Policy Brief

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Medicaid expansion in Kentucky

Susan Buchino, PhD, OTR/L, Monica Wendel, DrPH, MA, and Ryan Combs, PhD
University of Louisville, School of Public Health and Information Sciences, Commonwealth Institute of Kentucky

CONTEXT AND SIGNIFICANCE

The Medicaid program was signed into U.S. law in 1965 as a joint federal and state program to provide health coverage for individuals with limited resources who would not be able to afford health care. Specific eligibility criteria have changed over time, but the primary goal remains to serve individuals in poverty.

Kentucky adopted Medicaid two years later in 1967. Today, the program holds considerable importance for the state, as over 800,000 Kentuckians (19%) live in poverty.[1] Furthermore, Kentucky ranks 44th among the 50 states for overall health, with some of the nation's highest rates of cancer deaths, heart disease, diabetes, drug deaths, and smoking.[2]

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In 2013, the Commonwealth of Kentucky opted to expand the Medicaid program according to the provisions of the Patient Protection and Affordable Care Act (ACA). This action, which was ruled a state option by the U.S. Supreme Court,[3] was implemented by executive authority under KRS 205.520 ("Medical Assistance Act," 2005). With this expansion, Kentucky Medicaid uses the Modified Adjusted Gross Income (MAGI) methodology to cover individuals whose income is at or below 138 percent of the federal poverty level (FPL) in addition to those who qualify through traditional eligibility categories.

Since Medicaid expansion was implemented January 1, 2014, Kentucky's total Medicaid and Children's Health Insurance Plan (CHIP) enrollment has doubled; as of July 2016, 1.2 million Kentuckians (approximately 28 percent of the total state population) are served by these programs.[4] Of those, 429,402 enrollees have qualified under the guidelines of Medicaid expansion.[5] These numbers exceed enrollment predictions, and economists have reported that actual expenses for the expansion population have been greater than what was forecasted.[6] In the past two years, the federal government has provided 100 percent funding for Medicaid expansion. Beginning in 2017, the federal share will incrementally decline until 2020, at which time the federal government will reimburse 90 percent of patient care, and Kentucky will bear responsibility for 10 percent of the cost of Medicaid expansion. The cost of Medicaid expansion does not impact Kentucky's share of the cost of the traditional Medicaid program.

Kentucky's current administration, which took office in December 2015, asserts that the current Medicaid program, including expansion, is not fiscally sustainable.[7] On August 24, 2016, Governor Bevin submitted a Medicaid section 1115 demonstration proposal, entitled Kentucky HEALTH (Helping to Engage and Achieve Long Term Health), to the Centers for Medicare and Medicaid Services (CMS). This demonstration proposal falls under section 1115 of the Social Security Act, which enables innovative programs to be implemented and evaluated.[8] The purpose of Medicaid 1115 demonstrations, often known as "waivers," is to increase coverage, increase access to providers, improve health outcomes, and increase quality of care for low-income individuals while containing the costs of the program to the amount that the federal government would otherwise spend without the waiver. As it is written, Kentucky HEALTH will impact both individuals who initially qualified for Medicaid through traditional eligibility standards and the Medicaid expansion population.[9] Governor Bevin has stated that if Kentucky HEALTH is not approved, he will repeal Medicaid expansion altogether.[10]

This brief summarizes the evidence surrounding three policy options: maintaining Medicaid expansion, implementing Kentucky HEALTH, and retracting Medicaid expansion.

REVIEW OF POLICY OPTIONS

Medicaid expansion

Cost has been identified as the greatest barrier to health care access.[11] However, health insurance coverage can minimize that barrier, thus increasing access and utilization of health care services, particularly primary care, and improving health status.[12,13] Since the implementation of the ACA, the proportion of Kentucky residents who did not have health insurance decreased from 14.5 percent in 2013[14] to seven percent in 2015.[15]

Implementation of the ACA and Medicaid expansion has greatly affected working poor residents, with change in the uninsurance rate from 35 percent to 11 percent for Kentuckians with a household income below $25,000.[16,17] This includes Kentuckians working in low-wage jobs such as food service, construction, and retail.[18] Additionally, nearly 15,000 Kentucky veterans and their spouses have obtained health coverage from Medicaid expansion.[19]

