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ISSUE BRIEF

APRIL 2021

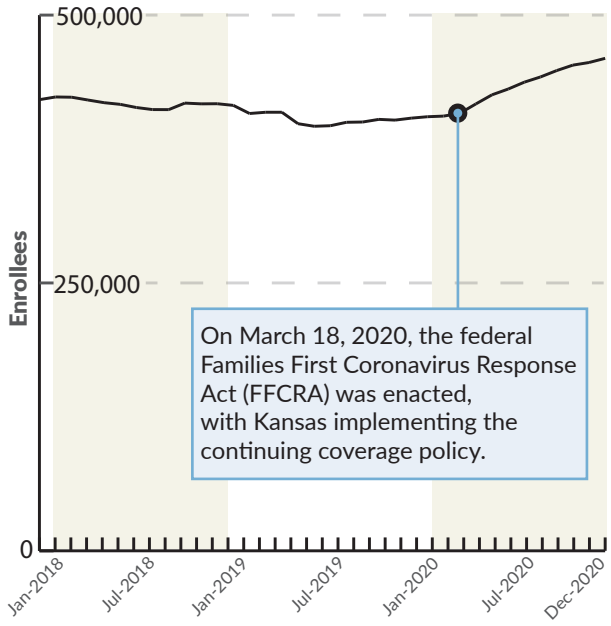
MEDICAID AND CHIP ENROLLMENT GROWTH DURING THE COVID-19 PANDEMIC

Many Kansans have lost employment, income and potentially health insurance amid the COVID-19 pandemic. When economic conditions worsen, Medicaid and the Children's Health Insurance Program (CHIP), known together in Kansas as KanCare, are a safety net for families who lose health insurance or can no longer afford it.

Congress passed a number of federal policy changes to strengthen Medicaid and CHIP in anticipation of increased reliance on the program by those affected by the pandemic. As of December 2020, enrollment in KanCare had increased 13.3 percent (53,887 people) since the COVID-19 pandemic began (*Figure 1*). Data provided to KHI from the Kansas Department of Health and Environment (KDHE) suggest that this increase in enrollment has been driven primarily by the state's decision to continue eligibility for KanCare enrollees throughout the pandemic. However, even with the increase in enrollment, this continuing coverage policy has reduced overall state KanCare costs due to an increase in the federal match rate.

This issue brief provides an overview of how the COVID-19 pandemic and related policy response has affected enrollment in KanCare and how it may continue to do so in the future.

Figure 1. **Total Medicaid and CHIP Enrollment, January 2018 through December 2020**



Source: Kansas Health Institute analysis of Kansas Department of Health and Environment Medical Assistance Reports.

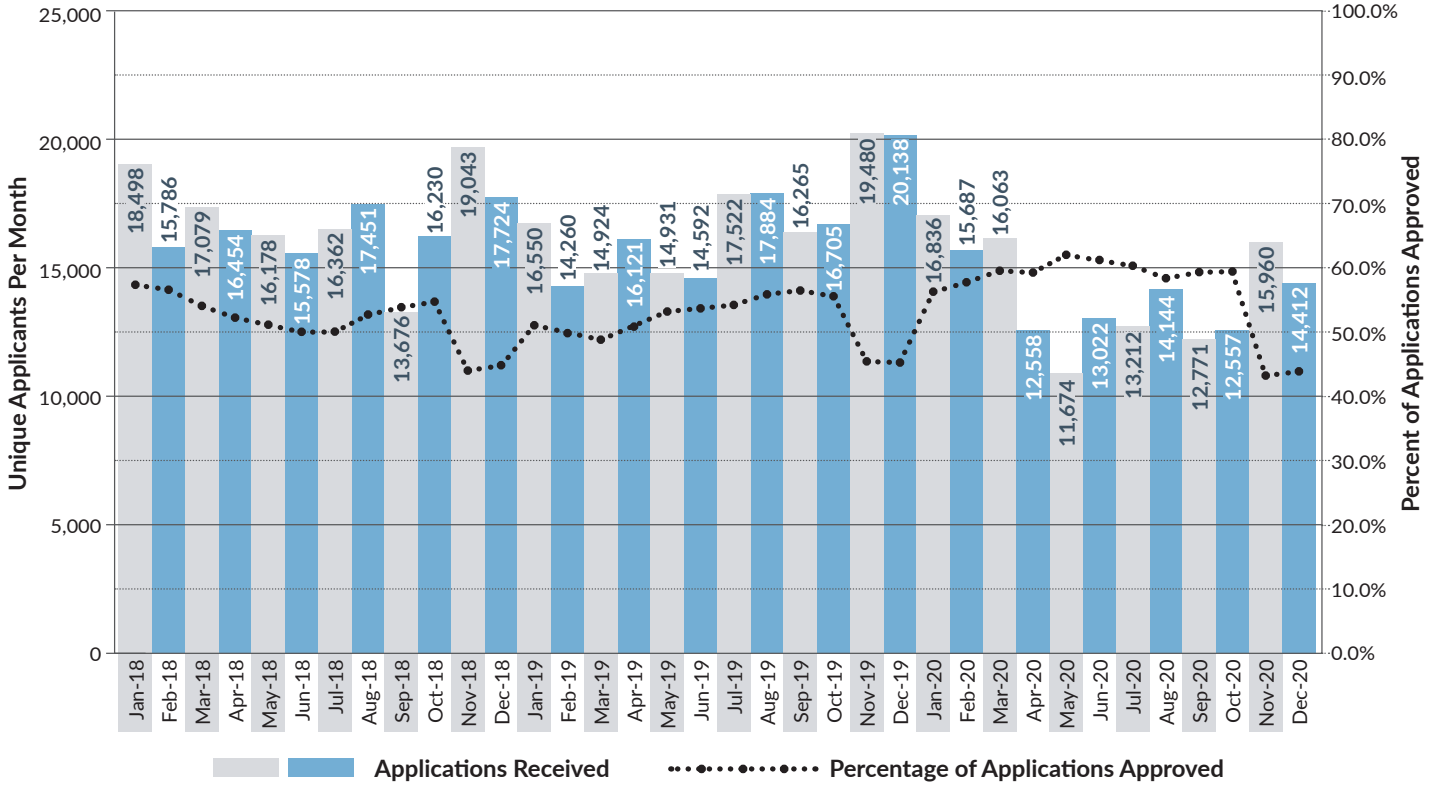
Federal and State Medicaid Enrollment Policy Response to COVID-19

