Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

August 17, 2018

VIA ELECTRONIC SUBMISSION

The Honorable Alex Azar, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Attention: Kentucky's Section 1115 Medicaid Research and Demonstration proposal

Dear Secretary Azar:

Thank you for the opportunity to comment on Kentucky's demonstration project "Kentucky Helping to Engage and Achieve Long Term Health (KY HEALTH)" and its component parts, including the Kentucky HEALTH program.

The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high-quality, affordable health coverage for America's children and families. As part of the McCourt School of Public Policy, Georgetown CCF conducts research, develops strategies, and offers solutions to improve the health of America's children and families, particularly those with low and moderate incomes. In particular, CCF examines policy development and implementation efforts related to Medicaid, the Children's Health Insurance Program (CHIP) and the Affordable Care Act (ACA).

On October 7, 2016, Georgetown CCF and the Center on Budget and Policy Priorities submitted comments on Kentucky HEALTH. We reiterated our concerns in a second comment letter with additional signatories on August 2nd, 2017. We urged that the Secretary not approve the proposed demonstration because it would make harmful changes in Kentucky's highly successful Medicaid expansion that would keep eligible people from enrolling and keep many of those enrolled from getting the care they need. We reaffirm all of our previous comments, copies of which are attached in Appendix 1, and request that they be considered by CMS and the Secretary as part of a review of these comments.

Our comments include numerous references to supporting research. In order to ensure the inclusion of certain evidence in the administrative record and its consideration by CMS and the Secretary, we have submitted two additional Appendices. Appendix 2 includes recently released data from the state of Arkansas which is in the process of implementing its Section 1115 Medicaid waiver that bears many similarities to Kentucky's proposal. *As we discuss below, the new data from Arkansas reinforces our fears that if Kentucky is allowed to implement its plans, many thousands of people, including parents and children, will lose their Medicaid coverage in Kentucky.* Appendix 3 includes the text of citations that may be difficult to access. For the remainder of the citations we have provided active hyperlinks. We request that the full text of each of the studies for which we have provided active hyperlinks be included in the administrative record and be considered by CMS and Secretary in determining whether or not to approve the State of Kentucky's proposal.

Summary

We urge CMS and the Secretary to disapprove Kentucky's demonstration request. The evidence is overwhelming that the state's plans will result in the loss of Medicaid coverage by eligible children and parents and other adults. The only question is how many will lose coverage, how quickly will they lose it, and for how long they will be uninsured. That is not a legitimate research question. To ask it violates the central objective of the Medicaid program: to provide affordable health insurance coverage to low income Americans.

In its July 3, 2017 modification request, the State estimates that Medicaid enrollment will begin declining in the first year of the demonstration, with the enrollment declines increasing every year until the 5th year, when the State expects 95,000 individuals to lose coverage. This estimate is almost certainly too low. A recent analysis of a Medicaid work requirement such as that proposed by Kentucky found that, based on a review of the research literature, disenrollment among beneficiaries who are already working or exempt from work requirements would range from 5% to 15%, and that disenrollment among beneficiaries not currently working and subject to the new work requirements would range from 25% to 50%.[1] Moreover, it appears that the State does not anticipate any children losing coverage as a result of coverage restrictions which affect their parents – the research on the relationship between parent and child coverage, as we discuss below, clearly suggests that this is not true.

These disenrollment rates do not account for other elements of the Kentucky HEALTH proposal that will also result in coverage loss, such the monthly premium requirement and the 6-month lock-out periods for failure to provide information for annual redetermination and failure to timely and accurately report a change in circumstances. And there is no indication that the State, in its estimates, has considered, much less accounted for the likely loss of coverage by eligible children of parents who lose coverage.

These comments focus on four sources of coverage loss in Kentucky HEALTH for eligible parents and children: the work requirement; the monthly premium requirement; the lockout periods; and the collateral damage for eligible children whose otherwise eligible parents lose coverage. In each case, we present the available research, which clearly indicates that the foreseeable effect of the policy will be to reduce Medicaid coverage among eligible parents and children.

