Economic Costs to Kansas Due to State's Failure to Expand Medicaid

Davut Ayan, Donna K. Ginther, and David J.G. Slusky

University of Kansas

Abstract:

Kansas is one of only 12 states that have not expanded Medicaid under the Affordable Care Act, despite the federal government covering more than the cost with additional Biden administration incentives. This report compares Kansas to states that expanded Medicaid in 2014 as well as states that did not expand Medicaid as of 2019. Compared to other non-expansion states, Kansas Medicaid expenditures are increasing post-2014, private insurance companies are increasing expenditures, families are paying higher health insurance premiums, and hospitals and providers are administering more health care services and prescriptions. Kansas residents are paying for healthcare differently than consumers in other states as a result of their state government's decision to not expand Medicaid eligibility under the ACA. 1) Kansas taxpayers are paying federal taxes which helps fund other states' expansions, allowing those states to draw down a higher percentage of federal reimbursement; 2) their state taxes are funding the increased state spending on its privatized Medicaid program, or "managed care", despite a stated goal of reducing healthcare costs; 3) an increasingly higher proportion of their local mill levies are being used by counties to support their local or regional hospital districts; and 4) privately insured Kansans are paying higher health insurance premiums to cover providers' increasing service delivery volumes.

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Background

The 2010 Affordable Care Act (ACA) provided federal funding for states to expand their Medicaid programs to cover adults up to 138% of the federal poverty level. Unlike existing Medicaid programs, covered individuals would be eligible based on income alone, and so would not have to be disabled, pregnant, or under the age of 18. Compared to previous Medicaid programs, where the federal government paid 50-70% of the costs and the states paid the rest, this expansion would initially be fully funded by the federal government, with an eventual minimum 90% in federal funding. The Biden administration added an additional 5% of federal funding for two years, creating an even greater reimbursement incentive for states to expand Medicaid.

Per the Supreme Court's 2012 decision in *National Federation of Independent Business v. Sebelius*, states could decline to adopt this expansion and only forgo the new funding, keeping their existing Medicaid funding. As of February 2022, Kansas is one of the only 12 states that has not yet expanded Medicaid under the Affordable Care Act (Kaiser Family Foundation 2022), despite hundreds of academic studies demonstrating the benefits of expansion (Guth, Garfield, and Rudowitz 2020; Guth and Ammula 2021) and new additional Biden administration financial incentives (Rudowitz, Corallo, and Garfield 2021).

In addition to providing the opportunity to expand Medicaid, the Affordable Care Act hospitals were expected to lose supplementary funding for the costs of uncompensated care. Because expanded Medicaid eligibility was determined to be likely to increase the number of insured patients using hospital services, at least initially, the Affordable Care Act attempted to reduce uncompensated care payments and disproportionate share hospital (DSH) payments. DSH payments are sent to hospitals with a large number of Medicaid and uninsured patients (Williams and Guth 2021). Cuts to DSH payments are scheduled to take place in federal fiscal year 2024.

In what follows, we examine whether failure to expand Medicaid in Kansas resulted in unintended economic consequences to the state, its residents, and ultimately its taxpayers. Our findings show that Kansas is spending more state money on Medicaid relative to other states, even those that also declined to expand their Medicaid program eligibility. In addition, privately insured patients are spending more than those in other states. Growth in both the provision of health care services and also hospitalizations has increased more quickly in Kansas. The proportion of county mill levies allocated to support public hospitals has also increased.

Methodology

This study uses a variety of data sets to quantify the economic consequences of the Kansas government's decision to decline billions of federal dollars in funding since 2014. These data sets are described in detail in the data appendix. We use data on Medicaid expenditures from the Center for Medicaid & Medicare Services. Data on health care utilization and expenditures for privately insured patients is from the Health Care Cost Institute (HCCI). Data on hospital admissions and daily patient census comes from the American Hospital Association. Additional data on employee share of health care premiums by state comes from the Medical Expenditure Panel Survey. Data on county and hospital district mill levies was provided by the Kansas Department of Revenue. All expenditures are adjusted for inflation, and all measures are adjusted to be per capita. We compare Kansas to the averages of two other groups of states: the other states that have not expanded Medicaid, and the states that expanded Medicaid in 2014 per the ACA. States that expanded Medicaid early or late are dropped to enable a more straightforward comparison. Figure 1 is a map of state Medicaid expansion.[1] We use states' Medicaid expansion status as of 2019 for

[1] Medicaid expansion status of the states are determined using data from Kaiser Family Foundation (2022) and Kaestner et al. (2017), Slusky & Ginther (2021) and Miller et al. (2021). **Regular expansion states:** Arizona,

this analysis since that is the last year of available data for much of the analysis. Since 2019, all Kansas border states of Missouri, Nebraska and Oklahoma have fully expanded eligibility for the Medicaid programs. The dark teal-colored states are regular expanders and represent our Medicaid "treatment" group. The orange and beige colored states are non-expanders as of 2019 and represent our "control" group. We follow the literature and drop early and late expansion states from the analysis. In keeping with our analysis of other peer-reviewed literature on this topic, we isolated Kansas from the control group to demonstrate how Kansas policies and expenditures potentially differ from the expansion and other non-expansion states. This inclusion of comparison groups is crucial to understanding both what would *likely* have happened to Kansas if it *had* expanded Medicaid, and to determine whether Kansas *has had* similar expenditure experiences to other states that *did not* expand.

Arkansas, California, Colorado, Connecticut, Hawaii, Illinois, Iowa, Kentucky, Maryland, Michigan, Minnesota, Nevada, New Jersey, New Mexico, North Dakota, Ohio, Oregon, Rhode Island, Washington, West Virginia. **Non-expansion states:** Alabama, Florida, Georgia, Idaho, Kansas, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Wisconsin, Wyoming. **Full prior expansion states**: Delaware, Washington DC, Massachusetts, New York, Vermont. **Late expansion states**: Alaska, Indiana, Louisiana, Maine, Montana, New Hampshire, Pennsylvania, Virginia.

