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MEDICAID EXPANSION AND MAIN STREET: PROJECTED EFFECTS OF EXPANDING KANCARE ON KANSAS EMPLOYERS

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212 SW 8th Avenue | Suite 300
Topeka, Kansas | 66603-3936

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APRIL 2021

Authors

Phillip Steiner, M.A.

Sydney McClendon

Kari M. Bruffett

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Executive Summary

Since the option to expand Medicaid to low-income adults under the terms of the Affordable Care Act (ACA) entered the policy debate in Kansas in 2012, many potential effects have been discussed, including projected enrollment, costs and savings for the state, access to care for the previously uninsured, reduced uncompensated care for providers, and effects on the state economy. Much less often discussed has been the potential effects of expansion on Kansas employers.

This report examines potential Medicaid expansion through the lens of Kansas businesses. Based on peer-reviewed articles, independent studies and an analysis of data from the U.S. Census Bureau and the Agency for Healthcare Research and Quality, this report investigates the potential effects of Medicaid expansion on Kansas employers, including the financial effects related to the cost of employee health insurance and non-financial effects related to employee health status and ability to work, as well as effects on the labor market.

A February 2021 report by KHI estimated that around 88,000 adults would newly enroll in Medicaid in the first year after expansion was implemented. It was further estimated that around 29,000 of these new enrollees will have switched from another form of coverage, including employer-sponsored insurance (ESI), to Medicaid. Based on experiences in other states that have expanded Medicaid, this new analysis estimates that employees switching to Medicaid from ESI would save private-sector employers in Kansas between $37.1 million and $71.4 million per year in contributions to employer-sponsored health plan premiums, and reduce tax penalties for private-sector employers by between $2.4 million and $9.1 million per year, for a combined total savings of between $39.6 million and $80.6 million per year.

In addition to the financial effects, there are non-financial effects for employers whose employees would newly enroll in Medicaid, including improvements in health and ability to work. These benefits may particularly – but not exclusively – accrue to those who were previously uninsured. Further, while some initially feared negative impacts on the labor market due to expansion, to date there have been minimal changes to the overall size of the labor force, hours worked, early retirements and wages in states that have expanded Medicaid.

Figure ES1 (page iv) outlines key findings identified in this report, organized by the research question addressed.

Figure ES1. **Key Findings by Research Question**

Research Question	Key Findings
What businesses employ Kansans who would be eligible for Medicaid if expanded?	• Nearly all Kansas industries employ Kansans who would potentially be eligible for Medicaid if expanded. • Businesses that provide Accommodation and Food Services employ the most Kansans – nearly 23,000, or 22.8 percent of the industry – who would potentially be eligible for Medicaid if expanded. • Other industries whose workforce would be most impacted by Medicaid expansion include Administration and Support and Waste Management (14.8 percent); Wholesale Trade (13.5 percent); Agriculture, Forestry, Fishing, and Hunting (12.6 percent); and Educational Services (12.3 percent). • While nearly two-thirds (66.3 percent) of employed Kansans potentially eligible for Medicaid if expanded worked full-time, Medicaid expansion-eligible employees were more likely to work part-time or part-year compared to all employed Kansans (33.7 percent compared to 17.0 percent).
What are the potential effects of Medicaid expansion on employers?	**Financial impacts:** Private-sector employers would save an estimated $39.6 million to $80.6 million per year on contributions to employer-sponsored health plan premiums and reduced tax penalties, depending on the number of employees who switch to Medicaid. **Non-financial impacts:** Studies have found that Medicaid expansion is tied to improved health, improved self-reported ability to work, and minimal impacts to the overall labor market, including the size of the labor force.

Introduction

Despite multiple proposals to expand Medicaid in Kansas since passage of the Affordable Care Act (ACA), Kansas is one of 12 states that has not expanded Medicaid. Missouri and Oklahoma voters approved Medicaid expansion in 2020, making Kansas the only state among its neighbors that has not adopted Medicaid expansion.

The potential effects of Medicaid expansion on businesses in Kansas is a relatively under-addressed question. While other studies have looked at the macroeconomic effects of expansion – for example on tax revenues and state economies – no study has looked at potential effects on Kansas industries and businesses as employers.

To profile the potential effects of expansion on Kansas employers, this report examines the industries that employ people likely eligible for Medicaid if expanded. Expanding Medicaid in Kansas under the terms of the ACA would extend eligibility to all adults age 19 to 64 with family income at or below 138 percent of the federal poverty level (FPL) – $36,570 for a family of four or $17,774 for an individual in 2021. Kansas adults between the ages of 19 and 64 are currently eligible for Medicaid if their family income is below 38 percent FPL – $10,070 per year for a family of four in 2021 – and they have a child living at home. Pregnant women, those who are blind or those living with disabilities may be eligible at other income levels.

Kansas businesses currently employ about 139,000 adults whose age and household income would make them eligible for Medicaid if expanded, although not all would enroll. The effects of expansion for employers range from savings related to the employer share of health insurance premiums and reduced tax penalties, to improvements in enrollee health and self-reported ability to work.

