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**2020
REPORT**
ON HEALTH
COVERAGE &
MONTANA'S
UNINSURED

CLG

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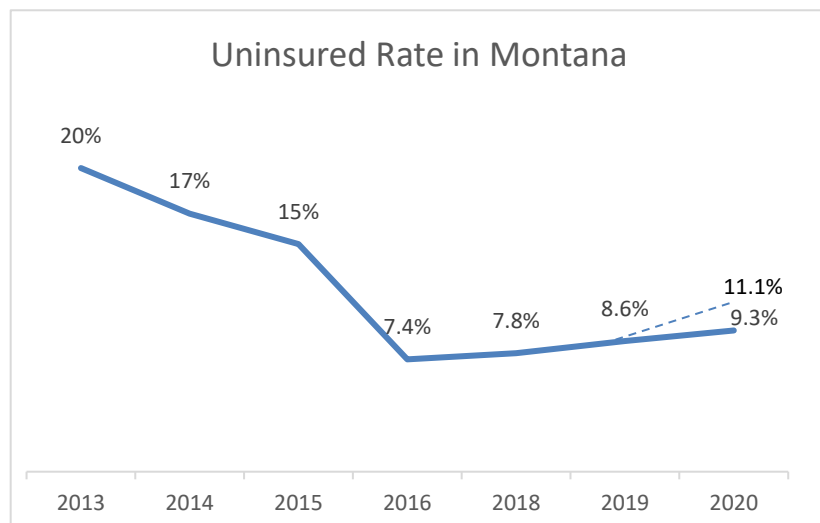
2020 REPORT ON HEALTH COVERAGE AND MONTANA'S UNINSURED

Introduction: Montana's Uninsured Rate

The Montana Healthcare Foundation (MCHF) commissioned this study of Montana's uninsured rate for 2020. In August 2020, an estimated 985,751 Montanans had health coverage out of a total population of 1,086,760, resulting in an estimated uninsured rate of 9.3%, an increase of almost 2% since 2016 and 0.7% higher than the 2019 rate.¹ However, this 2020 uninsured rate is only an estimate because the number of individuals who may have lost employer-sponsored coverage as a result of the pandemic and the nation's economic downturn is uncertain, and some of the employer data used comes from prior years. The uninsured rate for 2020 could be higher, perhaps as high as 11.1%, depending on the many factors discussed in more detail below.

The following sources were used to estimate Montana's uninsured rate:

- 1) Surveys of the three largest health insurers selling individual, small employer group, and large employer group major medical health insurance
- 2) Data obtained from the Montana Department of Public Health and Human Services on Medicaid and Children's Health Insurance Program (CHIP) enrollment
- 3) Publicly available data on Medicare enrollment²
- 4) Kaiser Family Foundation estimates on employer coverage³ encompassing all types of employer health plans, including:



¹ *Montana Population 2020*. World Population Review. <https://worldpopulationreview.com/states/montana-population>

² *Medicare Enrollment Dashboard*. Centers for Medicare & Medicaid Services. Retrieved August 2020, from <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Medicare-Enrollment/Enrollment%20Dashboard.html>

³ *Health Insurance Coverage of the Total Population*. (2018). State Health Facts. Kaiser Family Foundation. <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

- a. Self-funded health plans in which the employer assumes the financial risk for providing health care to its employees
 - b. Fully insured employer health insurance in which the employer pays premiums to a health insurance company for each employee and the insurance company covers the costs of the employees' health care (The fully insured market is divided into "small group" (50 or fewer full-time employees) and "large group" (51 or more full-time employees). Fully insured employer group insurance is regulated by the state, and enrollment information is public.)
- 5) Recent reports by the Montana Department of Labor and Industry, the Census' American Community Survey (ACS), and the Urban Institute that address changes in employment and insurance related to COVID-19