Federal legislation tied to the nationwide COVID-19 public health emergency, first declared on January 29, 2020, and extended for 90 days a fifth time on April 15, 2021,

KEY POINTS

- ✓ In anticipation of the health and economic impact of the COVID-19 pandemic, Congress implemented incentives to states to maintain enrollment in Medicaid and CHIP.
- ✓ A continuing coverage policy implemented by KDHE in response to federal incentives resulted in fewer members being disenrolled during the pandemic. In 2020, about 26,900 KanCare members disenrolled, less than one-third of the 90,750 on average who disenrolled during the same time in 2018 and 2019.
- ✓ KanCare enrollment increased 13.3 percent (53,887 enrollees) from February to December 2020.
- ✓ The continuing coverage policy qualified Kansas for an increase in the federal match rate. As a result, the state share of Medicaid expenditures decreased by approximately $153.2 million in FY 2020. These savings are expected to continue in FY 2021.
- ✓ The long-term effects of the increase in enrollment on the KanCare program and state budget are less certain. Once the public health emergency ends, annual reviews will resume for tens of thousands of KanCare enrollees while the additional federal financial support for maintaining their enrollment ends.

Figure 2. **Monthly Applications Submitted and Approved, January 2018-December 2020**



Note: The count of applications and the percent approved are calculated by the date an application was submitted. Application decisions are as of January 25, 2021, and are not necessarily made in the month that the application was received. Multiple applications by the same person in the same month are only counted once unless the application was submitted for a different eligibility category. Applications reflect both Medicaid and the Children's Health Insurance Program (CHIP). AIDS Drug Assistance Program (ADAP) applicants are excluded.

Source: Kansas Health Institute analysis of Kansas Department of Health and Environment application data.

provides states with flexibility and incentives to change how medical assistance programs such as KanCare are managed during the COVID-19 pandemic. One such incentive is provided through the federal Families First Coronavirus Response Act (FFCRA), enacted on March 18, 2020, which provides a 6.20 percentage point increase in the federal share of Medicaid spending referred to as the Federal Medical Assistance Percentage (FMAP) and indirectly a 4.34 percentage point increase in the enhanced FMAP for the Children's Health Insurance Program (CHIP) to states that meet certain requirements. Those requirements include:

- Applying Medicaid eligibility standards, methodologies and procedures that are no more restrictive than those in effect on January 1, 2020. States cannot increase Medicaid premiums above those in effect on January 1, 2020;
- Covering COVID-19 tests and treatments, including vaccinations, for Medicaid recipients with no cost sharing; and
- Continuing eligibility for Medicaid recipients enrolled on March 18, 2020, or thereafter, until the first day of the month after the public health emergency ends unless a recipient requests to end their Medicaid coverage, moves out of state, dies or was determined to not be validly enrolled (e.g., a mistake was made when their application or review was approved).

The FMAP increase for states adopting these policies was retroactive to January 1, 2020, and extends through the last day of the calendar quarter in which the COVID-19 public health emergency period ends. KDHE has elected to receive the FMAP increase and continue coverage (except in the permitted scenarios) during the public health emergency including those whose changing circumstances might have otherwise caused them to be disenrolled. Although not required in order to receive the increased FMAP, KDHE also elected to continue coverage for CHIP enrollees.

