Economic and Employment Effects of Expanding KanCare

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Executive Summary

Like many states, Kansas has been considering whether to expand Medicaid and, if so, whether to customize an expansion by seeking a federal Section 1115 waiver. As of October 2014, more than half the states in the nation have chosen to expand their Medicaid programs, some of them using additional flexibility permitted by federal waiver programs. More states are still considering expansions. This report examines the economic and employment consequences of expanding Medicaid eligibility.

KanCare, Kansas's Medicaid program, currently does not cover parents whose incomes are greater than 38 percent of the federal poverty level (about $5,600 for a family of three), and non-elderly, non-disabled adults without children are not eligible at all. The state's Medicaid eligibility levels are well below the levels used in most states. Nearly one out of every seven Kansans under age 65 (14.2 percent) were uninsured in 2013, exceeding the national average, and preliminary data suggest the percentage of uninsured Kansans increased in 2014.

Because Kansas did not expand KanCare in 2014, when this first became possible with support from substantial federal funding, the state is already experiencing negative consequences.

- The lack of an expansion in 2014 and 2015 means that Kansas is losing about $334 million in federal funding in 2014 and more than $380 million in 2015, compared to the amounts it would have earned had it expanded KanCare.
- In turn, this means that more than 3,000 fewer jobs are being created statewide in 2014 and more than 3,400 fewer in 2015.
- The state's total economy (as measured by gross state product) is about $220 million smaller in 2014 than its level if KanCare had been expanded, causing the state to lose more than $6 million in potential state tax revenue.

In the coming year, Kansas has the opportunity to revisit this issue, which could lead to implementation of a KanCare expansion by 2016. Such an expansion could enable about 100,000 low-income Kansas adults to gain coverage in 2016, and 144,000 by 2017. Deciding again not to expand KanCare would prolong the negative consequences into future years.

- If Kansas still declines to expand Medicaid, the state could lose an estimated $2.2 billion in federal funding between 2016 and 2020, compared to levels earned if an expansion began in 2016.

- As a result, more than 3,700 fewer jobs would be created by 2020 statewide. About half of the jobs affected would be in the health care sector, but the other half are in diverse sectors, including construction, retail and wholesale, professional/scientific/technical and food and beverage. Although a KanCare expansion increases funding for health care, the benefits spread more broadly as health care providers purchase additional goods and services and health care workers use new income to pay their mortgages, buy groceries, and make other consumption choices that influence the state's economy.
- Over the five-year 2016 to 2020 period, the potential state gross product will be more than $1.2 billion less than if KanCare expanded, and total business activity will be about $2.2 billion lower. Non-expansion will derail substantial economic gains that could otherwise boost the state economy.
- A KanCare expansion that triggers additional economic growth in Kansas would lead to greater state tax revenues, without changes in tax rates. These revenues could be used for other purposes, such as helping to balance the state's budget. In comparison, if KanCare is not expanded, more than $69 million in potential state revenue would be lost from 2016 to 2020.

Expanding KanCare by 2016 would empower Kansas to collect more than $2.2 billion in federal funds over five years, producing a net gain of $1.9 billion for the state once the additional $312 million in KanCare costs have been paid. Our analyses indicate, however, that the modest increase in state costs could be completely offset by gains in state tax revenues generated by economic expansion and potential savings in other health costs, such as costs for community mental health and substance abuse services, as currently uninsured patients get coverage through KanCare. The net state savings, including new costs, new revenues and potentially offsetting health savings, would equal $29 million in 2016 and about $36 million over the five year period 2016 to 2020. That is, the Medicaid expansion could be accomplished without an increase in net state expenditures.

KanCare expansion would stimulate economic growth and job creation in Kansas, as well as increase access to health care for about 150,000 state residents.

Introduction

Recent Census data reveal that in 2013 almost one in seven (14.2 percent) Kansans under 65 years old lacked health insurance coverage[1] However, data from a recent Gallup survey indicate that the percentage of uninsured adults in Kansas may have climbed by about five percentage points between 2013 and mid-year 2014.[2] Under the federal Patient Protection and Affordable Care Act (ACA), states have the option to expand their Medicaid programs to provide health insurance coverage for low-income adults with incomes up to 138 percent of the federal poverty line (133 percent plus a 5 percent standard deduction).[3] As of October 2014, 27 states and the District of Columbia are expanding Medicaid. Some states have directly expanded Medicaid eligibility, while others negotiated with the federal government for Section 1115 waivers to shape their state Medicaid expansions in a more customized fashion. Four states are expanding coverage under waivers (Arkansas, Iowa, Michigan and Pennsylvania); at least two additional states have applied for waivers (Indiana and Utah) and plan to expand if these are approved. Other states are still considering expansions under waivers. The Arkansas, Iowa and Pennsylvania waivers let the states offer premium assistance subsidies so that Medicaid-eligible adults can purchase Qualified Health Plans under their health insurance marketplaces.