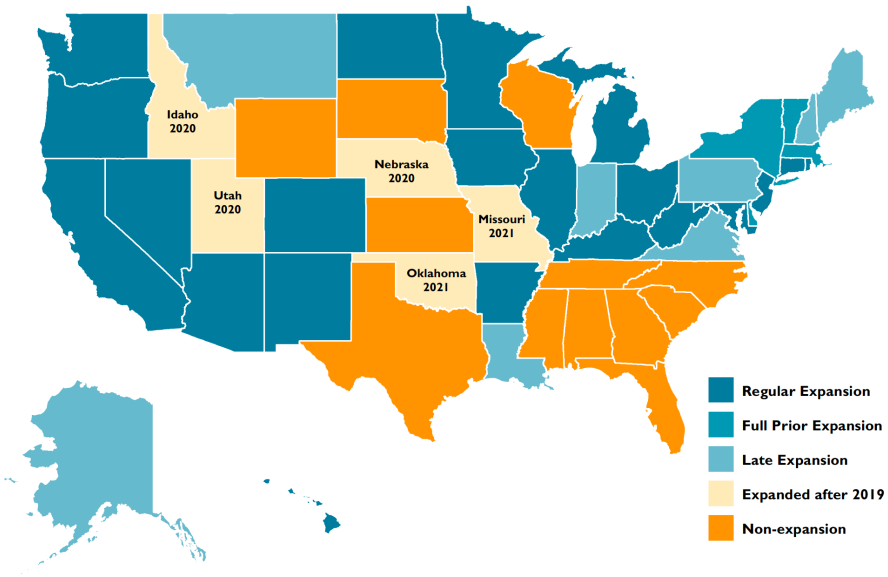
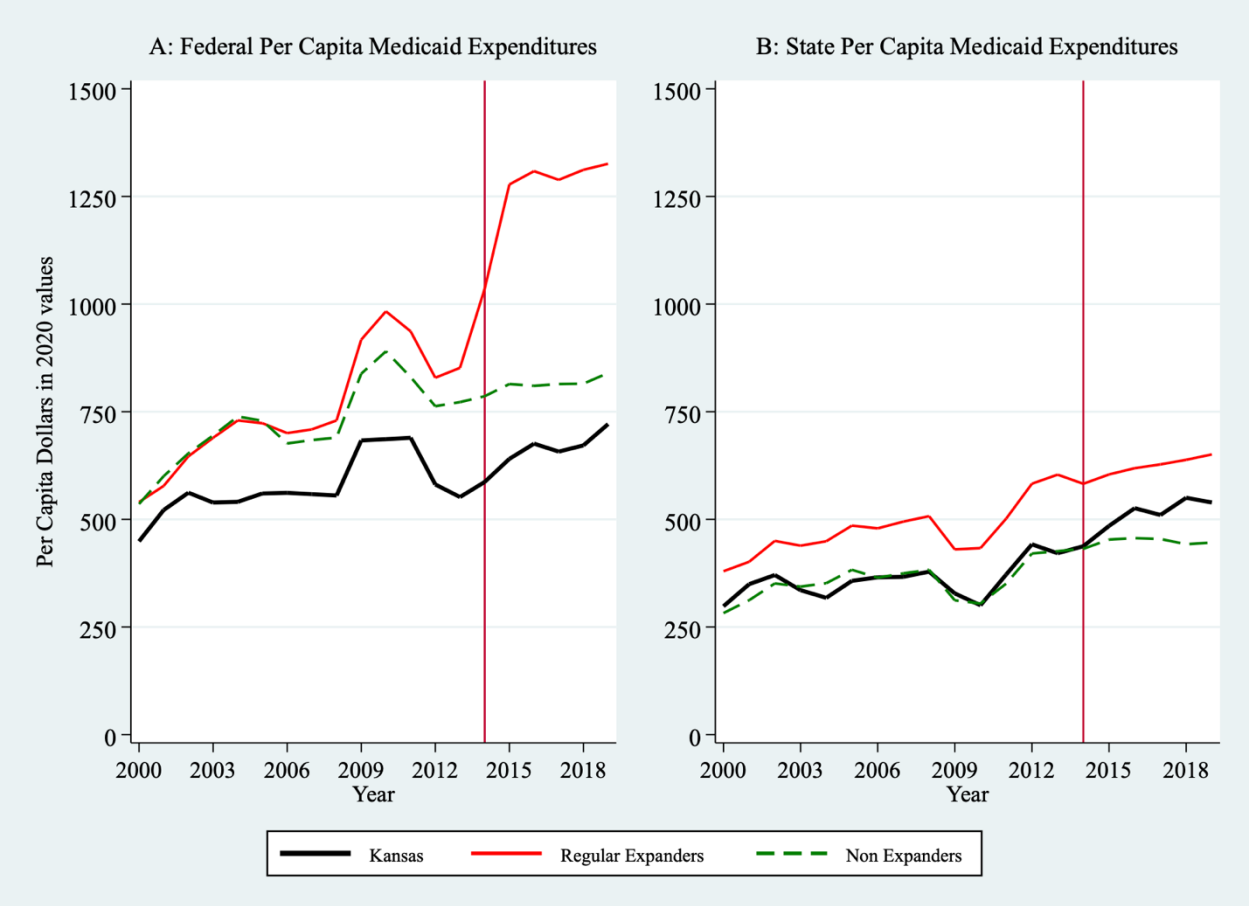


Figure 1: States by Medicaid Expansion Status, 2022.

Findings

First, we consider the per capita Medicaid expenditures from state and federal sources for Kansas, the other non-expansion states, and the regular expansion states, as shown in Figure 2. It should be noted that Kansas received significantly less in federal Medicaid dollars than other states even prior to the ACA, due to its historically low-income eligibility criteria. As would be expected, states that expanded Medicaid had large increases in federal per capita Medicaid spending, reflecting the higher available federal match. Other states that did not expand Medicaid had flat spending. However, Kansas experienced a notable increase in its state share of Medicaid expenditures post-2014—23%—relative to other non-expanding states, even converging to per capita expenditures for expansion states.

