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October 7, 2016

Submitted Electronically via Medicaid.gov

Secretary Sylvia Matthews Burwell
Department of Health and Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Kentucky Section 1115 Medicaid waiver application proposal

Dear Secretary Burwell:

The International Union, United Automobile, Aerospace and Agricultural Implement Workers of America ("UAW"), Region 8 is pleased to submit these comments on Kentucky's proposed 1115 Medicaid Waiver Application.

The UAW proudly represents over 400,000 active members, and 580,000 retired members throughout the U.S., Canada and Puerto Rico. Region 8 covers the Southeast, including Kentucky, and has over 50,000 active members. The UAW, in partnership with employers, works every day to ensure fair pay and benefits, and safe working conditions for its members. More importantly, the UAW is committed to improving the lives of working men and women everywhere by securing economic and social justice for those whose individual voices are often unheard or unheeded.

One critical aspect of the UAW's mission is to promote secure health care for all. It is this commitment to secure health care that compels us to express our concern over the regressive 1115 Medicaid waiver proposal submitted by the Commonwealth of Kentucky. It is our view that the waiver proposal, Kentucky HEALTH, fails to satisfy the standards for a 1115 waiver in that it will dramatically decrease coverage of low-income individuals, erect barriers to access of health care for the working poor, and negatively affect health outcomes for the people for whom Medicaid is designed to assist.

The Work and Community Service Requirement Should be Denied

To date, CMS has denied all other states' requests to tie work requirements to eligibility for Medicaid expansion. It should do so as well with Kentucky HEALTH. Medicaid is a government health care program, and allowing Kentucky to condition eligibility for Medicaid coverage on work or community service requirements directly conflicts with the objectives of Medicaid, i.e., to provide coverage for low-income people in order to improve their access to affordable health care. Furthermore, requiring Medicaid beneficiaries to engage in community

service is the equivalent of creating a volunteer workforce that could displace paying jobs and weaken labor markets in economically depressed areas of Kentucky.

The UAW is particularly concerned that the proposed requirement for community service may weaken workers' rights in more subtle ways by eroding wage protection laws such as the FLSA and Kentucky wage and hour laws. Frankly, we believe that a requirement to volunteer a person's services in order to secure the benefits of Medicaid coverage may be illegal under state and federal law.

Lastly, the proposed work and community service requirements will increase administrative costs in order to track each Medicaid beneficiary's work and volunteer hours to determine new or continued eligibility, decreasing the efficiency of the Medicaid program in Kentucky.¹ These barriers are antithetical to Medicaid's objectives of strengthening coverage and health outcomes, increasing access to providers, and increasing the efficiency and quality of care to poor Kentuckians.

Premiums are Incompatible with the Medicaid Program

The addition of premiums, at any amount, poses a barrier for low-income people that will cause reduced enrollment. Studies have shown that premiums are a hardship on the poor and lead to reduced enrollment and dropped coverage.² Such barriers to healthcare access are clearly in conflict with the goals of Medicaid, particularly when disenrollment for the failure to pay premiums is part of the proposal as is the case with Kentucky HEALTH.

In Michigan, which does not have a disenrollment penalty, premium collection rates tend to fall below 50%, leading to increased administrative costs in the form of reminder calls and other efforts to improve collections.³ Iowa has seen disenrollment rates as high as 40% when enrollees with incomes above poverty level fail to pay within a 90-day grace period.⁴ Likewise, Indiana reported disenrollment of 1,680 individuals from its Medicaid expansion program for failure to pay premiums in a three month period from November, 2015 to January, 2016.⁵

¹ See Pavetti, Ladonna, "Work Requirements Don't Cut Poverty, Evidence Shows," June 7, 2016 *available at* <http://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows>.

² See Andrea Callow, "Charging Medicaid Premiums Hurts Patients and State Budgets," Families USA Blog, April 2016 *available at* <http://familiesusa.org/product/charging-medicaid-premiums-hurts-patients-and-state-budgets>; Leighton Ku & Teresa Coughlin, *Sliding Scale Premium Health Insurance Programs: Four States' Experiences*, 36 *Inquiry* 471 (1999/2000).

³ Michigan Department of Health and Human Services, July 2016 *Program Evaluation Report on Healthy Michigan*, submitted to the Center for Medicare and Medicaid Services, *available at* <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/Healthy-Michigan/mi-healthy-michigan-qtrly-rpt-jan-mar-2016.pdf>.

⁴ CMS Quarterly Report, Iowa Wellness Plan, 4th Quarter 2015, Attachment 7, *available at* https://dhs.iowa.gov/sites/default/files/IWP.Q4.2015_o.pdf.

⁵ Healthy Indiana Plan Section 1115 Quarterly Report to CMS, *available at* <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-qtrly-rpt-nov-jan-2016-03312016.pdf>.

Kentucky HEALTH's proposed use of premiums is particularly problematic. The Kentucky proposal would require individuals with incomes below 100% of the poverty level that fail to keep premium payments current to make co-payments for all services, would suspend their My Rewards Account while removing \$25 from the account, and pay the past debt in addition to the premium for the reinstatement month in order to re-enroll. The proposal also includes a 6-month lock-out period if premiums are not paid within a 60-day grace period. Thus, the inclusion of premium payments in Kentucky's proposal constitutes a significant barrier to healthcare access for the poorest amongst us and should be denied.

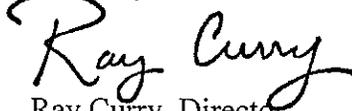
Penalties for Non-Emergency Use of ER Services are Excessive

Kentucky already has the ability to charge up to \$8 in co-pay for non-emergency use of emergency room services. The Kentucky proposal, however, would deduct from \$20 to \$75 from an enrollee's My Rewards Account, depending on the number of non-emergency ER visits. These deductions are the equivalent of a cost-sharing scheme barred by the Medicaid program and should be denied. The proposed deductions would cause a significant burden for low-income individuals, and have been shown to be ineffective at reducing ER utilization in Medicaid.⁶ As Kentucky already possesses a much less burdensome method of discouraging non-emergency use of the ER by charging up to \$8 in co-pays, the proposed increase in penalties should be denied.

Conclusion

Kentucky's original adoption of Medicaid expansion has proven to be wildly successful in decreasing the state's rate of uninsured (20.4% in 2013 to 7.5% in 2015), and providing Kentucky's poor with needed health care security. This progress in providing health care coverage to the most vulnerable populations in the state and the improving health outcomes that go along with it are at risk with the Kentucky HEALTH 1115 waiver proposal. If approved, Kentucky's proposal will erect significant barriers to healthcare coverage and access for low-income people, weaken health outcomes, and decrease the efficiency and quality of care of the Medicaid program in Kentucky. The UAW joins with the thousands of other individuals and groups that have submitted comments requesting CMS deny Kentucky HEALTH as regressive and against the purposes of Medicaid.

Sincerely,



Ray Curry, Director
UAW Region 8

⁶ Karoline Mortenson, Copayments Did Not Reduce Medicaid Enrollees' Nonemergency Use of the Emergency Departments, 29 Health Affairs 1643 (2010); David J. Becker et al., Co-payments and Use of Emergency Department Services in the Children's Health Insurance Program, 70 Med. Care Res. Rev. 514 (2013).