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**Moderator:** Caroline Au-Yeung  
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Caroline Au-Yeung: Hello, and thank you for joining us today for this webinar to present findings from the study of the impact of implementation of the Affordable Care Act in Kentucky. My name is Carry Au-Yeung and I'm a research fellow at the State Health Access Data Assistance Centre, or SHADAC. We are a health policy research centre at the University of Minnesota, School of Public Health and we conducted the research being presented today under a contract with the Foundation for a Healthy Kentucky.

Before we get started, we'll cover some technical items. You are all muted because of the large number of attendees on today's call. However, you can submit questions via the chat feature on the left-hand side of the viewing screen at any time for the Q&A session following today's presentations. You can also tweet your questions to us at @shadac on Twitter. If you're having technical difficulties with Ready Talk, please call 1800 843 9166 or you can ask for help via the chat feature. The slides for today are available for download at the link on the fourth bullet on the slide displaying right now. The webinar is being recorded and we will notify you when it is posted on our website.

And now Lynn Blewett will get us started.

Lynn Blewett: Hi, welcome everybody. I'm Lynn Blewett, Director of SHADAC and a Professor at the School of Public Health at the University of Minnesota. We've really enjoyed working for the past few years with the Foundation for Healthy Kentucky and documenting the impact of the Affordable Care Act over the last two years. The information we've collected will be important as additional changes are being made. First, Connective has been moved to the Federal Exchange and then Kentucky has developed and submitted a 1115 waiver to CMS to modify its Medicaid

expansion. Kentucky was one of the first and more successful states in terms of implementing the Affordable Care Act through its state-based marketplace Connect, and through its extensive outreach and enrolment effort to educate and help people find out for common most expanded Medicaid program. You'll hear today some of the foundational information that we've been able to document over the past two years, which will be important as we continue to work to document changes that are still occurring in Kentucky.

Now I'd like to introduce Gabriela Alcalde who will talk a bit about the Foundation and how the study findings will be used in the Commonwealth, Gabriela.

Gabriela Alcalde: Thank you Lynn. This is Gabriela Alcalde, I'm with the Foundation for a Healthy Kentucky. The Foundation for a Healthy Kentucky is a non-profit and philanthropic organisation which is mission-driven. Our mission is to address the unmet healthcare needs of Kentuckians. We've been around since 2001 and we focus on developing and influencing health policy to improve access to care, reduce health risks and disparities, and to promote health equity.

Because of our mission, we started in 2012 with an initiative called Promoting Health Policy, Promoting Responsive Health Policy. The initiative is aimed at making public health policy more responsive to the health and healthcare needs of Kentuckians and we identified four general areas of focus, and you'll notice these are quite broad areas. So it's been a very comprehensive initiative. We looked at increasing access to care, strengthening local public health, improving children's health and increasing the proportion of Kentuckians living in smoke-free jurisdictions. In order to advance these priorities, the Foundation has given out grants to advocacy and research organizations, we've invested in targeted research studies such as this one and data efforts. We've convened stakeholders in meetings and conferences and we have shared this information through our website, through publications and through other media opportunities.

The opportunity to look at the impact of the Affordable Care Act to us was a unique opportunity to really see the impact of a policy that was developed at the national level which would have to be embraced by the state, but really had to sort of hit the rubber, the rubber would hit the road at the local level. We were very interested in seeing how, the way that this policy was implemented by Kentucky, by both doing the Medicaid expansion and the state-based exchange which we called Connect, which has now been dismantled. How that would affect a number of areas that we wanted to focus on, and that is coverage, access, cost, quality and health outcomes. We were particularly interested in the historically under-served populations in Kentucky, that includes both communities of colour, low-income populations and rural populations. We were very interested in doing this in real-time, so we issued a request for quotations in November 2014, soliciting responses to a defined set of requirements that would result in an objective mixed-method study analysing key effects of the implementation of the Affordable Care Act in Kentucky over a three-year period.

The Foundation then convened a committee of anticipated end-users to review proposals and to make recommendations on selection. The committee then convened throughout the life of the study to provide guidance and feedback to the research team and the Foundation on the various findings. For example, they would provide feedback on the survey tool, the types of questions, the types of areas on the special reports, as well as what they were hearing from their constituents. So it was a very active feedback loop to the research team.

We wanted to study to really serve as a resource, not just for Kentucky policy makers and advocates, but also for other states that wanted to compare and learn from our state's experience in implementing the ACA because this is a natural experiment in which each state had the opportunity to implement the Affordable Care Act in its own way, we felt that this would be an incredibly valuable experiment to document.