This report also reviews recent research on the effects of expansion on the labor market and notes other questions for future research.

Section 1. Profile of Employers Likely to be Impacted by Medicaid Expansion

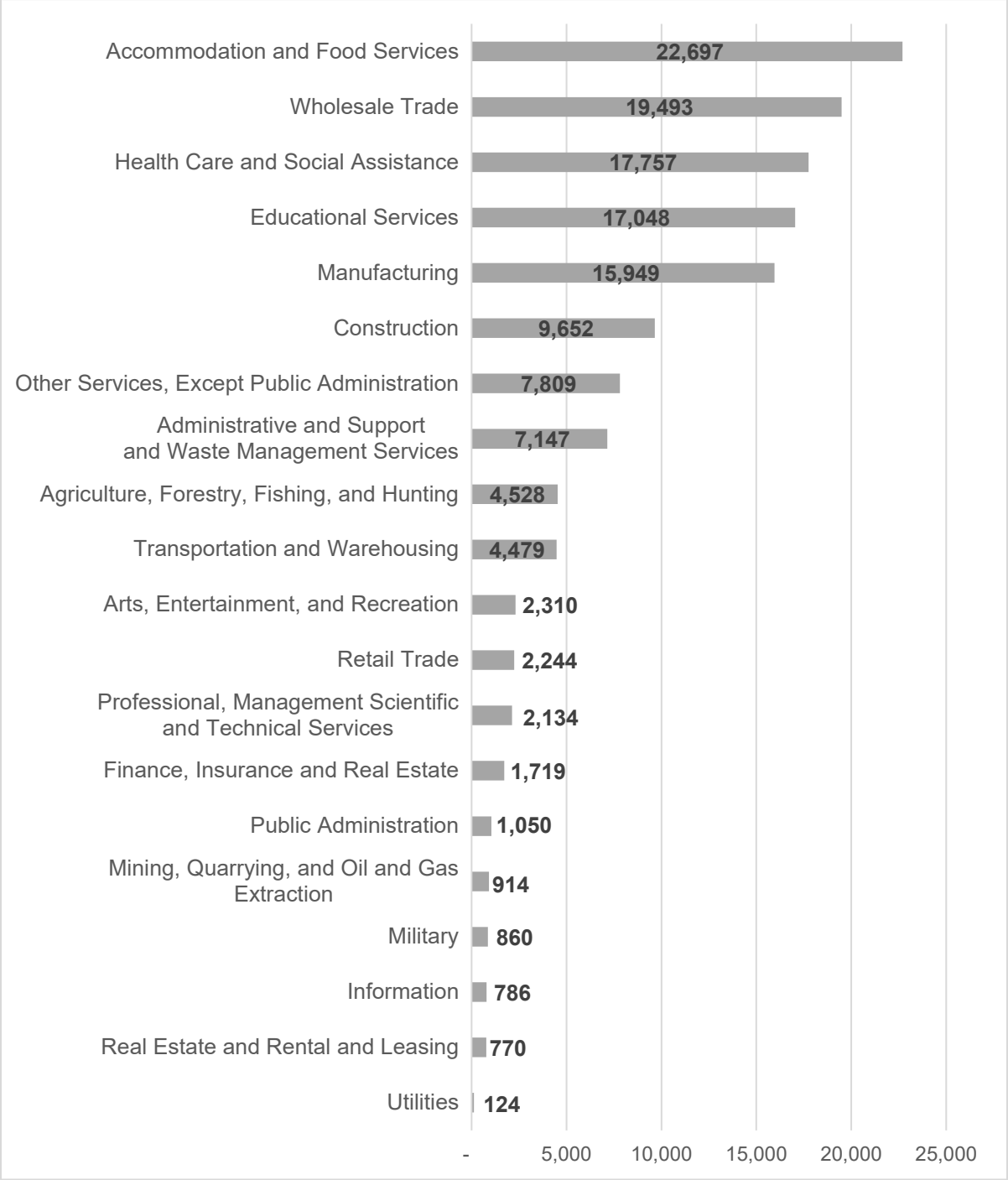
Medicaid expansion will impact employers of low-wage workers (the average hourly wage for employees eligible for Medicaid if expanded was $10.20 in 2019). This section identifies the industries and occupations of Kansans who are likely to be eligible for Medicaid if expanded.

Type of Industry and Occupation

While employers in nearly all industries in Kansas employ those who are potentially eligible for Medicaid if expanded, about two-thirds work in one of five industries: Accommodations and Food Services; Wholesale Trade; Health Care and Social Assistance; Educational Services; and Manufacturing. *Figure 1.1* (page 3) lists the industries in Kansas by the number employed who would potentially be eligible for Medicaid if expanded. *Figure 1.2* (page 4) lists the industries in Kansas by the percentage of employees who may be eligible for Medicaid if expanded out of all employees in the industry.