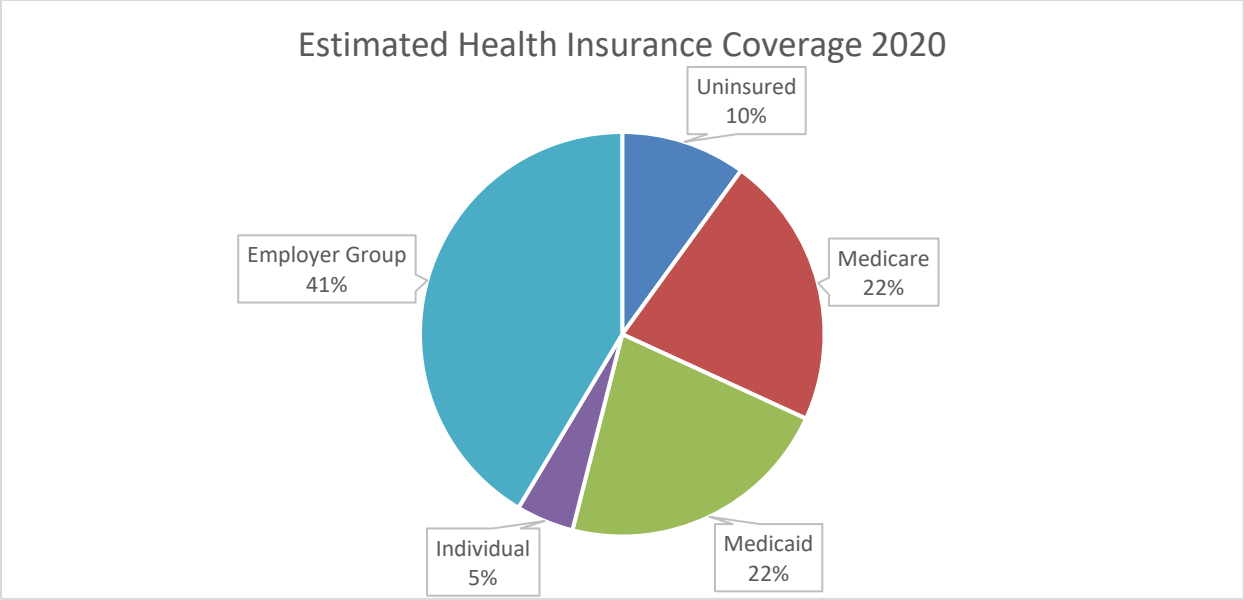
The self-funded employer coverage enrollment numbers are not public, and these plans make up a large share of overall employer coverage. For this reason, this estimate of the overall uninsured rate in Montana relies on the Kaiser estimates, which do not break out the changes to the fully insured small and large employer groups. Details about the changes in the number of fully insured for 2020 are reported below. Kaiser relies on the Census' ACS to estimate the rate of employer coverage each year. The most recent year of data that Kaiser has analyzed is 2018; therefore, the total employer coverage numbers are not current. This is a particularly important limitation due to the increase in unemployment related to COVID-19. To address this limitation, this report also considers more recent estimates by the Urban Institute and the Montana Department of Labor and Industry.

The sources and surveys used for this study mirror what was used by the Office of the Commissioner of Securities and Insurance in 2014, 2015, and 2016, and for the studies commissioned by MHCF for 2017, 2018, and 2019.

Summary of Health Coverage in Montana

Health Insurance Coverage				
	2016	2018	2019	2020
Uninsured	76,000	83,073	92,179	101,678 to 119,544
Medicare	201,000	217,983	226,228	236,473
Medicaid	193,231	246,039	257,142	239,198
Individual Market (Inside Exchange)	52,358	49,080	41,954	40,277
Individual Market (Outside Exchange)	28,261	13,372	10,074	9,634
Prison Population (Estimated)*	3,642	4,083	4,000	4,500
Employer Group (Estimated)	446,200 (est. in 2015)	440,500 (est. in 2016)	445,800 (est. in 2017)	435,000 to 455,000 (est. in 2018 for 2020)

*The prison population, once convicted and sentenced, is not eligible for private or public health coverage. It only has access to the health services that are provided and paid for by the prison. Individuals who are hospitalized for longer than 24 hours may be eligible for Medicaid. These numbers are estimates based on the prison population and do not include individuals who are being held in local jails pending trial or another type of resolution of their case.



Medicaid

There are various types of Medicaid programs, but only those that offer complete health coverage were counted in this report: regular Medicaid (pre-2016 eligibility requirements), CHIP covering children 18 and under up to 261% of the federal poverty level (FPL), and Medicaid expansion covering individuals up to 138% of FPL who did not previously qualify for regular Medicaid. Those with limited Medicaid benefits or who are dually eligible for Medicare and Medicaid were deleted from the total.