We wanted to be able to report in an informed manner on trends, coverage, access, quality, cost and outcomes, and to identify elements of the implementation that were important to the outcomes that we were interested in, whether it was positive or negative. We really pride ourselves on being objected and informing dialogue around health policy in the state without necessarily taking a position. So this research study was an important ingredient in our ability to inform this dialogue and understanding of how this particular health policy would affect the health of Kentuckians.

We were interested in really coming up with something that was rich in the experiences of providers and end-users as well as that utilised data from the state and national level. So when we issued the RSQ, those were some of the guidelines that we had provided.

The committee that we put together reviewed the proposals and issued a recommendation and we ended up giving the contract to SHADAC and we've been incredibly pleased with the process and with the product. I wanted to share a little bit about the products that SHADAC has produced for us, and that has been incredibly valuable and highly used in Kentucky. We first had a baseline report to help us compare as we moved forward. We then identified that there would be issues that would come up throughout the study, so these were not pre-determined at the beginning of the contract period. But what we ended up determining that we would focus on, again, through guidance and input with our committee, was looking at a special report on the impact of children's coverage, high-deductible health insurance plans, substance use and substance use treatment in Kentucky since the ACA was implemented, and emergency department utilisation. SHADAC also produced annual and semi-annual reports for us, quarterly data snapshots which we released widely and we've received feedback that they were one of the most valuable, as close to as in real-time information as we could get out there on the Affordable Care Act impacting Kentucky. And then a final report that really looked at the entire period and drew some conclusions for us. You can find all of these deliverables on our website, [www.healthy-ky.org/research](http://www.healthy-ky.org/research) and I would encourage you to go to our website and review these

documents and if you have any questions, please feel free to reach out to me with any questions or interest and insights of how we've utilised this data, how our partners in Kentucky and beyond have used this research. We have found that it has had very broad reach and it has allowed us to have a common language and a common set of facts with which to speak about research and with which to speak about the Affordable Care Act in Kentucky. It's really taken something that's become somewhat politicised in our state and allowed us to have a factual approach to it. So that's it for me, and I'd be happy to take questions at the end of the webinar.

Colin Planalp: Hi everybody. I'm Colin Planalp, I'm a research fellow here at SHADAC and I was an analyst and the project manager on this study here at SHADAC. So I want to jump into this with a little bit of an overview for those of you who aren't familiar with the history of the ACA in Kentucky. The ACA was signed into law in 2010 with its key coverage provision set to begin in 2014, namely the Medicaid expansion for low-income adults and marketplace-based financial assistance for people with moderate incomes. After legal challenges to the law, the US Supreme Court ruled in 2012 that the ACA was largely constitutional, but its decision also effectively made the Medicaid expansion optional for states. In 2014 Kentucky implemented the ACA's Medicaid expansion under executive authority of then Governor Steve Beshear, and it launched a state-based marketplace called Connect. In 2015, the Commonwealth elected a new governor, Matt Bevin who during the campaign said that he would reverse the state Medicaid expansion, and close Connect. In 2016, Kentucky submitted a waiver application to modify the state's Medicaid expansion, which would require monthly contributions and make a number of other changes. The state also closed its Connect system in 2016, switching to the healthcare.gov platform, but maintaining many of the other functions of a state-based marketplace.

SHADAC began our study in 2015 but we used a variety of data from 2012 through 2016 to investigate the impacts of the ACA in Kentucky. And for most of our indicators, we used 2012 as our baseline and we did that to avoid capturing early effects of the ACA. In some cases where that was impossible, we used 2013 as our baseline.

As a bit more background on the study, as I said, we began our work in 2015 as a multi-year project and we finished in February of 2017. For the most part, we used thorough survey data as well as federal and state administrative data, such as Medicaid claims and marketplace enrolment data. And as a framework, as Gabriela mentioned, we examined the impact of the ACA in five main domains, coverage, access, cost, quality and health outcomes.