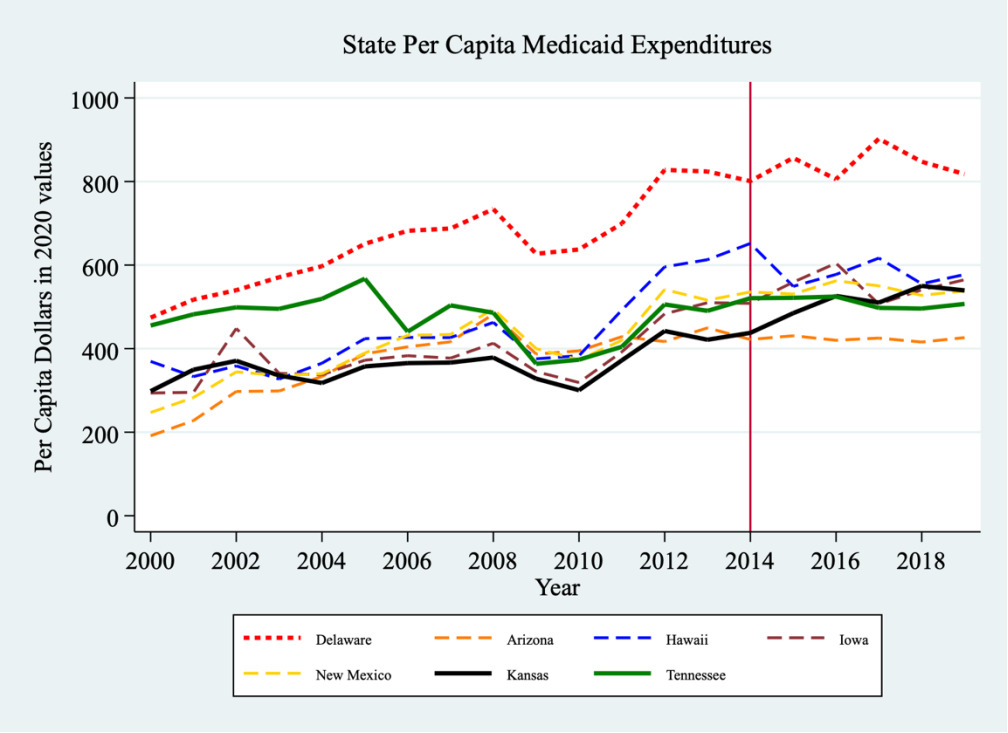
Figure 2: Per Capita Federal and State Medicaid Expenditures



Sources: www.medicaid.gov (expenditures) and Census Bureau (population denominators). All expenditures adjusted to 2020 dollars using the Personal Consumption Expenditure deflator.

Figure 2 shows per capita federal (Panel A) and state (Panel B) Medicaid expenditures from 2000 to 2018. Figure 3 expands the right panel, state per capita expenditures, from Figure 2 to include other individual states which, like Kansas, deliver their Medicaid programs for at least 70% of enrollees through contracts with private insurance companies. This process is called "managed care". This group includes an early expander (Delaware), a non-expansion state (Tennessee) and regular expansion states. While all other states with Medicaid managed care programs had flat expenses after 2014, state Medicaid expenditures in Kansas were growing. This rapid increase in state Medicaid expenditures coincides with the start of the KanCare