In order to make Medicaid expansions more affordable for states, the federal government is covering 100 percent of the costs of Medicaid eligibility expansions between the years 2014 and 2016. In 2017, the federal matching level will be reduced to 95 percent and the state must finance 5 percent of the costs. The federal matching rate then gradually declines to 90 percent in 2020 and the years following. Even so, these Medicaid expansion matching rates are substantially higher than the regular Medicaid federal matching rate, which is 56.63 percent for Kansas in 2015. The federal government is covering almost all the costs of Medicaid expansion, with the net result that billions of additional federal dollars flow into states that expand Medicaid.

This report offers a nonpartisan economic analysis of the implications of a decision to expand KanCare in Kansas. An earlier report by the Kansas Hospital Association[4] and reports by the Urban Institute[5] have examined the budgetary, economic and/or employment effects of KanCare expansion in Kansas; this report builds upon earlier efforts by using updated information. This report provides state-level estimates of:

- The level of additional federal funds that Kansas has lost because it did not expand KanCare in 2014 and the amount that Kansas could lose if it does not expand KanCare by 2016.
- The loss in Kansas's overall economy (gross state product) and business activity,
- The loss in jobs created,
- The loss of state tax revenues,
- Other state costs, such as burdens of uncompensated care or mental health service costs that are incurred because KanCare is not expanded.

This report provides estimates based on widely respected economic models. A variety of factors could alter the actual outcomes, including future changes in KanCare policies or state or local economic conditions.

Initial Evidence from Other States

Although the ACA insurance expansions only began in 2014, evidence is already accumulating that Medicaid expansions are decreasing the number of uninsured residents. Data from the Centers for Medicare and Medicaid Services indicate that between July-September 2013 and July 2014, 7.9 million more people enrolled in Medicaid nationwide, including 6.9 million in expanding states (19 percent increase) and 1.0 million in non-expanding states (5 percent increase).[6]

Data from a recent Gallup survey indicated that, nationwide, the percent of adults 19 to 64 who were uninsured fell from 20 percent in 2012-13 to 15 percent by mid-year 2014.[7] States that expanded Medicaid had greater reductions in the percent uninsured than states that did not expand Medicaid. The two states with the largest reductions were southern states: Arkansas, which expanded Medicaid using a waiver, and Kentucky, which had a regular Medicaid expansion.[8] Other surveys conducted by the Centers for Disease Control, the Urban Institute, and the Commonwealth Fund have reached similar conclusions about the effects of the ACA and of Medicaid expansions.[9] Changes in overall insurance coverage are also affected by other ACA policies, such as the creation of health insurance marketplaces and related federal tax credits to make insurance purchases more affordable, as well as by other economic changes.

Early studies have identified other effects related to Medicaid expansions. A recent federal report examined the potential effects of the ACA and of Medicaid expansions on uncompensated hospital costs, such as the cost of charity care for the uninsured, and estimated that uncompensated care costs would fall much more in Medicaid expansion states in 2014 than in non-expanding states.[10] The reductions are partly attributable to implementation of health insurance marketplaces, which were introduced in all states, but the Medicaid expansions have a larger effect since they are focused on low-income patients more likely to receive uncompensated and charity care. The Colorado Hospital Association examined early hospital financial data from 25 states and found that the volume of charity care costs and self-pay charges fell as the volume of Medicaid business grew in Medicaid-expanding states in 2014. Like the federal study, they found reductions were much larger in Medicaid expanding states.[11] A study of Massachusetts' health reform found that uncompensated care decreased by about one-third after their insurance expansions.[12] The Missouri Department of Economic Development analyzed changes in ten states between the first five months of 2013 and the same months in 2014 and found that employment in the health and social assistance category grew twice as fast in Medicaid expanding states as in non-expanding states.[13]

Kansas's KanCare Program

Kansas currently provides KanCare coverage to parents with family incomes up to 38 percent of the federal poverty line, but does not cover non-elderly adults without dependent children, regardless of their incomes.[14] This places Kansas in the lowest quartile of states in terms of Medicaid eligibility, below neighboring states of Oklahoma, Nebraska and Colorado, but above states like Mississippi, Alabama, Georgia or Texas.

