SB 252 Opponent Testimony – Written & Verbal
House Committee on Public Health & Welfare
Medicaid Expansion
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Chairman Suellentrop and Members of the Committee,

On behalf of the Kansas Policy Insitute, we appreciate this opportunity to submit testimony in opposition to SB 252. This bill expands federal-state joint subsidies for health insurance to able-to-work, childless adults. Our opposition stems from these positions.

1. There is no widespread public pressure for Medicaid Expansion
2. Medicaid Expansion creates unsustainable budgetary pressures
3. Medicaid expansion is inefficient as roughly 80% of potential Kansas recipients have alternative health insurance options
4. Medicaid Expansion doesn't improve health outcomes more than private health insurance options
5. Medicaid Expansion diverts state resources from those who genuinely need it
6. Medicaid Expansion will not "save" rural hospitals

There is no widespread public pressure for Medicaid Expansion

While proponents argue a need to expand Medicaid coverage due to overwhelming public demand, there's a considerable number of polls that say the opposite. Surveys done in 2018 by the Foundation for Government Accountability found that 48% of likely Kansas voters did not want to expand Medicaid. Also, the same poll found that after Kansans learn the facts, opposition to Medicaid Expansion rises to 52%.[1] In 2018, a survey conducted by Survey USA, who received an "A" grade from FiveThirtyEight, found a majority (54%) of Kansas voters do not want Medicaid Expansion.[2] In 2019, the survey was conducted again, and this time the share of Kansas voters not wanting Medicaid Expansion rose to 56%, and **71% want work requirements**.[3] Kansans, when given the truth, recognize that when you expand a taxpayer-funded subsidy program to more individuals, they, one way or another, are going to have to pay for it.

Medicaid Expansion creates unsustainable budgetary pressures

An essential feature of rational human behavior is that people respond to incentives. Medicaid Expansion creates the incentive of having someone else pay for their medical bills. By that logic, it is challenging to predict how many individuals will respond to that incentive. Since 2014, the vast majority of expansion states underestimated the number of enrollees and created substantial pressure on their state budget.

On average, two years after a state has expanded Medicaid, enrollment predictions underestimated actuals by 110%. In other words, enrollment doubled what was predicted. Next door in Colorado, the state budget prepared for 187,000 enrollees, but in October 2016 was

[1] Foundation for Government Accountability, *Kansas Voters Oppose Obamacare's Medicaid Expansion*, https://thefga.org/wp-content/uploads/2018/02/Kansas-Voters-Oppose-Medicaid-Expansion-2-14-18.pdf
[2] SurveyUSA, Market Research Study #24581, http://www.surveyusa.com/client/PollPrint.aspx?g=612c5448-8059-4c17-b7d3-742ed10e6993&d=0
[3] SurveyUSA, *Market Research Study #25044*, http://www.surveyusa.com/client/PollReport.aspx?g=f42ed964-8f02-480c-ac9a-205440612514

overwhelmed with 446,000. In Michigan, the state budget made for 477,000 enrollees, the expansion incentive drew in 630,000 by 2016. Today, Michigan is instituting work requirements to get better control over costs. [4] In 2014, Former Governor John Kasich promised enrollment in Medicaid Expansion would never exceed 447,000 by 2020.[5] By 2017, enrollment grew to 720,000, and the state legislature attempted to freeze enrollment to slow costs. The table below summarizes enrollment projections in states that expanded Medicaid in 2014.[6]

ObamaCare expansion states have enrolled more than twice as many adults as expected

STATE	MAX ENROLLMENT	ACTUAL ENROLLMENT	AS OF DATE	OVER PROJECTIONS
Arizona	297,000	397,879	9/2016	34%
Arkansas	215,000	324,318	10/2016	51%
California	910,000	3,842,200	5/2016	322%
Colorado	187,000	446,135	10/2016	139%
Connecticut	113,000	186,967	12/2015	65%
Hawaii	35,000	35,622	6/2015	2%
Illinois	342,000	650,653	4/2016	90%
Iowa	122,900	139,119	2/2016	13%
Kentucky	188,000	439,044	12/2015	134%
Maryland	143,000	231,484	12/2015	62%
Michigan	477,000	630,609	10/2016	32%
Minnesota	141,000	207,683	12/2015	47%
Nevada	78,000	187,110	9/2015	140%
New Hampshire	45,500	50,150	8/2016	10%
New Jersey	300,000	532,917	1/2015	78%
New Mexico	149,095	235,425	12/2015	58%
New York	76,000	285,564	12/2015	276%
North Dakota	13,591	19,389	3/2016	43%
Ohio	447,000	714,595	8/2016	60%
Oregon	245,000	452,269	12/2015	85%
Pennsylvania	531,000	625,970	4/2016	18%
Rhode Island	39,756	59,280	12/2015	49%
Washington	262,000	596,873	7/2016	128%
West Virginia	95,000	174,999	12/2015	84%
Combined	**5,452,842**	**11,466,254**		**110%**

