July 22, 2016

Commissioner Stephen Miller
Department for Medicaid Services
275 E. Main Street
Frankfort, KY 40621

Dear Commissioner Miller,

Families USA is a national health care advocacy organization based in Washington, DC. We work with groups across the country, including in Kentucky, to promote access to affordable, appropriate, high-quality care, with a focus on health coverage and access for low-income people, particularly those insured through Medicaid.

Our interest in the Commonwealth's HEALTH waiver proposal stems from our work in Kentucky and our interest in the Medicaid program nationally.

We greatly appreciate the opportunity to submit these comments for the Commonwealth's consideration.

Kentucky's Medicaid expansion has established a foundation for improving residents' health and financial wellbeing

As the HEALTH proposal notes, health statistics for Kentucky residents are below the national average on many measures. However, Kentucky is on a path to improve residents' health, largely due to the Commonwealth's decision to expand Medicaid coverage. The Medicaid expansion as it is currently structured has significantly increased health insurance coverage, as well as access to health services, for low-income residents across the state.

Greater insurance coverage

The implementation of the Affordable Care Act has led to dramatic increases in insurance coverage in Kentucky. Between 2013 and 2015, Kentucky saw a nearly 13 percent decrease in uninsured residents, tying with Arkansas for posting the largest percentage decrease in uninsured residents in the country.[1] For low-income residents eligible for the Medicaid expansion, the change was even more dramatic, with a 24 percent reduction in the uninsurance rate for that population.[2]

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[1] Kentucky and Arkansas both saw a 12.9% decrease in uninsured 2013-2015, the largest decrease in the nation. Dan Witters, "Arkansas, Kentucky Set Pace in Reducing Uninsured Rate," *Gallup,* February 4, 2016 online at http://www.gallup.com/poll/189023/arkansas-kentucky-set-pace-reducing-uninsured-rate.aspx.

[2] Joseph Benitez, et al., "Kentucky's Medicaid Expansion Showing Early Promise on Coverage and Access to Care," *Health Affairs* 35, no. 3 (2016) online at http://content.healthaffairs.org/content/early/2016/02/16/hlthaff.2015.1294.

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Expanded access to health services

Expanding Medicaid has meant both increased rates of insurance coverage ***and*** improved access to health services for Kentucky residents. This is apparent when one looks at the complete picture of Medicaid expansion enrollees' use of health services during the program's first year.

The HEALTH proposal states that the Medicaid expansion "has yet to impact the health status of Kentuckians," citing as evidence a statistic in a study by Deloitte that shows that 33,233 enrollees (only ten percent of the expansion enrollees) received an "annual wellness or physical exam" in the first year of the program.[3] That statistic is true, but looking at that alone paints an inaccurate and incomplete picture of service use and the impact of the state's Medicaid expansion. "Annual wellness or physical exam" is just one of 40 preventive services profiled in the Deloitte report cited in the HEALTH proposal.

The full Deloitte report gives more complete information on Medicaid expansion enrollees' access to health care. To note just a few of the preventive services profiled in that report, in year one of the program:

- 232,266 enrollees had non-annual physician visits;
- 159,886 received medication monitoring;
- 89,693 has LDL-C cholesterol screening;
- 149,201 received preventive or other dental visits;
- Nearly 80,000 received cancer screening.[4]

Kentucky's existing Medicaid expansion has resulted in impressive gains in health care access for program enrollees. It has reduced residents' unmet medical needs and increased access to primary care and preventive health services. [5] Access to preventive health services can improve individuals' health, reduce system wide incidences of high-cost conditions, and reduce associated disability—in short, support increases in population health.[6]

[3] Kentucky HEALTH proposal page 5, citing Deloitte, Commonwealth of Kentucky Medicaid Expansion Report (2014), available online at http://jointhehealthjourney.com/images/uploads/channel-files/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf.

[4] Deloitte, Commonwealth of Kentucky Medicaid Expansion Report (2014), Table 32, Preventive Services for Expansion Members," page 68, available online at http://jointhehealthjourney.com/images/uploads/channel-files/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf. The cancer screening calculation is the sum of enrollees receiving screening for colorectal, breast, cervical, and prostate cancers.

