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MEMO

Date: January 28, 2020

Re: Technical notes regarding the KHI Issue Brief, *Medicaid Expansion in Kansas: Elements in Competing Versions Affect Estimated Enrollment, Costs*, KHI/20-05, January 28, 2020.

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This memo provides technical information about the assumptions used to update estimates of enrollment and costs if Kansas were to expand Medicaid on January 1, 2021. If you would like additional information on this topic, please contact Kari Bruffett via phone at (785) 233-5443 or by email at kbruffett@khi.org.

Research Questions

- How many uninsured Kansas adults would become newly eligible and enroll if Medicaid were expanded under the terms of the Affordable Care Act (ACA)?
- How many currently eligible uninsured Kansas adults and children would enroll in Medicaid if expanded?
- How many Kansas adults and children with private coverage might opt for Medicaid or the Children's Health Insurance Program (CHIP) if Medicaid were expanded?
- What are the estimated costs of coverage for the newly enrolled population for each of the next 10 calendar years (gross cost)?
- What savings, additional revenues or expenditures would be associated with an expansion, and how would those affect state expenditures (net cost)?

Study Population

- Kansas adults with family income less than or equal to 138 percent of the federal poverty level (FPL) and children with family income less than 240 percent FPL.¹

¹ The Census estimates poverty status using the statistically developed poverty thresholds. The poverty guidelines, commonly referred to as the federal poverty level, that are used to determine Medicaid eligibility are considered equivalent to the poverty thresholds for the purposes of this report. The poverty guidelines are developed by applying a small adjustment to the September poverty thresholds and are published in January of the following year.

Data Sources

- Medical Assistance Report for state fiscal year (FY) 2019,² supplemented by data from the Kansas Department of Health and Environment (KDHE) and the Kansas Department of Corrections.
- American Community Survey 2018 1-year Public Use Microdata Sample, U.S. Census Bureau.
- American Community Survey 2018 1-year data from IPUMS USA, University of Minnesota.³
- 2018 Federal Poverty Guidelines, U.S. Department of Health and Human Services.
- CMS-64 claim forms and Federal Medical Assistance Percentages (FMAP) documents, Centers for Medicare and Medicaid Services.

Baseline Analytical Approach

1. KHI first estimated the number of insured and uninsured adults age 19 to 64 with family income less than or equal to 138 percent FPL and the number of insured and uninsured children with family income less than 240 percent FPL using the U.S. Census Bureau's American Community Survey 2018 1-year Public Use Microdata Sample.
2. Separate enrollment estimates then were calculated for the newly eligible – including those who may already be covered through another insurance program – and the currently eligible. The assumed enrollment rate for each estimate was based on the literature and are consistent with our previous estimates in 2016, 2018 and 2019.
3. Cost information was obtained from the FY 2019 Medical Assistance Report, supplemented by additional information provided by the Kansas Department of Health and Environment (KDHE). The cost in FY 2019 for Temporary Assistance for Families (TAF) adults was \$6,722 per consumer and the cost for Poverty Level Expansion (PLE) Pregnant Women was \$11,221 per consumer. For children, the cost in Medicaid was \$3,369 per consumer, the cost in CHIP was \$2,389 per consumer, and the cost in M-CHIP was \$2,399 per consumer (*Figure 1*, page 3). Assumptions about cost growth are described on page 4 in step 5.
4. Gross cost was estimated for calendar year (CY) 2021 by applying the fiscal year cost per person from Figure 1 to the enrollment estimates discussed in steps 1 and 2. Gross cost for CY 2022 to CY 2030 were projected to increase 4 percent per year.
5. We estimated state cost from the gross cost of coverage in step 4 above by applying the appropriate Federal Medical Assistance Percentage (FMAP). Additional detail on the baseline estimate of gross and state cost as well as the methods used to calculate offsetting savings and revenues and administrative costs associated with expansion are described on the following pages.

