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MEMO

Date: February 10, 2021

Re: Technical notes regarding the KHI Issue Brief*, Medicaid Expansion Estimates and the Effects of COVID-19,* KHI/21-08, February 10, 2021.

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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, 2022. 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 235 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) 2020,[2] supplemented by data from the Kansas Department of Health and Environment (KDHE) and the Kansas Department of Corrections.
- American Community Survey 2019 1-year Public Use Microdata Sample, U.S. Census Bureau.
- 2019 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.

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 235 percent FPL using the U.S. Census Bureau's American Community Survey 2019 1-year Public Use Microdata Sample.
2. Separate enrollment estimates were then calculated for the newly eligible – including those who may already be covered by another source of insurance – and the currently eligible. The assumed enrollment rate for each estimate was based on the literature and is consistent with our previous estimates in 2016, 2018, 2019 and 2020.
3. Cost information was obtained from the FY 2020 Medical Assistance Report, supplemented by additional information provided by the Kansas Department of Health and Environment (KDHE). The cost in FY 2020 for Temporary Assistance for Families (TAF) adults was $6,873 per consumer and the cost for Poverty Level Expansion (PLE) Pregnant Women was $11,641 per consumer. For children, the cost in Medicaid was $3,543 per consumer, the cost in CHIP was $2,491 per consumer, and the cost in M-CHIP was $2,534 per consumer (*Figure 1*, page 3). Assumptions about cost growth are described on page 4.
4. Gross cost was estimated for calendar year (CY) 2022 by trending the fiscal year 2020 cost per person from Figure 1 at an annual rate of 4 percent to CY 2022 and applying the projected CY2022 cost per person to the enrollment estimates discussed in item 1 and 2 above. Gross cost for CY 2023 to CY 2031 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

Figure 1. **Actual and Projected Cost Per Medicaid Enrollee, FY 2020 and CY 2022**

Population Subgroup	Consumers	FY 2020 Expenditures	FY 2020 Per Person Cost	CY 2022 Per Person Cost (Projected)
Parents in TAF	36,533	$247,491,286		
Parents in TAF Extended Medical	3,788	$29,590,996	$6,873	$7,434
Medically Needy Families	3	$72,280		
PLE Pregnant Women	6,856	$79,813,468	$11,641	$12,346
Children in TAF and PLE	184,439	$757,076,161	$3,543	$3,832
CHIP	47,613	$118,594,587	$2,491	$2,694
M-CHIP	14,136	$35,819,358	$2,534	$2,741
MediKan	744	$6,167,177	$8,289	$8,966
SSI-Blind and Disabled (Non-Dual) Capitation Payments	27,105	$447,435,267	$16,507	$17,854

Source: KHI analysis of FY 2020 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 in this analysis: 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) 2022 is the latest year that the Medicaid and CHIP FMAP has been published. The FFY 2022 FMAP was used for all years in the estimate – 2022 to 2031.

Figure 2. **Kansas Federal Medical Assistance Program Match Rates**

Fiscal Year	Standard Medicaid	CHIP Enhanced	Newly Eligible
2022	60.16%	72.11%	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, 2021, Through September 30, 2022 (2020).[3]

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 2019 vital statistics, we calculated a 7.260 percent delivery rate for 33,651 live or still births to Kansas women age 20 to 44 divided by 463,517 women age 20 to 44. If 7.260 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 estimated 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 (60.16 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 73.89 percent federal match for the estimated 2,396 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 2020. KDHE responded to a request to break out select populations in the MAR by age and income group. A 4 percent increase was applied to FY 2020 per capita cost to account for inflation and enrollment changes from FY2020 to CY2021. Another 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 2022 – CY 2031).
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 (72.11 percent). For children who are already enrolled, their per person cost was included in the FY 20202 MAR. The match rate and state costs were separately adjusted for the estimated 4,267 children with family income between 114 and 133 percent FPL who are expected to newly enroll in M-CHIP if Medicaid is expanded.

[3] https://www.federalregister.gov/documents/2020/11/30/2020-26387/federal-financial-participation-in-state-assistance-expenditures-federal-matching-shares-for

7. Administrative costs for each year were calculated as 4.48 percent of the total expenditures multiplied by the expected state share of the total net cost – 33.28 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 2019 Medicaid Financial Management Data.*[4] 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. The drug rebate 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 CHIP match rate.
4. MediKan is currently 100 percent state-funded with limited benefits, and all 744 consumers in FY 2020 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 2020, the MediKan consumer average per person annual cost was $8,289, which was entirely the responsibility of the state. Assuming expansion, we estimate a cost of $17,508 per person in CY 2022, of which 10 percent ($1,751 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 2020, there were 2,347 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 2022 is 60.16 percent). Under Medicaid expansion, Medicaid would cover those costs, including the previous spenddown amount, at a 90 percent federal share. Based

[4] https://www.medicaid.gov/medicaid/finance/state-expenditure-reporting/expenditure-reports/index.html

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 2022, 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, 2022, would be likely to enroll in the newly eligible group. After the initial year of implementation, for CY 2023 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) 252 introduced during the 2020 legislative session that there would be $2.2 million in net savings to the state if Medicaid covers more inmate medical costs for inpatient hospital stays of at least 24 hours. We assume this $2.2 million in net savings in CY2022 and expect the savings to increase each year by 4 percent consistent with overall expected growth in cost.
9. 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.[5]

Enrollment and Spending Comparison

If Kansas were to expand Medicaid up to the extent allowed by the ACA, this analysis concludes that 126,098 additional Kansans would newly enroll, representing a 30.6 percent increase in monthly enrollment compared to the average monthly enrollment over the last three fiscal years – FY2018, FY2019 and FY2020. *Figure 3* presents the average monthly enrollment in all Kansas Medicaid programs from FY2018 – FY2020.

Figure 3. **Pre-COVID-19 Kansas Medicaid Average Monthly Enrollment, FY2018 – FY2020**

FY2018	FY2019	FY2020	Average
416,476	410,579	408,138	411,731

Note: FY2020 includes three months of enrollment that had been affected by changing economic circumstances and policies related to the COVID-19 pandemic.
Source: Fiscal Years 2018 – 2020 Medical Assistance Report from the Kansas Department of Health and Environment

This analysis estimates that expanding Medicaid would increase state cost by $601,856,846 over 10 years, or by 2.7 percent per year on average compared to spending that might have been projected based on the pre-COVID-19 Medicaid spending trend. Using the state share of Medicaid spending from the five prior fiscal years and assuming a linear trend we calculate that state Medicaid spending currently increases each year by $93,933,342 on average. Projecting this annual increase forward from FY2020, state Medicaid spending is expected to be $22,190,027,394 over the 10 years FY2022 – FY2031. *Figure 4* presents the state share of Medicaid spending for all Kansas Medicaid programs from FY2016 – FY2020 and the linear trend.

Figure 4. **Pre-COVID-19 State Share of Kansas Medicaid Spending, FY2016 – FY2020**

FY2016	FY2017	FY2018	FY2019	FY2020	Trend
$1,238,594,019	$1,350,085,207	$1,523,783,087	$1,549,734,623	$1,608,436,019	$93,933,342

Note: FY2020 includes three months of spending that had been affected by changing economic circumstances and policies related to the COVID-19 pandemic.
Source: Fiscal Years 2018 – 2020 Medical Assistance Report from the Kansas Department of Health and Environment

[5] 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