[5] In the first two years of the Medicaid expansion, there has been a 40% reduction in unmet medical needs among long-income Kentuckians. Joseph Benitez, et al., "Kentucky's Medicaid Expansion Showing Early Promise on Coverage and Access to Care," *Health Affairs* 35, no. 3 (2016) online at http://content.healthaffairs.org/content/early/2016/02/16/hlthaff.2015.1294

[6] National Center for Chronic Disease Prevention and Health Promotion, *The Power of Prevention,* (Washington, DC: Department of Health and Human Services, Center for Disease Control and Prevention, 2009) online at http://www.cdc.gov/chronicdisease/pdf/2009-power-of-prevention.pdf; Andrea Callow, "Medicaid Expansion Linked to Earlier Diagnosis and Treatment of Diabetes," Families USA, March 25, 2015 available online at http://familiesusa.org/blog/2015/03/medicaid-expansion-linked-earlier-diagnosis-and-treatment-diabetes.

However, broad changes in population health are not immediate; they take time and sustained access to the health care system.[7] Program changes that make it more difficult for enrollees to keep coverage could erase Kentucky's significant gains.

Bridge to financial stability

The Medicaid expansion also lays the foundation for improved *financial* health and stability for program enrollees, helping them improve their economic situation.

Multiple analyses have found that by providing low-income individuals with insurance coverage, Medicaid expansion improves enrollees' financial security.[8] Medicaid expansions are associated with a reduction in important financial health measures including unpaid bills, credit card debt, and debts sent to collections.[9]

By helping individuals achieve better financial security, health coverage through Medicaid can help them move out of poverty, one of the goals of the HEALTH proposal. Program changes that add financial barriers to coverage or increase enrollees' financial stress would be in direct conflict with that goal.

Benefits to Kentucky's children

Expanding Medicaid has increased health coverage for many low-income parents in Kentucky. That not only improves their access to health care and financial stability, but it also helps their children, who are eligible for Medicaid regardless of the Medicaid expansion.

Giving health coverage to parents increases the likelihood that their children will be insured.[10] Low-income children who have Medicaid coverage are more likely to complete high school and attend college than their uninsured counterparts.[11] Educational attainment can help people move out of poverty—the Medicaid expansion is helping children, as well as adults, achieve greater financial stability.

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[7] A seminal study on the impact of a state's decision to expand Medicaid coverage to more adults pre-Affordable Care Act looked at 10 years worthy of data, 5 years prior to expanding coverage and 5 years after. The researchers considered 5 years the necessary time frame to measure changes in population health. The study found that expanding Medicaid was associated with a significant reduction in mortality. B.D. Sommers, et al., "Mortality and Access to Care Among Adults After State Medicaid Expansions," *New England Journal of Medicine* (2012: 367: 1025-34) available online at http://www.nejm.org/doi/pdf/10.1056/NEJMsa1202099.

[8] Amy Traver, "New Oregon Health Study's Findings Reaffirm That Medicaid Is Good Health Coverage", Families USA, May 2013, http://familiesusa.org/blog/new-oregon-health-studys-findings-reaffirm-that-medicaid-is-good-health-coverage

[9] Louija Hou et al., "The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Well-Being," National Bureau of Economic Research Working Paper No. 22170, Issued April 2016, available online at http://nber.org/papers/w22170; Nicole Dissault, "Is Health Insurance Good for Your Financial Health?" *Liberty Street Economics,* Federal Reserve Bank of New York, June 6, 2016 online at http://libertystreeteconomics.newyorkfed.org/2016/06/is-health-insurance-good-for-your-financial-health.html#.V4lHI6It7VJ.

[10] Jesse Cross-Call, "Medicaid Expansion Helps Drive Further Gains in Kids' Health Coverage," Center for Budget and Policy Priorities, September 28, 2015, online at http://www.cbpp.org/blog/medicaid-expansion-helping-drive-further-gains-in-kids-health-coverage.

[11] Dee Mahan, "Expanding Medicaid Helps Children Succeed in School," Families USA, July 8, 2014 available online at http://familiesusa.org/blog/2014/07/expanding-medicaid-helps-children-succeed-school.

Economic benefits to Kentucky

Studies of the budgetary and economic impact of Medicaid expansion have consistently found that Medicaid expansion has a positive effect on both state budgets and overall state economic performance.[12]

An in-depth study looking at a cross section of 11 very diverse states (including Kentucky) found that:

> Evidence from states that have expanded Medicaid consistently shows that expansion generates savings and revenue which can be used to finance other state spending priorities or offset much, if not all, of the state costs of expansion.[13]

That study found that states that expanded Medicaid: reduced spending on state-funded health programs and care for the uninsured; lowered Medicaid spending growth; increased health sector jobs; and experienced increased fiscal stability among rural hospitals.[14] That is only a partial list of the many economic benefits found.

