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ACA AT TEN YEARS

Unfinished Business

Where Colorado Stands on the Goals of the Affordable Care Act 10 Years Later

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Sen. Ted Kennedy once called health insurance "the great unfinished business" of the United States.

These words stand as a reminder that it's been a long journey to solve the many health care issues Americans face — and that the journey continues today.

In 2010, Congress passed the Patient Protection and Affordable Care Act, often called the ACA or "Obamacare." This ambitious legislation brought the largest change to the American health care system since the introduction of Medicare and Medicaid in 1965.

On the 10th anniversary of the ACA's passage on March 23, the Colorado Health Institute (CHI) is examining what has been accomplished over the past decade and what work remains to realize the goals of the ACA, including increasing insurance coverage.

This report looks at 10 research questions related to the ACA — one for each year. Five main objectives of the law will guide this analysis: expanding coverage, reducing costs, emphasizing prevention, increasing consumer protections, and fostering innovation. In addition to impacts resulting specifically from the ACA, these analyses will include relevant policy changes in Colorado intended to move the state closer to the ACA's goals.

While Colorado has taken many steps forward, it's clear that there is unfinished business in achieving aims that were set back in 2010.

PART 1

Colorado's Remaining Uninsured

Major provisions of the ACA that went into effect in 2014 drastically increased the number of people with health care coverage in Colorado.

These include the expansion of Medicaid to nearly all Coloradans with incomes at or below 138 percent of the Federal Poverty Level (FPL) and offering subsidies for people with incomes between 139 and 400 percent of FPL who buy their insurance on the state's individual marketplace. CHI's Colorado Health Access Survey (CHAS) found that between 2013 and 2015, the state's uninsured rate dropped from 14.3 percent to 6.7 percent, leveling off at around 6.5 percent, where it remained as of 2019.

Despite these gains, an uninsured rate of 6.5 percent means that roughly 361,000 Coloradans still go without coverage. People without insurance have less access to care, receive lower quality care, and have worse overall health outcomes than those with health insurance.[1]

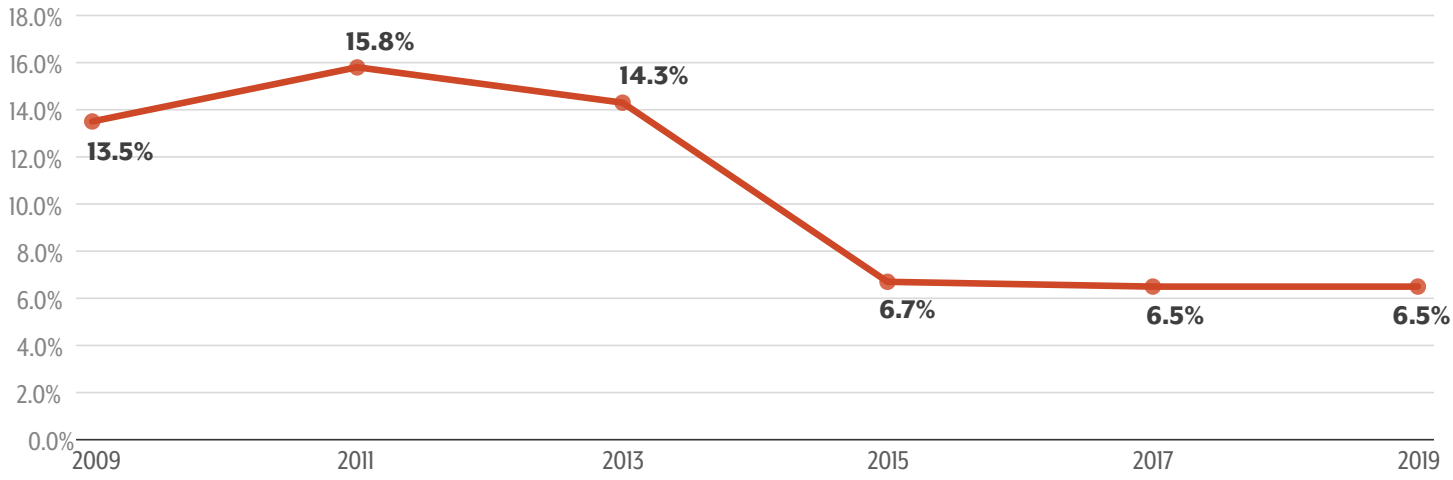
In this first chapter analyzing the impact of the ACA, CHI profiles the remaining uninsured.

The uninsured in Colorado are disproportionately likely to identify as Hispanic or Latinx. Hispanic or Latinx Coloradans account for a fifth of the state's overall population, but nearly a third of the uninsured population. This longstanding disparity is due to a mix of socioeconomic and historic factors, including the impact of regulations like the public charge, which may discourage families of immigrants from enrolling in public programs.[2,3]

Disparities by age persist as well. Coloradans ages 19 to 64 make up slightly more than 60 percent of the state's population, but account for 84 percent of the uninsured. Coverage expansion efforts have historically focused on children and older adults: The vast majority of adults 65 and older are enrolled in Medicare, while children in households making up to 260 percent FPL are eligible for Colorado's Medicaid or Child Health Plan Plus (CHP+) programs. Older adults and children may be the focus of policy attention because they are perceived as more vulnerable, leaving Coloradans ages 19 to 64 more likely to go without coverage.

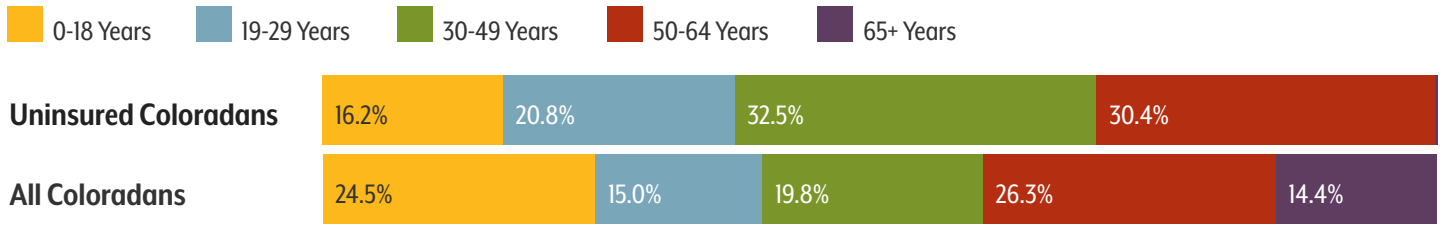
Most uninsured Coloradans are eligible to enroll in existing public coverage options or take advantage of subsidy options in the individual market. More than a quarter (27 percent) of the uninsured have incomes that qualify them for Medicaid or CHP+. Reasons these Coloradans remain uninsured may include a lack of knowledge about the programs or the personal choice not to enroll, perhaps because of beliefs about public programs. Subsidies for individual market coverage are available to another 28 percent of the uninsured, but this financial assistance may not be enough to cover the real costs of insurance premiums.

Colorado Uninsured Rate, 2009-2019

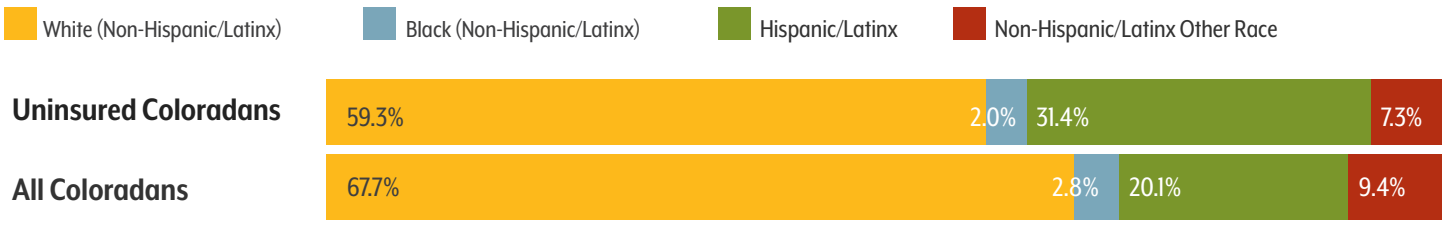


Source: 2019 Colorado Health Access Survey

Uninsured by Age, 2019



Uninsured by Citizenship Race/Ethnicity, 2019



Uninsured by Citizenship, 2019

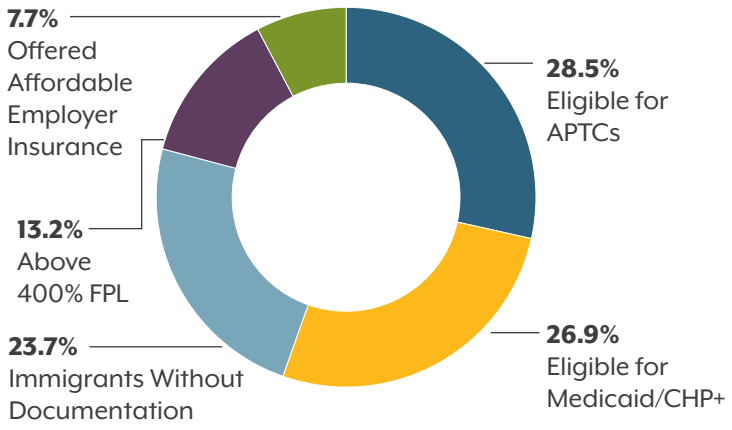
Source: 2019 Colorado Health Access Survey