So first I want to start out by presenting our findings on coverage. Here SHADAC analysed data from the Census Bureau's American Communities Survey and we found that Kentucky's uninsurance rate fell by more than half from 13.6% in 2012 to 6.1% in 2015. This slide shows uninsurance rates by race and ethnicity. Un-insurance dropped significantly for whites, blacks and people of multiple or other races, but Kentucky's uninsurance rate did not change significantly for Latinos or the state's Asian population. This chart shows uninsurance by age for children and non-elderly adults. Although the ACA's coverage expansions were designed primarily for non-elderly adults, we see that un-insurance rates declined among all ages, including children, and that's likely because some parents enrolled their kids in coverage when they themselves obtained coverage. We also see that young adults experienced the largest drop in uninsurance, of 15.3 percentage points, although this doesn't account for declines in uninsurance before 2012, that may have occurred as a result of the ACA's provision to allow young adults to enrol on their parent's coverage up to age 25. This chart shows un-insurance rates by income level according to federal poverty guidelines. Rates declined significantly among all groups, including a small drop among people with incomes above 400% of poverty guidelines, who weren't eligible for Medicaid expansion or marketplace-based tax credits. Consistent with the ACA's coverage provisions aimed at people with lower and moderate incomes, the declines in uninsurance were larger at the lower end of the income spectrum. And the largest decline of 15.6 percentage points was among people with incomes up 138% of federal poverty guideline, the group eligible for Medicaid under Medicaid expansions.

As another component of our study, SHADAC conducted a survey of non-elderly adults in Kentucky between March and May 2016, which we called the 'Kentucky Health Reform Survey'. Through that survey, we asked Kentuckians without insurance the main reason they didn't have coverage. The most common response was that coverage was too costly or that they couldn't afford it. We don't know whether these people actually priced coverage or just assumed that it's too expensive, but we can see here that price is still seen as a barrier to obtaining health insurance. Also notable was that less than one in five gave reasons suggesting they were opposed to getting coverage, such as believing that they didn't need it or not wanting government involved in their healthcare, suggesting there's probably still room for improvement in reducing Kentucky's un-insurance rate further.

At the same time un-insurance declined in the state, we found a statistically significant increase in Kentuckians reporting individual market coverage, from 4.4% to 5.3% in 2015. And this is likely the result of people obtaining coverage and financial assistance through Connect. This slide shows the number of plan selections through Kentucky's marketplace, Connect, during the first free open enrolment period under the ACA. During the first open enrolment period, about 83,000 people selected plans through Connect. In the second year, that increased by more than 25% to about 106,000 people. Then in the third year, plan selection declined to about 94,000. These data don't tell us why plan selections declined, but we refer to anecdotal reports of confusion about using Connect since there was talk at this time about closing the marketplace. Also, while it's not shown here, CMS recently released state-level data on plan selections from the latest open enrolment period which ran from November 2016 to January 2017 and they reported about 81,000 plan selections, which would be the lowest Kentucky marketplace enrolment since implementation of the ACA. Again, we don't know exactly why enrolment declined, but it could be in part due to Kentucky's transition from Connect to the federal healthcare.gov platform during that time.

We also found a statistically significant increase in Kentuckians reporting Medicaid or CHIP coverage, from 13.4% to 19.8% in 2015. In our analysis of administrative data shared by the Kentucky Cabinet for Health and Family Services, we found more than 500,000 non-elderly adults had enrolled in Kentucky's Medicaid expansion by the third quarter of 2016. We also found increased enrolment in traditional Medicaid, consistent with the welcome effect. Enrolment in Kentucky's Medicaid expansion increased in nearly every quarter since the ACA was implemented in the state, almost doubling since the beginning of 2014. Enrolment in traditional Medicaid, as we mentioned, such as for parents, grew at a slower pace of 24% since early 2014. This chart shows enrolment in traditional Medicaid in orange and Medicaid expansion in teal and it tells us a couple of things. Enrolment in both programs skews younger in traditional and Medicaid expansion, but despite that, Medicaid expansion still covers a substantial number of adults aged 45 and older, particularly compared to traditional Medicaid.

We found no significant change in rates of Kentuckians with employer-sponsored insurance since our baseline in 2012 but we did find a significant decline in the percentage of Kentucky employers that offer health insurance. That decline seems to be driven by small employers with less than 50 workers. Large employers with 50 or more workers continue to offer health insurance at rates that were unchanged since 2012.

Throughout the study, we also compared Kentucky on selected measures to a group of neighbouring states, Kentucky's seven border states plus Arkansas. We added Arkansas because it's similar in many ways to Kentucky, but it implemented the ACA with an important difference, it expanded its Medicaid program via a Section 1115 waiver, opting to use Medicaid dollars to purchase Medicaid beneficiaries' private plans through the state marketplace. This chart shows 2012 and 2015 un-insurance rates for Kentucky on the left, followed by the US and our group of comparison states. The last three states on this slide, Missouri, Tennessee and Virginia are grouped together because they were three comparison states that did not opt to expand their Medicaid programs. We see that Kentucky had the second-largest decline of all

these states, a drop of 7.5 percentage points. Only West Virginia had a larger decline in uninsurance, a drop of 8.7 percentage points.