There is another source of coverage loss that is likely of equal, and potentially of greater importance, than the three sources described above: the onerous documentation requirements and daunting complexity of Kentucky HEALTH. The most recent example comes from Arkansas, which is currently implementing Medicaid work requirements and lockouts under a Secretary-approved demonstration. The state requires individuals to go online and report work hours or an exemption or face losing coverage after three months of noncompliance. Of 15,137 individuals who needed to go online and comply with reporting requirements in the second month of Arkansas's implementation, 12,587—83 percent—did not do so.[2] At the end of this month, 5,426 Arkansans may lose their coverage if they do not comply with the state's reporting requirements. Given the similarity between Arkansas and Kentucky's approach we believe the newly released data from the Arkansas Department of Human Services clearly indicates that Kentucky cannot be allowed to go forward. Appendix 2 contains our two blog posts analyzing this new data as well as both months of data that Arkansas has released.

This "red tape effect," and how it leads to coverage loss, is also discussed in separate comments submitted by Tricia Brooks, a Senior Fellow at the Georgetown University Center for Children and Families and a recognized national expert on streamlining enrollment in Medicaid. She presents extensive evidence based on state experience that simplifications advance enrollment and coverage, while reversing simplifications and increasing paperwork requirements decreases enrollment and coverage.

The research is clear: work requirements, monthly premium requirements, lockout periods, and onerous reporting requirements will result in the loss of Medicaid coverage by eligible low-income parents, and those coverage losses will in turn lead to coverage losses among their children. The state itself estimates that Kentucky HEALTH will result in coverage losses for at least 95,000 Medicaid beneficiaries by year 5 of the demonstration. The research we present suggests that the Medicaid coverage losses could well be higher; we have seen no research that suggests the coverage losses are likely to be lower. Since a central purpose of the Medicaid program is to furnish coverage to eligible individuals, and since the State's plan will take coverage way for many tens of thousands, Kentucky HEALTH is not likely to promote the purposes of Medicaid. It therefore cannot and should not be approved.

If approved, Kentucky's work requirement will result in a loss of Medicaid coverage for parents

Kentucky HEALTH would require, as a condition of Medicaid coverage, non-exempt beneficiaries to document 20 hours per week (80 hours per month) of work or "community engagement" activities. Failure to meet the hourly requirement will result in suspension of benefits until the individual satisfies the requirement for a full month. The following individuals are exempt: children; pregnant women, individuals determined to be "medically frail;" and adults who are the "primary caregiver" of a dependent minor child (or a dependent adult with disabilities). In a two-parent household with one or more minor children, the parent who is not the "primary caregiver," not pregnant, and not "medically frail" will be subject to the 20-hour per week work requirement. Many of these non-exempt parents will likely not be able to comply with the requirement and therefor lose Medicaid coverage.

The Kentucky HEALTH application presents no data on the coverage impact of work requirements on parents, whether they are in the non-expansion adult group or in the expansion group. We know, however, that many parents will lose coverage. For example, the state's application projects that Medicaid enrollment in the non-expansion adult category – i.e., parents and other caretaker relatives -- will decline by 11,000 over the five years of the demonstration (Table 2.3). This projection understates the extent of the coverage loss among parents because it measures the decline against the first year of the demonstration, not against projected enrollment of non-expansion adults in Kentucky Medicaid without the work requirements. And it does not appear to take into account the coverage losses among parents in the expansion adult group.

There is strong evidence that work requirements in other programs (i.e. SNAP and TANF) result in loss of benefits. This research was recently reviewed by analysts at the independent Kaiser Family Foundation, who, as noted above, used the data to estimate a range of coverage losses (25% to 50%) for individuals likely not exempt from work requirements. Among the studies they noted: CBO's estimate of the Agriculture and Nutrition Act of 2018, which assumes that 24% of individuals potentially subject to a SNAP work requirement would no longer receive benefits;[3] and an evaluation of work requirements in SNAP by George Washington University researchers finding that enrollment dropped 50-85% among those subject to the requirement.[4] Similarly, a Kaiser review of the research on work requirements in TANF [5] finds, among other things, that work requirements result in disenrollment from TANF but do little to increase employment over time. [6]

We are unaware of any research indicating that imposing work requirements as a condition of eligibility in Medicaid is likely to maintain, much less increase, Medicaid coverage among eligible individuals

If approved, the Kentucky HEALTH monthly premium requirement will result in a loss of Medicaid coverage for parents.