Several factors contributed to those economic benefits, including increased insurance coverage reducing uncompensated care costs for states and providers; higher federal matching rates for some groups previously paid for through the state's traditional Medicaid program; and increased insurance coverage generating health sector jobs. The added federal funding and jobs creation from Medicaid expansion initially begins in the health sector, but ultimately "ripples through state economies, creates jobs, and strengthens struggling and rural hospitals."[15]

Kentucky has seen the fiscal and economic benefits of expanding Medicaid coverage, including a drop in uncompensated care,[16] increased health sector employment,[17] and an economic boost[18] Kentucky's

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[12] Deborah Bachrach, et al, *States Expanding Medicaid See Significant Budget Savings and Revenue Gains* (Princeton, NJ: Robert Wood Johnson Foundation, March 2016) available online at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097. See also, Kaiser Family Foundation, *The Effect of Medicaid Expansion on State Budgets: And Early Look at Selected States* (Washington, DC: Kaiser Family Foundation, March 2015), at http://files.kff.org/attachment/issue-brief-the-effects-of-the-medicaid-expansion-on-state-budgets-an-early-look-in-select-states; and, Michale Ollove, "States Find Savings through Medicaid Expansion," *Stateline,* The PEW Charitable Trust, April 29, 2015 at http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/4/29/states-find-savings-through-medicaid-expansion.

[13] A March 2016 study looking at data from Arkansas, California, Colorado, Kentucky, Michigan, New Mexico, Oregon, Maryland, Pennsylvania, Washington state, West Virginia and the District of Columbia consistently found state savings from Medicaid expansion. Deborah Bachrach, et al, *States Expanding Medicaid See Significant Budget Savings and Revenue Gains* (Princeton, NJ: Robert Wood Johnson Foundation, March 2016) available online at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097.

[14] Deborah Bachrach, *op cit.*

[15] *Ibid.*

[16] State Health Access Data Assistance Center, *Study of the Impact of the ACA Implementation in Kentucky, Quarterly Snapshot, January-March 2015* (Louisville, KY: Foundation for a Healthy Kentucky, 2015).

[17] Jason Bailey, "With Medicaid Expansion Healthcare Job Growth Picket Up in 2015," Kentucky Center for Economic Policy, KY Policy Blog, March 19, 2016, online at http://kypolicy.org/with-medicaid-expansion-kentucky-healthcare-job-growth-picked-up-in-2015/.

[18] Emily Parento, "Results Don't Lie; Medicaid Expansion Benefits Kentucky," Op-ed, Lexington Herald Leader, January 7, 2016 online at http://www.kentucky.com/opinion/op-ed/article53600710.html.

estimated General Fund savings for 2017 and 2018 will be greater than what the Commonwealth will need to put into the program. Even after the match reaches ten percent in 2020, estimates still project a large return based on state savings, tax revenue associated with jobs created, and the health benefits to residents.[19]

Far from putting pressure on Medicaid, the expansion creates health care savings that can be used to fund other aspects of the Medicaid program, fund other state priorities, or offset expansion costs starting in 2017.

Proposals that would increase the number of Kentuckians without coverage, which includes several items in the HEALTH waiver (see below), would reduce the Medicaid expansion's fiscal benefits, in addition to the adverse impact on Medicaid enrollees' access to health care. Certainly, ending the expansion would not only take insurance coverage away from hundreds of thousands of Kentuckians, but also increase the Commonwealth's health care costs and be a financial blow to Kentucky's health care providers.

The changes proposed in the HEALTH waiver would set Kentucky and Kentuckians back

We are deeply concerned that the changes proposed in the Commonwealth's HEALTH waiver proposal would place these considerable gains for Kentucky at risk, erode the strong foundation the Commonwealth has laid for improved health for hundreds of thousand Kentuckians, and increase costs to Kentucky taxpayers.

Our comments focus on the following areas of the waiver proposal:

- Adding premiums and other enrollee charges to the program and the premium structure proposed;
- Work/Community service requirement;
- Benefit changes.

Premiums

The proposal to add a premium requirement to Kentucky's Medicaid expansion would likely reduce program participation and increase program drop-out. For enrollees with incomes above poverty, the disenrollment penalty and lock-out will exacerbate this problem, and result in some enrollees having gaps in coverage and associated gaps in care. Even for enrollees not subject to disenrollment, the presence of the premiums could reduce enrollment. The complicated multi-account program with a deductible component is confusing and likely to cause enrollees at all income levels to delay needed care.

[19] Dustin Pugel, "Proposed Medicaid Waiver would Reduce Coverage and Move Kentucky Backward on Health Progress," Kentucky Center for Exonomic Policy, July 20, 2016 at http://kypolicy.org/proposed-medicaid-waiver-reduce-coverage-move-kentucky-backward-health-progress/.