Figure 3: Per Capita Federal and State Medicaid Expenditures by State

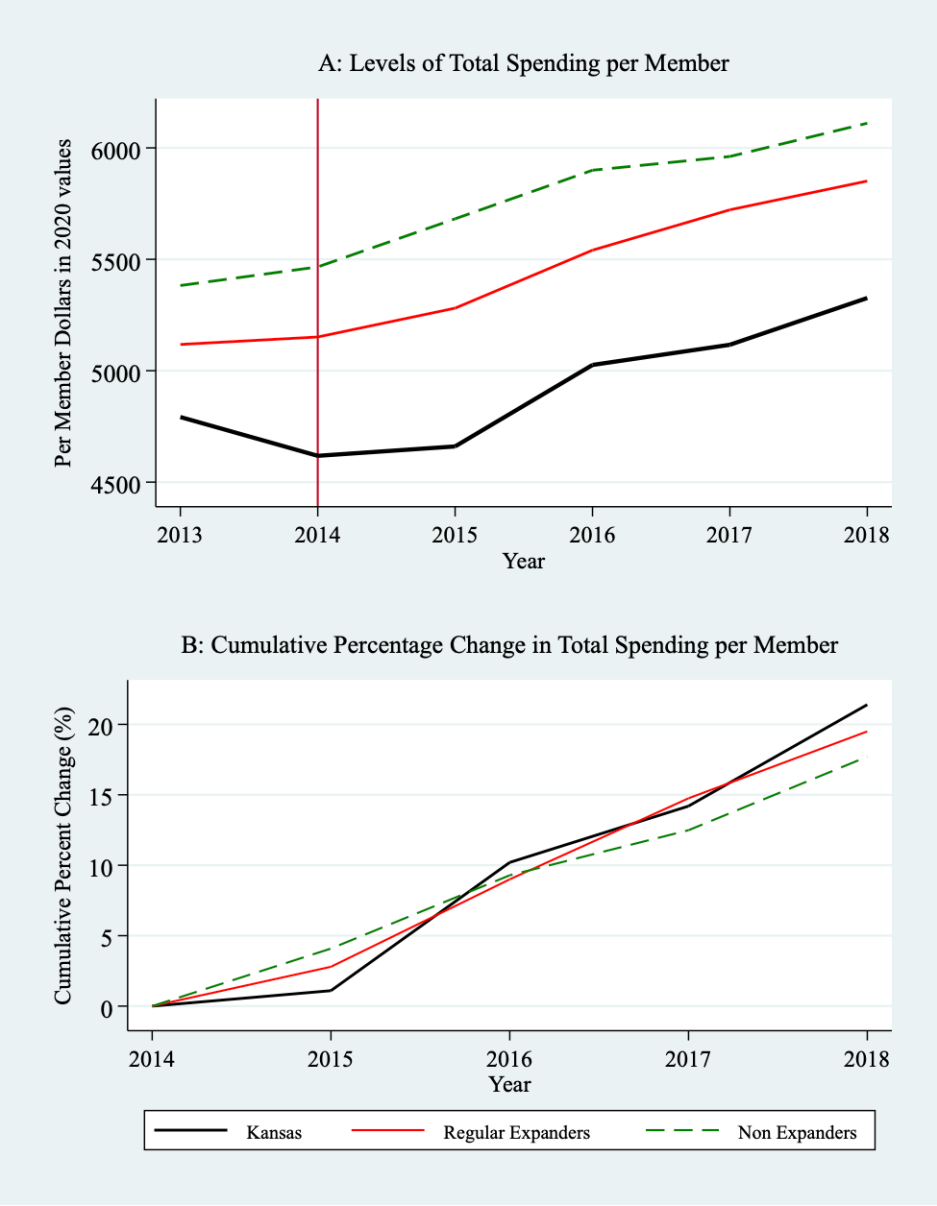


Sources: www.medicaid.gov (expenditures) and Census Bureau (population denominators). All expenditures adjusted to 2020 dollars using the Personal Consumption Expenditure deflator.

managed care Medicaid program in 2013. KanCare became fully operational in 2015. Kansas is a clear outlier in terms of spending compared to other states with managed care Medicaid programs, which have kept their costs relatively flat. This phenomenon may be a result of the types of populations included in Kansas's Medicaid managed care program or due to more generous contractual provisions than those offered by other states. Either way, this increase in state Medicaid expenditures warrants further study.

Next, we considered the economic impacts of Kansas not expanding Medicaid on individuals with private health insurance, including employer-based insurance and insurance purchased on the individual market. These numbers do not include Medicaid managed care patients. Figure 4 shows the level of total health insurer spending per privately insured individual.

Figure 4: Total Spending Per Privately Insured Individual

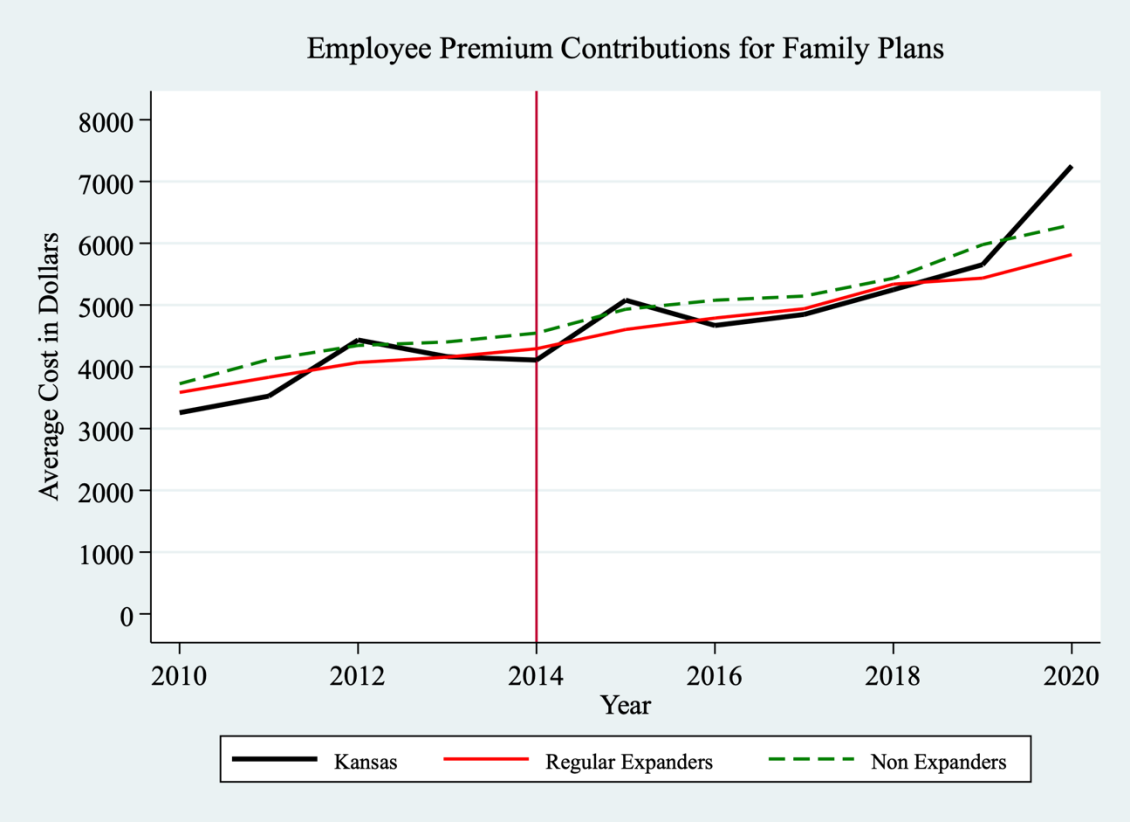


Source: HCCI data on privately insured individuals, including payer and patient shares per annualized member

While Kansas has lower total spending per privately insured individual than either expansion or non-expansion states (Panel A), the cumulative growth in spending per member in Kansas (Panel B) has been the highest relative to other states as of 2018, the last year for which data was available. The growth rate in total health care spending in Kansas exceeds 20% as of 2018, compared to 19.5% in regular expansion states, and 17.7% in non-expansion states.

