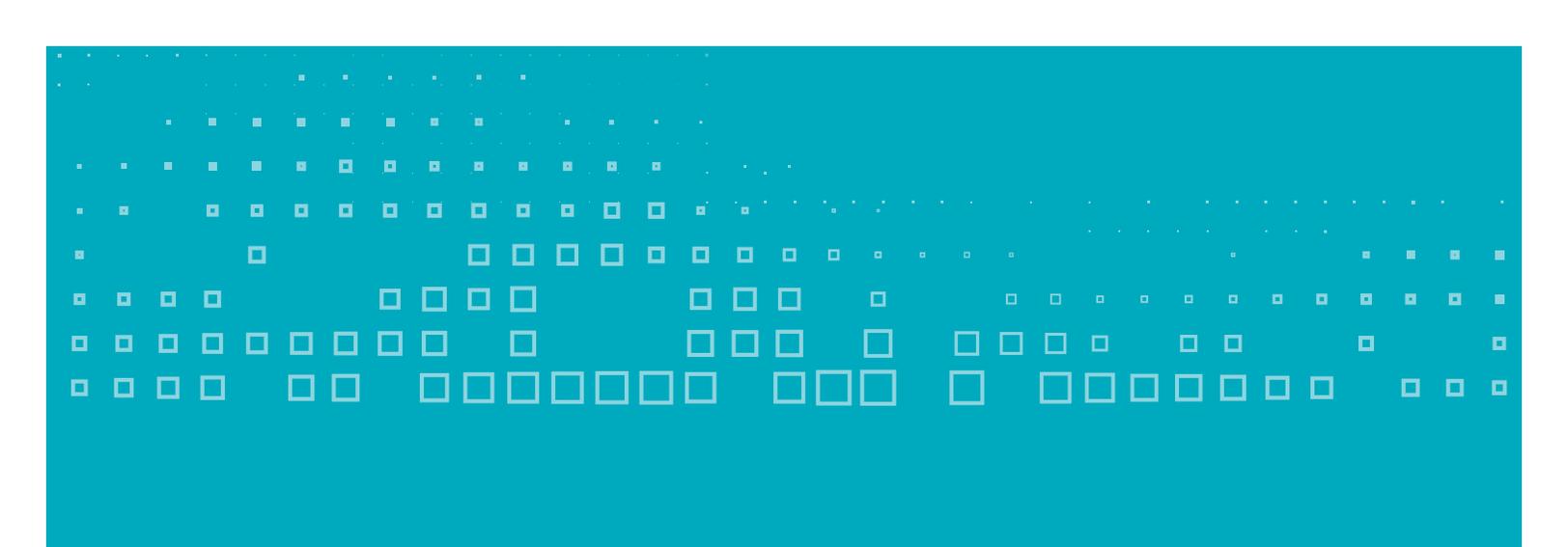


DECEMBER 2015

Impact of Medicaid Expansion on the Kansas State Budget

Prepared by Manatt Health for the Kansas
Grantmakers in Health

Deborah Bachrach, Partner
Cindy Mann, Partner
Kier Wallis, Senior Manager



This work was prepared for the Kansas Grantmakers in Health and was commissioned by the Sunflower Foundation.

About Manatt Health

Manatt, Phelps & Phillips, LLP is a preeminent law and consulting firm, combining legal excellence, public policy acumen, and industry savvy. Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is a fully integrated, multidisciplinary legal, regulatory, advocacy and strategic business advisory healthcare practice. Manatt has one of the leading health strategy practices in the country, with more than 80 professionals (consultants, policy advisors, project managers, analysts and healthcare attorneys) providing analysis, knowledge and expertise to a wide range of healthcare clients including community health centers, academic medical centers, healthcare systems, mental health agencies and other institutional providers; post-acute care providers; national and regional payers; healthcare trade associations; philanthropic foundations and state and federal agencies and policymakers.

Manatt's expertise and client engagements involve all aspects of healthcare, including delivery systems, processes, public and private coverage, financing and payment, and health information technology. Manatt maintains an extensive federal and state policy tracking system whereby we keep current on emerging policy developments related to Medicaid and the Affordable Care Act at both the federal and state levels.

