



PROJECTED COSTS AND ENROLLMENT OF MEDICAID EXPANSION IN KANSAS: UPDATED NUMBERS

Introduction

In December 2012, the Kansas Health Institute (KHI) released an issue brief detailing estimates of enrollment and costs of a potential Medicaid expansion in Kansas. At the time, state policymakers had not determined whether to expand Medicaid to low-income adults under the provisions of the Affordable Care Act (ACA).

Four years have passed, and Kansas remains among the 19 states that have not expanded Medicaid. The election of Donald Trump as president places the future of the ACA and its expansion of Medicaid in question. Trump made repeal of the ACA a central point of his campaign’s policy agenda, but aside from a proposal to make Medicaid a block grant, what that might mean for Medicaid expansion is less clear.

In 2012, KHI estimated that if Medicaid was expanded, more than 240,000 new beneficiaries would enroll—including more than 122,000 adults—over a seven-year period beginning in 2014, at a cost to the state ranging from \$220.8 million to \$912.3 million, including a “best estimate” of \$518.5 million.

The most recent estimate for Medicaid expansion in Kansas was provided by Aon Hewitt, actuaries for the Kansas Department of Health and Environment, in March 2015.

Aon Hewitt estimated that expansion would add 193,555 beneficiaries over a 10-year period beginning in 2016, and cost the state \$1.2 billion.

To provide policymakers with updated information at a time of uncertainty, KHI reviewed the assumptions in its original estimate, and has updated them to reflect current match rates, costs, population and enrollment.

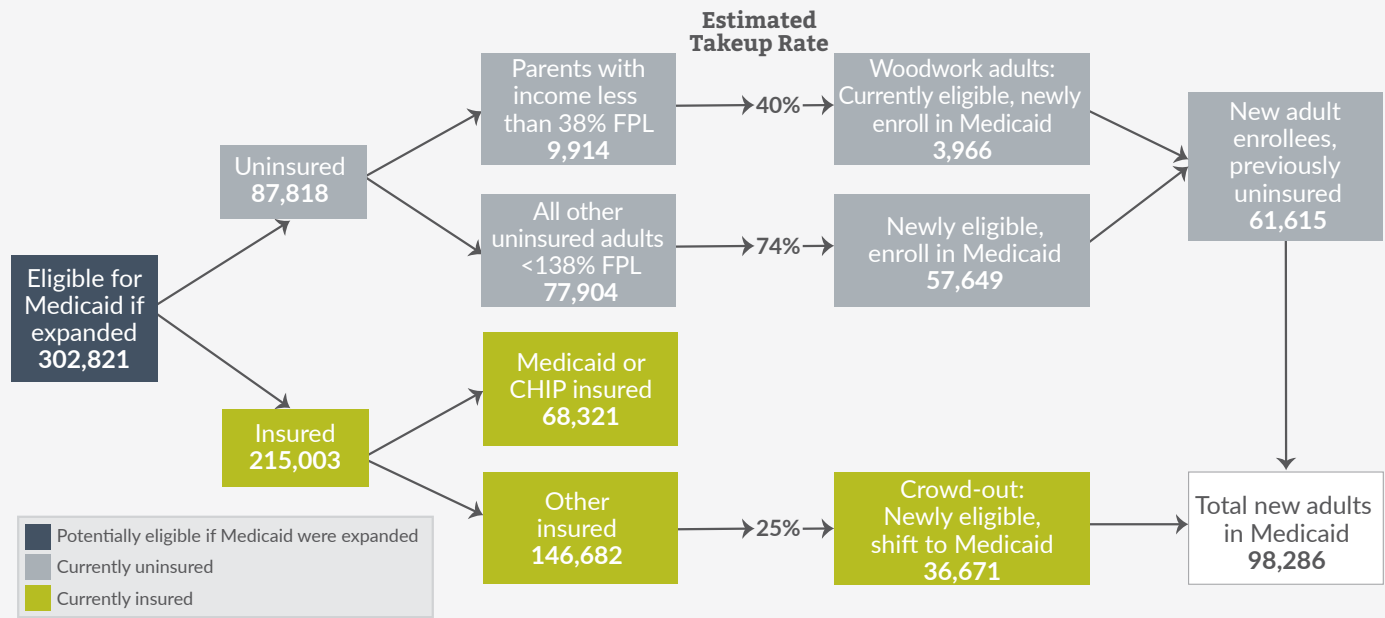
The result is a cost estimate still within the original range, even though key variables have changed substantially. It is estimated that Medicaid expansion over a seven-year period starting in 2018, under the existing terms of the ACA, would add 152,000 beneficiaries at a cost to the state of \$729.7 million. Extending the estimate to a full 10 years would place the estimated state cost at \$1.1 billion, similar to the 2015 Aon Hewitt 10-year projection.

