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Kentucky Special Report: State-Level Field Network Study of the Implementation of the Affordable Care Act

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KENTUCKY: SPECIAL REPORT

**State-Level Field Network Study
of the Implementation of the
Affordable Care Act**



June 2016

**Rockefeller Institute of Government
State University of New York**

The Brookings Institution

**Fels Institute of Government
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INTRODUCTION

Securing and sustaining cooperation between the federal and state governments on major policies has seldom been easy in the United States. This update on Kentucky's implementation of the Affordable Care Act (ACA) shows not only how much political division there still exists over the 2010 law, but also how difficult it is to reverse previous state decisions.

By most measures, Kentucky was uniquely successful among Southern states in reducing its large number of uninsured persons since its previous Democratic governor used executive actions to expand eligibility for the state's Medicaid program and established a state-based ACA health benefit exchange, called *kynect*. However, the recently elected Republican governor, Matthew Bevin, has announced his intention to reverse these decisions.

Altering the terms of Medicaid eligibility was made easier for the new governor by the U.S. Supreme Court's 2012 decision to prevent the federal government from withholding all Medicaid funds from states refusing to comply with the full terms of the expansion. Governor Bevin announced that he would seek federal waivers that would allow Kentucky to maintain broad Medicaid eligibility while imposing new responsibilities and costs on beneficiaries.

However, as authors Julia Costich and Glen Mays note in this report, it will be difficult for the governor to reconcile his policy objectives with the requirements of the waivers — which, in any event, would take years to put into effect. Also, many in the state's health industry oppose such a rollback, and it will cost the state a lot of money and administrative work to adjust to the elimination of *kynect*. What's happening in Kentucky will thus test the durability of the ACA and perhaps reveal new directions for its implementation.

This report underlines the importance of maintaining a nationwide yet state-based network of engaged scholars tracking and analyzing health policy and implementation changes occurring within the ACA framework. The Brookings Institution and the Rockefeller Institute of SUNY have established such a network of researchers in forty states. The ACA Implementation Research Network will continue to provide reports by experts on the ground as this new system of health care, and perhaps new system of federalism, continues to evolve.

The authors include Julia Costich, JD, PhD, a professor in the University of Kentucky College of Public Health, and Glen Mays, MPH, PhD, also a professor in UK's College of Public Health. Mays also directs the National Coordinating System for Public Health Services and Systems Research, funded by the Robert Wood Johnson Foundation. Their initial report on Kentucky's implementation of the ACA may be found [here](#).



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KENTUCKY: SPECIAL REPORT

State-Level Field Network Study of the Implementation of the Affordable Care Act

New Governor Prepares to Overhaul Coverage Expansion in Kentucky

Kentucky has made progress in reducing the proportion of residents without health care coverage.¹ But the November 2015 election of a Republican governor raises questions about the future of these gains. On December 30, 2015, the new governor announced the appointment of a seasoned health official to lead the development of a complex Medicaid waiver proposal to the Centers for Medicare and Medicaid Services (CMS).² The proposal is expected to replace the prior governor's Medicaid expansion with a program that requires participants to pay a greater share of the costs of their care. The initiative may resemble the strategy in place for the neighboring state of Indiana³ and, if the governor's intention is fulfilled, would be positioned for approval by the end of 2016 and implementation in 2017.

Medicaid is not the only part of coverage expansion targeted by the new administration. The governor also announced that he would not renew the marketing contract for the state's popular health benefit exchange, known as "kynect,"⁴ and would shut kynect down in favor of using the federal "healthcare.gov" mechanism.⁵ He confirmed this plan in his budget address.⁶ To complicate matters further, a month before the elections, the state's largest private provider of health insurance policies, the Kentucky Health Cooperative, announced that it was shutting down, following a national trend.⁷ The Cooperative had 51,000 enrollees, by far the largest proportion of the statewide commercial market, so its closure required thousands of enrollees to select new health plans.

This unfolding story is not only important to residents of Kentucky; it is also of national significance. Rollbacks in major health care policies have been rare in the past, but the deep party divisions over the Affordable Care Act (ACA) may change that dynamic. Also, with presidential elections in the nation's near future, Kentucky's reworking of coverage expansion is attracting attention as a potential model should Republicans regain control of the White House.

Medicaid

Opposition to former (Democratic) Governor Steve Beshear's Medicaid expansion program, which covers some 400,000 enrollees, was a major plank in (Republican) Governor Bevin's campaign platform. However, actual changes in Medicaid will be tempered by legal and political realities. Although the Bevin campaign signaled an intention to discontinue Kentucky's successful Medicaid coverage expansion under the ACA, postelection statements indicate more modest changes to the program's benefits and cost-sharing arrangements.

