

August 18, 2018

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

Re: Kentucky HEALTH Section 1115 Demonstration

Justice in Aging appreciates the opportunity to comment on Kentucky's proposal for Kentucky HEALTH, a demonstration project under section 1115 of the Social Security Act. Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries and populations that have traditionally lacked legal protection such as women, people of color, LGBT individuals, and people with limited English proficiency. Justice in Aging conducts training and advocacy regarding Medicare and Medicaid, provides technical assistance to attorneys and others from across the country on how to address problems that arise under these programs, and advocates for strong consumer protections at both the state and federal level.

We urge the Department of Health and Human Services (HHS) to reject the Kentucky HEALTH proposal. As more fully explained below, the state's proposals to require low-income Kentuckians to perform "community engagement" activities, to lock out eligible persons from coverage, and to eliminate retroactive coverage and coverage for non-emergency medical transportation will greatly harm older adults and cause thousands of Kentuckians to lose Medicaid coverage.

We have cited research demonstrating the harms of these proposals and we respectfully request that HHS review each of the sources cited and made available to the agency through active hyperlinks. We further request that the full text of each of the sources cited, along with the full text of our comments, be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

A. Work Requirements Will Cause Many Older Adults, People with Serious Health Conditions & Family Caregivers to Lose Coverage

Kentucky's proposal to take Medicaid coverage away from people who fail to meet "community engagement" requirements would greatly harm older Kentuckians with serious health conditions who are not eligible for Medicare. Taking away coverage for failure to meet a work requirement will harm many Medicaid enrollees across demographic groups. However, this policy will be particularly harmful to older adults and people with serious health conditions and functional limitations because they face additional challenges in meeting such requirements, and the health consequences of losing Medicaid coverage are likely to be especially severe.

Although Kentucky claims that the waiver primarily affects “able bodied” adults, the term “able-bodied” hides many harms that likely will result from the waiver. Medicaid eligibility rules may classify a person as “disabled” or “not disabled,” but in real life, disability is a continuum. A Medicaid beneficiary may not be formally “disabled” under Medicaid law but nonetheless face significant health-related challenges. Data from the National Center for Health Statistics shows that approximately 40% of working-age Medicaid beneficiaries “have broadly defined disabilities, most of whom are not readily identified as such through administrative records.”¹ Similarly, data from the March 2017 Current Population Survey (reflecting 2016 health insurance coverage) show that, among Kentucky’s non-elderly Medicaid population not receiving Supplemental Security Income due to disability, 51% cited being ill or disabled as the reason for not being employed.²

Likewise, Medicaid law classifies a beneficiary as either “aged”—age 65 or older—or not aged. But in reality some beneficiaries in their 50s or early 60s face many of the same health-related challenges that confront beneficiaries who are formally classified as “aged.” Many health problems are hidden by use of the term “able-bodied” to describe the population of persons who are under age 65 and not classified as disabled.

Work requirements would also greatly harm the health of many Medicaid beneficiaries who care for other family members. Many family caregivers leave the workforce or reduce their hours to provide informal care to seniors and other family members. Therefore, these caregivers are likely to be low-income and unlikely to have access to health insurance through a job or spouse. Kentucky’s proposal has a narrow exception for “adults who are the primary caregiver of a dependent, including a minor child or a disabled adult.” However, many caregiving responsibilities fall outside of these tightly drawn lines. Furthermore, even though Kentucky states it will count caregiving hours for “a non-dependent relative or other person with a chronic, disabling health condition” towards meeting the work requirement, imposing a work requirement puts an enormous and unnecessary burden on these caregivers to understand and comply with reporting requirements in the midst of their caregiving and other duties.³ Given these realities, many caregivers would be forced to choose between providing care for their loved ones and maintaining their own health.

Moreover, this policy would be counterproductive as low-income Kentuckians who lose coverage for failure to comply with a work requirement could see their health deteriorate, which in turn

¹ H. Stephen Kaye, Community Living Policy Ctr., How Do Disability and Poor Health Impact Proposed Medicaid Work Requirements? 2 (Feb. 2018), *available at* <https://clpc.ucsf.edu/sites/clpc.ucsf.edu/files/reports/Disability%20%26%20Medicaid%20Work%20Requirements.pdf>.

