# Economic and Employment Effects of Expanding KanCare in Kansas

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## Introduction

Kansas will soon decide whether it will expand its Medicaid program, KanCare, the publicly funded health insurance program for low-income residents. Under the Patient Protection and Affordable Care Act (ACA, sometimes known as Obamacare), states may decide whether to expand eligibility for their Medicaid programs to non-elderly adults whose family incomes are less than 133 percent of the federal poverty line (an annual income of about $31,000 for a family of four in 2013). To avoid creating undue financial burdens for states, the federal government will pay 100 percent of the medical costs of serving the newly eligible from 2014 to 2016, but its share will phase down to 90 percent for 2020 and the years thereafter.[1] The original intent of the ACA was that all states undertake this expansion, but the Supreme Court's decision in *National Federation of Independent Businesses v. Sebelius* established that states effectively had the option of whether to expand Medicaid eligibility. States may decide whether and when to implement an expansion, but, if it is adopted, Medicaid eligibility must rise to the 133 percent level.

The purpose of this report is to offer a balanced and comprehensive view of the economic, employment and budgetary effects of the decision of whether or not to expand

[1] States that had already expanded Medicaid coverage will have an enhanced matching rate for childless adults, eventually reaching 90 percent by 2020 and beyond.

This is an independent analysis of the economic impact of a Medicaid expansion, conducted by researchers at Regional Economic Models, Inc. (REMI) and the George Washington University (GW). This report was prepared for the Kansas Hospital Association and funded by the American Hospital Association. All opinions and conclusions in this report are those of the authors and do not represent institutional views of REMI, GW, the American Hospital Association or the Kansas Hospital Association.

Medicaid in Kansas. In considering whether to adopt the Medicaid expansion, a state must consider the budgetary and economic consequences of its decision, as well as the health consequences. In the normal course of consideration, a state office prepares a budget estimate of the cost to the state of adopting a new policy. While the budget estimates that are usually prepared are important, they often fail to provide a comprehensive view of the effects because they are focused solely on the direct costs that must be borne by the state.

This report offers a more comprehensive view of the total effect of a Medicaid expansion by also looking at the effect on:

- The level of additional federal funds that will be earned in Kansas due to the Medicaid expansion,
- Kansas' economic activity (that is, the gross state product),
- Employment levels in Kansas,
- State tax revenues that would increase due to higher economic activity, and
- Other budgetary savings, such as savings in other health care costs that may occur if Medicaid covers more low-income patients.

It is important to note that this report focuses on the effects of Kansas' decision to implement a Medicaid expansion, not the impact of the overall federal health law. Under the Supreme Court decision, other changes required by the ACA, such as the establishment of health insurance exchanges, increases in Medicaid primary care payment rates, or changes in how income is counted in Medicaid, will occur regardless of whether a state expands Medicaid or not. This report examines only the additional consequences of expanding Medicaid and assumes the other changes will take place as specified in the federal law.

## Kansas' Medicaid Program

Currently, Kansas' Medicaid program serves adults with dependent children (i.e., non-elderly parents) who have family incomes below the standards used for the cash assistance program (TANF) offered by state's Department for Children and Families (DCF). The standard varies by family size, where in the state the family lives, and whether additional people live in the home. According to state eligibility documents, a typical family of four qualified in 2012 if its countable income is less than $471 per month.[2] Including disregarded income, the eligibility standard is about 32 percent of the federal poverty level, or roughly $7,540 in annual income for a family of four in 2013. Only adult caregivers such as parents and guardians are eligible;

[2] Kansas Department of Health and Environment. KanCare/Medicaid eligibility guidelines for parents/caregivers (updated October 5, 2012). Retrieved February 12, 2013, from http://www.kdheks.gov/hcf/medical_assistance/apply_for_assistance.html.

Kansas does not provide coverage to childless adults under age 65 unless they qualify because of a disability.

Kansas shares the expense of providing Medicaid coverage with the federal government. Today, Kansas' is responsible for 43.5% of most Medicaid spending in the state, and the federal government covers the remaining percentage.[3] The ACA substantially increased the federal matching rates for persons who are newly eligible through the Medicaid expansions, which will reduce state costs for this population. From 2014 to 2016, the federal government will fund 100 percent of spending for this population. This enhanced federal match declines to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and thereafter.

