Indian Health Services (IHS). If they qualify for Medicaid-based on income, they may enroll. If they want to purchase health insurance, it will be more affordable and prices will be lower because the cost of uncompensated care will no longer be passed on to policy holders because they will have more choices for their healthcare.[xi]

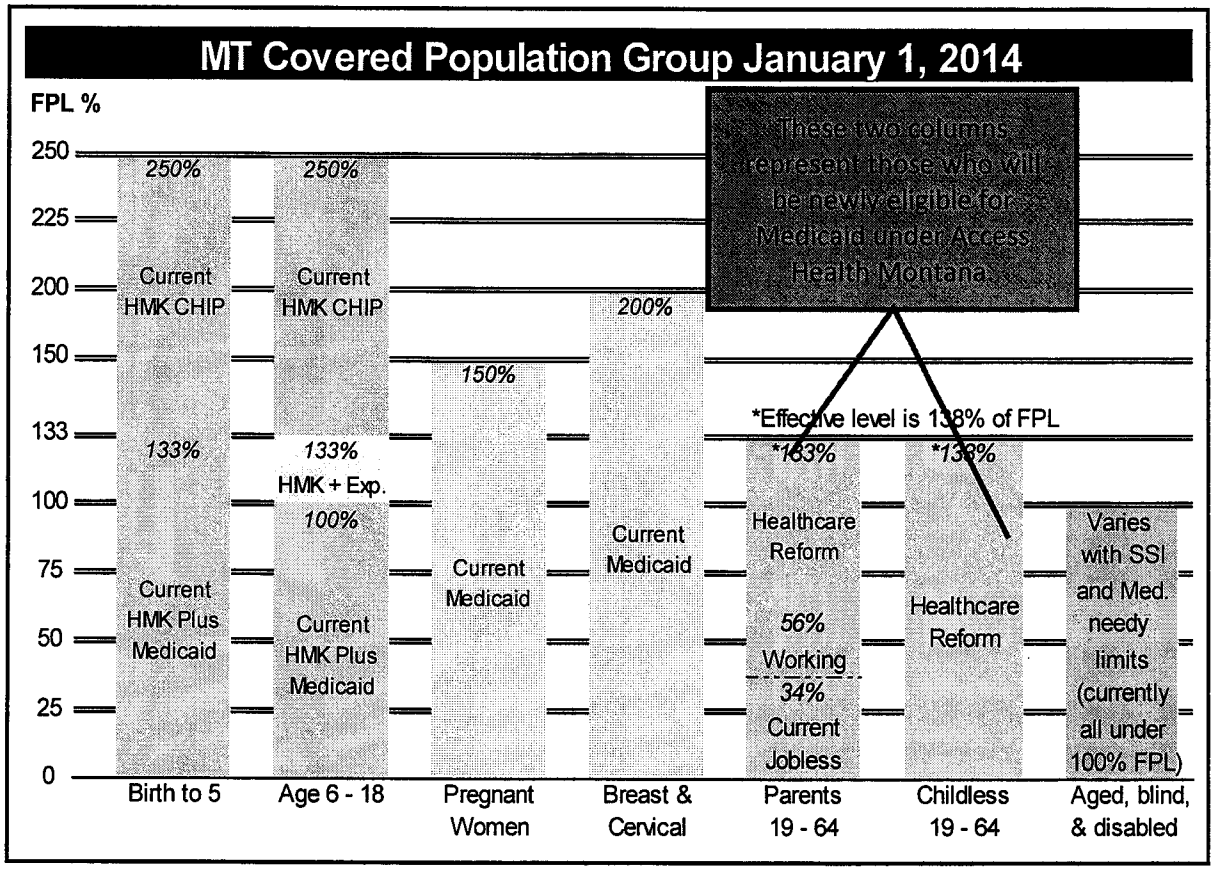
Contract Health Services are a large part of health care in Indian Country. Historically, contract health dollars have run out quickly to pay for the care of Indian people who often had no insurance coverage. With more of the community covered with some form of health insurance, contract health dollars will be available to care for the most vulnerable in Indian Country.

What is Medicaid funding currently paying for?

