ALLIANCE FOR A
HEALTHY KANSAS

Written Testimony
April Holman, Executive Director
Alliance for a Healthy Kansas
Special Committee on Medicaid Expansion
Tuesday, November 12, 2019

Chairman Landwehr and Members of the Committee –

Thank you for allowing me the opportunity to provide testimony regarding the Senate Medicaid Expansion Proposal as well as data regarding the people who are currently in the health insurance coverage gap.

My name is April Holman and I am the Executive Director of the Alliance for a Healthy Kansas. The Alliance is a broad-based statewide coalition of organizations and individuals that have come together to improve the health of Kansans. Alliance members include business leaders, doctors and hospitals, social service and safety net organizations, faith communities, chambers of commerce, advocates for health care consumers, and others. In addition to convening the coalition, the Alliance also conducts health policy analysis and education.

Coverage Gap Data

The Alliance has been working to close the coverage gap in our state since our inception in 2016. People in the coverage gap make too much money to qualify for Medicaid but not enough to qualify for subsidies to purchase private health insurance on the marketplace exchange. In Kansas, childless adults don't qualify for Medicaid regardless of how low their income may be and adults with children under the age of 18 at home only qualify if they earn 38% of the federal poverty level or less. That means that a single mother with two children already makes too much to qualify for Medicaid in Kansas if she earns $8,105 per year.

Coverage Gap Breakdown

The majority of Kansans in the coverage gap (64 percent) are working, but don't have insurance through their work either because their employer doesn't offer health insurance or they cannot afford to pay the premium. Across the country 43 percent of adults in the Medicaid population work full time in low-wage jobs and an additional 19 percent work in part-time jobs. About 15 percent of the adults in the Medicaid population are not working due to an illness or disability, while 11 percent are not working because they are providing care to a family member and 6 percent are not working because they are attending school. That leaves only 6 percent of the adult Medicaid population who are not working for some other reason.

Top Occupations in the Coverage Gap

Working Kansans in the coverage gap have jobs that our communities rely on every day. They hold service jobs that support infrastructure, business, and quality of life in our communities. The most common jobs where workers find themselves in the health insurance coverage gap in our state are:

- Food Preparation and Serving Occupations – cooks, bartenders, restaurant servers, and dishwashers
- Sales and Retail Occupations – cashiers, retail salespeople, travel agents and real estate brokers
- Office and Administrative Support Occupations – telephone operators, bank tellers, receptionists, secretaries
- Building and Grounds Cleaning and Maintenance Occupations – housekeepers, janitors, groundskeepers, and pest control workers
- Transportation and Material Moving Occupations – bus drivers, truck and tractor operators, and shipping and packaging workers

Medicaid Expansion Proposals

The Alliance has not had the opportunity to meet with our full coalition to discuss the Senate Medicaid Expansion Proposal so we don't have a firm position on the specific provisions at this time. However, as advocates for increased access to care, the Alliance is focused on two overarching principles when it comes to Medicaid Expansion policy. The first is that expansion should be free from barriers to participation that undermine the purpose of expansion, which is to provide insurance to more people thereby increasing access to healthcare and decreasing uncompensated care to providers. The second principle is that the implementation of Medicaid Expansion should take place as soon as possible without unnecessary delays.

Through the lens of our guiding principles of no barriers and no delays, the most efficient and effective approach would be a straight expansion of Medicaid eligibility to 138 percent of the federal poverty level accomplished through authorizing legislation and a State Plan Amendment.

Premiums. Premiums have been proposed in both the House and Senate versions of expansion.

Premiums create a barrier to participation for low-wage people. Budgets for families living in poverty and even those slightly above the poverty line are unbelievably tight. People in this situation regularly juggle making payments for household necessities like rent, groceries, utilities and transportation without enough income to make ends meet. Adding an additional monthly payment of $25 per adult as required by the House proposal or $50-plus per adult as required by the Senate proposal is just not feasible for families at this income level. The result will be that the intended beneficiaries of expansion will be priced out of participation.

No financial benefit to the state. It is important to note that premiums don't provide a significant, if any, financial benefit to the state. That is because the federal government receives a credit for 90 percent of the premium proceeds while the state retains only 10 percent of the proceeds but is responsible for paying half of the administrative expenses to collect the premium. As a result, it can actually cost the state more money to charge a premium to Medicaid consumers than if there was no premium.

Work Requirements. Work requirements for low-wage working people are difficult to structure legally and expensive to administer. At least three state work requirement policies are currently enjoined by the courts and the only state to have any track record operating a work requirement, Arkansas, saw 18,000 people lose their insurance in the first 6 months the policy was in place. There are several reasons for this, including the fact that many low-wage jobs have seasonal and other fluctuations in employee hours and low-wage workers often don't control the number of hour they are scheduled to work. Other reasons people did not comply with the work reporting requirement include that they didn't know about it or didn't understand it and that they didn't have the necessary online access to report their work electronically as required.

