

MEDICAID EXPANSION IN KANSAS

Elements in Competing Versions Affect Estimated Enrollment, Costs

ISSUE BRIEF

JANUARY

2020

Introduction

Multiple proposals to expand Medicaid for low-income Kansas adults age 19-64 have emerged for consideration in the 2020 legislative session. This issue brief updates previous Kansas Health Institute estimates of the effect of expansion on KanCare and describes how selected components in some proposals, such as premiums or alternate income limits, might affect enrollment and costs.

In Kansas, Medicaid and the Children's Health Insurance Program (CHIP) are together known as KanCare. The Affordable Care Act (ACA) created the opportunity for states to expand Medicaid to adults age 19-64 with income up to 138 percent of the federal poverty level (FPL). Kansas is one of 14 states that has not adopted expansion.

In 2019, the Kansas House passed legislation that would expand KanCare under the terms of the ACA. The bill was based on the proposal introduced by Governor Laura Kelly early in the session, which was a straightforward expansion to 138 percent FPL. The House version added an amendment to require premiums from expansion enrollees, among other provisions. The Senate did not take up the House-passed bill in 2019, but in the fall, a more complex proposal to expand Medicaid and stabilize the private health insurance marketplace emerged from the interim committee process. In early January, Governor Kelly and

Senate Majority Leader Jim Denning announced an agreement, introduced as Senate Bill (SB) 252, that merged provisions from the other proposals. A summary of the differences among various proposals is presented in the insert included with this report and will be updated online as needed.

Using the latest available population information and updated cost and revenue data, this analysis projects that a straightforward expansion akin to the Governor's original proposal would lead to enrollment of nearly 132,000 additional Kansans, including 93,000 adults and 39,000 children, at a net cost to the state in the first full calendar year (2021) of \$15.3 million for newly eligible adults, \$14.1 million for currently eligible but newly enrolled adults, and \$34.4 million for newly enrolled children. The estimate suggests that the proposed up to \$35 million annual hospital surcharge in SB 252 would, as designed, be sufficient to cover the cost of adult expansion.

Enrollment Estimate

This estimate differs from other estimates, including state fiscal notes, because it includes the indirect effect of expansion on children and currently eligible adults. The analysis used U.S. Census Bureau data from the 2018 American Community Survey to assess the number and insurance status of the population that would enroll in Medicaid if it were expanded.

KEY POINTS

- ✓ A total of 132,000 Kansans – including 93,000 adults and 39,000 children – are estimated to newly enroll in KanCare if Medicaid is expanded.
- ✓ This estimate differs from other estimates, including state fiscal notes, because it includes the indirect effect of expansion on children and currently eligible adults.
- ✓ Of projected new enrollees, about 77,000 were previously uninsured, while the remaining 55,000 had other coverage and are expected to switch to KanCare.
- ✓ The premiums included in some proposals would be expected to reduce adult enrollment by as many as 37,000 enrollees, but potentially could increase net cost to the state.
- ✓ Total net costs to the state in 2021, after accounting for new revenues, offsetting savings and additional administrative costs, are estimated to be \$15.3 million for newly eligible adults, \$14.1 million for currently eligible, newly enrolled adults, and \$34.4 million for newly enrolled children.
- ✓ If these estimates approximate the actual experience, then the up to \$35 million annual hospital surcharge proposed in SB 252 would more than cover the net state cost of newly enrolled adults.

The estimate of 92,527 new adult enrollees (Figure 1) includes 55,333 newly eligible adults who are currently uninsured, 3,557 adults who are currently eligible but uninsured, and 33,637 adults expected to switch from another insurance source to KanCare.

In addition, this brief considers some adult enrollment in KanCare that could shift to the expansion group, which is estimated to reduce state costs as discussed in the next section. Approximately 7,300 members who might otherwise have enrolled in pre-expansion eligibility categories could instead become initially eligible in the new expansion group. That effect would increase the adult enrollment in the expansion group but not total enrollment, so the group is not included among the nearly 132,000 estimated “new” enrollees.

Expanding Medicaid would not change the eligibility levels for children, but it is assumed that more currently eligible children would enroll in KanCare as enrollment efforts reached more people, particularly if their parents were to newly enroll. The estimate of 39,413 newly enrolled children (Figure 2, page 3) includes 17,852 currently uninsured children and 21,561 children whose coverage would shift to KanCare.

