The Colorado Health Foundation™



Big Numbers and Small Dignities

Five Years of the ACA in Colorado

The numbers have indeed changed in five turbulent years: The totals of uninsured dropping by the millions. Leaping insurance premiums, for now, calming to relatively tame levels. The government's predicted health insurance costs plummeting by the hundreds of billions.

And yet what may have changed most in the five years since the signing of the Affordable Care Act is not the big numbers, but a simple expectation: a sense of how life should feel, expanded from a luckier few to those who have spent much of their lives feeling less than lucky. "It's not trivial," is the way Jandel Allen-Davis, MD, finally puts it, after an hour of reflection. "To proudly show up and say, 'I have coverage.' It's a human dignity issue," says the Kaiser Permanente Colorado vice president for government and external relations. "There's enough toxic shame out there without that. Is the ACA always pretty? No. But are we better off? Absolutely."

That humane expectation – that access to health care is more a right for the many than a privilege for the fortunate – has been embedded in Colorado's collective psyche as much as it has been codified into state and federal law.

It's in the hundreds of thousands of state residents who had no health insurance coverage on December 31, 2013, and now do. It's in the gleaming additions to safety net clinics across the state, expanded to better serve the insured and uninsured alike. It's in the persistent progressive movement to extend coverage to the 500,000 Coloradans still left out after years of reform. It's in the mindset even of politicians who ideologically opposed health reforms but now feel compelled to mend reform's faults before scrapping them altogether. And it's in a health

delivery system come to accept the fact the great majority now walk in with coverage, quickly pivoting to the equally hard questions of cutting the cost and bureaucracy of delivering quality care.

Despite glitches, negative headlines, political acrimony and skepticism about a growing role for government, the main change of recent years is that access to care and coverage for the average citizen is “the new normal,” said Adam Fox, director of strategic engagement at the Colorado Consumer Health Initiative.

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> Jandel Allen-Davis, MD, vice president of government and external relations, Kaiser Permanente of Colorado

Small-business owner Truman Bradley could likely count himself among the “young invincibles” who no one was sure would sign up for ACA coverage. Yet he’s a big fan of the robust, ACA-enhanced Kaiser policy he buys for himself through the Connect for Health Colorado exchange.

“People in their 20s feel immortal, but I’ve seen freaky things happen,” said Bradley. “People are compelled to get the coverage they need now, and that’s perfect. I know the number of uninsured has gone way down, and that’s a really good thing.”

Bradley recalled an emergency room visit, pre-ACA, from a time when he could only afford catastrophic coverage. They treated an eye infection from a backpacking trip with a pain pill, a bottle of saline and a pat on the back – along

with a $900 bill. “That’s the kind of system we had before the ACA,” Bradley said. “I know I was paying for a lot of underinsured and uninsured people. We are a sophisticated society and we should take steps to ensure people have the coverage they need.”

The “new normal” is far from “ideal,” though, and supporters of progressive health coverage and care policies in Colorado face a new set of challenges in coming months to smooth the consumer experience and then attack the core problems of too-high health care costs.

In the fifth year of major changes from a successful health reform push that had eluded U.S. supporters in previous decades, the looming hurdles include:

- Rebuilding the operations, image and funding of the Connect for Health Colorado insurance marketplace into a sustainable and consumer-friendly agency. This includes a long-overdue heavy lean from state leaders on Medicaid and Connect for Health Colorado to align their computers and marketplace operations. It also includes a renewed push for largely ignored Small Business Health Options Program (SHOP) tax credits for providing insurance.
- Redoubling efforts to bring roughly 500,000 Coloradans left out of health insurance coverage – by immigration law, personal choice or lack of information – under the umbrella of a health care policy, or at the least, regular access to care.
- Attacking unnecessary high costs for procedures and drugs, the underlying and persistent health inflation that helped lead to 2010’s ACA passage in the first place. A combination of a state cost control commission, new pushes for consumer transparency, ongoing payment reform efforts and other measures will seek inroads into the complex cost puzzle.
- Absorbing the June U.S. Supreme Court decision confirming the legality of subsidies in the 36 state exchanges run by the federal government. Many

believe the decision cemented the future of the ACA for dozens of states, but opponents of the reforms may regroup and seek other legal strategies to overturn provisions of the law.

- Preserving health reform gains in a future recession – an economic downturn that is as unpredictable as it is inevitable. This hurdle adds a wild card few policymakers want to address. A major recession would put severe pressure on federal contributions to expanded Medicaid and the exchange subsidies, while even Colorado's smaller portion of expansion costs will appear more onerous in the next state budget crisis.
- Addressing waivers to current ACA rules open to states in 2017. There is growing Colorado sentiment to fashion alternatives to various regulations that would better fit needs in the Rocky Mountain state. The state could seek changes to minimum benefit mandates that make some individual policies unaffordable, alter how Medicaid is run or change the structure of the exchange marketplace.