Since Kansas is not expanding KanCare, it earns a federal match rate of 56.63 percent in federal fiscal year 2015 and the state pays 43.37 percent of medical costs in Medicaid. If it had expanded KanCare in 2014, the federal matching rate would have been 100 percent for parents

with incomes above 38 percent of poverty and for all childless adults. Kansas would retain that rate until 2016. If the state opts to expand KanCare by 2016, it will still earn the 100 percent matching rate, but only for that year and the rate will decline to 95 percent in 2017 and then to 90 percent by 2020 and subsequent years.

While Kansas has not expanded KanCare, there has nonetheless been some growth in KanCare enrollment. Data indicate that combined Medicaid-CHIP enrollment grew by 3,005 between July-September 2013 and August 2014, much less than in most other states, even other non-expanding states.[15] The KanCare growth that already occurred was among those who were already eligible under existing eligibility rules, for whom Kansas only receives the regular (56.63 percent) match rate. If Kansas had expanded eligibility, then the number of new enrollees would have been much larger and the federal government would have paid for 100 percent of the medical costs for those enrolled under the new eligibility criteria from 2014 to 2016.

It is likely that much of KanCare growth that already occurred in 2014 was related to the implementation of Kansas's health insurance marketplace and the related outreach and enrollment efforts; those applying for coverage through the marketplace may be determined Medicaid eligible if they do not qualify for the marketplace or federal tax credits. As of March 31, 2014, 358,000 had enrolled in Kansas's marketplace and selected a health insurance plan.[16] Because Kansas did not expand KanCare, federal tax credits are available to those with incomes between 100 and 400 percent of the poverty line. If, however, Kansas had expanded KanCare, then tax credits would only be available to those with incomes over the Medicaid income limit. (This analysis accounts for that shift.)

Under existing law, the federal matching rate for newly eligible enrollees is 100 percent only in 2016, then falls to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019 and 90 percent in 2020. Since most of the cost of a KanCare expansion would be borne by the federal government, expansion would result in billions of dollars in additional federal funding flowing into Kansas. The initial flow of funds will be as payments to health care providers, such as hospitals, clinics or pharmacies, as health care payments for Medicaid services. Next, the health care providers distribute these funds as salaries to health care staff, payments for goods and services (such as the costs of rent, equipment, medicine or medical supplies), and as state and local tax payments – generating a secondary flow of funds. These funds would flow into the broader state economy as workers and businesses use their income to pay for general goods and services, such as to pay for their mortgages or rent, utility bills, food bills, transportation, and educational services. In turn, the real estate, grocery, and other firms distribute these funds as salaries to their employees and buy other goods and services; these firms – and the recipients –of these funds – also pay taxes. Thus, the Medicaid funds multiply through the broader state economy, and the total economic impact ends up being larger than the initial amount of Medicaid payments because the money is recycled through many layers of the state economy. Economists sometimes refer to this phenomenon as the "multiplier effect," although the economic model, developed by Regional Economic Models, Inc. (REMI), uses a more sophisticated approach.

Key Definitions

The methodology for this report and the sources of data are described more completely in the Appendix on Data Sources and Methods at the end of this report. Some key definitions for measures used in this report are:

- Employment: This is the number of jobs that would be added or lost in the state related to KanCare expansion, full-time plus part-time. These include jobs in all sectors, including health-related jobs, construction, retail, professional jobs, state or local government, etc.
- Business Activity (Output): Output is equivalent to the sum of all revenue (public and private) generated by the KanCare expansion at the state level. For example, if a retail firm buys a product from a wholesaler for $1,000 and a customer pays $1,500 to the retailer for that same product, the increase in business activity is the sum of both levels of purchase (=$2,500). (Business activity, state gross product and state revenues are all based on constant 2014 dollar estimates, which adjust for inflation.
- Gross State Product: Gross product is a subset of output and refers to the "value added" by economic activity. GSP can be thought of as all net new economic activity or output minus the goods and services used as inputs to production. Effectively, it measures only the final stage of a transaction. In the example above, it would be the $1,500 paid by the customer to the retailer.
- State Revenue: This is the value of additional state government tax revenue related to the KanCare expansion. For example, if there are more purchases, then state sales tax revenue rises. Our analyses assume that state tax rates remain at current levels.