Because of uncertainty around the future of Connect and the Medicaid expansion in Kentucky, we included a question in our 2016 survey of non-elderly adults to gauge whether respondents were concerned about losing their coverage. We found that about one in ten reported this concern, but that rate was significantly higher among people with public coverage, about one in five people, and among those with lower incomes in the range for Medicaid expansion, about one in four people.

For several measures in the domain of access and cost, SHADAC used data from the National Health Interview Survey. Estimates from the NHIS typically aren't available at the state level, but SHADAC has a project to produce state level estimates which you can find at [statehealthcompare.shadac.org](http://statehealthcompare.shadac.org). As a quick note, we'll be holding a webinar on State Health Compare in May and you can learn more about this joining our mailing list. Using those data, we found a statistically significant increase in Kentuckians reporting they had a usual source of care, other than an emergency department. There is no significant change among children, and we weren't able to report separate estimates for elderly Kentuckians, because of limitations with the restricted data. This increase in Kentuckians reporting a usual source of care appears to be driven primarily by non-elderly adults who saw a significant increase of 8.8 percentage points.

We also looked at Kentuckians reporting they made changes to their medications due to cost, such as skipping doses or taking less than prescribed. This question is not asked about children, so we looked at non-elderly and elderly adults separately. Although the estimate for non-elderly adults was lower in 2015 than 2012, that difference was not statistically significant. However, the rate among elderly Kentuckians dropped nearly in half, from about 26% to 13% and this change was statistically significant. Because the ACA's coverage expansions weren't aimed primarily at elderly, this may seem surprising, however there's some evidence this may be due to the ACA's

provision to close the Medicare prescription drug donut hole. For example, the Centres for Medicare and Medicaid Services estimate that the ACA's donut hole provision gave beneficiaries an average of \$1000 in 2015.

We also looked at administrative data on services provided through Kentucky's Medicaid program, mostly preventative services. Here we show breast cancer screenings covered by Medicaid. As you can see, breast cancer screens increased for both Medicaid expansion and traditional Medicaid enrollees, and those trends are similar to the increases that we saw in enrolment since 2014. We also examined a few services that weren't preventative in nature, such as substance use treatment. In substance use treatment, we saw a much more dramatic increase than most other services. These data don't tell us the reasons for this rise, but there are likely multiple factors. For example, Kentucky's been particularly hard hit by the national opioid crisis, with some of the highest rates of overdose deaths in the country. Additionally, when Kentucky Medicaid, when Kentucky expanded its Medicaid program, the state included substance use treatment services for expansion beneficiaries as required by the ACA, but at the same time Kentucky also added additional optional substance use treatment service to its traditional Medicaid program, which was more limited before the law was implemented in the state.

As another measure of access, we examined rates of people who reported using an emergency department in the past year. Some analysts have argued that the ACA would decrease emergency department use, while others have argued that it would increase use. We didn't find significant changes in Kentucky, the US or any comparison states in rates of people reporting emergency department use in the past year. In addition to survey data of emergency department use, we also analysed data from the Kentucky Hospital Association on the number of emergency department visits for each hospital in the state. And this chart shows us a few things. First, we see changes in the pairs[?] for emergency department visits, the shared charge to Medicaid increased from less than a third in 2012 to nearly half in 2015 and the share reported as 'self-pay'

or 'charity care', which we use as a proxy for uninsured, dropped from nearly a quarter to less than one in ten in 2015. Second, the number of visits increased about 5%, from about 2.1 million in 2012 to 2.2 million in 2015. Initially this may seem to contradict the survey data which showed now increase, however there are some potential explanations for this difference. For example, it may be that some people are using the emergency department more frequently, but no more people are using the emergency department across the population.

Moving onto our next domain of cost, this chart shows rates of people reporting trouble paying medical bills or paying medical bills over time. For people of all ages, we saw a significant decline in trouble paying medical bills in Kentucky and the US as well as only one other state, Ohio. Additionally, this chart doesn't show breakouts by age groups, but I'd like to note that these rates declined significantly for non-elderly adults and children, but not for the elderly.

This chart shows rates of Kentuckians who reported they delayed or went without care due to cost. We weren't able to breakout separate rates for children and elderly, but here we show rates for Kentuckians of all ages, as well as for non-elderly adults. First, we see that rates of delayed care due to cost declined significantly for Kentuckians of all ages and non-elderly adults, dropping by nearly half for both groups. Second, we see a similar pattern in foregone care due to cost. This also declined significantly for Kentuckians of all ages and non-elderly adults, dropping by about half for both groups.