Furthermore, we examined data on private health insurance premiums paid by employees through 2020, as shown in Figure 5. Since 2014, employee premium contributions, or "employee share" have increased 77% in Kansas for family plans, but only 26% in non-expansion states and 25% in expansion states.

Figure 5: Employee Contributions for Private Family Health Insurance Plans

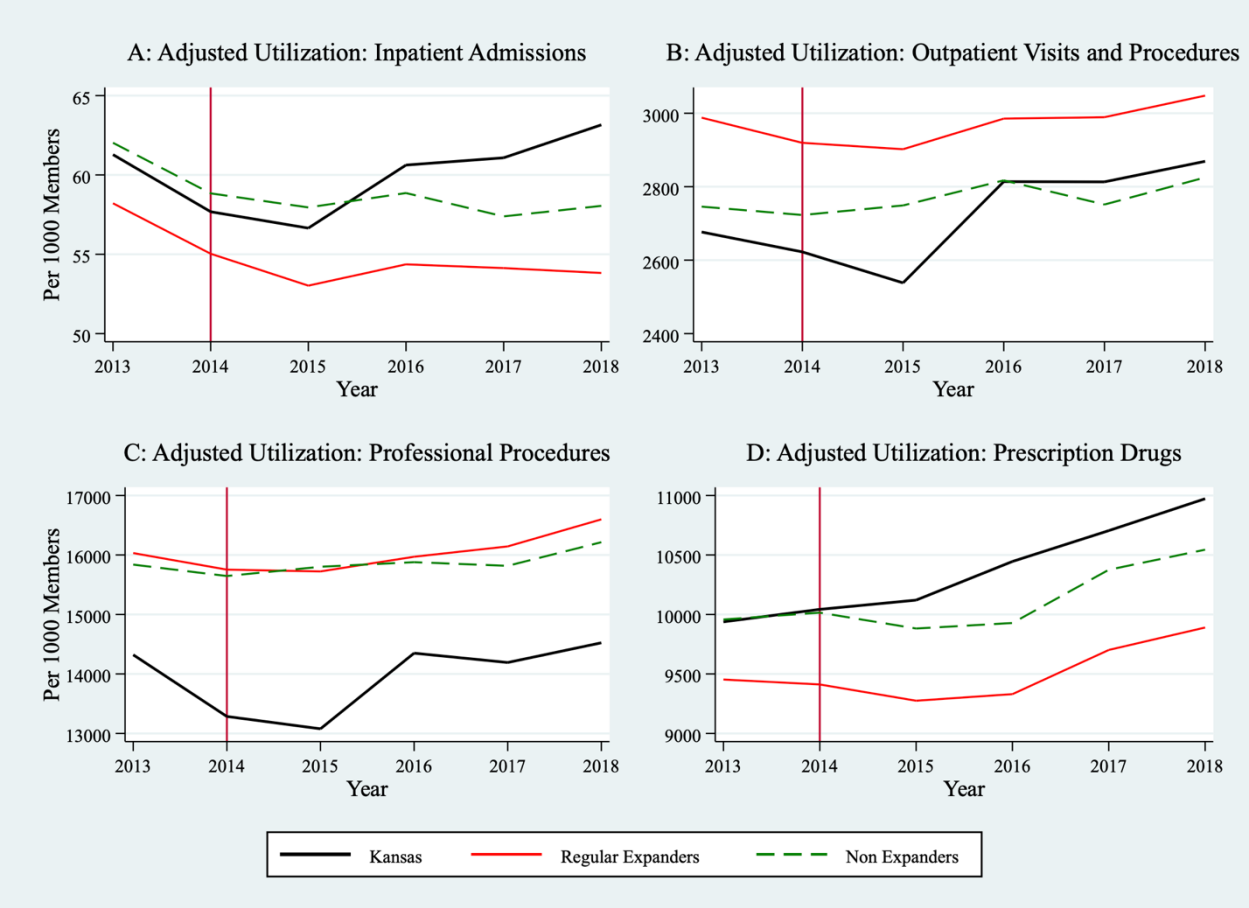


Source: Medical Expenditure Panel Survey, Commonwealth Fund

These spending and premium increases suggest that insurers reimbursing providers in greater sums than in previous years, or increasing their profit margins, or both. Figure 6 shows data from the same source as Figure 4, now adjusted for utilization by a variety of different types of health care. The adjustment represents a valuation of the intensity of the patient case mix, with a higher value indicating that a hospital treats a greater number of complex, resource-intensive patients, and thus should be reimbursed at a higher rate. Even after controlling for more complex health conditions, the data indicates that Kansas hospitals are admitting more patients with private insurance, whereas admissions are flat or falling in non-expansion and regular expansion states. And while Kansas had lower outpatient visits at the outset, the growth rate in outpatient visits is higher in the post-expansion period under review. Similarly, although Kansans received fewer professional procedures at the outset, the growth rate for professional procedures increased once expansion became an option that Kansas declined. Finally, the growth rate in the prescription of a 30-day supply of drugs in Kansas is also higher post-expansion. Figure A1 in the appendix shows the cumulative percentage change in each of these measures. Health care utilization has increased in Kansas for privately insured individuals by 10% post-Medicaid expansion in each of four areas: in-patient admissions, out-patient visits, professional services and prescription drugs. This is a higher rate increase than in both expansion and non-expansion states.