Both the House and Senate expansion proposals have work referral programs, which are preferable to work requirements. However, it is important that the work referral process remain as streamlined and seamless as possible for beneficiaries to comply.

Lockouts. Lockouts can happen in the area of premiums or work requirements and they involve consumers losing their insurance coverage and being prohibited from re-applying for a set amount of time. In the case of the House proposal there is a permanent lockout for non-payment of the premium three times. In the case of the Senate proposal there is a 6 month lockout for failure to pay the premium.

Lockouts create a barrier to participation in expansion and undermine the purpose of increasing the number of people with health insurance and reducing uncompensated care to providers. They can be particularly devastating to individuals experiencing financial hardship due to active illness like cancer, resulting in the loss of insurance just when the patient needs it the most. While it is our position as health consumer advocates that lockouts should be avoided entirely, at the very least the policy should allow the consumer to re-apply in a reasonable amount of time and provide administrative flexibility to prevent the loss of coverage for consumers facing catastrophic illness and other reasons.

Viability of Partial Expansion. One of the reasons that 36 states have already expanded their Medicaid programs is because the federal government pays an enhanced rate of 90 percent of the cost while states are only responsible for a 10 percent match. In order to receive this enhanced match states are required to expand eligibility for their Medicaid program to 138 percent of the federal poverty level. In fact, the Centers for Medicare and Medicaid Services (CMS) has recently issued a definitive statement to this effect, saying: "A number of states have asked CMS for permission to cover only a portion of the adult expansion group and still access the enhanced federal funding. … While we have carefully considered these requests, CMS will continue to only approve demonstrations that comply with the current policy."

States have the ability to adopt a partial expansion by increasing their eligibility to a lower percentage of the federal poverty level but this would receive the traditional Medicaid match rate, with about 55 percent paid by the federal government and 45 percent paid by the state of Kansas.

While the House proposal is based on the full expansion to 138 percent of the federal poverty level, which would draw down the enhanced, 90/10 match the Senate proposal would require the submission of two 1115 waivers requesting a partial expansion up to 100 percent of the federal poverty level. This partial expansion appears to be tied directly to the start date for expansion of January 1, 2021, without a guarantee of enhanced match. We are concerned that the higher 45 percent responsibility for the state could be unsustainable and might jeopardize expansion if the partial expansion went into effect.

Waivers Resulting in Delay. Waivers to provisions of the federal law are not always negative. In fact, they can foster innovation and efficiencies that benefit consumers and providers. However, waivers can create significant delays in implementation if they prevent the state from proceeding with planning and implementation of Medicaid Expansion. These delays stem from the amount of time it takes to prepare the waiver and the time involved in the waiver approval process, which is unlimited in the case of 1115 waivers.

The federal 1332 reinsurance waiver in the Senate Proposal also has the potential to hinder implementation of the expansion process. While reinsurance has been beneficial in other states it does not need to be tied to expansion and in fact is part of a completely separate federal waiver process.

Waivers would be required in both the House and Senate Expansion proposals. We would prefer a bifurcated process that allows implementation of expansion through a State Plan Amendment at the same time that the waiver process is underway. This minimizes the delay to implementation.

Measuring the Success of Expansion

One of the benefits to being one of the last states to expand our Medicaid program is that we are able to learn from the experience of states that have already expanded. The Alliance has identified the following measures as effective ways to measure the success of expansion policies based on a scan of some of the reports that other states already produce.

- Coverage
    - X new adults enrolled in expansion coverage
    - X children enrolled in coverage
        - Preventative health
            - % increase in primary care visits
            - % increase in diagnosed conditions (such as early detections of cancer)
            - Diabetes/asthma care

    - Tobacco cessation rates
    - # of individuals diagnosed and/or treated for a substance use disorder or mental health condition
- Work referral
    - X referred to work supports
    - % increase employed among expansion eligible
    - % increase in individuals who said they were better able to work or look for work as a result of having coverage
- Economic impacts
    - % increase in state GDP
    - % increase in general fund revenue
    - % increase in household earnings
    - X amount of state budget savings (such as from reduced uncompensated/free/charity care programs or related programs, like the amount the Dept of Corrections pays for inpatient hospitalization of inmates)
    - X of jobs added/created (in health care, health care-adjacent or other sectors)
    - Reduction in medical debt (either the # of people with debt or the amount of the debt itself)
    - Reduction in borrowing rates/Improvement in credit scores

In closing, I would like to thank you again for allowing me to share the Alliance for a Healthy Kansas coalition and consumer perspective. We are encouraged that the conversation has shifted to when and not if Medicaid Expansion will happen in Kansas. I am happy to stand for questions.