

**Kentucky's Health:
A Report on the Impact of the ACA in Kentucky
and Implications of the Proposed 1115 Waiver
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Malea Hoepf Young, PhD(c), MPH
Susan Buchino, PhD, OTR/L

BACKGROUND

The importance of healthcare coverage in the United States (U.S.) cannot be overstated. It influences health decision making, facilitates access to treatment, protects financial health, and reduces risk of premature death.¹ The Patient Protection and Affordable Care Act (ACA), passed in 2010, dramatically changed the healthcare landscape in the U.S., particularly around health insurance coverage. With the implementation of key components of the new law in 2014, individuals were able to purchase subsidized insurance plans through health benefit exchanges at the state or national level. States could also choose to expand Medicaid eligibility to individuals at or below 138 percent of the federal poverty level (FPL), in addition to the traditional Medicaid-eligible groups of low income children, parents of dependent children, pregnant women, and people with disabilities. This report examines the impacts of the ACA in Kentucky, whose unique experience has drawn national attention. Initially, this was due to its role as the only Southern state to expand Medicaid and implement a state-facilitated health benefit exchange called *kynect*, which integrated enrollment of both private insurance and Medicaid. However, the state has also gained attention for the subsequent elimination of *kynect* and ongoing attempts to alter Medicaid expansion through an 1115 waiver (see Appendix 1 for timeline). Therefore, this report also explores the potential health and economic implications for Kentuckians, should ACA programs and protections be altered or dismantled.

IMPACT OF THE ACA IN KENTUCKY

Insurance Coverage

The increase in insurance coverage under the ACA was the most immediate and well-documented result of implementation. The national uninsured rate fell from 17.3 percent in 2013 to 10.9 percent in 2016, and fell furthest in those states that adopted Medicaid expansion.² Multiple sources have been used to measure insurance coverage over time, including polling data, census data, and other surveys, causing some variation in estimates. However, the evidence consistently supports that Kentucky saw the largest decline in the uninsured rate in the country. Gallup polling estimates Kentucky uninsured rate fell from 20.4 percent in 2013 to 7.8 percent in 2016,² while census data reflect a change from 14.3 percent to 5.1 percent in that same timeframe.³ Multiple studies have documented this rapid drop, particularly among low-income adults. A repeated telephone survey among this group found a significant drop in uninsured rate, from 40.3 percent in 2013 to 12.4 percent in 2016 ($p < .001$).⁴ In any report, this substantial change was attributed to the integrated state-facilitated marketplace (*kynect*) and comprehensive outreach and marketing strategy.⁵

Like many states, Kentucky has experienced a “woodwork” or “welcome mat” effect, in which those eligible but unenrolled in traditional Medicaid sought coverage during ACA open enrollment, likely due to the well-advertised outreach and enrollment efforts around the state.^{5, 7} Since the end of 2014, the numbers have remained relatively consistent; as of February

2019, Kentucky's Medicaid program served nearly 1.4 million individuals,⁸ over 500,000 more than were enrolled in December 2013.⁹

Health equity and insurance coverage

While increases in insurance coverage were seen throughout the state, there were particular advances for poor and underserved residents. There were dramatic gains in Southeastern Kentucky (see Appendix 2) and benefits for individuals in rural counties across the state, with adult enrollment in Medicaid nine percentage points higher in non-metropolitan counties than in metropolitan counties.^{10, 11} Data also show reductions in health insurance coverage disparities by race and ethnicity. African Americans experienced the largest reduction in uninsurance, falling from 16.7 percent in 2013 to 5.5 percent in 2015, which is no longer significantly different from coverage rates among white Kentuckians.¹⁰

In contrast, the group with the highest rates of uninsurance is the state's Latinx population. Although the population's uninsurance rate fell from 34.2 percent in 2013, it has remained higher than the state average, at 24.2 percent in 2015. This disparity may be because many of Kentucky's Latinx residences are recent immigrants to the U.S., and most immigrants are barred from public services, including Medicaid, for at least the first five years of legal residence. Undocumented immigrants (including Deferred Action for Childhood Arrivals [DACA] recipients), are barred from Medicaid or from purchasing insurance on the health benefit exchange. Moreover, language barriers may have prevented some eligible people from taking advantage of available services.¹² In a study of the remaining uninsured population following Kentucky's successes in enrollment, individuals cited reasons for remaining uninsured that were related to complexity of enrollment, the inability to afford private insurance plans (either through the exchange or through their employers), and confusion around the ACA and insurance in general.¹³

