October x, 2016

Honorable Sylvia Mathews Burwell
Secretary, Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Burwell:

The undersigned organizations appreciate the opportunity to submit comments on Kentucky HEALTH, Kentucky's proposal for a demonstration project under section 1115 of the Social Security Act, which would make significant changes in Kentucky's highly successful Medicaid expansion. Many of the changes Kentucky is proposing would keep eligible people from enrolling and keep others from getting the care they need.

State's Proposal Would Reverse Kentucky's Gains in Coverage and Care

Kentucky has made impressive progress in extending health coverage to its residents under health reform, cutting in half the share who are uninsured and covering over 400,000 newly eligible people in Medicaid. The expansion of coverage is leading to improvements in health, as a recent study comparing Kentucky and Arkansas to Texas has shown.[1] The changes Kentucky is proposing are modeled in large part on Indiana's demonstration project called the Healthy Indiana Plan 2.0 (HIP 2.0). The results of the state-sponsored evaluation of the first year of HIP 2.0 shows that allowing Kentucky to replicate its key features would likely decrease participation by eligible people and make it harder for many who do enroll to get the care they need.[2]

Medicaid demonstration projects must increase and strengthen coverage for low-income individuals, increase access by stabilizing and strengthening provider networks, improve health outcomes, or increase the efficiency and quality of care through transformation of health care delivery systems.[3] Our comments show that Kentucky's proposal fails to meet these criteria.

CMS Should Not Allow Kentucky to Make Eligibility for Coverage Contingent on Work or Work-Related Activities

Kentucky's proposal to require Medicaid beneficiaries to work, volunteer, or go to school in order to maintain their Medicaid benefits would reduce access to health care, unravel the gains made by the state's Medicaid expansion, and increase poverty. The experience of the Temporary Assistance for Needy Families (TANF) program demonstrates that imposing a work requirement on

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[1] Sommers, Blendon, and Orav, "Both the 'Private Option' and Traditional Medicaid Expansions Improved Access to Care for Low-Income Adults," *Health Affairs*, January 2016.
[2] Judith Solomon, "Indiana Medicaid Waiver Evaluation Shows Why Kentucky's Medicaid Proposal Shouldn't Be Approved," Center on Budget and Policy Priorities, August 1, 2016.

[3] Centers on Medicare & Medicaid Services, About Section 1115 Demonstrations at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html

Medicaid would lead to the loss of health coverage for substantial numbers of people who are unable to work or face major barriers to finding and retaining employment. Moreover, research shows that work requirements result in little or no long-term gains in employment.

Kentucky's proposal includes an exemption for people who can't work, but it would be administratively challenging to identify and track people whose disabilities or circumstances ought to exempt them. State TANF programs have failed on this front, with studies showing that TANF recipients who are sanctioned for not meeting a work requirement have significantly higher rates of disability than those who are not sanctioned.[4]

In addition to being ineffective in increasing employment over time, a work requirement would add considerable complexity and costs to Kentucky's Medicaid program. State experience in implementing the TANF work requirements suggests that adding such requirements to Medicaid could cost states thousands of dollars per beneficiary.[5] The proposal states that Kentucky would have to "ensure appropriate resources are available and to monitor the impact of this new requirement," but the proposal does not describe how this would be accomplished.

Kentucky Should Implement Its Premium Assistance Program Without a Waiver

We question whether a waiver approach is necessary to expand the state's Health Insurance Premium Payment (KyHIPP) program as the state is already operating this program under section 1906 authority. Beneficiaries eligible under the expansion who have access to employer-sponsored insurance could be enrolled in the current program and be required to participate if cost-effective. This would be a reasonable approach to take for people in the expansion group who have access to employer-sponsored insurance, although the state's projections of how many beneficiaries would have access to cost-effective employer-sponsored insurance appears unduly optimistic.

Section 1115 waiver authority is needed to charge premiums and limit benefits. Kentucky's premium approach parallels the approach it wants to take for other beneficiaries in the expansion group, which as noted below is likely to lead to reduced participation. While the proposal states that members will have access to all Kentucky HEALTH benefits (or KCHIP benefits) through a wrap-around, one of the waivers requested on page 41 of the proposal is a waiver of amount, duration and scope "to the extent necessary to enable Kentucky to allow individuals to receive the benefits provided through their employer-sponsored plan." Instead of allowing premiums and limiting benefits, CMS should work with the state to fashion an approach that builds on the existing KyHIPP program, which would not require a waiver.

We have additional concerns regarding the inclusion of children enrolled in Kentucky's CHIP program in KyHEALTH and KyHIPP even though their parents have incomes above 138 percent of the poverty line making them ineligible for Medicaid in most cases. Subsidizing employer-sponsored insurance for children in these families may be a worthwhile approach, but it should be pursued under state plan authority with voluntary participation for families.

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[4] LaDonna Pavetti, Michelle Derr, and Emily Sama Martin, "Assisting TANF Recipients Living with Disabilities to Obtain and Maintain Employment: Conducting In-Depth Assessments," Mathematica Policy Research, Inc., February 2008.

[5] Gayle Hamilton *et al.*, "National Evaluation of Welfare-to-Work Strategies: How Effective Are Different Welfare-to-Work Approaches? Five-Year Adult and Child Impacts for Eleven Programs," Manpower Demonstration Research Corporation, December 2001, Table 13.1.

