Covered Clips

A Summary of News and Activities for the Cover Arizona Coalition[](http://stylegirlfriend.com/wp-content/uploads/2012/04/paper-clips-style-girlfriend.jpg)

Weeks of April 18th and 25th

**One of Arizona’s Largest Health-Care Insurers to Exit Marketplace; Second Could Follow**

The Arizona Republic

The nation's largest health-care insurer, UnitedHealthcare, will exit the Affordable Care Act marketplace in Arizona next year, a move that will reduce or eliminate options for consumers to buy subsidized plans in more than half of the state's counties.

Blue Cross Blue Shield of Arizona also said it will evaluate “all options,” including discontinuing marketplace plans, in some counties for coverage that begins Jan. 1, 2017.

UnitedHealthcare and Blue Cross Blue Shield are the only health-care insurers that sold marketplace plans in every Arizona county this year. If Blue Cross Blue Shield also drops marketplace plans in some rural counties, it could leave consumers in those counties without a way to get subsidized health-care insurance.

UnitedHealthcare said Tuesday that it will quit marketplaces in all but a "handful of states." While the insurer did not specify in which states it will remain, the insurer told the Arizona Department of Insurance in a letter Tuesday that it won't sell individual plans to Arizonans next year.

Blue Cross Blue Shield, meanwhile, said it lost $185 million on individual plans in 2014 and 2015, the first two years of the marketplace, as new enrollees racked up expensive claims and some consumers hopped in and out of coverage.

Blue Cross Blue Shield representatives said the company will examine each Arizona county and decide whether to continue to sell plans or change the types of plans it sells.

Blue Cross Blue Shield of Arizona is considering discontinuing marketplace plans in some Arizona counties for coverage that begins Jan. 1, 2017. (Photo: Sue Dorfler/The Republic)

"The losses are not really something that are sustainable," said Jeff Stelnik, Blue Cross Blue Shield's senior vice president of strategy, sales and marketing. "We have to look county by county and make sure it makes sense to offer a product going forward."

Similarly, UnitedHealth Group CEO Stephen Hemsley cited the financial difficulty of the federal marketplace in his company's decision to drop plans in most states.

"The smaller overall market size and shorter-term, higher-risk profile within this market segment continue to suggest we cannot broadly serve it on an effective and sustained basis," Hemsley said during an earnings conference call Tuesday. "Next year, we will remain in only a handful of states, and we will not carry financial exposure from exchanges into 2017."

Rural counties may feel impact

More than 135,000 Arizonans enrolled and paid for a health plan as of Dec. 31, and most of those sign-ups were in Maricopa and Pima counties, where consumers had plenty of options. Maricopa County consumers could buy from eight insurance companies, and Pima County residents had five insurance providers.

But experts say losing UnitedHealthcare and Blue Cross Blue Shield as an option on Healthcare.gov would be devastating in rural counties that may be left without marketplace options.

Consumers who want to buy a subsidized health-care plan must purchase it over the federal marketplace. If no insurer sold a marketplace plan in a county, consumers there would not have access to subsidized health-care insurance.

"It is a notable concern that is not lost on the Department (of Insurance) and others," said Erin Klug, an Arizona Department of Insurance spokeswoman.

Blue Cross Blue Shield and UnitedHealthcare's All Savers are the only Arizona health-care insurance companies available through the ACA marketplace in eight counties where more than 30,000 people chose a plan — Cochise, Graham, Greenlee, La Paz, Pinal, Santa Cruz, Yavapai and Yuma counties.

Kim VanPelt, who oversees state health policy and advocacy for Vitalyst Health Foundation, formerly known as St. Luke's Health Initiatives, said she would like to see the state and federal government work "to make sure communities are not left out of getting access to health coverage."

"My concern is that rural Arizona is left with too few choices," she said.

Deadline approaches for plan proposals

Health-care insurers must file proposals for 2017 plans and rates with the Arizona Department of Insurance by May 11, Klug said.

At that point, Arizona regulators will know which insurers, including Blue Cross Blue Shield, intend to sell plans next year.

Stelnik said other areas of Blue Cross Blue Shield's health-insurance business are financially healthy, including insurance plans sold to large and small businesses, seniors and federal employees.

http://www.azcentral.com/story/money/business/health/2016/04/20/united-healthcare-to-exit-arizona-obamacare/83242532/

**Immigrants, the Poor and Minorities Gain Sharply Under Health Act**

The New York Times

The first full year of the Affordable Care Act brought historic increases in coverage for low-wage workers and others who have long been left out of the health care system, a New York Times analysis has found. Immigrants of all backgrounds — including more than a million legal residents who are not citizens — had the sharpest rise in coverage rates.