Covered Population	Medicaid	Healthy Montana Kids
Birth - age 5	133% of FPL	134% to 250% of FPL
Age 6 - 19	100% of FPL	101% to 250% of FPL
Parents of these children, working	56% of FPL	
Parents of these children, jobless	34% of FPL	
Pregnant Women	150% of FPL	
Breast and Cervical	200% of FPL	
Aged, blind, and disabled	Varies, all under 100% of FPL	

State Fiscal Year 2011 Medicaid Benefit Expenditures





[i] Center on Budget and Policy Priorities analysis of U.S. Census Public Use Microdata Sample (PUMS) 2011 data. As accessed in the Montana Budget and Policy Center report online here.

[ii] University of Montana Bureau of Business and Economic Research
http://csi.mt.gov/health/media/BBER_MedicaidExpansion.pdf

[iii] [Sources: University of Montana Bureau of Business and Economic Research, National Bureau of Economic Analysis, Global Insight Forecasts]

[iv] [Sources: University of Montana Bureau of Business and Economic Research, National Bureau of Economic Analysis, Global Insight Forecasts]

[v] Kaiser Family Foundation. EXPLAINING HEALTH CARE REFORM: Questions About Health Insurance Subsidies July 2012
http://www.kff.org/healthreform/upload/7962-02.pdf

[vi] Kaiser Family Foundation. EXPLAINING HEALTH CARE REFORM: Questions About Health Insurance Subsidies July 2012
http://www.kff.org/healthreform/upload/7962-02.pdf

[vii] Source: CBO's July 24, 2012 letter to Speaker Boehner

[viii] Healthcarereform.gov Primary Care Workforce investments
http://www.healthreform.gov/newsroom/primarycareworkforce.html/

[ix] U.S. Department of Health and Humans Services. http://www.hhs.gov/news/press/2012pres/05/20120509b.html

[x] The New England Journal of Medicaid, The ACA's New Weapons against Health Care Fraud. John K. Iglehart, N Engl J Med 2010; 363:304-306July 22, 2010DOI: 10.1056/NEJMp1007088. As accessed 2/25/2-13 at http://www.nejm.org/doi/full/10.1056/NEJMp1007088

[xi] Source for the information in the following paragraphs: United States Department of Health and Human Services http://www.hhs.gov/iea/acaresources/nativeamerican.pdf]

	Medicaid Recipients in County	Medicaid Dollars Spent	Uninsured Adults Eligible for Medicaid Expansion	Anticipated Additional Medicaid Spending	Anticipated Increase in Jobs per Year	Anticipated Increase in Labor Income per Year	Current Unemployment Rate
Beaverhead County	766	$6,059,487	746	$5,818,800	150	$6,221,000	4.60%
Bighorn County	3092	$16,759,871	1168	$9,110,400	230	$9,739,000	13%
Blaine County	1137	$7,563,400	607	$4,734,600	120	$5,062,000	5.60%
Broadwater County	374	$2,785,477	333	$2,597,400	70	$2,777,000	8.40%
Carbon County	618	$3,530,242	537	$4,188,600	110	$4,478,000	4.10%
Carter County	51	$757,579	96	$748,800	20	$801,000	3.00%
Cascade County	7962	$56,416,156	4151	$32,377,800	830	$34,613,000	5.10%
Choteau County	353	$2,394,296	372	$2,901,600	70	$3,102,000	3.30%
Custer County	1103	$7,990,343	642	$5,007,600	130	$5,353,000	3.50%
Daniels County	113	$1,227,823	86	$670,800	20	$717,000	4.50%
Dawson County	543	$5,558,075	394	$3,073,200	80	$3,285,000	3.20%
Deer Lodge County	1068	$8,722,780	525	$4,095,000	110	$4,378,000	7.10%
Fallon County	151	$1,678,462	135	$1,053,000	30	$1,126,000	1.70%
Fergus County	902	$7,098,494	775	$6,045,000	160	$6,462,000	5.90%
Flathead	9879	$55,291,051	5,943	$46,355,400	1190	$49,556,000	9.10%
Gallatin	4515	$23,725,266	4,757	$37,104,600	950	$39,667,000	4.90%
Garfield	78	$600,159	109	$850,200	20	$909,000	4%
Glacier	2936	$19,325,884	1,243	$9,695,400	250	$10,365,000	12.40%
Golden Valley County	89	$294,876	78	$608,400	20	$650,000	3.70%
Granite	190	$1,547,723	210	$1,638,000	40	$1,751,000	9.60%
Hill	2600	$14,946,976	1,122	$8,751,600	230	$9,356,000	5.30%
Jefferson	809	$6,516,060	504	$3,931,200	100	$4,203,000	4.80%
Judith Basin County	133	$697,387	171	$1,333,800	30	$1,426,000	4.30%
Lake	4559	$29,115,941	2,378	$18,548,400	480	$19,829,000	8.50%
Lewis and Clark County	5439	$31,395,368	2,808	$21,902,400	560	$23,415,000	4.40%
Liberty	128	$956,659	193	$1,505,400	40	$1,609,000	4.70%
Lincoln	2498	$17,499,065	1,512	$11,793,600	300	$12,608,000	14.80%
McCone	71	$464,366	128	$998,400	30	$1,067,000	2.10%
Madison	379	$3,458,892	496	$3,868,800	100	$4,136,000	5.60%
Meagher	294	$1,423,306	175	$1,365,000	40	$1,459,000	7.40%
Mineral	610	$4,132,838	334	$2,605,200	70	$2,785,000	10.80%
Missoula	10152	$66,071,970	7,699	$60,052,200	1540	$64,199,000	5.60%
Musselshell	550	$4,174,276	321	$2,503,800	60	$2,677,000	5.40%
Park	1232	$7,670,499	1,107	$8,634,600	220	$9,231,000	7.10%

