HHS Approves Harmful Section 1115 Waiver Project in Kentucky – Including Work Requirements, Lockouts, and Waiting Periods

By Catherine McKee and Leonardo Cuello

Earlier today, HHS approved the "Kentucky HEALTH" section 1115 waiver.[1] The approval allows Kentucky to ignore numerous critical and long-standing Medicaid protections for eligible Kentuckians. The approved project is effectively a health care cut that will worsen or eliminate access to Medicaid for low-income individuals. It is a huge step backwards for Kentucky's Medicaid expansion, which had been held out as a national model. This radical project even goes a step further, also harming many traditional Medicaid enrollees. All told, nearly a hundred thousand Kentuckians living below the poverty level or nearly in poverty will be hurt by this 1115 project.[2]

Under the law, HHS is only allowed to approve section 1115 demonstration programs that are experimental and likely to promote the objective of Medicaid — which is to help *furnish* health services to enrollees.[3] HHS's approval raises a number of legal questions involving not only the purported demonstration quality of the project but also whether the harm that the project will cause – reducing access to coverage and care for low-income Kentuckians-reflects Medicaid's objectives.

Among the worst features of the approved Kentucky project are:

- **Work requirements for enrollees**
  - Work requirements like these have never been approved because they are not permitted by the Medicaid Act and do not meet the section 1115 standards. Just over one year ago, HHS reviewed the possibility of work requirements and concluded the agency lacks the legal authority to allow states to implement them.[4]
  - These are the facts: The majority of Medicaid enrollees are in a working household. The vast majority of those who are not working have a disabling condition or are retired, in school, or caretakers. Most unemployed Medicaid enrollees who *can* work simply cannot find a job.[5]
  - Work requirements harm all Medicaid enrollees, *including workers*. All enrollees will need to prove they are working or meet one of the exceptions. Enrollees who fail to show that documentation will be disenrolled. Many individuals will not even know they have to file paperwork, and many others will not have the needed paperwork.
  - Studies show that mandatory work requirements are also ineffective at fostering long-term secure employment. Kentucky modeled mandatory Medicaid work requirements on those used in food support programs.[6] In Wisconsin's food support program that uses a similar work requirement, for every person that gained employment, more than three people lost access to

food support.[7] In contrast, voluntary employment support programs have proven highly effective.[8]
    - There is no evidence that mandatory work programs make people healthier. In contrast, there is evidence that health coverage helps people gain and maintain employment.[9] As a policy to promote work, mandatory work requirements are counterproductive.

- **Coverage lock-outs**
    - Individuals who fail to file paperwork or make premium payments on time, or who fail to quickly report changes in their circumstances that affect eligibility, will be terminated and prohibited from re-enrolling for 6 months. Many people will be unaware of these requirements or unable to submit paperwork on time because they have moved or are homeless and never receive the forms.
    - Even if individuals correct the paperwork or payment errors, they will *still* be locked out of coverage until they comply with additional requirements, such as taking a class. This may be true even if individuals are in the middle of cancer treatment or have a regular critical health need, such as kidney dialysis, unless they are able to qualify for an exception.
    - Locking people out of coverage directly contradicts the objective of Medicaid – to furnish coverage.

- **Waiting periods for enrollment**
    - Under the law, states must promptly enroll everyone who is eligible for Medicaid, and coverage is effective as of the month individuals apply. However, Kentucky will subject some applicants living in poverty to a waiting period of up to two months (depending on how fast they pay premiums) before their coverage is effective.
    - Many individuals apply for Medicaid soon after they have a health care crisis and find out they have no insurance. A nearly two month delay in treatment will be a matter of life-or-death for many of these individuals. Of those who do at least manage to get emergency treatments, many will be bankrupted by the medical bills.
    - The most important and entirely predictable result of delaying enrollment for individuals who need health care is worse health outcomes and medical bankruptcies – this is not an innovative experiment.

- **Premiums and terminations**
    - Medicaid law expressly prohibits premiums for individuals under 150% of the federal poverty line.
    - HHS has allowed Kentucky to charge premiums to individuals in and near poverty (even those with no income) *and* terminate those near poverty when they fail to pay. The premiums apply to some traditional Medicaid populations, not only individuals who qualify due to Medicaid expansion.

- For some enrollees, the Kentucky policy will violate a core Medicaid protection that prohibits out of pocket costs from exceeding 5% of income.
- Numerous studies consistently show that imposing premiums on low-income individuals reduces coverage. There is nothing experimental about charging premiums, and the known outcome contradicts the objectives of Medicaid.

- **Retroactive coverage eliminated**
  - Many individuals apply for Medicaid *after* an accident or serious illness that requires urgent treatment. Federal Medicaid law requires states to provide retroactive coverage so that treatment received prior to application is covered.
  - This provision helps protect consumers and medical providers (such as hospitals) from bankruptcies due to expensive, uninsured care.
  - This policy explicitly reduces coverage for enrollees and is the opposite of furnishing medical assistance as per the objectives of Medicaid.

- For some enrollees, the Kentucky project will also eliminate transportation services. This reduction in benefits will reduce access to care, sometimes with deadly consequences, and has no experimental value.

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[1] Centers for Medicare and Medicaid Services, Kentucky Health Approval Letter and Special Terms and Conditions (Jan. 12, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-ca.pdf.

[2] Kentucky's own estimate predicts about 100,000 people will lose coverage as a result of this § 1115 project. See Kentucky's § 1115 application "member month" estimates on pages 11 and 12, available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa2.pdf.

[3] See Social Security Act §§ 1115 and 1901.

[4] *See* Centers for Medicare and Medicaid Services, AHCCCS 1115 Demonstration Extension 2 (Sept. 30, 2016), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-demo-ext-09302016.pdf; Letter from Vikki Wachino, Director, CMS, to Jeffrey A. Meyers, Comm'r, N.H. Dep't of Health & Human Servs. 1-2 (Nov. 1, 2016), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-cms-response-110116.pdf.

[5] Rachel Garfield, Robin Rudowitz and Anthony Damico, Kaiser Family Foundation, *Understanding the Intersection of Medicaid and Work* at Figures 1 and 6 (Dec. 2017), http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work.

[6] Kentucky HEALTH § 1115 Demonstration Modification Request 4 (July 3, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa2.pdf.
[7] *FoodShare Employment and Training (FSET) Program Cumulative Data*, Wisc. Dep't of Health Servs. (May 5, 2017), https://www.dhs.wisconsin.gov/initiatives/fset-cumulative.htm.
[8] Howard Bloom et al., MDRC, *Promoting Work in Public Housing: The Effectiveness of Jobs-Plus* (2005), https://www.doleta.gov/research/pdf/jobs_plus_3.pdf; James A. Riccio, MDRC, *Sustained Earnings Gains for Residents in a Public Housing Jobs Program: Seven-Year Findings from the Jobs-Plus Demonstration* (2010), http://files.eric.ed.gov/fulltext/ED514703.pdf.
[9] *See* Ohio Department of Medicaid, *Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly* 46 (Dec. 2016), http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf; Jean P. Hall, Adele Shartzer, Noelle K. Kurth, Kathleen C. Thomas, *Effect of Medicaid Expansion on Workforce Participation for People With Disabilities*, 107 Am. J. Pub. Health 262-264 (Feb. 1, 2017).