

Date: June 3, 2025

Re: Technical notes regarding the KHI Issue Brief, *Medicaid Expansion Estimates: Enrollment, Costs and Characteristics of the Expansion Population*, KHI/25-49, June 3, 2025.

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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, 2026. 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

- 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 subsets of the expansion population (e.g., individuals who are incarcerated), and how would those affect state expenditures (net cost)?
- What are recent state policy considerations around Medicaid that could impact the expansion population? What are “pay for” provisions based on the latest expansion proposal and how will it impact overall costs of expansion (e.g., drug rebate costs)?
- 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 impacts of potential federal policy changes and incentives?

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

Data Sources

- American Community Survey 2023 1-year Public Use Microdata Sample IPUMS USA, University of Minnesota, www.ipums.org.

¹The 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.

- 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>).
- Medical Assistance Report for state fiscal year (FY) 2024,² supplemented by data from the Kansas Department of Health and Environment (KDHE) and the Kansas Department of Corrections.
- 2025 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 and Medicaid Services.
- 2023 Kansas Vital Statistics Annual Summary Full Report.
- Population and 5-Year Growth by Age Group by Wichita State University Center for Economic Development and Business Research (CEDBR).
- Centers for Medicare and Medicaid Services (CMS) 2023-2024 Marketplace Open Enrollment Period (OEP) Public Use Files.

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 2023 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 9. 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 public health emergency (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 from 2016-2024.
3. Cost information was obtained from the FY 2024 Medical Assistance Report for currently eligible parents or caretakers and children, supplemented by additional information provided by KDHE. FY 2020 data is used for the following selected groups because more recent years were significantly affected by the COVID-19 public health emergency and Medicaid unwinding, which distorted enrollment and cost patterns. Since these pandemic-related impacts continued through FY 2024, KHI used FY 2020 as a more stable baseline for analysis. With the end of the public health emergency and completion of the unwinding process in 2024, KHI anticipates returning to the use of the most recent available data in future analyses. 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 the Children's Health Insurance Program (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 2024 for MediKan was \$12,717 and the cost for SSI and Disabled (Non-Dual) Capitation Payments was \$21,828. Assumptions about cost growth are described on page 3.

² <https://www.kancare.ks.gov/data-policy/spending-enrollment-reports>

4. Gross cost was estimated for calendar year (CY) 2026 by trending the FY 2024 or FY 2025 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 2026 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.
6. Estimates of characteristics associated with meeting work requirements are primarily based on analysis of the 2023 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.
7. Marketplace enrollment analysis in the brief reflects data from 2023 to align with the data year for the enrollment estimates data. However, enrollment among Kansans with incomes below 138 percent of FPL increased significantly in 2024, rising from 38,627 in 2023 to 68,522 – a nearly twofold increase. This growth was partly driven by enhanced federal subsidies available to individuals with incomes between 100-150% FPL. These subsidies are currently set to expire in 2025, which could lead to some enrollees under 138 percent FPL losing coverage or transitioning to Medicaid, should it be expanded. If the subsidies do expire, the number of marketplace enrollees under 138 percent FPL is expected to decline. Detailed data for 2025 marketplace enrollment were not available at the time this analysis was completed.

Figure 1. Actual and Projected Cost Per Medicaid Enrollee, FY 2020, FY 2024 and CY 2026

Population Subgroup	Consumers	FY 2020 Expenditures	FY 2020 Per Person Cost	CY 2026 Per Person Cost (Projected)
Parents in TAF	36,533	\$247,491,286	}	\$6,873
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	\$13,083
Children in TAF and PLE	184,439	\$757,076,161	\$3,543	\$4,027
CHIP	47,613	\$118,594,587	\$2,491	\$2,831
M-CHIP	14,136	\$35,819,358	\$2,534	\$2,880
Population Subgroup	Consumers	FY 2024 Expenditures	FY 2024 Per Person Cost	CY 2026 Per Person Cost (Projected)
MediKan	471	\$5,989,614	\$12,717	\$13,199
SSI-Blind and Disabled (Non-Dual) Capitation Payments	27,085	\$591,220,216	\$21,828	\$22,655

Note: More recent experience (FY 2024) was used for adults with a disability and adults age 65 and older since those enrollees were less impacted by the enrollment policies during the COVID-19 pandemic.

Source: Kansas Health Institute analysis of FY 2020 and FY 2024 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) 2026 is the latest year that the Medicaid and CHIP FMAP has been published. The FFY 2026 FMAP was used for all years in the estimate – 2026 to 2035.

Figure 2. Kansas Federal Medical Assistance Program Match Rates, FFY 2026

Fiscal Year	Standard Medicaid	CHIP Enhanced	Newly Eligible
2026	60.67%	72.47%	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 Oct. 1, 2025, through Sept. 30, 2026 (2024).

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 2024 vital statistics, KHI calculated a 6.918 percent delivery rate for 32,587 live or still births to Kansas women age 20 to 44 divided by 471,058 women age 20 to 44. If 6.918 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 (60.67 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 1,932 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 7, 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 2024. FY 2020 per person cost was applied for children and adults age 19 to 64 without a disability. FY 2020 data is used for this group because COVID-19 and Medicaid unwinding distorted enrollment and costs in later years. With the public health emergency and unwinding ending in 2024, KHI expects to return to using the most recent data in future analyses. Because policies 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 to 64 with a disability or adults age 65 or older are based on FY 2024 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 2026 or from FY 2024 to CY 2026 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 2026 to CY 2035). *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
2022 to 2027	5.33%	6.16%	5.1%	4.1%
2028 to 2032	5.37 %	6.73%	5.1%	4.1%
2033 to 2037	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. Children enrolled in CHIP tend to be older and with lower average expenditures than children in Medicaid. 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 2024 MAR. The match rate and state costs were separately adjusted for the estimated 1,700 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 3.57 percent of the total expenditures multiplied by the expected state share of the total net cost – 33.7 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 2023*