Access to Care

The ACA has expanded access to care through multiple pathways. Not only did the ACA introduce additional ways to access coverage through expanded Medicaid, it also introduced health benefit exchanges through which individuals could purchase health plans (known as qualified health plans [QHPs]), potentially with income-based tax credits to offset cost, and allows young adults to remain on their parents' coverage plans up to age 26. Beyond new coverage options, the ACA prohibits denial of coverage based on preexisting conditions and demands more comprehensive coverage. The law requires insurance plans to cover ten essential health benefits,ⁱ and requires that behavioral health and substance abuse disorder services be provided at parity with other types of coverage.¹⁴ These components of the law

ⁱ These benefits include: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services. See <https://www.cms.gov/ccio/resources/data-resources/ehb.html>.

expand access to care, and as data emerge about the impacts of the ACA, the body of evidence generally supports that there has been an increase in use of primary care, mental health services, and decreased lengths of hospital stays. There is also national evidence of increases in preventive screenings, such as Pap Tests and prostate cancer screening.¹⁵ In a study of Medicaid expansion versus non-expansion states (Kentucky and Arkansas versus Texas), researchers found that among states that expanded Medicaid, there has been a significant increase in individuals reporting having a primary care physician and decreased reliance on emergency room care.¹⁶

Other early research on ACA impacts shows increased diagnosis of chronic diseases and initiation of treatment for these conditions.¹⁷ While the expansion population entering the Medicaid rolls is healthier than the traditional Medicaid population, individuals who have chronic diseases are more likely to have conditions that have been poorly controlled.¹⁸ Researchers have found a significant increase in glucose screening and cholesterol monitoring in expansion states in comparison to non-expansion states,¹⁹ as well as an increase in the percentage of adults obtaining regular care for chronic conditions.²⁰

Following national trends, after Medicaid expansion, Kentucky saw a sizable uptake in preventive services among Medicaid members, including:

- 111 percent increase in cholesterol screenings;
- 116 percent increase in preventive dental services;
- 88 percent increase in cervical cancer screenings;
- 43 percent increase in flu vaccinations; and
- 69 percent increase in enrollment in smoking cessation programs.²¹

Beyond those newly insured under Medicaid, a 2016 evaluation of ACA implementation in Kentucky using National Health Interview Survey (NHIS) and Behavioral Risk Factor Surveillance System (BRFSS) data found that between 2011 and 2015, more Kentuckians overall reported a usual source of care, rising from 82.3 percent to 89.7 percent.⁶ There was also an increase in those reporting a health care provider visit in the past year, rising from 73.8 percent to 78.7 percent.⁶ Notably, these healthcare encounters excluded emergency department (ED) visits, and the report found no significant change in ED use after ACA implementation.

Health Outcomes

Initial improvements in health insurance coverage and access to healthcare can be measured relatively soon after ACA implementation. However, the complex determinants of overall health status result in a longer timeline for measures of change in health outcomes attributable to ACA policies. Environmental exposures, social determinants such as poverty and discrimination, individual behaviors, and genetics all play important roles, and changes in any of these take time to manifest in health outcome data.²² Still, a systematic review of the peer-reviewed literature on ACA outcomes found evidence supporting Medicaid expansion's association with improved overall health, including self-report of psychological distress, poor

mental health days, and general health self-assessment. Furthermore, the study found no evidence of reported decreases in self-reported health.¹⁵ Researchers comparing Kentucky, Arkansas, and Texas found that the proportion of adults in expansion states reported higher rates of excellent health in 2015 than before the expansion ($p=.04$), but did not find significant changes in self-reported mental health.^{16, 19}

Kentucky's pre-ACA poor health indicators mean that the state remains low in national rankings, but has risen from 47th in 2014 to 42nd in 2017 according to the United Health Foundation's American Health Rankings.²³ In the Commonwealth Fund's ranking of health system performance, Kentucky rose eight places between 2013 and 2017, largely due to increases in insurance coverage, but still ranked 39th in the country in 2017.²⁴ In 2018, Kentucky was ranked at 42nd, however, this reflects a change in measurement and scoring, and is not directly comparable to previous years' results.²⁴ Despite overall changes, specific health indicators for the state remain problematic, such as the high adult smoking rate (26 percent in 2013 and 25 percent in 2018), the percentage of the adult population missing six or more teeth (16 percent in 2013 and 17 percent in 2018), and adults reporting poor or fair health status (21 percent in 2013 and 20 percent in 2018).²⁴ These findings support ongoing investment in health insurance coverage options and access to care, but indicate that additional policies and programs are needed to support lasting improvement in health outcomes.

