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Establishing the KanCare Bridge to a Healthy Kansas

House Bill 2064

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To improve the health of all Kansans by supporting effective policymaking, engaging at the state and community levels, and providing nonpartisan, actionable and evidence-based information.

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Chairman Hawkins and Members of the Committee:

Good afternoon. My name is Kari Bruffett, director of policy at the Kansas Health Institute (KHI). KHI is a nonprofit, nonpartisan health policy and research organization based here in Topeka, founded in 1995 with a multiyear grant from the Kansas Health Foundation.

The Kansas Health Institute does not take positions on legislation, and therefore we are not here to speak either for or against HB 2064. To help inform the committee's discussion on this issue, KHI is presenting as a neutral conferee to provide the committee with material KHI has developed to describe the potential effects of a decision related to Medicaid expansion in Kansas.

Included with my testimony and available online at www.khi.org are the following publications produced by KHI surrounding this topic:

1) **Health Insurance in Kansas 2015:** A preview of the Kansas population coverage profile from the upcoming Annual Insurance Update.
2) **Projected Costs and Enrollment of Medicaid Expansion in Kansas*: Updated Numbers:*** A November 2016 issue brief that revised KHI's 2012 estimate to reflect changes that have occurred since the original estimate.
3) **The Future of Health Care Reform: *What changes will November's election bring?:*** An October 2016 issue brief that summarized health reform proposals from then-candidates Donald Trump and Hillary Clinton, as well as the U.S. House Republican plan "A Better Way."
4) **Interpreting Early Medicaid Expansion Results: *How have states been impacted so far?:*** In September 2016, KHI released a brief discussing the interpretation of expansion results in states that expanded Medicaid under the Affordable Care Act (ACA) starting in January 2014. The brief described the types of models that had been approved, how states measure effects, and what to watch for in the future.

There are many issues that the committee should consider when looking at the implications of expanding Medicaid to additional low-income adults. Today's testimony is focused primarily on the update of KHI's expansion estimate, but it is important to note that the estimate is not a fiscal note for House Bill 2064; it instead describes the estimated enrollment and direct costs of expansion. It assumes a straightforward expansion of the existing KanCare model rather than any of the alternative models adopted in some states that include cost-sharing or premium assistance for purchasing private coverage.

It does not include offsets from drug rebates or managed care privilege fees, nor does it include any effects on administrative costs. Neither the 2012 estimate nor the update assessed offsetting savings that may be achieved if Medicaid were expanded – for example, savings related to the potential elimination of optional eligibility categories or from state-funded programs (e.g., mental health and safety net expenditures).

What we hope it does is help the committee understand the key assumptions that go into any estimate of Medicaid expansion. We will walk through some of those assumptions and explain how they might vary, which can help us understand why some expansion states have had experiences that differed from expectations.

But before we get into the estimate, we want to share with you the profile of the 2015 Kansas population, broken out by type of coverage. The data for this infographic comes from the 2015 American Community Survey (ACS) conducted by the U.S. Census Bureau and released in the fall of 2016.

The chart shows the estimated coverage status, by insurance type, for every Kansan who is not in an institution. It further helps us understand who the nearly 264,000 uninsured Kansans are – how many are children, adults 19-64, or seniors, and how many likely are eligible for public programs. It also gives us an idea of how many uninsured adults in 2015 would have qualified for Medicaid if it had been expanded in Kansas.

The same data was used to develop KHI's Medicaid expansion update, starting with a very similar methodology, then applying assumptions based upon academic literature and experience in Kansas and states that had previously expanded their programs. The result suggests that raising eligibility for adults to 138 percent of the federal poverty level ($33,600 for a family of four in 2017) would cover an additional 98,000 low-income adults, including almost 62,000 who are currently uninsured.

Under the current terms of the ACA, if Kansas expands its program, the federal government would pay 94 percent of the cost of newly eligible enrollees in 2018, 93 percent in 2019, then 90 percent in 2020 and thereafter.

The children of these newly eligible adults, as well as other currently eligible but unenrolled children, might be more likely to enroll in Medicaid through a so-called **"woodwork"** or **"welcome mat"** effect. The health care costs for these newly enrolled children would be subject to the regular state Medicaid or Children's Health Insurance Program (CHIP) match rate. The updated KHI projection estimates that nearly 54,000 children would newly enroll in Medicaid or CHIP if Kansas expanded Medicaid eligibility for adults.

The combined estimated effect of expansion on enrollment would be 152,000 new enrollees in KanCare, a program that currently has around 450,000 enrollees. The costs for newly enrolled--but currently eligible—members at the regular matching rate, plus the reduction in the federal share of Medicaid expansion costs over time, are the direct state costs of expansion. In November, KHI projected those costs to start at $68 million in 2018 and nearly double by the seventh year (2024). Starting in 2018, state costs were estimated at about $730 million over seven years.