Hispanics, a coveted group of voters this election year, accounted for nearly a third of the increase in adults with insurance. That was the single largest share of any racial or ethnic group, far greater than their 17 percent share of the population. Low-wage workers, who did not have enough clout in the labor market to demand insurance, saw sharp increases. Coverage rates jumped for cooks, dishwashers, waiters, as well as for hairdressers and cashiers. Minorities, who disproportionately worked in low-wage jobs, had large gains.

The [health care law](http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/health_insurance_and_managed_care/health_care_reform/index.html?inline=nyt-classifier) was one of the most bitterly contested pieces of legislation in the country’s history. It remains controversial because of its costs to both taxpayers and insurance customers. The high premiums and high deductibles of many plans still make coverage a crushing financial burden for some families.

And the law is not close to achieving the goal of universal coverage, in part because 19 states have declined to expand their [Medicaid](http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/medicaid/index.html?inline=nyt-classifier) programs for the poor, an option the Supreme Court granted them in a landmark 2012 case. Nevertheless, the Times’s analysis shows that by the end of that first full year, 2014, so many low-income people gained coverage that it halted the decades-long expansion of the gap between the haves and the have-nots in the American [health insurance](http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/health_insurance_and_managed_care/index.html?inline=nyt-classifier) system, a striking change at a time when disparities between rich and poor are growing in many areas.

The law has clearly reduced broad measures of inequality,” said David Cutler, an economics professor at Harvard, who served in the Clinton administration and advised the 2008 Obama campaign on health issues. “These are people who blend into the background of the economy. They are cleaning your hotel room, making your sandwich. The law has helped this population enormously.”

Until now, the impact of the law has been measured mostly in broad numbers of newly insured people — about 20 million [by the administration’s most recent account](http://obamacarefacts.com/sign-ups/obamacare-enrollment-numbers/). But the Times’s analysis of census data from 2014, the first year the heart of the law was in full effect, provides a finely detailed look at who the newly insured actually are — by race, education, occupation, immigration status, and family structure.

The analysis shows how the law lifted some of the most vulnerable citizens. Part-time workers gained insurance at a higher rate than full-time workers, and people with high school degrees gained it at double the rate of college graduates. Adults living in households headed by relatives, such as siblings or cousins — often a marker of economic distress — gained insurance at double the rate of those in traditional households.

The law’s passage, without a single Republican vote, capped decades of efforts to enact a broader health insurance system. Medicaid and [Medicare](http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/medicare/index.html?inline=nyt-classifier) passed in the 1960s, but did little to help workers who did not receive insurance through their jobs. Presidents Nixon, Carter and Clinton all tried and failed to win approval for expanded coverage, and the number of uninsured Americans [grew to nearly a fifth of adults under the age of 65 by 2010](http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201602.pdf), the year the Affordable Care Act passed.

Advertisement

[Continue reading the main story](http://www.nytimes.com/2016/04/18/health/immigrants-the-poor-and-minorities-gain-sharply-under-health-act.html?utm_campaign=KHN:+First+Edition&utm_source=hs_email&utm_medium=email&utm_content=28546798&_hsenc=p2ANqtz-9cUk83zOJjR58R7Ma28Ww47hqwYchxa4&tr=y&auid=16635339&_r=0#story-continues-3)

The findings from the census data could inform the national dialogue, especially in this election year. Hispanics are a powerful voting force and the law is viewed favorably in Hispanic neighborhoods. But whether the sharp increase in coverage rates for Hispanics will translate into votes for Democrats who supported the law, or whether some Republicans might temper their vows to repeal it, is not clear. And the fact that so many who benefited under the law were not citizens (or voters) — 1.2 million out of the total 8.7 million who got health insurance in 2014 — could set off a new round of debate in a year when immigration has become a deeply polarizing issue.

About 60 percent of those noncitizens were Hispanic, mostly natives of Mexico and Central America who had been living in the United States for decades. Another third were Asian, mostly newer arrivals living in states like California, New York and Texas. Illegal immigrants are not eligible for insurance under the law, but legal immigrants who have been in the country for more than five years are.

The vast majority of the country’s 11 million illegal immigrants, about 70 percent of whom are Hispanic, still lack coverage, said Mark Hugo Lopez, director of Hispanic research at the Pew Research Center.

Though the law has withstood two Supreme Court rulings that would have undermined its central elements, it continues to face challenges.

It requires most Americans to have health insurance and gives subsidies to those who cannot afford it. Even so, many still cannot afford policies. While it expanded Medicaid to cover more of the country’s poor, the Supreme Court allowed states to opt out and [19 have](http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/), leaving millions of people still uncovered.

But in low-income neighborhoods like this one in South Los Angeles, a historically poor patch of the city dotted with palm trees, small ranch houses and home to a growing Hispanic population, the law is having a big effect.