Nearly a quarter (24 percent) of the uninsured are immigrants without documentation—a status that currently disqualifies them from Medicaid or CHP+ coverage and private insurance subsidies. The remaining 21 percent are offered an affordable insurance plan through their employer (one that costs less than 9.7 percent of their annual household income) but choose not to enroll in it, or do not qualify for subsidies because they make more than 400 percent of FPL.[4] Recent efforts in Colorado like House Bill 18-1205, which would have provided subsidies to those earning between 400 and 500 percent of FPL, have failed.

But while Colorado's uninsured rate has remained stubbornly static since 2015, the state legislature is gearing up to debate initiatives like reinsurance and the public option in the 2020 legislative session, ensuring that the goal of expanding access to insurance will remain on the policy agenda.

Ideally, all Coloradans would be insured and have access to the medical care they need. As it stands, covering the remaining uninsured will be no small feat. Ten years after the ACA's passage, bringing health coverage to more Coloradans will require understanding and addressing the unique reasons different Coloradans and communities are uninsured.

Profiling the Uninsured in Colorado, 2017



Source: Colorado's Eligible But Not Enrolled, 2018

PART 2

Medicaid Expansion in Colorado

The historic drop in Colorado's uninsured rate may stand as one of the biggest success stories from the ACA in the state.

This decrease was due in large part to Colorado's decision to expand Medicaid in 2013.

The expansion of Medicaid means more people are able to access affordable health insurance when they need it most. In 2019, more than 380,000 of the 1.3 million Coloradans who were enrolled in Medicaid were covered because of expansion.[5] This accounts for the entire decline in the uninsured population seen between 2013 and 2015, according to the Colorado Health Access Survey (CHAS).

Before the ACA took effect, Medicaid in Colorado covered parents with incomes up to 60 percent of the federal poverty level (FPL) and children in households with incomes up to 147 percent. As part of the ACA, the federal government provided financial incentives for states to expand Medicaid coverage to nearly all adults with incomes up to 138 percent of the FPL (about $17,608 annually for a single person or $36,156 for a family of four), including those without children. Colorado opted to expand Medicaid in 2013, making it one of 37 states that have expanded the program as of early 2020.[6,7]

The newly eligible under Medicaid expansion weren't the only ones who got covered. Some people also enrolled as a result of a phenomenon known as the "welcome mat" effect. These Coloradans would have been eligible for Medicaid under pre-expansion guidelines but enrolled afterword due to the greater awareness provided through expansion and the media coverage surrounding it. In 2015, the Colorado Department of Health Care Policy and Financing (HCPF) estimated that 13 percent of new Medicaid enrollees joined not because of expansion, but due to this "welcome mat" effect.[8] In 2020, about 55,000 residents have coverage due to the "welcome mat."

Altogether, about 8 percent of Colorado's residents are covered either because of Medicaid expansion or the "welcome mat."

Despite these substantial gains, in 2019, 361,000 Coloradans were still uninsured.[9] CHI estimates that a quarter of these people (24.3 percent) are eligible for Medicaid. Increasing Medicaid outreach and education and simplifying the enrollment process could increase enrollment among this group. A bill expected in Colorado's 2020 legislative session would use the tax filing process to identify eligibility and streamline enrollment for Medicaid and other forms of public insurance.

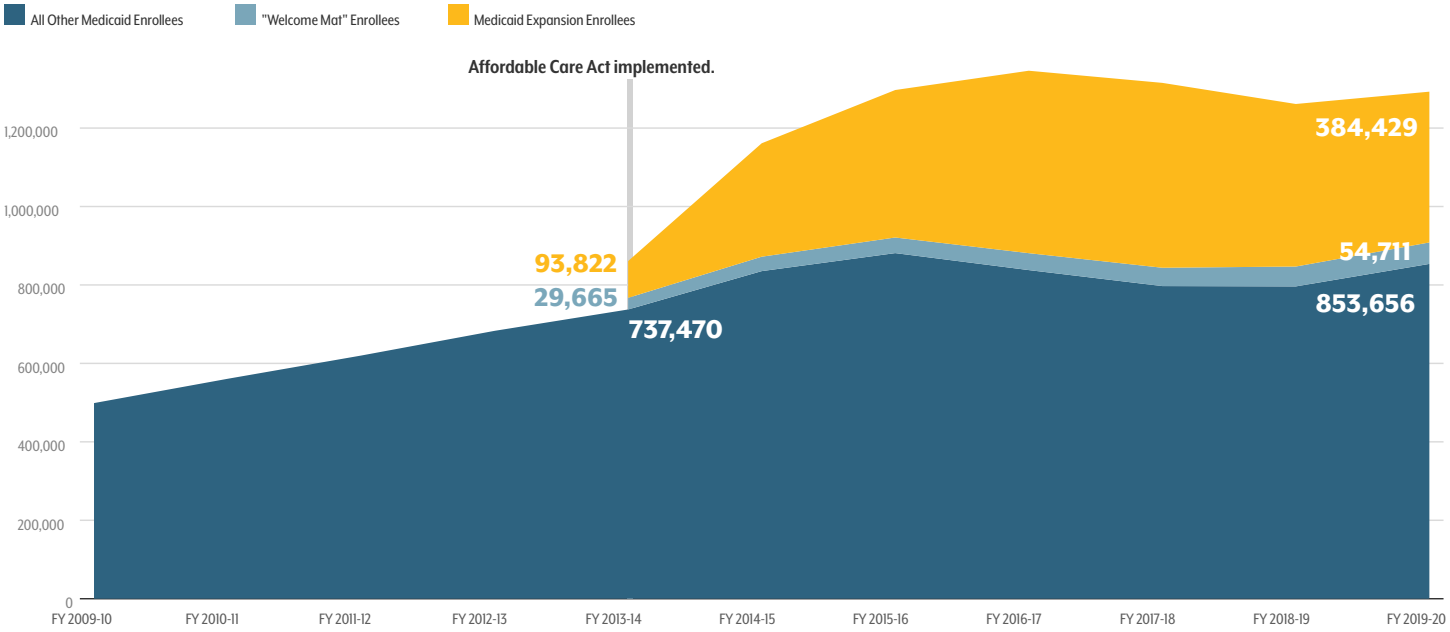
Some low-income Coloradans aren't eligible for Medicaid. For instance, one in four uninsured Coloradans (24.6 percent) is an immigrant without documentation.[10] This group is currently ineligible for Medicaid except for emergency coverage, which provides support for the most severe medical emergencies.[11]

At the same time, Colorado is now seeing a drop in Medicaid enrollment that began in 2017. Medicaid covers 50,000 fewer Coloradans in 2020 than in 2016. In a recent brief, the Colorado Center on Law & Policy (CCLP) described six possible reasons for this decline. These include promising trends, such as increased employment due to an improving economy.[12] But they also include concerning factors ranging from issues with HCPF's income verification policy to anti-immigrant sentiment and policies such as the

Medicaid Expansion Covers Many Who Were Formerly Uninsured

Source: 2019 Colorado Health Access Survey

Medicaid Expansion Led to Coverage Gains



Source: CHI Analysis of Data from the Colorado Department of Health Care Policy & Financing

"public charge" rule, which can dissuade residents from enrolling in government insurance, regardless of eligibility or need.

In the decade since the ACA was passed, Colorado has made historic gains in Medicaid coverage and seen significant reductions in the number of Coloradans without insurance. But challenges remain: Not everyone is able to be covered, not everyone who is eligible for Medicaid is covered, and more recent declines in enrollment point to a need for continued attention to the factors that affect Coloradans' access to this public program.

Next, we turn our attention to enrollment changes in the individual market, where state legislators have placed much of their effort, including reinsurance and the proposed public option.