Some of the key assumptions that any estimate must address include the following:

1) **How many adults age 19-64 would be newly eligible for Medicaid if expanded, and how many of them might enroll?**
    a. The 2015 ACS indicates there were about 303,000 Kansas adults who would be eligible for Medicaid if it expanded. Our estimate suggests that about 98,000 of them would enroll in Medicaid if expanded, derived from the following groups.
    b. Of those 303,000 adults, about 215,000 had insurance, including more than 68,000 already in Medicaid. From the 147,000 with other insurance, research and evidence from other states suggests that about a quarter (25 percent) would shift to Medicaid if it were expanded, resulting in about 37,000 new Medicaid enrollees. This is what is sometimes called the **"crowd-out"** effect, and the assumption of **"crowd-out"** is one of the major differences among expansion estimates.
    c. Among uninsured adults under 138 percent of FPL, about 10,000 were parents with household incomes less than 38 percent of FPL, most of whom likely were already eligible for Medicaid but not enrolled. Research and evidence from other states suggests that about 40 percent would enroll because of increased enrollment efforts if Medicaid were expanded, resulting in about 4,000 new enrollees. That is what is called **"woodwork"** or **"welcome mat"** effect, as discussed earlier. Like **"crowd-out"**, assumptions around the **"woodwork effect"** can drive differences in estimates.
    d. Around 78,000 uninsured adults under 138 percent of FPL were not currently eligible, either because they had incomes above 38 percent of FPL, or were not parents. Research and evidence from other states suggests that about 74 percent of those Kansans would enroll in Medicaid if expanded, resulting in about 58,000 new enrollees. The newly eligible **"take-up rate"** assumption is another variable that can lead to differences among estimates and drive differences between estimates and actual experience.

2) **How many children who are already eligible might enroll if Medicaid expanded?**
    a. Children are already eligible up to 243 percent of FPL through either Medicaid or CHIP, so there would be no newly eligible children as a result of Medicaid expansion. Still, an estimated 54,000 children under 243 percent of FPL would be expected to newly enroll in Medicaid under expansion, derived from the following groups. *(Note: The Supreme Court ruling on Medicaid expansion did not make expansion for children optional, so in Kansas and other states, some children previously eligible for CHIP are now eligible for Medicaid. Some of these children are in the so-called M-CHIP group, or children who are technically Medicaid eligible but for whom the state receives the CHIP matching rate.)*
    b. There are about 139,000 children under 243 percent of FPL who already have some kind of insurance other than Medicaid or CHIP. Research and evidence from other states suggests that about 25 percent of them would shift from private insurance to Medicaid under an expansion. This **"crowd-out"** effect would result in about 35,000 newly enrolled children.
    c. There are about 29,000 children under 243 percent of FPL who are already eligible but not enrolled in Medicaid or CHIP. Research and evidence from other states suggests that 65 percent of these children would enroll in Medicaid if expanded. This **"woodwork"** or **"welcome mat"** effect would result in about 19,000 additional newly enrolled children.

3) **How much would the federal government contribute?**
    a. The federal share of the newly eligible adults, under the ACA, started at 100 percent in 2014-2016 then steps down to 90 percent by 2020.
    b. The federal share of already eligible (but unenrolled) adults and children in the Medicaid program will vary each year according to the Federal Medical Assistance Program (FMAP) match rate. KHI's estimate uses the Federal Fiscal Year (FFY) 2018 FMAP standard rate of 54.74 percent federal share for already eligible Medicaid enrollees, even though FMAP changes annually. Making different assumptions about FMAP over time would change any estimate.
    c. The federal share for the CHIP program was enhanced temporarily by the ACA; the KHI estimate assumes the enhanced FFY 2018 federal share (91.32 percent for purposes of the estimate) will expire Sept. 30, 2019, per the ACA, and revert to previous levels (68.32 percent in the estimate) thereafter. Some other estimates assume that the enhanced match rate would continue, which if so would decrease state costs in the KHI estimate by nearly $100 million. KHI also assumed that CHIP would not be allowed to sunset; the current federal authorizing legislation expires Sept. 30, 2017.
    d. Despite discussions in Washington D.C. around possible ACA repeal and the potential effects on expansion, or the possibility of **"block grants"** for Medicaid, the KHI estimate used current law to estimate the federal share of expansion.

4) **What are the costs per person for new enrollees?**
    a. The 2016 KHI estimate used costs per enrollee for similar populations in the current KanCare program as a basis for the estimated annual costs per new enrollee in expansion. Actual annual capitation costs for non-disabled adults age 19-64 in KanCare were $5,569 in state fiscal year 2016. The per member cost for non-disabled children in KanCare was $2,261 in FY 2016. The KHI estimate used the FY 2016 KanCare costs and applied a 2.5 percent annual inflation factor after 2018. Using the 2015 national average annual per member cost of $6,366 for newly eligible adults in expansion-state managed care programs, as reported by the Centers for Medicare and Medicaid Services, would have resulted in a higher estimate.

The nature of all estimates is that they are very unlikely to be precisely accurate, particularly as more assumptions must be used. KHI's analysis of experience in other states that expanded Medicaid has so far focused on enrollment and costs. In general, expansion states have seen higher-than-expected Medicaid enrollment, but cost results have been mixed.

Other organizations researching the experience of states that have expanded Medicaid have looked at outcomes related to behavioral health care access, the use of primary care, emergency room utilization, uncompensated care,

employment opportunities for beneficiaries (both obtaining and retaining jobs), financial security, and the identification of previously undiagnosed medical conditions, among other outcomes.

If you have any questions regarding the information included with my testimony, or if we could be of further assistance in informing this issue, please do not hesitate to contact KHI at 785-233-5443 or email me at kbruffett@khi.org. Thank you, and I am happy to stand for questions at the appropriate time.