As has always been the case in health reform, every knowledgeable actor has his own favorite part in need of rewriting.

"The cost question still seems so insurmountable," said Tammy Niederman, a leader in the Colorado broker community who has supported the state marketplace while working to preserve access to private insurance. "One of the biggest challenges with the ACA is that it did not address the cost of care. It did not address why it's not affordable for a majority of middle-class Americans. So you attack one smaller thing at a time."

"The Supreme Court decision is a very big piece of it," said state Rep. Lois Landgraf, a Republican representing Fountain and other areas south of Colorado Springs. "How much do you put into any of this when it could all go away? I know there's a push to end the exchange; what I'd like to see is if we can look into these waivers. How could we do this better?"

This edition of *Health Elevations* explores not just five years of Colorado changes since the 2010 signing of the ACA, but goes deeper into the past of previous state-sponsored reforms and further into the future of pending challenges. Is Colorado better off in the five years since diving into the changes made possible by the ACA? Can the state improve on the ACA and guarantee its future? Was the ACA a start at making health care make sense in the U.S. or only a false start? And can the dream of near-universal care survive the inevitable roller coaster of the broader economy?

In other articles in this edition, we take a close look at individual pieces of the health care and policy community since the ACA:

Are Colorado hospitals meeting their required community benefit spending? How has Denver Health transformed in a city that now has near-universal health coverage? Can rural hospitals hang on with help from the ACA or are too many still threatened? How has a doctor's practice changed under the ACA revolution? And what has happened to the private insurance market, public advocacy groups and other key players in the last five years?

First, a quick trip in the time machine to 2008 and 2009, when the national atmosphere over health insurance and health care was bitter, tumultuous and all-consuming. Presidential candidates staked their fortunes on passing or blocking the first major federal reform since Medicare in the 1960s. Congressional hearings spotlighted sick patients cruelly canceled by allegedly greedy insurers (the word "rescission" quickly became part of the political and social lexicon); Americans stuck in the turbulent individual insurance market grew used to premium hikes of 40 percent or more.

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"We had a big ol' target on our chests," said Allen-Davis, referring to Kaiser and other high-profile insurance companies. "Some of those practices need to change." The Commonwealth Fund said in 2009 that 36 percent of those who tried to buy individual insurance plans faced some form of discrimination because of a pre-existing condition.

Colorado was ahead of some reforms, having long before added protections in the small group market such as guaranteed issue and "business groups of 1" to help small-business owners. A state tobacco tax in 2004 expanded Medicaid coverage, and the hospital provider fee in 2009 further expanded eligibility while shoring up state Medicaid's long-term financing. Commissions and legislation from the Gov. Bill Ritter administration forward pushed advocacy, business and political interests together to craft bipartisan health solutions.

Yet, reflecting the problem of the uninsured in the rest of the U.S., 800,000 to 900,000 Coloradans – out of a population of about 5 million – were without insurance coverage and had limited access to health care. That mix included adults between jobs who didn't qualify for Medicaid, workers whose employers didn't provide coverage, undocumented immigrants barred from state benefits and those

who might afford insurance who simply declined to buy it. The health system shifted costs for that group to employer-based insurance and anyone else who could pay; state residents avoided necessary care because they couldn't afford it; premiums jumped to the double digits, and federal Medicare costs for the growing elderly population soared. Health costs rose to 17 percent of the U.S. gross domestic product and threatened to consume an ever-higher portion of public resources.

Enter the ACA, signed into law in March of 2010. The major provisions include:

- No lifetime limits on many insurance benefits, an end to "rescission," coverage for kids on private insurance up to age 26 and free preventive care, beginning in the fall of 2010.
- Planning grants for states wanting to set up their own insurance marketplaces to channel subsidies and increase private competition for individual plans, beginning in 2011.
- Launching of the state exchanges in fall of 2013, with coverage to begin in 2014.
- Expansion of Medicaid to cover all people with incomes up to 133 percent of the federal poverty level, with coverage beginning in 2014. "I find all the discussions of the exchanges to be ironic," said Adam Atherly, a professor and health care policy expert at the University of Colorado Denver's School of Public Policy. "The core of the ACA is a major expansion of Medicaid, and that seems to be the state secret."
- A mandate that all individuals who can afford it buy insurance coverage in exchange for a mandate that insurance companies issue policies even to those with pre-existing medical conditions, beginning in 2014.
- A pool of federal funds to promote experimentation in health cost and health delivery, including support for the Colorado HealthOP insurance plan, shared savings deals with Medicare providers, grants for electronic health records

and integration of mental health care.
- Multimillion-dollar federal grants to safety net and community health clinics to better serve the expanded Medicaid population, and to improve sliding-scale payment care to those still left uninsured after the ACA implementation. Clinica Family Health Services, for example, got $3.8 million to expand in Thornton, while Metro Care Provider Network got $10.2 million to replace its Jefferson County family health center. (Both clinics also received private grants from the Colorado Health Foundation to aid the expansions.)