Finally, the report examines state budgetary consequences of expanding KanCare, looking at state funds spent to pay for additional KanCare costs, as well as how these are offset by additional state revenues and by potential savings in other state health care expenditures, such as costs of uncompensated hospital care and mental health-related savings.

Findings

Earlier reports, such as those by the Urban Institute, estimated how much states would lose in federal matching funds if they do not expand Medicaid. This analysis probes further to estimate broader economic and employment effects of not expanding KanCare. The lack of KanCare expansion not only means that more than one hundred thousand low-income Kansans will not be insured, but also that hospitals, physicians' offices, clinics, pharmacies and other health care providers have less revenue and bear the costs of more uncompensated care. Thus, without KanCare expansion, health care providers will employ fewer staff and make fewer purchases for medical supplies, information technology, professional services (e.g., legal or accounting), facilities construction and maintenance, and other goods and services. In turn, workers will purchase fewer goods, such as clothing or groceries, and will pay less in rent or mortgages. Reductions in incomes will also lead to lower state revenue, which could be used to pay for diverse government services such as education or criminal justice.

This report provides estimates of economic and employment effects related to not adopting the KanCare expansion option. Two scenarios are examined:

> (1) What are the consequences of Kansas's decision to not expand KanCare in 2014, when it could first be implemented? Effects are already being felt in 2014 and will continue in 2015.

(2) What would be the consequences if Kansas does not expand KanCare by 2016? The next legislative session will occur in early 2015, so an expansion by 2016 could be adopted, on a delayed schedule.

Consequences of Not Expanding KanCare in 2014

Since KanCare was not expanded in 2014, Kansas is already experiencing economic repercussions. Table 1 summarizes estimates of amounts lost. Implementation of an expansion in 2014 is no longer possible and, because the Kansas State Legislature will not meet until early 2015, it seems unlikely that an expansion could begin in 2015. The table presents changes in employment, output, state gross products and state revenues in 2014 and 2015, compared to estimates of what would have happened if Kansas implemented KanCare expansion in 2014. Under existing law, the federal government pays 100 percent of the medical costs in 2014 to 2016 for Kansans who qualify for KanCare because of the expanded eligibility levels, and 95 percent of those costs in 2017. This analysis assumes that the full impact of KanCare expansions is felt by 2017. Because of the decline in federal contributions, growth in the amount of federal funding to cover the costs of eligibility expansions slows after 2016 and the amount the state contributions must rise.

Table 1. State-level Losses in Federal Funding, Employment, Economic Activity and Tax Revenue Because Kansas Did Not Expand KanCare in 2014 (Compared to Levels If KanCare Had Been Expanded).

Category	2014	2015	2016 to 2020
Federal Funding Lost (mil $)	$334	$382	$3,077
Total Jobs Not Created	3,096	3,455	n/a
State Gross Product Lost (mil $)	$220	$246	$1,788
Business Activity Lost (mil $)	$380	$425	$3,089
State Tax Revenue Lost (mil $)	$6.2	$13.4	$104.8

All dollars are in constant 2014 dollars

As seen in Table 1, because Kansas did not expand Medicaid in 2014, the state lost an estimated $334 million in federal funds in 2014 and will lose another $382 million in 2015 compared to a scenario in which KanCare was expanded in 2014. The level rises under the assumption that expansions take time to fully ramp up, as experienced in prior Medicaid expansions and as expected by other analysts such as the Congressional Budget Office.

Because Kansas has not gained these additional federal funds, almost 3,100 jobs were not created in 2014 and more than 3,400 jobs will not be created in 2015. (Note: the job levels are the difference in levels estimated with and without KanCare expansion in each year. They are not cumulative. The number of jobs not created in 2015 is approximately 350 more than the number in 2014.) Kansas's seasonally adjusted unemployment rate in August 2014 was 4.9 percent.[17] About 73,000 Kansans were unemployed in August 2014; the number of unemployed could have been much smaller if Medicaid had been expanded, so the August unemployment rate might have been closer to 4.7 percent if there was a Medicaid expansion. As the national economy

picked up over the past year, Kansas's unemployment rate has been falling, but employment gains could have been even stronger.