Estimates by the non-partisan Urban Institute indicate that implementation of the Medicaid expansion will increase the number of people in Kansas covered by Medicaid by 169,000 people by 2022.[4] These results are similar to those recently released by the Kansas Department of Health and Environment which estimated that an expansion would increase Medicaid enrollment by about 157,000 by 2022.[5] The Urban Institute projects that an additional 53,000 people who are eligible under today's eligibility rules but not currently enrolled will subsequently sign up due to the publicity and outreach related to health reform; sometimes people call this a "woodwork" effect. Kansas will have to pay the regular matching rate (currently 43.5%) for any Medicaid-covered services obtained by these individuals. Our estimates account for this woodwork effect, but it is worth noting that there will be a woodwork effect regardless of whether Kansas implements a Medicaid expansion or not. There will be substantial publicity and outreach because of the creation of the Health Insurance Exchange and other aspects of the ACA, and individuals with incomes in the Medicaid range should be referred to the Medicaid agency even if they initially applied for the Health Insurance Exchange. The woodwork effect would be somewhat smaller if Kansas does not expand Medicaid, as outreach efforts would likely focus on higher income populations eligible for the Health Insurance Exchange.

If Kansas does not expand Medicaid to 133 percent of poverty, some residents with incomes between 100 and 133 percent of poverty may instead get health insurance through the Health Insurance Exchange. These individuals likely will be fewer in number than those who enroll in Medicaid because the Exchanges will require greater contributions from recipients to enroll and to receive health care. Our analyses account for the fact that some in the 100 to 133

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[3] The 43.5% matching rate applies to expenditures from October 2012 through September 2013.

[4] Holahan, J., Buettgens, M., Carroll, C. and Dorn, S. "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis." Kaiser Commission on Medicaid and the Uninsured. Nov. 2012.

[5] Kansas Department of Health and Environment. Analysis of Affordable Care Act Impact to Kansas Medicaid/CHIP Program, Feb. 13, 2013. Report by Aon Hewitt.

percent of poverty bracket will instead enroll in Health Insurance Exchanges if Medicaid is not expanded. Barring changes to the eligibility standards for the Exchanges set forth in the ACA, childless adults with family incomes below 100 percent of poverty ($23,550 for a family of four in 2013), but above the eligibility level for Kansas' Medicaid program ($7,540 for a family of four in 2013), will not be eligible for either the Exchange or for Medicaid.

## Methods

The underlying purpose of this report is to illustrate the broad economic and employment consequences of a Medicaid expansion in Kansas. It is fundamental to understand that a Medicaid expansion has very broad economic impact, beyond the state budgetary costs. Since most of the increased costs will be borne by the federal government, there will be a substantial inflow of federal funds to Kansas, although some will also be paid by the state government. These funds will initially be paid to health care providers, such as hospitals, clinics, pharmacies and health insurance plans, as health care payments for Medicaid services. That represents the initial flow of funds. Next, the health care providers distribute these funds as salaries to health care staff, payments for other goods and services (such as the costs of rent, equipment, medical supplies, and other goods and services), and as state and local tax payments. This represents the secondary flow of funds. Finally, these funds flow into the broader state economy as workers and businesses use their income to pay for general goods and services, such as 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 to buy other goods and services. Thus, the Medicaid funds trickle through the broader state economy and the total economic impact ends up being larger than the initial amount of Medicaid payments, since the money is recycled through many layers of the state economy. Economists sometimes refer to this phenomenon as the "multiplier effect," although the REMI model uses a more sophisticated approach.

Researchers from the George Washington University (GW) estimated the additional state and federal Medicaid expenditures (or savings) resulting from Medicaid expansion, based on recent estimates published by the Kaiser Commission on Medicaid and the Uninsured, based on the non-partisan Urban Institute's Health Insurance Policy Simulation Model.[6] The GW experts allocated these estimated expenditures among four health care sectors used in the fiscal and economic effects model, described below. The allocations rely on information from several sources, including state Medicaid expenditure data from the Centers on Medicare and Medicaid Services, Medicaid spending and enrollment projections from the Congressional Budget Office,

[6] Holahan et al., Nov. 2012

and publicly available reports and projections from the Kansas Department of Health and Environment, its contractors, and other Kansas-based analysts.