Kentucky Medicaid pays for medically necessary services. Overall emergency department use has increased since the implementation of the ACA[20] and research has not explained this yet. Medicaid has covered an increased share of those services as more people are insured.[20] Use of preventive services, including chronic disease screening, cancer screening, and tobacco use counseling increased in the Medicaid population from 2013 to 2014,[19] and the Medicaid expansion population has utilized behavioral health services that they could not previously access.[21] Chronic conditions are more prevalent in the Medicaid expansion population than those who were traditionally eligible for Medicaid.[22] The expansion population only accounted for 25 percent of total Medicaid spending in 2014.[19]

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Short-term studies in both Kentucky and other states have not documented substantial improvements in health outcomes from Medicaid expansion, but have linked expansion with an increase in the number of adults self-reporting excellent health.[23-25] Former studies comparing health outcomes by payer source demonstrate there are variations in care options and social determinants for consumers using Medicaid when compared to individuals on private insurance, which also play a role in health outcomes.[26,27] Longer-term studies in other states (with observations five years post-expansion) associate Medicaid expansion with a reduction in mortality rates and improved self-reported health status, including a reduction in poor physical health days, poor mental health days, and days with health-related limitations.[28,29]

Medicaid expansion has had an economic impact on the state, communities, and individuals. One hundred percent of patient care costs for this population have been reimbursed through federal funding brought into Kentucky from 2014 through 2016. Kentucky has saved millions of dollars in administrative costs by allowing individuals to qualify through MAGI methodology rather than pursuing alternative routes that require case-by-case determination.[30] Although hospital use by Medicaid beneficiaries increased between 2013 and 2015, self-pay and charity care has declined.[20] This means that hospitals and providers have benefited from Medicaid expansion due to reduced uncompensated care costs, and formerly uninsured individuals have experienced less financial burden when they seek care.

Medicaid expansion in Kentucky has yet to result in increases in the labor market supply by beneficiaries, but as noted, many beneficiaries of Medicaid expansion were already employed. Studies have been inconclusive in demonstrating the relationship between obtaining Medicaid benefits and changes in employment.[31-33] However, Kentucky experienced an increase in labor market demand through health care and social assistance job growth from 2014 to 2016.[34] There remains a shortage in health care providers in Kentucky, which influences the population's ability to access needed services,[35] but also provides opportunity for additional job creation because more people utilize the health care system once they are insured.

Kentucky HEALTH

Although Kentucky HEALTH is a unique design, many of its elements have been employed in other states' section 1115 demonstrations. Some components of the proposal require additional waivers to the requirements of section 1902 of the Social Security Act that initially set these Medicaid standards.[9] The entire plan impacts beneficiaries of Medicaid expansion. Elements of the proposal, such as the requirement to actively renew coverage annually and to transition to employer coverage also impact other beneficiaries, including parents with dependent children, individuals deemed medically frail, pregnant women, and children.

As proposed to CMS, Kentucky HEALTH aims to transition employed beneficiaries and children of employed parents from Medicaid to employer-sponsored insurance plans with premium assistance with the goal to familiarize beneficiaries with commercial insurance.[9] Medicaid programs that use this model must ensure that beneficiaries have the same essential health benefits that Medicaid offers while continuing to utilize the Medicaid network of providers. There are limited data from other state demonstration projects to determine the costs and benefits of this model. Available evidence, does however, reflect increases in system complexity for beneficiaries, providers, and the state.[36]

Kentucky HEALTH proposes to require beneficiaries to pay premiums or co-payments to give beneficiaries some responsibility in the cost of their care. According to the proposed policy, failure to pay will result in disenrollment for six months. Currently, Kentucky Medicaid beneficiaries have some cost-sharing requirements, but the Managed Care Organizations (MCOs) that contract with Medicaid may not enforce them because the associated administrative burden can be more costly than the revenue recovered.[19] Cost-sharing by Medicaid beneficiaries increases administrative costs for the state and MCOs that are not covered by the premiums themselves.[37,38] For example, Arkansas spends over 15 dollars in taxpayer-funded administrative costs for every

dollar of premiums collected and Michigan collects just over one-fourth the administrative costs of their program.[38] Many Kentuckians report that they remain uninsured because health insurance is cost-prohibitive.[39,40] Enforcing cost-sharing for the low-income population that qualifies for Medicaid increases their financial obligation for health care; this may effectively disincentivize consumers from purchasing coverage or utilizing needed services, resulting in higher costs to the system downstream.[41] Although Indiana reports success collecting Medicaid premiums, multiple other states have experienced low rates of payment, resulting in negative consequences for those who do not submit payment.[37,38,42,43] Examples inlcude Michigan, where data reflect 40 percent of eligible participants are past due on their premium payment, and Iowa, where 5,760 participants were sernt to collections in just one month and 3,520 participants disenrolled in another.[38]