² Rachel Garfield et al., Kaiser Family Foundation, Understanding the Intersection of Medicaid and Work 10 (Appendix Table 2) (Jan. 2018), *available at* <http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work>.

³ Paperwork requirements have been shown to reduce Medicaid enrollment across populations. See Margot Sanger-Katz, “Hate Paperwork? Medicaid Recipients Will Be Drowning in It,” *The New York Times*, January 18, 2018, www.nytimes.com/2018/01/18/upshot/medicaid-enrollment-obstacles-kentucky-work-requirement.html.

will make it harder for them to become or remain employed.⁴ Recent reports show that Medicaid can reduce health barriers to finding or holding a job for beneficiaries who are not working.⁵ For example, in Michigan, 55% of those who were out of work said Medicaid coverage made them better able to look for a job while 69% of those who had jobs said they did better at work once they got coverage.⁶ Ohio Medicaid enrollees reported similarly that Medicaid coverage made it easier to both seek employment and continue working.⁷ For many individuals, access to health services could be the pathway to employment; if blocked from Medicaid coverage, they could find it much more difficult to find and hold a job.

Finally, a recent Urban Institute analysis estimates that among Kentucky Medicaid beneficiaries who are working and do not qualify for a student or caregiver exemption, 55,000 are at risk of losing Medicaid coverage at some point during the year because they do not work enough hours or may not work consistently enough to satisfy the work requirement each month.⁸ Furthermore, issues with finding and maintaining steady jobs in a volatile job market⁹ are even more profound for older adults who also face employment discrimination based on their age.¹⁰ This data demonstrates that adding work requirements is likely to provide little actual assistance and put an already burdened population in greater danger of losing health insurance.

B. Enrollment Lock-Outs Are Inappropriately Punitive.

Kentucky's waiver would also authorize six-month enrollment lock-outs to penalize persons who otherwise meet Medicaid eligibility standards.¹¹ The punitive nature of this provision is

⁴ Coverage interruptions could lead to increased emergency room visits and hospitalizations, admissions to mental health facilities, and health care costs, research has shown. Leighton Ku and Erika Steinmetz, "Bridging the Gap: Continuity and Quality of Coverage in Medicaid," Association for Community Affiliated Plans, September 10, 2013, www.communityplans.net/Portals/0/Policy/Medicaid/GW%20Continuity%20Report%209-10-13.pdf

⁵ Larisa Antonisse & Rachel Garfield, Kaiser Family Foundation, "The Relationship between Work and Health: Findings from a Literature Review" (Aug. 7, 2018), available at www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review/.

⁶ Kara Gavin, "Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches," University of Michigan Health Lab, June 27, 2017, <http://labblog.uofmhealth.org/industry-dx/medicaid-expansion-helped-enrollees-do-better-at-work-or-job-searches>

⁷ Ohio Department of Medicaid, *Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly* (Jan. 2017), available at <http://medicaid.ohio.gov/portals/0/resources/reports/annual/group-viii-assessment.pdf>.

⁸ Anuj Gangopadhyaya et al., Urban Institute, *Kentucky Medicaid Work Requirements: What Are the Coverage Risks for Working Enrollees?* 3 (Aug. 2018), available at www.urban.org/sites/default/files/publication/98893/2001948_kentucky-medicaid-work-requirements-what-are-the-coverage-risks-for-working-enrollees.pdf.

⁹ See Brynne Keith-Jennings, Center on Budget & Policy Priorities, *Policy Brief: Labor Market Facing SNAP and Medicaid Participants Offers Low-Paying, Volatile Jobs* (July 24, 2018), available at <https://www.cbpp.org/research/poverty-and-inequality/policy-brief-labor-market-facing-snap-and-medicaid-participants>.

¹⁰ See Julia Angwin, "Dozens of Companies Are Using Facebook to Exclude Older Workers from Job Ads," (Dec. 20, 2017), www.propublica.org/article/facebook-ads-age-discrimination-targeting.