For more information, please contact Deborah Bachrach at DBachrach@manatt.com or 212-790-4594, or Cindy Mann at CMann@manatt.com or 202-585-6572, or Kier Wallis at KWallis@manatt.com or 415-291-7414.

Key Findings

The cost of Medicaid expansion in Kansas is projected to average just over \$50 million annually between 2016 and 2020. Based on publicly available data and the experiences of states that

expanded in 2014, it appears that Kansas should be able to generate sufficient savings and revenue gains to cover the costs of expansion during this time period – in other words,

expansion should be budget neutral. Expansion, in fact, may generate savings and new revenue in excess of the costs of expansion.

Background

In 2012, the United States Supreme Court ruled the provisions of the Affordable Care Act (ACA) that required states to expand their Medicaid programs could not be enforced, making a state's decision to expand voluntary. However, the financial incentives for states to expand coverage remain. As of November 2015, 30 states and the District of Columbia have expanded their Medicaid programs. To date, Kansas has not and accordingly the State is unable to tap into enhanced federal matching funds. These funds are available to support Medicaid coverage for "childless

adults" with incomes below 138% of the Federal Poverty Level (FPL) (\$16,243 per year); today, with limited exception, "childless adults" in Kansas are not eligible for Medicaid unless they are pregnant, disabled or over 65. Expansion would also extend Medicaid to parents with incomes above 33% of the FPL (\$6,630 per year for a family of three, Kansas' current eligibility level for parents) and below 138% of the FPL (\$27,724 per year for a family of three). The vast majority of adults who would gain coverage are in working families.¹

This paper reviews the implications of Medicaid expansion for the Kansas State budget, drawing on the State's fiscal impact analysis, publicly available data on Kansas Medicaid costs and the experiences of states that expanded in 2014.² Because the State's analysis did not consider where expansion would generate savings and new revenue, we focus particularly on these savings and revenue opportunities. This paper does not consider the broader economic and employment consequences of the infusion of federal funds.

The Impact of Medicaid Expansion on the Kansas State Budget

We started our review by analyzing the cost estimates prepared by the Kansas Division of the Budget (Fiscal Note: House Bill (HB) 2319)³ based on work done by AON Consulting. The Fiscal Note's estimates include costs attributable to covering three different populations: (1) newly eligible (expansion) adults; (2) people who were previously eligible but not enrolled in Medicaid (often referred to as the woodwork effect); and (3) individuals on the State's Home and Community Based Services

(HCBS) waiting lists. For the five-year period from 2016 to 2020, the total State costs of these three population groups is estimated to be \$790 million. Of this amount, \$524 million relates to the cost of covering individuals on the HCBS waiting lists. These costs, however, have no bearing on State expansion costs; expansion does not require the State to reduce or eliminate the HCBS waiting lists. If the HCBS costs are removed from the Division of the Budget's estimate, the five-year cost of

expansion would be about \$264 million⁴ or about \$53 million a year through 2020. These costs arise because beginning in 2017, the State would assume a portion of the cost of the newly eligible adults; the State share never rises above 10% (see Table 1).

Notably, early expansion states have generated significant savings as well as new revenue that will cover most, if not all, of the costs of the program for several years after the federal share drops below 100%.

Table 1. Enhanced Federal Matching Rate for Newly Eligibles Up to 138% of the FPL

Year	Share of Costs for the Expansion	
	State Share	Federal Share
2014	0%	100%
2015	0%	100%
2016	0%	100%
2017	5%	95%
2018	6%	94%
2019	7%	93%
2020+	10%	90%

Savings and Revenue Opportunities for Kansas

In the balance of this paper, we identify the areas where early expansion states saw savings or new revenue and suggest where Kansas might also see savings and new revenue sufficient to cover its cost of expansion. This is new information for Kansas; the Division of the Budget's Fiscal Note does not offset any of these savings and revenue opportunities against the projected cost of expansion.

Savings Opportunities: Replacing State General Funds with Federal Medicaid Funds.⁵

Kansas uses State general funds to support health care services for uninsured individuals. With expansion, many of these individuals will gain coverage, and the State will be able to fund the services with federal rather than State funds. Potential areas of savings follow.