*Medicaid Financial Management Data.*³ 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 costs are 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 ACA. Expenditures for 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 (65.67 percent) to the projected state KanCare spending for qualifying currently enrolled members with the standard FMAP (60.67 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 ended. This analysis assumes all members who are no longer eligible were 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
2026	\$2,094,707,206	\$1,828,810,257	\$265,896,949
2027	\$2,178,750,630	\$1,902,188,508	\$276,562,122
Total	\$3,876,143,849	\$3,730,998,765	\$542,459,070

Source: Kansas Health Institute analysis of FY 2024 and FY 2025 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.

³<https://www.medicaid.gov/medicaid/finance/state-expenditure-reporting/expenditure-reports/index.html>

4. 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 219 to 255 percent FPL 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 471 consumers in FY 2024 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 2024, the MediKan consumer average per person annual cost was \$12,717, which was entirely the responsibility of the state. Assuming expansion, KHI estimated a cost of \$16,890 per person in CY 2024, of which 10 percent (\$1,689 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 2024, there were 1,204 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 2024 is 60.67 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 2024, 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.
7. 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 2026, 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, 2026, would likely enroll in the newly eligible group. After the initial year of implementation, for CY 2027 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.

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. Inmate medical costs for inpatient stays at least 24 hours was provided by the Kansas Department of Corrections (KDOC). KDOC estimated \$3.7 million in net savings to the state if Medicaid covers more inmate medical costs for inpatient stays of at least 24 hours based on 2024 data. KHI assumes this \$3.7 million in net savings in CY 2026 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. Potential policy scenarios related to changes in how Medicaid expansion is funded at the federal level were determined through conducting an environmental scan of congressional documents and national-level sources. Analysis was conducted for two potential policy options, including
 - a. Eliminating the ARPA incentive for states that newly expand Medicaid — an additional 5 percentage points on their regular FMAP for two years. If Kansas expands in 2026, it would receive an estimated \$542 million from this incentive, equivalent to about nine years of net state expansion costs. If Congress were to eliminate the ARPA incentive, Kansas and other non-expansion states would lose access to this enhanced federal funding.
 - b. Reducing the FMAP for the expansion population (currently 90 percent) to the state’s 2026 regular match rate (60.67 percent).

Figure 5 presents the estimated state net cost of expansion for Kansas from 2026 to 2035 under four potential federal policy scenarios. Using the projected state costs under current law, analysis was performed based on four scenarios that could result from the two potential policy changes described above.

Figure 5. Kansas State Costs of Expansion Under Select Federal Policy Scenarios, 2026 to 2035, by Calendar Year

Federal Policy Scenario	State Net Cost of Expansion, 2026-2035
State net cost of expansion with 90 percent federal match rate and ARPA incentive (current law)	\$75 million
With 90 percent federal match rate and no ARPA incentive	\$617 million
With 60.67 percent (regular) federal match rate and ARPA incentive	\$2.645 billion
With 60.67 percent (regular) federal match rate and no ARPA incentive	\$3.188 billion

Source: Kansas Health Institute analysis of IPUMS USA 2023 American Community Survey data, U.S. House of Representatives Reconciliation Options, January 2024, Fiscal Year 2024 and 2025 Medical Assistance Reports from the Kansas Department of Health and Environment, and the Kansas Department of Corrections.

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.⁴ The "household" definition 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. Due to the 2023 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. Without those adjustments, the number of uninsured could have been understated. KHI estimates that 1,782 adults disenrolled from Medicaid would likely enroll under expansion. For children, a 16 percent churn rate was applied to the total impacted number of 9,061 children that were estimated to be impacted by unwinding. After accounting for take up rates, an estimated 1,020 children who lost eligibility would be likely to re-enroll in Medicaid if expanded (See *Figure 7*, 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 6* (page 10) 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

⁴ https://www.shadac.org/sites/default/files/publications/HIU%20brief_2020.pdf

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 7*).

Figure 6. 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 7 shows the impact of adjusting for immigration status and the impact of unwinding.

Figure 7. Impact of Methodology Adjustments on New Enrollment After Medicaid Expansion

Population Group	2023 1-year ACS IPUMS USA (Health Insurance Unit)	2023 1-year ACS IPUMS USA, Immigration Status and Unwinding Adjustment
Newly Eligible Adults	85,5886	80,388
Currently Eligible Adults	3,079	2,819
Currently Eligible Children	14,490	36,950
Total	103,158	120,157

Source: Kansas Health Institute analysis of 2023 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, 2024

Enrollment and Spending Comparison

If Kansas were to expand Medicaid up to the extent allowed by the ACA, this analysis concludes that 120,157 additional Kansans would newly enroll, representing a 29.2 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 8* presents the average monthly enrollment in all Kansas Medicaid programs from FY 2018-FY 2020.

Figure 8. 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 \$74,966,262 over 10 years, or by 0.03 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 \$25,947,361,100 over the 10 years FY 2026 to FY 2035. *Figure 9* (page 11) presents the state

share of Medicaid spending for all Kansas Medicaid programs from FY 2016 to FY 2020 and the linear trend. The enhanced federal Medicaid matching funds provided during the COVID-19 pandemic under the Consolidated Appropriations Act were phased out as of December 2023. As a result, future estimates will reflect the most current available data on state Medicaid spending, accounting for the reduction in federal support.

Figure 9. 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.