¹¹ Under the Waiver, lock-outs can be imposed in three situations: when a beneficiary did not timely report changed circumstances, did not timely submit documentation for renewing eligibility, or did not pay a premium

striking—for such transgressions as not timely submitting documentation, otherwise eligible persons are barred from Medicaid eligibility for up to six months. And while there are certain narrow exemptions from the lock-outs and means to regain coverage before the end of the lock-out period, beneficiaries face the administrative burden of proving that they are eligible for the exemption or have completed the requirements to regain coverage. As discussed above, requiring beneficiaries to complete paperwork and submit documentation has been shown to reduce Medicaid enrollment across populations.¹²

The unfairness and inappropriateness of lock-outs is exacerbated by the likelihood that the underlying “violation” may never have happened or may have happened through no real fault of the beneficiary. Research on the Temporary Assistance for Needy Families (“TANF”) program (which provides cash benefits) found that beneficiaries with disabilities and poor health are more likely to lose benefits due to an inability to navigate the system.¹³ In accord, this research indicates that the existence of exemptions does not necessarily ameliorate problems, since a beneficiary may likely have difficulty understanding and obtaining the exemption. In a similar vein, a recent nationwide report from the U.S. Department of Agriculture found that implementing work requirements for the Supplemental Nutrition Assistance Program (“SNAP”) was an “administrative nightmare” that was “error prone” in multiple states.¹⁴ In several instances, the Department found that the state was terminating beneficiaries’ SNAP benefits even though the beneficiary qualified for an exemption.¹⁵

Likewise, the Kentucky Medicaid program is likely to take improper actions, and beneficiaries with chronic conditions or functional limitations have less ability to contest those improper actions. Furthermore, in many cases, the result of those improper determinations will be truly draconian—loss of Medicaid eligibility for six months.

C. Eliminating Retroactive Coverage Will Lead to Unavoidable Delays and Deprive Low-Income Persons of Needed Coverage.

Kentucky seeks to waive the important patient protection that allows Medicaid coverage to begin up to three months prior to a person’s application, as long as the person met the

within 60 days of the due date. The premium-related lock-out applies only to those beneficiaries with incomes exceeding \$1,012 monthly and does not apply to pregnant women, former foster care youth, and “medically frail” beneficiaries. Also, certain circumstances can exempt a beneficiary from a lock-out, including hospitalization, death of a family member, eviction, natural disasters, and domestic violence. Finally, a beneficiary subject to a lock-out can reenroll prior to the expiration of the lock-out period by paying required premiums and completing a reenrollment education course on health or financial literacy.

¹² Sanger-Katz, *supra* note 3.

¹³ Yeheskel Hasenfeld, et al., Social Service Review, The Logic of Sanctioning Welfare Recipients: An Empirical Assessment 304, 306–07 (June 2004), available at https://repository.upenn.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1028&context=spp_papers.

¹⁴ U.S. Dep’t of Agric., Office of the Inspector Gen., FNS Controls Over SNAP Benefits for Able-Bodied Adults Without Dependents 5 (Sept. 29, 2016), available at www.usda.gov/oig/webdocs/27601-0002-31.pdf.

¹⁵ *Id.*

Medicaid eligibility standards during those months. Eliminating the retroactive coverage protection goes against Medicaid’s objectives by denying coverage to persons who cannot afford health care or private insurance coverage.

When the retroactive coverage guarantee was established in 1972, the Senate Finance Committee noted that the provision would “protect[] persons who are eligible for [M]edicaid but do not apply for assistance until after they have received care, either because they did not know about the [M]edicaid eligibility requirements or because the sudden nature of their illness prevented their applying.”¹⁶ This statement is just as true now as it was 45 years ago, and Congress has continued to support such coverage by rejecting recent legislative efforts to eliminate this protection.