Medicaid grew from approximately 193,231 covered lives in early 2016, when Medicaid expansion first started, to approximately 257,142 by March 2019, and then declined to 239,198 in August 2020. The largest age group covered by Medicaid/CHIP is children between 0 and 18 years of age. Of the 239,198 individuals enrolled with access to full coverage in August 2020, approximately 48.3% were children. The next largest category was individuals aged 19 to 34, which was 22.9% of the total enrollment. The highest Medicaid/CHIP enrollment (32.1%) was in the rural areas of the state. Detailed information about age groups and the location of Medicaid enrollees can be found in the attached spreadsheet.⁴

Medicaid/CHIP covers approximately 22% of the population. According to the Montana Department of Labor and Industry, only about 3,446 individuals became newly eligible for Medicaid and unemployment benefits because of job losses that were probably related to COVID-19 between the middle of March and the end of July 2020.⁵

Medicare

Montana has the fifth highest elderly population among all the states. Medicare enrollment expanded from 201,000 in 2016 to 237,162 in August 2020, which was approximately 22% of the population. Only about 9% of that population was enrolled only in the free Part A coverage, which just provides hospitalization benefits.⁶

⁴ 2020 Health Plan Enrollment Data Spreadsheet, Attachment No. 1

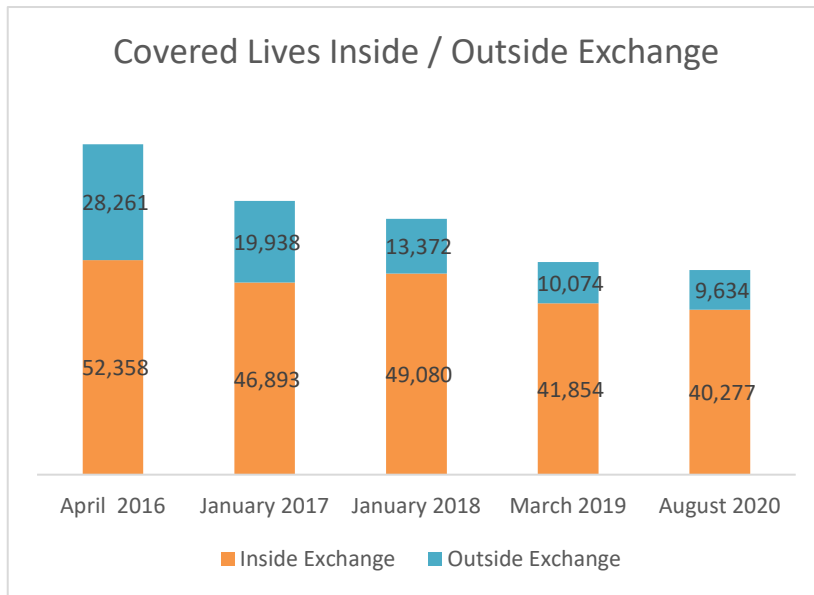
⁵ LMI Medicaid and Unemployment Data Spreadsheet, August 2020, Attachment No. 2

⁶ *Number of People Receiving Medicare.* (2019). National Committee to Preserve Social Security & Medicare. <https://www.ncpssm.org/our-issues/medicare/medicare-fast-facts/>

According to the Kaiser Family Foundation, 86% of Medicare enrollees had both Part A and Part B (outpatient coverage) and a form of supplemental coverage, such as Medicare Advantage, Medicare supplement insurance, employer retiree coverage, or Medicaid. Among Medicare enrollees, 71% purchased Part D or Medicaid Advantage prescription drug coverage.⁷

Individual Health Insurance Market

The individual health insurance market covers only a small segment of the population, both nationally and in Montana. However, the individual market is an important safety net, and many people obtain coverage there, at least for a short period of time. Individual health insurance provides coverage for individuals who have lost employer health coverage, are self-employed, are aging out of their parents’ coverage, are waiting to become eligible for Medicare (early retirees), or are transitioning out of Medicaid.



Between 2016 and 2020, the individual market declined significantly. By August 2020, individual market enrollment had decreased to 49,911, down from 80,619 in 2016.

There are several reasons for this decline. First, a significant number of individuals transitioned from the individual market to Medicaid and Medicare. Medicaid was expanded in 2016, and it is estimated that approximately 10,000 to 15,000 people transitioned to Medicaid between 2016 and 2018.⁸

Second, premiums in the individual market increased significantly in 2017, in part because a federal reinsurance program created by the Affordable Care Act (ACA) ended that year. In 2018, the cost of silver plans in particular increased by 11% to 24%. This occurred because the federal government stopped reimbursing health insurers for the “cost-sharing reduction” (CSR) benefit that individuals below 250% of FPL may receive, but the law still required those insurers to continue paying the benefit. Therefore, insurers increased the cost of silver plans for all consumers to make up the difference. This is referred to as “silver loading.” In 2020, average premiums **decreased** significantly, 13.4% to 14.1%, in part because a new state-based reinsurance program was implemented by the legislature in 2019.⁹ This new Montana Reinsurance Program was partially funded by federal dollars that the state was able to obtain through seeking a “1332 waiver,” which permits a state to waive certain elements of the ACA in