A health advisor to Governor Bevin, Mark Birdwhistell, is on loan from the University of Kentucky's health care system and has served previous administrations in several roles, including as Medicaid director and secretary of the Cabinet for Health and Family Services. Birdwhistell has deep experience with Medicaid and the state's major health care stakeholders, experience that will prove useful in crafting and negotiating the state's Medicaid waiver proposal.

The mechanism contemplated for the state's health coverage changes is a combination of the longstanding section 1115 waiver process specific to Medicaid and a new section 1332 waiver authority created by the ACA, the so-called "innovation waiver" that will become available in 2017, allowing states to modify federal rules regarding private health insurance covered benefits, subsidies, insurance marketplaces, and individual and employer mandates.⁸ Section 1332 waivers do not support changes to state Medicaid or Children's Health Insurance Program (CHIP) programs, although the application process has been streamlined so states may submit a combination of 1115 and 1332 waivers in the same application.

Supporters of the widely praised ACA implementation initiatives of the previous administration may take some consolation from recent CMS guidance emphasizing that states cannot use 1332 waivers to gut their states' programs or shift costs to the federal government.⁹ The secretaries of the U.S. Treasury Department and the Department of Health & Human Services may only:

approve a waiver if they find that the waiver would provide coverage to a comparable number of residents of the state as would be provided coverage absent the waiver, would provide coverage that is at least as comprehensive

and affordable as would be provided absent the waiver, and would not increase the Federal deficit.¹⁰

The Bevin administration has hinted that Indiana's ACA Medicaid expansion program, Healthy Indiana Plan 2.0, might serve as a model for Kentucky's new Medicaid strategy. However, CMS has indicated that any replication of this approach would not be approved until an expedited evaluation is completed.¹¹ Indiana's model combines two features that appeal to analysts who believe that typical Medicaid benefits are too generous and do not require sufficient personal accountability: health savings accounts (HSAs) and enrollee premiums. In Indiana, the state-funded HSAs are ostensibly discretionary with regard to beneficiary contributions, but Medicaid enrollees who do not contribute are required to take on additional cost-sharing. Premiums are limited to 2 percent of household income, with further protections for the lowest-income households. An individual enrollee at the highest income level would thus pay about \$28 per month.¹² Enrollees would also have access to premium support for the purchase of commercial coverage, a concept that has attracted support in other Republican-led states.

Kentucky has some experience with cost-sharing and premiums in covering health care for low-income residents. The state's Children's Health Insurance Program, KCHIP, originally charged premiums for the highest-income enrollees, those with household income between 185 and 200 percent of the federal poverty level. Evidence questioning the cost-effectiveness of collecting small amounts from individual households, as well as detailed support for the premiums' impact discontinuity in coverage among the affected group,¹³ led the state to drop the premiums early in the Beshear administration. The second likely element of the waiver proposal, cost-sharing, has been analyzed in many contexts, including its use in Kentucky Medicaid; cost-sharing has been found to have no discernible positive effects and some negative ones.¹⁴ Kentucky has no experience with implementing Health Savings Accounts, and their use for Medicaid beneficiaries in other states is too new to have been subjected to much scrutiny. Effective implementation of this complex approach in Kentucky is far from certain.

In addition to the obstacles to sweeping change in Kentucky's Medicaid expansion, the fact that it has enrolled nearly 10 percent of the state's population, bringing total Medicaid enrollment to a figure that equals one-fourth of all Kentuckians, raises political barriers. The state Republican Senate president pro tem, Robert Stivers, was quoted as having cautioned the new governor to consult with the state legislature before acting unilaterally. Stivers's position appears to reflect a desire to avoid the potential backlash from Medicaid changes that would lead to the loss of coverage for hundreds of thousands of people, as well as the loss of reimbursement for the state's powerful health care provider community.¹⁵ However, the Bevin administration can exercise the same

executive branch powers that allowed his predecessor to pursue a federally funded Medicaid expansion without state legislative approval. Most recently, the Bevin administration announced its intent to move enrollment and renewal functions for some categories of nonexpansion Medicaid beneficiaries to a new multipurpose electronic platform.¹⁶ Thus far, the administration's planning for Medicaid reforms has occurred without formal legislative input, other than approval of the full Medicaid budget request by the 2016 General Assembly.

The governor is expected to enjoy considerable influence in the state legislature following the fall elections, which saw Republicans expand their majority in the state Senate and come within five members of a majority in the House. The House now stands as the only state legislative chamber in the South that remains under Democratic Party control. This control was threatened by four special elections during the legislative session, including two triggered by Governor Bevin's appointment of Democratic House members to executive branch and judicial offices, but Democrats prevailed in all but one of them.