We have extensive experience with persons who need significant health and long-term care services provided through Medicaid. The need for these services can arise unexpectedly and when the person needing care and their family are already experiencing the stress of dealing with a sudden or a prolonged illness. In many instances, a person in need of health care cannot be expected to apply for Medicaid coverage at the exact moment they become eligible. They may be hospitalized after an accident or unforeseen medical emergency. They may also be unfamiliar with Medicaid, or unsure about when their declining financial resources might fall within the Medicaid eligibility threshold. However, under the proposal, a person could be hit by an uninsured driver on the evening of April 29 and be liable for thousands of dollars of hospital expenses due to the “failure” to file a Medicaid application within 36 hours, when April becomes May. For example, one woman who experienced an emergency hospitalization incurred pre-Medicaid application health care bills totaling approximately \$50,000.¹⁷

The three-month retroactivity window is a rational and humane response to these concerns—allowing persons both to get healthcare when they need it and preventing devastating financial loss. We note and emphasize that retroactive eligibility is only available to persons who meet Medicaid eligibility standards for the month(s) in question.

Kentucky justifies waiver of retroactive coverage by claiming that “[e]liminating Medicaid retroactivity encourages individuals to obtain and maintain health insurance coverage, even when the individual is healthy” and further asserts that this elimination is “consistent with the commercial market and federal Marketplace policies.”¹⁸ But persons are eligible for Medicaid precisely because they cannot afford private health insurance. Moreover, Medicaid coverage is based on financial need, not on payment of premiums—indeed, the federal Medicaid statute either prohibits premiums or, for persons with incomes above 150% of the federal poverty

¹⁶ S. Rep. No. 92-1230, at 209 (1972), in Amendments to the Social Security Act 1969–1972, vol. 3, p. 221 of 1273.

¹⁷ *Schott v. Olszewski*, 401 F.3d 682, 685 (6th Cir. 2005) (more than \$40,000 in unpaid bills and more than \$8,000 in reimbursement due to patient for bills she had paid herself).

¹⁸ Commonwealth of Kentucky, Kentucky HEALTH: Helping to Engage and Achieve Long Term Health (Aug. 2016) 20.

level, caps total cost sharing at 5% of income.¹⁹ Thus limiting Medicaid coverage does not incentivize purchase of private health insurance, but instead leads only to more uninsured persons, deficient health care, and unpaid health care bills. Accordingly, Kentucky has no legitimate policy reason to deny Medicaid coverage for health care received within three months prior to the application month, since such coverage only is available for months in which the person meets financial eligibility requirements.²⁰

D. Eliminating Nonemergency Medical Transportation Harms Older Adults' Access to Health Care

Kentucky is also seeking to waive the requirement that the Medicaid program ensure necessary transportation to and from health care services. Under federal law, “necessary” transportation can include both emergency and non-emergency transportation,²¹ but the waiver eliminates non-emergency medical transportation (“NEMT”) for persons in the Medicaid expansion population. Many low-income people simply cannot afford to buy a car or hire a transportation service, and some lack access to affordable and reliable public transit. These issues—when compounded with still widespread physical accessibility barriers—make the NEMT benefit particularly critical for persons with chronic conditions or functional limitations. Indeed, the Government Accountability Office (GAO) found that “excluding the NEMT benefit would impede . . . enrollees’ ability to access health care services, particularly individuals living in rural or underserved areas, as well as those with chronic health conditions.”²²

Furthermore, lack of NEMT has consequences. When transportation is unavailable, the person does not receive needed health care and the risk of hospitalization, nursing-home admission, or institutionalization increases. Kentucky relies, in part, on data showing that, from June 2014 through June 2015, the Kentucky “expansion” population of more than 400,000 beneficiaries utilized less than 140,000 non-emergency trips.²³ But the fact that many beneficiaries did not use NEMT is not determinative; the crucial fact is the 140,000 instances in which a Medicaid beneficiary relied upon Medicaid-funded NEMT. And these 140,000 instances are more likely situations in which Medicaid beneficiaries had a chronic condition or functional limitation that necessitated Medicaid-covered transportation.

¹⁹ 42 U.S.C. §§ 1396o(c)(1), 1396o-1(b)(1)–(2)

²⁰ 42 U.S.C. § 1396a(a)(34); 42 C.F.R. § 435.915(a)(2).

