HEALTH REFORM BRIEF

Affordable Care Act's Expansion of Medicaid Expected to Boost Kansas Enrollment

KANSAS HEALTH INSTITUTE

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Medicaid eligibility rules that take effect in 2014 could increase enrollment by 130,000 in Kansas.

Online readers can select the words underlined in blue to get more in-depth information.

INTRODUCTION

One of the main objectives of the Affordable Care Act (ACA) is to reduce the number of uninsured Americans. One way it accomplishes that is by expanding Medicaid, the public health insurance program that serves mainly low-income women and children and the disabled.

The expansion of Medicaid was one of the parts of the ACA that Kansas and 25 other states challenged in a federal lawsuit. Whether the Supreme Court will issue a ruling on — or even review — the Medicaid expansion is in question. However, the court is likely to issue a ruling on the individual mandate — the requirement that virtually all Americans purchase health insurance starting in 2014. The mandate is an issue in a number of lawsuits, including the one in which Kansas is participating.

This brief — the fourth in a series on the impact of health reform in Kansas — examines the changes that will occur in Medicaid if the ACA is implemented as written.

WHAT IS IN THE LAW?

- Medicaid eligibility changes will take effect in 2014, significantly increasing the number of people who qualify for the program.
- States are required to maintain current eligibility standards until expansion occurs and health insurance exchanges are operational in 2014.
- The federal government, which shares the cost of Medicaid with the states, will temporarily pay the full cost of covering those made eligible for the program by the 2014 expansion. However, it will continue to pay only about 60 percent of the cost for new participants who were eligible but not enrolled prior to the expansion.
- The federal government will pay a higher share of the cost of the Children's Health Insurance Program (CHIP) starting in 2015.
- The federal government will increase Medicaid reimbursement rates for primary care and prevention services in 2013 and 2014 to encourage primary care providers to provide services for what is expected to be a significant increase in adults eligible for the program.

KANSAS IMPACT

More Eligible Adults

The new eligibility rules scheduled to take effect in 2014 will include many low-income adults in Kansas who today do not qualify for Medicaid. All Kansans under age 65 with annual incomes at or below 133 percent of the Federal Poverty Level (FPL) — $29,726 for a family of four — will be eligible. The change will be more significant in Kansas than many other states because currently only adults with dependent children who earn less than 27 percent of FPL — $6,035 for a

family of four — are eligible for the program (Figure 1). Childless adults do not qualify regardless of their income unless they are elderly or disabled.

Increased Enrollment

Estimates done by the Urban Institute for the Kaiser Family Foundation indicate that Medicaid enrollment in Kansas could increase 42 percent by 2019, compared with an estimated average increase of 27.4 percent nationally during the same period.

Currently, more than 300,000 Kansans are enrolled in Medicaid, most of them low-income women and children. The expansion in 2014 is expected to make many more Kansans eligible for Medicaid. However, not all of them are expected to enroll. Some may have access to affordable employment-based insurance coverage while for a variety of reasons others may remain uninsured. Preliminary estimates suggest that the expansion in eligibility could increase Medicaid enrollment in Kansas by about 130,000 people.

Cost of Expansion

The Kansas Medicaid program costs about $2.8 billion a year and has grown by approximately 27 percent over the last five years. The state's share of that cost is now approximately $1.1 billion. The administration of Governor Sam Brownback has made slowing the growth in Medicaid costs a priority and has requested a waiver from some federal requirements to give the state more flexibility to restructure the program.