On this chart, we show data that Kentucky hospitals report to the state on charges for charity care and self-pay patients. We use this as a proxy for uncompensated care. An important caveat here is these data don't account for undercompensated care, such as if reimbursement from pairs, such as Medicare or Medicaid don't fully cover a hospital's costs of delivering care. Overall, we see that from 2012 to 2015, charity care and self-pay charges declined by about two thirds, from \$2.3 billion in 2012 to under \$800 million in 2015.

We also monitored costs for marketplace plans in Kentucky and other states. Here we're looking at an analysis of a Robert Wood Johnson Foundation's hits[?] compared dataset comparing median 2016 premiums in Kentucky and neighbouring states for a 30-year old couple with two children. We see that Kentucky in this case had the lowest premiums for that scenario. This infographic shows the percentage of marketplace enrollees receiving tax credits and the average size of those tax credits for Kentucky and the US in 2015 and 2016. There are a couple of things here that I'd like to point out. First, in both years the percentage of Kentuckians receiving tax credits was lower than the US, although it did increase between 2015 and 2016. Second, in both years, the average tax credits in Kentucky were smaller than the US and that provides additional evidence that Kentucky has lower marketplace premiums than other states.

In contrast with earlier domains of coverage, access and cost, we did not find many clear improvements in quality. While some changes were positive, some changes were negative. Most remain largely unchanged. Rates of low birth weight are a good example. Here we see that low birth weight for Kentucky's overall population remained unchanged at 8.7% of births and disparities continue to persist with rates among black Kentuckians higher than whites and non-Hispanics. However, rates of breastfeeding initiation have shown an improvement of about six percentage points since 2012 to almost 69% in 2015. While there may be other factors that contributed to this growth, such as increased cultural acceptance of breastfeeding nationally, the ACA included a number of provisions to support breastfeeding. For example, the law required that maternity and new-born care be covered as essential health benefits for individual market coverage, and it requires that breastfeeding counselling and equipment such as pumps be covered without cost sharing.

In the domain of health outcomes, most of our Kentucky measures remained unchanged since implementation of the ACA, and this is a good example of that. In this case, the US experienced a small but statistically significant decline in adults reporting poor or fair health as opposed to good or excellent health, as did Ohio and Virginia. However, Kentucky's rate had not changed

significantly, remaining stable at nearly a quarter of Kentuckians reporting poor or fair health. It's not particularly surprising that we haven't seen large changes here, but health status is still important to monitor for a fuller understanding of the impacts of the ACA in Kentucky.

Before we open up the webinar for questions, I want to make a few concluding points. Kentucky's seen clear improvements in coverage since the ACA, and there are also some positive signs in access and cost, however, the state hasn't yet seen clear changes in quality or outcomes. Overall, these findings suggest that the ACA may be having some positive effects in Kentucky. It'll be interesting to follow Kentucky as it pursues additional changes to its implementation of the law.

Caroline Au-Yeung: All right, thank you Colin. And now we'll be moving onto our question and answer portion of today's webinar. We had some questions coming in on the chat feature, feel free to keep those coming and you can also still submit questions to Twitter, if you send us a tweet to @shadac, we can grab those off of there. And I will just start relaying what we're hearing. The first question I have is, with regard to lowering numbers of unnecessary ED visits, what mechanism is driving down those numbers in a measurable way? Can you speak to that, Colin? And I think that might be asking from a policy perspective, what about the ACA would be driving that down?

Colin Planalp: Yeah, so there have been competing arguments about what the effects of the ACA may be on emergency department visits. So on one side of the argument is that increasing access to health insurance may allow people to obtain care in other settings, such as going to see a primary care doctor rather than going to the emergency department. So that's one argument. Another argument is that if people are receiving health coverage, then that coverage may reduce some of the cost barrier to seeking care in emergency departments. But kind of what we saw from the data in Kentucky is essentially we're not seeing any increase or decrease in the percentage of Kentuckians reporting they're using an emergency department in the past year, but if we think

back to that slide where we showed the total number of visits, there has been about a 5% increase in the number of visits. So again, what may be going on there is you may be seeing some people who are using the emergency department more frequently.

Caroline Au-Yeung: Got it. Okay. The next question is, can other states get the barriers to access measures from the NHIS that you have referred to? I don't know if you can talk a little bit more about where you got those.