Kentucky HEALTH would require the payment of monthly premiums by parents and other adults ranging from $1 per month for individuals with incomes less than 25 % of the Federal Poverty Level (FPL) to $15 per month for individuals with incomes between 100% and 138% of poverty in the first year, $37.50 per month by the 5th year. For parents with incomes above 100% of FPL, failure to pay the premium (after a 60-day grace period) will result in a six-month lockout. Only "medically frail" individuals, pregnant women, and children would be exempt.

The research is overwhelming that this monthly premium requirement will lead to Medicaid coverage losses; all that remains in doubt is how drastic the coverage losses will be. Last year the Kaiser Family Foundation published a review of the research on the effects of premiums on low-income populations. The Kaiser analysts cited 29 different studies finding that "premiums increase disenrollment from Medicaid and CHIP among adults and children, shorten lengths of Medicaid and CHIP enrollment, and deter eligible adults and children from enrolling in Medicaid." [7] To cite just one of these studies, the researchers found that for parents without a worker in the household, a $500 annual increase in public premiums lowered the probability of having public insurance coverage (by nearly 10 percentage points) and increased the probability of being uninsured (by nearly 7 percentage points). [8]

We are unaware of any research showing that the imposition of premium requirements on individuals with incomes between 100% and 138% of the federal poverty level maintains Medicaid coverage among this population, much less increases it.

If approved, the Kentucky HEALTH lockouts will result in a loss of Medicaid coverage for parents.

Kentucky HEALTH would terminate coverage for Medicaid beneficiaries for a period of up to six months who do not comply with certain requirements for a period of up to six months. During this "lockout" period, Medicaid would not make payment for any needed medical care for which the individual would otherwise be eligible. The lockouts would be applied if (1) a beneficiary with an income above 100% of FPL who is not "medically frail" or pregnant does not pay a required premium; (2) a beneficiary fails to complete his or her paperwork for annual redetermination of eligibility; and (3) a beneficiary fails to timely report changes in income and/or employment, or falsely reports work hours. In the case of the failure to pay a required premium, individuals could re-qualify for coverage prior to 6 months by paying an amount equal to 3 months of premiums and attending a financial or health literacy course. In the case of failing to complete paperwork, an individual could re-qualify for coverage by completing a financial or health literacy course.

If that description of Kentucky's lockout policies sounds confusing, that is because it is enormously complicated to follow – even health policy researchers like myself.

The likelihood of Medicaid beneficiaries, providers and caseworkers understanding all of the nuances is low.

Lockouts are, by definition, periods during which the beneficiary loses Medicaid coverage, so it is difficult to understand how they promote Medicaid's central objective of furnishing coverage. Indeed, preliminary analyses of Indiana's demonstration project have shown that close to 25,000 individuals lost benefits or coverage in the first year due to failure to pay premiums.[9] There is also evidence from Indiana and Michigan to suggest that the policies associated with lockouts may be confusing to beneficiaries and providers alike.[10] An inability to obtain clear and accurate information on the program's complex payment and reporting policies required to avoid lockouts may therefore result in many people who are eligible for Medicaid and in need of health care services not applying for benefits or losing them.

What is indisputable is that lockouts will increase eligibility "churn"— and promote periods of uninsurance i.e., when beneficiaries are disenrolled, then reenrolled, even though they continue to be eligible during the period of disenrollment, and regardless of whether they are in a course of treatment or develop a medical condition during disenrollment. Churn can result from eligibility systems glitches, paperwork requirements, or small temporary fluctuations in income. An analysis of churn conducted in 2015 by researchers at George Washington University for the Association for Community Affiliated Plans found that, in FY 2012, eligibility churn in Kentucky for non-elderly adults, as measured by continuity ratio (the lower the ratio, the greater the churn), was significantly greater than the national average (64.0% for Kentucky as compared to 71.7% overall). [11] The three lockouts proposed by Kentucky HEALTH would only aggravate these already-high levels of churn among parents and other non-elderly adults in the state.