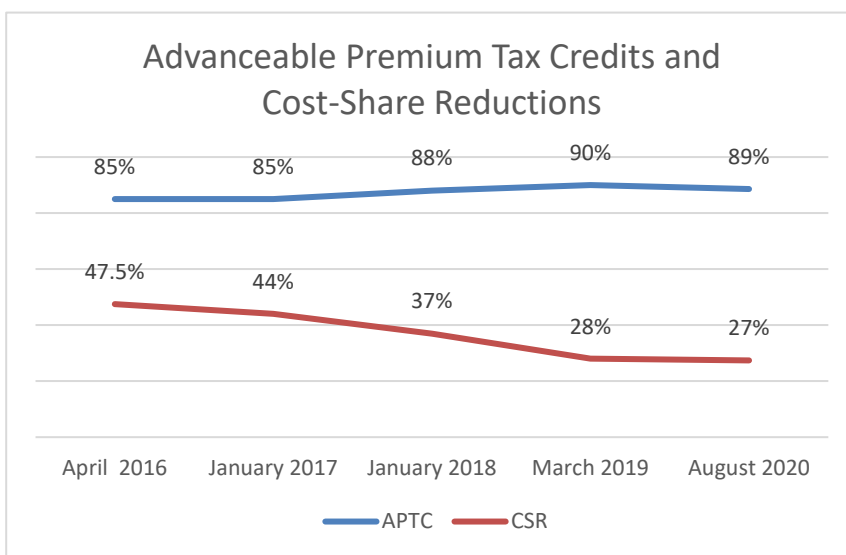
⁷ Umans, Ben and Nonnemaker, K. Lynn. (2009, January). *The Medicare Beneficiary Population Factsheet*. AARP Public Policy Institute. https://assets.aarp.org/rgcenter/health/fs149_medicare.pdf

⁸ Wakely Individual Market Stabilization – Medicaid Expansion Analysis, August 14, 2018, Attachment No. 3

⁹ *Tracking Section 1332 State Innovation Waivers*. (2020, September 23). Kaiser Family Foundation. <https://www.kff.org/health-reform/fact-sheet/tracking-section-1332-state-innovation-waivers/>

order to pursue innovative strategies to provide residents access to high quality, affordable health insurance.¹⁰ In 2020, the Montana Reinsurance Program continues to keep rates lower: the proposed average rate increase for 2021 is 0% to 5%.¹¹ Advanceable Premium Tax Credits (APTCs) can be used by consumers to lower their monthly insurance payments on plans purchased through the individual marketplace. APTC caps an individual’s premium contribution at a percentage of their income—approximately 3.3% (at 133% of the federal poverty level) to 9.6% (at 399% of federal poverty level). In 2020, 88.6% of exchange policies issued qualified for APTCs—73% of the total individual market—and 27% of the policies sold in the exchange qualified for CSRs.

Partially due to the increased cost of silver plans, the percentage of individuals purchasing bronze plans—which have higher cost-sharing requirements—in the individual market increased significantly in 2018, 2019 and 2020. This increase is concerning because many of the individuals purchasing bronze plans cannot afford the higher cost-sharing, which leads to them becoming underinsured. A bronze plan has an actuarial value of 60%. Cost-sharing reduction silver plans



have actuarial values of 73%, 87%, and 94%, depending on income levels. Between 2016 and 2020, the percentage of bronze plans sold in the individual market rose by 30%. Most individuals who were not eligible for CSRs and/or APTCs could not afford silver plans also opted for bronze plans.¹²