PART 3

The Individual Market

The ACA aimed to reform the individual health insurance market by increasing enrollment and ensuring more comprehensive coverage.

In Colorado, those goals have only been partially met. In 2020, all individual market plans meet new quality standards, but enrollment remains unchanged from its pre-ACA levels.

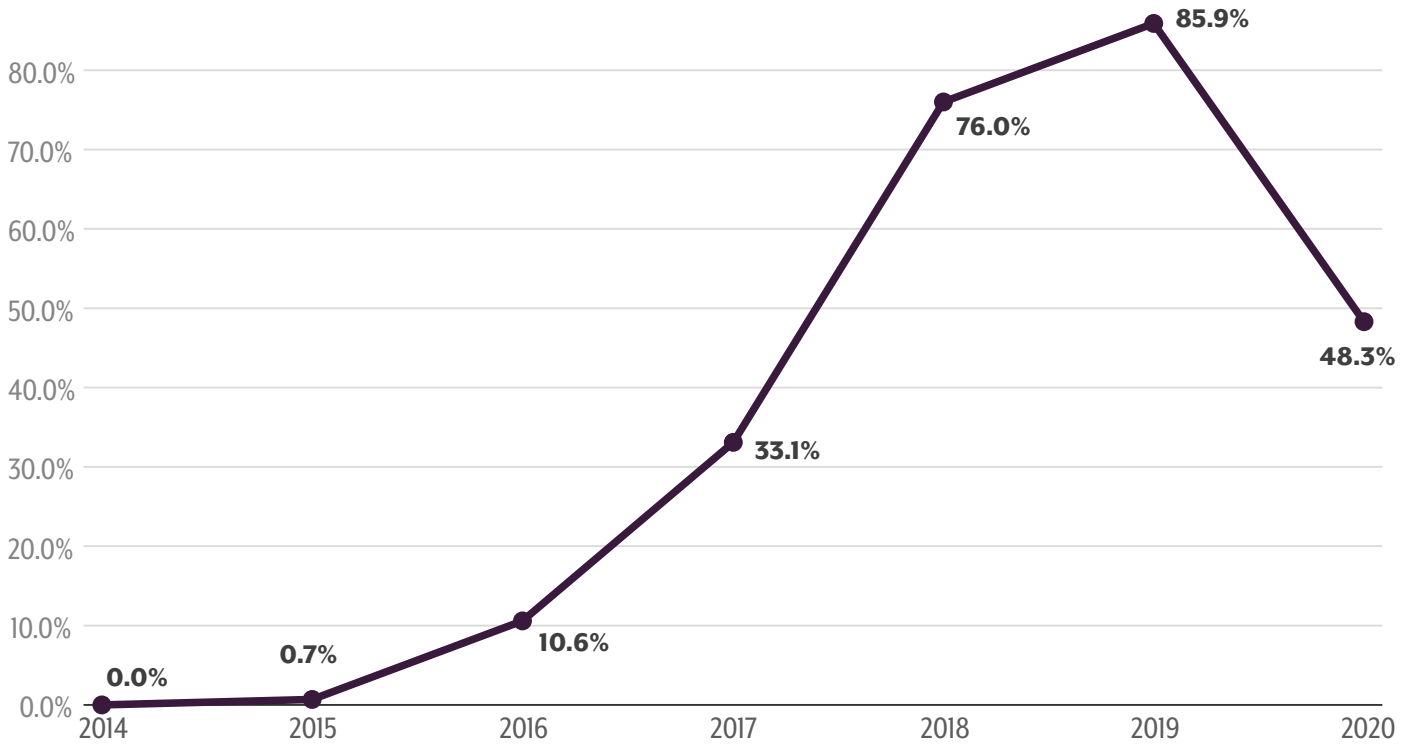
The ACA instituted consumer protections intended to ensure access to quality health insurance. These include coverage for essential health benefits, bans on lifetime limits to the amount insurance plans would spend on a given person, and protections for people with preexisting conditions. These requirements were designed to ensure that insurance plans were accessible for more people and that the plans people purchased covered their real health needs. Protections for preexisting conditions shield the one in four adults (27 percent) under age 65 who would have been ineligible for many insurance plans due to a preexisting condition prior to the ACA.[13]

One of the most visible features of the ACA was the establishment of health insurance marketplaces for each state. These offer a single place for consumers to shop for and purchase health coverage. Colorado's marketplace, Connect for Health Colorado, enrolled 170,000 people in 2019.[14] Colorado is one of 12 states — plus the District of Columbia—to operate its own online marketplace. The rest use the federal website, healthcare.gov.

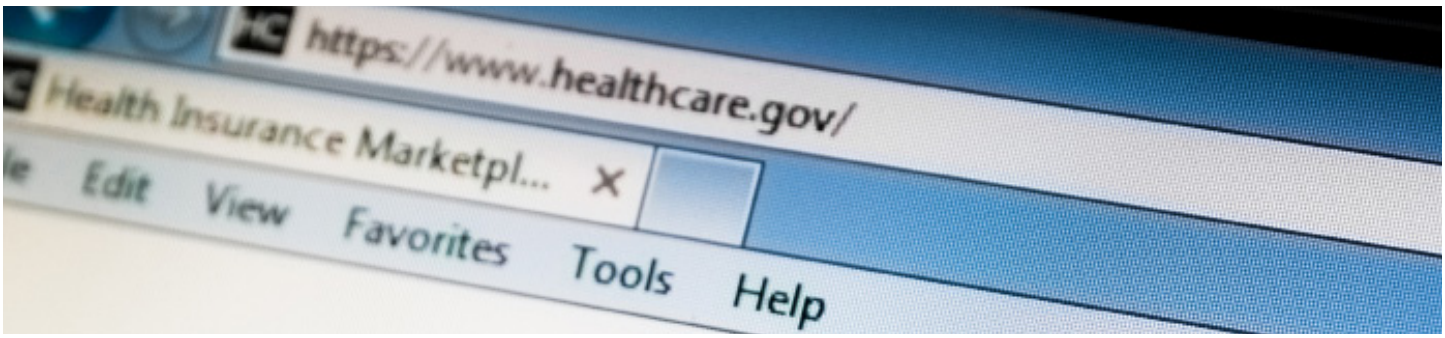
But more comprehensive plans, simplified enrollment, and locally driven marketing have not been enough to increase individual market enrollment in Colorado.

The percentage of Coloradans enrolled in the individual market has remained 7 to 8 percent since 2009, according to the Colorado Health Access Survey.

Cumulative Percentage Increase in Individual Market Premiums Since 2014



Source: CHI Analysis of Division of Insurance data



By comparison, enrollment in the individual market grew by more than 50 percent nationally after the ACA went into effect.[15] It's unclear why Colorado's experience differs, but the high cost of insurance in the state may be to blame.

Creating an Affordable Market

The ACA created Advance Premium Tax Credits (APTCs) to reduce monthly premiums and make individual market insurance plans more affordable. APTCs are available to Coloradans with incomes between 138 and 400 percent of the federal poverty level (FPL) —$25,750 to $103,000 for a family of four in 2020.[16] But subsidies operate on a sliding scale and only take effect after higher-earning Coloradans have spent just under 10 percent of their income on premiums. For many families, that means insurance is a major expense even with subsidies.

And prices have increased over time: Prices in 2019 were nearly double relative to 2014. Approved rates in 2020 brought the first decrease to the individual market post-ACA, but premiums are still up by nearly 50 percent. Individual market enrollees who receive tax credits are largely unaffected by these increases, but those without subsidies remain unprotected. These Coloradans have been the focus of a variety of bills aimed at reducing costs on the individual market.

These high costs are just one reason the individual market remains an area of focus for Colorado policymakers, even though it covers fewer than one in eight residents. The individual market is one of the few insurance markets that the state can directly control. The state Division of Insurance also regulates the small group market and some large employer policies, although most large business policies are exempt from state regulation.

One idea on the table in Colorado in 2020 is the public option. This would require carriers to offer a state-designed plan on the individual market. Hospitals and providers would be required to accept both this insurance and the reimbursements set and paid by the state through the public option. Studies estimate that this plan could lower premiums by an average of 10 percent, with even greater reductions in high-cost areas like the Western Slope.

Colorado is also moving forward with reinsurance, an approach to cost reduction approved during the 2019 legislative session. Through reinsurance, the state "insures" insurers by covering their most expensive bills. Reinsurance reduced individual market premiums by an average of 20 percent in 2020.[17] While some Coloradans will see their premiums decrease, others — including low-income enrollees on the Front Range — might see a small increase because reinsurance drove down the size of APTCs, causing them to pay more overall.