Economic Impact

Concerns about the cost of Medicaid expansion often focus on the increasing cost of expansion to the state, as the Federal Government pays a smaller percentage of the cost over time.ⁱⁱ While expansion states such as Kentucky experienced an increase in their Medicaid budgets, this increase is largely offset by other benefits. In the first two years that Kentucky has contributed a share of expansion costs, the increase in Medicaid costs has been outweighed by savings in general state funds related to care for vulnerable groups who were ineligible for Medicaid prior to expansion.²⁵

National data have shown evidence of reduced uncompensated care and increased Medicaid revenues. Moreover, the increase in demand has not resulted in harmful provider shortages or dramatic changes in emergency department use that some critics predicted.¹⁵ In fact, Kentucky's experience reflects national workforce trends, with investments in the healthcare system contributing to job growth in the health and social services sectors that have outpaced job growth in the rest of the private sector.²⁵ In Kentucky, Medicaid expansion channeled \$2.9 billion into the state's healthcare system within the first two years, which has also reduced costs related to charity care, as well as collections for medical debts.²⁵

ⁱⁱ The federal cost-sharing rate declined from 100 percent in 2014-2016, to 95 percent in 2017, and continues to drop annually until reaching 90 percent in 2020. States are responsible for the remaining program costs for beneficiaries of Medicaid eligible through expansion. See <https://www.kff.org/medicaid/issue-brief/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates/>.

Researchers estimate that each Medicaid dollar spent in the healthcare system generates \$1.35 to \$1.80 in the state economy.^{26, 27} An influx of Medicaid dollars from the federal government also contributes to health and social assistance jobs, which have grown steadily in Kentucky. Despite the beginning of the recession in December 2007, these jobs increased by 15.8 percent in the past decade, and began outpacing other private sector growth only after Medicaid expansion.²⁶

This has particular importance for rural areas in Kentucky, since nationally, nine of the ten rural counties with the highest percentage of adult Medicaid members are in Kentucky (including Bell and Wolfe Counties, in which 50 percent of adults are enrolled in Medicaid).²⁸ A study of health sector influence on the county economy in Southeastern Kentucky found that insurance payments, including Medicaid and Medicare, drew external funds into the local economy. Although some individuals on Medicaid may travel to receive care, considerable amounts of Medicaid funding flows through local medical facilities and service providers, and ultimately becomes part of local economies. In Harlan County, where the uninsurance rate of adults ages 18 to 64 declined from 24.5 percent in 2013 to 7.1 percent in 2016, health and social services provided nearly one-fifth of all jobs in 2014.^{29 30}

Individual Financial Benefits

In addition to financial benefits for the healthcare sector, states that expanded Medicaid have shown decreases in individual-level out-of-pocket medical spending in low-income populations, and decreases in medical debt and bills sent to collection.¹⁷ Prior to ACA implementation, nearly half of all Kentuckians reported trouble paying medical bills, which dropped to 37.6 percent by 2015. Additionally, other research has shown a drop in past-due medical debt, which declined 27 percent from 2012 to 2015 in Kentucky.³¹ A reduction in out-of-pocket costs has been linked to increased use of services; Sommers, Blendon, and Orav found that Medicaid expansion was associated with significant reduction in cost-related barriers to care ($p < .001$) and unfilled prescriptions ($p < .001$).⁴ Another study found that by the end of 2015, low-income individuals in Kentucky reported a 16 percent drop in unmet need for care due to cost, compared to 2013.³²

However, data have not yet shown a noticeable change in out-of-pocket medical costs for all Kentuckians, suggesting that healthcare costs are still an important issue for the state.⁶ This was reaffirmed in a 2018 statewide survey that found widespread difficulties due to the cost of healthcare and health insurance coverage. Of 900 Kentuckians surveyed, 55 percent reported delaying or foregoing health care in the past year due to cost, and 57 percent reported difficulties paying medical bills.³³ Eighty-two percent of respondents expressed that they were “somewhat” or “very” worried about being able to afford health insurance in the future, including 71 percent of Medicaid recipients. This was attributed to fears of upcoming system changes.³³