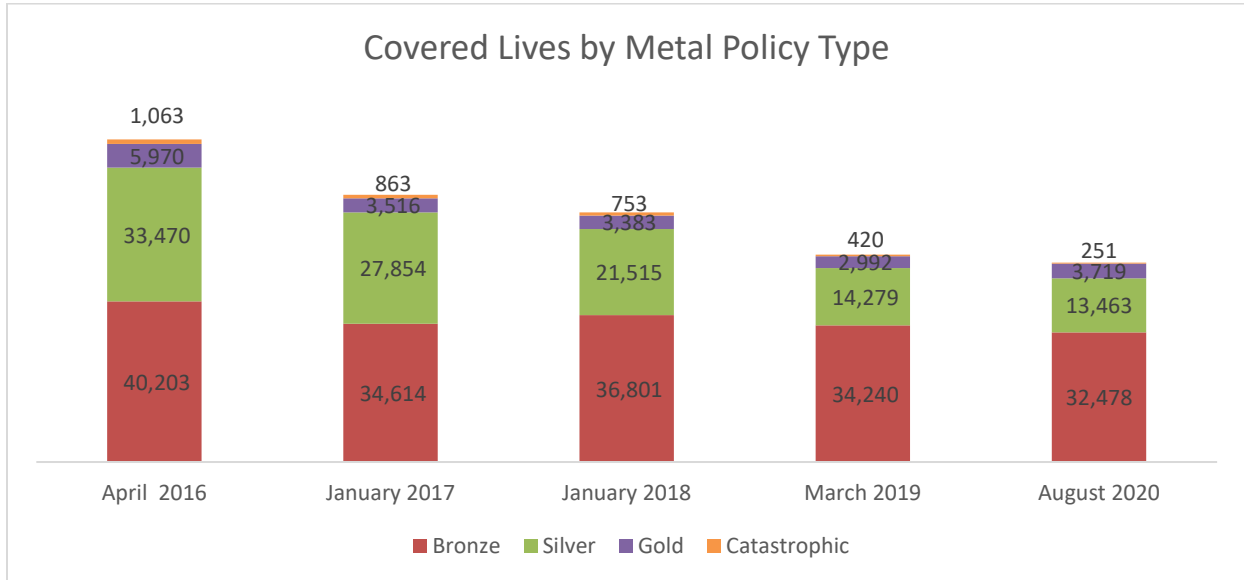
The APTC amounts are calculated according to a formula that relies on the price of the second-lowest-cost silver plan. When the price of the silver plan increases, the amount of the APTC increases. The premiums for bronze plans increase at a much slower rate. This situation results in many individuals switching to a bronze plan because their premium is \$0. However, individuals below 250% of the federal poverty level also qualify for a CSR silver plan, which has much lower cost-sharing. Many consumers do not understand that they could qualify for a CSR silver plan, which may explain the decrease in the percentage of individuals receiving a CSR plan—from 47.5% in 2016 to 27.4% in 2020. Premiums were reduced in 2020 by 13% to 14%, in part because of the Montana public reinsurance program, and therefore APTCs also decreased. However, the trend of purchasing bronze plans did not change significantly. According to a recent study done by Kaiser, about 15,000 currently uninsured Montanans who

¹⁰ Under ACA Section 1332, states may apply to CMS to waive certain provisions of the ACA, subject to specific “guardrails,” to implement innovative programs. Any federal savings may be passed on to the state to fund the innovation.

¹¹ *2021 Rate Filings and Rate Review*. Office of the Montana State Auditor and Commissioner of Securities and Insurance. <https://csimt.gov/your-insurance/health/2021-rate-filings-and-rate-review/>

¹² Dorn, Stan. (2019, June 3). *Silver Linings for Silver Loading*. Health Affairs. <https://www.healthaffairs.org/doi/10.1377/hblog20190530.156427/full/>

qualified for \$0 premium bronze plans in 2020 could have paid a very small amount of premium and received a silver CSR plan with much lower cost-sharing.¹³



Insurer competition in the individual health insurance market strengthened between 2012 and 2020. In 2012, there were only two health insurers with a market share of more than 4% in the individual market, and one insurer dominated the market. In 2016, there were three health insurers in the individual market, with a market share of 10% or more. In 2020, there were still three health insurers in the individual market, each with a market share of 25% or more, and all three of them are still participating in the exchange.

Small Employer Group Insurance Market

In 2012, the small employer group health insurance market (employers with 50 or fewer full-time employees) had approximately 54,500 covered lives. In 2020, there were 44,071 covered lives in the small group market, which represents a 19% decline. Most small employer health plans in 2020 were silver or gold, and only 26% were bronze.

In 2014 and 2015, individual market premiums were lower than small employer group premiums, so some of these employers, especially family-owned businesses, shifted to the individual market, where they might also qualify for premium tax credits. Other factors accounting for the lower enrollment in the small group market were the loss of premium



¹³ Fehr, R., Cox, C., & Rae, M. (2019, December 10). *How Many of the Uninsured Can Purchase a Marketplace Plan for Free in 2020?* Kaiser Family Foundation. <https://www.kff.org/private-insurance/issue-brief/how-many-of-the-uninsured-can-purchase-a-marketplace-plan-for-free-in-2020/>

assistance previously available to some small employers through the Insure Montana program (eliminated by the Legislature in 2015) and the movement of some small employers into self-funded health plans.