The public option and reinsurance both focus on lowering individual market costs, but their approaches differ. A public option could save money in the health care system, but it comes with more government involvement and oversight in setting provider prices. Reinsurance doesn't require more government control, but lower premiums are accomplished not by reducing actual costs, but by shifting costs from individual market enrollees to the state budget and, to a lesser extent, hospitals.

The ACA's changes to the individual market were meant to modernize coverage and provide affordable and comprehensive options for those without access to other sources of insurance. Today, Coloradans on the individual market have more comprehensive coverage than they did prior to the ACA, but high costs in this market have prohibited more from enrolling. Addressing those costs continues to be a work in progress for the state's policymakers.

PART 4

Employer-Sponsored Insurance

While the ACA may be best known for expanding Medicaid coverage and remaking the individual market, the law also changed requirements for employers who offer health insurance to employees.

Just over half of Coloradans, nearly 3 million residents, received health insurance coverage from their employer in 2019, according to the Colorado Health Access Survey. The ACA changed the rules for employers that insure this group, encouraging them to offer insurance to more employees and changing the types of plans they could offer.

The ACA aimed to maintain — and even expand — access to affordable, quality employer-sponsored insurance (ESI). Consumer protections were added as part of the ACA such as capping out-of-pocket costs and requiring coverage for essential health benefits. The ACA also employed a mix of incentives and penalties for large and small employers. Large employers (those with staff sizes of 50 or more) are required to offer affordable health insurance or face a steep penalty. Small employers are excluded from this mandate but receive tax incentives to offer coverage.

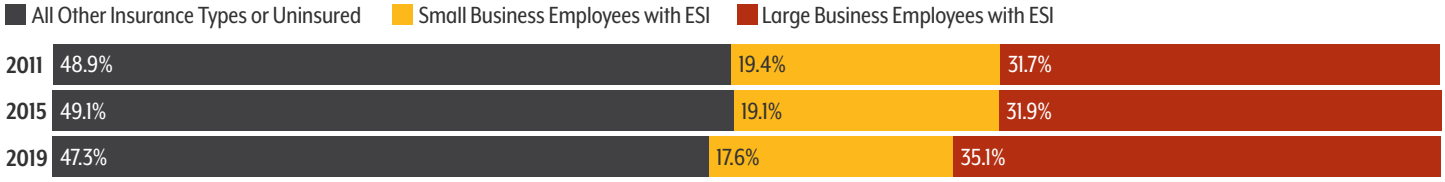
The stick has proven to be slightly more effective than the carrot in Colorado. The vast majority of large employers (94.1 percent) offered health insurance to their employees in 2018.[18] This is a slight increase from the 92.5 percent that were offering health insurance to their employees in 2013, before the law was passed.[19] And while the increase for large group employers was small, the ACA helped make coverage more affordable for these workers. Employers that fail to meet affordability standards can be charged $2,000 per employee per year.[20] The requirement and penalties are a major reason Colorado's large group employer-sponsored coverage market has grown since 2011.

By contrast, just 27.6 percent of Colorado's small businesses — which make up more than three in four businesses in Colorado — offer insurance coverage.[21,22] Fewer small businesses in 2018 are offering their employees coverage than in 2013 when nearly one in three small businesses, 30.7 percent, were offering coverage.[23] The high cost of offering health insurance is not always offset by the ACA's tax incentives. Businesses that can't afford to offer coverage often send their employees to the individual market for more affordable plans. High costs to employers and the few employees who are offered and enroll in small business ESI helps explain why this figure has been decreasing over time.

But even among employees who are offered workplace coverage, gaps remain in the employer-sponsored market.

One example, known as the "family glitch," can put employees in a tough spot where neither employer coverage nor the individual market offers an affordable option for their families. This happens when a working family member is offered

Small and Large Business Employees With Employer-Sponsored Insurance* (ESI)



** Employer size does not always capture the true source of insurance. There may be cases where an employee is covered by an employer of a different size e.g. spousal coverage*

Source: 2019 Colorado Health Access Survey

employer-sponsored coverage that is defined as affordable for that individual employee — costing less than 9.78 percent of household income — but the cost of covering dependents on the plan is higher. Having access to a plan that technically meets the affordability threshold but does not offer affordable coverage for all family members makes that family ineligible for subsidies on the individual market. The result can be steep monthly premiums and no financial aid.

A federal law passed in 1974 also limits the impact of the ACA on employer-sponsored plans: the Employee Retirement Income Security Act, or ERISA. ERISA, which places self-funded employer plans under a different set of federal rules, regulated 61 percent of all employer-sponsored plans in 2019.[24]

ERISA plans are excluded from many protections required by the ACA, such as offering coverage for all essential health benefits and meeting affordability standards. Oversight from ERISA has hampered the ACA's efforts to increase employee access to affordable and comprehensive plans. ERISA survived attempts to enforce compliance with ACA reform through two Supreme Court challenges. The interaction between ERISA and ACA regulations paints a complex picture of what happens when multiple federal insurance reform efforts collide. Future reform efforts targeting the private health insurance market will have to involve serious consideration about navigating ERISA regulations, unless policymakers push to remove them entirely.

PART 5

Emphasizing Prevention

The first four parts of this report looked at historic gains in access to insurance coverage. The idea that underlies that goal – and all health policy – is to create conditions that help people be healthier.

Health insurance alone is not enough to improve health outcomes, but it does play a crucial role in helping people access providers and treat conditions before they become complex and costly. Under the ACA, health insurance must cover certain preventive health services, such as blood pressure screenings or vaccinations, at no cost to patients. These services are proven to promote health and save lives.

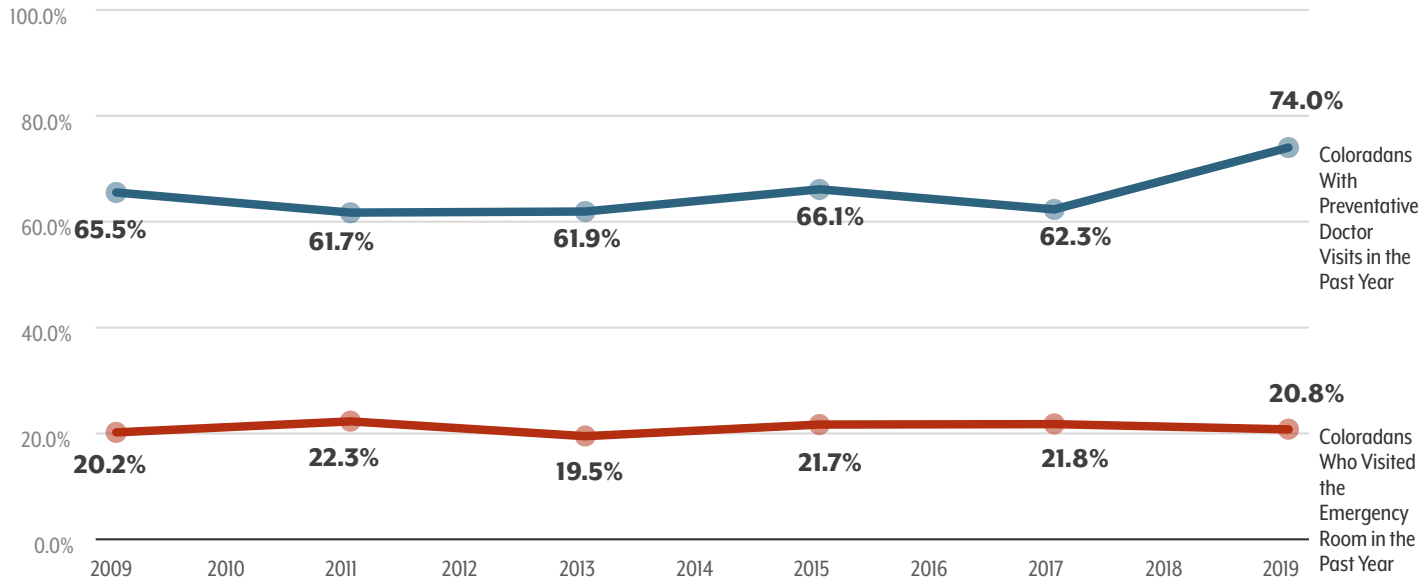
But are Coloradans healthier today than they were 10 years ago, before the ACA established these requirements?

In some ways, Colorado is on the right track. Preventive care visits are at an all-time high. Nearly three out of four Coloradans (74.0 percent) had a preventive visit with their general doctor in the past year, according to the 2019 Colorado Health Access Survey (CHAS). This is up from 65.5 percent in 2009, before coverage provisions of the ACA took effect.[25] The increase from 2009 means that each year, over 650,000 more Coloradans are accessing care and more effectively managing their health outcomes.

