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MEMO

Date: April 25, 2022

Re: Technical notes regarding the KHI Issue Brief*, New Federal Incentive Lowers the Estimated Cost of Medicaid Expansion,* KHI/22-20, April 25, 2022.

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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, 2023. 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) 2021,[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 IPUMS USA, University of Minnesota, www.ipums.org.
- 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 IPUMS USA's American Community Survey 2019 1-year Public Use Microdata Sample. A family was defined using the State Health Access Data Assistance Center (SHADAC) health insurance unit (HIU) discussed further on page 8. This is a methodology change implemented this year to better reflect the KanCare program's family definitions. Estimated immigration status also was incorporated in this year's estimates to reflect KanCare eligibility requirements.
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 take-up rate for each estimate was based on the literature and is consistent with previous KHI estimates in 2016, 2018, 2019, 2020 and 2021.
3. Cost information was obtained from the FY 2020 Medical Assistance Report for currently eligible parents or caretakers and children, supplemented by additional information provided by 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) 2023 by trending the FY 2020 or FY 2021 cost per person from *Figure 1* at a growth rate that accounted for changes in per capita cost growth and population growth based on age and eligibility group (*Figure 3*, page 5). Projected CY 2023 per person costs were applied to the enrollment estimates discussed in items 1 and 2 above.
5. KHI 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] https://www.kancare.ks.gov/policies-and-reports/medical-assistance-report

Figure 1. **Actual and Projected Cost Per Medicaid Enrollee, FY 2020, FY 2021 and CY 2023**

Population Subgroup	Consumers	FY 2020 Expenditures	FY 2020 Per Person Cost	CY 2023 Per Person Cost (Projected)
Parents in TAF	36,533	$247,491,286	$6,873	$7,921
Parents in TAF Extended Medical	3,788	$29,590,996		
Medically Needy Families	3	$72,280		
PLE Pregnant Women	6,856	$79,813,468	$11,641	$13,417
Children in TAF and PLE	184,439	$757,076,161	$3,543	$4,006
CHIP	47,613	$118,594,587	$2,491	$2,817
M-CHIP	14,136	$35,819,358	$2,534	$2,865
Population Subgroup	**Consumers**	**FY 2021 Expenditures**	**FY 2021 Per Person Cost**	**CY 2023 Per Person Cost (Projected)**
MediKan	854	$6,167,177	$9,039	$9,412
SSI-Blind and Disabled (Non-Dual) Capitation Payments	28,501	$476,463,032	$16,717	$17,763

Note: More recent experience (FY 2021) was used for adults with a disability and adults over age 65 since those enrollees are less impacted by the enrollment policies during the COVID-19 pandemic.

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 newly eligible adult enrollees than for currently eligible adults who meet the current Kansas Medicaid rules, which allow parents or adult caretakers with family income below 38 percent FPL and, beginning in FY 2023, pregnant women with family income below 171 percent FPL for up to one year postpartum. 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 who had not given birth in the last year. Parents or caretakers with family income below 38 percent FPL and pregnant women and postpartum women with family income below 171 percent FPL would remain in the currently eligible group, and a lower federal match rate would be applied. Since this analysis was completed before House Substitute for Substitute for Senate Bill 267, which provided the funding to extend Medicaid coverage from 60 days to one year postpartum, was enacted, the impact of extending postpartum coverage on the estimated enrollment and cost associated with Medicaid expansion was not accounted for.
2. Children are not directly impacted by Medicaid expansion, but some children who are currently eligible would be expected to newly enroll if Medicaid is expanded. Children who are currently eligible for Medicaid include those under age 1 with family income up to 171 percent FPL, those age 1 to 5 with family income up to 149 percent FPL and those age 6 to 18 with family income up to 133 percent FPL. In 2019 (the source data year) children in Kansas were eligible for CHIP if they were not eligible for Medicaid and their family income was at or below 235 percent FPL. K.S.A. 38-2001 provides that children are

eligible for CHIP if their family income is at or under 250 percent of the 2008 federal poverty income guidelines for 2010 and subsequent years. Thus the eligibility for CHIP changes each year when the federal poverty guidelines are updated. KHI does not project the eligibility income for future years. House Substitute for Substitute for SB 267, Section 70(i), sets CHIP eligibility at 250 percent of the current FPL for Fiscal Year 2023. At the time the analysis was completed this policy change had not been enacted, and therefore is not reflected in the estimated number of CHIP eligible children who would newly enroll if Medicaid is expanded.