In 2020 the premium difference between the individual and small group markets was no longer significant. However, many small employers and their employees may qualify for APTC, thereby keeping individual premiums more affordable than small group premiums for some individuals. In 2020, the federal government stopped supporting a Small Business Health Options Program (SHOP) exchange platform for small employers, so coverage was no longer being sold through the SHOP in Montana, although some other states still have a SHOP exchange. In the past, small employers that enrolled through the SHOP could become eligible for a two-year federal premium tax credit.

Insurer competition in the small group market has gotten stronger. In 2012, there were four health insurers in the small group market with a market share greater than 4%, but the market was dominated by one insurer. In 2020, there were two health insurers with a market share greater than 38% and two insurers with much smaller market shares that were actively marketing small group health plans in Montana.

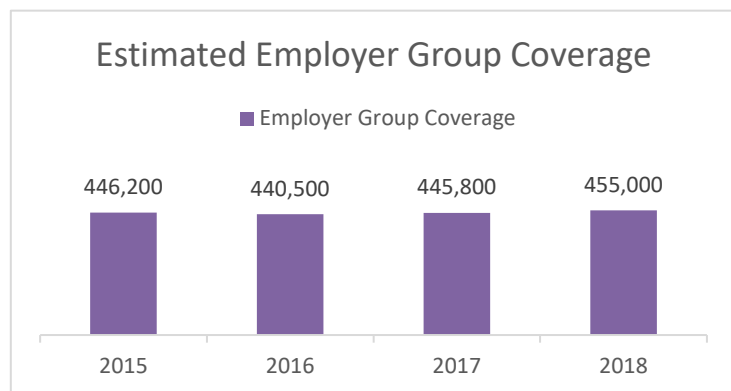
Detailed information about individual, large group, and small group employer health insurance coverage can be found in the attached spreadsheet. It has been broken out into the following categories: age groups, rating areas, metal levels, and cost-sharing reduction plans.¹⁴

Large Employer Group/Commercially Insured

Most large employers (those with 51 or more employees) are “self-funded,” especially if they have more than 100 employees. Therefore, the “fully insured” large employer group market in Montana is not large. In August 2020, there were 33,469 covered lives in the commercially insured large employer group market. This number increased slightly from 29,881 in March 2019.

All Types of Employer Health Coverage

According to the statistics provided by the Kaiser Health Foundation, all types of employer group coverage (self-funded and fully insured large and small employer group health coverage) had increased to **455,000 in 2018**. In Montana, 44% of the population got coverage through their employer in 2018, compared to 49% in the United States.¹⁵ A more recent study conducted by the Montana Department of Labor and Industry



¹⁴ 2020 Health Plan Enrollment Data Spreadsheet, Attachment No. 1

¹⁵ *Health Insurance Coverage of the Total Population*. (2018). State Health Facts. Kaiser Family Foundation. <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

and two other state agencies indicates that only 40% of Montana’s workers were covered by their employer’s health plan in 2019.¹⁶

The Kaiser numbers on employer-sponsored insurance (ESI) are based on the Census’ ACS. The survey asks a statistical sample of the U.S. population about their access to health coverage in the previous calendar year, which is why these estimates are delayed. The ACS numbers for 2019 became available on September 15, 2020, but Kaiser statistics will not be updated until later this year. The ACS numbers must be analyzed to produce the estimates on total enrollment that Kaiser publishes. The Kaiser number includes all types of employer coverage, including self-funded health plans and all fully insured health plans from both large and small employers. Because most employer health plans are self-funded (not fully insured), it is not possible to obtain complete enrollment numbers through the surveys conducted for this report because that information is protected by ERISA, which preempts states and private parties from collecting enrollment information for health plans that are not fully insured.

The just released ACS data captures statistics for 2019. However, even this updated data would not account for the significant changes that are still occurring in the economy because of the COVID-19 pandemic. That said, the initial 2019 ACS preliminary estimates indicate that the national uninsured rate increased from 8.9% in 2018 to 9.2% in 2019.¹⁷

There is much speculation about the potential for large losses of employer-sponsored insurance coverage because of the COVID-19 pandemic.¹⁸ A study by the Urban Institute conducted in May 2020 estimated the loss of ESI due to increased unemployment rates, using 15%, 20%, and 25% unemployment rates by state. According to this report, a 15% unemployment rate in Montana could result in 61,000 individuals losing their ESI.¹⁹ If those estimates are reduced to reflect the actual unemployment rate in Montana in August 2020 (5.6%), the ESI losses would be closer to 20,000 individuals.