KENTUCKY'S 1115 WAIVER: Kentucky HEALTH

The election of Governor Matt Bevin in 2015 led to major changes in ACA implementation for the state. One of the administration's first actions was ending the extensive advertising campaign associated with *kynect*, which research has indicated was a significant driver of visitors to the *kynect* website.³⁴ Soon after, the administration dismantled *kynect*, shifting Medicaid applications to the state-facilitated *benefind* system, and private insurance applications to the federal healthcare.gov system.³⁵ The *benefind* transition was particularly challenging, with large numbers of Medicaid members experiencing disruptions in coverage during the transition.³⁶ The administration also moved to change administration of the Medicaid expansion program through an 1115 waiver, titled Kentucky Helping to Engage and Achieve Long Term Health (HEALTH). Section 1115 of the Social Security Act allows the Secretary of Health and Human Services (HHS) to approve state applications for waivers of certain Medicaid requirements in order to test new methods of administration, as long as they are cost neutral to the Federal Government, expand coverage, increase access to services, improve service quality, and/or increase efficiencies. Four states introduced these waivers as a precondition of expansion. One of those states, Arkansas, modified Medicaid expansion by offering private insurance plans to those otherwise eligible for public assistance under the expansion group, resulting in the second largest decline in rate of uninsured in the nation. Indiana's Healthy Indiana Plan (HIP 2.0) introduced premiums and required participants to demonstrate they are looking for work.³⁷ Ohio submitted a waiver introducing work requirements, but was rejected by Centers for Medicaid and Medicare Services (CMS) under the Obama administration.³⁸

In June 2016, the Bevin administration submitted the Kentucky HEALTH 1115 waiver to CMS. Similar to Indiana's HIP 2.0, the intention of the waiver was to curb the costs of Medicaid expansion, as well as to "to provide dignity to individuals as they move towards self-reliability, accountability, and ultimately independence from public assistance."³⁹ Conditions proposed in the waiver include:

- The introduction of monthly premiums;
- Multiple six-month lockout periods, discontinuing coverage if premiums are not paid;
- The introduction of incentive accounts for participants to manage and earn credits to pay for previously covered benefits such as dental and vision services;
- The introduction of "Partnering to Advance Training and Health" (PATH) Community Engagement requirements, with failure to comply resulting in loss of benefits;
- A requirement to transition to an employer plan if it is available; and
- The elimination of retroactive coverage and non-emergency medical transportation.^{40, iii}

Initially submitted under the Obama administration, the waiver was ultimately presented to CMS under the Trump administration. Marking a major shift in policy, in November of 2017, CMS released guidance for 1115 waivers that included encouragement of work requirements

ⁱⁱⁱ With current Medicaid regulations, DMS reimburses for services incurred up to three months before a person enrolled in Medicaid, if they were eligible at that time.

and removal of criteria that a waiver “increase and strengthen overall coverage of low-income individuals in the state.”^{41, iv} Kentucky HEALTH was approved by HHS in January 2018, and was originally scheduled to take effect on July 1, 2018, with PATH requirements rolling out monthly by county throughout the remainder of the year (see timeline in Appendix 1, and map in Appendix 3).⁴²

Shortly after Kentucky HEALTH was approved, a group of Medicaid beneficiaries filed a lawsuit against the Secretary of HHS challenging the approval. Just before the implementation of Kentucky HEALTH on July 1, 2018, Judge James Boasberg of the U.S. District Court for the District of Columbia issued his opinion on the court case, ultimately vacating the approval of Kentucky’s 1115 waiver. He cited inadequate consideration of whether the waiver program would meet the central objective of the Medicaid program, which is “furnishing medical assistance” to vulnerable populations, and cited comments submitted by the public during the federal comment period. Judge Boasberg concluded that the decision to approve the waiver was arbitrary and capricious, vacated the decision, and remanded it back to HHS and CMS.⁴³ While this did block the implementation of the Kentucky HEALTH, the narrow focus of the case did not change the admissibility of work requirements for Medicaid, or other factors that would directly impact other states that have also received approval for work requirements— Indiana and Arkansas— or states who have submitted similar requests to CMS.⁴⁴ CMS opened a new 30-day comment period on the Kentucky waiver proposal after the court’s decision, which resulted in over 9,000 unique comments, consisting of 20 times more comments in opposition to the waiver than those supporting it.⁴⁵ HHS issued its reapproval of the waiver on November 20, 2018, with few technical changes. The Kentucky Cabinet for Health and Family Services announced intentions to roll out implementation of waiver provisions beginning in April 2019; however, other legal challenges are now in progress.^{46, 47, 56}