“From the vantage point of the poor and working poor, Obamacare has been profound,” said Jim Mangia, president of the St. John’s Well Child and Family Center, a federally funded health clinic in South Los Angeles that has enrolled 18,000 new patients under the law, nearly all of them Hispanic or black and the vast majority in Medicaid. The clinic reported a 44 percent increase in [cervical cancer](http://health.nytimes.com/health/guides/disease/cervical-cancer/overview.html?inline=nyt-classifier) screenings, a 25 percent increase in tobacco cessation therapy, and a 22 percent increase in the share of patients with controlled [hypertension](http://health.nytimes.com/health/guides/disease/hypertension/overview.html?inline=nyt-classifier) since 2014, the result, he said, of more patients having insurance.

One new patient, Angela Cruz, 60, is a typical example of a winner under the law. A legal immigrant who is not a citizen, she came to this country from El Salvador in 1990. She had never had health insurance in her 25 years of working in the United States, most recently as a nanny. She stitched together medical care through emergency rooms, free clinics and home remedies. When she needed to pay for medicine for a painful bout of [kidney stones](http://health.nytimes.com/health/guides/disease/kidney-stones/overview.html?inline=nyt-classifier), she stopped buying meat.

Then she got coverage under the health law’s expansion of Medicaid in California.

Now, she said, “I don’t have the stress of wondering — can I pay this — when sometimes I didn’t have anything to pay it with.”

Hispanics remain the least insured Americans, with only 67 percent having coverage in 2014, in part because so many illegal immigrants are uninsured.

Gains for blacks were muted because they disproportionately live in states that chose not to expand Medicaid. About 60 percent of poor blacks live in states that did not expand Medicaid. While the share of poor blacks covered by Medicaid did rise by two percentage points in those states, the rate rose by six points in states that expanded the program.

In all, minorities gained more than whites, making up two-thirds of the increase in insured adults across the country, and 70 percent of the increase in private insurance. Minority men who work as groundskeepers and janitors saw substantial gains, rising to 59 percent insured, up from 51 percent in 2013. Hispanic male construction workers rose to 43 percent insured, from 36 percent in 2013.

One such worker, Sergio Ortega, 51, a legal immigrant from Mexico who had never been insured before getting covered by Medicaid in 2014, said making a doctor’s appointment seemed unthinkable without insurance, so he often simply ignored his health problems.

Several years ago, he started feeling tired, a condition that eventually drove him to quit his job demolishing buildings and start selling fruit from a street cart. By the time he sought treatment through his new coverage and discovered he had [diabetes](http://health.nytimes.com/health/guides/disease/diabetes/overview.html?inline=nyt-classifier), his lower leg had to be amputated.

“I realized it was getting really bad because my foot started turning purple,” said Mr. Ortega, who is a patient at St. John’s.

Perhaps the biggest unmet promise of the law is that many it was supposed to help still cannot afford insurance. Alberto Torres, 50, a driver for a garment company in Los Angeles who could not afford insurance before the law, had signed up for a plan in 2014 for $41 a month. But this year his monthly premium jumped to $106 — too much, he said, for his meager salary.

“I’m feeling not so good,” he said recently, waiting in line for help to look for a less expensive plan.

High deductibles are another big obstacle. “If you are living paycheck to paycheck and have nothing in the bank, [insurance with a $3,000 deductible might feel like no insurance at all](http://kff.org/health-costs/issue-brief/consumer-assets-and-patient-cost-sharing/),” said Larry Levitt, a senior vice president of the Kaiser Family Foundation.

Having insurance does not necessarily mean better health, but experts hope it could start to ease some of the worst disparities that have kept the United States close to the bottom of health rankings of rich countries.

Mr. Ortega has been fitted for a prosthetic leg. He is still learning how to use it.

“Now I don’t worry,” he said. “It’s a security, a comfort that I feel.”

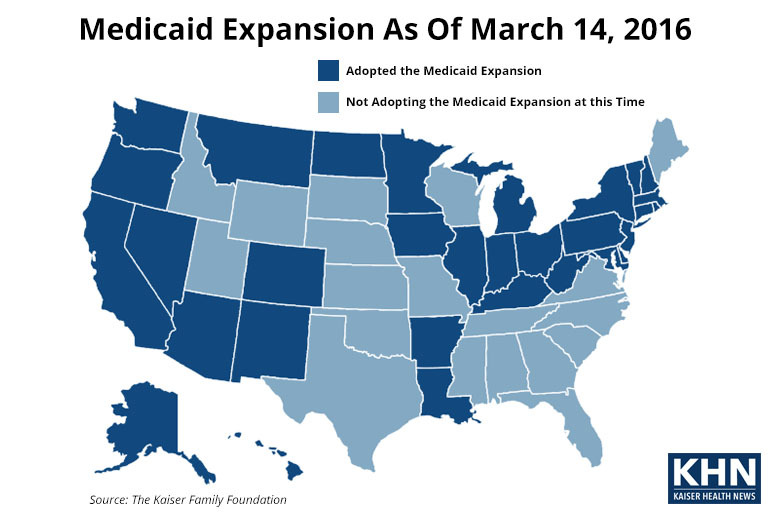
<http://www.nytimes.com/2016/04/18/health/immigrants-the-poor-and-minorities-gain-sharply-under-health-act.html?utm_campaign=KHN:+First+Edition&utm_source=hs_email&utm_medium=email&utm_content=28546798&_hsenc=p2ANqtz-9cUk83zOJjR58R7Ma28Ww47hqwYchxa4&tr=y&auid=16635339&_r=0>

**Study: Medicaid Expansion Encourages More Poor Adults to Get Health Care**

In states that expanded Medicaid under the Affordable Care Act, low-income adults were more likely to see a doctor, stay overnight in a hospital and receive their first diagnoses of diabetes and high cholesterol, according to a study published Monday.