3. KHI used 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.
4. Federal fiscal year (FFY) 2023 is the latest year that the Medicaid and CHIP FMAP has been published. The FFY 2023 FMAP was used for all years in the estimate – 2023 to 2032.

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

Fiscal Year	Standard Medicaid	CHIP Enhanced	Newly Eligible
2023	59.76%	71.83%	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, 2022, through September 30, 2023 (2021).[3]

5. 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, KHI 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 2020 vital statistics, KHI calculated a 7.014 percent delivery rate for 32,692 live or still births to Kansas women age 20 to 44 divided by 466,078 women age 20 to 44. If 7.014 percent of women age 19 to 44 who enroll in the newly eligible expansion group would become pregnant over the course of the year, KHI 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 (59.76 percent) and 46 percent of the newly eligible expansion match rate (90 percent) was applied. KHI calculated that the state would receive the equivalent of a 73.67 percent federal match for the estimated 2,957 newly eligible women who would become pregnant. However, potential cost could differ depending on how the state administers eligibility and

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

capitation payments. See page 7, item 7, for the effect on the current eligibility category for pregnant women.

6. Expenditures for each population group were obtained from the Kansas Medical Assistance Report (MAR) for state FY 2020 and FY 2021. FY 2020 per person cost are applied for children and adults age 19 – 64 without a disability. Because policy enacted in response to the COVID-19 Public Health Emergency (PHE) resulted in a significant increase in enrollment for those groups, KHI assumed that enrollment would return to pre-pandemic levels after the PHE ends. Per person cost for adults age 19 – 64 with a disabililty or adults age 65 or older are based on FY 2021 since those groups were less affected by the continuous enrollment policy. KDHE responded to a request to break out select populations in the MAR by age and income group. Per capita cost were increased to account for inflation and enrollment changes from FY 2020 to CY 2023 or from FY 2021 to CY 2023 depending on the population group. An additional increase was subsequently applied for inflation and changes in enrollment for each additional year in the projection window (CY 2023 – CY 2032). *Figure 3* identifies the growth factor applied to each population group by year.

Figure 3. **Per Capita Cost Growth Rate by Population Group**

Calendar Years	Children Age 0 – 18	Adults Age 19 – 64 without a disability	Adults Age 19 – 64 with a disability	Adults Age 65 or Older
2020 – 2024	5.04%	5.84%	4.1%	2.7%
2025 – 2029	5.01%	6.04%	4.1%	2.7%
2030 – 2032	4.96%	6.38%	4.1%	2.7%

Source: KHI analysis of population projections from Wichita State University's Center for Economic Development and Business Research and Congressional Budget Office's July 2021 Medicaid Baseline.

7. CHIP children tend to be older and with lower average expenditures than Medicaid children. In late 2015, Kansas children age 6 – 18 with family income between 113 and 133 percent FPL were converted to the M-CHIP program – a Medicaid program for which the state receives the enhanced CHIP FMAP (71.83 percent). For children who are already enrolled, their per person cost was included in the FY 2020 MAR. The match rate and state costs were separately adjusted for the estimated 3,192 children with family income between 113 and 133 percent FPL who are expected to newly enroll in M-CHIP if Medicaid is expanded.
8. Administrative costs for each year were calculated as 4.93 percent of the total expenditures multiplied by the expected state share of the total net cost – 26.4 percent. Administrative cost as a percent of total expenditures was based on the actual administrative fees (less the cost of Health Information Technology incentives and school-based administration) as a percentage of total Kansas Medicaid cost in the *FFY 2020 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.

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

New State Revenue and Offsets

1. The federal American Rescue Plan Act of 2021 (ARPA) would increase the FMAP applied for most currently enrolled KanCare members by 5 percentage points for two years if Kansas expanded Medicaid under the terms fo the Affordable Care Act (ACA). KanCare members enrolled in CHIP and those receiving assistance through Title IV of the Medicaid program, which includes Foster Care and Adoption Support, are excluded. The incentive value was determined by comparing projected state KanCare spending for qualifying currently enrolled members with an increased FMAP (64.76 percent) to the projected state KanCare spending for qualifying currently enrolled members with the standard FMAP (59.76 percent) applied over two years (2023 and 2024). *Figure 4* shows the projected spending for current enrollees eligible for the FMAP increase. The applicable growth rate from *Figure 3* (page 5) was applied to project current spending forward to 2023.