Costs of Kentucky HEALTH

In a financial analysis included in the waiver proposal, the state anticipated \$2.2 billion in savings over the five-year course of the program, largely due to Medicaid members not complying with new requirements, and therefore losing coverage, or shifting to private insurance.⁴⁰ However, increased costs per member are projected, even as the number of members decreases. The waiver approved by HHS described an expected 10 percent decrease in members enrolled in expanded Medicaid

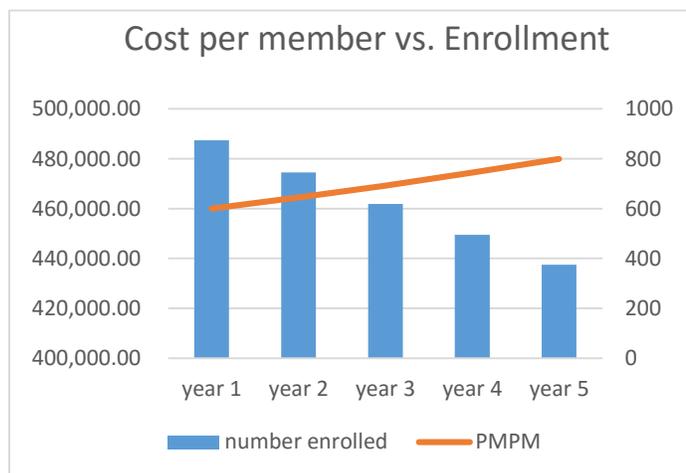


Figure 1: Cost per member vs. Enrollment
 Note: eligible member months were divided by 12 to represent number of people enrolled in coverage per year.

^{iv} For side by side comparison of the waiver language, see: https://ccf.georgetown.edu/wp-content/uploads/2017/11/Section1115_2.png.

coverage over the five-year demonstration period, while per member per month costs paid to managed care organizations to increase by 25 percent over the same period (see Figure 1).³⁹

Populations impacted by Kentucky HEALTH

The implementation of community engagement or work requirements for Medicaid in various states has caused concern for Medicaid beneficiaries, consumer advocates, and health care providers. Medicaid members must log their time each month through online portals. In Arkansas, the required work hours can only be reported online, and under Kentucky's waiver, Medicaid participants will have to manage multiple benefit accounts online as well. These reporting expectations subject participants to complex new administrative systems and potential errors. According to national-level American Community Survey data, one in three Medicaid members never uses a computer, and four in 10 report that they never use the internet.⁴⁸ Additionally, these requirements pose particular challenges for those working multiple jobs and those with variable hours and seasonal employment.⁴⁸

Moreover, most Medicaid participants already work, or have a condition that would make them exempt from work requirements. Nationally, an estimated 43 percent of Medicaid beneficiaries work full time, 19 percent work part-time, and 18 percent are part of a working family, while only six percent of adults targeted by waivers fall into the category of adults who are able to work but do not.⁴⁸ This includes non-elderly adults who are not receiving SSI, not already working, not potentially medically frail, or who otherwise report not working for a reason that would be likely to qualify for an exemption.

Dramatically increasing the complexity of coverage, without making other types of private coverage more accessible, will likely impact the uninsured rate in Kentucky. Qualitative data from Louisville on previous enrollment efforts, specifically the introduction of new enrollment technology following the dismantling of *kynect*, highlighted that major technological changes can lead to erroneous disenrollment, and that low-income workers dependent on this coverage are less able to take steps to correct these mistakes.¹³ One report states, "a low-income working individual cannot wait on the phone for two hours during the day. They don't have time to go into an [DCBS] office during a day they're working."¹³