The starting year for potential implementation drives many of the differences in the estimates. An expansion beginning in 2018 rather than in 2014 would not include any of the initial three years in which the federal government would have paid the full cost of newly eligible adult enrollees. There are also now fewer uninsured low-income adults and children, reducing the number of potential new enrollees. In addition, annual costs per enrollee in the current program have increased.

KEY POINTS

- Nearly 152,000 Kansans (98,000 adults and 54,000 children) are estimated to enroll in KanCare if Medicaid expands under current law.
- Of the new projected enrollees, about 80,000 are currently uninsured, while about 71,000 are already insured and would likely switch to Medicaid or CHIP.
- This updated estimate includes fewer expected enrollees but higher costs per enrollee than the 2012 estimate.
- Annual state costs are estimated to start at \$68 million and nearly double by the seventh year. Starting in 2018, state costs are estimated at \$729.7 million over seven years, and \$1.1 billion over 10 years.
- The future of Medicaid expansion is in question, as President-elect Donald Trump made repeal of the ACA a central feature of his campaign policy agenda.

Figure 1. Potential Enrollment of Kansas Adults if Medicaid is Expanded



Source: KHI analysis of 2015 American Community Survey data.

What Assumptions Changed

Federal Match Rate

Despite Democratic proposals to extend three years of 100-percent federal payment for newly eligible enrollees in states that have not yet expanded Medicaid on one hand, and the Trump pledge to repeal the ACA on the other, the law still reads that the federal government will pay a decreasing share of Medicaid expansion costs. Beginning in 2017, the federal share will decline each year until 2020, from 95 percent to 90 percent. This estimate assumes it will remain at 90 percent thereafter.

Federal match rates for those already eligible for Medicaid are modified each year to reflect changes in the states' relative economic positions. This estimate uses the fiscal year (FY) 2018 Federal Medical Assistance Program standard match of 54.74 percent over the full seven years of the projection for that group, even though that percentage may increase or decrease from year to year.

KHI's update also assumes the Children's Health Insurance Program (CHIP) FY 2018 enhanced 91.32 percent match rate will revert to the lower pre-ACA level (this estimate assumes 68.32 percent) when the enhanced rate expires on September 30, 2019. If Congress were to extend the higher ACA CHIP match rate permanently, the seven-year cost of expansion to the state would be \$100 million less than this estimate

projects. Furthermore, the latest CHIP authorization legislation expires on September 30, 2017. However, this estimate assumes the program will not be allowed to sunset.

Population and Coverage

The original KHI estimate and this update use data from the U.S. Census Bureau to assess the numbers and insurance status of the population that would be eligible for Medicaid if expanded. The update uses detailed data from the 2015 American Community Survey (ACS), which reflects the second full year of implementation of the major insurance provisions of the ACA. The new ACS data show 39,000 fewer uninsured adults under 138 percent of the federal poverty level (FPL) than in the prior estimate, and 16,000 fewer uninsured children eligible for Medicaid or CHIP.

Newly Eligible Take-Up Rate

KHI's 2012 analysis included an assumption that 65 percent of newly eligible, uninsured adults would enroll in KanCare, the state's Medicaid managed care program. The updated estimate revises that "take-up rate" to 74 percent, consistent with assumptions in national studies.

Woodwork/Crowd-Out

The largest change from the 2012 KHI estimate to this update is related to the "woodwork" and "crowd-out"

effects. The 2012 methodology included distinct take-up rate assumptions for currently eligible adults and children who at that time had not yet enrolled in Medicaid or CHIP. The assumption was that 40 percent of already-eligible uninsured adults and 65 percent of already-eligible uninsured children would enroll regardless of whether the state expanded Medicaid. This was largely because of the increased enrollment activities surrounding the ACA, and is referred to as the “woodwork effect.”