New Applications

Figure 2 shows the count of applications submitted and the percentage of applications approved by month from January 2018 through December 2020. Since the COVID-19 pandemic began,

136,373 KanCare applications were submitted, a 19.1 percent decrease compared to the average number of applications submitted during the same time in the prior two years. However, consistent with reduced income and job loss associated with the pandemic, the application approval rate has increased to 56.3 percent since the pandemic began from an average of 51.2 percent during the same time in the prior two years.

Annual Reviews

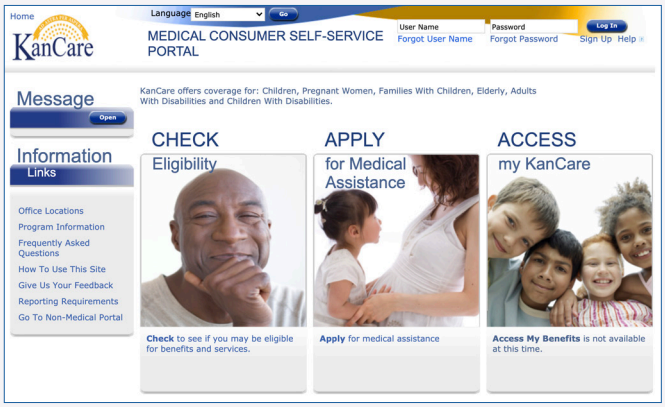
The number of applications submitted during the COVID-19 pandemic may be lower than prior years because many who might have reapplied after disenrollment remained enrolled. Most KanCare enrollees receive 12 months of coverage from the month their application is submitted. After 12 months, KDHE conducts a review to redetermine the enrollee's eligibility and disenrolls members who are no longer eligible. This review and possible disenrollment are now delayed until after the public health emergency ends.

Before the COVID-19 pandemic, KDHE on average processed 22,075 reviews each month, and of these 5,538 (25.1 percent) were discontinued, resulting in disenrollment. Low-income individuals and households often experience housing instability and fluctuations in income that may result in delayed paperwork or income above the qualifying limit, causing them to lose eligibility during their annual review. However, some of these enrollees may still qualify for Medicaid later in the year and will reapply. Of the approximately 5,000 individuals that were disenrolled each month before the pandemic because of a discontinued annual review, an average of 1,243 (22.4 percent) reapplied and were approved within one year.

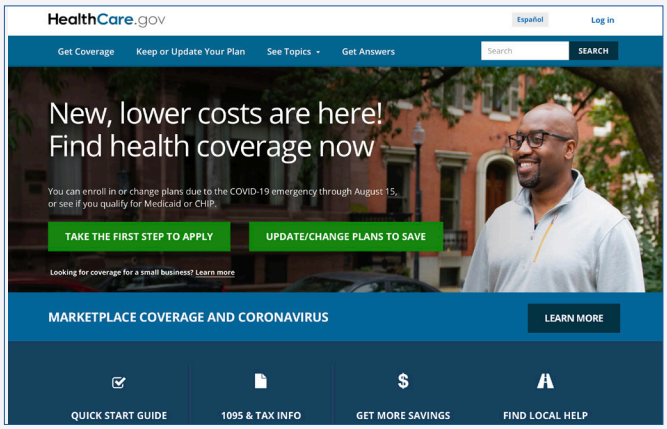
Other Disenrollment

Disenrollment also occurs for reasons other than the annual review. KanCare members can disenroll themselves if, for example, they receive insurance through an employer or move out of state. KDHE may disenroll members if data (e.g., date of birth) show they are no longer eligible. Some KanCare members ordinarily receive less than 12 months of eligibility, such as pregnant women who are eligible for KanCare at higher income levels during their pregnancy but are disenrolled 60 days after giving birth unless they qualify for another eligibility group.

How Applications are Verified



Information provided by applicants — either online through a KDHE self-service portal or healthcare.gov, or by mail or fax — about eligibility criteria such as income, citizenship, immigration status, family composition and state residency are first verified electronically through the Kansas Eligibility Enforcement System (KEES) by cross referencing the information with other state and federal data sources. If an applicant's information conflicts with other sources, or cannot be verified electronically, staff at KDHE or its contractor review the application and documentation provided before determining eligibility.