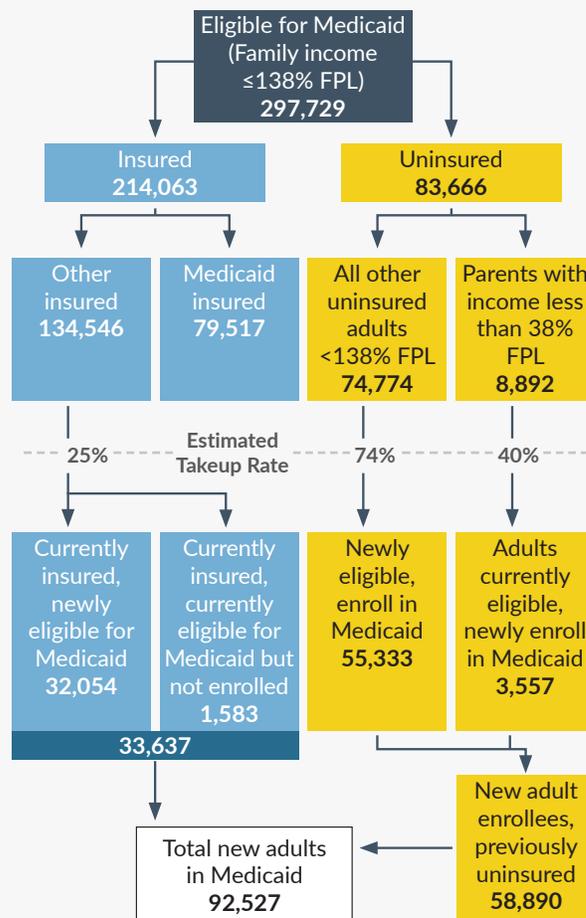
Cost Estimate

This estimate assumes expansion would be implemented Jan. 1, 2021. Total gross costs in this estimate are higher than in previous KHI estimates primarily because actual KanCare per capita costs, which are the basis for the assumptions in the analysis, have increased, and the projected annual increase for expansion-related costs now more closely reflects assumptions made in federal projections of increases in Medicaid costs.

The estimate of net cost to the state also includes estimated new revenues, savings from adults who would enroll in the new expansion group rather than another eligibility group with a less favorable match rate, and additional administrative costs from new enrollment. The resulting estimated costs are presented in Figure 3, page 4.

Estimated new annual revenues include managed care privilege fees, increased drug rebates collected by the state, and additional CHIP premiums collected. Savings each year related to the effect on other, current eligibility categories come from enrollees who previously may have qualified as Medically Needy, women who become pregnant

Figure 1. Projected Kansas Adults Age 19-64 in Medicaid Expansion Population under 138 percent FPL



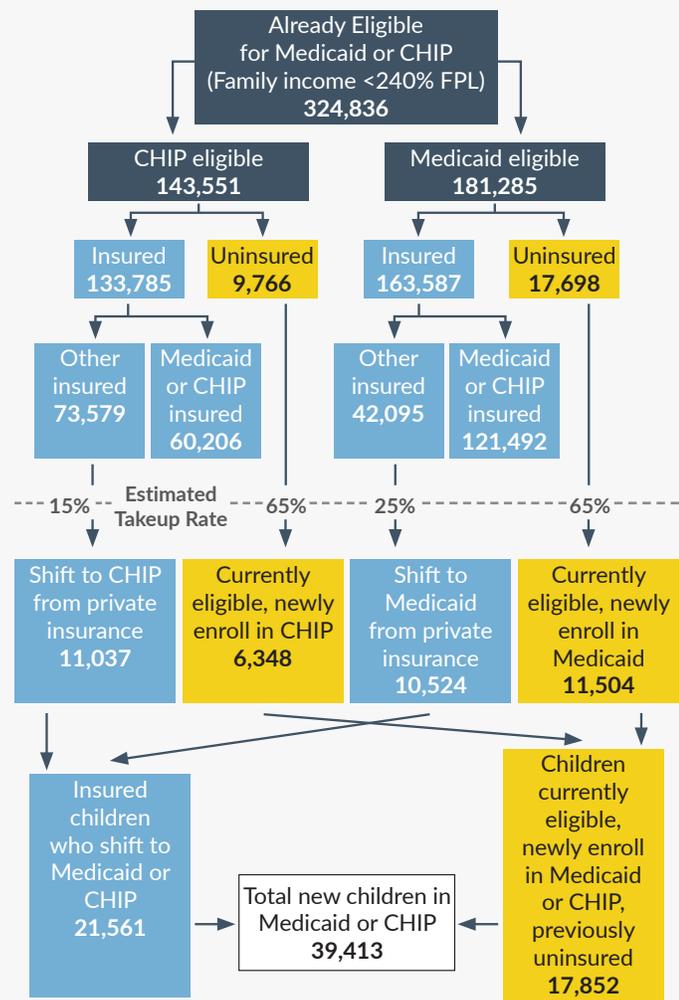
Note: The figure does not include 7,307 adults who are expected to enroll in the new adult group who otherwise might have enrolled in other categories, such as the Medically Needy.