CMS Should Not Approve Kentucky's Proposal for Premiums, Accounts, and Cost-Sharing

All Kentucky HEALTH enrollees except pregnant women, children, and those found to be medically frail would have to pay monthly premiums. If premiums aren't paid within 60 days, people with incomes below the poverty line would be enrolled but they would have to pay copayments for most health care services. People with incomes above the poverty line would not be enrolled. Enrollees would have two types of accounts: a $1,000 account funded by the state used to pay services falling within a $1,000 deductible and a "My Rewards" account that can be used to obtain benefits such as vision and dental care not otherwise available to enrollees. The state would provide funds in the rewards account based on certain behaviors such as completing a job assessment, participating in community service, and completing a health risk assessment.

Extensive research (including research from Medicaid demonstration projects conducted prior to health reform) shows that premiums significantly reduce low-income people's participation in health coverage programs.[6] It appears that that has also been the case in Indiana where the state has not met its enrollment targets.[7] Charging premiums to current enrollees and new applicants in Kentucky would likely result in reduced participation. The state's own projections show a decrease in participation amounting to about 56,000 adults over the 5-year period of the demonstration project. Kentucky should also not be allowed to implement a six-month lock-out for people with incomes above the poverty line who don't pay their premiums.

No state has been allowed to terminate coverage for beneficiaries with incomes below the poverty line for nonpayment. Likely recognizing this, Kentucky proposes to charge copayments to beneficiaries who don't pay. This approach has been shown to leave beneficiaries worse off in Indiana. In Indiana enrollees who had to make copays were more likely to use the emergency room, both in general and for non-emergency reasons. They also had lower rates of primary and preventive care suggesting that they were less likely to have adequate access to preventive and primary health care services.

The structure of the Kentucky accounts is extremely complex. Enrollees can roll-over up to 50 percent of the deductible account to their rewards account at the end of the year. In Indiana, most enrollees didn't even know about their accounts or understand how they worked so the roll-over didn't work as an incentive. Moreover, the design of the incentive penalizes people with health problems who need more than $500 in care during the year who wouldn't qualify for a roll-over.

CMS Should Not Approve Kentucky's Request to Make Coverage Contingent on Payment of an Initial Premium.

Kentucky would delay coverage until eligible individuals make a premium payment. The proposal requires individuals with incomes below the poverty line to remain without Medicaid coverage for up to 60 days until they make a premium payment. Leaving them without coverage for 60 days makes little sense if they can't afford the premiums. They will not be able to get their prescriptions

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[6] Laura Snyder and Robin Rudowitz, "Premiums and Cost-Sharing in Medicaid," Kaiser Commission on Medicaid and the Uninsured, February 2013, https://kaiserfamilyfoundation.files.wordpress.com/2013/02/8416.pdf.

[7] Solomon, fn. 1

covered in the interim and they may not be able to get other health care services they need. If they do receive care, providers will not be able to receive reimbursement.

Indiana's experience shows that the waiting period for coverage may also decrease participation. According to the evaluation of the first year of Indiana's program, in any given month, as many as 30,000 people are in a "conditional eligibility status" — i.e., have been found eligible within the past 60 days but are not enrolled because they haven't made premium payments. Of those, only two-thirds enroll by the end of their 60-day payment period.

CMS Should Not Approve Kentucky's Request For an "Open Enrollment" Period

Kentucky proposes to lock people out of coverage if they don't complete their annual re-determination of coverage in a timely manner. Individuals would be locked out of coverage for six months unless they come back within a three-month period following the termination of coverage for not completing the renewal process before the end of their 12-month enrollment period. In order to come back earlier they would have to complete a financial or health literacy course.

CMS has already found that a similar request from Indiana is not consistent with the objectives of the Medicaid program. CMS rightly recognized that many low-income individuals face challenges in completing the renewal process such as language access and problems getting mail. CMS also found that mental illness or homelessness can make completing the renewal process difficult and that gaps in coverage that would result from a lockout could lead to harm. Kentucky's proposal would also keep some beneficiaries from obtaining access to necessary health care and should also be rejected.

CMS Should Not Approve Kentucky's Request to Waive the Non-Emergency Transportation Benefit

Kentucky seeks to waive the NEMT benefit for enrollees in Medicaid expansion's new adult group, saying the benefit has been underutilized by the group to date. Yet Kentucky reports that *140,000 non-emergency trips* were utilized in a single year, which contradicts the claim of underutilization. Transportation help is critical for some low-income beneficiaries to access needed care, especially in a state like Kentucky where many beneficiaries live in rural areas and have to travel long distances for medical appointments.

Kentucky notes that Indiana and Iowa have waived the NEMT benefit and doing so has not obstructed access to care in those states. In comments on these state's proposals to waive the NEMT benefit, we have shown that the data from Indiana and Iowa suggest otherwise. For example, a recent state evaluation in Indiana found transportation problems were the top-cited reason Medicaid expansion enrollees gave for missing a medical appointment with people.

Thank you for your willingness to consider our comments. If you would like any additional information, please contact Judy Solomon (solomon@cbpp.org) or Joan Alker jca25@georgetown.edu).

American Congress of Obstetricians and Gynecologists
American Lung Association
Center on Budget and Policy Priorities
Children's Defense Fund

Community Transportation Association of America
First Focus
Georgetown University Center for Children and Families
HIV Medicine Association
March of Dimes
National Alliance on Mental Illness
National Association of Community Health Centers
National Women's Law Center
Service Employees International Union