These trends were corroborated using data from the American Hospital Association, as shown in Figure A2 in the appendix. This figure indicates that admissions and hospitalizations in Kansas have increased overall, not just for privately insured patients. The average daily census increased by 10 percentage points and inpatient admissions increased by 15 percentage points between 2014 and 2019. Figures 6 and A2 show that patient experience in Kansas does not mirror that of residents in other non-expansion states, nor those in expansion states. This increase in health

Figure 6: Adjusted Healthcare Utilization for Patients with Private Insurance



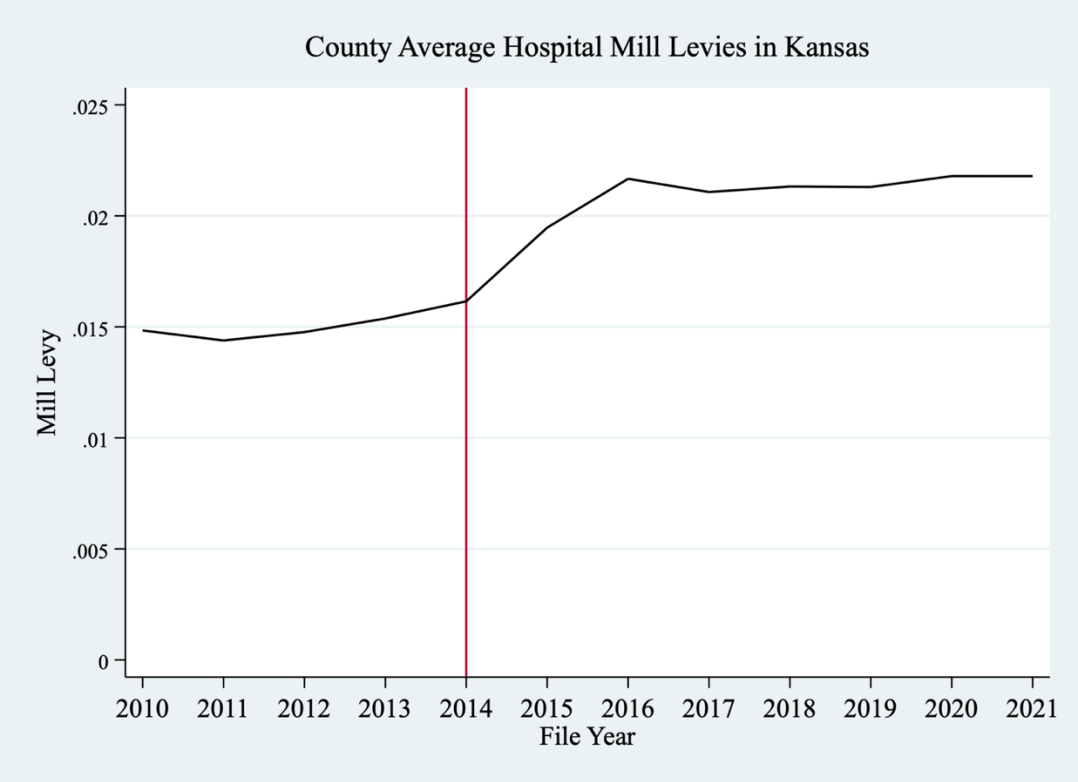
Source: HCCI. Notes: Prescription drug utilization is for a 30-day supply.

care utilization and hospitalization rates constitute another direct cost to Kansans to which their peers in other states are not subjected.

Finally, we considered the impact of failure to expand Medicaid on support for local hospitals in the state of Kansas. The Kansas Department of Revenue provided data on county and hospital district mill levies. Kansas currently has 76 publicly supported hospitals (some with multiple locations). Figure 7 shows the time series of the average hospital mill levy across the state from 2010 to 2021. The average mill levy (tax rate) paid in counties and hospital districts increased from 0.0162 to 0.0217, a jump of 34%, between 2014 and 2016. In some counties such as Barber, Crawford, Haskell, Sumner and Washington, hospital mill levies have more than doubled between

2014 and 2021. One likely cause of this increase is that Kansas hospitals that expected loss of DSH funding as a result of the Affordable Care Act and the state's failure to expand Medicaid subsequently turned to their local units of government for additional revenues to offset those losses. This analysis did not find that overall mill levies at the county level increased, indicating that local policymakers may be choosing to subsidize their public hospitals at the expense of other local services.

Figure 7: Average Hospital Mill Levies in Kansas Counties and Hospital Districts



Source: Kansas Department of Revenue

Conclusions

This analysis indicates there are a number of economic consequences to Kansas residents and taxpayers associated with state policymakers' decision to not expand its Medicaid program.

Kansas Medicaid expenditures are increasing post-2014, unlike other states that have also privatized their Medicaid programs. There is increased spending by private insurance companies operating in the state. Kansas workers are paying a higher share of family health insurance premiums as part of the employer-sponsored plans, compared to those in other states. Hospitals are admitting more patients, and privately insured patients are receiving more outpatient visits, more professional procedures, and more prescriptions than their counterparts in other states. In counties with publicly supported hospitals, the percentage of mill levies going to support those hospitals has increased 34%.

Overall, Kansas residents appear to be paying more and differently for healthcare than residents in other states as a result of their state government's decision to not expand Medicaid. First, Kansans are paying federal taxes that are funding other states' expansions. Estimates indicate that Kansas has foregone $4.9 billion in federally available Medicaid funds between 2014 and 2021. The American Rescue Plan could provide the state with an additional $450 million should Kansas opt to expand its Medicaid program eligibility in 2022. Furthermore, studies have estimated a multiplier effect of total Medicaid expenditures ranging from 1.5 to 2.0 (Chernew 2016). At a 90% federal match, this means that every federal dollar of Medicaid funding in the state would likely generate $1.35 in additional economic activity. Using the amount of aforementioned foregone federal Medicaid expenditures and the 1.35 multiplier, this spending would have resulted in $6.62 billion in additional economic activity for the state. Even a more conservative multiplier would result in billions of dollars of state economic activity.

Second, Kansans state taxes are being used to fund the increased state spending on Medicaid, despite the move to a managed care model, which was purportedly adopted by state policymakers to slow state Medicaid expenditures. Third, privately insured Kansans are paying

more for health insurance and are receiving a higher volume of services relative to residents of other states. Fourth, in those counties with a much-needed publicly supported hospital, Kansans are spending a higher share of their total property taxes to support those hospitals.