Source: KHI analysis of 2018 American Community Survey data.

while already enrolled in the expansion group, offsets to capitation costs in other eligibility groups, a reduction in the number of people who may be eligible through Supplemental Security Income, and moving the group that would have enrolled in the now entirely state-funded MediKan program to the expansion group. State savings also are estimated to account for inmates who could be eligible for Medicaid in the case of a hospital admission of more than a day. The estimate also includes increased administrative costs associated with expansion. Details of each assumption are provided in a technical supplement available at bit.ly/MedicaidNote.

Total net costs do not include the projected effects on the workforce and the overall state economy. John Leatherman, a professor in the Department of Agricultural Economics at Kansas State University, estimated in March 2019 that expanding KanCare would generate additional state tax revenue of between 2.9 percent and 3.6 percent of the federal cost of new enrollees each year for 10 years

Figure 2. Projected Kansas Children Affected by Potential Medicaid Expansion for Adults



Source: KHI analysis of 2018 American Community Survey data.

(in addition to local tax revenues of between 2.4 percent and 3 percent of the federal cost). Scaled to the total estimate in this brief, the assumptions would produce additional state tax revenues each year ranging from \$20.2 million to \$36.0 million, which would further offset the estimate of net cost.

This cost estimate also does not assume the state would reduce funding for other programs that currently provide services for uninsured Kansans, including safety net clinics and community mental health centers. Figure 4, page 4 summarizes other potential economic factors that could be affected by expansion but for which the impact of expansion is difficult to isolate and are not included in the cost estimate in this report.

Factors That Might Affect Enrollment and Costs

The insert included with this report illustrates some of the major differences among the various Medicaid expansion proposals that may be considered by the Legislature. A

more detailed version is available online at bit.ly/KSBillTracker, and will be updated regularly.

SB 252 combines elements from other proposals described in this brief as well as a bill pre-filed by Senate Minority Leader Anthony Hensley in December. SB 252 would expand Medicaid to adults age 19-64 up to 138 percent FPL and includes monthly premiums “up to” \$25 for those with income above 100 percent FPL. It also includes a hospital surcharge of up to \$35 million, designed to fully cover state net costs associated with adult enrollment.

In association with the requirement for the state to submit a proposal for federal approval to create a reinsurance program for the individual health insurance marketplace, SB 252 also directs the state to request federal approval for adults with income between 100 and 138 percent FPL to be transitioned from Medicaid to ACA marketplace coverage by Jan. 1, 2022. The Centers for Medicare & Medicaid Services has not approved that authority in other states, but if the Kansas option were to be approved, it is estimated to reduce projected new enrollment by 34,504 adults and reduce net cost by \$10.1 million in 2022.

Other provisions that have been debated in Kansas include work requirements. None of the current expansion proposals include work requirements, and while some, including SB 252, have work assessments and referrals, there are no associated financial or enrollment penalties for enrollees. The potential impact on enrollment and costs of such program elements are not included in this estimate, but the state likely would incur additional administrative costs administering the program.

The House-passed bill, as amended, included premiums of \$25 to be collected from newly eligible enrollees, regardless of income. It also included a three-month lockout period for nonpayment and a permanent enrollment ban after a second episode of nonpayment. CMS has not approved cost-sharing above a nominal level for enrollees with income under 100 percent FPL, and generally has not approved disenrollment for that group. It also has not approved a permanent enrollment ban. If the proposal were to be adopted and approved, it is projected that about 37,000 potential newly eligible adult enrollees would either never enroll or at some point fail to make payments after initial enrollment and be disenrolled.

