KENTUCKY EQUAL JUSTICE CENTER
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Via Email

February 27, 2019

Chase Coffey, Executive Administrative Assistant
Office of Legislative and Regulatory Affairs
275 East Main Street 5 W-A
Frankfort, KY 40621

Re: Comments on proposed amendment to 907 KAR 1:604. Recipient cost-sharing.

Dear Sir or Ms,

Kentucky Equal Justice Center is a poverty law advocacy and research center. We work with multiple community partners on issues affecting low-income Kentuckians. During implementation of the ACA we chose to register two staff to become Certified Application Counselors for coverage.

Hands-on help to consumers made us better policy advocates. It showed us what worked right, it enabled us to report glitches and problems, and it gave us eyes and ears in the community through outreach and enrollment at diverse sites.

We saw firsthand the difference that new coverage made in the lives of people we met—from a life-saving cardiac procedure to long-delayed dental care to help for depression.

Comments submitted by my colleague Miranda Brown reflect these realities—and the confusion and barriers to care already caused under the emergency regulation. This comment focuses on the advisability of cost-sharing as a strategy to achieve health.

Cost barriers already have been studied and the lessons incorporated into law

Cost barriers are a clumsy tool to manage health. They call on patients rather than providers to distinguish medically necessary from unnecessary care. They have been studied for at least 40 years, since the RAND Corporation Health Insurance Experiment of the 70s and 80s. It is difficult to imagine that anything new can be demonstrated or any different result achieved. See Rand here.[i]

The RAND team found that most of the time, for most people, copayments did not reduce medically necessary care. People either found a way to pay them or skipped care without harm. But for low income people Rand found health effects:

> "free care led to improvements in hypertension, dental health, vision, and selected serious symptoms. These improvements were concentrated among the sickest and poorest patients."

Stand that on its head and it means that low-income and sicker people lost access to medically necessary and beneficial care in detectible ways when faced with cost barriers. We are seeing this already. Example: patients struggling to maintain their mental health prescription regimen.

Findings like the Rand data have influenced cost sharing policies to be smarter. We refrain from imposing copayments on children, or pregnant women, or for preventive services, or for key elements of disease management.

Congress wisely has adopted a requirement that they be nominal. Under Kentucky HEALTH, the Cabinet would impose them as an alternative to a troubling new cost barrier: premiums, permitted up to a higher level (4% of income) than so far permitted for any state.

If the Cabinet were confident in the legality and wisdom of Kentucky HEALTH provisions, it need not impose this alternate cost-sharing regimen now, just months ahead of planned implementation. It need only make its case for the waiver.

Perhaps the most distressing part of the current copayment is that it puts the health of even more vulnerable and lower income people on the line than contemplated in the waiver—the so called "medically frail" below poverty.

A worse policy does not, however, justify a bad one. The Rand findings predict a troubling health result for vulnerable Kentuckians either way. We are seeing the results already.

Please send me a copy of the Statement of Consideration of comments.

Sincerely,

Richard J. Seckel
Director

[i] https://www.rand.org/pubs/research_briefs/RB9174.html