The proposal to increase premiums after an individual is on the program for three years would essentially penalize individuals for being poor, including many hard working Kentuckians who happen to work at low-wage jobs that do not provide health insurance. Additionally, we believe that this aspect of the premium program is not allowable under federal Medicaid law.

The outcome of this proposal is likely to be poorer health outcomes for residents and higher health costs for the Commonwealth, an outcome that is contrary to the stated goals of the HEALTH proposal. Additionally, monitoring payments and collections will add to program administrative costs.

Premiums reduce Medicaid enrollment and coverage retention.

- ***Premiums reduce participation.*** The HEALTH program would impose premiums on all non-disabled adult Medicaid enrollees, excluding pregnant women. A multi-state study found that premiums as low as 1 percent of income—a lower percentage than Kentucky is proposing—reduced Medicaid enrollment by up to 15 percent.[20]

- ***Reduced coverage retention*.** Premiums also make it difficult for Medicaid enrollees to retain coverage. Even among higher income Medicaid enrollees, premiums result in enrollees dropping coverage.[21]

- ***Medicaid expansion enrollees have had difficulty making premium payments.*** The difficulty that premium payments pose on low-income people, and associated losses in coverage, can be seen across Medicaid expansions that include premiums.
  - **Michigan's** demonstration requires premiums for enrollees above poverty, although there is no disenrollment penalty. Collection rates are generally below 50 percent, attesting to the difficulty even higher income enrollees have meeting premium payments. In an attempt to improve collections, program administration has been expanded to include reminder phone calls, increasing administrative costs.[22]

  - **In Iowa**, disenrollment for non-payment of premiums has been high. Expansion enrollees with incomes above poverty are placed in the Marketplace Choice program. They must pay premiums and there is a non-payment disenrollment penalty after a 90-day grace period. In its 4th Quarter 2015 report to CMS, the state reported that roughly 40 percent of Marketplace Choice enrollees were disenrolled that quarter for failure to

[20] David Machledt, *Medicaid Premiums and Cost Sharing* (Washington, DC: National Health Law Project, March 2015) available online at http://www.healthlaw.org/about/staff/david-machledt/all-publications/Medicaid-Premiums-Cost-Sharing#.V40oKKIt7VJ.

[21] A study of Medicaid enrollees in Wisconsin found that increasing premiums from 0 to $10/month for higher income Medicaid enrollees (incomes 133-150 percent of poverty, higher incomes than Kentucky HEALTH covers), reduced the probability of individuals remaining enrolled for a full year by 12 percent. Laura Dague, "The effect of Medicaid premiums on enrollment: A regression discontinuity approach," *Journal of Health Economics,* May 2014, available online at http://ccf.georgetown.edu/wp-content/uploads/2012/03/Dague-Premiums.pdf.

[22] 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 online 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.

pay premiums.[23]

- **In Indiana**, November 2015 through January 2016, the state disenrolled 1,680 individuals from its Medicaid expansion HIP 2.0 program for failure to pay premiums (POWER account contributions).[24]

Losing Medicaid coverage and gaps in coverage can have a negative effect on health outcomes and increase overall health costs for Kentucky.

- ***Coverage gaps increase health costs and services use.*** The negative effects of gaps in health coverage in Medicaid are well documented and are contrary to the stated objective of the HEALTH proposal.
    - A multi-state analysis found that individuals who have multiple transitions into and out of Medicaid have higher emergency room utilization, more office visits, more hospitalizations, and refill their prescriptions less often.[25]
    - Interruptions in Medicaid coverage are associated with a higher risk of hospitalization.[26]
    - Gaps in care are associated with increased health care costs as well as poorer outcomes.[27]
- ***Gaps in coverage will negatively impact the effectiveness of substance use disorder treatment.*** The Commonwealth correctly places addressing substance use disorders as a health care priority, and notes that addressing that issue is a priority for the HEALTH program. For those needing treatment for substance use disorder, gaps in coverage can mean breaks in care that will make treatment less effective.

The current Medicaid expansion can help reduce Kentucky's health disparities; instituting policies that make it harder for people to keep coverage, like premiums, could erase that progress.