² http://www.kdheks.gov/hcf/medicaid_reports/default.htm

³ <https://www.ipums.org>

Figure 1. Actual and Projected Cost Per Medicaid Enrollee, FY 2019 and CY 2021

Population Subgroup	Enrollees	FY 2019 Expenditures	FY 2019 Per Person Cost	CY 2021 Per Person Cost (Projected)
Parents in TAF	39,478	\$259,576,111	}	\$6,722
Parents in TAF Extended Medical	4,777	\$29,433,718		
Medically Needy Families	2	\$155,215		
PLE Pregnant Women	6,330	\$71,027,750	\$11,221	\$12,659
Children in TAF and PLE	185,300	\$624,291,445	\$3,369	\$3,735
CHIP	43,499	\$84,639,297	\$2,389	\$2,628
M-CHIP	13,078	\$28,453,997	\$2,399	\$2,634
MediKan	628	\$4,559,778	\$7,261	\$8,167
SSI-Blind and Disabled (Non-Dual) Capitation Payments	27,126	\$425,132,875	\$15,673	\$17,629

Source: KHI analysis of FY 2019 Medical Assistance Report and data from the Kansas Department of Health and Environment.

State Cost of Medicaid Expansion

1. There are two types of income-eligible new enrollees: newly eligible and currently eligible. Newly eligible enrollees are Medicaid eligible because of the ACA and currently eligible enrollees were Medicaid eligible before the ACA was enacted. States receive a higher federal match rate for the newly eligible adult enrollees than for the currently Medicaid-eligible adults meeting the current Kansas Medicaid rules, which allow parents or adult caretakers with family income below 38 percent FPL and pregnant women with family income below 171 percent FPL to enroll in Medicaid. In general, if Medicaid is expanded to the full extent allowed by the ACA, the newly Medicaid-eligible group would consist of all non-disabled, non-pregnant adults ages 19 to 64 with family income less than or equal to 138 percent FPL. Parents or caretakers with family income below 38 percent FPL and pregnant women with family income below 171 percent FPL would remain in the currently eligible group, and a lower federal match rate would be applied.
2. We use a 74 percent take up rate for uninsured newly eligible adults, and a 40 percent take up rate for currently Medicaid-eligible uninsured adults. The take up rate for currently Medicaid-eligible or CHIP-eligible uninsured children is assumed to be 65 percent. The rate for all otherwise insured Medicaid-eligible adults and children is assumed to be 25 percent. Otherwise insured CHIP-eligible children are assumed to enroll at a lower rate of 15 percent, because their parents would not be eligible for expansion.
3. Federal fiscal year (FFY) 2021 is the latest year that the Medicaid and CHIP FMAP has been published. The FFY 2021 FMAP was used for all years in the estimate – 2021 to 2030.

Figure 2. Kansas Federal Medical Assistance Program Match Rates

Fiscal Year	Standard Medicaid	CHIP Enhanced	Newly Eligible
2021	59.68%	71.78%	90.00%

Source: Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children’s Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2020, Through September 30, 2021 (2019).⁴

4. Women in the newly eligible group who become pregnant after they enroll must move to the current pregnant women eligibility group if they are pregnant at their annual redetermination date. States can claim the 90 percent federal match rate for newly eligible pregnant women until they are moved to the current pregnant women eligibility group. To account for this, we estimated the number of women age 19 to 44 with family income less than or equal to 138 percent FPL who would newly enroll in Medicaid. Then, using the Kansas 2018 vital statistics, we calculated a 7.437 percent delivery rate for all Kansas women age 20 to 44 (34,458 live or still births divided by 463,330 women age 20 to 44). Assuming that 7.437 percent of women age 19 to 44 who enroll in the newly eligible expansion group would become pregnant over the course of the year, we assumed that, on average, two-thirds of the months of their pregnancies would remain in the newly eligible group and one-third would be in the current pregnant women eligibility group. The estimate of cost for women who would become pregnant after enrolling in the new adult group includes an adjustment for the KanCare practice of separate delivery capitation payments. A mixed FMAP with 54 percent of the standard Medicaid match rate (59.68 percent) and 46 percent of the newly eligible expansion match rate (90 percent) was applied. We calculated that the state would receive the equivalent of a 73.69 percent federal match for the estimated 2,447 newly eligible women who would become pregnant. However, potential cost could differ depending on how the state administers eligibility and capitation payments. See page 6, item 6, for the effect on the current eligibility category for pregnant women.
5. Expenditures for each population group were obtained from the latest Kansas Medical Assistance Report (MAR) for state FY 2019. KDHE responded to a request to break out select populations in the MAR by age and income group and provided an estimate of the average change in rates for select population groups as a result of changes to the Health Care Access Improvement Program (HCAIP). A onetime increase with an average effect of 3.9 percent was applied to FY 2019 per capita cost to account for the expected update (see page 6, item 9 for a discussion of the HCAIP offset applied to remove the net cost to the state). An additional 4 percent increase was applied to FY 2019 per capita cost to account for inflation and enrollment changes. In total FY 2019 per capita costs were increased by 7.9 percent on average to approximate gross per person expenditures for CY 2020. The 4 percent increase for inflation and changes in enrollment was subsequently applied to develop the cost estimates for each additional year in the projection window (CY 2021 – CY 2030).
6. CHIP children tend to be older and with lower average expenditures than Medicaid children. In late 2015, Kansas children age 6 to 18 with family income between 114 and 133 percent FPL were converted to the M-CHIP program – a Medicaid program for which the state receives the enhanced CHIP FMAP (71.78 percent). For children who are

