August 17, 2018

VIA ELECTRONIC SUBMISSION

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

Attention: Kentucky HEALTH Demonstration Project

Dear Secretary Azar:

The Children’s Dental Health Project (CDHP) appreciates the opportunity to comment on Kentucky’s demonstration project "Kentucky Helping to Engage and Achieve Long Term Health (Kentucky HEALTH)" and its component parts, including the Kentucky HEALTH program. As an independent organization aiming to advance innovative policy solutions so that no child suffers from tooth decay, we are driven by the vision of all families and children achieving optimal oral health in order to reach their full potential. As such, we welcome the Department of Health and Human Services’ (HHS) ongoing attention to affordability, flexibility, and innovation in its efforts to support states’ Medicaid programs.

We urge CMS and the Secretary to disapprove the Kentucky HEALTH demonstration because it will create undue burdens for access and bring harm to children and families. These comments focus on the likely coverage loss in Kentucky HEALTH for eligible parents and its impact on children if the state is allowed to proceed.

**If approved, the Kentucky HEALTH monthly premium requirement will result in a loss of Medicaid coverage for parents.** The research is very clear that monthly premium requirements will lead to Medicaid coverage losses. Last year the Kaiser Family Foundation published a literature review on the effects of premiums on low-income populations. The Kaiser analysts cited 29 different studies finding that “premiums increase disenrollment from Medicaid and CHIP among adults and children, shorten lengths of Medicaid and CHIP enrollment, and deter eligible adults and children from enrolling in Medicaid.”  

**If approved, the Kentucky HEALTH work requirement and lockout periods will result in a loss of Medicaid coverage for parents.** A parent who is not the “primary caregiver,” not pregnant, and not “medically frail” will be subject to the 20-hour per week work requirement. Though

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they may be employed, many of these non-exempt parents will likely not be able to comply with the requirement due to unstable employment and the fluctuating work hours typical of low-wage work, and will therefore lose Medicaid coverage.

Even more troubling from our perspective are the many “lockouts” included in the demonstration. A parent could be locked out for failure to pay a required premium, failure to complete paperwork for annual redetermination of eligibility, or failure to report a change in their income in a timely fashion or falsely reporting work hours. In the case of the failure to pay a required premium, individuals could re-qualify for coverage prior to six months by paying an amount equal to three months of premiums and attending a financial or health literacy course. In the case of failing to complete paperwork, an individual could re-qualify for coverage by completing a financial or health literacy course.

Lockouts introduce new barriers to continuous enrollment for parents and other adults. The Kentucky proposal disregards research showing that the opposite approach – implementing policies that reduce barriers to continuous enrollment – is most likely to improve the efficiency of state Medicaid programs. But more importantly, parents who lack coverage for any period of time are exposed to medical debt and bankruptcy – which puts the entire family at risk for worsening their economic prospects. It has been well established that Medicaid coverage reduces medical debt and protects families from an inability to access coverage due to cost barriers.

Medicaid coverage losses by parents resulting from Kentucky HEALTH (if approved) will result in decreased access and utilization of vital services by children and families. Research shows a connection between providing public coverage to low-income parents and “increased receipt of recommended pediatric preventive care for their children.” Parents with coverage, the researchers posited, have more opportunities to understand local healthcare systems, and the

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coverage may mean they can devote income that would have otherwise gone to their own healthcare costs, to their children.⁴

Of specific concern, would be that re-approval of Kentucky HEALTH will also eliminate dental coverage from the standard benefits package for many Kentucky adults’ Medicaid. Currently, Medicaid eligible adults have limited preventive and restorative dental coverage, which includes: exams, cleanings, x-rays, and fillings. Given the historic issues with poor oral health in Kentucky, the state has made important strides towards improvement in oral health by increasing access and preventive services.⁵

This loss of preventive dental care for parents will have a troubling impact on children. Analysis of data by Connecticut Voices for Children showed that when parents had access to preventive care there, was an increased likelihood that their children would also receive preventive care.⁶ Receiving routine dental care allows for chronic disease management and early detection of chronic diseases that display symptoms in the mouth. The health of the mouth in turn affects overall health. After Medicaid expansion in 2014, over 100,000 more Kentuckians, mostly adults, received dental services than in 2013. Children also benefit when their parents have access to routine dental care. If parents have access to dental services, they will be likely to take their children. The impact of this waiver on the oral health of children in Kentucky would be a move in the wrong direction.

**Medicaid coverage losses by parents resulting from Kentucky HEALTH (if approved) will result in Medicaid coverage losses from children.** When parents lose coverage, it puts their child’s coverage at significant risk, even if the child remains eligible. A very recent study by researchers at the Urban Institute finds that it is almost unheard of for an insured parent to have an uninsured child (0.9 percent), but more than one in five children (21.6 percent) of uninsured parents are uninsured themselves.⁷

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⁴ M. Venkataramani, C Pollack, E. T. Roberts, “Spillover Effects of Adult Medicaid Expansions on Children’s Use of Preventive Services” Pediatrics Dec 2017, 140 (6) e20170953; DOI: 10.1542/peds. 2017-0953 Available at [http://pediatrics.aappublications.org/content/140/6/e20170953](http://pediatrics.aappublications.org/content/140/6/e20170953)


This association between parents’ coverage and children’s coverage is well established in research. For example, a 2015 study of the coverage effects of the Oregon Medicaid lottery for adults found that children whose parents were selected for the lottery and enrolled in Medicaid were twice as likely to have Medicaid coverage as children whose parents were not selected and did not receive coverage.\(^8\) Similarly, the researchers also found that, over a 9-year period, children with at least one parent on Medicaid were more likely to have coverage than children whose parents were not enrolled.\(^9\)

Medicaid coverage matters greatly to low-income children and families in Kentucky and elsewhere. Children with Medicaid coverage have better access to needed care than do uninsured children. Compared to uninsured children, children with Medicaid or CHIP are significantly more likely to have a regular source of care and to have a physician visit and dental visit in the last two years.\(^10\)

For all these reasons, we urge you to disapprove the Kentucky HEALTH demonstration project because it will harm children and their families. Thank you for your consideration of our comments. We ask that you include the full text of each of the studies and other materials cited through active hyperlinks in our comments in the formal administrative record for purposes of the Administrative Procedures Act. Please contact us at dvishnevsky@cdhp.org if you have any questions or if we can be of further assistance.

Respectfully submitted,
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Policy Analyst

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