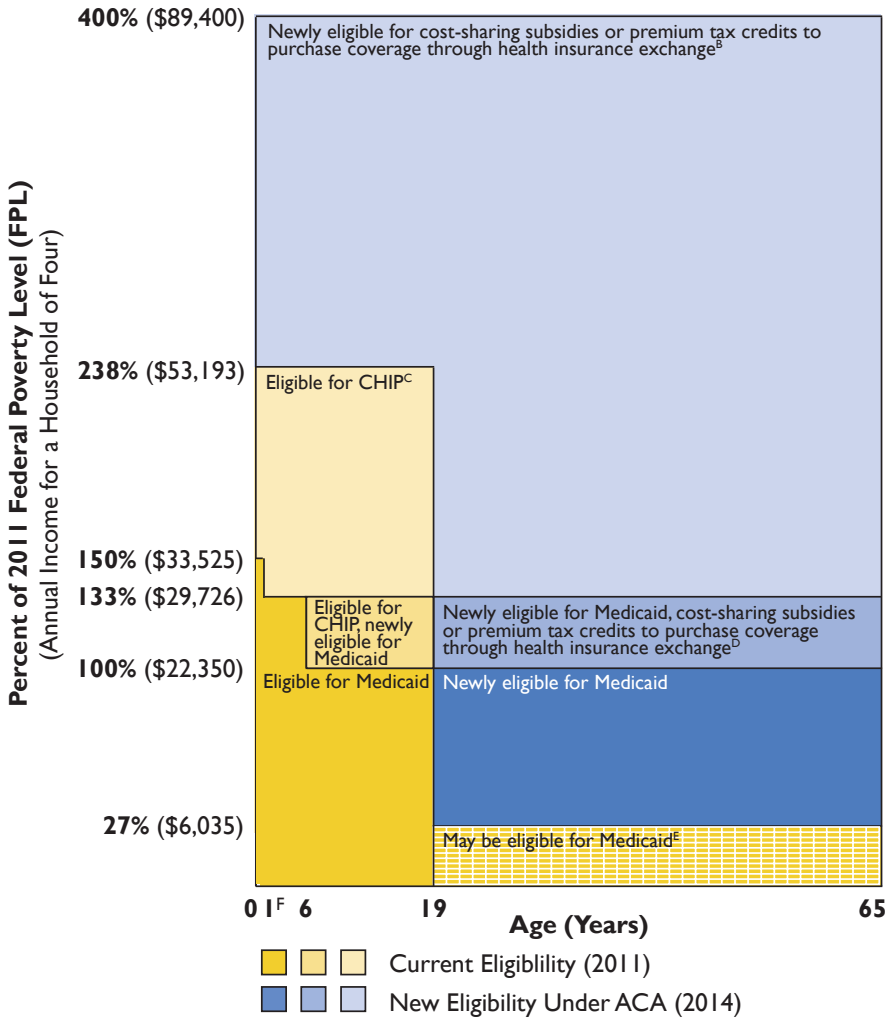
The ACA attempts to address the budget concerns of state officials by requiring the federal government to pay the full cost of covering people made eligible for Medicaid by the changes scheduled to take effect in 2014. The law requires the federal government to continue to cover those costs until 2017, after which the federal share will gradually decrease until it reaches 90 percent in 2020. Even so, many state officials remain concerned about the so-called "woodworking effect." That refers to the phenomenon of people already eligible for Medicaid but not enrolled coming out of the woodwork after the expansion. The federal government would pay only 60 percent of the cost of serving these people.

The Kansas Health Policy Authority (which has since merged with the Kansas Department of Health and Environment) estimated in 2010 that increases in federal cost-sharing for Medicaid and CHIP would limit the impact of the Medicaid expansion on the state budget (Figure 2). Nationally, the expansion is expected to cost the federal government approximately $450 billion between 2014 and 2019.