It's often thought that effective preventive care decreases visits to the emergency room, which can be costly and are often not the best way to address non-emergency issues, like symptoms from the common cold. This isn't always the case. Despite increasing use of preventive care, the percentage of Coloradans who used the emergency room in the past year has not budged over the last decade. Additionally, Coloradans who had a preventive visit in the past year are more, not less, likely to have also

Mixed Messages in Prevention: Despite Encouraging Upward Climb for Preventive Visits, Emergency Room Use Also Grew

Coloradans With Preventive Doctor Visit and One Emergency Room Visit in the Past Year



Source: 2019 Colorado Health Access Survey

used the emergency room than those who went without preventive care (22.0 percent compared to 14.4 percent).[26]

For the consumer, both cost and convenience play a major role in deciding to go to the emergency room. Since more Coloradans now have health insurance, emergency room visits may be more affordable for many people — and this may be one of the factors that is sustaining utilization over time.

Prevention advocates often highlight the financial savings this upstream approach can bring the health system, but evidence of overall savings is mixed.[27] However, effective preventive care can lead to better health outcomes and better quality of life — improvements that don't carry a price tag. That's why policymakers prioritize prevention in the first place. Future arguments for increased investment in preventive care by policymakers and providers should be rooted in improving health outcomes, not only the potential for cost savings alone.

Ten years after the ACA, Colorado policymakers are still focusing on preserving and expanding access to preventive care through policy. In 2020, lawmakers introduced Senate Bill 156, which would formally record the ACA's preventive services into Colorado law and add services, such as screenings for sexually transmitted infections, to the list of benefits Colorado insurers must cover at no cost for patients. Colorado's efforts are in contrast to Trump administration's attempts to roll back the ACA's preventive care requirements for insurers, such as expanding access to short-term insurance or "skinny" plans that do not have to cover essential health benefits as ACA plans do.

PART 6

Consumer Protections

The ACA set out to protect consumers from high health care costs, which often led to stress, skipped care, or even financial ruin.

The law's protections have resulted in significant improvements in cost and coverage for many Coloradans, including a dramatic drop in medical bankruptcies. But the cost of health care is still a challenge — in many cases, an unpredictable one — for many consumers.

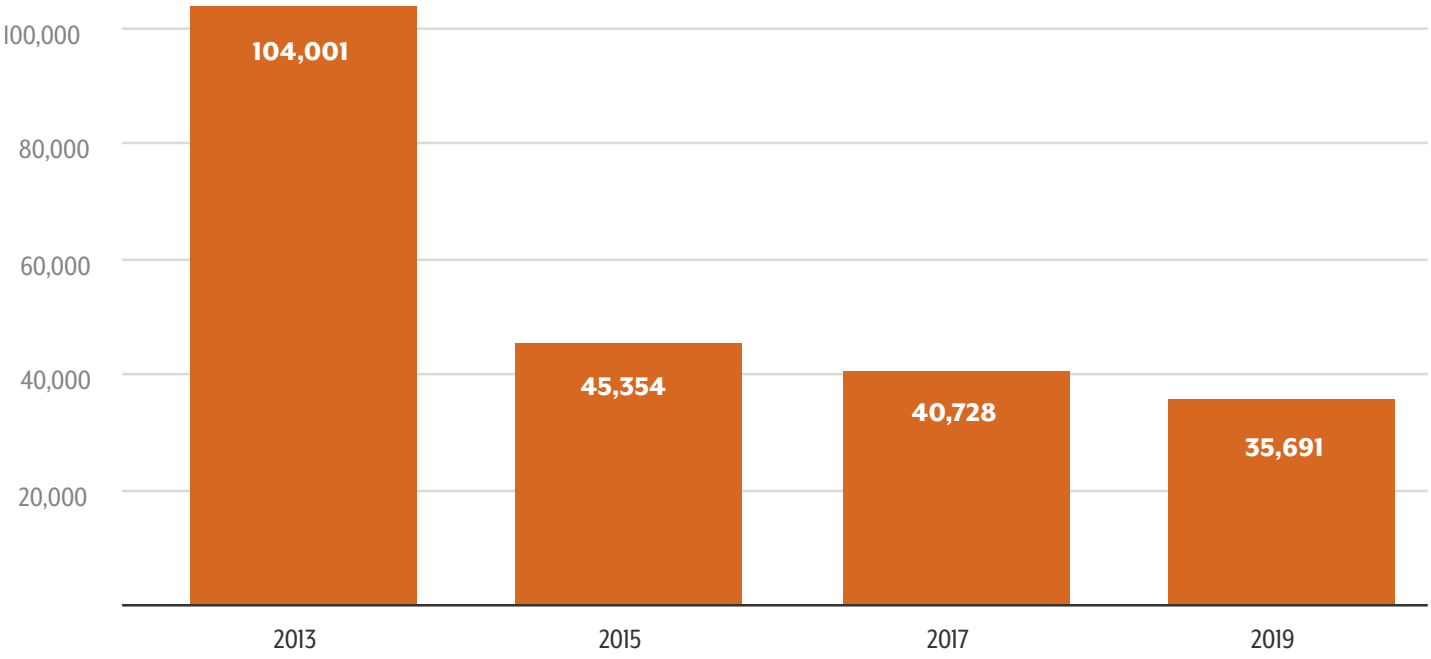
The ACA's consumer protections guaranteed the availability of health insurance coverage to people who were previously denied it; ensured that a wide variety of health benefits were covered by health insurance plans; and limited some of the costs that insurers could pass along to patients.

One of the law's provisions, for instance, bans insurers from setting lifetime limits or caps on the expenses they will cover for a patient. Prior to the ACA, patients with diagnoses such as cancer that involve expensive care often had to pay for their own health care after their bills climbed past a certain amount. This had dire financial consequences, including forcing patients to take out loans or even declare bankruptcy to afford the care they needed.

Indeed, according to the Colorado Health Access Survey (CHAS), in 2013 more than one million Coloradans reported problems paying medical bills — and one in 10 of these (104,000) said they had declared bankruptcy in the past year because of health care costs.[28] While a similar number of Coloradans struggled to pay medical bills in 2019, the number of people filing for bankruptcy due to health care costs had been reduced by more than two-thirds, to 36,000 people.[29] Medical bankruptcy is still a problem for too many Coloradans, but this dramatic reduction suggests that tens of thousands of people have been shielded from health care costs that could have had a disastrous impact on their lives.

But another major consumer concern — surprise billing, which occurs when patients receive bills for unexpected costs — is not directly addressed by the ACA. Surprise bills often occur when a patient

Fewer Coloradans Declare Bankruptcy from Medical Bills After Implementation of Key ACA Provisions



Source: 2019 Colorado Health Access Survey

unknowingly receives out-of-network care, which can be delivered at in-network facilities. Feeling taken by surprise when receiving a medical bill isn't a rare occurrence in our state: In 2019, 30.6 percent of Coloradans reported getting a surprise bill.[30]

Colorado's legislature has tried to make it easier for consumers to understand which providers are, or aren't, in their network. Bills introduced in the 2017 and 2018 sessions focused on increasing disclosures from insurance carriers, but none were successful. The 2019 session saw a bill signed into law with strong bipartisan support: House Bill 19-1174 limits how much out-of-network providers can be reimbursed when they are providing emergency care or when they are working at an in-network facility — two common precursors to receiving a surprise medical bill.[31] The bill also requires health insurance carriers to more effectively disclose when consumers may face an out-of-network bill and establishes an arbitration process to hear billing disputes. Proponents see this as a step forward but say work remains to be done; they have introduced bills to clarify other aspects of medical billing in the current legislative session.

Protections such as these can prevent lives from being ruined by financial burdens after a trip to the hospital. But everyday costs, like deductibles and premiums, can also be difficult to afford. The next three parts will dive deeper into the troubling issue of high health care costs from three distinct perspectives: consumers, the government, and hospitals and providers.

PART 7

Consumer Costs

The cost of health insurance has increased since the ACA took effect, and many of those with coverage struggle to afford care.