Statewide, Kansas's gross state product was lower by an estimated $220 million in 2014 and $246 million in 2015 than it would have been with KanCare expansion. Expressed in terms of potential business activity, Kansas is losing $380 million in 2014 and $425 million in 2015. (Note: all financial estimates are in constant 2014 dollars, adjusted for inflation.) Given this reduction in the state's economy, state tax revenues are also lower than under a KanCare expansion. In 2014, total state revenue was lower by $6.2 million and is expected to be approximately $13.4 million lower in 2015. These losses will continue to mount if KanCare is not expanded.

What Would Be the Effects of Not Expanding KanCare Beginning in 2016?

KanCare expansion could be approved in the next legislative session in early 2015, in which case it would likely begin in 2016. This report assumes 2016 implementation, with enrollment ramping up to full projected participation levels by 2017. (It is possible that KanCare could be expanded sooner and could begin expansion in 2015; in that event, the additional federal revenues and economic benefits would begin to accrue more rapidly than shown in the estimates below.) About 96,000 more adults would enroll in KanCare in 2016 and about 144,000 more in 2017. After that period, enrollment would stabilize, rising or falling slightly depending on economic conditions. The 100 percent federal matching rate for newly-eligible enrollees only applies in 2016 and would decline to 95 percent in 2017. This analysis estimates the effects of not expanding KanCare, compared to adopting an expansion in 2016:

- If Kansas does not expand KanCare, it will lose an estimated $ 300 million in federal revenue in 2016 and approximately $435 million in 2017, compared to the amounts gained if expansion began in 2016 (Table 2). These levels would continue to rise and reach $533 million in lost federal funding by 2020. In total, Kansas would lose $2.2 billion in federal funds from 2016 to 2020.

Table 2. State-level Losses in Federal Funding, Employment, Economic Activity and Tax Revenue If Kansas Does Not Expand KanCare by 2016 (Compared to Levels If KanCare Is Expanded).

Category	2016	2017	2018	2019	2020	2016-20
Federal Funding Lost (mil $)	$ 299.22	$ 435.30	$ 465.77	$ 498.38	$ 533.26	$ 2,231.93
Total Jobs Not Created	2,546	3,601	3,711	3,781	3,830	n/a
State Gross Product Lost (mil $)	$ 182.94	$ 259.89	$ 269.03	$ 275.50	$ 280.72	$ 1,268.08
Business Activity Lost (mil $)	$ 315.97	$ 448.75	$ 464.38	$ 474.78	$ 482.81	$ 2,186.69
State Tax Revenue Lost (mil $)	$ 5.21	$ 12.79	$ 15.88	$ 17.07	$ 18.10	$ 69.05

All dollars are in constant 2014 dollars.

- Not expanding KanCare by 2016 would cost the state more than 2,500 jobs in 2016 and 3,600 in 2017. By 2020, approximately 3,800 fewer jobs would have been created. (Estimates of job not created are the number of jobs lost in each year compared to the number that would exist had KanCare been expanded. The job losses are not cumulative, so they are not summed over the 2016 to 2020 period.)

- Kansas's gross state product would be approximately $183 million lower in 2016 and nearly $260 million less in 2017 than with a KanCare expansion. Between 2016 and 2020, the state's cumulative gross product would be more than $1.2 billion lower.

- Total business activity would be more than $315 million less in 2016 and more than $448 million lower in 2017. Over the total 2016 to 2020 period, the amount of potential business activity lost would exceed $2.1 billion.

- State revenues would be $5.2 million lower in 2016 and about $12.8 million lower in 2017 because of reduced economic activity in Kansas. Cumulative state revenues would be $69.5 million lower over the 2016-2020 period.

Employment Effects by Sector. Since KanCare is a health insurance program, one might imagine that only health care jobs are affected by the decision to expand. This is not the case. While the initial, direct effects are in health care, as funds flow from the health care sector through the rest of the state economy, most employment sectors are affected. Table 3 summarizes the employment effects statewide of not expanding KanCare beginning in 2016 by industry sector.

Table 3. Estimated Jobs Not Created by Industry Sector If KanCare Is Not Expanded by 2016 (Compared to Levels If KanCare Is Expanded).