- **Mental Health and Substance Abuse.** In State fiscal year (SFY) 2014, Kansas spent \$69 million in State general funds for mental health programs and \$6.3 million for substance abuse treatment. Were the State to expand, many, perhaps most, of the individuals who rely on these programs would gain Medicaid coverage and the State could reduce its

spending accordingly. Savings generated from expansion could be used for reinvestment in the behavioral health delivery system or to fund the non-federal share of the costs of the expansion population.

- **Prisoners' Inpatient Care.** According to an analysis by the Pew Charitable Trusts and the MacArthur Foundation, Kansas spent nearly \$47 million on prisoner health care in 2011, 20% of which (or, just over \$9 million) is estimated to be on inpatient care.⁶ Medicaid will cover the inpatient costs of prisoners who are eligible for Medicaid (other health care costs are not covered by Medicaid during incarceration). With expansion, the vast majority of inmates could qualify for Medicaid, and the State could substitute federal Medicaid funds for State general funds now spent on inpatient care. In addition, states that have expanded Medicaid are able to immediately enroll inmates leaving prison in Medicaid, and these individuals (many of whom have ongoing behavioral health needs) are thereby able to secure the services, care management and medications they need.

A large body of research conducted prior to the ACA suggests that such efforts will reduce state and local criminal justice costs as well as costs related to emergency department visits and hospitalizations.⁷

- **MediKan.** Using State general fund dollars, Kansas spent over \$4.9 million in SFY 2015 to provide medical services to individuals receiving General Assistance who do not now qualify for Medicaid. Were the State to expand, these patients would be eligible for Medicaid and the State appropriation would no longer be needed.
- **Uncompensated Care.** To support infrastructure and uncompensated care costs of Federally Qualified Health Centers, Rural Health Centers and Community Mental Health Centers, the State spent \$28.9 million in State general fund dollars in SFY 2014. Some of this support would still be needed, but this spending could decrease in the context of a Medicaid expansion as these facilities would see their uncompensated care costs reduced.

***Savings Opportunities:
Accessing Enhanced Federal
Matching Funds.***⁸

Kansas can also expect to see savings as certain currently eligible Medicaid populations move from targeted eligibility categories with a regular federal matching rate of 56% to the new eligibility group, for whom the State may draw down the much higher enhanced match. Some areas where the State can expect to see savings are as follows:

- **Disabled Individuals.** In SFY 2015, Kansas spent approximately \$348 million on the blind and disabled Supplemental Security Income (SSI) population. With expansion, some low-income individuals who previously would have had to pursue a disability determination to qualify for Medicaid will be able to enroll in the new adult group based on income alone. As a result, early expansion states are reporting sharp drops in the number of individuals seeking disability determinations. In the near-term, the State would see savings from the reduced administrative costs of conducting disability determinations, and in the long term, from fewer individuals in the disability category. (When individuals are covered in the disability category, Kansas receives a regular

federal match (56%); when they are covered in the new adult category, Kansas will receive an enhanced match.) For example, in the first year after expansion, Oregon saw its disability determinations drop from 7,000 to 1,400. And, in Arkansas, spending on the SSI disabled group had been increasing annually by approximately 5%; after its Medicaid expansion, spending on this population remained flat, saving the State \$10.5 million. Arkansas expects greater savings in the out years.⁹

- **Medically Needy Spend Down Populations.** Kansas covers low-income parents and disabled individuals whose incomes or resources are above current Medicaid eligibility levels but who have high medical expenses; these individuals “spend down” to a medically needy threshold once they have incurred a certain amount of medical bills. Kansas receives a regular federal match for this program. In SFY 2015, total federal and State costs for this population was \$471 million; Kansas’ share was approximately \$201 million. Were the State to expand, many of these individuals¹⁰ would be able to gain coverage through the new adult group and the State share of the costs would drop from 44% to no more than

10%. (See Table 1 above.) State administrative costs would likewise drop.

- **Pregnant Women.** In SFY 2015, Kansas Medicaid spent \$61.5 million in State general funds on pregnant women with incomes up to 166% of the FPL. With expansion, women who become pregnant while enrolled in the new eligibility group (first time parents and parents with incomes above 33% of the FPL) will remain in the new eligibility group at least until their renewal. As long as they are in the new eligibility group, the State will be able to claim the enhanced federal match for the costs of the services they receive. Previously, they would have been covered throughout their pregnancy in the State’s pregnant women category where the State receives a regular match. For example, Arkansas spending on pregnant women dropped by 50% after it expanded Medicaid. Kansas would likewise save money in this category; however, it would be at a somewhat lower rate as the State’s current income eligibility level for parents (at 33% FPL) is higher than Arkansas’ was pre-expansion (17% FPL), meaning fewer women in Kansas will qualify as newly eligible adults.¹¹

Potential Revenue.