Yet researchers found no improvement in adults’ own assessments of their health, a conclusion echoed by [similar studies](http://jama.jamanetwork.com/article.aspx?articleid=2411283), the authors wrote in the [Annals of Internal Medicine.](http://annals.org/article.aspx?articleid=2515051)

Two factors might explain the lack of perceived improvement. People did not sign up for Medicaid as soon as it expanded in January 2014 so there was little time to better their health. Also, survey participants’ increased contact with health providers and fresh knowledge about their health might have negatively affected their opinions, the authors said.



Researchers at University of Michigan and the University of California-Los Angeles who did the study said it provides the first evidence of low-income adults’ increased use of health services in states that expanded Medicaid. Federal surveys of adults living in poverty conducted in the second half of 2014 were the foundation for the study. Twenty-six states and District of Columbia expanded Medicaid in 2014 and five more have since then.

Medicaid enrollment has soared [past 70 million people](http://khn.org/news/medicaid-spending-soars-mostly-in-expansion-states/) since states began expanding the program in 2014 using federal dollars from the law. [Medicaid rolls](https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/december-2015-enrollment-report.pdf) have grown by more than 14 million people in that time.

Opponents of expansion have cited many reasons why states should not expand the program including fiscal concerns and doubts about Medicaid’s effectiveness in in improving health to the poor.

Joel Cantor, director of the Rutgers University Center for State Health Policy, said the study confirms that enrolling people in Medicaid means they are more likely to access health services. He anticipates better results in 2015 after people have more time to use their healthcare coverage. “Health status is not a leading indicator. It’s a lagging indicator,” said Cantor, who was not involved in the study.

“The first step is people get coverage. Second, they get care,” he said. The third step is better health and we will see that in later years.”

The study’s authors also said low-income adults’ greater use of health services could pay dividends in the future.

“The increased detection of chronic health conditions under the Medicaid expansions could have important implications for both population health and national health care spending if it leads to improved management and control of these conditions,” noted the study.

Among the study’s findings:

* The share of respondents who said they saw or talked to a doctor increased from 58 percent before expansion to nearly 68 percent after expansion. There was virtually no change in states that did not expand.
* Those who said they were diagnosed with diabetes rose from 8.3 percent before expansion to nearly 13 percent after expansion. In non–expansion states, the diabetes diagnosis dropped slightly.
* Those who said they had no usual source of care due to costs fell from 13.3 percent pre-expansion to 6.6 percent after expansion. This number dropped only marginally in non-expansion states.

Before the Affordable Care Act’s passage in 2010, a concern was whether the health care workforce was large enough to handle increased demand from a larger insured population, said Vernon Smith, a Medicaid expert and principal with consulting firm Health Management Associates.

“The study shows that the health care system has accommodated the increased demand and access improved for those who were newly insured,” he said.

“The results provide compelling evidence that states that expanded Medicaid did a very, very good thing for their citizens, because those who got coverage are now more likely to get medically necessary care when they need it,” Smith added.

<http://khn.org/news/study-medicaid-expansion-encourages-more-poor-adults-to-seek-health-care/?utm_campaign=KHN:+First+Edition&utm_source=hs_email&utm_medium=email&utm_content=28601112&_hsenc=p2ANqtz--QpK9UG4czVvGavw3PIXXbkUQ6hvp5dBcbWTFj7MvqfdJmpnh&tr=y&auid=16638861>

**Obamacare Seems to Be Reducing People’s Medical Debt**

The New York Times

Even if you lack health insurance, you’ll probably be able to get treatment at a hospital in the event of a catastrophe — you’re struck by a car, say. But having insurance can mean the difference between financial security and financial ruin.

A new study is showing that, by giving health insurance to low-income people, Obamacare seems to have cut down on their debt substantially. It estimates that medical debt held by people newly covered by Medicaid since 2014 has been reduced by about $600 to $1,000 each year.

The study, [published Monday as a working paper](http://nber.org/papers/w22170) by the National Bureau of Economic Research, builds on earlier evidence [from Oregon](http://www.nber.org/oregon/3.results.html#financial) [and Massachusetts](https://www.aeaweb.org/articles?id=10.1257/pol.2015-0045&&from=f) that offering health insurance to low-income Americans can help them avoid debt and financial shocks.

