KANSAS HEALTH INSTITUTE

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ISSUE BRIEF

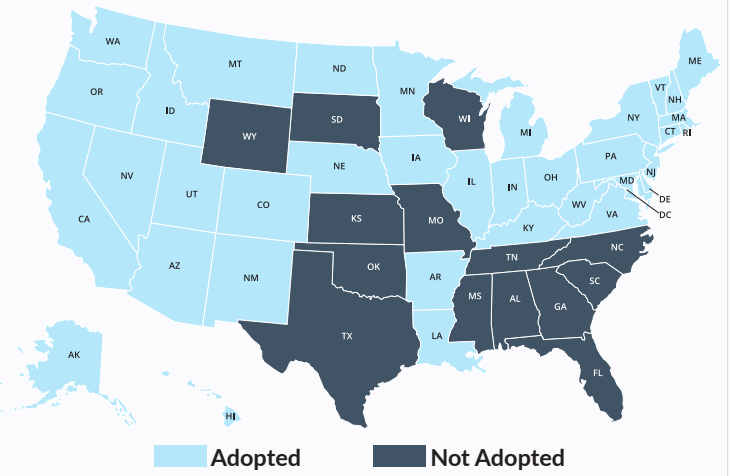
JUNE

2019

# WHAT KANSAS CAN LEARN FROM MEDICAID EXPANSION IN OTHER STATES

Almost nine years after the passage of the Affordable Care Act (ACA), 36 states and the District of Columbia have expanded their Medicaid programs. Fourteen states, including Kansas, have not (*Figure 1*). This issue brief examines different state approaches to expansion, as well as enrollment and cost trends and the effects of expansion on health outcomes and state economies.

*Figure 1.* **Status of State Action on Medicaid Expansion**




*Source: Kaiser Family Foundation, as of April 26, 2019, accessed April 29, 2019.*

Most states have expanded Medicaid simply by raising the eligibility level to 138 percent of the federal poverty level (FPL) ($35,535 for a family of four in 2019) as envisioned by the ACA. However, eight states (AZ, AR, IN, IA, KY, MI, MN, NH) have implemented Medicaid expansion under Section 1115 demonstration waivers. These states have proposed a variety of approaches, only some of which have been approved by the Centers for Medicare and Medicaid Services (CMS) (*Figure 2*, page 2).

## Enrollment Results

States that expanded Medicaid have experienced large increases in Medicaid enrollment, in some cases far exceeding initial projections, especially among states that expanded on January 1, 2014 (*Figure 3*, page 3). However, in states that expanded after 2014, enrollment projections have improved in some cases (*Figure 4*, page 4). The enrollment gains have come from three distinct groups: uninsured adults made "newly eligible" for Medicaid under expansion; uninsured children and adults who already were eligible

## KEY POINTS

- ✓ Between mid-2013 and August 2018, total Medicaid enrollment in expansion states increased by 37.3 percent. Among non-expansion states for the same period, total enrollment increased by 11.1 percent.
- ✓ Multiple studies suggest that Medicaid expansion can result in (1) the offsetting of state costs in other areas, such as costs related to behavioral health services and crime, (2) lower marketplace premiums, and (3) growth in the economy, in the form of new jobs.
- ✓ According to the CMS actuary, the average per-enrollee costs for expansion adults in 2014 were $5,511. These costs grew to $6,365 in 2015, then decreased to $5,965 in 2016 and $5,813 in 2017.
- ✓ Studies have found an association between Medicaid expansion and improved patient outcomes, including improved glucose monitoring rates for patients with diabetes, better hypertension control, improved rates of cancer screenings and reductions in self-reported rates of psychological distress and days of poor mental health.
- ✓ For safety-net hospitals, recent studies suggest there have been reductions in uncompensated care and improved financial status of hospitals in states that have expanded Medicaid compared to those in states that have not.

before expansion but not enrolled (known as the "woodwork" or "welcome mat" effect); and children and adults who had private insurance before expansion but switched to Medicaid after expansion (known as the "crowd-out" effect).

*Figure 2.* **Alternative Medicaid Waiver Approaches Proposed to CMS, as of April 2019**