   Enrollment is expected to return to pre-COVID-19 levels after the PHE ends. This analysis assumes the emergency ends and all members who are no longer eligible are disenrolled by January 1, 2023. Last year federal policymakers indicated that the PHE would end in January 2022. However, the PHE was extended 90 days on January 16, 2022, as COVID-19 cases increased due to the Omicron variant, and extended again on April 12, 2022, for 90 days from April 16, 2022. If the increased FMAP is still in effect and Medicaid expansion was implemented, the temporary 6.2 percentage point increase in the regular federal match rate would apply in addition to the 5 percentage point ARPA incentive for qualifying beneficiaries. The temporary 6.2 percentage point increase would not apply to the enrollees newly eligible from expansion who receive a 90 percent match rate. This estimate only considers the 5 percentage point increase from ARPA.

Figure 4. **Projected State Spending Eligible for Increased Federal Medical Assistance Percentage (FMAP)**

Calendar Year	State Spending Current FMAP	State Spending ARPA Incentive FMAP	Decrease in State Spending
2023	$1,647,709,207	$1,442,973,968	$204,735,239
2024	$1,716,482,318	$1,503,201,712	$213,280,606
Total	$3,364,191,525	$2,946,175,679	$418,015,846

Source: KHI analysis of FY 2020 and FY 2021 Medical Assistance Report and data from the Kansas Department of Health and Environment.

2. 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. This analysis assumes 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.
3. 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 estimate included only adults. Without additional information on the per capita rebate for children, the estimate of drug rebates in this analysis could be overstated, as KHI applied the same rate to adults and children.

4. 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.
5. MediKan is currently 100 percent state-funded with limited benefits, and all 854 consumers in FY 2021 are assumed to earn less than or equal to 138 percent FPL. KHI estimated 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. KHI estimated additional cost at the SSI per person cost level, which would increase total expenditures but reduce the state share. In FY 2021, the MediKan consumer average per person annual cost was $9,039, which was entirely the responsibility of the state. Assuming expansion, KHI estimated a cost of $17,763 per person in CY 2023, of which 10 percent ($1,776 per person) would be the responsibility of the state.
6. Non-waiver, non-buy-in, non-dual 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 2021, there were 1,505 non-dual 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 2023 is 59.76 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 for FY 2021, KHI estimated 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. In response to the COVID-19 pandemic KanCare members were not disenrolled regardless of whether or not spenddown amounts were paid, which may have impacted the savings in this estimate.
7. 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 (or, beginning in FY 2023, some who are within one year postpartum) 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 2023, the first year of expansion, KHI estimated 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. This analysis also applied a 74 percent enrollment assumption to calculate which women not already pregnant on January 1, 2023, would be likely to enroll in the newly eligible group. After the initial year of implementation, for CY 2024 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.

8. Based on literature demonstrating a 2 percent reduction in SSI participation in expansion states, KHI assumed 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.
9. 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. KHI assumes this $2.2 million in net savings in CY 2023 and expects the savings to increase each year by the percent for currently eligible adults without a disability consistent with KHI expectations for growth in cost.
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 February 2021 it could be estimated that between 3.1 percent and 3.9 percent of federal spending on new Medicaid enrollees would be collected through existing state taxes.[5]

Increasing the Precision of Enrollment Estimates

This year's estimate includes two changes in the methodology for estimating the number of Kansans who would newly enroll if Medicaid were expanded that more closely aligns the estimate with KanCare eligibility rules.

1. Income as a percent of FPL was determined based on the Health Insurance Unit developed by the State Health Access Data Assistance Center (SHADAC) rather than the U.S. Census Bureau's household definition. The Census Bureau defines households in the American Community Survey as all persons who occupy a housing unit as their usual place of residence. A housing unit is a house, an apartment, a mobile home, a group of rooms, or a single room that is occupied (or if vacant, is intended for occupancy) as separate living quarters. Separate living quarters are those in which the occupants live and eat separately from any other persons in the building and which have direct access from outside the building or through a common hall. The occupants may be a single family, one person living alone, two or more families living together, or any other group of related or unrelated persons who share living arrangements. (People not living in households are classified as living in group quarters.) The Health Insurance Unit (HIU) is a narrower definition of "family" that excludes nondependent relatives such as grandparents, adult siblings, aunts/uncles, etc., who may be household members but are

[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

unlikely to be considered as part of the "family unit" as defined for the purposes of determining eligibility for health insurance. For example, three adult siblings who are living together would be considered a "family" within a household due to their related status and cohabitation, wheras the HIU definition would place each sibling in their own HIU since it is unlikely that one could extend their health insurance coverage to the other.[6] The "household" defintion would combine the income from these three adult siblings together to determine their potential eligibility for KanCare while the "health insurance unit" would treat each of them independently and the KanCare eligibility determination would be based on each individual's income instead of all-combined.