Using these inputs, experts at Regional Economic Models, Inc. (REMI) used a structural macroeconomic model to quantify the impact of the ACA on the broader Kansas economy, with and without the Medicaid expansion. Using its Tax-PI software, REMI simulated the statewide net fiscal and economic effects of expansion, and assessed the net effect of the changes in healthcare 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's models have been used in thousands of national and regional economic studies, including studies of health care reform and health care issues around the United States. More information about the Tax-PI model is available in a technical appendix to this report.

The model used in this analysis covers the state of Kansas and includes 70 industry sectors, three of which pertain most closely to the health care industry data used in this analysis. The three health care sectors used in the model are outlined below with definitions from the U.S. Census Bureau's North American Industry Classification System along with one consumption category:

**Ambulatory Health Care Services:** Establishments in this sector provide health care services directly or indirectly to ambulatory patients and do not usually provide inpatient services. Health practitioners in this sector provide outpatient services, with the facilities and equipment not usually being the most significant part of the production process.

**Hospitals:** This sector provides medical, diagnostic, and treatment services that include physician, nursing, and other health services to inpatients and the specialized accommodation services required by inpatients. Hospitals may also provide outpatient services as a secondary activity. Establishments in the hospitals sector provide inpatient health services, many of which can only be provided using the specialized facilities and equipment that form a significant and integral part of the production process.

**Nursing and Residential Care Facilities:** Industries in the Nursing and Residential Care Facilities subsector provide residential care combined with either nursing, supervisory, or other types of care as required by the residents. In this subsector, the facilities are a significant part of the production process and the care provided is a mix of health and social services with the health services being largely some level of nursing services.

**Spending on Pharmaceuticals:** Pharmaceutical costs fall into two broad areas: distribution and manufacturing costs. Distribution costs include the retail, wholesale and transportation related costs, which are primarily local in nature. Pharmaceutical manufacturing often occurs in another state. REMI assumes that a portion of manufacturing costs may remain

in the state, based on estimates of state manufacturing for pharmaceuticals obtained from other REMI models.

**State Government Spending:** This analysis does not include the state's share of funding for the Medicaid expansion. Given the balanced budget requirement, any additional dollar spent on Medicaid must come from somewhere else in the state. Revenue can come from economic growth, reallocation from other spending, new revenue sources, and cost savings in other health care programs. The net result of all these spending changes is likely to be negligible and thus it is excluded from this simulation.

Table 1 shows a summary of the estimated annual federal Medicaid expenditures by sector associated with the incremental federal funds received for a Medicaid expansion. These represent the "inputs" to the Tax-PI model. (We do not include the state funds on the assumption that the state would have used these funds on an alternative expenditure which would also have a multiplier impact, whereas the federal funds represent new money that would not otherwise be available to the state.)

**Table 1: Inputs to Tax-PI Rounded (millions of nominal dollars)**

| Detail | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|---|---|
| Ambulatory health care services | $160 | $189 | $215 | $220 | $238 | $255 | $275 |
| Hospitals | $84 | $93 | $104 | $106 | $114 | $122 | $132 |
| Nursing and residential care facilities | $40 | $42 | $44 | $42 | $42 | $42 | $43 |
| Pharmaceutical and other medical products | $50 | $58 | $65 | $67 | $72 | $78 | $84 |
| Adjustment for manufacturing costs | -$27 | -$31 | -$35 | -$36 | -$39 | -$42 | -$45 |
| Adjustment for in-state manufacturing | $2 | $3 | $3 | $3 | $3 | $4 | $4 |
| Total increase in federal funding | $334 | $382 | $428 | $435 | $466 | $498 | $533 |

The REMI model treats the input data as demand variables for the health care sectors. The demand variable induces increased growth of those industries, which simulates the effect of expanding government spending on health care. We note that only a portion of the health care expenditures result in increased output by state firms. For example, some patients, particularly those living near state borders, may receive care in an out-of-state facility. The most populous region in Kansas is the northeastern part of the state, along the border with Missouri, with many providers in the greater Kansas City area. Consequently, not all of the new Medicaid spending will be in-state. The regional purchase coefficient estimates the amount of demand satisfied locally. (Of course, in turn, if a bordering state expands Medicaid, Kansas health care providers would have increased revenue. But since this report focuses only on Kansas policies we effectively assume that no bordering states expand Medicaid. In this respect, these estimates may be a conservative representation of increased demand by Kansas health care providers.)