²¹ 42 C.F.R. § 431.53

²² GAO, Medicaid: Efforts to Exclude Nonemergency Transportation Not Widespread, but Raise Issues for Expanded Coverage 15 (Jan. 2016), available at www.gao.gov/assets/680/674674.pdf.

²³ Commonwealth of Kentucky, *supra* note 18, at 45.

E. Kentucky’s Waiver Will Roll-Back Recent Coverage Improvements and Create Particular Risks for Older Kentuckians and Others with Chronic Conditions or Functional Limitations.

Extending Medicaid to the “expansion” population has led to significant improvements for Kentuckians between the ages of 18 and 64. A recent study surveyed Kentuckians from age 19 through 64, with incomes not exceeding 138% of the federal poverty. In 2013, 40.2% of this low-income population was uninsured, but this percentage fell to 12.4%, 8.6%, and then 7.4% in 2014, 2015, and 2016, respectively.²⁴

Furthermore, the increased level of insurance coverage led to health care improvements. Preventive care improved from 2013 to 2016, indicated by increases of 26%, 27%, and 19% in annual check-ups, annual cholesterol checks, and annual blood sugar checks.²⁵ Similar improvements were seen in the quality of care for persons with preexisting health care conditions: High-risk patients—those with histories of heart disease, stroke, diabetes, or hypertension—experienced an 11% increase in cholesterol checks. Likewise, patients with diabetes saw a 7% increase in blood sugar checks. Persons with chronic conditions were 13% more likely to receive regular care to address that condition.²⁶

The Kentucky HEALTH waiver, however, may well reverse many of these gains, with a significant burden falling on expansion population beneficiaries in their 50s and 60s or younger expansion population beneficiaries with chronic conditions or functional limitations. These persons are not eligible for Medicare because they are not 65 years of age and (in most cases) do not meet the strict Social Security definitions of “disabled,” but they are relatively more likely to be facing significant health problems.

Prevalence of chronic conditions, including both physical and mental health conditions, increases significantly with age. Reviewing health care expense data, the Agency for Healthcare Research and Quality found that 57% of persons from ages 55 through 64 have at least two chronic conditions. An additional 20.3% of these persons have one chronic condition, and only 22.7% have no chronic condition.²⁷ AARP came to similar conclusions in an analysis of data for

²⁴ Benjamin Sommers et al., Three-Year Impacts of the Affordable Care Act: Improved Medical Care and Health among Low-Income Adults, 36 *Health Affairs*, No. 6, at 1119 (2017), available at <http://nrs.harvard.edu/urn-3:HUL.InstRepos:33330546>. The data cited in this brief are taken from Appendix Table 3, which is in the article found via the above-listed internet address for Digital Access to Scholarship at Harvard, but not in the article as published in *Health Affairs*.

²⁵ The percentage of persons receiving annual check-ups increases from 46.3% to 58.4%, a 26% increase. Annual cholesterol checks and blood sugar checks increased from 45.8% to 58.1% (a 27% increase), and from 44.5% to 52.9% (a 19% increase), respectively.

²⁶ Sommers et al., *supra* note 24, Appendix Table 3. The percentage of persons receiving care for chronic conditions increased from 69.4% to 78.3%, a 13% increase.

²⁷ Steven Machlin et al., Agency for Healthcare Research and Quality, Statistical Brief #203: Health Care Expenses for Adults with Chronic Conditions, 2005, at 1–2, 5 (Figure 1) (May 2008), available at www.meps.ahrq.gov/mepsweb/data_files/publications/st203/stat203.pdf.

the age 50–64 population, finding that 72.5% have at least one chronic condition, and almost 20% suffer from some sort of mental illness.²⁸ The National Institute on Aging and National Institutes of Health reached similar results based on surveys of tens of thousands of respondents. Sixty percent of respondents from the age of 55 to 64 reported at least one health problem, with 25% reporting at least two problems (for the purposes of this study, a “problem” was defined as being related to one of six categories: hypertension, diabetes, cancer, bronchitis/emphysema, heart condition, and stroke).²⁹

All these data demonstrate how low-income beneficiaries in their 50s and 60s—along with some younger low-income beneficiaries with chronic conditions or functional limitations — depend upon the Kentucky Medicaid program and are threatened by the restrictions imposed by the waiver. Lost months of Medicaid coverage have a human cost: less preventive care, greater decline, and avoidable deterioration in physical and mental health.