Bottom Line for Change

And what has been the net effect of the ACA for Coloradans in the past five years?

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> Lorez Meinhold, former top health advisor to Gov. John Hickenlooper

For those who favored health care reforms to help the uninsured, the most important number is the total of new Medicaid expansion clients and individuals who bought insurance through Connect for Health Colorado who did not previously have policies. The state Department of Health Care Policy and Financing, which runs Medicaid with state and federal funds, estimates more than 352,000 of its current 1.2 million clients were newly eligible in the January 1, 2014, expansion. Though Connect for Health Colorado has not done its own

survey, national surveys would indicate that about 37 percent of the 140,000 exchange customers did not previously have insurance.

Lisa Marie Meyer of Westminster is among the many Coloradans who feel the extension of health coverage and care to the greater public has been a life-saving umbrella.

Meyer, 47, was scraping out a living delivering flowers to shops at hospitals and other institutions when imaging recommended by a chiropractor revealed large shadows of tumor-like masses in her midsection. She'd never had insurance coverage, not even as a child. University of Colorado Health helped her sign up for Colorado's indigent care program, but using those minimal benefits for expensive surgeries is often a battle.

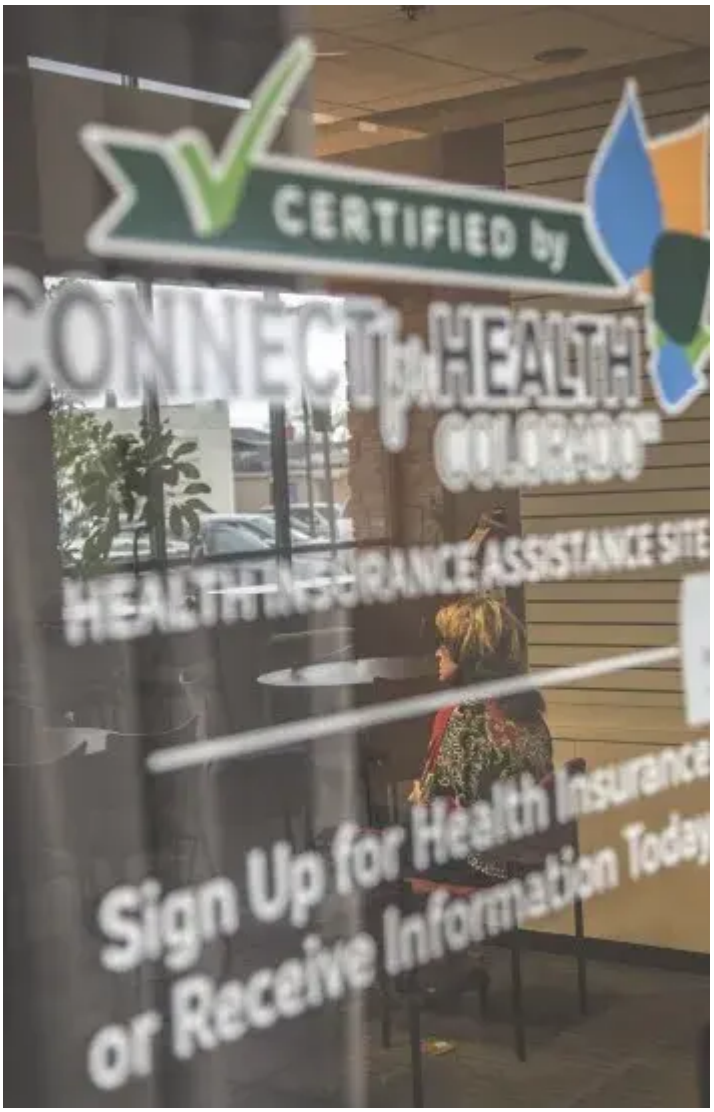
Clinica, and in particular a nurse practitioner named Ruth Garcia, finally walked Meyer through the process of signing up for expanded Medicaid. Surgery removed growths that were massive but benign; Garcia and pharmacists helped her find the right medication for lifelong migraines; Clinica handed her to in-house counseling and group therapy for a difficult divorce and other issues.

"I am living proof" about the reach of the ACA, Meyer said. "I absolutely could have died. When I didn't have insurance, it was a constant fear. Now I don't have to look over my shoulder for that giant shadow."

Nationally, a RAND Corp. study released in May reported a net gain of 17 million health insurance consumers since 2013, in line with other estimates. Gallup polls in recent months have indicated the Colorado rate of uninsured had dropped from 17 percent to 11.2 percent by 2014; some state health leaders believe that with continuing Medicaid sign-ups, the rate might be closer to 10 percent.