**Table 2: Regional Purchase Coefficients - Averages 2014 - 2020**

| Category | Average |
|---|---|
| Ambulatory health care services | 81% |
| Hospitals | 74% |
| Nursing and residential care facilities | 90% |

**Table 3: Estimated Demand for Health Services In-State and Out-of-State, 2014-2020 ($ millions)**

| Industry | Total In-State Inputs | Funds Out-of-State |
|---|---|---|
| Ambulatory health care services | $1,265 | $287 |
| Hospitals | $556 | $197 |
| Nursing and residential care facilities | $266 | $29 |

# Results

Any expansion of Medicaid will have economic impacts. This section estimates the inputs and results, and describes the cause and effect relationship between them. The results reflect the projected economic growth created by the ACA and its expansion of Medicaid coverage in Kansas. These outputs include an array of economic and demographic indicators including total state employment, gross state product, personal income, and total revenues. All following amounts are in nominal (i.e. not inflation adjusted) dollars.

## State and Federal Expenditures for Expansion

Our estimates differ somewhat from other estimates currently available to the public, although they fall comfortably within the range of projections.[7] All estimates—others and ours—are approximate since it is impossible to know in advance exactly what the condition will be of the state's economy, how many people will participate or how high medical costs will be in the future. However, our projections provide a general sense of the overall magnitude and direction of expected economic and budgetary impacts. We compared our estimates of state costs with those produced by other organizations, such as the Kansas Department of Health and Environment, The Lewin Group and the Kansas Legislative Research Department. The estimates we have used are broadly comparable to most of the other estimates. For example, the Department of Health and Environment estimated that the state Medicaid cost associated with an

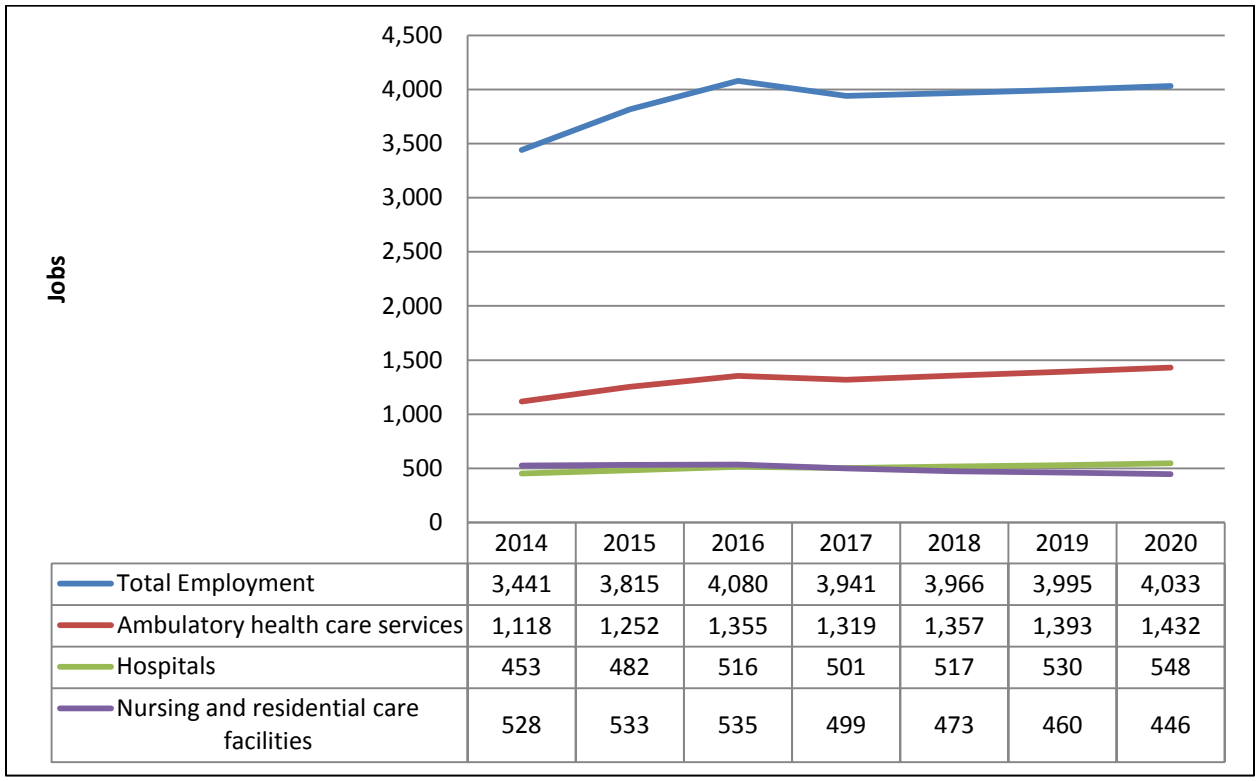
[7] A compilation of estimates from various sources by the Kansas Legislative Research Department is available at http://www.khi.org/documents/2013/feb/08/summary-cost-estimates-medicaid-expansion/. The Kansas Department of Health and Environment, Analysis of Affordable Care Impact to Kansas Medicaid/CHIP Program (by consulting firm Aon Hewitt) on February 13, 2013.