I’ve written before about [the big benchmarks I’m watching](http://www.nytimes.com/2014/10/28/upshot/what-to-look-for-in-judging-the-affordable-care-act.html) to evaluate the success of the health law. Its impact on people’s financial security is an important one.

Robert Kaestner, one of the authors of the new study, said he and his co-authors think the financial impacts of Medicaid could have cascading effects for the program’s beneficiaries. Previous research [has linked hospitalizations among the uninsured](http://economics.mit.edu/files/10958) to higher risk of bankruptcy, unpaid bills and a lowered credit score.

“Financial distress has many subsequent consequences,” said Mr. Kaestner, a professor of health economics at the University of Illinois. “If people are skipping bills and going into debt, then it can have other repercussions — for example you lose your car, you fall behind on rent.”

This year, [we heard from thousands of readers](http://www.nytimes.com/interactive/2016/01/11/upshot/12up-medicaldebt.html) about how medical bills [can alter finances and daily life](http://www.nytimes.com/2016/01/06/upshot/lost-jobs-houses-savings-even-insured-often-face-crushing-medical-debt.html).

“I just turned 26, and I can’t even get a new contract with AT&T without a $750 security deposit, let alone finance a new (used) vehicle,” wrote Richard Barnes, a reader who was uninsured when he was struck with appendicitis three years ago. “When I was moving in May 2015, I had extreme trouble finding somebody who would rent to me.”

[A survey](http://kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundationnew-york-times-medical-bills-survey/) that The Upshot conducted with the Kaiser Family Foundation found that about one in five Americans still struggle to pay a medical bill, even after the Affordable Care Act. But several studies show that [the number has declined](http://www.nytimes.com/2015/06/23/upshot/medical-insurance-is-good-for-financial-health-too.html) as insurance coverage has expanded.

The new study homed in on the impacts for the lowest-income Americans. The researchers examined credit reports on a sample of Americans across the country. They compared debt incurred by people in two very different sets of states: those that expanded Medicaid to provide free insurance to all individuals earning under about $16,000 and those that either chose not to cover that popuation or had expanded their programs earlier.

By focusing on the 25 percent of ZIP codes with the highest percentage of low-income, uninsured people before 2014, the researchers were able to compare debt incurred by people in the unchanged states with the debt of residents of states that offered new insurance options.

Over two years, they didn’t find major changes in every measure of financial distress. But Medicaid expansion did move the needle on the number of bills sent to collections and the amount of debt sent to collections. That’s important because that’s the pattern of debt-stressed people after an expensive health crisis, Mr. Kaestner said.

The researchers’ estimate of $600 to $1,000 involved some back-of-the-envelope math, but the money is substantial in the context of a population earning less than $16,000 a year. Medical debt also isn’t spread out evenly across the population; about 20 percent of low-income Medicaid beneficiaries end up hospitalized in a given year. That means that a smaller group of people was protected against huge bills.

The study had some limitations. It could look only at people who had a credit report; government research has found that [about 30 percent of people with very low income](http://files.consumerfinance.gov/f/201505_cfpb_data-point-credit-invisibles.pdf) aren’t tracked by the credit agencies.

The research also couldn’t tell whether any particular individual got Medicaid. Instead, it tracked everyone in the places where researchers anticipated the biggest changes in Medicaid enrollment. But the differences were clear enough that the researchers are confident that they represent a real change in the financial circumstances of people who signed up for new Medicaid plans.

The authors pointed out that the lower debt burden for the newly insured indirectly helps other people. The credit reports also track debt and unpaid bills outside of health care. The insurance coverage means more bills are paid to doctors and hospitals — but also to banks, utility companies and landlords.

Those financial ripples often receive less attention than the health law’s more obvious effects on people’s access to health care. But they are also an important effect of the law.

http://www.nytimes.com/2016/04/21/upshot/obamacare-seems-to-be-reducing-peoples-medical-debt.html?tr=y&auid=16643231&\_r=0

**Analysis: Modest Effect if UnitedHealth Withdraws from Exchanges**

NPR

Insurance giant United Healthcare Group has griped that the Obamacare insurance exchanges for health coverage are money-losers and has threatened to stop selling plans on them.

United Healthcare's latest move is to drop out of the Obamacare insurance market in Oklahoma in 2017. It's the fourth state that the company is abandoning because it says selling insurance plans on exchanges there is unprofitable.

United Healthcare has already said it's pulling out of the exchanges in Michigan, Arkansas and parts of Georgia. The company may announce more changes when it reports first quarter financial results Tuesday.

If the company withdraws from markets across the country (and isn't replaced by rivals), premiums for exchange plans could rise modestly — about 1 percent on average — according to a county-by-county [analysis released](http://kff.org/health-reform/issue-brief/analysis-of-unitedhealth-groups-premiums-and-participation-in-aca-marketplaces/) Monday by the Kaiser Family Foundation Monday. The premium increase would amount to about $4 a month.