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The proposed Kentucky HEALTH plan requires work and community engagement activities of beneficiaries. Research to date does not support work requirements for individuals to receive Medicaid coverage. First, work requirements are administratively costly for states and add to governmental complexity.[44] Further, studies have shown that employment gained through a work requirement tends to be short-term, and individuals in these programs remain in poverty.[44,45] The current evidence reflects that in the long-term there is no difference in employment outcomes between those who are mandated to work and those who are not.[45] Many Kentuckians who receive benefits through Medicaid expansion are already working.[18] Thus, the work requirements may result in an increase in Kentucky's uninsurance rate without affecting employment or poverty.[44]

Kentucky HEALTH proposes that dental and vision benefits will not be standard in the plan for adults, but can be earned through a beneficiary's participation in health-related activities or community engagement. For beneficiaries living in poverty or working multiple low-wage jobs, fulfilling these requirements to receive dental and vision benefits may not be feasible. As with general medical insurance, dental and vision insurance are positively linked with timely utilization of care. Since Medicaid expansion, more Kentuckians have visited the dentist.[46] If tooth decay remains untreated, consequences may include nutrition problems, other infections, missed days of work, and emergency care for preventable dental conditions.[47] Likewise, lack of access to vision services can be detrimental, as vision loss is a leading cause of disability.[48] Of note, 10.6 percent of Kentuckians have been diagnosed with diabetes,[49] which is a risk factor for eye disease and vision loss.[50]

The Kentucky HEALTH proposal eliminates the non-emergency medical transportation benefit from the Medicaid plan, which currently enables beneficiaries to use transportation services to get to medical appointments. Transportation is a significant factor in access to services; non-emergency medical transportation is most often used by individuals with low-incomes to obtain behavioral health, including substance abuse services, dialysis, preventive care, specialist visits, rehabilitation, and adult day health care services.[51] This population has been noted to have more chronic diseases than the general population, and the provision of transportation services for routine care has been found to be cost-effective.[52]

In response to the opioid epidemic, Kentucky HEALTH proposes a pilot program to expand services to treat substance use disorders. Historically, substance abuse treatment has not been integrated into the health care system,[53] which has impacted payment for care programs. The ACA mandates Medicaid coverage of substance abuse and mental health services at parity with coverage for physical conditions,[53] which is important because individuals in treatment for substance abuse disorders are often low-income and uninsured, which limits access to care.[54] The program in Kentucky HEALTH would expand the number of facilities that could accept Medicaid patients, which would likely increase enrollment of individuals into substance abuse treatment programs who previously were unable to access such services..

Finally, Kentucky HEALTH would present new challenges to the Medicaid population due to the added complexity of the benefits package, tracking requirements, and individual beneficiary accounts. Research indicates that insurance is overwhelming and confusing[39] and that Kentuckians demonstrate poor health insurance literacy.[40,55]

Retracting Medicaid expansion

If Medicaid expansion is retracted in Kentucky, over 400,000 residents are at risk of returning to uninsured status.[5] Uninsurance is associated with higher costs to both the individual and the community.[41] Analysis prior to ACA implementation predicted that states opting out of Medicaid expansion would experience a continuation of high uninsurance rates, ongoing challenges with health outcomes, and harmful economic consequences.[56]

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Uninsurance is associated with poor health and increased mortality.[57-59] In part, this is because uninsured individuals are less likely to seek care, particularly preventive services, which have been shown to improve individuals' health[60-62]

and yield cost savings.[63] Current research indicates that when uninsured individuals are sick, they are more likely to wait to seek care until their symptoms impair their ability to function, which means the cause of the illness has become more difficult and costly to treat.[41] They are also less likely than insured individuals to follow through with treatment recommendations, which can result in additional costs and are less likely to have positive health outcomes.[57] Conclusive evidence demonstrates that in Kentucky, uninsured individuals do not get the health care they need.[39,40]