- ***Racial and ethnic minorities in Kentucky have worse health outcomes than whites.*** Racial and ethnic minorities in Kentucky do worse than whites on a range of health outcome measures,

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[23] In October 2015, Iowa reported that there were over 9,000 individuals enrolled in its Marketplace Choice program and over 6,000 cases were sent to collections that month. In November, over 3,500 enrollees were disenrolled for failure to pay premiums within the state's 90-day grace period. CMS Quarterly Report, Iowa Wellness Plan, 4th Quarter 2015, Attachment 7, available online at https://dhs.iowa.gov/sites/default/files/IWP.Q4.2015_0.pdf

[24] CMS Quarterly Report, Iowa Wellness Plan, 4th Quarter 2016, 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

[25] Banerjee, Ziegenfuss, Shah, *Impact of discontinuity in health insurance on resource utilization,* BMC Health Services Research, July 2010, online at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2914034/

[26] Bindman, Cattopadhyay, Auerback, *Interruptions in Medicaid Coverage and Risk for Hospitalization for Ambulatory Care-Sensitive Conditions*, Annals of Internal Medicine, December 2008, available online at: http://www.ncbi.nlm.nih.gov/pubmed/19075204

[27] Hall, Harman, Zhang, *Lapses in Medicaid coverage: impact on cost and utilization among individuals with diabetes enrolled in Medicaid*, Medical Care, December 2008, online at: http://www.ncbi.nlm.nih.gov/pubmed/19300311

including rates of cancer, asthma and diabetes.[28]

- ***By increasing health coverage among racial and ethnic minorities, the current Medicaid expansion can help improve health outcomes.*** Research shows that insurance coverage leads to improved preventive care and health outcomes for racial and ethnic minorities.[29] Kentucky's Medicaid expansion has led to significant decreases in uninsurance rates among African Americans, Asians, and multiracial individuals, laying the foundation for improving health outcomes for those groups and ultimately reducing health disparities.[30] Program changes that would make it more difficult for individuals to retain coverage, like the HEALTH premium proposal, risk setting back that progress.

Increasing premiums based on time on Medicaid penalizes individuals for being poor and is inconsistent with the goal of providing low-income Kentuckians with access to affordable health care.

- ***Increasing premiums for those with incomes above poverty who are enrolled in the program for three years or more essentially punishes people for being poor.*** There are many reasons individuals may need Medicaid coverage for three years or more, including: working in a low-wage job that does not provide health insurance; being unable to work because of health conditions or injuries; living in a community where jobs simply are not available. The policy is punitive, essentially punishing individuals for being poor.

- ***The proposal would penalize Kentuckians working at low-wage jobs.*** Most who are eligible for Medicaid because of the Commonwealth's Medicaid expansion are working.[31] They are working low-wage jobs across a host of industries, from food services, to sales, to health care support in jobs like cooks, waiters and waitresses, cashiers, home health aides, and child care workers. Most do not get health coverage at work; some work part-time and do not qualify for benefits; some are not employees, but rather work as contractors with no benefits available. The policy proposed would penalize these hard working Kentuckians.

- ***Medicaid is a health coverage program designed to help those who meet income and other eligibility criteria; tying cost sharing to time on program is not allowed under federal Medicaid law.*** Medicaid is a health insurance program for individuals who meet its eligibility criteria. It is designed to advance public health and the health of the individuals it serves. There is no provision in Medicaid law allowing cost sharing or any other program aspect to be linked to time that an individual needs Medicaid insurance.

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[28] Kentucky Department of Public Health, Office of Health Equity, *2015 Kentucky Minority Health Status Report,* November 23, 2015, online at http://chfs.ky.gov/NR/rdonlyres/0DBADAD5-90A8-4EB2-9D95-8EB751EBF8A6/0/2015KYMinorityHealthStatusReportFINAL21516latestayedits2.pdf

[29] Henandez-Cancio, Mahan, Stoll, *Medicaid Expansion and Health Disparities*, Families USA, September 2014, http://familiesusa.org/product/medicaid-expansion-and-health-disparities-african-americans

[30] SHEDAC and Foundation for Healthy Kentucky, *Study of the Impact of the ACA Implementation in Kentucky*, March 2016, http://healthy-ky.org/sites/default/files/REVISED%20FINAL%20FULL%20Annual%20Report%203.21.pdf

[31] Dee Mahan, *Medicaid: Health Insurance for Working Kentucky Residents*, Families USA, October 2015 http://familiesusa.org/product/medicaid-health-insurance-working-kentucky-residents

The premium structure envisioned will add administrative costs that will likely outweigh any payments collected and will be an added cost to Kentucky taxpayers.

- ***Premiums expand bureaucracy and increase program costs.*** There is a significant administrative cost to collecting premiums, tracking payments, sending notices, and administering disenrollment and reenrollment.
  - Virginia briefly included premium payments in its Children's Health Insurance Program, but stopped when they found that the cost of collecting premiums exceeded the revenue collected.[32]
  - In 2006, Arizona studied what it would cost to institute premiums and cost-sharing in Medicaid. Even looking at the maximum amount the state could legally collect, the study found that state costs would be three times higher than what the state would make.[33]

Work Requirement (Gateway to Work)

The proposed work program is unnecessary. Most adults who are eligible for Medicaid are already working. Of those not working, the majority are not in the workforce, e.g., they are students, family caregivers, medically unable to pursue employment. The requirement is also unlikely to increase employment and may exacerbate poverty among many, in direct opposition to the program's goal to "break the cycle of poverty."

