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MANAGING HEALTH REFORM

# KENTUCKY: ROUND 1

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

August 2014

Rockefeller Institute of Government  
State University of New York

The Brookings Institution

Fels Institute of Government  
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## KENTUCKY

### ROUND 1

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Network Study of the  
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## MANAGING HEALTH REFORM

# KENTUCKY: ROUND 1

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

### Part 1 – Setting the State Context

#### 1.1 Decisions to Date

Kentucky has taken the route of full Affordable Care Act (ACA) implementation through a state-based health insurance exchange and Medicaid expansion. Both decisions were implemented by executive branch action because of the clear understanding that the divided and conservative state legislature would never pass enabling legislation. The exchange was established by [Executive Order 2012-587](#) on July 17, 2012,<sup>1</sup> while the Medicaid expansion was undertaken under the authority of KRS 205.520(3), which provides legislative authorization for the executive branch to “take advantage of all federal funds that may be available for medical assistance.”

The lack of legislative authorization raises some concern about the durability of Kentucky’s ACA implementation initiatives, but for the time being, the state’s posture is one of total commitment. Governor Steve Beshear’s [September 26, 2013, op-ed](#) in the *New York Times* sets out his position in unambiguous terms.<sup>2</sup>

The decision to proceed with a state-based exchange was supported by a [stakeholder survey](#) conducted in 2011, which showed strong support for state rather than federal control of the exchange from a wide range of sectors that included hospitals, physicians, business groups, and other provider groups.<sup>3</sup> The decision has been vociferously and persistently opposed, notably by tea party activists who heckled the secretary of the Cabinet for Health and Family Services at the initial public forum on exchange

implementation in May 2012 and continued to attend Advisory Board meetings in some numbers. The state tea party leader, David Adams, has brought suit on the matter; the litigation has been allowed to proceed, but the Franklin County Circuit Court declined to suspend exchange implementation [pending a final ruling](#) in the matter.<sup>4</sup> Medicaid coverage expansion has also been the subject of repeated criticism by Republican state legislators, not to mention the state's two prominent Republican senators, Rand Paul and Mitch McConnell, and most of its congressional delegation.

The exchange, formally known as the Kentucky Health Benefit Exchange (KHBE) and branded as [kynect](#),<sup>5</sup> is a state agency located within the Cabinet for Health and Family Services. Kentucky has received nearly \$250 million in federal funding for exchange planning and implementation, including a federal planning grant and additional funding for the development of information and enrollment systems.

The decision to expand Medicaid was announced in March 2013 after extensive data gathering and deliberation on the part of the Governor's Office and his advisors. As a Democratic governor in a conservative state with a high rate of poverty, Beshear was understandably challenged to balance the inevitable political backlash with the obvious benefit to low-income Kentuckians. Since the decision was announced, however, the Beshear administration has been fully supportive.

## 1.2 Goal Alignment

Kentucky's official actions are clearly in the affirming category.

## Part 2 – Implementation Tasks

### 2.1 Exchange Priorities

The balance between timeliness and functionality in exchange implementation is a national challenge amply reflected in Kentucky's experience. While all the major areas of implementation have been given roughly equal priority, there have been delays in two – the process of contracting for statewide assister organizations and the announcement of Small Business Health Options (SHOP) issuers. In both cases, these delays are attributable to issues in the contracting process. In the first case, the call for proposals from prospective "kynectors" was reissued for three of the state's eight geographic regions, and awards were announced on November 1, 2013. In the second, negotiations with participating providers were incomplete at the time of the original deadline, but concluded well in advance of the October 1st rollout.

### 2.2 Leadership – Who Governs?

The Kentucky Health Benefit Exchange is governed by state officials who are responsible for its activities; the Board is only advisory and its input is not binding upon the exchange.

The director, Carrie Banahan, is a career state official with extensive experience in both the Department of Insurance (DOI) and the Department for Medicaid Services (DMS). She was most recently director of the state Office of Health Policy (OHP) and Medicaid commissioner. The deputy director, William Nold, is an attorney and former DOI official.

### 2.3 Staffing

KHBE staff members have been drawn primarily from other state agencies and the pool of recent state retirees. An exception is the outreach and consumer education director, who is new to state government and has extensive experience in not-for-profit marketing. The experience of other staff members includes work in the state's Legislative Research Commission, OHP, DOI, and DMS. At least two are registered nurses, and another holds a doctoral degree in public policy.