⁴ <https://www.govinfo.gov/content/pkg/FR-2019-12-03/pdf/2019-26207.pdf>

already enrolled, their per person cost was included in the FY 2019 MAR. The match rate and state costs were separately adjusted for the estimated 4,393 children with family income between 114 and 133 percent FPL who are expected to newly enroll in M-CHIP if Medicaid is expanded.

7. Administrative costs for each year were calculated as 5.05 percent of the total expenditures multiplied by the expected state share of the total net cost – 31.74 percent. Administrative cost as a percent of total expenditures was based on the actual administrative fees (less the cost of HIT incentives and school-based administration) as a percentage of total Kansas Medicaid cost in the *FFY 2017 Medicaid Financial Management Data*.⁵ The state share of the total net administrative cost was calculated using the actual federal match rate for Kansas administrative costs from the same source. Administrative cost is expected to increase 2 percent per year throughout the projection window.

New State Revenue and Offsets

1. The privilege fee paid by managed care organizations is 5.77 percent of the total calendar year premiums paid. The state receives half of the annual fee in March, and the other half in September. We assume that KanCare expansion enrollees would all be included in managed care, and that the privilege fee would be applied to the total cost of care for new enrollees.
2. Drug Rebates. The estimate used the numbers from previous KDHE fiscal notes adjusted by the difference in the enrollee total in this estimate. KDHE previously estimated an average per person rebate collected of \$164.63; however, the KDHE estimates included only adults. Without additional information on the per capita rebate for children, our estimate of drug rebates could be overstated, as we apply the same rate to adults and children.
3. CHIP premiums collected were calculated assuming that children from 167–191 percent FPL pay a \$20 monthly premium; 192-218 percent FPL pay a \$30 monthly premium; and 219 percent FPL and above pay a \$50 monthly premium. The state share was calculated using the corresponding CHIP match rate.
4. MediKan is currently 100 percent state-funded with limited benefits, and all 628 enrollees in FY 2019 are assumed to be less than or equal to 138 percent FPL. We estimate that if MediKan beneficiaries (who are seeking disability determinations) enroll in the new expansion group, their costs and coverage may resemble beneficiaries in the non-dual, non-waiver Supplemental Security Income (SSI) group. We estimate additional cost at the SSI per person cost level, which would increase total expenditures but reduce the state share. In FY 2019, the MediKan average per person annual cost was \$7,261, which was entirely the responsibility of the state. Assuming expansion, we estimate a cost of \$17,629 per person in CY 2021, of which 10 percent (\$1,763 per person) would be the responsibility of the state.
5. Non-waiver, non-buy-in Medically Needy Blind and Disabled enrollees age 19 to 64 with family income less than or equal to 138 percent FPL may choose to participate in the expansion group, as they would not be required to meet the spenddown requirement, and their first dollar of medical expenses would be covered. In FY 2018, there were 1,979

⁵<https://www.medicaid.gov/medicaid/finance/state-expenditure-reporting/expenditure-reports/index.html>

Medically Needy beneficiaries. Under current Medicaid, they are responsible for a spenddown amount similar to deductibles, and Medicaid pays the rest (federal share for CY 2021 is 59.68 percent). Under Medicaid expansion, Medicaid would cover those costs, including the previous spenddown amount, at a 90 percent federal share. Based on data provided by KDHE, we estimate that the total cost to cover this population in the new adult group would increase total Medicaid program cost due to the amount that is currently spenddown, but because of the higher match rate for the newly eligible group net savings would still accrue to the state.