While the same take-up rates for already-eligible but unenrolled members are assumed in this update, because of a decreased number of uninsured, the result is a smaller woodwork effect for both children and adults.

Estimates of the number of people enrolling because of “crowd-out,” which occurs when an already-insured, low-income Kansan switches to Medicaid, are lower than the 2012 estimate as well. In 2012, a blended crowd-out assumption was applied to all insured Kansans who would be eligible for Medicaid. In this estimate, the same 25 percent take-up rate is applied only to insured low-income Kansans who have coverage other than Medicaid or CHIP.

Enrollee Costs

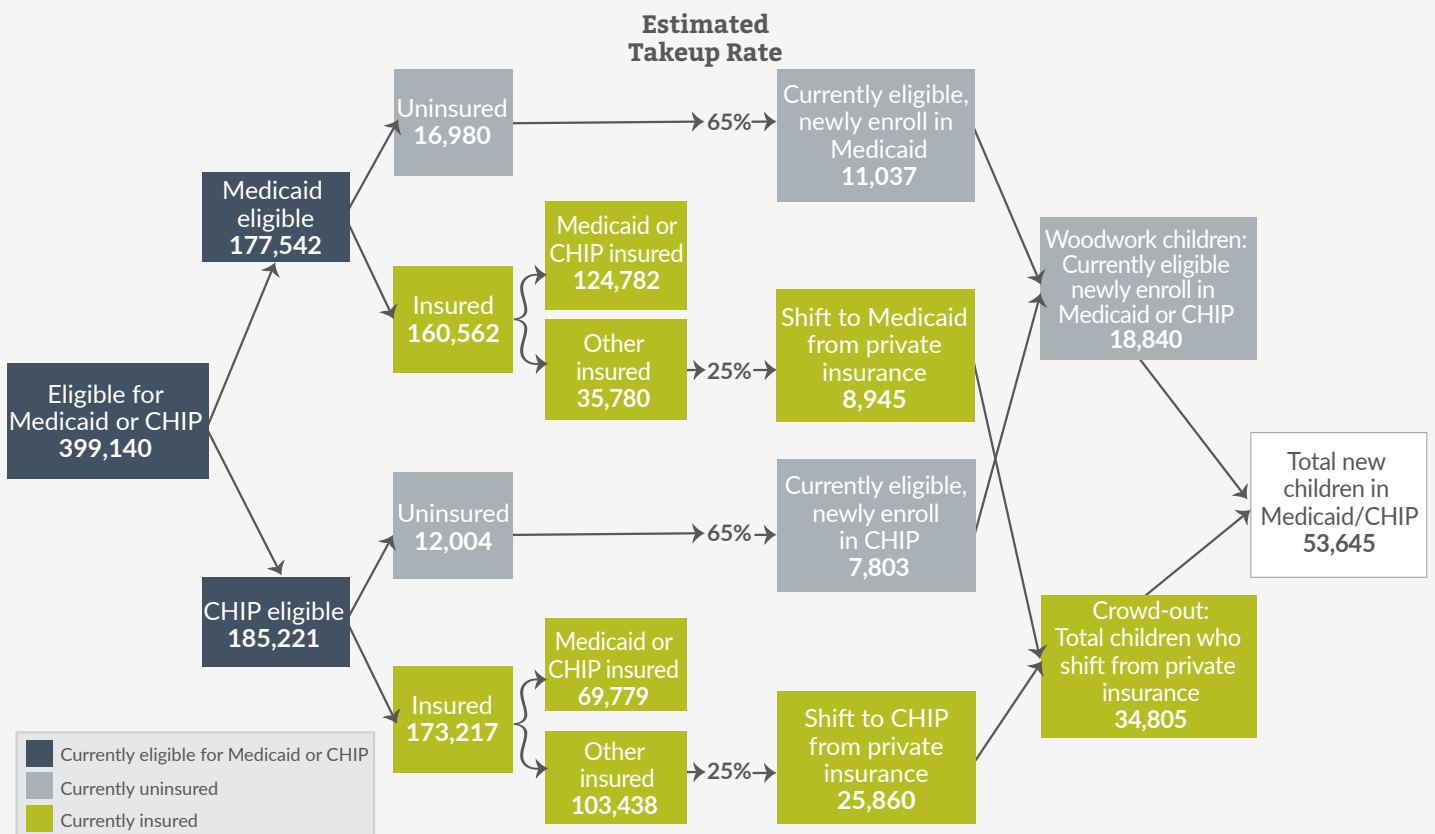
The 2012 annual cost estimates per enrollee ranged from \$2,351 to \$4,278 for low-income adults, and \$1,341 for children. Actual capitation costs for non-disabled adults age 19-64 in KanCare were \$5,569 in state FY 2016. This rate approaches the 2015 national average annual per member cost of \$6,366 for newly eligible adults in expansion-state managed care programs. The per member cost for non-disabled children in KanCare was \$2,261 in FY 2016. The updated estimate uses the FY 2016 KanCare costs and applies a 2.5 percent annual inflation factor after 2018.