[4] Bridge Magazine, *Michigan the latest to roll out Medicaid work rules. Can it avoid pitfalls?*, https://www.bridgemi.com/michigan-health-watch/michigan-latest-roll-out-medicaid-work-rules-can-it-avoid-pitfalls
[5] Dayton Daily News, *Kasich expands Medicaid under Obamacare*, https://www.daytondailynews.com/news/state--regional-govt--politics/kasich-expands-medicaid-under-obamacare/iYlvALgMH7P5n2fE4zwiZM/
[6] Foundation for Government Accountability, *Obamacare Expansion Enrollment is Shattering Projections*, https://thefga.org/wp-content/uploads/2016/12/ObamaCare-Enrollment-is-Shattering-Projections-1.pdf

According to the U.S. Census Bureau, there are roughly 106,000 residents of Kansas City, Missouri, with income between 50% and 149% of the federal poverty limit. Can the state budget afford Medicaid Expansion if a share of these individuals cross state lines, reside in Kansas, to be eligible for the state's Medicaid?[7]

In the state of Lousiana, Medicaid Expansion has not only led to cost overruns but payments to ineligible Medicaid Expansion recipients. According to the Medicaid Audit Unit of the Lousiana Department of Health, the state paid somewhere between $62 to $86 million for Medicaid recipients who did not qualify for Medicaid coverage. [8] The Office of Inspector General testified to the U.S. Senate Finance and Health Care committee regarding states failing to ensure recipients of Medicaid Expansion funds are eligible.[9] See the table below.

Report Title	Report Number	Date Issued	Ineligible		Potentially Ineligible	
			Beneficiaries	Dollars	Beneficiaries	Dollars
Colorado Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries	A-07-16-04228	August 2019	85,085	$66,525,688	13,372	$26,797,483
New York Did Not Correctly Determine Medicaid Eligibility for Some Non-Newly Eligible Beneficiaries	A-02-16-01005	July 2019	383,893	$520,295,792	618,057	$1,297,308,200
California Made Medicaid Payments on Behalf of Non-Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements	A-09-17-02002	December 2018	802,742	$536,039,109	3,100,260	$2,616,843,793
California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements	A-09-16-02023	February 2018	366,078	$628,838,417	79,055	$402,358,529
New York Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries	A-02-15-01015	January 2018	47,271	$26,221,803	0	-

[7] U.S. Census Bureau, https://factfinder.census.gov/bkmk/table/1.0/en/ACS/17_5YR/B17024/0400000US20|320M400US2928140

[8] Lousiana Department of Health: Medicaid Audit Unit, *Medicaid Eligibility: Wage Verification Process of the Expansion Population*, http://app.lla.state.la.us/PublicReports.nsf/0/1CDD30D9C8286082862583400065E5F6/$FILE/0001ABC3.pdf

[9] Office of inspector General, *Testimony: Medicaid: Compliance with Eligibility Requirements*, https://oig.hhs.gov/testimony/docs/2019/ritchie-testimony-10302019.pdf

Medicaid expansion is inefficient as roughly 80% of potential Kansas recipients have alternative health insurance options

Medicaid Expansion is the quintessential proof of government duplicating services already provided by the private sector. According to the Kansas Health Institute, 3 out of 4 potential expansion recipients could immediately find health insurance coverage elsewhere.[10] As shown in the adjacent table, more than a third of the 150,000 Kansans "helped" by Medicaid Expansion are children. These Kansas children, along with roughly 4,000 adults, qualify for traditional Medicaid. 26,000 Kansas adults could apply and receive a premium tax credit from the federal exchange. This is a partial goal of SB 252, but it goes to show that Kansas can help these individuals now. This leaves around 32,000 Kansans that are uniquely eligible for Medicaid Expansion. However, the status quo can still help these individuals as 30,000 job vacancies offer health insurance benefits. [11]

Roughly 80% of Medicaid Expansion Kansans Have Alternative Insurance Options		
Cohort	Adults	
	Number	Percent
Traditional Medicaid Eligible (Uninsured w/ Income Under 38% FPL)	3,966	4%
Medicaid Expansion Eligible (Uninsured w/ Income Under 100% FPL)	31,589	32%
Federal Exchange Eligible (Uninsured w/ Income Above 100% FPL)	26,060	27%
Medicaid Expansion Eligible (Private Insurance)	36,671	37%
Total Adults	98,286	
Cohort	Children	
	Number	Percent
Traditional Medicaid or CHIP Eligible (Uninsured)	18,840	19%
Traditional Medicaid or CHIP Eligible (Private Insurance)	34,805	35%
Total Children	53,645	
Total Kansans "Claimed" by Medicaid Expansion	151,931	
Total Kansans Uniquely Eligible for Medicaid Expansion	31,589	
Source: U.S. Census Bureau		

Medicaid Expansion doesn't improve health outcomes more than private health insurance options

First and foremost, Medicaid Expansion is not healthcare. Despite the reports brought by supporters, there's little evidence of any independent study showing that Medicaid recipients are healthier than those with private insurance. The reason why is because Expansion is a government mandate that the taxes of others will pay the medical bills for some.