| APPROVED | |
|---|---|
| Allowing "private option," which is the use of Medicaid funds to purchase private insurance coverage for newly eligible residents (AR, NH[1]) | Cost sharing that is higher than allowed under Medicaid law (KY[2]) |
| Work requirement and referral programs (AZ, AR, IN, KY[2], MI, NH, OH, UT, WI) | No coverage for costs incurred three months prior to Medicaid eligibility[3] (AZ, AR, IA, IN, KY[2], NH, NM) |
| Health savings accounts for enrollees (AZ, AR, IN, KY[2], MI) | No coverage for non-emergency medical transportation (IA, IN, KY[2]) |
| Premium payments required for some enrollees (AZ, AR, IA, IN, KY[2], MI, MT, NM) | No coverage for EPSDT (early and periodic screening, diagnosis and treatment for conditions that can affect development) (UT[4]) |
| Lock-out periods or disenrollment for non-payment of premiums, non-renewal filing, failure to report work hours (AZ, IN, KY[2], MI, MT, NM) | Lock-out periods for nonpayment of premiums for enrollees below 100 percent of FPL (WI[5]) |
| **NOT YET APPROVED** | |
| Block grants | Time limits on number of months individuals are eligible for coverage (KS[6]) |
| Partial expansion to 100 percent of FPL with enhanced federal match (UT, WI) | Drug screening and testing as condition of coverage (WI) |
| Asset test (counting assets in addition to income when determining eligibility) (ME, NH) | Adoption of closed prescription drug formularies (MA) |

[1] NH was approved to terminate its public option in Nov. 2018

[2] KY waiver is currently on hold pending outcome of pending litigation

[3] Six other states received approval for this waiver prior to March 2010

[4] Approved only for 19-20 year olds

[5] Disenrollment and lock-out for 6 months

[6] Rejected by CMS in May 2018

*Source: KHI analysis of decisions by CMS about alternative Medicaid waiver principles.*

The first full state fiscal year (SFY) that included Medicaid expansion was 2015. Between July and September 2013 and August 2018, total enrollment in Medicaid expansion states increased by 13.8 million enrollees or 37.3 percent. Among non-expansion states for the same period, total enrollment increased by 2.2 million or 11.1 percent.

## Spending on the Newly Eligible

According to the CMS actuary, the average per-enrollee costs for expansion adults in 2014 were $5,511. These costs grew to $6,365 in 2015, then decreased to $5,965 in 2016 and $5,813 in 2017.

In fiscal year (FY) 2015, total Medicaid spending growth in expansion states far exceeded growth in non-expansion states. Across the 29 expansion states (including D.C.) in FY 2015, total spending increased by 17.7 percent. Across the 22 states not implementing expansion in FY 2015, total spending growth was 6.1 percent.

After the large increases in spending in 2015, growth of total Medicaid spending slowed in SFYs 2016 and 2017 for both expansion and non-expansion states. For 2016, the median rate of growth in total Medicaid spending in expansion states was 7.1 percent compared to 3.8 percent for non-expansion states.

Beginning in SFY 2017, state spending growth began to rise as expansion states were required to start paying 5 percent of the costs of their newly eligible adult enrollees on January 1, 2017. Most states have reported they are financing the state share of expansion costs with general fund dollars, while a few states have listed other sources of financing, including new or increased provider taxes/fees or other savings that accrue from the expansion.

## How Expansion Affects Health and Quality of Life

In a study published in the journal *Health Affairs* in June 2018, the authors analyzed 77 studies published since 2014 addressing the association between ACA Medicaid expansion and changes in health insurance coverage, access to care, health care costs and patient outcomes. While some of the studies reviewed by the authors reached differing conclusions, overall they found:

- Expansion was associated with an increase in insurance coverage among all potentially eligible

*Figure 3.* **Medicaid Expansion Enrollment Experiences in Select States Expanding on January 1, 2014, Initial Estimate Versus 2017 Actual Enrollment of "Newly Eligible" Adults**

| Colorado | Iowa | Nevada | New Mexico | North Dakota |
|---|---|---|---|---|
| **Initial Enrollment Estimate:** 160,000 | **Initial Enrollment Estimate:** 100,000 | **Initial Enrollment Estimate:** 78,000 | **Initial Enrollment Estimate:** 64,810-89,114 | **Initial Enrollment Estimate:** 20,500-32,000 |
| **September 2017 Enrollment:** 451,018 | **September 2017 Enrollment:** 137,631 | **September 2017 Enrollment:** 211,428 | **September 2017 Enrollment:** 249,748 | **September 2017 Enrollment:** 19,287 |

*Source: KHI analysis of governors' statements and research reports, and https://catalog.data.gov/dataset/medicaid-enrollment-new-adult-group, accessed May 15, 2019.*

individuals, including major racial, ethnic, age, marital status and income groups, with the largest coverage gains for adults without a college degree.

- Improvements in appointment availability or wait times followed expansion.
- The share of adults who reported problems accessing care due to cost and problems paying medical bills in the past year decreased.
- The likelihood of U.S. citizens age 19-64 with incomes below 138 percent of FPL having a personal physician increased and reliance on the ED as a usual source of care decreased.
- Expansion was associated with an increase in the use of primary care, mental health and preventive visits among Medicaid enrollees, but studies showed mixed results regarding hospitalization and emergency department (ED) visits. Several studies showed decreases in hospitalizations and hospital lengths of stay among newly insured Medicaid enrollees, while others reported increases in hospitalizations and ED visits.
- There were improved glucose monitoring rates for patients with diabetes, better hypertension control, improved rates of prostate cancer screenings and higher rates of Pap testing.
- There were reductions in self-reported rates of psychological distress and days of poor mental health.