Montana’s unemployment rate was 3.6% in March 2020, 11.9% in April 2020, and 5.6% in August 2020 (seasonally adjusted), and these numbers are much lower than the 15% unemployment rate used as the starting point in the Urban Institute study. However, these unemployment rates do not tell the whole story. COVID-19 caused many people to leave the labor force because of the high mortality risk for some workers, as well as the school and daycare closures that forced some parents to stay at home with their children. The official unemployment rate would not capture these workers as unemployed. A recent report, “Understanding the Unemployment Rate During the COVID-19 Pandemic,” published by the Montana Department of Labor and Industry, indicates that in April

¹⁶ Holom, N., McNay, A., Wagner, B., & Watson, A. (2020, September 15). Medicaid Expansion & Montana Employers: An Update to the Joint Report by the Montana Departments of Labor & Industry, Revenue, and Health & Human Services. <http://lmi.mt.gov/Portals/193/Publications/LMI-Pubs/Special%20Reports%20and%20Studies/Medicaid-Report-2020.pdf>

¹⁷ Greenstein, R., Sherman, A., & Broaddus, M. (2020, September 15). *Uninsured Rate Rose in 2019; Income and Poverty Data Overtaken by Pandemic Recession*. Center on Budget and Policy Priorities. <https://www.cbpp.org/research/poverty-and-inequality/uninsured-rate-rose-in-2019-income-and-poverty-data-overtaken-by>

¹⁸ Bantlin, Jessica & Holahan, John. (2020, August). *Making Sense of Competing Estimates: The COVID-19 Recession’s Effects on Health Insurance Coverage*. Urban Institute. https://www.urban.org/sites/default/files/publication/102777/making-sense-of-competing-estimates_1.pdf

¹⁹ Garrett, Bowen and Gangopadhyaya, Anuj. (2020, May). *How the COVID-19 Recession Could Affect Health Insurance Coverage*. Urban Institute. https://www.urban.org/sites/default/files/publication/102157/how-the-covid-19-recession-could-affect-health-insurance-coverage_0.pdf

2020, 18,189 workers left the labor force and were not counted in the unemployment numbers.²⁰ An alternative measure of labor underutilization, the U-6 unemployment rate, defines unemployment more broadly to include such workers. The U-6 includes workers who are not actively seeking employment but searched for work in the last 12 months (marginally attached workers) and workers who are working part-time because they cannot find full-time work (involuntary part-time workers). At the state level, the U-6 is a four-quarter moving average. For the most recent period ending in the second quarter of 2020, the U-6 was 9.7% in Montana, which is 4.7 percentage points higher than the rolling average of the official unemployment rate of 5% for the same period.

In light of these early studies, it is probable that the uninsured rate in Montana in 2020 was actually higher than what has been represented in this report using ACS ESI data from 2018 or even using ACS ESI data from 2019. Extrapolating from the Urban Institute study indicates that approximately 20,000 may become uninsured because of a loss of employer coverage. Additionally, the more recent estimate from the Montana Department of Labor and Industry indicates that only 40% of Montanans have employer health coverage, not 44%, as indicated in the 2018 Kaiser statistics, which would reduce the number of individuals with employer coverage by about 20,000. This would lower the estimated number of people with employer coverage from 455,000 to 435,000 and increase the estimated percentage of uninsured in the state from 9.3% to 11.1%. However, some individuals losing job coverage may migrate to another form of coverage, such as Medicaid or the individual market; therefore, these numbers are speculative.²¹

Health Programs Not Counted as Insurance

Indian Health Service

As of the 2010 Census, there were about 78,000 American Indians and Alaska Natives (AI/AN) living in Montana, with approximately 53% living on a reservation.²² Many are eligible for services provided by the U.S. Indian Health Service (IHS), but the IHS only provides services on reservations. The IHS is not health insurance and does not offer an established benefits package.²³ Some direct health care services are provided at IHS facilities or by tribes that have contracted with the IHS to assume management of IHS facilities and services. In Montana, each reservation has IHS or tribal facilities that provide some clinical services. The Crow, Blackfeet, and Fort Belknap IHS Service Units operate some emergency room and inpatient services, but other reservations provide only outpatient care. Few specialty services or surgical procedures are available on Montana reservations.