Colin Planalp: Yeah, so SHADAC produces these estimates from the National Health Interview Survey through a project in a research data centre, and what that allows us to do is to produce estimates that typically aren't available at a state level. And we post all those estimates that we're able to disclose through the, through those restrictions on the SHADAC, [statehealthcompre.SHADAC.org](http://statehealthcompre.SHADAC.org) website, and that has a tool that you can go through and look at those different access and cost measures by state and look at those over time. There are a variety of ways that you can look at that. And like I mentioned earlier, SHADAC's going to be holding a webinar on that tool later on May, so if you're interested in those measures, that would be a great place to kind of learn a little bit more about how that tool works and what's available through that tool.

Caroline Au-Yeung: Okay, thank you. The next question I have I think is best for Gabriela. Is the Foundation going to be collecting data to assess the impact of the changes in Medicaid under the new 1115 waivers?

Gabriela Alcalde: Thank you. At this point we are not planning on doing that. We assume, as many others do, that the waiver will be passed and will be implemented in the coming months. However, we have not made any decisions at this point as to whether we're going to invest in a research study for the waiver.

Caroline Au-Yeung: Thank you. Next question is framed as, the Medicaid expansion enrolment and payment information SHADAC has gotten has been invaluable. Did the Foundation and SHADAC get that info through a Memorandum of Understanding or some other form, and could it be replicated by other partners in Kentucky?

Colin Planalp: So just to clarify, I believe this question is asking about the Medicaid data, specifically?

Caroline Au-Yeung: Yup.

Colin Planalp: So, these are data that SHADAC has obtained the course of ACA implementation in the state through the Kentucky Cabinet for Health and Family Services. I don't recall the details of that agreement off of the top of my head but I would think that that would be an option for other researchers interested in using those data to understand the impacts of ACA implementation in the state. And regarding some of the other data sources, a lot of the other data that we used to understand, for example, the impact and the costs and access measures related to the state marketplace, some of those data came from state-level reports released through Connect, and many of those data came through federal-level reports, through the Assistant Secretary for Planning and Evaluation at the US Department of Health and Human Services as well the federal CMS agency.

Caroline Au-Yeung: All right.

Gabriela Alcalde: If I could help answer that question. I wanted to reiterate that we had the committee looking at, that informed the decision on the RSQ for the study, but that committee also worked with us throughout the study. On that committee were representatives from the Cabinet of Health and Family Services in Kentucky who would have access to the Medicaid data as well as representatives from the Kentucky Hospital Association. So we worked closely with those partners and developed relationships which provided us access to that data. So I just want to

emphasise that we didn't actually have a formal Memorandum of Agreement on access to the Medicaid data, it was provided through SHADAC, through the relationships that we have developed.

Caroline Au-Yeung: All right, thank you Gabriela and I actually have another question for you here. What do you think was the most important aspect of the study for Kentucky and how visible were the very positive results and are they having any impact at the legislature, or do you feel that they will?

Gabriela Alcalde: That's a pretty big question. I have a hard time really saying which part was the most important. I think that the whole study has been incredibly useful and informative, it has really guided and shaped the public discourse in Kentucky and beyond, I think, at the national level in terms of how well Kentucky did with outreach and enrolment. And as we learned throughout the study on the positive impact that it was having on access, for example, I think it was, both policy makers and advocates and other entities, whether it's providers or hospitals or consumer representatives were able to inform the conversation with the facts that we were able to attain from the study. I do think that having those special reports on the one hand, that provided the deeper dives into certain issues of interests, I think especially the substance use and substance use treatment have been very salient and there's been a lot of interest around that, as well as the quarterly snapshots. That just, I know and I've heard, again, this is more anecdotal, but also through our evaluation efforts, we've learned that those were really highly valuable to our partners as well as to grantees in Kentucky.

In terms of the second part of the question, do I think that it has had an impact, I think was the question, policy makers. The different aspects of the study have been cited and have been used and presented to the legislature. We've had legislators who have actually cited our study, it has been used by advocates and professional associations in presentations to health and welfare committees for example here in Kentucky. So it definitely has been used and therefore in that

way it has informed the dialogue. It is our hope, of course, that health policy will be informed and shaped by evidence and by what is best for Kentuckians, so we also continue to hope that the study will continue to inform the dialogue. And as the final report has been issued relatively we hope that that conversation will continue.

Caroline Au-Yeung: Okay, thank you. And I will... who will be best to speak to this at this point, Colin or Gabriela, but there's a question about key measures that would be a good idea to keep an eye on as the 1115 waivers are implemented and the other health reforms are implemented. Just that you would recommend as tracking in Kentucky. Colin, do you want to speak to that first?