Although limited results are available from other states with waivers, early findings reflect declines in Medicaid enrollment. Arkansas, New Hampshire, and Indiana are the only other states with approval to introduce work requirements as part of an 1115 waiver, and each had received a 1115 waiver with novel approaches to Medicaid expansion prior to this approval. As of December 2018, only Arkansas has implemented work requirements, while Indiana and New Hampshire plan to enforce work requirements beginning in 2019.⁴⁹ Arkansas implemented their waiver program, beginning with adults ages 30 to 49.^v Under the regulations in Arkansas' waiver, those who did not meet requirements for three months during the year are locked out of Medicaid until the end of the calendar year.⁵⁰ When the first three months of the program

^v Only adults 19-49 are subject to work and community engagement requirement in Arkansas.

period ended, the state announced that 4,353 people had lost coverage, out of the group of 26,000 Medicaid Members initially subject to the requirements.⁵¹ By the end of 2018, more than 18,000 Arkansans lost Medicaid coverage due to work requirements,⁵² and only 1,910 of them re-enrolled in the first two months of 2019.⁵⁷ Additionally, nearly 6,500 of over 116,000 beneficiaries did not meet work requirements in both January and February, and are now at risk of losing coverage with a third month of noncompliance.⁵⁸

Indiana received approval in 2018 to amend its existing HIP 2.0 program to incorporate work requirements. While this aspect of its waiver has not yet been implemented, an evaluation of the program elements already implemented found that, of those subject to premium payments, 55 percent failed to meet the requirement for at least one month.^{53, 54} Reasons given for non-payment included affordability, confusion about the payment process, and lack of awareness that payment was required. Similar results were found in a telephone survey, which found limited awareness of premium requirements, which are paid online through accounts known as POWER accounts.⁵⁵ Of those low income adults likely eligible for Medicaid through HIP 2.0, 39 percent reported that that they were not aware of the POWER accounts and 26 percent knew about them but did not consistently make their required payments. Only 36 percent of respondents were aware of the accounts and regularly made their required payments. Those with lower education were significantly less likely to have heard about POWER accounts.⁵⁵

CONCLUSION

ACA implementation— and in particular, Medicaid expansion— in Kentucky has resulted in substantial improvements in insurance coverage and access to care, as well as a major influx of federal dollars into the state’s healthcare system. Evidence points to increased use of preventive services that have resulted in positive gains in health outcomes. Despite these positive outcomes, efforts to make substantive changes to the Kentucky Medicaid system, not only requiring conditional access to coverage but adding administrative complexity, persist. Other states’ attempts at similar experiments have produced negative results for consumers— residents who already have limited resources and have been deemed vulnerable enough to require medical assistance. As healthcare reform continues, new policies should aim to preserve the population health improvements generated by the ACA, while promoting systemic changes that continue the upward trajectory of health gains.

Appendix A: Timeline

March 2010

The Patient Protection and Affordable Care Act, often shortened to the Affordable Care Act (ACA) passed into federal legislation

November 2011

Introduction of Medicaid Managed Care statewide in Kentucky

May 2013

Governor Beshear uses administrative authority to accept federal funds through expanded Medicaid

July 2013

Governor Beshear issues an executive order creating Kentucky health benefit exchange (*kynect*)

October 2013

First open enrollment for *kynect* begins

January 2014

Medicaid expansion and coverage through state-based exchange plans go into effect in Kentucky

November 2015

Governor Matt Bevin elected

December 2015

Governor Bevin announces dismantling of the state-based health benefit exchange (*kynect*), with the intent to direct consumers to the federal exchange, and plans to reform the state's Medicaid administration through an 1115 waiver

August 2016

Kentucky submits 1115 waiver draft to CMS, named Kentucky Helping to Engage and Achieve Long Term Health (Kentucky HEALTH)

October 2016

CMS approves Governor Bevin's request to end *kynect*

March – September 2017

Congressional attempts to repeal and replace the ACA, including the American Health Care Act (AHCA), American Healthcare Freedom Act (known as "skinny repeal"), and the reintroduction of the AHCA with the Graham-Cassidy Amendment

July 2017

Kentucky submits amendment to initial waiver application, with provisions including elimination of a 12-month ramp-up of PATH requirements, resulting in immediate requirement of 20-hour-per-week activities related to work and community service, and expansion of punitive measures for delays in reporting changes in work hours or wages

November 2017

CMS redefines purpose and objectives of the 1115 Medicaid waiver

January 2018

CMS approves Kentucky HEALTH waiver application; HHS issues a letter to all state Medicaid directors encouraging the inclusion of work requirements for conditional eligibility