expansion would be $421 million from 2014 to 2022. Our estimate is slightly higher, $525 million from 2014 to 2022, but these estimates are comparable given the uncertainties of any long-term budgetary projections.

## Total Change in Employment and Earnings

One of the most obvious ways that the economy affects people's lives is through creation of new jobs. The additional spending made necessary by expanding Medicaid will lead to millions of dollars of new money going into the health care industries noted above. Most beneficial to Kansas is the commitment of the federal government to cover 100% of the cost through 2016. The small reduction in the federal money coming into Kansas explains the small decrease in employment gains in 2017 and the steady increase thereafter. Figure 1 shows the expected change in employment resulting from the increase in demand for health care and the ripple effects and these changes. The net increase in overall state employment will be between 3,500 and 4,000 jobs. While the majority of these jobs will be in the health care sector, a substantial share will occur in other economic sectors, reflecting the broad multiplier effect of the Medicaid expansion on many sectors of the state economy. For example, to the extent that health care facilities need to expand to serve the newly covered patients, there will be real estate and construction costs that will boost employment in those sectors as well.

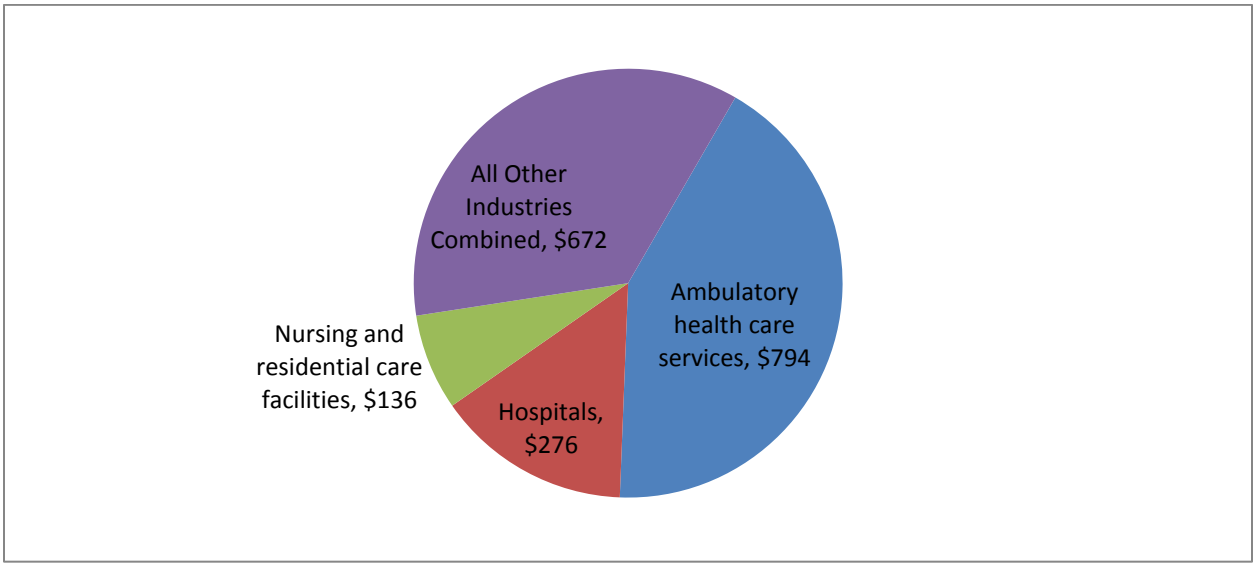
**Figure 1: Changes in Employment Levels Due to Medicaid Expansion**




| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|---|---|
| Total Employment | 3,441 | 3,815 | 4,080 | 3,941 | 3,966 | 3,995 | 4,033 |
| Ambulatory health care services | 1,118 | 1,252 | 1,355 | 1,319 | 1,357 | 1,393 | 1,432 |
| Hospitals | 453 | 482 | 516 | 501 | 517 | 530 | 548 |
| Nursing and residential care facilities | 528 | 533 | 535 | 499 | 473 | 460 | 446 |

Each of the jobs shown in Figure 1 will come with a paycheck. Those paychecks together form Total Earnings by Place of Work, which is the sum of wages, benefits, and proprietors' income paid to employees working in Kansas. These earnings form the basis of Personal Income and increased consumption in the state. As such, they are of primary importance in driving changes in income and sales tax revenues. Figure 2 shows the cumulative change in earnings paid to those employed in Kansas.

**Figure 2: Cumulative Earnings (2014-2020) (millions of nominal $)**




## Total Economic Activity

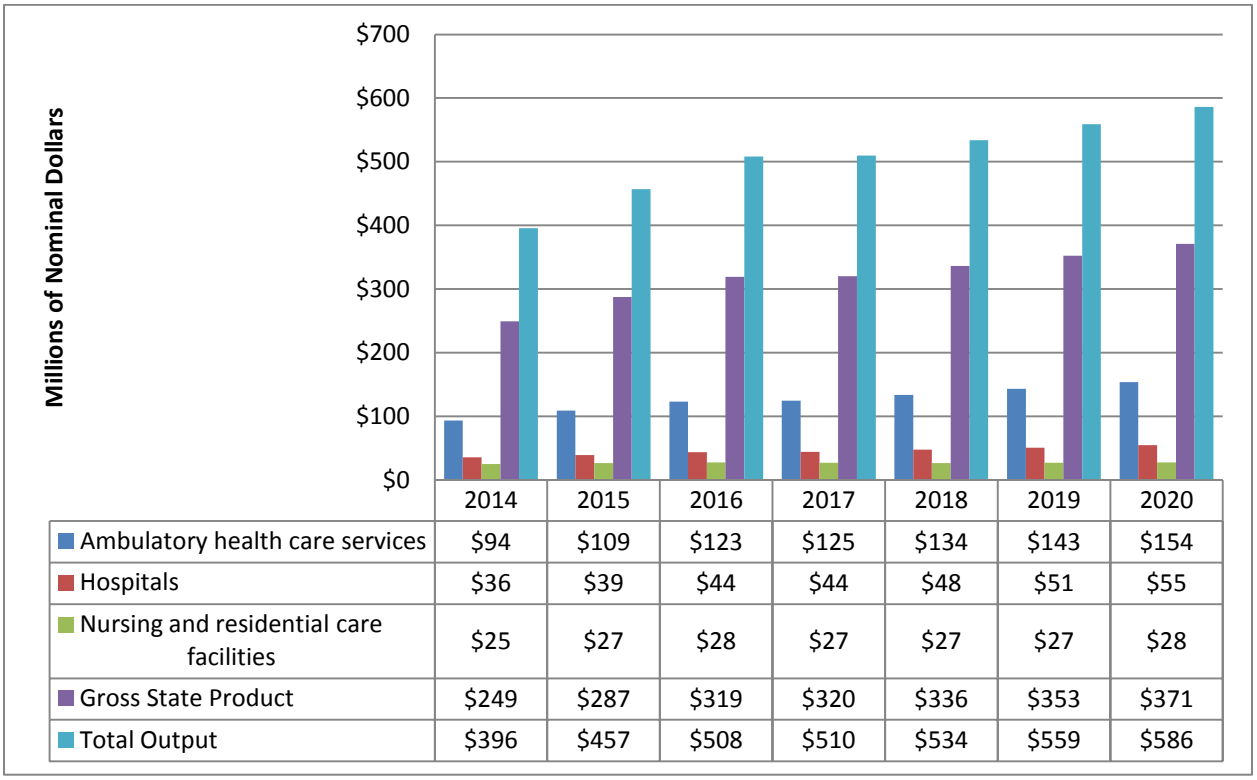
Because there is some leakage out of the state when using the demand variable, it is not a fair assessment of the results to equate the input amounts with the direct, *local* impacts. If we do this, we are underestimating the effect each dollar of local spending has had on the local economy. For example, we estimate that about 25 percent of the inputs in the hospital sector will be received by out-of-state hospitals. Therefore, it is unreasonable to use the full value of spending in the Hospital sector as the increase in revenues going to in-state hospitals.