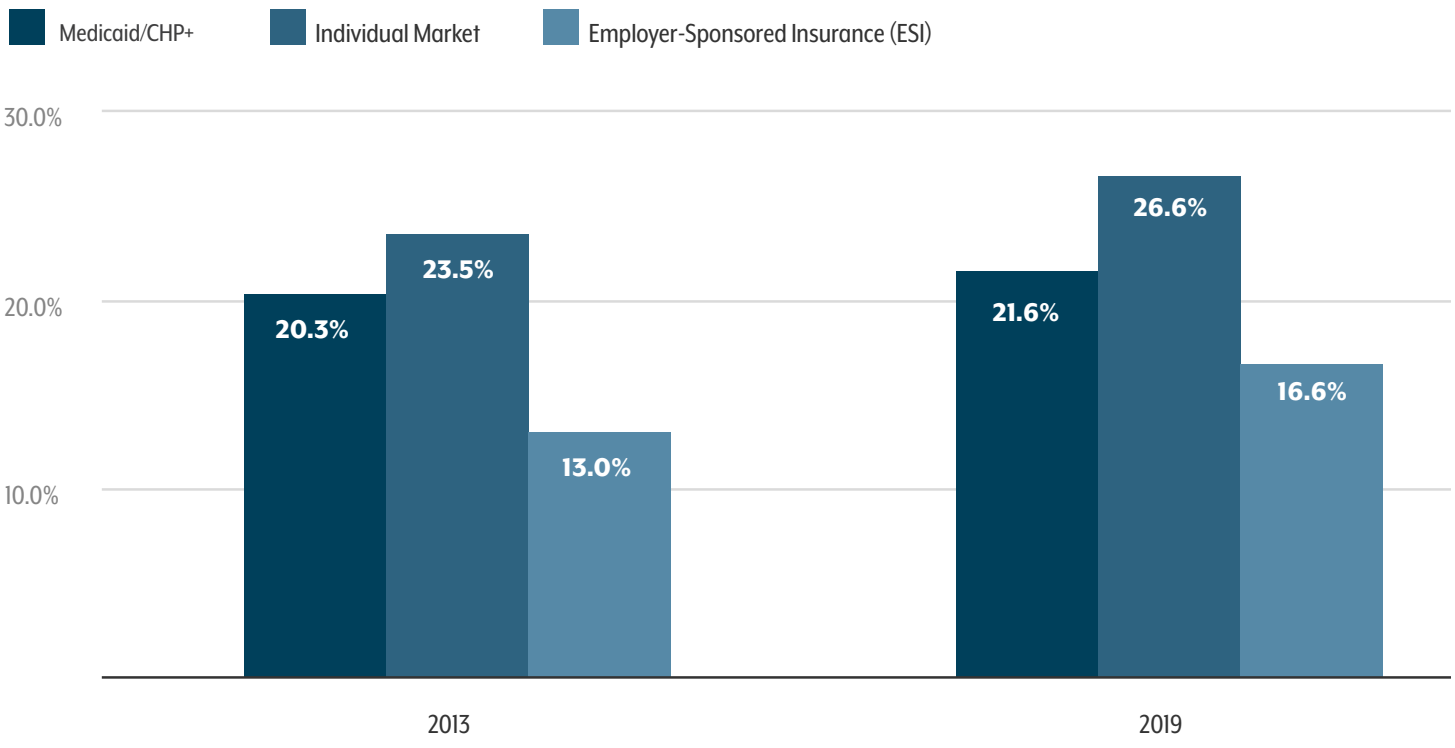
Colorado expanded Medicaid to nearly all adults in 2014, doubling the number of people covered by the program. Medicaid requires only a small copayment from enrollees when they receive care and does not include a monthly premium, making it a relatively affordable coverage option.

But most Coloradans are enrolled in private insurance, either through the individual market or through their employer. And the cost of coverage and care for Coloradans with private coverage has actually increased since the ACA took effect.

Health insurance plans on the individual market were nearly 50 percent more expensive in 2019 than in 2014, the first year the ACA's provisions affecting the individual market took effect. Some individual market shoppers are eligible for subsidies that shield them from price changes, but those without subsidies are highly vulnerable to rising premiums. And the subsidies aren't always enough to make coverage truly affordable, which could explain why Coloradans between 139 and 400 percent of the federal poverty level (FPL), who are eligible for subsidies, have a higher uninsured rate (9.6 percent) than those lower incomes (6.9 percent), who are eligible for Medicaid, or those with higher incomes (4.1 percent), who are not eligible for subsidies or Medicaid.[32]

Meanwhile, for the 52.7 percent of Coloradans who get insurance through an employer, costs are reaching new heights. The average annual family premium for those enrolled in employer-sponsored insurance has increased from $13,360 in 2009 to $18,314 in 2018.[33,34] Employers often pay most of the

Coloradans With Insurance Through Individual Market More Likely to Avoid Care Than Those With Medicaid or ESI



Source: 2019 Colorado Health Access Survey

premium costs, but consumers' costs have also increased dramatically.[35]

These increases are in part a response to a changing health care landscape. Hospitals in Colorado have increased the prices they charge private insurance since 2009.[36] Insurers also lost financial help from the federal government, which in 2017 stopped paying for cost-sharing reductions meant to offer stability for carriers and compensate them for efforts to reduce deductibles, copayments, and coinsurance.[37] Insurers have passed some of the cost of changes on to consumers.

Even With Coverage, Care Is Costly

Apart from insurance premiums, many Coloradans struggle to afford health care. The 2019 Colorado Health Access Survey found that cost kept one in five Coloradans (20.2 percent) from getting care they needed from a doctor or specialist or from filling a prescription in the past year.

While the cost of insurance itself is lower for those with public coverage, one in five of these Coloradans struggles to afford care, despite low or non-existent copayments for services. A low copay may still be unaffordable for some Medicaid enrollees. Others may be trying to access providers or services that are not covered by Medicaid.

Coloradans enrolled in insurance through the individual market are most likely to face cost-related barriers to care. More than one in four (26.6 percent) avoided health care in the past year due to the cost. Policies on the individual market often come with high deductibles.[38] Although the ACA ensured more comprehensive coverage for people with plans from the individual market, it did little to address the affordability of care for this group.

And while those with employer-sponsored insurance have been the most insulated from cost-related barriers to care, they are the largest group and have seen the largest increase —from 13.0 percent in 2013 to 16.6 percent in 2019.[39] This means that nearly half a million Coloradans with insurance through an employer skipped care in 2019 because it was too expensive. The rising costs of insurance and care are having a real effect on Coloradans with all types of health coverage.

PART 8

Government Costs

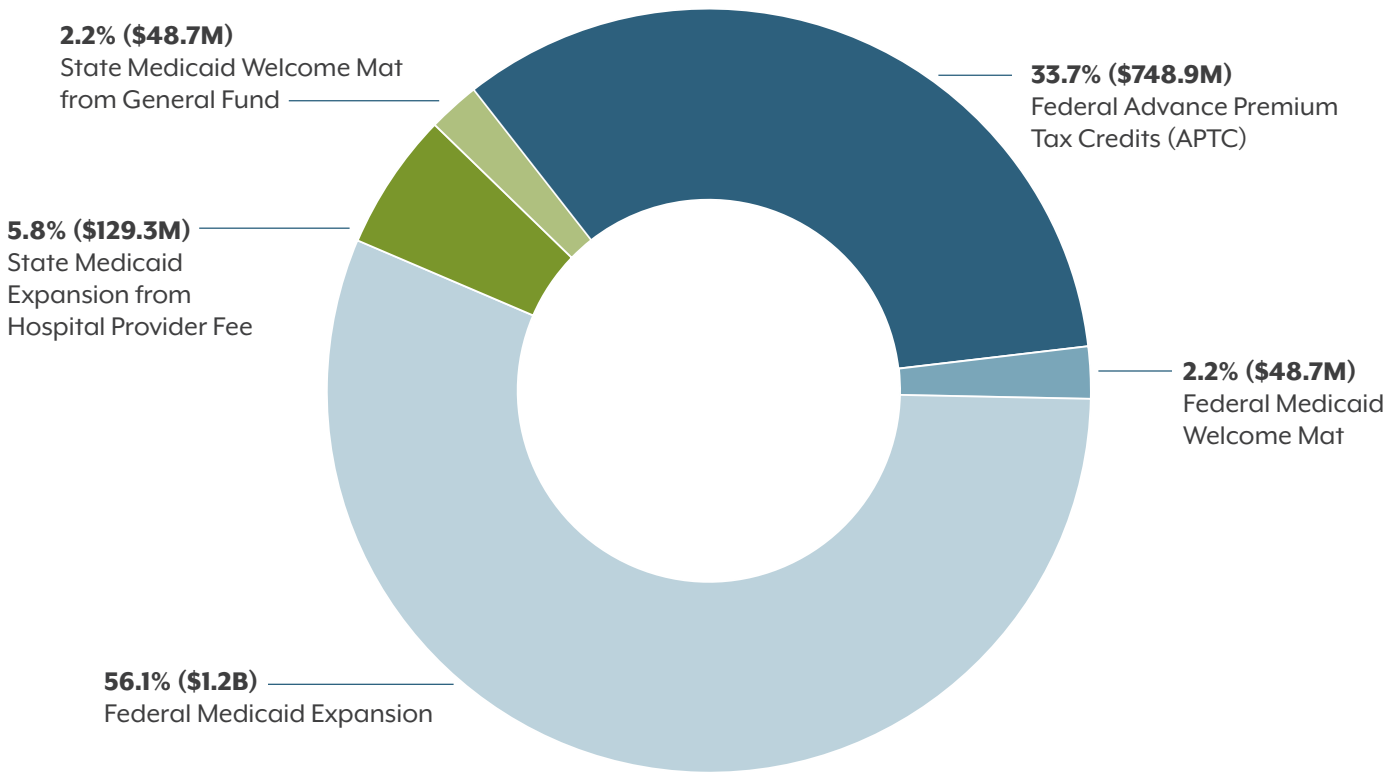
Efforts to increase insurance coverage through the ACA, including Medicaid expansion and tax credits for the individual market, have come at a cost to state and federal governments. In Colorado's 2019-20 fiscal year, costs related to coverage stemming from the ACA came with a $2 billion price tag for the federal government and $178 million for the state of Colorado.[40,41,42]