### 2.4 Outreach and Consumer Education

Outreach and consumer education vehicles include organizational grants and contracts, training opportunities for certified application assisters, and extensive self-directed online aid. Billboards, media advertisements, and appearances at many civic events across the state have featured the distinctive [kynect characters](#)<sup>6</sup> and personal contact from both officials and "kynectors," the term used for the entire group of trained assisters. Development of the Kentucky outreach initiative was coordinated with input from the Outreach and Education Subcommittee of the Kentucky Health Benefit Exchange, including several rounds of testing and feedback.

### 2.5 Navigational Assistance

As of November 1, 2013, the exchange had awarded contracts for navigational assistance in all Medicaid regions. The grantees are the regional area development district in the greater Louisville area, the state primary care association in the Appalachian eastern part of the state (Medicaid region 8), and the state community action council association in the remaining six Medicaid regions.

Funding was also provided for several agencies of the Cabinet for Health and Family Services on the basis that they could build on established partnerships with local agencies, including the Department for Behavioral Health, Developmental and Intellectual Disabilities; the Commission for Children with Special Health Care Needs; the Family Resource and Youth Services Centers; the Department of Aging and Independent Living; and the Department for Public Health (DPH).

The limited amount of funding through the DPH is intended to support outreach and enrollment activities performed by staff of local and district health departments. Some state-local tensions have surfaced over the comparatively small amount of navigation funding directed to local health departments, given that the DPH

previously instructed these departments not to apply for the much larger regional contracts to provide navigational assistance. Most local health departments in Kentucky are also ineligible for the federal outreach and enrollment funding made available to federally qualified health centers (FQHCs) from the ACA’s Prevention and Public Health Fund (Prevention Fund).

The tensions expressed by local public health officials also reflect a more generalized disappointment with recent reductions in federal funding through the Prevention Fund, due in part to sequestration and in part to U.S. Department of Health and Human Services (HHS) decisions to divert federal Prevention Fund dollars from public health programs in order to support implementation of other ACA provisions (such as the FQHC outreach and enrollment effort). State officials generally have viewed local health departments as important components of the outreach and enrollment effort because of their ability to reach younger and healthier uninsured populations who may not have regular contact with the health care system (including FQHCs). Local officials express concern that these public health roles are becoming another “unfunded mandate” placed on local agencies by a state government that has reduced public health funding significantly in the wake of the 2008 economic recession.

**2.6 Interagency and Intergovernmental Relations**

As a state agency staffed primarily with veteran state employees, the Kentucky Health Benefit Exchange has close relationships with other state agencies, notably Medicaid and the state Department of Insurance. It has also been on excellent terms with the federal Center for Consumer Information and Insurance Oversight (CCIIO) throughout the development process, according to reports from staff at committee and advisory board meetings.

**2.7 QHP Availability and Program Articulation**

Kentucky’s exchange follows the clearinghouse model and is not an active purchaser.

Three issuers are offering Qualified Health Plans (QHPs) in the nongroup exchange market. Humana coverage is currently limited to the greater Lexington, Louisville, and northern Ken-

tucky (suburban Cincinnati) areas. The other two nongroup issuers are the Kentucky Health Co-op and Anthem/Wellpoint. Anthem’s federal plan (Anthem OPM) is also offered at the silver and gold levels (Table 1).

**Table 1. Kynect’s Individual Offerings**

Issuer	Catastrophic	Bronze	Silver	Gold	Platinum	Total
Anthem	1	5	4	1	0	11
Anthem OPM	0	0	1	1	0	2
Co-Op	1	1	1	1	1	5
Humana	4	4	4	4	4	20



**Table 2. Kynect's SHOP Offerings**

Issuer	Bronze	Silver	Gold	Platinum	Total
Anthem	2	2	2	0	6
Bluegrass	2	4	4	2	12
Co-Op	1	1	1	0	3
United HealthCare	1	1	1	0	3

Four issuers are offering QHPs in the SHOP exchange: Anthem, the Kentucky Health Co-op, Bluegrass Family Health (limited to central Kentucky) and United Healthcare. At least three metal levels are offered by each issuer (Table 2).

Kentucky Medicaid is now primarily provided through publicly traded managed care organizations: WellCare, Humana, Coventry (now an Aetna subsidiary), and Anthem. The fifth managed care organization, Passport Health, is a not-for-profit entity sponsored by a state university medical center and other providers that has served the greater Louisville area since 1996 and is expanding to statewide coverage. Exchange applicants who qualify for Medicaid will have the opportunity to shop for coverage in the same general manner as the other exchange applicants.