On the big marks, including signing up 300,000 new Coloradans for coverage and care, reversing the cost shift, supporting community hospitals, and promoting

innovative care models, the ACA scores well, said Joe Sammen, executive director of the Colorado Coalition for the Medically Underserved. “The ACA has really changed the culture of how we cover health care and deliver it in this country,” he said.



Local outreach centers have been key to lowering the uninsured rate.

The exchange marketplace has landed sign-ups within its early range of predictions, but has been severely undercut by computer glitches that leave thousands waiting for answers and by high costs of call centers sorting out problems with the Medicaid/exchange interface. Heavy turnover of top personnel, infighting on the exchange board and a failure to cooperate fully and early with Medicaid further damaged the operation and the image.

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“Both sides need to come together more than they have. The blame game has got to stop,” said Lorez Meinhold, the former top health care advisor to Gov. John Hickenlooper and a key architect of early adoptions of the ACA format in Colorado. Meinhold is now a health expert with Keystone Policy Center in Denver. “Now we need to learn from other states” that have worked together more seamlessly, including Kentucky, Meinhold said. The Washington Post in early May estimated nearly half of the 17 local exchanges in states and the District of Columbia were struggling financially, many reporting the same technology problems and lack of long-term operational financing troubling Colorado.

One of Colorado’s unique and most visible ACA crises was the soaring rates of exchange premiums in the mountain resort counties, an exaggeration of a long-standing cost differential for remote-yet-popular locations. A benchmark silver-level plan on the exchange for Summit County, packed with ski resort workers needing coverage, shot to $484 a month. The state Division of Insurance responded with a widening of the geographic rating system, spreading the risk among a larger population, and the next year’s silver plan for Summit dropped to $266. Mountain counties are likely to enjoy even more price competition starting in January of 2016, when Kaiser, often one of the lower-priced plans because of its HMO network control, opens offices in Summit and Eagle counties.

Supporters of the ACA and some independent analysts say the main goal of health reform has been achieved.

“The Affordable Care Act has greatly expanded health insurance coverage, but it has caused little change in the way most previously covered Americans are getting health insurance coverage,” said economist Katherine Carman, the lead author of the RAND study who was quoted in The Hill.

Critics of the ACA said its various mandates might ruin health insurance for the majority of working Americans who get private insurance through their employer by raising costs and encouraging business to dump employees into the exchanges. But Colorado’s private insurance rates have reported lower annual increases in recent years than in the worst years of the early and mid-2000s, when double-digit hikes were the norm.

A recent estimate by the Congressional Budget Office lowered the net federal cost of implementing the ACA by $142 billion for the years 2016 to 2026. Federal costs will be 29 percent lower from 2015 to 2019 than originally projected in 2010, according to the Commonwealth Fund report.

Still, for those looking at a bigger picture than signing up the uninsured, the overall evaluation of the ACA still ranks as “to be determined.”

“We don’t have enough information to know if it’s benefiting society overall,” said Bill Lindsay, president of the benefits group at Lockton Companies, a consultant for employers who also led the Blue Ribbon Commission recommending Colorado health reforms under the Ritter administration. “The benefits are primarily the insurance reform that’s taken place. It was necessary and very important to people. Now if you need insurance, you can get it. The rest of the changes – the expanded Medicaid population, the consolidation of the hospitals, the doctors being purchased by hospitals, all those changes that are occurring in the delivery system – the question is what is the value of that? That’s still an open question.”

And those who remain opposed to the ACA's expansion of government responsibility, especially the mandate to buy coverage, want to hear more about the ACA's negative impacts on middle-class insurance buyers. Those individuals are required to buy coverage for minimum benefits they may never use, have seen their provider networks narrowed after thinking they could keep their doctors and pay sky-high deductibles before their insurance ever kicks in, critics said.

> I've seen the difference. I feel like [health care] access for my community is better.
>
> Lorena Osorio, neighborhood activist

"The constituents I hear from are those who had insurance and now pay twice as much as they used to pay," said Landgraf, the legislator. "They attribute that to the ACA, as do I. A person who wants basic coverage can no longer get just a basic coverage plan."

The widely varying assessments of the ACA put a spotlight on one of the act's most progressive constructs – the idea that much of the reform's impact would be felt soonest by underserved communities whose gains might be subsidized by the nation as a whole. That fact was not always the chosen political message, even among supporters. But its power is felt in places not prominent on cable news.

"I've seen the difference," said Lorena Osorio, a neighborhood activist in largely Hispanic and modest-income ZIP codes in Westminster and south Adams County. The local safety net clinics have built additions, hired bilingual providers and staff, reduced their sliding-scale prices for the uninsured and added integrated care like nutrition classes and mental health, Osorio said through an interpreter. They can take more patients, and they do.

“I feel like access for my community is better,” she said.

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