Multiple studies suggest that eligibility churn is associated with increases in emergency room visits, higher levels of unmet health care needs during periods of uninsurance, more frequent use of costly treatments for conditions that could have been prevented through early detection and care, and significantly higher administrative costs.[12]

Periods of uninsurance expose families with children to medical debt and even bankruptcy – a prospect which undermines the financial stability and economic prospects of these families. It is well established in the research literature that Medicaid reduces financial barriers to obtaining needed care and improves.[13]

Medicaid coverage losses by parents resulting from Kentucky HEALTH (if approved) will result in Medicaid coverage losses among children.

On paper, children under 19 are exempt from Kentucky HEALTH. In the real world, however, if their parents lose Medicaid coverage, they will be at significant risk of losing their own coverage, even though they will remain eligible. The research on

this point is compelling. A 2015 study of the coverage effects of the Oregon Medicaid lottery for adults found that children whose parents were selected for the lottery and enrolled in Medicaid were twice as likely to have Medicaid coverage as children whose parents were not selected and did not receive coverage.[14] Similarly, the researchers also found that, over a 9-year period, children with at least one parent on Medicaid were more likely to have coverage than children whose parents were not enrolled.[15]

A very recent study by researchers at the Urban Institute finds that it is almost unheard of for an insured parent to have an uninsured child (0.9 percent), but more than one in five children (21.6 percent) of uninsured parents are uninsured themselves.[16] The researchers conclude: "We find a strong association between the coverage statuses of parents and children. Children with uninsured parents were significantly more likely to be uninsured than whose children whose parents had coverage."

Medicaid Coverage is Critical to the Health of Low-Income Children and Families

Medicaid coverage matters greatly to low-income children and families in Kentucky and elsewhere. The research on this point is robust. Children with Medicaid coverage have better access to needed care than do uninsured children. Compared to uninsured children, children with Medicaid or CHIP are significantly more likely to have a regular source of care and to have a physician visit and dental visit in the last two years. [17] Children with Medicaid or CHIP are also more likely to receive preventive care and have a personal physician or nurse than children who are uninsured.[18] The same study found that children who are uninsured are more likely to have unmet medical and dental needs than children with Medicaid/CHIP coverage. [19] Mothers covered by Medicaid are more likely than uninsured mothers to have a regular source of care, a doctor visit, and to receive preventive care. [20]

The research results are similar for parents. Parents and other adults covered by the Medicaid expansion under the ACA were more likely to have a personal doctor and have a dental visit than adults living in states that did not expand Medicaid.[21] Uninsured adults who gained coverage through Medicaid were almost twice as likely to have an annual checkup than individuals who remained uninsured. [22] Similarly, a study that focused on Medicaid eligibility expansions for parents between 1997 and 2009 found improved mental health outcomes for low-income parents. [23] Medicaid coverage may play a particularly important role improving access to mental health care; participants in the Oregon Experiment reported significantly better mental health with no significant changes in physical health one year after gaining coverage. [24]

The research is also clear that children and families covered by Medicaid have access to needed services comparable to that of children and families covered by private insurance. One study found that children with Medicaid or CHIP coverage are more likely than children with employer-sponsored insurance (ESI) to have a

routine checkup. [25] Children with Medicaid or CHIP coverage are equally likely to have a regular source of care, and they experienced similar levels of difficulty finding general doctors, specialists and dentists compared to children with ESI.[26] These and other studies demonstrate Medicaid's success as a health insurer at improving access to care for low-income children and families.[27]

Conclusion

Kentucky HEALTH is designed to reduce Medicaid coverage among eligible state residents. It would deploy a number of different techniques for reducing coverage, including work requirements, monthly premium requirements, lockouts, and onerous reporting requirements. As the research we present in these comments indicates, (as well as that presented by my colleague, Tricia Brooks), it would succeed. In fact, Kentucky HEALTH would in all likelihood exceed its expected enrollment reduction of 95,000 by year 5. Because it would take away, rather than preserve or improve coverage, Kentucky HEALTH is not likely to promote the central objective of the Medicaid program—to furnish medical assistance to eligible Americans. The application therefore should not—indeed cannot—be approved.

Thank you again for the opportunity to provide these additional comments. Please contact me if you have questions at jca25@georgetown.edu.

Sincerely,
Joan Alker
Research Professor, McCourt School of Public Policy, Georgetown University and Executive Director of the Georgetown University Center for Children and Families

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