Kentucky's Department for Medicaid Services is on track to implement an entirely new enrollment and eligibility system in December 2013, just in time for full articulation with the kynect system. This enormous project involves not only replacement of a system in its fourth decade of operation, but also alignment with Modified Adjusted Gross Income (MAGI) and other new eligibility standards.

**2.8 Data Systems and Reporting**

Exchange data systems seem to be functioning with fewer problems in Kentucky than in other states, although initial volume was very challenging and required temporary doubling of server capacity. Systems development was outsourced to Deloitte and its subcontractors. It is too early for a full assessment of functionality, but the user interface seems to be working. According to [state data](#)<sup>7</sup> as of April 21, 2014, there had been some 1.5 million unique visitors to the kynect website, 886,502 had gone through the screening process, and 413,410 individuals had been enrolled, of whom 330,615 were in Medicaid coverage and 82,795 were in qualified health plans. Of the 1,605 small businesses that had initiated applications, 628 had completed them.

Some 839,398 calls had been managed by the call center, prompting the contractor to hire seventy-six additional staff. It is also noteworthy that 22,147 individuals were enrolled in stand-alone dental plans, and 52 percent of the enrollees were thirty-five years of age or younger

A separate data source, the [Kentucky Health Issues Poll](#),<sup>8</sup> reported an increase in the proportion of Kentuckians with employer-sponsored coverage from 37 percent to 44 percent, and a

decrease in the number reporting having been uninsured at some point in the preceding twelve months, from 41 percent to 33 percent. It is important to note that this survey was administered in October-November 2013, before exchange-based coverage began to take effect.

### **Part 3 – Supplement on Small Business Exchanges**

#### **3.1. Organization of Small Business Exchanges**

Kentucky's SHOP exchange is separate from the nongroup exchange for the purposes of risk pooling and qualified health plan participation. Outreach is conducted by the same groups under contract for kynect outreach as a whole. Anecdotally, insurance agents and brokers are far more likely to interact with SHOP clients than with nongroup households seeking coverage.

As noted above, four issuers are offering QHPs in the SHOP exchange: Anthem, the Kentucky Health Co-op, Bluegrass Family Health (limited to central Kentucky), and United Healthcare. At least three metal levels are offered by each issuer. As of April 21, 2014, 628 small businesses had been approved to enroll their employees in qualified health plans.

### **Part 4 – Summary Analysis**

Although Kentucky's implementation of the ACA is frequently named among the most successful in the country, the only major political figure apart from Beshear who has expressed stalwart support is the sole Democrat in the state's congressional delegation, John Yarmuth of Louisville. Even Secretary of State Alison Lundergan Grimes, the Democratic challenger to McConnell, steers clear of supporting President Obama's signature initiative. The reason, obviously, is that Kentucky trends strongly Republican, particularly in its large rural areas. President Obama is quite unpopular among Kentucky voters, so "Obamacare" is immediately tainted as a political issue, regardless of its success within the state. This problem is reflected in the tally of winners and losers to date, as well as the ambiguous future for Kentucky's ACA programs.

#### **4.1 Policy Implications**

Kentucky has a high rate of poverty, and low-wage workers are among the major winners in the state's successful ACA implementation. If conventional political wisdom holds, however, the large cohort of newly insured Kentuckians, particularly those newly eligible for Medicaid, cannot be relied upon to support pro-ACA candidates, if they make it to the polls at all. Kentuckians are disproportionately dependent upon transfer benefits, yet they generally vote against candidates who support government aid to the disadvantaged. Conversely, the small businessperson or self-employed worker whose health insurance premium increases under the new coverage requirements is probably among the

typical middle class voting public. In addition, negative experiences with health care coverage are likely to be attributed to the ACA regardless of their actual origin, and given the complexity of the topic, misrepresentations may not be identified by the general public. Public education about health reform is a daunting task that is far from complete in Kentucky.

Some of the obvious winners, in addition to beneficiaries themselves, are large provider groups and insurance carriers, including the state's five Medicaid managed care organizations. Kentucky is seeing a slow but steady trend to health system consolidation. Larger provider groups have the resources and sophistication to take advantage of opportunities under the ACA, but smaller practices, hospitals, and other health care providers are increasingly challenged to avoid harm from new regulatory regimes.