There are two concepts commonly used to quantify economic growth: output and gross state product. Output is the same as revenues so every time a transaction is completed where money is exchanged output increases whether it is a business-to-business sale or one to the household consumer. As a result of the Medicaid expansion, output in Kansas is expected to increase by an average of $507 million per year for a cumulative increase of $3.55 billion from 2014 through 2020.

Gross State Product (GSP) is a subset of output and is the total new value created within Kansas. GSP can be thought of as all net new economic activity or output minus the goods and serves used as inputs to production. Which transactions are counted is the key difference between GSP and output: where output counts every transaction, GSP only counts the final transaction. As a result of the Medicaid expansion, GSP in Kansas is expected to increase by an average of $319 million per year for a cumulative increase of $2.24 billion from 2014 through 2020.

When choosing between the two concepts output is most appropriate when referring to changes in business activity, as it shows the total amount of new revenues received by all businesses in the state. However, when referring to new growth or value created in the state's economy, GSP is the best measure to use.

**Figure 3: Contributions to Gross State Product by Industry and Other Totals Due to Medicaid Expansion**




| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|---|---|
| Ambulatory health care services | $94 | $109 | $123 | $125 | $134 | $143 | $154 |
| Hospitals | $36 | $39 | $44 | $44 | $48 | $51 | $55 |
| Nursing and residential care facilities | $25 | $27 | $28 | $27 | $27 | $27 | $28 |
| Gross State Product | $249 | $287 | $319 | $320 | $336 | $353 | $371 |
| Total Output | $396 | $457 | $508 | $510 | $534 | $559 | $586 |

## State Tax Revenue Changes

The economic growth created by expanding Medicaid will create more revenue for the state. A simple way to understand where these revenues come from is to use the output growth shown in Figure 3 as an example. Each of these dollars means greater income for businesses which means more corporate income tax revenue for the state. This example can easily be

expanded to understand how economic growth supports greater general tax revenues. Table 4 shows state revenues gained from economic growth.

**Table 4: Change in State Revenues (millions of nominal $)**

| Category | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | Total |
|---|---|---|---|---|---|---|---|---|
| Total Revenues | $6.1 | $13.5 | $15.9 | $17.4 | $18.5 | $19.9 | $21.3 | $112.5 |

## Other State Savings

The expansion of Medicaid eligibility has the potential to reduce other state or local expenditures for health care. Two prominent examples are state mental health expenditures and other state Medicaid-related eligibility categories including; MediKan, the state-funded health insurance program for general assistance enrollees waiting for disability determinations, and the medically needy for families component of Medicaid. Enrollees from both of these existing programs would be eligible for the Medicaid expansion instead.