The vast majority — 92 percent — of spending on ACA-related health coverage comes from the federal government, and most of those funds are dedicated to people enrolled in coverage through Medicaid expansion. The federal government covered 100 percent of these costs through 2016 but has since decreased its share.[43] This fiscal year (FY2019-20), over $1.4 billion is budgeted to cover Medicaid expansion in Colorado, with the federal government now paying 90 percent.[44]

Federal funds also cover 50 percent of the cost of other Medicaid enrollees, including nearly $50 million in FY2019-20 for "welcome mat" enrollees — those who were previously eligible for Medicaid but didn't enroll in the program until expansion took effect in 2014.[45]

The federal government also pays the entire cost of Advanced Premium Tax Credits (APTCs), which help people with incomes between 138 and 400 percent of the federal poverty level afford coverage on the individual market. The 115,000 Coloradans who received APTCs in 2019 received just under $750 million in premium assistance, around $6,500 per person per year, a figure that has been increasing over time.[46]

Federal Funds Support More Than 90% of ACA Coverage



Source: CHI Analysis of Data from the Colorado Department of Health Care Policy & Financing

Colorado's spending on most ACA programs, including Medicaid expansion, is not covered by Colorado taxpayers, but by the Hospital Provider Fee established in 2009 through House Bill 09-1293. Hospitals in Colorado pay a fee to the state, which results in a dollar-for-dollar federal match. Together, these funds cover charity care hospitals provide the uninsured or indigent, higher reimbursements paid to hospitals for seeing patients covered by Medicaid, and Colorado's 10 percent share of Medicaid expansion costs, which totaled just under $130 million this fiscal year.[47]

The state's general fund, meanwhile, covers Colorado's 50 percent share of costs for the people who gained Medicaid coverage as part of the "welcome mat" phenomenon. This amount varies depending on Medicaid enrollment; it came to over $48 million in the current fiscal year (FY 2019-20).[48]

But tensions are brewing between the federal government and states when it comes to paying ACA expenses. In November 2019, the Centers for Medicare and Medicaid Services (CMS) proposed the Medicaid Fiscal Accountability Regulation, which includes new reporting requirements for states, alters rules around financing mechanisms, and makes other changes that could reduce the amount of federal funds available for Medicaid and other safety net programs.[49] The Colorado Hospital Association says the proposed rule would put $3 billion in Medicaid payments from Colorado's provider fee at risk each year. While its potential impacts are unclear, this reduction in funding could interrupt care and coverage for those enrolled in traditional Medicaid and those who enrolled as a result of Medicaid expansion in Colorado.[50]

PART 9

Provider Costs

Expansions in health coverage brought about by the ACA should have been a boon for providers' bottom lines, especially for those who serve large numbers of Medicaid patients or provide care for the uninsured. But data show a more complex story.

When more patients have insurance coverage, hospitals have to provide less charity care and take on less bad debt. The ACA brought a substantial decrease in how much care providers are writing off — from $700 million in charity care and bad debt in 2013 to $286 million in 2017.[51]

Dramatic increases in Medicaid coverage have meant that more dollars are paid to providers through Medicaid reimbursements. In fact, hospitals in Colorado have seen payments from Medicaid nearly double since the passage of the ACA, from $1.3 billion in 2013 to nearly $2.2 billion in 2017.[52] While Medicaid reimburses for services at lower rates than private insurance, it offers more consistent reimbursements than uninsured patients, whose payments make up only about a quarter of the costs providers incur to treat them.[53,54]

Providers should have benefitted from increased Medicaid reimbursements and decreased amounts of charity care and bad debt. But Medicare and Medicaid pay providers and hospitals less than it costs to provide care, which is known as underpayment.[55] Providers have seen a large increase in underpayment, from missing out on $1.6 billion in 2013 to nearly $2.5 billion in 2017.[56] The increases in underpayment have been more than enough to offset the decrease in charity care over time.

Uncompensated care — the combination of charity care, bad debt, and underpayment from Medicare and Medicaid — has risen since the passage of the ACA, from $2.3 billion in 2013 to $2.8 billion in 2017.[57] This increase is due to rising underpayment from Medicare and Medicaid.

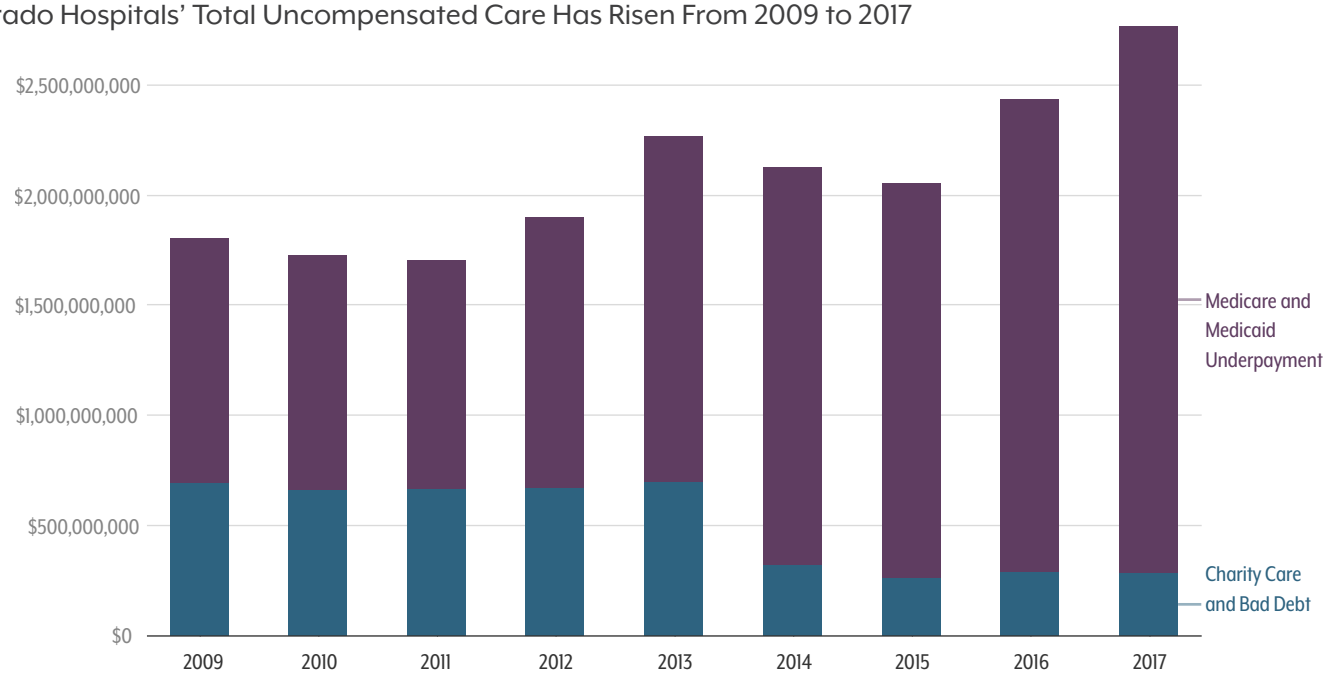
Despite the rise in uncompensated care, hospitals and providers are making record profits.[58]

Payments from commercial insurance plans have skyrocketed, rising by a total of $3.4 billion since 2009 and topping $9 billion in 2018.[59] The cost of caring for commercially insured patients totaled $5.6 billion in 2018, an increase from $3.9 billion in 2009.[60]