6. The current PLE Pregnant Women eligibility category of the Medicaid program covers pregnant women with family income less than 171 percent FPL. In the future, it is estimated that this eligibility category would shrink, as some months of pregnancy could be covered in the newly eligible group as long as the women were enrolled in Medicaid prior to becoming pregnant (see discussion of timing on page 4). However, some women with family income below 38 percent FPL with a child in Medicaid may be considered as currently eligible adults and others would have income above the expansion group eligibility level. In the first year of expansion, the state would not likely realize the full savings, as women already pregnant would not qualify for the new expansion group and the state would receive a regular match rate for their costs. For CY 2021, the first year of expansion, we estimate that two-thirds of the months of pregnancy for women who would have enrolled in Medicaid whether or not Medicaid expanded, with family income less than or equal to 138 percent FPL, would be in the current pregnant women eligibility category, while one-third of total months would fall within the newly eligible category. We also applied a 74 percent enrollment assumption to calculate which women not already pregnant on January 1, 2020, would be likely to enroll in the newly eligible group. After that initial year of implementation, for CY 2021 and beyond, the assumption is that on average two-thirds of the months of pregnancy for women enrolled in the newly eligible group could qualify for the 90 percent federal match. Like the estimate of cost on page 4, item 4, the estimate of savings for women who would become pregnant after enrolling in the newly eligible adult group includes an adjustment for the KanCare practice of separate delivery capitation payments. Potential savings could differ depending on how the state administers eligibility and capitation payments.
7. Based on literature demonstrating a 2 percent reduction in SSI participation in expansion states, we assume a 2 percent reduction in non-dually eligible SSI adults who are not on waivers for home and community-based services. These adults could receive medical coverage through expansion, avoiding the complicated and lengthy SSI application process or the low SSI income and resource limits when medical care coverage may be the main benefit some seek. The state's savings comes from the conversion of 2 percent of non-dual SSI expenditures with regular FMAP to the 90-percent federal match.
8. The Kansas Department of Corrections responded in the fiscal note for Senate Bill (SB) 54 that there would be \$2.2 million net savings to the state if Medicaid covers more inmate medical costs for inpatient hospital stays of at least 24 hours. This savings is expected to increase each year by 4 percent consistent with overall expected growth in cost.
9. While the adjustment for updates to the HCAIP program discussed in item 5 on page 4 would increase the total cost for the Medicaid program, the HCAIP adjustment is not expected to increase the total state cost related to the newly eligible expansion population. State costs are expected to be fully offset by the provider assessment, and an

increase in expenditures for one population group is expected to be offset by a proportional decrease (or a lesser increase) in expenditures for another population group. Thus, we include an offset to our estimate of gross state cost of Medicaid expansion that is equal to the average increase in per person cost attributed to the update to the HCAIP program.

10. In addition to an estimate of the cost, revenues and offsets related to Medicaid expansion, the brief also references an estimate of additional state tax revenue resulting from the economic effect of Medicaid expansion. Using the parameters estimated by Dr. John Leatherman in March 2019 it could be estimated that between 2.9 percent and 3.6 percent of federal spending on new Medicaid enrollees would be collected through existing state taxes.⁶

Assumptions of Alternative Medicaid Expansion Scenarios

The estimate assumes that Medicaid would be expanded to include all adults age 19 to 64 with family income at or below 138 percent FPL without condition. In the brief we also include estimates of the impact of premiums, disenrollment, and partial expansion to demonstrate how provisions in House Bill (HB) 2066 and SB 252 may affect enrollment and cost. The assumptions for premiums, disenrollment, and partial expansion are based on the limited experience available from other states. Except where otherwise noted assumptions are identical to the assumptions made in the baseline estimate, and estimates are made independently (i.e., the cost impact of partial expansion does not consider the effect of partial expansion and premiums).