Taken together, the Kansas legislature's failure to expand Medicaid, despite strong public support, appears to be a costly decision for its residents and the state budget. As a state Kansas has a choice: like most other states in the country, and all of those bordering it, Kansas can accept federal Medicaid dollars that will support its hospitals, reduce or stabilize local tax rates for public hospitals, reduce health care utilization and expenditures, and contribute to economic growth. Or, it can continue down the path of paying higher health care costs, increasing local taxes and foregoing the benefits of federal taxes already paid, and risk the closure of more hospitals that will reduce health care access for vulnerable and mostly rural populations. At the time of this analysis, the Kansas legislature appears to be poised to once again reject the option to expand Medicaid.

Data Appendix

Variable Definitions:

Adjusted Admissions: Adjusted Admissions reflect the sum of admissions and equivalent admissions attributed to outpatient services derived by multiplying admissions by the ratio of outpatient revenue to inpatient revenue. Variable is normalized as per 10,000 population. Source: American Hospital Association (AHA).

(Adjusted Admissions = Admissions + (Admissions * (Outpatient Revenue/Inpatient Revenue)).

Adjusted Average Daily Census: Adjusted Inpatient Days/Number of Days in Reporting Period. This is defined as total adjusted inpatient days divided by the number of days in reporting period. Adjusted inpatient days reflect the sum of inpatient days and the number of equivalent inpatient days attributed to outpatient services derived by multiplying Inpatient days by the ratio of outpatient revenue to inpatient revenue. Variable is normalized as per 10,000 population. Source: American Hospital Association (AHA).

(Adjusted Patient Days = Inpatient Days + (Inpatient Days * (Outpatient Revenue/Inpatient Revenue)).

Adjusted Utilization: These variables measure the utilization of health services per 1000-member. Utilization is adjusted for the intensity of the health services. Four type of health services are Inpatient Admissions, Outpatient Visits and Procedures, Professional Services and Prescription Drug 30-days Supply. Source: Health Care Cost Institute (HCCI).

Employee Premium Contributions for Family Plans: Average cost of employee premium contribution in dollars for family plans. Source: Medical Expenditure Panel Survey (Collins et al. 2022).

Federal Medicaid Expenditure: Per Capita Federal Medicaid Expenditure is the federal government portion of total Medicaid expenditures in a state. It is normalized by the total population of the state and adjusted for inflation by PCE to 2020 values.

State Medicaid Expenditure: Per capita State Medicaid Expenditure is the state government portion of total Medicaid expenditures in a state. It is normalized by the total population of the state and adjusted for inflation by PCE to 2020 values.

Total Spending Per Member: Total spending per annualized member on medical services includes payer and patient shares. It is further adjusted for inflation by PCE to 2020 values. Source: Health Care Cost Institute (HCCI).

Data Sources:

Medicaid Expenditures: State and federal Medicaid expenditures data is acquired from the Center for Medicare & Medicaid Services (CMS). CMS Data Center is the main source of Medicaid expenditures data. CMS Data Center collects itemized expenditures on the Medical Assistance Program for each fiscal year. Each expenditure item is broken down by federal and state responsibility. https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html. Accessed 22 February 2022.

Population: Yearly state population data collected through the US Census Bureau is used for calculating per capita measures. https://www.census.gov/programs-surveys/popest/data/data-sets.html. Accessed 22 February 2022.

Personal Consumption Expenditures (PCE): PCE is used for inflation adjustment supplied by the Federal Reserve Bank of St. Louis. https://fred.stlouisfed.org/series/PCEPI#0. Accessed 22 February 2022.

Health Care Cost Institute (HCCI): HCCI collects health care cost data from a large sample of individuals with employer-sponsored insurance in the USA.

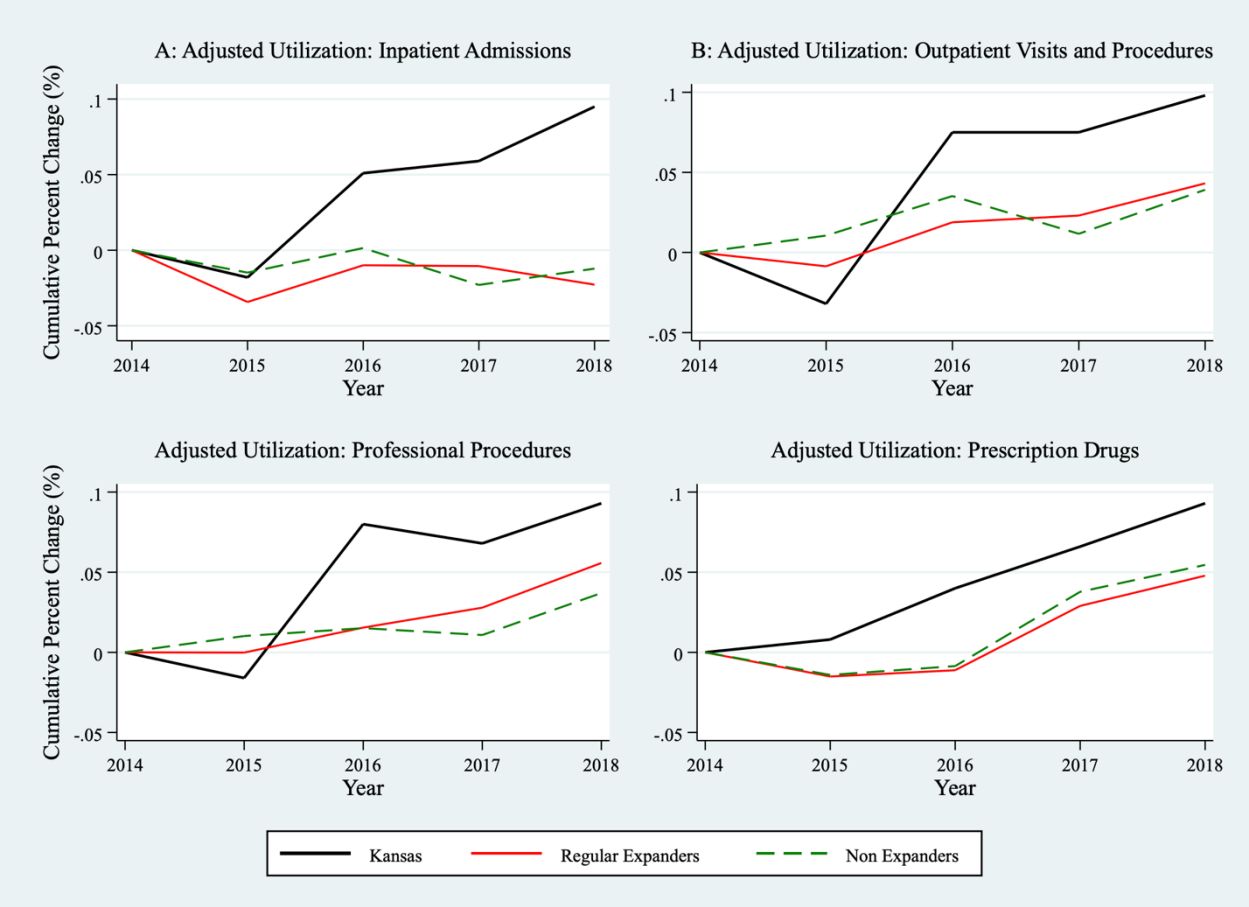
American Hospital Association (AHA): AHA collects hospital-level health care statistics through the AHA Annual Survey from a sample of 6200 hospitals and health care systems in the US.

