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MEMO

Date: February 29, 2024

Re: Technical notes regarding the KHI Issue Brief*, 2024 Medicaid Expansion Estimates: Enrollment, Costs and Characteristics of the Expansion Population,* KHI/24-22, February 29, 2024.

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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 Jan. 1, 2025. If you would like additional information on this topic, please contact Sheena Schmidt via phone at (785) 233-5443 or by email at sschmidt@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)?
- What are characteristics of Kansas adults who would be eligible if Medicaid were expanded under the terms of the ACA that are relevant to Gov. Laura Kelly's proposed Medicaid Expansion work requirement and exemptions?

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 or equal to 255 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.

Data Sources

- Medical Assistance Report for state fiscal year (FY) 2023,[2] supplemented by data from the Kansas Department of Health and Environment (KDHE) and the Kansas Department of Corrections.
- American Community Survey 2022 1-year Public Use Microdata Sample IPUMS USA, University of Minnesota, www.ipums.org.
- Estimates of poverty level use the Health Insurance Unit (HIU) definition of family from the State Health Access Data Assistance Center (SHADAC) (https://www.shadac.org/publications/SHADAC-HIU).
- 2024 Federal Poverty Guidelines, U.S. Department of Health and Human Services.
- CMS-64 expense forms and Federal Medical Assistance Percentages (FMAP) documents, Centers for Medicare & 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 255 percent FPL using IPUMS USA's American Community Survey 2022 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 methodology is designed to reflect the KanCare program's family definitions. Estimated immigration status was also incorporated in this year's estimates to reflect KanCare eligibility requirements. This updated estimate accounts for the effect of unwinding on adults and children who may have lost eligibility at the end of the PHE continuous coverage period.
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, 2021, and 2022.
3. Cost information was obtained from the FY 2023 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 of Medicaid was $3,543 per consumer, the cost of CHIP was $2,491 per consumer, and the cost of M-CHIP was $2,534 per consumer (*Figure 1*, page 3). The cost in FY 2023 for MediKan was $12,650 and the cost for SSI and Disabled (Non-Dual) Capitation Payments was $18,738. Assumptions about cost growth are described on page 4.
4. Gross cost was estimated for calendar year (CY) 2025 by trending the FY 2023 or FY 2024 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 2025 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

[2] https://www.kancare.ks.gov/policies-and-reports/medical-assistance-report

offsetting savings and revenues and administrative costs associated with expansion are described on the following pages.

6. Characteristic estimates are primarily based on analysis of the 2022 American Community Survey (ACS data). For the characteristics based on ACS data, estimates are provided for all adults age 19 to 64, earning less than or equal to 138 percent of FPL and for likely eligible adults age 19 to 64, earning less than or equal to 138 percent of FPL. Those in the *likely eligible* category do not include those already enrolled in Medicare or Medicaid.

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

Population Subgroup	Consumers	FY 2020 Expenditures	FY 2020 Per Person Cost	CY 2025 Per Person Cost (Projected)
Parents in TAF	36,533	$247,491,286		
Parents in TAF Extended Medical	3,788	$29,590,996	$6,873	$7,777
Medically Needy Families	3	$72,280		
PLE Pregnant Women	6,856	$79,813,468	$11,641	$13,516
Children in TAF and PLE	184,439	$757,076,161	$3,543	$4,035
CHIP	47,613	$118,594,587	$2,491	$2,837
M-CHIP	14,136	$35,819,358	$2,534	$2,886
Population Subgroup	**Consumers**	**FY 2023 Expenditures**	**FY 2023 Per Person Cost**	**CY 2025 Per Person Cost (Projected)**
MediKan	432	$5,464,895	$12,650	$13,291
SSI-Blind and Disabled (Non-Dual) Capitation Payments	28,805	$539,752,775	$18,738	$19,688

Note: More recent experience (FY 2023) was used for adults with a disability and adults age 65 and older since those enrollees are less impacted by the enrollment policies during the COVID-19 pandemic.

Source: Kansas Health Institute analysis of FY 2020 and FY 2023 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 would be 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 at or below 38 percent FPL and pregnant women with family income less than or equal to 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 adults age 19 to 64 with family income less than or equal to 138 percent FPL who are not pregnant, enrolled in Medicare, or part of a mandatory Medicaid coverage group. Parents or caretakers with family income less than or equal to 38 percent FPL and pregnant women with family income less than or equal to 171 percent

FPL would remain in the currently eligible group, and a lower federal match rate would be applied.