Industry Sector	2016	2017	2018	2019	2020
Ambulatory health care services	790	1,096	1,113	1,133	1,155
Construction	111	199	239	255	257
Food services and drinking places	64	96	106	114	120
Hospitals	647	904	926	950	974
Professional, scientific, and technical services	42	57	54	51	47
Retail and Wholesale trade	325	455	466	472	476
Social assistance	3	5	6	7	7
State and Local	217	311	327	338	346
All Others	347	478	473	462	449
Total	2,545	3,601	3,711	3,780	3,830

- In total, about 2,500 potential jobs would not be created in 2016 if KanCare is not expanded. About half of the jobs lost are in the health care sector: there would be around 790 fewer ambulatory health jobs in 2016 and 645 fewer hospital jobs. Healthcare fields pay over 10% of the wages in Kansas, for instance, which means it accounts for over 10% of total consumer spending. Almost half of the 2,500 jobs lost would be in other sectors and they are broadly distributed, including jobs in construction, retail and wholesale, real estate, professional/technical/scientific, food and beverage, social assistance and state/local sectors. By 2017, potential job losses would rise to 3,600 and would continue to climb to more than 3,800 by 2020.

What Are the Budgetary Effects of Expanding KanCare by 2016?

To state policy officials, a critical issue is the cost or savings related to a major policy change. Table 4 examines state-level costs and how they are offset by increased state revenues as well as by potentially offsetting health savings if KanCare is expanded in 2016.

Table 4. State-Level Estimates of Direct Costs of Expanding KanCare in 2016, Stgate Revenues and Potential Offsetting Health Savings, 2016 to 2020

	2016	2017	2018	2019	2020	2016-2020
State Medicaid Match Cost (mil $)	$10.3	$68.4	$72.9	$77.6	$82.7	$311.9
State Tax Revenues Gained (mil $)	-$5.2	-$12.8	-$15.9	-$17.1	-$18.1	-$69.1
Potential Health Savings						
Substance Use Grants (mil $)	*-$9.4*	*-$14.8*	*-$15.5*	*-$16.3*	*-$17.1*	*-$73.0*
Community Mental Health (mil $)	*-$24.7*	*-$40.0*	*-$43.3*	*-$46.8*	*-$50.7*	*-$205.5*
Subtotal, Potential Health Savings (mil $)	-$34.1	-$54.8	-$58.8	-$63.1	-$67.8	-$278.5
Potential Net State Costs/Savings (mil $)	**-$29.0**	**$0.8**	**-$1.8**	**-$2.6**	**-$3.2**	**-$35.7**
Federal Revenue Gained (mil $)	**$299.2**	**$435.3**	**$465.8**	**$498.4**	**$533.3**	**$2,231.9**

Note: Positive numbers mean KanCare expansion will increase state-level costs, while negative numbers mean that there are savings, compared to a scenario without KanCare expansion.

Over the period 2016-2020, the state share of KanCare costs is estimated at $311.9 million. About one-fifth of that amount would be offset by increased state tax revenues generated by additional economic growth, as discussed earlier. These revenue increases reduce the net impact on the state budget. There are also potential savings for the state in reduced health care expenses currently borne for uninsured people who would gain insurance if KanCare was expanded.

Together, the analyses indicate that Kansas would have a net budget savings of $29 million in 2016 and a cumulative budget savings of almost $36 million from 2016 to 2020. There is a very small net cost to the state in 2017 (less than $1 million), but there are generally substantial savings for the state in most years. Even the small state cost in 2017 is trivial when compared to the $425 million in additional federal funds that would be brought into Kansas in 2017 and the $2.2 billion in additional federal revenue from 2016 to 2020.

The first issue is the amount the state must pay for as the state share of KanCare. In 2016 these costs are low because the federal government pays 100 percent of the costs for those newly eligible; there are slight costs due because some more people who were eligible under prior criteria would be attracted to apply if there is publicity about an eligibility expansion. (As noted earlier, the other health reform expansions and outreach that already occurred in Kansas contributed to an increase in KanCare enrollment of about 86,000 in 2014 even though eligibility was not expanded. Most notably, people who applied for health insurance marketplace benefits were referred to KanCare if they appeared to be KanCare-eligible.) In 2017 and later years, the state costs grows because the matching rate for those newly eligible declines to 95 percent in 2017, then to 90 percent by 2020. Thus, over the period 2016-2020, there is an estimated $312 million cost for the state.