This is where the numbers become difficult to interpret. Uncompensated care measures payments against

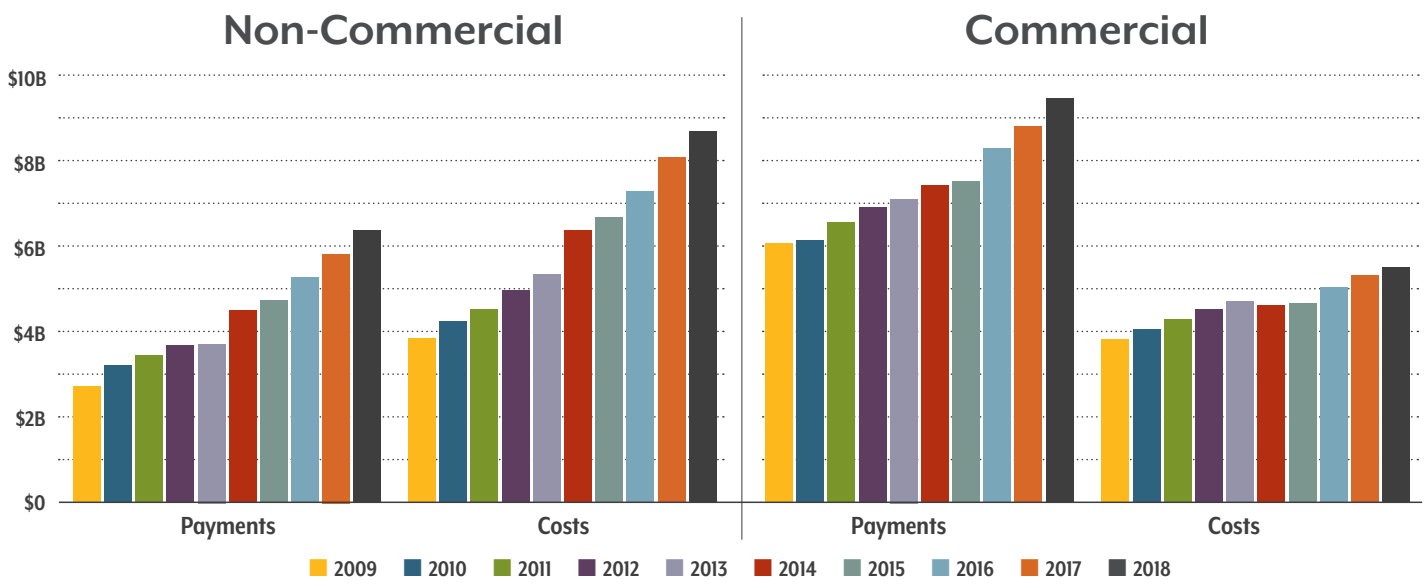
While Charity Care and Bad Debt Decrease, Underpayment from Public Insurance Rises

Colorado Hospitals' Total Uncompensated Care Has Risen From 2009 to 2017



Source: CHI Analysis of Data from the Colorado Department of Health Care Policy & Financing

Non-Commercial Insurance Cost Increases are Outpacing Commercial Cost Increases from 2009 to 2018



Source: CHI Analysis of Data from the Colorado Department of Health Care Policy & Financing

hospitals' internal costs. The crux of the issue is that the hospitals themselves define how much caring for patients has cost their organization. These costs factor into the community benefits non-profit hospitals must provide to retain their tax exempt status.

Hospitals' internal costs of caring for Medicare and Medicaid patients have risen dramatically since the ACA took effect. While we don't know what is driving costs up, increasing demand is likely part of the equation. Research shows that people with health coverage are more likely to seek out health care than people who are uninsured.[61]

However, officials in Gov. Jared Polis' administration and their legislative allies have argued that hospitals could be more disciplined in controlling their internal costs, which would reduce the amount of uncompensated care because their dollars from Medicare and Medicaid would go further. Hospitals say they already operate efficiently. Without better data on hospital finances, it's not possible to say which argument is more accurate.

Doctors' offices and hospitals are private businesses, which limits transparency and public knowledge of their financial data. But profit data is public. Some hospitals, especially in urban areas, are bringing in more money than ever before: hospitals in Colorado reported $2.9 billion of net income in 2018.[62] Rural and critical access hospitals often have very small profit margins, so these profits aren't reflective of all hospitals' experiences. In fact, just four hospital systems accounted for nearly all of the $2.9 billion profit: HealthONE, UC Health, SCL Health, and Centura Health.[63] The increase in income is tied to year-over-year price increases across all payer types.[64]

Lofty hospital revenues, coming as more Coloradans are struggling to afford health care, have led to skepticism from the public and increased efforts from the legislature to crack down on health care prices. Better hospital financial transparency is one way to learn more: House Bill 19-1001 requires hospitals to share additional information on what they include in uncompensated costs and how they spend their income. The first reports under that bill are due this summer.

Physicians, and the practices they own, are being caught up in these larger system dynamics. In recent years, large health systems have gotten larger by buying smaller hospitals and physician-owned practices. Over half of hospitals in Colorado (43 of 83 hospitals) were part of a health system in 2018, an increase from 26 hospitals in 2009.[65]

Representatives of large health systems cite economies of scale as opportunities to decrease costs to consumers, but opponents point towards increasing prices and decreasing quality of care as evidence against this argument.[66] Arguments over provider profits and practices are among the most complex and contentious questions in health care that were not solved by the ACA.

PART 10

Innovation in Data

Our report marking 10 years of the ACA concludes with an examination of a decade of change in health data.

The ACA itself was not a landmark law for health data. That's because just a year earlier, Congress had already passed a major health data law as part of the stimulus bill that addressed the Great Recession. The Health Information Technology for Economic and Clinical Health (HITECH) Act set standards for adopting electronic health records (EHRs) and provided funding to speed the transition. Several ACA initiatives relied on a future where clinical and other health data were accurate and widely available.

For example, the ACA contained numerous provisions intended to move the health system away from fee-for-service payments and towards rewarding providers based on the quality of care. It also encouraged providers to coordinate care and services. Both of these measures rely heavily on the use of EHRs to track care quality and medical histories.

The HITECH Act included financial incentives for providers to adopt and use EHRs. These incentives have been effective: in 2017, 86 percent of doctors' offices were using an EHR, up from 42 percent in 2008.[67]

But despite this broad adoption, the use of EHRs in practice is anything but perfect. Different health providers use different systems. EHRs are often unable to work with one another, which can interrupt a patient's data as it moves between providers. EHR fields are not always accurate or up-to-date and don't always meet the complex health needs of patients. And the adoption of EHRs has also come with an increase in health care providers reporting burnout and job dissatisfaction due to administrative responsibilities.

In addition to leveraging EHRs to improve patient care, the ACA introduced a new focus on population health, which requires its own data support. Health Information Exchanges (HIEs) are a population health tool incentivized by the HITECH Act. HIE platforms aggregate EHR data and allow different systems to "talk" with one another, enabling data sharing across different care settings and geographies.

There are two HIEs in Colorado: Quality Health Networks (QHN), which serves the Western Slope, and the Colorado Regional Health Information Organization (CORHIO), which covers most of the rest of the state. Having multiple HIEs within a state can ensure more comprehensive coverage, but it also means that there is no single, universal EHR communication platform to share data from medical records. QHN and CORHIO each connect with 33 different EHRs — adding to the complexity of the system.[68,69]

To be effective, EHR data must be high-quality and trustworthy. The field of data governance has emerged to manage the availability, usefulness, quality, and security of sensitive medical data. In Colorado, it's still a work in progress: The state's Office of eHealth Innovation is prioritizing data governance as part of its 2019 Health IT Roadmap to improve EHR data quality in Colorado.[70] Future efforts in innovation must overcome previous shortcomings in data alignment and quality.

A decade after the ACA, more data are being collected than ever before — but there is significant room for improvement in a complicated and often uncoordinated system. New policies and practices created at the local, health systems, and state levels can continue to advance our state's progress. Colorado is nationally recognized as being on the cutting edge of health system innovation.[71] The rest of the country will continue to look to us as a bellwether state, closely watching our results.

This was CHI's final chapter in our series examining what the ACA has accomplished over the last decade and what work remains to realize its ambitious goals. In 2020, not all Coloradans have access to coverage and those with insurance are still struggling with affordability. But a great deal of change has taken place, and clear progress has been made in areas ranging from data collection to access to preventive care and insurance coverage. These issues will continue to be at the center of the conversation as people look for ways to improve health care and access in 2020 and beyond.

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