2. With some exceptions for select groups (e.g., refugees and asylees) Medicaid enrollees are generally required to either be U.S. citizens or have lived in the United States for five years with a lawful immigration status. The American Community Survey asks survey participants about their citizenship status but, for non-citizens, it does not ask whether they are legal or undocumented immigrants. However, researchers at the Migration Policy Institute (MPI) have estimated the number of insured and uninsured Kansans by citizenship status and source of coverage. *Figure 5* shows the estimated percentage of undocumented immigrants and their source of insurance coverage. The percentage of undocumented immigrants who had private coverage and the percentage who were uninsured was applied before estimating the number of new enrollees to account for Kansans who would have enrolled in Medicaid if expanded but for their citizenship status.

Figure 5. **Insurance Status and Source of Coverage by Citizenship Status, All Kansans 2014 – 2016**

Source of Coverage	Undocumented Immigrants	All Kansans	Estimated Percent Undocumented Immigrants
Private Coverage	28,000	2,152,000	1.30%
Public But No Private Coverage	3,000	474,000	0.63%
Uninsured	37,000	290,000	12.76%
Total	68,000	2,916,000	2.33%

Note: The Migration Policy Institute uses the term unauthorized immigrant to mean those who entered the United States without inspection or who overstayed a valid visa. The term undocumented immigrant is used here with the same meaning.

Source: KHI analysis of Migration Policy Institute Policy Brief: Health Insurance Coverage and Latinos in the Kansas City Metro Area (Caps and Ruiz Soto), Table A2.

[6] https://www.shadac.org/sites/default/files/publications/HIU%20brief_2020.pdf

Figure 6 shows the impact of the two changes in the enrollment estimates for this year's brief compared to last year by age group and eligibility if Medicaid was expanded.

Figure 6. **Impact of Methodology Changes on New Enrollment After Medicaid Expansion**

Population Group	2019 1-year ACS U.S. Census	2019 1-year ACS IPUMS USA (Health Insurance Unit)	2019 1-year ACS IPUMS USA and Immigraiton Status
Newly Eligible Adults	83,427	115,541	105,507
Currently Eligible Adults	4,146	3,589	3,293
Currently Eligible Children	38,525	41,961	39,249
Total	126,098	161,091	148,049

Note: There are 7,138 additional children in IPUMS USA data that are excluded from the U.S. Census PUMS because they are under age 15 and likely in the care of an unrelated adult in the household.
Source: KHI analysis of 2019 1-year American Community Survey (ACS) Public Use Microdata Sample and IPUMS USA 1-year American Community Survey Public Use Microdata Sample.

Enrollment and Spending Comparison

If Kansas were to expand Medicaid up to the extent allowed by the ACA, this analysis concludes that 148,049 additional Kansans would newly enroll, representing a 36.0 percent increase in monthly enrollment compared to the average monthly enrollment for the three fiscal years before the COVID-19 pandemic – FY 2018, FY 2019 and FY 2020. *Figure 7* presents the average monthly enrollment in all Kansas Medicaid programs from FY 2018 – FY 2020.

Figure 7. **Pre-COVID-19 Kansas Medicaid Average Monthly Enrollment, FY 2018 – FY 2020**

FY 2018	FY 2019	FY 2020	Average
416,476	410,579	408,138	411,731

Note: FY 2020 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 $319,505,129 over 10 years, or by 0.14 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 fiscal years before the pandemic and assuming a linear trend, KHI calculated that state Medicaid spending increased each year by $93,933,342. Projecting this annual increase forward from FY 2020, state Medicaid spending is expected to be $23,129,360,810 over the 10 years FY 2023 – FY 2032. *Figure 8* presents the state share of Medicaid spending for all Kansas Medicaid programs from FY 2016 – FY 2020 and the linear trend.

Figure 8. **Pre-COVID-19 State Share of Kansas Medicaid Spending, FY 2016 – FY 2020**

FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	Trend for Annual Increase
$1,238,594,019	$1,350,085,207	$1,523,783,087	$1,549,734,623	$1,608,436,019	$93,933,342

Note: FY 2020 includes three months of spending that had been affected by changing economic circumstances and policies related to the COVID-19 pandemic.
Source: Fiscal Years 2016 – 2020 Medical Assistance Report from the Kansas Department of Health and Environment.