Behavioral Risk Factor Surveillance System (BRFSS): BRFSS collects state-level information about risk factors for chronic diseases and death by surveying residents of the US. Then the survey data is weighted and supplied by Centers for Disease Control and Prevention (CDC). https://data.cdc.gov/browse?q=&sortBy=relevance Accessed 22 February 2022.

Kansas Hospital Mill Levies. Kansas Department of Revenue, Property Valuation Division.

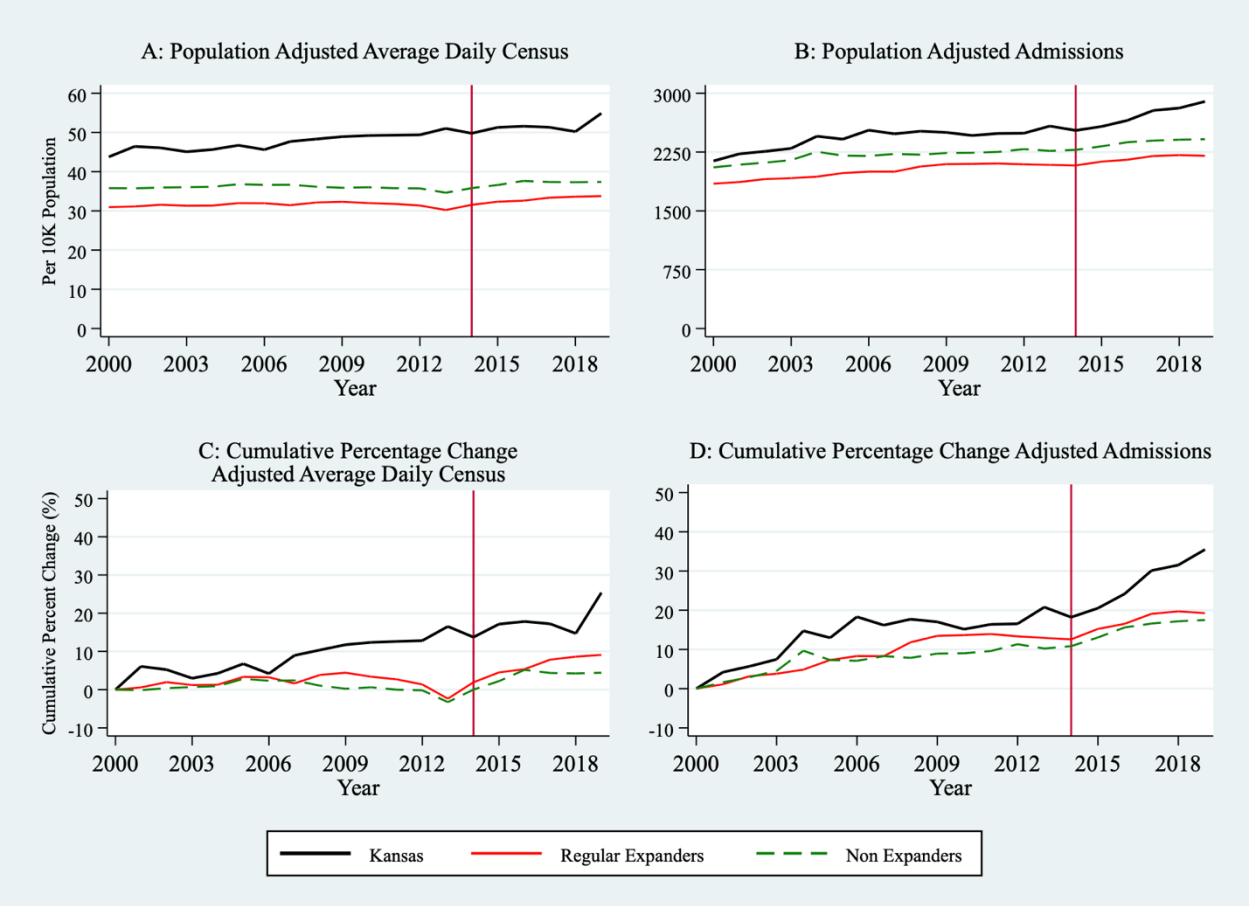
Appendix 1:

Figure A1: Cumulative Percentage Change Since 2014 in Health Care Utilization



Source: HCCI. Notes: Prescription drug utilization is for a 30-day supply.

Figure A2: Adjusted Hospital Average Daily Census and Admissions



Source: American Hospital Association

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