June 29, 2018

Federal judge blocks implementation of Kentucky HEALTH

July 1, 2018

State eliminates dental, vision, and non-emergency medical transportation benefits, and institutes mandatory copays for Medicaid expansion recipients immediately and without notice; due to communication, regulatory, training, and system deficits, other Medicaid recipients are also affected

July 19, 2018

State reinstates benefits for nearly 500,000 Medicaid members

July 27, 2018

State pauses mandatory collection of copays

July 2018 (Blocked)

Kentucky HEALTH officially begins, requirements roll out in Campbell County

August 2018 (Blocked)

Kentucky HEALTH requirements begin in Boone County

September 2018 (Blocked)

Kentucky HEALTH requirements begin in Kenton County

October 2018 (Blocked)

Kentucky HEALTH requirements begin in Breckinridge, Grayson, Hardin, LaRue, Marion, Meade, Nelson, and Washington, Bullitt, Henry, Jefferson, Oldham, Shelby, Spencer, Trimble, West Kentucky, Christian, Bath, Boyd, Bracken, Fleming, Greenup, Lewis, Mason, Montgomery, and Robertson Counties

November 2018 (Blocked)

Kentucky HEALTH requirements begin in Ballard, Caldwell, Calloway, Carlisle, Crittenden, Fulton, Graves, Hickman, Hopkins, Livingston, Lyon, Marshall, McCracken, Muhlenberg, Todd, Trigg, Green River, Daviess, Hancock, Henderson, McClean, Ohio, Union, Webster, West Kentucky, Ballard, Caldwell, Calloway, Carlisle, South Central, Allen, Barren, Butler, Edmonson, Hart, Logan, Metcalfe, Monroe, Simpson, and Warren Counties

November 20, 2018

CMS reapproves Kentucky HEALTH

December 2018 (Blocked)

Kentucky HEALTH requirements begin in Adair, Casey, Clinton, Cumberland, Green, Laurel, McCreary, Pulaski, Rockcastle, Russell, Taylor, Wayne, Anderson, Bourbon, Boyle, Clark, Estill, Fayette, Franklin, Garrard, Harrison, Jessamine, Lincoln, Madison, Mercer, Nicholas, Powell, Scott, Woodford, Breathitt, Carter, Elliott, Floyd, Jackson, Johnson, Knott, Lawrence, Lee, Leslie, Macon, Martin, Menifee, Morgan, Owsley, Pike, and Wolfe Counties

January 1, 2019

State reintroduces mandatory copays for Medicaid members, with some exemptions

April 1, 2019

Kentucky HEALTH requirements for Alternative Benefit Plan members scheduled to begin phased implementation, with dental and vision services accessed through “My Rewards” accounts; premium payment requirements scheduled to begin, but are waived for all plans for this month; non-emergency medical transportation will cease for most adults

May 1, 2019

Premium payments will be required for most adults; individuals above 100 percent of FPL will be subject to coverage loss for nonpayment (with a six-month lockout), while individuals at or below 100 percent FPL who miss premium payments will be charged copays at the site of service

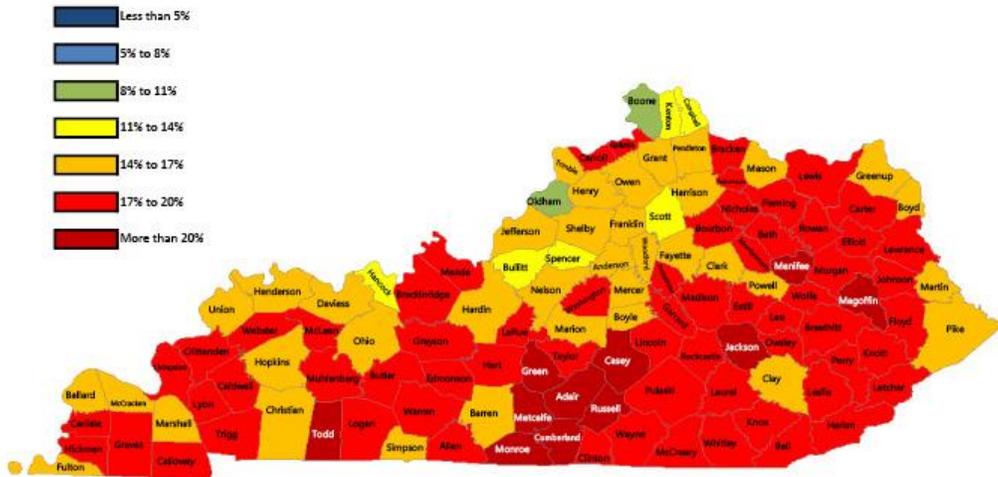
July 1, 2019

Community engagement requirements for Alternative Benefit Plan members are scheduled to go into effect “no earlier than July 1”