The state's major insurance carriers have been active participants in ACA-related policy development and implementation, providing many hours of service on the KHBE advisory council and subcommittees. This donation of time and expertise is motivated, in part, by the clear understanding that successful implementation brings them tens of thousands of new health plan members, and that shaping systems to minimize market disruption will avoid excessive administrative costs.

Trade associations for which health insurance commissions are a major income stream will lose considerable revenue under the ACA. The medical loss ratio requirements of the ACA will reduce their commission revenue and threaten the viability of health insurance as a line of business for them. Trade associations have substantial political clout in Kentucky because they represent locally prominent interests across the entire state, with connections to most state senators and representatives. Again, these local automobile dealerships, Farm Bureau members, oil and gas vendors, building contractors, and other trade association constituents are mostly Republicans and would oppose the ACA's coverage mandates even in the absence of fiscal impact on the association itself.

The Governor's Office recently estimated that the ACA will produce nearly \$167 million in savings for the state budget over the next biennial budget cycle by generating new federal Medicaid funding for services provided by local health departments and community mental health centers that were previously supported by state outlays. These projected savings allowed the governor's budget proposal to exempt many public health and mental health programs from another round of budget cuts that will apply to most other state programs in FY 2015-16. These projected savings have also allowed the governor to propose targeted expansions in state spending for oral health and cancer screening programs, particularly for population groups that remain without insurance coverage for these services.

## 4.2. Possible Management Changes and Their Policy Consequences

Two looming challenges to the long-term viability of Kentucky's ACA implementation are the 2014 elections and funding for KHBE operations. Democrats currently hold a majority in Kentucky's House of Representatives (Republicans control the Senate), but the entire House will be up for reelection in 2014, and it is entirely possible that Republicans will take control. The other 2014 contest with major implications for the ACA, both in the state and nationally, is McConnell's reelection. McConnell is closely allied with Kentucky's Senate President Pro Tem Robert Stivers. If (as seems likely) McConnell is reelected, the full might of his political position will be felt at the state level through concerted opposition to KHBE funding and other ACA-related measures.

Funding for KHBE operations is problematic once federal grant dollars are no longer available. The state continues to face major revenue shortfalls in general and a substantial cut to the tobacco master settlement agreement (MSA) funding in particular. The latter issue arises because MSA funding is a major component of the funding stream transferred from the old state high-risk pool to KHBE, along with a 1 percent surcharge on commercial premiums. The transfer of these funding streams may also be the subject of litigation challenging the reach of executive branch power in the absence of legislative authorization.

In summary, while Kentucky's health benefit exchange has thus far been among the nation's leaders in successful implementation, its sustainability will depend on political leadership, the ability of supporters to mount successful public relations and constituent campaigns, and ongoing fiscal support. All these elements will be hotly contested in the next year.

## Endnotes

- 1 See Steven L. Beshear, Governor of Kentucky, Executive Order 2012-587, July 17, 2012, [execjournalimages/2012-MISC-2012-0587-222943.pdf](http://execjournalimages/2012-MISC-2012-0587-222943.pdf).
- 2 See Steve Beshear, "My State Needs Obamacare. Now." *The New York Times*, September 26, 2013, [http://www.nytimes.com/2013/09/27/opinion/my-state-needs-obamacare-now.html?\\_r=0](http://www.nytimes.com/2013/09/27/opinion/my-state-needs-obamacare-now.html?_r=0).
- 3 See Cabinet for Health and Family Services Office of Health Policy, Stakeholder Perspectives on Health Benefit Exchanges, June 2012, <http://healthbenefitexchange.ky.gov/SiteCollectionDocuments/Stakeholder%20Report%202012.pdf>.
- 4 See David Adams, Et Al v. Commonwealth of Kentucky, Et Al, Sally Jump, Clerk (Franklin Circuit Court, Commonwealth of Kentucky, Division 1, No. 13-CI-605), <http://hr.cch.com/hld/adamsvkentucky1.pdf>.
- 5 See kynect website, <https://kyenroll.ky.gov/>.
- 6 Ibid.
- 7 See Office of Kentucky Governor Steve Beshear, "A Healthier Kentucky: Health Insurance Coverage for Every Kentuckian," Updated as of April 21, 2014, <http://governor.ky.gov/healthierky/Pages/default.aspx>.
- 8 See Foundation for a Healthy Kentucky, "More Kentuckians Report Having Health Insurance," January 13, 2014, <http://www.healthy-ky.org/news-events/newsroom/more-kentuckians-report-having-health-insurance>.