While it is too early to have much of the data needed to fully understand the impact, early studies suggest that states that expanded Medicaid had a significantly smaller increase in cardiovascular mortality rates among middle-aged adults and have shown modest improvement in access to cancer treatment, including higher rates of diagnosis and treatment of patients with certain cancers at earlier stages. Other recent studies found that expansion has reduced the percentage of people with medical debt and the probability of new bankruptcy filings related to medical debt.

## Impact on Safety-Net Hospitals

For safety-net hospitals, including public hospitals, academic medical centers and certain private hospitals, recent studies suggest there have been reductions in uncompensated care and improved financial status of hospitals in states that have expanded Medicaid compared to those in states that have not. In a study published by the Commonwealth Fund in November 2017, the authors looked at the changes in financial status of 326 hospitals in states that expanded Medicaid prior to 2015 compared to 268 hospitals in states that did not expand or expanded in 2015 or after and found:

- Operating margins for safety-net hospitals in Medicaid expansion states improved compared with declines for those in states that did not.
- From 2012 to 2015, safety net hospitals in expansion states experienced larger growth in Medicaid utilization than those in non-expansion states, including a rise in inpatient days of 13.5 percent compared with a decrease of 0.9 percent for hospitals in non-expansion states.

- From 2012 to 2015, safety-net hospital Medicaid revenues as a share of net patient revenues rose 12.7 percent in expansion states compared to a 1.8-percent decline in non-expansion states.
- Profit margins on Medicaid patients fell from 6.8 percent to 0.7 percent at safety-net hospitals in expansion states, suggesting revenues for the newly eligible patients did not keep pace with the cost of treating them.
- By 2015, uncompensated care costs among safety-net hospitals declined from 6.7 percent in 2012 in expansion states to 3.5 percent (a 47.4-percent reduction), compared to a decline from 5.7 percent in 2012 to 5.3 percent in non-expansion states.

## Economic Effects

Multiple studies suggest that Medicaid expansion can result in offsetting state costs in other areas, including costs related to behavioral health services, crime and the criminal justice system, and Supplemental Security Income program costs. For example, a study in Montana revealed that as the Medicaid role in financing substance use disorder (SUD) services has grown under expansion, federal Medicaid dollars have replaced federal block grant and state dollars previously used to fund services for uninsured Montanans with SUD, freeing up these dollars to be reinvested in Medicaid and other state priorities.

Research suggests that Medicaid expansion also may contribute to lower marketplace premiums. A study in Arkansas showed that the private option has increased the number of carriers offering marketplace plans statewide, generated a younger and relatively healthy risk pool and contributed to a 2-percent drop in the average rate of marketplace premiums.

For the effects of expansion on employment, a study in Colorado found that growth in the economy, as a result of Medicaid expansion, added more than 31,000 additional jobs as of SFY 2015. A study in Kentucky has estimated expansion will create over 40,000 jobs in the state through SFY 2021. In early 2017, researchers projected that additional employment associated with increased Medicaid spending in Michigan beginning in 2014 will yield approximately $145 million to $153 million annually in new state tax revenue, which nearly would offset all the projected new spending by the state for expansion in 2017 and 37 percent of costs in 2021.

In Ohio, most expansion enrollees who were unemployed but looking for work reported that Medicaid enrollment made it easier to seek employment and over half of the expansion enrollees who already were employed reported that enrollment made it easier to continue working. No studies have found any negative effects of expansion on employment or employee behavior, such as transitions from employment to non-employment or from full- to part-time employment.

*For more information about this subject, visit khi.org for the list of reference materials used in this analysis.*

*Figure 4.* **Medicaid Expansion Enrollment Experiences in Select States Expanding in 2015 and 2016, Initial Estimate Versus 2017 Actual Enrollment of "Newly Eligible" Adults**

| Alaska | Louisiana | Montana |
|---|---|---|
| **Initial Expansion Date:** Sept. 1, 2015 | **Initial Expansion Date:** July 1, 2016 | **Initial Expansion Date:** Jan. 1, 2016 |
| **Enrollment Estimate:** 41,910-42,260 | **Enrollment Estimate:** 365,000-653,305 | **Enrollment Estimate:** 65,319 |
| **September 2017 Enrollment:** 37,144 | **September 2017 Enrollment:** 445,598 | **September 2017 Enrollment:** 85,212 |

*Source: KHI analysis of state government documents and research reports, and https://catalog.data.gov/dataset/medicaid-enrollment-new-adult-group, accessed May 15, 2019.*

**ABOUT THE ISSUE BRIEF**

This issue brief is based on work done by Linda J. Sheppard, J.D., and Sydney McClendon. It is available online at khi.org/policy/article/19-33.

**KANSAS HEALTH INSTITUTE**

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