Factors Not in Estimate

Offsetting Savings

Neither the 2012 estimate nor this update assessed offsetting savings that may be achieved if Medicaid were expanded—for example, savings related to the potential elimination of optional eligibility categories or savings from state-funded programs.

Figure 2. Potential Enrollment of Kansas Children if Medicaid is Expanded



Source: KHI analysis of 2015 American Community Survey data.

Administrative Costs

Similarly, neither analysis made assumptions regarding additional administrative costs related to an expanded Medicaid program—for example, costs related to eligibility determination or program management.

Alternative Expansion Models

Some policymakers have called for the adoption of alternative expansion models that could include cost-sharing for enrollees or incorporate premium assistance for purchasing private coverage, both of which have been approved in other states. Other proposals that have not been approved yet, but may fare differently under a Trump administration, include work requirements and converting Medicaid to a block grant to the states. This estimate, however, assumes a straightforward expansion of the existing KanCare model.

What the Estimate Represents

This estimate provides an updated view of the likely effects of Medicaid expansion under current federal law by incorporating changes that have occurred over the last four years in cost, population, coverage status and enrollment.

The 2012 analysis estimated a wide range of state costs, from \$221 million to \$912 million over seven years beginning in 2014, representing a range of take-up rates and estimated costs per enrollee. The \$518.5 million “best estimate” represented a midpoint of sorts. The updated estimate of \$729.7 million in state costs over seven years beginning in 2018 should also be thought of as the midpoint of another range—total state costs could be higher or lower depending on actual enrollment experience and program costs.

As the evidence from states that have already expanded Medicaid has illustrated, it is likely that if Kansas expands Medicaid under current law, enrollment and costs would vary at least somewhat from the assumptions made in this update.

Figure 3. Year-by-Year Cost Estimates of Medicaid Expansion in Kansas, in millions

2012 “BEST ESTIMATE”								
	2014	2015	2016	2017	2018	2019	2020	TOTAL
Total Cost (All Funds)	\$445.4	\$454.3	\$476.2	\$485.5	\$498.5	\$511.8	\$525.6	\$3,397.3
State Cost	\$70.1	\$71.8	\$55.9	\$71.1	\$76.0	\$81.1	\$92.5	\$518.5
2016 UPDATED ESTIMATE								
	2018	2019	2020	2021	2022	2023	2024	TOTAL
Total Cost (All Funds)	\$668.7	\$685.4	\$702.5	\$720.1	\$738.1	\$756.6	\$775.5	\$5,046.8
State Cost	\$67.6	\$74.4	\$111.8	\$114.6	\$117.5	\$120.4	\$123.4	\$729.7

Note: Green shaded boxes indicate years included in both estimates.

Source: KHI enrollment projections from analysis of 2015 American Community Survey. KanCare enrollee cost data from the Kansas Department of Health and Environment Data Analytic Interface, FY2016.

ABOUT THE ISSUE BRIEF

This brief is based on work done by Kari M. Bruffett and Cheng-Chung Huang, M.P.H. It is available online at khi.org/policy/article/16-12.

KANSAS HEALTH INSTITUTE

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