2. 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. Insured CHIP-eligible children are assumed to enroll at a lower rate of 15 percent, because their parents would not be eligible for expanded Medicaid.
3. Federal fiscal year (FFY) 2025 is the latest year that the Medicaid and CHIP FMAP has been published. The FFY 2025 FMAP was used for all years in the estimate – 2025 to 2034.

Figure 2. **Kansas Federal Medical Assistance Program Match Rates, FFY 2025**

Fiscal Year	Standard Medicaid	CHIP Enhanced	Newly Eligible
2025	61.87%	73.31%	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, 2024, through September 30, 2025 (2023).[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, 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 Kansas 2022 vital statistics, KHI calculated a 6.982 percent delivery rate for 32,884 live or still births to Kansas women age 20 to 44 divided by 471,010 women age 20 to 44. If 6.982 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 estimate assumes expansion would have a net neutral effect on state cost in the postpartum period, which was extended to 12 months in 2023, because the additional months would not change movement to the current eligibility group on a member's redetermination date. . A mixed FMAP with 54 percent of the standard Medicaid match rate (61.87 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 74.81 percent federal match for the estimated 2,353 newly eligible women who would become pregnant. However, potential cost could differ depending on how the state administers eligibility and capitation payments. See page 7, item 8, for the effect on the current eligibility category for pregnant women.
5. Expenditures for each population group were obtained from the Kansas Medical Assistance Report (MAR) for state FY 2023. FY 2020 per person cost was applied for children and adults age 19 to 64 without a disability. Because policies enacted in

[3] https://www.federalregister.gov/documents/2023/11/21/2023-25636/federal-financial-participation-in-state-assistance-expenditures-federal-matching-shares-for

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 to 64 with a disability or adults age 65 or older are based on FY 2023 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 costs were increased to account for inflation and enrollment changes from FY 2020 to CY 2025 or from FY 2023 to CY 2025 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 2025 to CY 2034). *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 to 18	Adults Age 19 to 64 Without a Disability	Adults Age 19 to 64 With a Disability	Adults Age 65 or Older
2021 to 2026	5.33%	6.16%	5.1%	4.1%
2027 to 2031	5.37 %	6.73%	5.1%	4.1%
2032 to 2036	6.01%	6.80%	5.1%	4.1%

Source: Kansas Health Institute analysis of population projections from Wichita State University's Center for Economic Development and Business Research and Congressional Budget Office's July 2023 Medicaid Baseline.

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 113 and 133 percent FPL were converted to the M-CHIP program – a Medicaid program for which the state receives the enhanced CHIP FMAP (73.31 percent). For children who are already enrolled, their per person cost was included in the FY 2023 MAR. The match rate and state costs were separately adjusted for the estimated 2,504 children with family income between 113 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 4.46 percent of the total expenditures multiplied by the expected state share of the total net cost – 30.0 percent. Administrative cost as a percent of total expenditures was based on the actual administrative cost (less the cost of Health Information Technology incentives and school-based administration) as a percentage of total Kansas Medicaid cost in the *FFY 2022 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 after the first year throughout the projection window.

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 of the Affordable Care Act (ACA). Expenditures for KanCare members enrolled in CHIP and those receiving assistance

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

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 (66.87 percent) to the projected state KanCare spending for qualifying currently enrolled members with the standard FMAP (61.87 percent) applied over two years (2025 and 2026). *Figure 4* shows the projected spending for current enrollees eligible for the FMAP increase. The applicable growth rate from *Figure 3* was applied to project current spending forward to 2025.

The COVID-19 PHE ended in May 2023. Enrollment is expected to return to pre-COVID-19 levels after the unwinding ends. This analysis assumes all members who are no longer eligible would be disenrolled by Jan. 1, 2025.

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
2025	$1,890,569,263	$1,642,519,170	$248,050,092
2026	$1,985,574,587	$1,725,057,851	$260,516,736
Total	$3,876,143,849	$3,367,577,021	$508,566,828

Source: Kansas Health Institute analysis of FY 2023 and FY 2024 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. An annual hospital Medicaid expansion support surcharge for hospitals that will be implemented starting in CY 2027 was included in the new revenue calculations. The new revenue will be $233 per Medicaid expansion enrollee. This total surcharge will not exceed $35 million for any calendar year, and no surcharge fee will be imposed for any period after the FMAP becomes lower than 90 percent. KHI estimates that this surcharge will be about $25 million per calendar year for the estimated 102,951 new adults and the 7,097 current KanCare members that would become eligible in the new expansion group, totaling about 110,000 enrollees.
4. 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.
5. CHIP premiums collected were calculated assuming that children from 167 to 191 percent FPL pay a $20 monthly premium; 192 to 218 percent FPL pay a $30 monthly premium; and 255 percent FPL and above pay a $50 monthly premium. The state share was calculated using the CHIP match rate.
6. MediKan is currently 100 percent state-funded with limited benefits, and all 432 consumers in FY 2023 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 2023, the MediKan consumer average per person annual cost was $12,650, which was entirely the responsibility of the state. Assuming expansion, KHI estimated a cost of $16,890 per person in CY 2023, of which 10 percent ($1,689 per person) would be the responsibility of the state.