In addition to the savings opportunities identified above, expansion would generate additional revenue through **Kansas' HMO Privilege Fee.** The privilege fee equals 3.31%

of the total of all premiums and subscription charges and is expected to raise \$47 million in SFY 2016. Expansion would automatically increase the funds generated by the fee as total Medicaid premium revenues

would increase as newly eligible adults enroll in health plans that contract with Medicaid.

The Bottom Line

In sum, based on the Kansas Division of the Budget's Fiscal Note, it appears that between 2016 and 2020, the State's average annual cost of expansion would be about \$53 million. This paper identifies areas where the State could save money or generate new revenue as a result of expansion. Based on publicly available data and

the experiences of states that expanded in 2014, it appears that Kansas should be able to generate sufficient savings and revenue gains to cover the costs of expansion between 2016 and 2020 – in other words, expansion should be budget neutral. In fact, expansion may generate savings and new revenue in excess of the costs of expansion during

this period. Finally, the paper is narrow in scope; it focuses only on the direct budget implications of expansion. It does not consider the impact on the finances of hospitals or other providers, nor the ripple effect from hundreds of millions of federal dollars flowing into the State's economy.¹²

¹R. Garfield and J. Young, *How Does Gaining Coverage Affect People's Lives? Access, Utilization, and Financial Security among Newly Insured Adults*. Kaiser Family Foundation. June 2015.

²D. Bachrach, P. Boozang and D. Glanz, *States Expanding Medicaid See Significant Budget Savings and Revenue Gains*. Robert Wood Johnson Foundation and Manatt Health. April 2015.

³S. Sullivan, *Fiscal Note for HB 2319 by House Committee on Appropriations*. Kansas Division of the Budget. March 2015.

⁴The \$264 million cost estimate is likely somewhat high as it includes the costs of the woodwork effect. For the most part, the woodwork effect has already occurred in connection with the opening of the Marketplace, the simplification of the Medicaid application process and the outreach that began in 2014. In addition, the cost estimate includes the woodwork effect related to CHIP.

⁵Kansas State Budget numbers were drawn from The Governor's Budget Report, Volume 1, Fiscal Year 2016 and the Kansas Department of Health and Environment Division of Health Care Finance, Fiscal Year 2015 (July 2014 – June 2015), Kansas Medical Assistance Report.

⁶Pew Charitable Trusts and the MacArthur Foundation, *State Prison Health Care Spending*, July 2014.

⁷J. Guyer, D. Bachrach and N. Shine, *Medicaid Expansion and Criminal Justice Costs: Pre-Expansion Studies and Emerging Practices Point Toward Opportunities for States*. Robert Wood Johnson Foundation. November 2015.

⁸Kansas State Budget numbers were drawn the Kansas Department of Health and Environment Division of Health Care Finance, Fiscal Year 2015 (July 2014 – June 2015), Kansas Medical Assistance Report.

⁹Communication with Arkansas State official, October 20, 2015.

¹⁰Individuals in the medically needy category who are over 65 would not be eligible for coverage through the new adult group.

¹¹Communication with Arkansas State official, October 20, 2015.

¹²D. Bachrach, P. Boozang and M. Lipson, *The Impact of Medicaid Expansion on Uncompensated Care Costs: Early Results and Policy Implications for States*, Robert Wood Johnson Foundation and Manatt Health, June 2015; P. Cunningham, R. Garfield and R. Rudowitz, *How are Hospitals Faring under the Affordable Care Act? Early Experiences from Ascension Health*, Kaiser Family Foundation, April 2015; A. Ellison, *A State-by-State Breakdown of 57 Rural Hospital Closures*, Becker's Hospital Review. September 2015 (Close to 9% of rural hospitals are vulnerable to closure in expansion states, while nearly 17% are in non-expansion states.)

manatt

Albany

Los Angeles

New York

Orange County

Palo Alto

Sacramento

San Francisco

Washington, D.C.