Appendix B: Kentucky's Uninsured Rates

Kentucky's Uninsured Before ACA

Percentage of the Population Under 65 that was Uninsured Prior to ACA
[2012 Small Area Health Insurance Estimates]



After ACA

Potential Percentage of the Population Under 65 that is Uninsured
[Assumes 75% of New Enrollees were previously uninsured]



Appendix C: PATH Rollout Map in June vs. December 2018

PATH Community Engagement Rollout Schedule

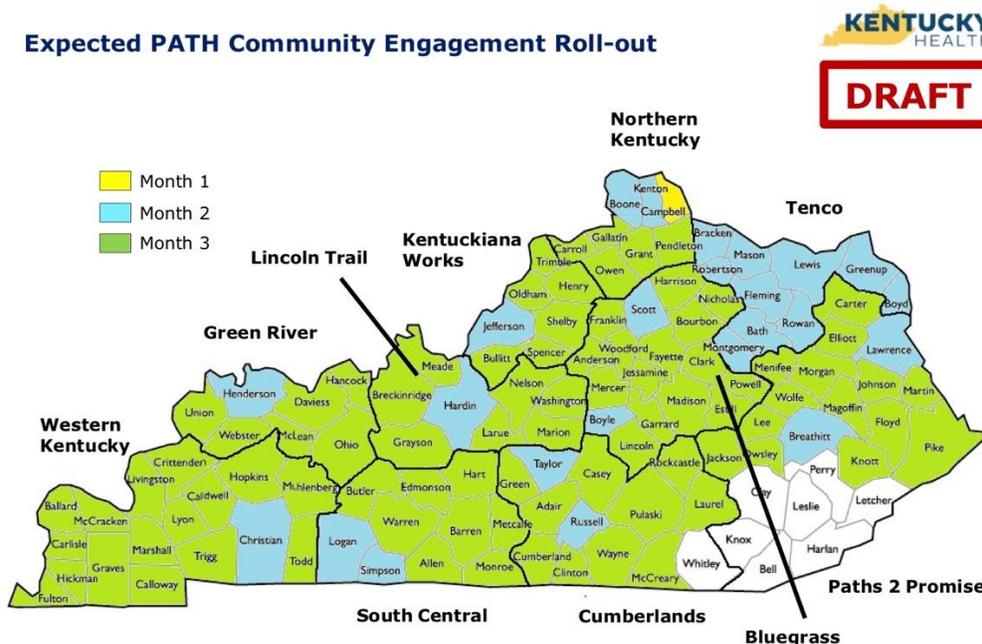
Below is the PATH rollout schedule, as of June 18, 2018. Please note this is subject to change.



*The counties labeled white are Paths 2 Promise counties. These counties are exempt from the PATH requirement through 2018. Additional information on requirements for these counties will be provided at a later date.

Source: [https://kentuckyhealth.ky.gov/SiteCollectionDocuments/PATH%20Rollout%20Plan Toolkit June18.pdf](https://kentuckyhealth.ky.gov/SiteCollectionDocuments/PATH%20Rollout%20Plan%20Toolkit%20June18.pdf). Accessed June 28th, 2018.

Expected PATH Community Engagement Roll-out



*The counties colored white on the map are Paths 2 Promise counties. These counties are exempt from the PATH requirement through the duration of the Paths 2 Promise study. Additional information on requirements for these counties will be provided at a later date.

Source: [https://kentuckyhealth.ky.gov/SiteCollectionDocuments/DRAFT Kentucky%20HEALTH%20Stakeholder%20Advisory %20Forum December v9.pdf](https://kentuckyhealth.ky.gov/SiteCollectionDocuments/DRAFT%20Kentucky%20HEALTH%20Stakeholder%20Advisory%20Forum%20December%20v9.pdf). Accessed December 13, 2018.

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