Table 5 below provides a rough estimate of the value of state-funded community mental health expenditures[8] that might be instead covered by a Medicaid expansion. We assume that by 2016, one-third of those expenditures could be averted because the mental health patients could be served under Medicaid, and that savings ramp up gradually in 2014 and 2015. We also assume that MediKan and medically needy eligibility would no longer be needed because these adults could be served by the Medicaid expansions instead.[9]

**Table 5: Potential Offsetting Health Care Savings If Medicaid is Expanded (millions of nominal $)**

| Category | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | Total |
|---|---|---|---|---|---|---|---|---|
| Community Mental Health | $10.5 | $22.8 | $37.0 | $40.0 | $43.3 | $46.8 | $50.7 | $251.1 |
| MediKan & Medically Needy For Families | $7.8 | $8.1 | $8.4 | $8.8 | $9.1 | $9.5 | $9.9 | $61.5 |
| Total Offsetting Savings | $18.3 | $30.9 | $45.4 | $48.8 | $52.4 | $56.3 | $60.5 | $312.7 |

[8] Data for state community mental health funding for years 2005 to 2010 came from the National Association of State Mental Health Directors Research Institute and were projected, assuming growth rates comparable to historical levels. This excludes funding for psychiatric hospitals, prevention, research, training and administration costs. Medicaid can cover the costs of ambulatory mental health services, but not inpatient psychiatric costs for adults.

[9] Data are based on FY 2012 Medicaid expenditures reported by the state Medicaid agency for MediKan and medically needy for families. We projected these expenditures assuming 4% annual growth.

It is likely that other savings are possible, such as costs of other miscellaneous state health programs or prison-related care, but we do not have a reasonable basis for providing estimates at this time. We note that such savings may not be possible if there are other needs for these services that are not now being met. For example, it is plausible that there are additional mental health needs that are not now being met by state funds; if a Medicaid expansion reduced the need for some current funding, these funds might instead be used to address other behavioral health needs.

## Net State Costs

Table 6 summarizes overall net state costs for the Medicaid expansion. Again, we note that these costs are the incremental costs associated with expanding Medicaid vs. not expanding Medicaid. The state will have to cover ongoing Medicaid expenditures and other ACA-related changes regardless of the decision to expand Medicaid eligibility or not. These estimates suggest that the combination of new state revenues and offsetting savings could actually lead to substantial state savings in 2014 to 2016 and would be essentially almost budget neutral from 2017 to 2020, saving about $89 million from 2014 to 2020. While the state will incur small state costs in the years 2017 to 2020, it is worth remembering that the federal government will provide about $1.9 billion in matching funds in those years, far outweighing the modest state costs.

**Table 6: Net State Government Costs of a Medicaid Expansion (in millions of nominal $)**

**Kansas Fiscal Impacts**

| Year | Increased State Medicaid Costs | New State Revenues | Offsetting State Health Savings | Net State Savings |
|---|---|---|---|---|
| 2014 | $13.0 | $6.1 | $18.3 | $11.4 |
| 2015 | $13.9 | $13.5 | $30.9 | $30.5 |
| 2016 | $14.8 | $15.9 | $45.4 | $46.5 |
| 2017 | $68.4 | $17.4 | $48.8 | ($2.2) |
| 2018 | $72.9 | $18.5 | $52.4 | ($2.0) |
| 2019 | $77.6 | $19.9 | $56.3 | ($1.4) |
| 2020 | $82.7 | $21.3 | $60.5 | ($0.9) |
| **Total** | **$343.2** | **$112.5** | **$312.7** | **$82.0** |

## Conclusion

Expanding KanCare to non-elderly adults with family incomes up to 133 percent of the federal poverty level will provide considerable economic benefits to Kansans on top of providing health insurance coverage for more than one hundred thousand Kansans. Our estimates of the enrollment increases and state costs are similar to, but not exactly the same as the estimates of the Kansas Department of Health and Environment; projections of future impacts always have some uncertainty. This analysis shows that expansion will increase direct Medicaid costs to the state, particularly after 2016 when the federal support for the expansion population begins to decrease. However, the state investments also enable the state to draw down billions of dollars in additional federal funding that will support jobs and maintain the state's health care infrastructure. The increases in employment and economic activity will occur both within the health care sector as well as in other sectors of the state economy. While Medicaid costs will increase, the state will realize additional state tax revenues that should offset a portion of the higher Medicaid costs. In addition, there are other potential offsetting state health care savings that could further reduce overall state costs, so there would be a net savings to the state's budget.