Colin Planalp: Sure, I can give... also would be important to, I think it also would be important to look at many of those cost measures again, because some of the specific policy proposals in the Section 1115 waiver that they looked at requiring monthly contributions or implementing health savings account-style components and deductible-style components. But really long-term, I think it's also important to keep an eye on those health outcome measures to see whether over the course of many years whether Kentucky does begin to see some changes and some improvements in those health outcome measures, such as poor, fair health and the number of chronic conditions which is another measure we looked at but weren't included in these slides.

Caroline Au-Yeung: Thanks Colin, and I apologise, the sound went out for a second there. Gabriela, I don't know if there's anything you wanted to add on to what Colin was saying?

Gabriela Alcalde: Yes, and I heard the last bit of what Colin said. So if I'm repeating some of what you said, I apologise. I think because of some of the components in the 1115 waivers it will be important to look at whether there's disenrollment, either because of the lack of automatic re-enrollment or because of the penalties placed on non-payment. They will have to look at, are people losing coverage and are those people coming back or are they staying uninsured. We need to look at how the waiver or any changes, really, affect different populations, particularly

rural, low-income communities of colour. We want to make sure that any changes do not have an inequitable impact. I also think it's too early at this point, while we did look at health outcomes, it's too early to expect health outcomes to really be changing within such a short time of the, within the study time period. So I think we'll need to look at health outcomes over the long-term. More immediately we'll have to see if there are changes in access. And more broadly, thinking about research on the impact of having insurance on economic wellbeing and bankruptcy, we'll want to see if there are any changes on medically-caused bankruptcy to Kentuckians. So any changes, not just in health, but also economic and social wellbeing, I think we'll need to keep an eye on.

Caroline Au-Yeung: Okay, thank you. The next question is whether there is any data on changes to structural barriers to receiving care in Kentucky, such as finding a provider, or providers that accept Medicaid or exchange plans. Have you seen any of that or is any of that available to your knowledge? Colin or Gabriela?

Colin Planalp: Yeah, so I can speak to that a little bit. We didn't specifically look at whether there were specific barriers to access through Medicaid or marketplace-based plans, but one thing that we did look at that wasn't included in these slides was look at some measures of access to care across the state population. And what we saw is that for example, more than 90% of Kentuckians before the ACA said they were able to find a doctor when they needed and that they were able to find a doctor that accepted their health insurance and we didn't see any changes in that since the implementation of the ACA. Which tells us that one concern that some people had about the potential impacts of the ACA was that with so many more people gaining coverage it would be harder to find a provider, that there would be a worsened provider shortage. And looking at those measures, we didn't really see any evidence of that.

Caroline Au-Yeung: Great. Last minute question came through here. Colin, could you talk a little bit more about the opioid issue in Kentucky and the impact that the Medicaid expansion seems to be

having on providing needed services and where the data came from for that portion of your analysis?

Colin Planalp: Sure. So as a little bit of background, as Gabriela mentioned, we produce a special report as part of this study looking more specifically at the issue of substance use with a particular focus on the opioid crisis in Kentucky. And as a little bit of background that I didn't discuss here, Kentucky's seen very large increases in overdose and death related to prescription opioids and heroin over the past several years. And one component of the Affordable Care Act that has some potential to address this issue is the law requires individual market and small group plans to cover substance use treatment and cover substance use treatment in parity with, for example, medical and surgical treatment, under the law as essential health benefits provision. Substance use is one of those ten essential health benefits. And in addition, those ten essential health benefits are required to be covered under Medicaid expansion. So, looking back to some of those data that we showed earlier in the slides, that that large increase in substance use treatment services through Kentucky's Medicaid program is probably in part due to the increase in the issue of opioid use in the state and probably also related to that increase in access to treatment through the Medicaid program in the state.

Caroline Au-Yeung: Okay, thank you. The next question has to do with the findings about changes in the uninsured levels. Why do you think there is a significant impact on un-insurance rates with respect to declines for whites and blacks but not for Latinos and Asians living in Kentucky? Could this be a sample size issue?

Colin Planalp: Yeah, so that's a really good question. Like the questioner mentioned, we did see declines among the overall population, whites, blacks and people reporting multiple or other races. With the Asian population, it's possible that what we're seeing there is an issue with sample size, there appears to be some volatility in those estimates year to year for the state's Asian population. For the state's Latino population, we, as we saw even before the ACA, that

group in Kentucky had higher rates of uninsurance than the other groups, so we may be in part seeing some kind of artefact of that earlier higher un-insurance rate. But that may also be a result of the way the ACA does not... where the ACA's coverage expansions do not extend to unauthorised immigrants and some of those people may be unauthorised immigrants or some people may just be avoiding getting coverage through the Medicaid program or Connect due to concerns related to that.