	Medicaid Recipients in County	Medicaid Dollars Spent	Uninsured Adults Eligible for Medicaid Expansion	Anticipated Additional Medicaid Spending	Anticipated Increase in Jobs per Year	Anticipated Increase in Labor Income per Year	Current Unemployment Rate
Petroleum	21	$105,835	47	$366,600	10	$392,000	6.10%
Phillips	489	$3,718,983	308	$2,402,400	60	$2,568,000	5.70%
Pondera	871	$5,620,503	492	$3,837,600	100	$4,103,000	5.20%
Powder River County	58	$976,633	124	$967,200	20	$1,034,000	7.50%
Powell	622	$5,103,051	343	$2,675,400	70	$2,860,000	7.50%
Prairie	73	$856,472	91	$709,800	20	$759,000	3.80%
Ravalli	4143	$23,752,818	2,724	$21,247,200	550	$22,714,000	8.20%
Richland	504	$4,722,248	528	$4,118,400	110	$4,403,000	2.20%
Roosevelt	2707	$18,883,635	865	$6,747,000	170	$7,213,000	6.60%
Rosebud	1502	$8,086,433	593	$4,625,400	120	$4,945,000	6%
Sanders	1382	$9,464,954	1,013	$7,901,400	200	$8,447,000	14.10%
Sheridan	236	$2,023,888	181	$1,411,800	40	$1,509,000	3.40%
Silver Bow County	4258	$32,360,303	1,895	$14,781,000	380	$15,802,000	5.50%
Stillwater	614	$3,559,872	384	$2,995,200	80	$3,202,000	4.80%
Sweet Grass County	169	$1,802,902	218	$1,700,400	40	$1,818,000	2.80%
Teton	525	$3,750,523	400	$3,120,000	80	$3,335,000	4.40%
Toole	435	$3,514,710	305	$2,379,000	60	$2,543,000	5%
Treasure	51	$199,797	45	$351,000	10	$375,000	5.20%
Valley	861	$5,968,100	417	$3,252,600	80	$3,477,000	4%
Wheatland	215	$1,060,942	186	$1,450,800	40	$1,551,000	5.40%
Wibaux	46	$835,603	64	$499,200	10	$534,000	2.40%
Yellowstone	14529	$95,462,055	7,245	$56,511,000	1450	$60,413,000	4.10%

Data source: Impact Analysis for Planning (IMPLAN) from the Bureau of Business and Economic Research at the University of Montana