There are five nonprofit urban Indian health centers in Montana cities, each of which offers certain outpatient primary care and behavioral health services and receives a small amount of IHS funding. Purchased/Referred Care (PRC), an IHS program that pays for referrals for services that are not available at IHS facilities, is provided by non-IHS health care providers and facilities. PRC payments are authorized based on clearly defined guidelines and are subject to the availability of funds, but the IHS cannot guarantee that funds are always available. Funds

²⁰ Bradley, Christopher. (2020, August). *Understanding the Unemployment Rate During the COVID-19 Pandemic*. Montana Department of Labor and Industry. <http://lmi.mt.gov/Portals/193/Publications/LMI-Pubs/Articles/2020/0820-UnemploymentCOVID19.pdf>

²¹ Keith, Katie. (2020, October 7). *Tracking the Uninsurance Rate in 2019 and 2020*. Health Affairs. <https://www.healthaffairs.org/doi/10.1377/hblog20201007.502559/full/>

²² *Montana Indians: Their History and Location*. Montana Office of Public Instruction. <http://opi.mt.gov/Portals/182/Page%20Files/Indian%20Education/Indian%20Education%20101/Montana%20Indians%20Their%20History%20and%20Location.pdf>

²³ *Frequently Asked Questions*. Indian Health Services. <https://www.ihs.gov/forpatients/faq/>

appropriated by the U.S. Congress currently cover an estimated 60% of the health care needs of eligible American Indian and Alaska Native people, but that varies depending on the tribe and the location.

Services obtained under PRC are prioritized, with life-threatening illnesses or injuries being given the highest priority. The patient medical referral is reviewed according to established priorities and the amount of funding that is available at that time. Historically, many tribes run out of funding for PRC long before the year ends. Because Medicaid expansion now provides coverage and a payment source for some AI/AN people on reservations, PRC dollars have been available to cover the costs of essential services that were not previously available to uninsured and underinsured residents. While limited clinical services are available at IHS facilities, there is still a need for health insurance coverage because it provides a source of reimbursement to tribal, IHS, and urban Indian health center facilities for their services.

The total number of AI/AN people covered by Medicaid in August 2020 was 45,467. Approximately 14,263 AI/AN people were enrolled in Medicaid expansion as of June 1, 2020. In 2020, only 101 AI/AN people were enrolled in exchange coverage, receiving premium tax credits and a cost-sharing reduction plan with \$0 cost-sharing. Starting in 2014, the ACA required tribal employers, which employ many tribal members, to offer a health plan to their employees or pay a penalty, the same as any other large employer. Now, many more AI/AN people have access to employer-sponsored insurance, but the exact number has not been identified.

Veteran's Health Care Services

The veteran population that is eligible to receive health care services from the Veterans Administration (VA) was not included in this report because, like Indian Health Services, the VA is not health coverage. Instead, the VA is a health care provider that may provide free or low-cost health care services to eligible individuals under certain circumstances. In 2017, the Montana Legislature published a report indicating that there were 98,386 veterans living in Montana,²⁴ and 65% of them were aged 60 to 99. Therefore, most of the veteran population is eligible for Medicare and is counted in the Medicare numbers. Estimates from the Montana Budget and Policy Center indicate that approximately 9,500 veterans are eligible for Medicaid expansion, and many more are employed and covered under their employer plans.²⁵

Anyone who served on active duty in the military may be eligible for at least some VA benefits. But the VA health system cannot provide full care for all veterans, so it has set up a complicated priority system to determine veterans' benefits and out-of-pocket costs. The system divides veterans into eight groups, with the highest priority groups eligible for the most services at the lowest costs. The priority groups are based on service-connected disability, other disability, and income. Veterans with severe service-connected disabilities get the broadest range of services; veterans without a disability or a low income get the least VA care.

According to Kaiser, 20,800 individuals were covered by the "military" (including VA services) in Montana in 2018. Some of those individuals are probably active military covered under Tricare, but the description is not detailed, and other studies include Tricare under employer coverage. Historically, those numbers have not been counted in previous reports in order to avoid double-counting, so those numbers have not been counted in this year's report either.

²⁴ *Montana Veteran Demographics*. (2017, January 6). Veterans Health Administration. [https://leg.mt.gov/content/Committees/Interim/2017-2018/State-Administration-and-Veterans-Affairs/Meetings/Sept-2017/Montana%20Veteran%20Demographics%20\(as%20of%20Jan.%206%202017\).pdf](https://leg.mt.gov/content/Committees/Interim/2017-2018/State-Administration-and-Veterans-Affairs/Meetings/Sept-2017/Montana%20Veteran%20Demographics%20(as%20of%20Jan.%206%202017).pdf)

²⁵ *142,000 Montanans Face Uncertainty of Health Coverage with Threat of ACA Repeal*. (2017, January). Montana Budget & Policy Center. https://montanabudget.org/report/aca_repeal_threat#bodynote%5Bxxxi%5D

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