In some markets, the rates could go up much more. The study shows premiums rising more than $100 a month in 13 counties where there is little competition. And more than half of U.S. counties would have only two insurance companies offering plans on the exchanges, the analysis found.

"With millions of Americans insured through the marketplaces, it's clear that this is a growing business for insurers, and it's a product consumers want and need," Department of Health and Human Services spokesman Ben Wakana said in a statement. "The marketplace should be judged by the choices it offers consumers, not the decisions of any one issuer. That data shows that the future of the marketplace remains strong."

In January, UnitedHealth [said](http://www.unitedhealthgroup.com/~/media/UHG/PDF/2015/UNH-Q4-2015-Release.ashx?la=en) it had recorded losses of $720 million on individual exchange policies, including $245 million put on the books in 2015 for losses the company expected to incur in 2016.

In February, [Peter Lee](http://hbex.coveredca.com/executive/), who runs Covered California, the state's insurance exchange, said UnitedHealth has only itself to blame. The insurer, he said, blundered on setting its rates and in putting together networks of hospitals and doctors to provide care.

"Instead of saying, 'We screwed up,' they said, 'Obamacare is the problem and we may not play anymore,' " Lee said in an interview with [California Healthline](http://californiahealthline.org/about-us/). "It was giving an excuse to Wall Street and throwing the Affordable Care Act under the bus."

<http://www.npr.org/sections/health-shots/2016/04/18/474694680/analysis-modest-effect-if-unitedhealth-withdraws-from-exchanges>

**HHS Acts to Help More Ex-Inmates Get Medicaid**

Kaiser Health News

Administration officials moved Thursday to improve low Medicaid enrollment for emerging prisoners, urging states to start signups before release and expanding eligibility to thousands of former inmates in halfway houses near the end of their sentences.

Health coverage for ex-inmates “is critical to our goal of reducing recidivism and promoting the public health,” said Richard Frank, assistant secretary for planning for the Department of Health and Human Services.

Advocates praised the changes but cautioned that HHS and states are still far from ensuring that most people leaving prisons and jails are put on Medicaid and get access to treatment.

“It’s highly variable. Some states and jurisdictions are having a lot of success” enrolling ex-prisoners, said Kamala Mallik-Kane, a researcher at the Urban Institute who has studied the process. “Others of them have initiatives in place that aren’t reaching the kinds of numbers that are making a dent.”

Use Our Content

This KHN story can be republished for free ([details](http://khn.org/syndication)).

The 2010 health law made nearly all ex-prisoners eligible for Medicaid in states that chose to expand the state and federal insurance program for the poor. Many welcomed the chance to cover a group with high rates of chronic disease, mental illness and substance abuse problems.

But prisons and jails, burdened with ineffective computers, understaffing and complicated Medicaid enrollment procedures, have been slow to sign up released inmates.

Federal and state prisons let out more than 600,000 people a year. Millions more cycle through jails. But a study [published in Health Affairs](http://content.healthaffairs.org/content/34/12/2044.abstract) found prisons and jails nationwide enrolled only 112,520 emerging inmates between late 2013 up to January 2015.

In Maryland, often cited for progressive social policy, the prison system is enrolling fewer than one in 10 released inmates, Kaiser Health News [reported this week](http://khn.org/news/thousands-leave-maryland-prisons-with-risky-health-problems-but-no-coverage/).

Much of [HHS’ guidance](https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf) repeats existing policy, reminding states that those on probation or parole are eligible for Medicaid and urging states to keep prisoners’ names in the Medicaid computers while they’re locked up. (That eases re-enrollment.)

Inmates are generally ineligible for Medicaid while incarcerated. Prison and jail medical systems care for them.

HHS is “providing encouragement and a nudge” to states to improve sign-ups as well as money to upgrade enrollment computers, said Colleen Barry, a professor at the Johns Hopkins Bloomberg School of Public Health who has studied ex-inmate enrollment. “They understand that this is a technology issue.”

Making up to 96,000 halfway-house inmates eligible for Medicaid is new policy, designed to connect people with care before they’re fully released. Prisoners often move to halfway houses or home detention near the end of their terms, closely supervised but frequently allowed to shop, apply for jobs and see a doctor.

Under the new policy, “if you have a fair amount of freedom of movement” in a halfway house, “you’re not considered an inmate” for Medicaid purposes, said Sarah Somers, an attorney for the National Health Law Program, an advocacy group. “That will be very helpful for a lot of people who are trying to transition out of incarceration.”

Nathan Sharpe recently spent two months in a home detention program in West Baltimore between leaving prison and being fully released. He wanted to get a checkup to make sure there was no lasting damage from a stabbing he received last summer in Maryland’s Jessup Correctional Institution.