7. 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 2023, there were 1,134 non-dual Medically Needy beneficiaries with household income less than or equal to 138 percent FPL. Under current Medicaid, they are responsible for a spenddown amount similar to deductibles, and Medicaid pays the rest (federal share for CY 2023 is 61.87 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 2023, 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 spenddown amounts were paid, which may have impacted the savings in this estimate.
8. The current PLE Pregnant Women eligibility category of the Medicaid program covers pregnant women with family income at or below 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 enrollees who later became pregnant were enrolled in Medicaid prior to becoming pregnant (see discussion of timing on page 4). However, some women with family income less than or equal to 38 percent FPL with a child 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 new enrollees who were already pregnant would not qualify for the new expansion group, and the state would receive a regular match rate for their costs. For CY 2025, the first year of expansion, KHI estimated that two-thirds of the months of pregnancy for women who would have enrolled in Medicaid, whether 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 Jan. 1, 2025, would likely enroll in the newly eligible group. After the initial year of implementation, for CY 2026 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. The estimate assumes expansion would have a net neutral effect on state cost in the postpartum period, which was extended to 12 months in 2022, because the additional months would not change movement to the current eligibility group on a member's redetermination date. Potential savings could differ depending on how the state administers eligibility and capitation payments.

9. 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.
10. Inmate medical costs for inpatient stays at least 24 hours was provided by the Kansas Department of Corrections. KDOC estimated $2.7 million in net savings to the state if Medicaid covers more inmate medical costs for inpatient stays of at least 24 hours based on 2022 data.. KHI assumes this $2.7 million in net savings in CY 2025 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.
11. 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

The estimate includes three adjustments to the Census data that allow closer alignment 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 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, whereas 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" definition would combine the income from these three adult

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

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. Due to the 2022 ACS being administered during continuous coverage, adjustments were made to the number of adults and children who likely would be uninsured after the end of unwinding based on administrative data of individuals disenrolled during the first eight months of unwinding for adults and first nine months for children. A 1.5 multiplier was applied to the adult number to account for the entire period of unwinding. Without those adjustments, the number of uninsured could have been understated. KHI estimates that 12,819 adults disenrolled from Medicaid would likely enroll under expansion. For children, a 16 percent churn rate was applied to the total impacted number of 50,548 children that were estimated to be impacted by unwinding. After accounting for take up rates, an estimated 5,913 children who lost eligibility would be likely to re-enroll in Medicaid if expanded (See *Figure 6,* page 10).
3. 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 respondents 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. Undocumented immigrants are defined as those who enter the United States without inspection or who overstay a valid visa. The percentage of undocumented immigrants with private coverage (1.30 percent)and who were uninsured (12.76 percent) were removed from the numbers used to calculate the estimated number of new enrollees. This percentage of undocumented immigrants was not applied to estimate the characteristics of those likely to enroll (See *Figure 6*, page 10).

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

Source of Coverage	Undocumented Immigrants	All Kansans	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%

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

Figure 6 shows the impact of adjusting for immigration status and the impact of unwinding.

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

Population Group	2022 1-year ACS IPUMS USA (Health Insurance Unit)	2022 1-year ACS IPUMS USA, Immigration Status and Unwinding Adjustment
Newly Eligible Adults	98,457	102,951
Currently Eligible Adults	3,781	3,498
Currently Eligible Children	14,963	45,447
Total	117,202	151,897

Source: Kansas Health Institute analysis of 2022 IPUMS USA 1-year American Community Survey Public Use Microdata Sample, SHADAC's Health Insurance Unit (HIU) definition of family, Kansas Department of Health and Environment Administrative Data, 2023.

Enrollment and Spending Comparison

If Kansas were to expand Medicaid up to the extent allowed by the ACA, this analysis concludes that 151,898 additional Kansans would newly enroll, representing a 36.6 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* (page 10) 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 $171,222,488 over 10 years, or by 0.07 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 $25,008,027,680 over the 10 years FY 2025 to FY 2034. *Figure 8* presents the state share of Medicaid spending for all Kansas Medicaid programs from FY 2016 to 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.