These costs would be partly offset by increased state revenues that are generated by higher

economic and employment growth if KanCare is expanded. From 2016 to 2020, state revenue would rise by $69 million, offsetting about one-fifth of the direct costs.

The other area is potential savings from other state health care costs. Currently, the state contributes to care for low-income uninsured patients in various ways. KanCare expansion would provide health insurance to many of these patients, reducing the need for the state funding support. These health savings could potentially offset some of the additional costs of a KanCare expansion, or enable state funding to support a more patients or broader services.

While we expect that Medicaid expansion would greatly reduce the level of uncompensated care borne by Kansas hospitals, as uninsured patients are instead covered by Medicaid, we do not include these as direct state savings since no hospitals in Kansas are directly supported by the state. The reduction in uncompensated care may, however, enable Kansas hospitals to improve services, make other financial adjustments or offset other losses that they may experience (for example due to reductions in Medicare payments).

State savings may be generated by state funding for mental health and substance abuse services. Kansas also spends millions of grant dollars to support a variety of mental health and substance abuse services, and these programs serve many patients who currently are uninsured. Many of these costs could potentially be averted if more adults are covered by KanCare; we estimate potential savings of mental health savings of about $206 million and substance abuse savings around $73 million from 2016 to 2020. Community mental health and substance abuse services are included in the package of services covered by KanCare, although Medicaid does not generally pay for inpatient care for adults at psychiatric hospitals nor for care provided in prisons. Again, we note that these are potential savings; mental health and substance abuse services are often underfunded and Medicaid savings might be redirected to expand the scope of services for others.

Conclusion

The report illustrates how policies to not expand KanCare have broad economic and employment consequences for Kansans. While KanCare expansion policies first affect the health sector of the state, they have broader economic and employment repercussions, in addition to effects on the state budget. Because KanCare was not expanded in 2014, Kansas has already lost hundreds of millions in federal funding, which has led to lower employment, less economic activity and lower tax revenues across the state, than if KanCare was expanded in 2014. KanCare expansion would stimulate economic growth and job creation in Kansas, as well as increase access to health care for about 150,000 state residents.

Appendix: Methods and Data Sources

The estimates in this report are based on multiple sources of information and a widely-used regional economic model to estimate the economic and employment effects of Medicaid expansion. The levels of additional state and federal Medicaid expenditures associated with Medicaid expansion are based on state-level estimates of additional expenditures and enrollment levels published by the Kaiser Commission on Medicaid and the Uninsured and the Robert Wood Johnson Foundation, based on the non-partisan Urban Institute's Health Insurance Policy

Simulation Model.[18] Based on requirements of the ACA, eligibility for federal tax credits applies to those with incomes between 100 and 138 percent of the poverty line if there is not a Medicaid expansion, but if Medicaid is expanded, the minimum income for tax credits is 138 percent of poverty. Thus, the estimates assume some reduction in federal tax credits related to the exchange, but a larger increase in Medicaid expenditures.

These estimates examine the effect of a "regular" Medicaid expansion in Kansas. They are net of other effects of the ACA, such as changes in insurance coverage due to the creation of health insurance marketplaces, which have already been implemented in Kansas. The effects might be slightly different if Kansas expanded KanCare using Section 1115 waiver authority to modify the structure of the expansion, but since Medicaid waivers must be "budget neutral", economic and employment effects should be roughly equivalent regardless. Changes in delivery systems, such as the use of accountable care organizations might also affect the economic impact, but these would be relatively minor compared to the effect of whether KanCare is expanded and would likely not have a major impact on the general estimates in this report.

State-level estimates of additional federal funds received from a Medicaid expansion were allocated to four sectors: hospital, ambulatory care, nursing home and residential care, and pharmaceutical drugs. Generally, experience in Kansas for adult beneficiaries indicates that about two-fifths (40 percent) of the funding will be spent on ambulatory care, two-fifths (44 percent) on hospital care (including inpatient, outpatient hospital and emergency care), one-seventh (15 percent) on pharmaceuticals and very small amounts on nursing home or residential care (1 percent). These estimates were trended forward to years through 2020, guided by Congressional Budget Office projections in changes in Medicaid expenditures and changes in the federal matching share for expansion eligible from 100 percent from 2014 to 2016 to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent by 2020. Historical evidence indicates enrollment increases in Medicaid expansions are not fully implemented in the first year, but take time to ramp up. In our analysis, we primarily focus on the concept that a KanCare expansion could be implemented by 2016, since it would need to be approved in a 2015 legislative session. In a secondary analysis, we ask what would have happened if Kansas had expanded in KanCare in 2014, like about half the states. This addresses the question of what benefits Kansas has already lost by not adopting an expansion earlier.