But he had to wait until home detention ended last week to be covered by Medicaid, he said.

“That helps a lot” if people like him could get on Medicaid after they first leave prison, he said. “People can get the health care they need sooner. I’ve been out a week now and I still haven’t been able to see a doctor because I don’t have my card.”

Ex-inmates have extremely high rates of HIV and hepatitis C infection, diabetes, mental illness and substance abuse problems. They are especially vulnerable after they leave the prison medical system and before they connect with community doctors.

One study in Washington state showed that ex-inmates were [a dozen times more likely to die](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836121/) than the general population in the first two weeks after their release.

Immediate Medicaid coverage “can mean the difference between life in the community and recidivism and even life and death,” Michael Botticelli, the White House’s director of national drug control policy, told reporters.

HHS has been urging states to enroll ex-inmates in Medicaid for years. But the Affordable Care Act’s Medicaid expansion made many more of them eligible for coverage, giving policymakers a new reason to promote sign-ups, advocates said.

So far 31 states and the District of Columbia have expanded Medicaid under the law.

<http://khn.org/news/hhs-acts-to-help-more-ex-inmates-get-medicaid/?utm_campaign=KHN:+First+Edition&utm_source=hs_email&utm_medium=email&utm_content=29078818&_hsenc=p2ANqtz-8uCYKfZgCpEBYVtSSvBln4dwaP5FdKxL2x8rpk67EWfO3cAFYhL6bZYix55pE3MlWj2ewlSgIILp&tr=y&auid=16671747>

**Colorado Weighs Replacing Obama’s Health Policy with Universal Coverage**

The New York Times

For years, voters in this swing state have rejected tax increases and efforts to expand government. But now they are flirting with a radical transformation: whether to abandon President Obama’s health care policy and instead create a new, taxpayer-financed public health system that guarantees coverage for everyone.

The estimated $38-billion-a-year proposal, which will go before Colorado voters in November, will test whether people have an appetite for a new system that goes further than the Affordable Care Act. That question is also in play in the Democratic presidential primaries.

The state-level effort, which supporters here call the ColoradoCare plan, would do away with deductibles. It would allow patients to choose doctors and specialists without distinguishing between those “in network” and those “out of network.” It would largely be paid for with a tax increase on workers and businesses, and cover everyone in the state. Supporters say most people would end up saving money.

Insurance groups, chambers of commerce and conservatives have already lined up in opposition. They say the plan’s details are vague, its size and cost galling. The proposed health system would have a budget bigger than that of Colorado’s entire state government. A new 10 percent tax on payroll and incomes to pay for the system would push Colorado’s tax rates to some of the highest in the nation.

The proposal’s chance of success is dubious. Colorado has a mixed record when it comes to ballot measures, though it has passed some notable ones over the years, including marijuana legalization and the Taxpayer Bill of Rights, an anti-tax, anti-spending constitutional amendment.

But the proposal had enough support to garner 100,000 signatures, which put it on the ballot. It has also worried insurers, and some in the medical community and the business community, enough for them to organize in opposition, even enlisting a Democratic former governor to help in their campaign.

In this season of political discontent, the notion of dismantling the [health insurance](http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/health_insurance_and_managed_care/index.html?inline=nyt-classifier) system has tapped an aquifer of frustration from voters. People say that even after the Affordable Care Act, they still pay too much in premiums, plus thousands in deductibles, and still have to worry about being bankrupted by a disabling car crash or an extended hospital stay.

Advertisement

[Continue reading the main story](http://www.nytimes.com/2016/04/29/us/colorado-weighs-replacing-obamas-health-policy-with-universal-coverage.html?utm_campaign=KHN:+First+Edition&utm_source=hs_email&utm_medium=email&utm_content=29078818&_hsenc=p2ANqtz-_3dG5voNN2FslhXZmEYftMZTdh1fwy&tr=y&auid=16671752&_r=0#story-continues-3)

“I think insurance is one of the biggest jokes and crooks,” said Brandon Barta, 38, of Denver. He said his father, Dixon, who worked at a gas station, never received aggressive enough treatment for his [prostate cancer](http://health.nytimes.com/health/guides/disease/prostate-cancer/overview.html?inline=nyt-classifier). He died last May at the age of 64.

“He was overlooked,” Mr. Barta said.

Mr. Barta said he was intrigued by the idea of a universal health plan that covered maternity care, checkups, emergency room visits and hospital stays, all the way through end-of-life care. Like millions of Americans, he has health insurance tied to his work. His coverage lapsed recently when he switched jobs to start working for a golf entertainment complex, and he is still waiting for his new plan to kick in.

Still, he has questions about how universal coverage would work and how much it would cost taxpayers like him.

The answers: If a majority of voters say yes, the system would start running in 2019, and essentially be a start-up health cooperative bigger than companies like Nike and American Express, according to the Colorado Health Institute, an independent policy group. A 21-person elected board would set the benefits and budgets. The system would be financed by payroll taxes of 3.3 percent for workers and 6.7 percent for employers. It would impose a 10 percent tax on investment income, people who are self-employed and some small-business income.