F. Kentucky’s Proposals Do Not Promote the Medicaid Program’s Objectives

Section 1115 of the Social Security Act requires an “experimental, pilot, or demonstration project ... [that] is likely to assist in promoting the objectives” of the Medicaid program.³⁰ Medicaid’s primary objective is to furnish medical assistance to low-income persons.³¹ The Kentucky HEALTH proposal, including its provisions requiring low-income adults to work in order to get Medicaid coverage, locking out eligible persons from coverage, and eliminating retroactive coverage and coverage for non-emergency medical transportation, do not promote that objective. In fact, these proposals would terminate or reduce coverage for thousands of low-income Kentuckians.

As demonstrated above, work requirements in particular would end coverage for thousands of Medicaid eligible adults and increase the number of uninsured Kentuckians. Most non-elderly adults who receive Medicaid are working but at low-wage, unstable jobs that do not provide health insurance.³² Only 13.3% of part-time private-sector employees in Kentucky were eligible for employer-sponsored health insurance in 2017.³³ Therefore, there is no reason to believe that requiring a Medicaid-eligible individual to work will lead them to employer-sponsored coverage, and private insurance coverage is financially out of reach for persons who meet Medicaid financial eligibility standards.

²⁸ AARP Public Policy Institute, *Chronic Care: A Call to Action for Health Reform 11–12, 16* (March 2009), available at www.aarp.org/health/medicare-insurance/info-03-2009/beyond_50_hcr.html.

²⁹ Nat’l Institute on Aging and Nat’l Institutes of Health, *Growing Older in America: The Health & Retirement Study 23* (March 2007), available at www.nia.nih.gov/sites/default/files/2017-06/health_and_retirement_study_0.pdf.

³⁰ 42 U.S.C. § 1315(a).

³¹ See 42 U.S.C. § 1396-1.

³² Aviva Aron-Dine, et al., Center on Budget & Policy Priorities, *Many Working People Could Lose Health Coverage Due to Medicaid Work Requirements* (Apr. 11, 2018), available at www.cbpp.org/research/health/many-working-people-could-lose-health-coverage-due-to-medicaid-work-requirements.

³³ Anuj Gangopadhyaya, *supra* note 8, at 3.

We recognize that Kentucky legally may facilitate private health care coverage or, under the proper circumstances, terminate eligibility for failure to submit required information, provided that the beneficiary receives all due process protections.³⁴ Medicaid law, however, does not allow for denying eligibility to otherwise eligible persons. Thus, imposing enrollment lock-outs is inconsistent with Medicaid objectives.

Kentucky bases its request for lockouts on inapt comparisons with private insurance, which both conflicts with the purpose of the Medicaid program and fails to recognize Medicaid beneficiaries' low-income reality. Again, Medicaid exists precisely to provide health care coverage for persons who otherwise cannot afford such coverage. Data show that extending coverage to this population reduced the uninsured rate from 40.2% to 7.4% among the eligible population.³⁵ Medicaid beneficiaries do not use Medicaid coverage because they are unfamiliar with private coverage—they use it because they cannot afford private coverage. Waivers should be used to improve coverage, not to leave Medicaid-eligible persons without coverage.

G. Conclusion

Thank you for consideration of our comments. Kentucky's proposal does not meet the statutory standards for waiver under Section 1115 and would cause great harm to low-income older adults and other Kentuckians. Therefore, we urge HHS to reject Kentucky HEALTH.

Sincerely,



Jennifer Goldberg
Directing Attorney

³⁴ See, e.g., 42 C.F.R. §§ 431.200–250 (right to notice and administrative hearing), 435.916 (redeterminations of eligibility).

³⁵ Sommers et al., *supra* note 24, Appendix Table 3.