The economic and employment effects of Medicaid expansion are driven by the additional federal revenue associated with a Medicaid expansion. We do not include changes in state Medicaid expenditures due to Medicaid expansions in the models (although we examine the state budget impact later). If Kansas did not use state funds to cover expansion costs from 2017 to 2020, these funds would likely have been used for another purpose, with similar economic impacts.

The state-level estimates of federal Medicaid expenditures were then analyzed using regional economic model software, Tax PI, version 1.4.103, for Kansas, developed by Regional Economic Models, Inc. (REMI). The Tax PI model uses a structural macroeconomic model to quantify the impact of a Medicaid expansion on Kansas's economy. This permits simulation of the state-level fiscal and economic effects of expansion, and assesses the effect of the changes in health care spending along with the direct costs to the state from additional enrollees, while considering the federal contribution both in the short and longer term. REMI software has been used in thousands of national and regional economic studies, including studies of health care

reform and health care issues around the United States, including fiscal analyses by the Kansas Department of Revenue and the Kansas Hospital Associations' report on KanCare expansion.

The data in the REMI model on healthcare output and consumption comes from public sources. REMI spreads the output of the healthcare industry at the national level based on compensation at the state- or regional-level, giving a consistent series where areas with large quantities of compensation in the healthcare industry have large industry clusters there. This data comes from the Bureau of Economic Analysis (BEA).[19] REMI estimates demand for healthcare at a regional-level based on consumer income and demographic characteristics like age, where national consumption of healthcare is known and spread between the regions and counties of the United States based on the relative wealth and age of the area. The data for this process comes from the Bureau of Economic Analysis (BLS)[20] and the Consumer Expenditure Survey (CES).[21] REMI uses a gravity methodology to account for cross-county purchases of healthcare services, where areas with large outputs in healthcare but minimal demand supply healthcare services to nearby areas with large outputs but smaller quantities demanded. Each revenue source is assigned an economic driver from the dynamic impact model that will form the basis of future estimates of the amount of revenue gained from that particular source. For example, REMI will find the amount of personal income tax revenue collected and connect that to the amount of personal income earned in the state in that year as given by Tax-PI's baseline economic and demographic forecast. Using these two pieces of information (collections and driver), Tax-PI creates a quantified relationship between the two that can then predict changes in the future. A similar process is carried out for each revenue source used.

The economic and employment estimates assume that there are some outflows to other states, particularly neighboring jurisdictions. For example, because of Medicaid expansion, a hospital may receive an additional $10 million, which might be used to increase wages by $6 million and to purchase $4 million more in goods like medical supplies, information systems, construction services or so on. But some of the goods purchased are from another state, so some funds flow out of the area. And some of the workers may reside in another state or purchase goods that come from another state, so some of those funds also flow out. Most health care expenditures are for services, which are typically local or nearby, but others, such as pharmaceutical costs, may flow to another state where manufacturing occurs. The economic models adjust for these outflows.

State-level data about state- funded community mental health expenditures came from a report by the National Association of State Mental Health Directors Research Institute and were projected, assuming growth rates comparable to historical levels. Based on prior research[22], we assumed that the expansion of Medicaid could lead to a one-third reduction in the uncompensated hospital costs and a one-third reduction in community mental health and inpatient psychiatric funding, with a slightly lower level in 2016, when the expansion is ramping up. Data on substance abuse grants funded by the Department of Human Services (Aging and Disability Services) or Department of Corrections are based on appropriations reports for 2015 and were also projected forward. Given that a large share of substance abuse services are connected to the justice system and that a large number of people who may be covered by a Medicaid expansion could be former prisoners, we assumed that, when fully ramped up, Medicaid expansion could defray about half the costs of the substance abuse grants.

We note also that there is some evidence that a Medicaid expansion could generate other savings for correction services if the provision of mental health, substance abuse and other medical care reduces the likelihood that former prisoners commit additional crimes and return to prison.[23] However, since the evidence in this area remains preliminary, we did not include potential savings due to reductions in recidivism among former prisoners.

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