In the contest for the Democratic presidential nomination, Hillary Clinton, echoing many moderate Democratic leaders here, has said that she wants to keep and improve the Affordable Care Act, Mr. Obama’s signature legislative legacy. But her opponent, Senator Bernie Sanders, who won Colorado’s Democratic caucuses last month by nearly 20 points, has advocated abandoning the health law for a “[Medicare](http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/medicare/index.html?inline=nyt-classifier) for all” approach. His proposal is similar to the ColoradoCare plan.

The campaign over the Colorado initiative has had the unusual effect of putting conservative critics in the position of defending Mr. Obama’s health plan against an assault from the left. At the same time, it is energizing progressives, who say the Affordable Care Act was a giveaway to the insurance industry that, even with an estimated 20 million people newly insured, has left too many others without coverage.

“No matter how long we hang in there with the Affordable Care Act, we will never cover everybody,” said Jeanne Nicholson, a former Democratic state senator and nurse who is a leading supporter of universal care here. “We don’t understand why we should compromise and say some people can have bronze coverage, some can have silver and some can have gold. Why can’t we all have platinum plus?”

Nathan Wilkes, 42, who lives in the Denver suburbs, said that years of trying to get care for his son, who has [hemophilia](http://health.nytimes.com/health/guides/disease/hemophilia/overview.html?inline=nyt-classifier), had worn his family thin and made him an advocate for universal coverage. He said the family had spent thousands of dollars and destroyed its credit because of insufficient coverage. The Affordable Care Act offered some benefits, he said, but its gaps were still too big and “not sustainable.”

Unlike its conservative neighbors, Colorado jumped to get on board with the Affordable Care Act. It set up its own insurance marketplace and expanded [Medicaid](http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/medicaid/index.html?inline=nyt-classifier) coverage for poorer residents. But there have been stumbles. People in mountain towns with few providers faced eye-popping premiums for coverage. Colorado’s biggest health cooperative, Colorado HealthOP, shut down in October, forcing more than 80,000 people to find new plans.

Colorado’s plan would replace many private workplace plans, but it would sit alongside Medicare and federal health coverage for veterans, and private insurers could still sell coverage to people who wanted more.

The Colorado Health Institute, an independent policy group, said the plan’s passage would be “the most far-reaching [health care reform](http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/health_insurance_and_managed_care/health_care_reform/index.html?inline=nyt-classifier) in any state” since the Affordable Care Act.

“It’s replacing a system that I think has become really dysfunctional,” said Irene Aguilar, a Democratic state senator and physician who is leading the effort. “The game has been rigged by the for-profit corporations to ensure they win.”

Opponents say that it could wreck the state’s humming economy and drive away doctors and businesses, and that its costs could spiral out of control.

If it passes, ColoradoCare would become part of the state Constitution, and become virtually impossible to significantly alter without a statewide vote. It would also fall outside the reach of the Taxpayer Bill of Rights, a 1992 amendment to the Colorado Constitution that put strict limits on spending and new taxes.

“It would be a disastrous economic impact on the state,” said Walker Stapleton, Colorado’s treasurer and a co-chairman of the opposition campaign. “If you think legalized pot brought a lot of people to Colorado, you should try free health care.”

Like many other Republicans here, Mr. Stapleton opposed the Affordable Care Act and continues to criticize how it has been put in place. But to defeat the new initiative, he now finds himself defending the federal health law.

Sean Duffy, a Republican and a spokesman for the opposition campaign, said many of his neighbors in the conservative Denver suburb of Highlands Ranch had eagerly signed the petition to put the question on the November ballot because they saw it as a way to get rid of Obamacare.

Some Democratic officials also oppose the state’s universal care effort. They include Gov. John Hickenlooper, who said during his 2014 re-election fight that he was “no big fan of the Affordable Care Act.”

Colorado’s previous Democratic governor, Bill Ritter, also opposes it.

Michelle Lucero, general counsel at Children’s Hospital Colorado, is among the health care officials lining up against the measure. (The hospital itself also opposes it.) She worries that it could threaten research dollars or drive away doctors.

“They’re going to choose to go to a state that’s not hamstrung by this,” she said.

http://www.nytimes.com/2016/04/29/us/colorado-weighs-replacing-obamas-health-policy-with-universal-coverage.html?utm\_campaign=KHN:+First+Edition&utm\_source=hs\_email&utm\_medium=email&utm\_content=29078818&\_hsenc=p2ANqtz-\_3dG5voNN2FslhXZmEYftMZTdh1fwy&tr=y&auid=16671752&\_r=0

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Covered Clips is a publication of the Cover Arizona Coalition. Questions or suggestions? Contact Jon Ford at jford@vitalysthealth.org