STATE OF KANSAS

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ASSISTANT MAJORITY LEADER
HOUSE OF
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COMMITTEE ASSIGNMENTS
CHAIR: HEALTH & HUMAN SERVICES

MEMBER: APPROPRIATIONS
SOCIAL SERVICES BUDGET

Chairman Rhoades and Fellow Committee Members,

Thank you for the opportunity to testify before you today. I stand in support of the House Concurrent Resolution that would discourage Medicaid expansion in Kansas.

1. Approximately 380,000 low income Kansans are currently covered by Medicaid or KanCare as of January 1, 2013. Two thirds are children and adults who have children who receive medical services under the program. The other one third represent our disabled population who receive medical, as well as community supports and services, through Medicaid waivers that keep them in the community and out of institutional care. Although the Waiver or disabled represent only one third of the population, they represent two thirds of the cost.

2. Currently total Medicaid spending in Kansas is about $3.2 billion with our share at about $1.3 billion. Medicaid spending is now our second largest budget item and is crowding out our ability to fund education and public safety programs. Even without expansion Medicaid is projected to grow 7.4% annually through 2018.

3. Medicaid expansion under the ACA would cover adults without children up to 138% of poverty. Although an accurate prediction is impossible, the KHI predicts that 122,000 could enroll of which 47,000 would be moving from private health insurance into Medicaid in 2014. This is known as the "crowd-out effect." The KDHE Aon Hewitt Study projects an enrollment increase in Medicaid by 226,003 by 2016. In addition, KHI estimates that 88,500 children would move from private insurance into Medicaid or CHIP.

4. A very important consideration under that ACA is the "woodwork effect." There are approximately 29,400 adults and 45,300 children who are eligible

for Medicaid or CHIP who have never enrolled. With the individual mandate under the ACA, many of these individuals will enroll. The state will be required to cover this group at the current match rate of 43% at a cost of approximately $70 million per year the first 2 years and $55.9 million in subsequent years. So in effect we are expanding Medicaid coverage in Kansas even if we opt out of expansion. The KDHE Aon Hewitt Study projects 41,538 enrollment increase due to the woodwork effect without expansion and 74,800 enrollment increase with expansion.

5. Estimates of the cost to the state to expand Medicaid are all over the place, which tells me there is no accurate method of predicting the cost. The KHI predicts a low 7 year cost of $220.8 million and a high of $912.3 million. The Aon Hewitt Study projects a 10 year $1.14 billion increase in state spending with Medicaid expansion and, even without expansion, a $513.5 million increase due to the woodwork effect.

6. My biggest concern is the cost to the federal government for Medicaid expansion. The 7 year cost in Kansas, according to KHI, ranges from a low of $2.2 billion to a high of $6.5 billion. Our national debt threatens our national security, as well as vital programs such as Social Security, Medicare and Medicaid. At a time when our federal government must reduce entitlement spending, it would not be wise to borrow more money to fund Medicaid expansion.

7. Going forward in Kansas our primary concern should be to insure continued Medicaid coverage to our disabled. We know that the cost to fund the Physical Disability Waiver, Frail Elderly Waiver and Nursing Home costs are going to rise with the aging of our Baby Boomer generation. We already participate in two programs that pull down enhanced Medicaid funding. The Hospital Provider Assessment will capture $66.6 million in additional federal Medicaid funding each year. The Hospital Provider Assessment will continue to be used to maintain the 25.8% increase in Medicaid payment rates for hospitals and physicians. The Nursing Home Provider Assessment captures about $23 million in additional federal Medicaid funding each year to support our state nursing home industry. Do we really feel that we can meet these needs while at the same time expanding Medicaid to a total of approximately 530,000 Kansans? Once we make the decision to expand coverage it will be difficult, if not impossible, to eliminate that coverage.

8. The Supreme Court, in their ruling regarding the ACA, gave states the option to opt out of participation in the Medicaid expansion provision. The Court ruled that, in regard to the Spending Clause Power of congress, the law crossed the line resulting in unconstitutional coercion of the states. The Court understood the significant financial burden the Medicaid expansion could place on the states and federal government.

Additional information:

- Disproportionate Share Hospital (DSH) payment to Kansas hospitals in 2013:
  - Federal: $43.3 million
  - State: $33.3 million
  - Total: $76.6 million

- Quarterly payments:
  - 2/3 ($51 million) to 63 community hospitals
  - 1/3 to Institutes for Mental Disease (IMD):
    - Larned: $12.6 million
    - Osawatomie: $6.9 million
    - Rainbow: $1.5million

- DSH Reductions (non-IMD):
  - 2014: $ 2,618,201
  - 2015: $ 3,028,899
  - 2016: $ 2,977,561
  - 2017: $ 8,778,672
  - 2018: $ 23,974,503
  - 2019: $ 26,130,668

The formula for the reductions is tentative and has yet to be finalized by the Secretary of Health and Human Services. The Supreme Court rules that made the ACA provision for Medicaid expansion optional for states may have further implications on DSH reductions.

Medicaid Disproportionate Share Hospital (DSH) Payments

What is DSH?

Disproportionate Share Hospital (DSH) payments provide additional help to those hospitals that serve a significantly disproportionate number of low-income patients; eligible hospitals are referred to as DSH hospitals. States receive an annual DSH allotment to cover the costs of DSH hospitals that provide care to low-income patients that are not paid by other payers, such as Medicare, Medicaid, the Children's Health Insurance Program (CHIP) or other health insurance. This annual allotment is calculated by law and includes requirements to ensure that the DSH payments to individual DSH hospitals are not higher than actual uncompensated costs.

How much to Kansas DSH hospitals receive each year?

Kansas hospitals receive a federal allotment of $43.3 million, which is matched by the state based the Medicaid FMAP rate for a total of $76.6 million in DSH payments for FY 2013. Payments are made on a quarterly basis to hospitals. $25.3 million, or one-third goes to Institutes for Mental Disease which includes Larned State Hospital ($12.6 million), Osawatomie State Hospital ($6.9 million) and Rainbow Mental Health Facility ($1.5 million). The remaining $51.3 million is distributed among 63 community hospitals.

Medicaid DSH Payments and the Affordable Care Act

Under the Affordable Care Act, Medicaid DSH payments will be reduced from 2014-2019. According to the Congressional Budget Office, the reductions would start at 5.1 percent in 2014 and increase to 50.9 percent in 2019. The reduction provisions in the ACA were based on the assumption there would be less uncompensated care at hospitals as more people gained coverage through either the health insurance exchanges or Medicaid expansion. The Supreme Court's decision that Medicaid expansion was optional for states did not, however, eliminate the DSH reductions. Based on the CBO estimates, Kansas DSH reductions would be as follows:

Statewide DSH Reductions 2014-2019
All Funds
(projected impact utilizing current DSH funds and FMAP)

	2014	2015	2016	2017	2018	2019	Total
IMD	$ (1,289,561)	$ (1,491,846)	$ (1,466,560)	$ (4,323,824)	$ (11,808,337)	$ (12,870,329)	$ (33,250,457)
Non IMD	(2,618,201)	(3,028,899)	(2,977,561)	(8,778,672)	(23,974,503)	(26,130,668)	(67,508,505)
Total	$ (3,907,762)	$ (4,520,744)	$ (4,444,122)	$ (13,102,496)	$ (35,782,841)	$ (39,000,998)	$ (100,758,962)