The program envisioned would, however, be extremely costly to administer and a significant added program cost to Kentucky taxpayers.

Furthermore, tying Medicaid eligibility, cost sharing or any other aspect of the program to work status is not allowed under federal Medicaid law.

There are less costly, more effective ways to support employment among Medicaid enrollees that are not in conflict with Medicaid law.

The work requirement is unnecessary.

- ***The work requirement is unnecessary because most who are eligible for the program are working.*** Most Kentuckians who can benefit from Medicaid expansion (the vast majority of non-disabled adults eligible for Medicaid) are working (55 percent).[34] An additional 23 percent are

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[32] Tricia Brooks, *Handle with Care: How Premiums Are Administered in Medicaid, CHIP and the Marketplace Matters*, Georgetown Center for Children and Families, December 2013, http://www.healthreformgps.org/wp-content/uploads/Handle-with-Care-How-Premiums-Are-Administered.pdf

[33] Arizona Health Care Cost Containment System, Fiscal Impact of Implementing Cost Sharing and Benchmark Benefit Provisions of the Federal Deficit Reduction Act of 2005. December 2006. Available online at: http://citeseerx.ist.psu.edu/viewdoc/download;jsessionid=6205E959C49B77AE4B63671D2B6EBE4B?doi=10.1.1.482.6057&rep=rep1&type=pdf.

[34] Dee Mahan, *Medicaid: Health Insurance for Working Kentucky Residents*, Families USA, October 2015 http://familiesusa.org/product/medicaid-health-insurance-working-kentucky-residents

not in the workforce—these include students, family caregivers, and individuals with health conditions that preclude them from working.[35] Nearly 80 percent of those eligible for the program are working or not in the workforce for a variety of reasons, and most are working.

Data shows that work requirements in safety-net programs are ineffective and counterproductive; results could be contrary to the stated goals of the HEALTH program.

- ***Work requirements in safety-net programs are ineffective.*** Data from safety-net programs that include work requirements shows that they do not reduce poverty or increase long-term employment.[36] To the contrary, the vast majority of people in safety-net programs who were subject to work-requirements remained poor and some became poorer.[37] This is in conflict with the stated goals of the HEALTH program waiver.

- ***Medicaid is a health insurance, not a cash benefit, program; providing health coverage can help individuals move out of poverty.*** Medicaid provides qualifying individuals with health insurance. Payments are made to the doctors, hospitals, and other care givers who provide enrollees with health care.[38] It is not a cash benefit program; but it does protect enrollees from health care costs (as all health insurance does). That insurance function provides Medicaid's low-income enrollees with greater financial stability. Medicaid coverage is associated with lower financial stress and reduced debts.[39] The insurance coverage itself can help individuals move out of poverty. It gives enrollees freedom to seek medical care when needed, allowing them to stay healthier and better able to work.

- ***The community service requirement will not increase employment and could decrease employment.*** It is unclear how this requirement will assist individuals in obtaining employment. There is also the potential for this requirement to shift work away from employed individuals, who would be replaced with community volunteers, thus increasing the ranks of the unemployed in the Commonwealth. This is particularly of concern in low-income communities where there are few employment opportunities, and likely few community service opportunities. These are precisely the communities where a larger number of residents may rely on Medicaid coverage.

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[35] Families USA. Calculation based on data from the American Community Survey, 2010-2012, looking at the work status of uninsured adults with incomes under 138 percent of poverty who could be eligible for the Medicaid expansión.

[36] LaDonna Pavetti, "Work Requirements Don't Cut Poverty, Evidence Shows", Center for Budget and Policy Priorities, June 2016, available online at: http://www.cbpp.org/sites/default/files/atoms/files/6-6-16pov3.pdf

[37] LaDonna Pavetti, "Work Requirements Don't Cut Poverty, Evidence Shows", Center for Budget and Policy Priorities, June 2016, available online at: http://www.cbpp.org/sites/default/files/atoms/files/6-6-16pov3.pdf

[38] An exception is programs that allow payments directly to individuals with disabilities for home care services; however, these services are not covered under the Medicaid expansion.

[39] http://familiesusa.org/blog/new-oregon-health-studys-findings-reaffirm-that-medicaid-is-good-health-coverage; Louija Hou et al., "The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Well-Being," National Bureau of Economic Research Working Paper No. 22170, Issued April 2016, available online at http://nber.org/papers/w22170; Nicole Dissault, "Is Health Insurance Good for Your Financial Health?" *Liberty Street Economics,* Federal Reserve Bank of New York, June 6, 2016 online at http://libertystreeteconomics.newyorkfed.org/2016/06/is-health-insurance-good-for-your-financial-health.html#.V4lHI6It7VJ.