State Flexibility Restricted

The ACA requires states to maintain the Medicaid eligibility standards that were in place when the law took effect in March of 2010. This requirement, referred to

Figure 1. **Current Eligibility (2011) and New Eligibility Under ACA (2014)[A]**



A. This chart represents eligibility based on income but does not capture eligibility due to disability or other criteria.
B. Eligibility for subsidies is tied to the lack of other affordable coverage options such as an employer plan.
C. A monthly premium between $20 and $75 applies to families with incomes between 150 percent and 238 percent FPL.
D. In the Affordable Care Act (ACA) there appears to be overlap between the populations eligible for Medicaid and those eligible for cost-sharing subsidies or premium tax credits between 100 percent and 133 percent FPL.
E. Some parents up to about 27 percent of FPL are eligible to receive Medicaid. Income guidelines vary slightly by county. Childless adults are not eligible.
F. Pregnant women up to 150 percent of FPL are also eligible for Medicaid.

as maintenance of effort (MOE), prevents states from making any changes in Medicaid adult eligibility until a health insurance exchange is established in 2014. The exchange would be an online marketplace where Kansans would purchase private coverage. Many low- to middle-income Kansans who do not qualify for Medicaid will be eligible for federal subsidies or premium tax credits to help them purchase coverage in the exchange.

The MOE requirement also prohibits the state from making any changes in eligibility for children until 2019.

The Brownback administration has asked for a global waiver from the MOE requirements and other Medicaid rules to give it a freer hand in reforming the program and reducing its cost. But federal officials have so far been unwilling to grant such a waiver. A violation of the MOE requirement could result in a loss of all federal Medicaid funding to the state.

Reducing Barriers to Enrollment

The ACA contains three initiatives that could affect participation in Medicaid.

- Presumptive eligibility. In 2014, Kansas hospitals will be allowed to use preliminary information gathered from uninsured patients to presume them temporarily eligible for Medicaid.
- Premium assistance for employment-based insurance. Some Medicaid beneficiaries have access to employment-based insurance but do not purchase coverage for a variety of reasons, including cost. Starting in 2014, the ACA requires states to offer premium assistance and wrap-around benefits (if it is cost-effective) to those who are eligible for Medicaid and have the option of purchasing employment-based insurance.
- Medicaid for former foster children. Currently in Kansas, young adults who age out of the foster care system are able to receive Medicaid coverage until age 21. Beginning in 2014, the ACA extends Medicaid coverage to these individuals up to age 26.

Primary Care Incentives

To encourage primary care providers to participate in Medicaid, the ACA increases Medicaid reimbursement rates in 2013 and 2014 for primary and preventive services to match those of Medicare. The federal government is expected to cover the full cost of this payment increase.

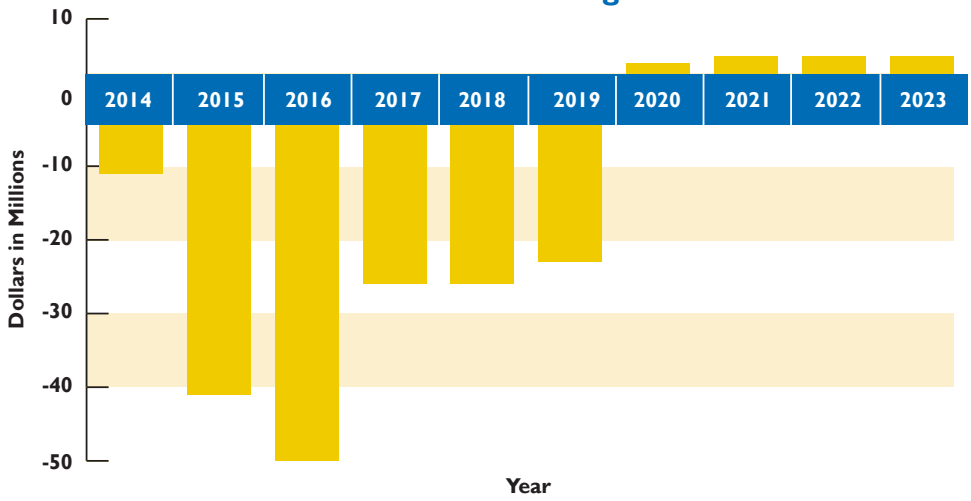
This reimbursement increase will not affect Kansas primary care providers as significantly as it will those in other states. Nationally, Medicaid reimbursement rates average 66 percent of Medicare rates. But in Kansas, Medicaid reimbursements average 94 percent of the Medicare payment rate due to changes made in 2008.