Figure 3. Estimated Direct and Indirect Costs Related to Medicaid Expansion, 2021 to 2030, by Calendar Year (in Millions)

	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	Total
Combined Federal and State Spending on New Enrollees	\$836.3	\$869.8	\$904.5	\$940.7	\$978.4	\$1,017.5	\$1,058.2	\$1,100.5	\$1,144.5	\$1,190.3	\$10,040.8
State Gross Cost of New Enrollees	\$131.2	\$136.5	\$141.9	\$147.6	\$153.5	\$159.6	\$166.0	\$172.6	\$179.6	\$186.8	\$1,575.4
New State Revenues ¹ , Offsetting Savings, Administrative Costs	(\$67.4)	(\$72.0)	(\$75.2)	(\$78.5)	(\$81.9)	(\$85.4)	(\$89.1)	(\$93.0)	(\$97.0)	(\$101.2)	(\$870.7)
State Net Cost of New Enrollees											
Newly Eligible Adults	\$15.3	\$14.0	\$14.3	\$14.7	\$15.1	\$15.5	\$15.8	\$16.2	\$16.7	\$17.1	\$154.7
Currently Eligible Adults	\$14.1	\$14.7	\$15.2	\$15.8	\$16.4	\$17.1	\$17.8	\$18.5	\$19.2	\$19.9	\$168.7
Currently Eligible Children	\$34.4	\$35.8	\$37.2	\$38.6	\$40.1	\$41.7	\$43.3	\$45.0	\$46.7	\$48.6	\$411.3

¹ New State Revenues do not include the annual hospital surcharge of up to \$35 million proposed in Senate Bill 252 or taxes related to increased economic activity, as discussed in the "Cost Estimate" section of this brief.

Note: This analysis presents results by Calendar Year, assuming a January 1, 2021, implementation. Numbers may not sum due to rounding. Detailed assumptions are available in a technical supplement available at bit.ly/MedicaidNote.

Source: KHI analysis of data from the 2018 American Community Survey, the Fiscal Year 2019 Medical Assistance Report, the Kansas Department of Health and Environment and the Kansas Department of Corrections.

While 90 percent of the value of premiums collected would effectively reduce the federal share, the remaining 10 percent, or \$1.6 million per year, would accrue to the state. However, the costs of administering the premium would be shared equally between the state and the federal government, and the premiums also would reduce some of the offsetting savings associated with expansion, as premiums would not apply to current eligibility groups. As a result of the administrative cost and lost savings, implementing premiums as proposed in the House bill could increase the net cost of expansion to the state by up to \$4.5 million in the first year.

By allowing the state to implement a sliding scale premium structure, applying it only to those with income above 100 percent FPL, allowing hardship exemptions and not including a lockout period,

the premium structure in SB 252 would have a lower impact on enrollment and costs. However, it is still likely that the state cost of administering the premiums would exceed the funds that would accrue to the state.

Finally, outreach efforts will influence enrollment and cost. Most states that have expanded Medicaid have experienced incremental enrollment in Year 1, suggesting the potential for lower enrollment and overall cost in 2021. However, lower initial enrollment could lead to higher per capita costs, whether for the state or for managed care organizations, as those with greater medical needs would be more likely to enroll. While this estimate does not model incremental enrollment in Year 1, its potential effects could be considered by policymakers as they consider outreach and communication about expansion.

Figure 4. Other Considerations Not in Estimate

Factor	Potential Effect From Expansion	Example
Economic Activity	New jobs added	Colorado: 31,000 additional jobs as of fiscal year 2015-2016
State and Local Taxes	Increased revenues	Leatherman Kansas projection: 5.3 to 6.6 percent of federal cost of new enrollees
Marketplace Plans	Lower premiums	2018 study found Marketplace premiums 11 percent lower in expansion states
Hospitals	Lower chance of closure	2018 study found hospitals were 84 percent less likely to close in expansion states than in non-expansion states

Source: Kansas Health Institute

ABOUT THE ISSUE BRIEF

This issue brief is based on work done by Kari M. Bruffett and Phillip Steiner, M.A. It is available online at khi.org/policy/article/20-05.

KANSAS HEALTH INSTITUTE

The Kansas Health Institute supports effective policymaking through nonpartisan research, education and engagement. KHI believes evidence-based information, objective analysis and civil dialogue enable policy leaders to be champions for a healthier Kansas. Established in 1995 with a multiyear grant from the Kansas Health Foundation, KHI is a nonprofit, nonpartisan educational organization based in Topeka.

Copyright© Kansas Health Institute 2020. Materials may be reprinted with written permission. Reference publication number KHI/20-05.

212 SW 8th Avenue | Suite 300
Topeka, Kansas | 66603-3936

785.233.5443

khi.org

[f /KHIorg](https://www.facebook.com/KHIorg)

[@KHIorg](https://twitter.com/KHIorg)

[in KHIorg](https://www.linkedin.com/company/KHIorg)