KANSAS HEALTH INSTITUTE

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Senate Committee on Public Health and Welfare
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Neutral Testimony

Establishing the KanCare Bridge to a Healthy Kansas

House Bill 2044

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Kansas Health Institute

To improve the health of all Kansans by supporting effective policymaking, engaging at the state and community levels, and providing nonpartisan, actionable and evidence-based information.

Informing Policy. Improving Health.

Chair Schmidt and Members of the Committee:

Good morning. Thank you for the opportunity to provide neutral testimony on House Bill 2044. I am Robert F. St. Peter, M.D., President & CEO for the Kansas Health Institute (KHI). KHI is a nonprofit, nonpartisan health policy and research organization based here in Topeka, founded in 1995 with a multiyear grant from the Kansas Health Foundation.

KHI does not take positions on legislation, and therefore we do not advocate either for or against HB 2044. To help inform the committee's discussion on this issue, KHI is providing the committee with material we have developed to describe the potential effects of a decision related to Medicaid expansion in Kansas.

Included with my testimony and available online at www.khi.org are the following publications produced by KHI surrounding this topic:

1) **Health Insurance in Kansas 2015:** An infographic providing a preview of the Kansas population coverage profile from our upcoming Annual Insurance Update.
2) **Projected Costs and Enrollment of Medicaid Expansion in Kansas*: Updated Numbers:*** A November 2016 issue brief that revised KHI's 2012 estimate to reflect changes that have occurred since the original estimate.

There are many issues that the Committee should consider when looking at the implications of expanding Medicaid to additional low-income adults. The materials provided include the November 2016 update of KHI's estimate of expansion enrollment and costs. It is important to note that the estimate was not intended as a fiscal note for the bill you are considering today; it instead describes the estimated enrollment and direct costs of expansion. It assumes a straightforward expansion of the existing KanCare model rather than any of the alternative models adopted in some states that include cost-sharing or premium assistance for purchasing private coverage, and it does not include any assumptions related to the American Health Care Act (AHCA) currently being debated in Washington.

The November expansion estimate does not include offsets from drug rebates or managed care privilege fees, nor does it include any effects on administrative costs. Neither the 2012 estimate nor the 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 from state-funded programs (e.g., mental health and safety net expenditures).

We hope the estimate can help the committee understand the key assumptions that go into any estimate of Medicaid expansion. The brief walks through some of those assumptions and explains how they might vary, which can help clarify why some expansion states have had experiences that differed from expectations.

In addition, we wanted to share with you the profile of the 2015 Kansas population, broken out by type of health insurance coverage. The data for this infographic comes from the 2015 American Community Survey (ACS), conducted by the U.S. Census Bureau and released in the fall of 2016.

The chart shows the estimated coverage status, by insurance type, for every Kansan who is not in an institution. It further helps clarify who the nearly 264,000 uninsured Kansans are—how many are children, adults age 19-64, or seniors, and how many are likely eligible for public programs. It also indicates that more than 80,000 uninsured adults in 2015 would have qualified for Medicaid if it had been expanded in Kansas.

The same data was used to develop KHI's Medicaid expansion update, starting with a very similar methodology, then applying assumptions based upon academic literature and experience in Kansas as well as states that had previously expanded their programs. The result suggests that raising eligibility for adults to 138 percent of the federal poverty level ($33,600 for a family of four in 2017) would cover an additional 98,000 low-income adults, including almost 62,000 who are currently uninsured.

Under the current terms of the ACA, if Kansas expands its program, the federal government would pay 94 percent of the costs of newly eligible enrollees in 2018, 93 percent in 2019, then 90 percent in 2020 and thereafter. (Note: The AHCA as introduced would still allow states to expand Medicaid but would change the formula by ending the enhanced reimbursement in 2020 for adults who were not already enrolled on December 31, 2019.)

The children of these newly eligible adults, as well as other currently eligible but unenrolled children, might be more likely to enroll in Medicaid through a so-called "woodwork" or "welcome mat" effect. The health care costs for these newly enrolled children would be subject to the regular state Medicaid or Children's Health Insurance Program (CHIP) match rate. The updated KHI projection estimates that nearly 54,000 children would newly enroll in Medicaid or CHIP if Kansas expanded Medicaid eligibility for adults.

The combined estimated effect of expansion on enrollment would be 152,000 new enrollees in KanCare, a program that currently has around 425,000 enrollees. The costs for newly enrolled—but currently eligible—members at the regular matching rate, plus the reduction in the federal share of Medicaid expansion costs over time, are the direct state costs of expansion. In November, KHI projected those costs to start at $68 million in 2018 and nearly double by the seventh year (2024). Starting in 2018, state costs were estimated at about $730 million over seven years.

KHI is working on a summary of the AHCA, and we will continue to follow developments in Washington that could affect Medicaid in the future. For example, we are examining the implications of a per-enrollee allotment for state Medicaid programs, and we are analyzing recent policy statements from the new leadership at the Centers for Medicare and Medicaid Services.

If you have any questions regarding the information included with our testimony, or if we could be of further assistance in informing this issue, please do not hesitate to contact KHI at 785-233-5443 or email me at RStPeter@khi.org. I will also be available to address any questions you may have today at the appropriate time. Thank you for the opportunity to provide testimony, and I will now stand for questions.