The fact that state government will share the responsibility for financing Kentucky's Medicaid expansion beginning in 2017 is one of the political issues motivating discussions about state Medicaid reforms and necessitating legislative input. The state's share of expanded Medicaid financial obligations is projected to total \$74 million in 2017, rising to \$363 million in 2021 when the 10 percent state cost-sharing provision is fully phased in.¹⁷ Savings in other state-funded programs as a result of Medicaid expansion are projected to offset this financial obligation, reducing the net state cost of the Medicaid expansion to \$246 million in 2021. Any new state outlays for Medicaid will require appropriations from the state legislature, guaranteeing the need for legislative input in future Medicaid reform discussions.

Kentucky's hospitals continue to reap large financial gains from Medicaid expansion in Kentucky and are likely to continue to provide strong political support for the expansion.¹⁸ Facilities across the state have reported large reductions in their uncompensated care obligations and corresponding growth in their Medicaid revenues in 2015. The state's switch to a statewide mandatory Medicaid managed care model in 2011 has likely helped moderate expansion-related growth in Medicaid spending, allowing the state to rely on one state-based not-for-profit and four national commercial health plans to constrain provider reimbursement and service utilization.¹⁹

The overall growth in inpatient and outpatient service utilization following Kentucky's Medicaid expansion has led some observers to express concerns about the expansion's long-run budgetary impact and economic sustainability. However, corresponding increases in cancer screenings, diabetes management services, and utilization of substance abuse treatment services provide early signals of the expansion's beneficial health impacts.

Local public health agencies across the state express concern that recession-driven reductions in state funding for nonclinical prevention programs — such as those targeting tobacco use, physical activity, and environmental health — will not be restored amid a perception that Medicaid expansions offset the need for these community-wide programs. Meanwhile, the expansion's impact on the overall state economy, employment, and tax revenue remain subjects of considerable debate and uncertainty.

Commercial Coverage

The Kentucky Health Cooperative's closure appears to have resulted from CMS's inability to provide full coverage for the excess financial risk the Cooperative took on. The Cooperative provided CMS with documentation supporting \$77.0 million in risk corridor payments but received only \$9.7 million.²⁰ The organization is now in the process known as rehabilitation under the auspices of the Kentucky Department of Insurance and appears determined to make providers whole for costs incurred caring for Cooperative members to the greatest extent possible.

The concept of dismantling kynect and migrating the enrollment process to healthcare.gov has obvious political appeal, but the cost of this move remains a point of contention.²¹ A January 21, 2016, *New York Times* editorial suggested that the state should be required to repay the entire \$290 million federal investment in kynect.²² As one of the few high-functioning state exchanges, kynect has enrolled over half a million individuals, including over 80,000 in commercial qualified health plans.²³ Slowing the rate of enrollment may be part of the new administration's strategy for undermining the statewide impact of coverage expansion. Former Governor Beshear's weekly release of enrollment numbers has terminated, so specific updates are unavailable.

One important issue ties the healthcare.gov move back to Medicaid. The Medicaid enrollment process has been managed through kynect for the past two years, and unlike commercial enrollment, Medicaid eligibility is determined throughout the year. The healthcare.gov site refers Medicaid applicants back to their state eligibility determination process, but with kynect dismantled, applicants will be forced to rely on the Benefind system. Because this system was not designed for Medicaid expansion enrollees, the application assistants known as kynectors are unable to access it. Maintaining eligibility determination functions will be an important consideration as Birdwhistell and his team assemble the waiver documentation.

What Next?

Several other unanswered questions will determine the nature and timing of Kentucky Medicaid's future direction:

- Will Birdwhistell succeed in crafting a waiver proposal that meets both the objectives of the Republican administration and CMS requirements?

- What changes will the 1332 waiver proposal address in the commercial market?
- How long will it take to negotiate the ultimate fate of the waiver proposal?

Additional questions involve other state and federal policies and their effects, such as:

- Will actions at the federal level change the ACA's ground rules with regard to state flexibility or other critical elements?
- Will outreach and enrollment remain robust without the terminated marketing campaign?
- Will the prospect of more complex requirements deter a significant proportion of current Medicaid expansion enrollees from renewing their coverage?

None of these issues will be resolved quickly. Even though the governor has notified CMS of the state's intent to move to healthcare.gov, such action requires a year's notice, so the status quo seems likely to remain in effect until after the inception of 2016's open enrollment period. Medicaid changes would take even longer, so the existing coverage options would remain in effect until at least mid-2017. Meanwhile, former Governor Beshear has begun an assault on the Bevin administration's plans through a campaign called Save Kentucky Healthcare.²⁴

Despite the structural delays, the threat of major cutbacks to the state's coverage expansion may have a chilling effect on new enrollment. Introducing further complications to Medicaid enrollment is well-known to suppress uptake,²⁵ and the former Cooperative enrollees who are having to find new plans are likely to experience rate increases above the normal year-on-year changes. Coverage expansion through Medicaid has withstood many changes in state party control,²⁶ but Republican opposition to the ACA has become so deeply ingrained that defending coverage gains is likely to be a greater challenge.

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