The program will increase administrative costs for the Commonwealth and is in conflict with Medicaid law.

- ***The program is administratively complex and will be costly to operate.*** Existing work programs in safety net programs are costly for states to administer, and the program envisioned in the HEALTH proposal is particularly complicated.[40] This complexity is acknowledged by the phased implementation. It will require significant tracking and monitoring, including development of community service capacity in communities across the state. This will add to taxpayer costs, yet data indicates that it is unlikely to increase employment.

- ***Tying Medicaid benefits to work or work related activities is not allowed under federal law***. CMS has clearly stated that Medicaid funds cannot be used for promoting employment.[41] This is consistent with Medicaid's role as a health insurance program. Kentucky can use state funds to promote employment but it cannot tie participation in such programs to Medicaid eligibility or services.

- ***There are more productive ways to support employment that are not in conflict with Medicaid law***. A work requirement does not address the barriers that many long-term unemployed may have to finding a job: time out of the work force because of child care or other responsibilities; lack of skills; lack of connections to conduct a job search; a criminal record. A more productive approach would be to connect Medicaid enrollees to voluntary programs that can build skills or assist in job placement.[42] Such programs are consistent with federal law, less costly to administer than the program outlined in the waiver proposal, and more likely to produce results. Such programs are part of the Medicaid expansions in Indiana and New Hampshire.

Benefit Changes

This focuses on two benefit changes included in the HEALTH proposal: the proposal to eliminate non-emergency transportation (NEMT) and the proposal to tie dental benefits to premium payments.

Eliminating NEMT would hinder the HEALTH program's health promotion and wellness goals. It may also increase program costs by making it more difficult for enrollees to get the health care they need. Eliminating this benefit disproportionately affects individuals with chronic conditions who are in need of regular access to care, including individuals who need behavioral health care and treatment for substance use disorders. Omitting NEMT can actually increase health care costs.

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[40] United States Government Accountability Office, Temporary Assistance for Needy Families: Implications of Recent Legislative and Economic Changes for State Programs and Work Participation Rates, May 2010, http://www.gao.gov/new.items/d10525.pdf

[41] Centers for Medicare and Medicaid Services, CMS and Indiana Agree on Medicaid Expansion. January 2015, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-01-27.html

[42] LaDonna Pavetti, "Work Requirements Don't Cut Poverty, Evidence Shows", Center for Budget and Policy Priorities, June 2016, available online at: http://www.cbpp.org/sites/default/files/atoms/files/6-6-16pov3.pdf

Access to dental care has been one of the many successes of the Commonwealth's Medicaid expansion, with nearly 150,000 dental visits in year one.[43] Improved dental health is related to improved general health and improved employment prospects. Making dental coverage contingent on premium payments will have a negative health impact on the lowest income Kentuckians for whom meeting the premium requirement will be the most difficult.

Non-emergency Medical Transportation (NEMT)

Providing Medicaid enrollees with NEMT can improve health outcomes and reduce costs; omitting NEMT does not align with the HEALTH proposal's goals.

- ***Lack of transportation is a significantly greater barrier to health care access for the Medicaid-eligible population than the general population.*** A 2012 study based on National Health Interview Survey data published in the *Annals of Emergency Medicine* found that between 1999 and 2009, only .6 percent of those with private insurance reported that transportation was a barrier to accessing timely primary care treatment, while seven percent of Medicaid beneficiaries did.[44]

- ***Providing NEMT can support better health outcomes and lower health care costs.*** Studies have consistently shown that providing Medicaid enrollees with transportation to non-emergency care results in fewer missed appointments, shorter hospital stays, and fewer emergency room visits. Alternatively, poor access to transportation is related to lower use of preventive and primary care and increased use of emergency department services.[45]

- ***Results from Iowa's Medicaid expansion support the need for NEMT, particularly to address substance use.*** Iowa received a waiver to omit NEMT from its Medicaid expansion. There have been several program evaluations filed that provide substantial data supporting the need for NEMT to support enrollees' access to critical medical services. In Iowa:

    - Those in poor health were the most affected by the lack of NEMT services.[46]

    - The lack of NEMT affected Medicaid enrollees at all income levels, and affected the lowest income enrollees the most. Almost 20 percent of expansion enrollees with incomes below 100 percent of poverty and 10 percent of those with incomes above poverty reported

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[43] Deloitte, Commonwealth of Kentucky Medicaid Expansion Report (2014), Table 32, Preventive Services for Expansion Members," page 68, available online at http://jointhehealthjourney.com/images/uploads/channel-files/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf. The cancer screening calculation is the sum of enrollees receiving screening for colorectal, breast, cervical, and prostate cancers.