Caroline Au-Yeung: Okay, and I also have a question about, related to that, whether there are any plans that you, Colin or Gabriela, are aware of, to do an in-depth analysis of the quality of care and racial inequality not abating in the wake of ACA implementation in Kentucky. Why those might not be going away? Are you aware of any plans to study that further?

Colin Planalp: Yeah, so at this point I don't think we have any plans since the study's concluded to look into those issues in a lot of detail. But one thing that I do want to mention is, just thinking back to those slides showing those uninsurance rates by race and ethnicity, so while we didn't see declines among the state's Latino or Asian populations, we did see a significant and pretty large decline among the state's African-American population to the point that that appears to be pretty equivalent to the uninsurance rate for the white population. So it seems we may actually be seeing some change in equities there.

Caroline Au-Yeung: Okay. Gabriela, did you have anything to add on that?

Gabriela Alcalde: Yeah, we don't currently have any plans to do a study like that from the Foundation, although that is something that we would be very interested in and I think that is the kind of research that requires deeper qualitative research as well to understand the experiences of communities of colour, particularly immigrant communities in Kentucky to understand what else, what other variables may be at play, whether it's the fears around immigration, mixed-status

families, language access, cultural competency, whatever it may be. I think that there is definitely room for us to learn more about why those inequities persist.

Caroline Au-Yeung: Okay. And I have a question that you may have already answered, so I do apologies. A question about the Kentucky Hospital Association data and how you obtained that and whether the data's publicly available? I don't know if you talked about that with the Medicaid data discussion.

Colin Planalp: No, I should have mentioned that earlier. But some of those data that we showed on the slides came from the Kentucky Hospital Association. The Kentucky Hospital Association was very gracious in working with us to share some of those data with us. Those data aren't publicly available to my knowledge, we were able to gain access to those data because, as I think Gabriela mentioned, some representatives from the Kentucky Hospital Association were part of the study's oversight committee and we worked with them based on that. But it's possible, I frankly don't know off the top of my head, that some of those data may be publicly available through the state. I believe that KHA collects quite a bit of data for the state as a contractor.

Caroline Au-Yeung: Just a general follow-up question, looking back on the two year study, what would you say to someone else considering a similar analysis in another state? What would your recommendations be to them, having done this analysis? In terms of data, research questions, areas to look out for, is there anything you would share with other people looking at this?

Colin Planalp: Yeah, so I would first say, it's helpful to do kind of a full data scan at the beginning and take a look at what you already know is available through state data or federal data, through administrative data and survey data. Maintain some flexibility so that you can make use of new data sources as they become available, that's something that I think really added to this study is that when we learned that we would be able to obtain some additional data on say, emergency department visits from the Kentucky Hospital Association, that was very useful. And in addition, if

you have the budget in your study, it's also helpful to do some of your own primary data collection. That was a very helpful part of this study, we conducted the Kentucky Health Reform Survey which was a survey that we developed in consultation with the Foundation and the oversight committee. And what that allowed us to do was really to kind of tailor some of those questions that we wanted to ask and get answered that we weren't able to answer through other data sources. And that was an area where SHADAC was able to also build on our own experience conducting similar surveys in the state of Minnesota through the Minnesota Health Access Survey. And, just again to plug the State Health Compare website, look at places where you might be able to get data that aren't always publicly available, that's a great place to look at, back to those National Health Interview Survey questions, data that's available at a state level that typically wouldn't be accessible through the data sets, through the federal survey micro-data.

Caroline Au-Yeung: Great. Well, we're nearing the top of the hour, so I think we'll start winding down.

Thank you everyone for attending today's webinar and thank you again to Gabriela Alcalde from the Foundation of a Healthy Kentucky and thank you to Colin Planalp from SHADAC for talking with us today about the impact of the implementation of the Affordable Care Act in Kentucky. This has been really informative. And do feel free to follow up with us with any additional questions you didn't have a chance to ask today or think about after the fact, you can always email us at [shadac@umn.edu](mailto:shadac@umn.edu) or find us online. Today's webinar slides are posted on the SHADAC website and we'll be adding links to any follow-up items, any unanswered questions or materials referenced during today's webinar. We'll include a link, of course, to the Foundation for a Healthy Kentucky from there and a recording of the webinar should be available early next week. We will include a direct link to the recording and a follow-up email along with all the links presented today that you'll receive in a few days here from us. Thank you to everyone for attending. This concludes today's webinar.