Comparing KDHE data on approved applications to the Kansas Medical Assistance Report suggest that 26,927 enrollees have disenrolled since the COVID-19 pandemic began, less than one-third of the 90,742 on average who were disenrolled for all reasons during the same time in the last two years. *Figure 3*, page 4, provides changes in new enrollment based on approved applications, disenrollment from discontinued reviews, other disenrollments and the net change in enrollment by year from 2018 to 2020. While the number of new enrollees is lower since the pandemic began, the total change in enrollment, which had been decreasing, increased sharply in

2020. Since the number of new enrollees has not increased, this implies that fewer people are disenrolling and the increase in KanCare enrollment during the COVID-19 pandemic has been driven primarily by the policy decision to delay acting on annual reviews until after the COVID-19 public health emergency ends.

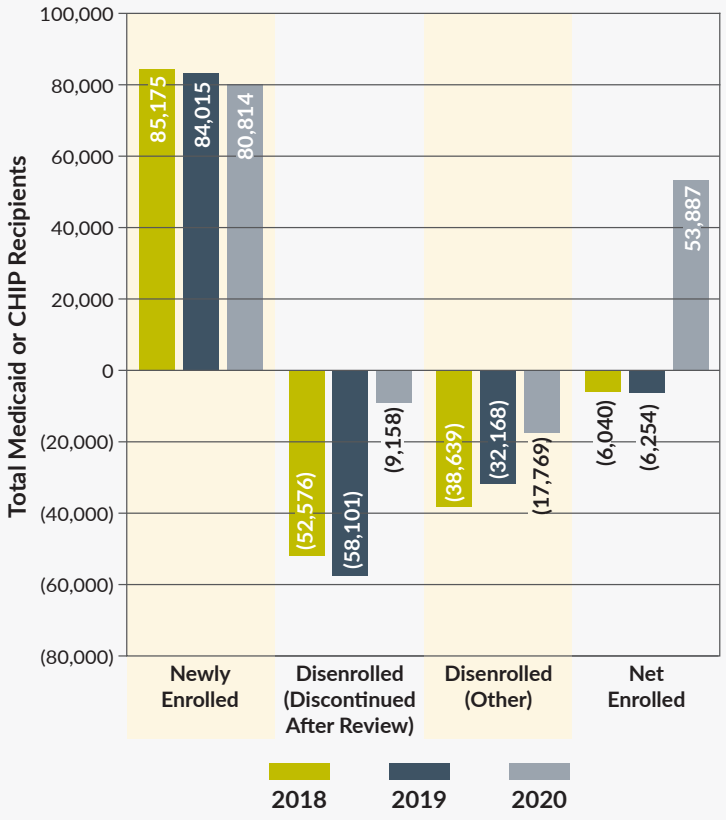
Discussion

The continuing coverage policy has many short-term benefits. In addition to covering the cost of COVID-19 vaccines and treatment for KanCare members, the policy has extended eligibility for many enrollees who would have otherwise been disenrolled, possibly without another health insurance option in the midst of a pandemic.

The continuing coverage policy also has reduced the state's overall KanCare costs. Because the state contracts with managed care companies to provide KanCare benefits, the cost for additional enrollees is largely fixed. The 6.20 percentage point increase in federal funds for the entire KanCare population has more than offset costs for the additional enrollees and for COVID-19 testing and treatment for KanCare members.

Volume 1 of the FY 2022 Governor's Budget Report states that the increased FMAP, which was retroactive to January 1, 2020, had decreased the required state share of Medicaid expenditures by approximately $153.2 million in FY 2020 and would reduce expenditures by an estimated $161.4 million in FY 2021, assuming the increased FMAP expired on March 31, 2021. However, the Biden Administration extended the COVID-19 public health emergency another 90 days and has announced intentions to continue extending it through at least the end of 2021, so it is expected that the increased FMAP also will continue until then.

Figure 3. **Newly Enrolled, Disenrolled and Net Change in Enrollment by Year, 2018-2020**



Source: Kansas Health Institute analysis of Kansas Department of Health and Environment Medical Assistance Reports.

The long-term effects of the increase in enrollment on the KanCare program and state budget are less certain. Once the public health emergency ends, annual reviews will resume for tens of thousands of KanCare enrollees while the additional federal financial support for maintaining their enrollment ends. Many of the enrollees who have retained eligibility will be disenrolled. Some will re-enroll and others will be covered through other insurance or become uninsured. If the economic effects of the pandemic outlast the health crisis, a rapid return to pre-pandemic KanCare enrollment may be unlikely.

ABOUT THE ISSUE BRIEF

This brief is based on work done by Phillip Steiner, M.A., and Wen-Chieh Lin, Ph.D. It is available online at khi.org/policy/article/21-21.

KANSAS HEALTH INSTITUTE

The Kansas Health Institute supports effective policymaking through nonpartisan research, education and engagement. KHI believes evidence-based information, objective analysis and civil dialogue enable policy leaders to be champions for a healthier Kansas. Established in 1995 with a multiyear grant from the Kansas Health Foundation, KHI is a nonprofit, nonpartisan educational organization based in Topeka.

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