Administrative Simplification

To simplify the Medicaid eligibility determination process and potentially decrease administrative costs, the ACA standardizes income eligibility calculations, using a Modified Adjusted Gross Income (MAGI) standard, to determine whether a non-elderly, non-disabled individual qualifies for Medicaid. This standardization will, among other things, allow Kansas officials to compare Medicaid applications with federal income tax records to confirm eligibility.

Additionally, Kansas is developing an automated enrollment and eligibility system to simplify how individuals apply for Medicaid and how applications are processed. The federal government is covering about 90 percent of the $135 million cost of the Kansas Eligibility Enforcement System (KEES). Once completed, the new system will allow Kansans to enroll in Medicaid online

Figure 2. **Net Impact of the ACA Medicaid/CHIP Provision on the Kansas Budget**



Note: Initial state budget reductions result from greater federal funding for the Children's Health Insurance Program (CHIP). These reductions are gradually offset by the state's responsibility for newly eligible Medicaid recipients.

Source: Kansas Health Policy Authority, September 2010 PowerPoint from the American Public Human Service Association IT Solutions Management for Human Services (ISM) Conference.

Increased federal spending will minimize the impact of Medicaid expansion on the state budget, but reducing the program's cost remains a focus of the state's reform effort.

and better alert officials to potential fraud. It also will be integrated with the health insurance exchange to determine eligibility for federal subsidies for private insurance coverage.

ACA Impact on CHIP

CHIP was established in 1997 and provides insurance coverage for children in low- to modest-income families that do not meet income requirements to qualify for Medicaid. The ACA authorizes funding for CHIP through 2015.

The ACA's MOE requirement for Medicaid also applies to CHIP, and states must maintain their March 2010 eligibility standards until 2019. After the ACA was signed into law, the Kansas Legislature attempted to increase CHIP premiums by $40 per month. However, the Centers for Medicare and Medicaid Services disallowed the increase on the basis that it violated the MOE requirements.

In 2015, the ACA requires the federal government to increase its match of state funds for CHIP. The federal match in Kansas will increase from about 72 percent to around 95 percent. The increases in the CHIP match rate are largely responsible for the projected reduction in state Medicaid spending from 2014 through 2019 illustrated in Figure 2.

CONCLUSION

The expansion of Medicaid in 2014 is one of the main ways in which the ACA attempts to reduce the number of uninsured Americans. Thousands of Kansas adults who today do not qualify for Medicaid will become eligible for the program by the expansion. As currently written, the ACA requires the federal government to cover the full cost of the Medicaid expansion until 2017. After that, the federal share of the expansion costs will gradually drop until it reaches 90 percent in 2020, where it will remain indefinitely.

Despite federal assurances, the Brownback administration and other Kansas policymakers are concerned that the expansion of Medicaid will contribute to what they already see as unsustainable growth in the program's cost. They are also concerned that efforts to reduce the federal budget deficit could require corresponding reductions in the funding promised to states to offset the costs of the expansion.

Adding to the complexity of the issue in Kansas, the Brownback administration is developing its own plan to reform Medicaid and reduce its cost. It is unclear how the goals of that initiative will line up with those of the federally required expansion of Medicaid. What appears clear, however, is that significant changes are likely for the state's largest health care program.

More Information

This brief is the fourth in a series about the impact of health reform in Kansas. It is based on work done by Gina Maree, M.S.W., LSCSW, and Emily Meissen-Sebelius, M.S.W. Other contributions were made by Suzanne Cleveland, J.D.; Duane Goossen, M.P.A.; Jim McLean; Cathy McNorton and Robert F. St. Peter, M.D. This document and the other briefs in the series are available online at www.khi.org.

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KANSAS HEALTH INSTITUTE

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