[44] Annals of Emergency Medicine, National Study of Barriers to Timely Primary Care and Emergency Department Utilization Among Medicaid Beneficiaries, March 2012, http://www.annemergmed.com/article/S0196-0644%2812%2900125-4/abstract

[45] Community Transportation Association, "Medicaid Non-Emergency Transportation (NEMT) Saves Lives and Money", August 2014, available at: http://web1.ctaa.org/webmodules/webarticles/articlefiles/NEMTpaper.pdf

[46]Bentler et al, *Non-Emergency Medical Transportation and the Iowa Health and Wellness Plan, University of Iowa*, March 2016, submitted to CMS as part of 1115 waiver evaluation, available online at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Wellness-Plan/ia-wellness-plan-nemt-rpt-mar-2016.pdf

needing help with transportation to a healthcare visit.[47]

  - The lack of NEMT most affected individuals' access to regularly scheduled, non-emergency medical trips for behavioral health services, substance abuse treatment, and dialysis treatment.[48] These are critical health services where missing an appointment could make treatment less effective or, in the case of dialysis, have catastrophic and costly health consequences.

- **Waiving NEMT does not align with the other elements of the KY HEALTH program.** Two major pieces of the KY HEALTH plan, the My Rewards Account and the inclusion of a deductible, are intended to promote preventive care and healthy behaviors and discourage unnecessary ER use. The program should be designed to support enrollees' efforts to meet the wellness requirements that can help lower their out of pocket costs for certain services. It is incongruous to have a wellness program structure yet omit a benefit (NEMT) that would make it easier for enrollees to complete the program requirements.

Dental

Providing access to dental care can improve overall health and employment prospects; tying dental access to premium payments for the lowest income enrollees places their dental coverage at risk.

- ***Untreated dental disease is a particular issue among low-income individuals.*** Adults with low incomes are more than twice as likely as adults with higher incomes to have untreated dental caries.[49] Low-income adults are twice as likely as higher-income adults to report that the state of their mouth causes: problems with biting and chewing, pain, and difficulty sleeping.[50]

- ***Untreated dental disease can have a negative impact on overall health.*** Difficulty eating, sleeping, and chronic pain all have significant health implications beyond oral health. Poor oral health is also linked to complications for people with diabetes, heart and lung disease, and to poor birth outcomes.[51]

- ***Access to dental services can improve health and employment prospects.*** Twenty-nine percent of low-income adults – nearly twice the rate of those with higher incomes – report that the state of their mouth negatively affects their ability to interview for a job.[52]

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[47]Ibid
[48]Ibid
[49] Elizabeth Hinton and Julia Paradise, Access to Dental Care in Medicaid: Spotlight on Nonelderly Adults, Kaiser Family Foundation, March 2016, http://kff.org/medicaid/issue-brief/access-to-dental-care-in-medicaid-spotlight-on-nonelderly-adults/
[50] Ibid
[51] US Department of Health and Human Services, Oral Health in America: A Report of the Surgeon General (Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000), http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/Documents/hck1ocv.@www.surgeon.fullrpt.pdf
[52] US Department of Health and Human Services, Oral Health in America: A Report of the Surgeon General (Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial

- ***Tying dental coverage to premiums can reduce coverage, hindering access to care.*** Research shows that when states reduce or eliminate adult dental benefits in Medicaid, unmet dental care needs increase, preventive dental service use decreases, and emergency department use for dental problems increases.[53]

Conclusion

Kentucky's existing Medicaid expansion has meant access to affordable health care for many Kentuckians. It has also helped the Commonwealth make tremendous strides towards improved health outcomes for residents. However, we are concerned that many of the elements of the HEALTH proposal will set that progress back by making it more difficult for residents to keep coverage.

We urge Kentucky to continue the existing program structure, which has so successfully increased low-income Kentuckians' access to health services.

We appreciate the opportunity to submit these comments and appreciate your careful review of these and all comments received during the state comment period.

Respectfully submitted,

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Research, National Institutes of Health, 2000), http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/Documents/hck1ocv.@www.surgeon.fullrpt.pdf

[53]Kaiser Family Foundation, Access to Dental Care in Medicaid: Spotlight on Non-Elderly Adults, March 2016 http://kff.org/medicaid/issue-brief/access-to-dental-care-in-medicaid-spotlight-on-nonelderly-adults/