Here are some studies that back such a claim. Studies show that Medicaid patients tend to experience health outcomes worse than those under private insurance after adjusting for economic, admission, and other factors.[12] Another study randomly selected 900,000 surgeries over four years. It found that Medicaid patients were 93% more likely to pass away than those with private insurance.[13] A study, this time in the New England Journal of Medicine, couldn't find a statistically

[10] Kansas Health Institute, *Projected Costs and Enrollment of Medicaid Expansion in Kansas, November 2016*, https://www.khi.org/policy/article/16-12
[11] Kansas Department of Labor, *Job Vacancy Survey 2019*, https://public.tableau.com/profile/kdol#!/vizhome/KansasJobVacancySurvey2019/JobVacancySurvey2019
[12] National Institutes of Health, Morbidity and mortality of colorectal carcinoma surgery differs by insurance status, https://www.ncbi.nlm.nih.gov/pubmed/15382089
[13] National Institutes of Health, *Primary payer status affects mortality for major surgical operations*, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3071622/

significant difference in health outcomes between Medicaid expansion patients and those with no health insurance at all.[14]

Medicaid Expansion diverts state resources from those who genuinely need it

Money is a fungible resource, or in other words, mutually interchangeable. Under SB 252, state government must devote resources to pay $35 million for Medicaid Expansion, and that's if you consider enrollment projection accurate. Due to the inherent features of money, more state resources devoted to Medicaid Expansion means fewer resources available for traditional Medicaid.[15] This means that pregnant women, disabled persons, children, and deficient income families risk remain on the traditional Medicaid waiting list until there are enough state resources to provide the services.

According to the latest participation report, there are roughly 1,500 physically disabled, and 4,000 developmentally disabled Kansans on traditional Medicaid waiting lists.[16] Adding insult to injury, the state share resources devoted to Medicaid Expansion is roughly the same amount of spending needed to eliminate the state's current waiting list.[17]

Medicaid Expansion will not "save" rural hospitals

When it comes to an understanding of the plight of rural hospitals in Kansas and the nation at large, the problem is mostly one of economic forces.[18] In rural parts of Kansas, there's been an out-migration of working-age individuals, residents who remain tend to be very old or very young. This leads to higher rates of uncompensated care in hospitals. There have also been changes to inpatient care; many rural hospitals were built post-WWII to provide a level and volume of care that is simply no longer needed. Today, the average rural hospital has 50 beds, over 300 employees, but a daily census of 7 patients. Hospitals must react to this new reality not double-down on budget management practices that may have worked in the past.

Medicaid Expansion does not address these economic trends, a payer mix degradation, and/or decline of inpatient care. In fact, by guaranteeing a stream of revenue, Medicaid Expansion discourages hospital administrators from adapting to their changing economic environment. There's no more exceptional example than in Fort Scott, KS. Even though the city hospital closed its doors, healthcare services were still provided in the city. After community health centers filled the hole left by the hospital, city manager Dave Martin told Kaiser Health Network, "we will not have – or do we need – a hospital, "

We urge the committee to reject SB 252 in its current form and appreciate your consideration of this matter.

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[14] New England Journal of Medicine, *The Oregon Experiment – Effects of Medicaid on Clinical Outcomes*,
[15] U.S. Department of Health and Human Services, *2016 Actuarial Report on the Financial Outlook for Medicaid*, https://www.medicaid.gov/medicaid/finance/downloads/medicaid-actuarial-report-2016.pdf
[16] KDADS, *December 2019 HCBS Monthly Summary*, https://www.kdads.ks.gov/docs/default-source/csp/hcbs/monthly-waiver-program-participation-reports/2019/waiver-program-participation-report-12-15-19.pdf?sfvrsn=8f2902ee_0
[17] KHI News Service, *Medicaid expansion could cost more than $100M per year*, https://www.khi.org/news/article/kdhe-medicaid-expansion-could-cost-more-than-100m-per-year
[18] Navigant, *Rural Hospital Sustainability*, https://www.navigant.com/-/media/www/site/insights/healthcare/2019/navigant-rural-hospital-analysis-22019.pdf

KANSAS POLICY INSTITUTE

KANSANS
ON MEDICAID EXPANSION

A recent survey reveals that Kansas voters want lawmakers to reject Medicaid expansion or reduce spending to pay for it.

Kansas voters were asked

HOW SHOULD KANSAS PAY FOR MEDICAID EXPANSION?

22% want to reduce other spending to pay for it

14% want income or sales tax increases to pay for it

AND

56%

OF KANSANS ARE OPPOSED TO MEDICAID EXPANSION ALTOGETHER

Across political parties

71%

OF VOTERS WANT WORK REQUIREMENTS

only 15%

are opposed to work requirements for able bodied recipients

On average, **costs have more than doubled predictions** in expansion states. There are **solutions** to lower the cost of health care and help Kansans without Medicaid expansion.

Voters demand solutions.

THERE ARE ALTERNATIVES.

KANSASPOLICY.ORG/EXPANSION2020

SURVEYUSA INTERVIEWED 675 ADULTS FROM THE ENTIRE STATE OF KANSAS 12/10/19 THROUGH 012/14/19 EXCLUSIVELY FOR KANSAS POLICY INSTITUTE