Premiums:

Kansas HB 2066, as amended, requires that each covered individual pay a \$25 monthly fee, up to \$100 per family. SB 252 requires a premium of up to \$25 per person or \$100 per family for those with family income greater than 100 percent FPL. In either HB 2066 or SB 252 the state would realize 10 percent of the total collected premium, which is the state share for the expansion population.

1. We assume that cost sharing requirements such as premiums would only apply to newly eligible adult enrollees. The baseline estimate assumes that nearly 100,000 individuals, including those who could otherwise be currently eligible, would be enrolled in the newly eligible group. If premiums were required for all newly eligible enrollees, we expect that some individuals who could otherwise become eligible in a current eligibility group would not enroll in the newly eligible group.
 - a. The baseline estimate included an assumption that some women with family income less than or equal to 138 percent FPL who became pregnant after enrolling in the newly eligible group would remain in the newly eligible group. Per CMS guidance, women can continue to be enrolled in the new adult expansion category after becoming pregnant until their annual renewal if already enrolled in Medicaid, but they must be allowed to choose whether to move to another category. Adding a premium to the expansion population might incent women to move to the eligibility category for pregnant women, as it is not permissible to charge premiums to pregnant women. We assume that if premiums or additional cost sharing were required all pregnant women with income up to 138 percent

⁶ https://www.kha-net.org/criticalissues/kancareexpansion/kancareexpansionresources/preliminary-estimates-of-the-state-and-local-tax-revenue-generated-by-the-expansion-of-medicaid-expenditures_151274.aspx?plain=true

FPL would enroll in the current pregnant women eligibility category when they became pregnant, and that the lower federal match rate (59.68 percent) would be applied.

- b. We additionally assume that the savings resulting from a 2 percent reduction in non-dually eligible SSI adults who are not on waivers for home and community-based services would not occur if premiums were applied from 0-138 percent FPL, as potentially eligible adults would pursue the SSI eligibility path in order to avoid premiums. However, all SSI enrollees were assumed to have family income below 100 percent FPL, so in scenarios in which premiums are applied only to those with income over 100 percent FPL, the savings associated with a reduction in SSI enrollment were preserved.
 - c. Two-thirds of currently enrolled pregnant women were assumed to have family income below 100 percent FPL.
2. For HB 2066 we expect 58 percent, or 50,753 of the remaining 87,547 newly eligible adults, would choose to enroll in the newly eligible group and would pay 12 months of premiums, and another 6 percent, or 5,519, are expected to enroll and pay an average of six months of premiums but later either fail to pay premiums and be disenrolled or choose to disenroll.
 3. We assume that implementing premiums as described in HB 2066 would add an additional \$4.5 million to administrative cost in 2021.

Partial Expansion:

As introduced, SB 252 includes an option to transition adults under age 65 who earn between 100-138 percent FPL to an ACA marketplace plan in 2022. Adults under age 65 who are not pregnant and who have family income up to 100 percent FPL would remain in the Medicaid program. In our estimate 34,504 newly eligible adults have family income between 100 and 138 percent FPL. Transitioning these individuals to an ACA marketplace plan is expected to reduce the state's net cost by \$10.1 million in 2022.

Household Definitions:

The Census data for this analysis defines an individual's FPL status based on family income where a family is defined as a householder and one or more other people living in the same household who are related to the householder by birth, marriage, or adoption. The same FPL is assigned to all persons in the same family. The FPL calculation using the Census definition of a family includes extended family members or in some cases unrelated individuals living in the household who may or may not have income that would qualify them for federally subsidized health insurance or Medicaid. An alternative approach would be to calculate FPL using a variable known as the health insurance unit (HIU). The HIU methodology calculates FPL by tax filing status rather than the Census family definition. Applying the HIU methodology to this analysis using data from IPUMS USA (<https://www.ipums.org>) would add 8 to 9 percent to past and current Medicaid expansion enrollment estimates and 10 percent to this cost estimate.