Not only is health insurance associated with access to care, but it also lowers the probability that individuals have unpaid bills that are sent to collections.[64-66] Specifically, Medicaid coverage for the low-income population leads to a decrease in bankruptcies by reducing out-of-pocket medical costs that these individuals cannot afford.[64]

Systemically, an increased uninsurance rate will likely increase costs to the state because uninsured individuals are less likely to have a primary care provider, and they are more likely to utilize emergency resources, which are more costly than outpatient office visits. The ACA includes a substantial reduction in Disproportionate Share Hospital (DSH) payments to hospitals providing uncompensated care,[67] so hospitals will be unable to recoup lost funding if individuals cannot pay. Analysis of hospital revenue following Medicaid expansion revealed that rural hospitals have experienced a more drastic increase in Medicaid payments than urban hospitals, but uncompensated care remained relatively static.[68] If Medicaid expansion is retracted, 68 rural Kentucky hospitals[69] will lose a substantial portion of their payer mix that will not be compensated through DSH payments as they were before expansion was enacted.

CONCLUSIONS

When making decisions about health policy, Kentucky's administration has to balance access to care and health outcomes with health care costs to the state. Prior to expansion, over 600,000 Kentuckians were uninsured and had poor access to care, and health status was consistently ranked among the worst in the country.[2] Following expansion, the uninsurance rate substantially declined and the number of Kentuckians reporting excellent health increased.[15,25]

Evidence from other states suggests that Medicaid expansion can result in a variety of positive outcomes for both the health of a population and the economy. In general, it is noted that Medicaid has a positive impact on local economic activity by bringing federal matching dollars to health care providers and enabling low-income individuals to spend their earned wages otherwise in their communities.[70] Long-term studies of children covered by Medicaid demonstrate a substantial return on investment.[71] Other long-term studies suggest that Medicaid expansion for adults reduces mortality rates as well as self-reported health status.[28,29] Predictive studies indicate the cost of Medicaid expansion to states when they are responsible for sharing some of the cost will be minimal and offset by the reduction of health care spending for the uninsured.[72]

Short-term outcomes in Kentucky to date have been similar. From 2014-2016, CMS paid for the cost of care in the Medicaid expansion population. That period was not long enough to measure changes in health outcomes among Kentuckians, but it is reasonable to expect similar results based on both an increase in the number of Kentuckians with health coverage and an increase in the use of preventive services that lead to long-term improvements in health outcomes.

The proposed waiver attempts to shift responsibility for cost onto consumers and to eventually move them from Medicaid onto private health insurance. However, using employer-sponsored plans with premium assistance, implementing cost-sharing, and posing work requirements has proven in other states to be ineffective and associated with an increased administrative cost to providers and the state. Furthermore, by eliminating benefits, Kentucky HEALTH does not meet the 1115 demonstration goals of improving access to care and ensuring improved health outcomes for that population. Inarguably, returning to a system without Medicaid expansion will have negative effects on the health of Kentuckians. Over 400,000 people will likely return to uninsurance, which is associated with poor health care utilization patterns, lost work and productivity, higher costs because of delayed care, and worse health outcomes. Additionally, the health care system will suffer substantial financial losses due to the provision of uncompensated care.

In balancing access to care and health outcomes with health care costs to the state, policy-makers must consider indirect costs as well. As Kentucky incurs the direct costs associated with Medicaid expansion, evidence indicates that economic gains will offset the financial burden. CMS has previously denied other state waiver requests with similar elements to Kentucky HEALTH that are deemed to reduce coverage or increase the barriers to accessing coverage.[73] However, there are Medicaid 1115 demonstrations that have proven to be as effective as Medicaid expansion in terms of access to care and use of preventive services.[74] As Kentucky looks to revise its current system, the administration will need to work with CMS to explore options for containing costs to the system and the state while maintaining access to care and improved health outcomes for low-income adults.

UNIVERSITY OF LOUISVILLE.
SCHOOL OF PUBLIC HEALTH & INFORMATION SCIENCES

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