Industries are defined based on the primary activities of the employing organizations. Some industries include a wide range of activities. For example, Manufacturing includes employees of firms that process food, fabricate materials or tools and manufacture cars and airplanes. Other industry groups, such as Accommodation and Food Services, which includes restaurants, caterers, hotels (including hotels with casinos) and bars, are more limited in the scope of activities that are included. Because industries are assigned by the primary activity, Public Administration is limited to regular government functions such as legislative, judicial, administrative and regulatory activities. Other government organizations are classified in each industry by the activity they perform. For example, public schools are classified under Educational Services, and public hospitals are classified under Health Care and Social Assistance.

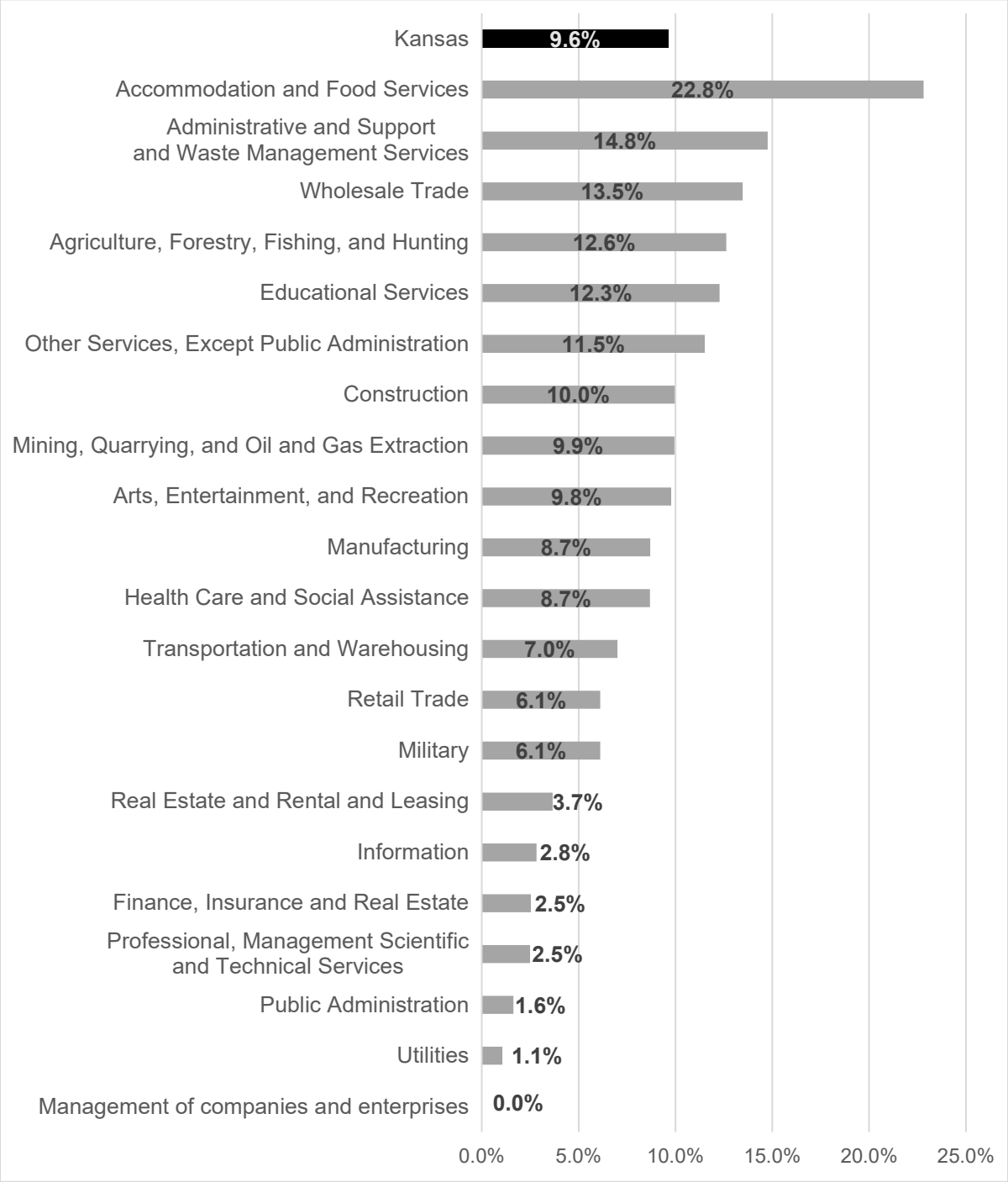
Figure 1.1. **Industries with the Largest Number of Employed Kansans Potentially Eligible for Medicaid if Expanded, 2019**



Note: Kansans who are employed and potentially eligible for Medicaid if expanded = 139,470 adults age 19 to 64 with family income at or below 138 percent FPL. Public and private-sector employees are included for each industry. The Census Bureau classifies survey responses from individuals about the types of businesses or activities they are doing and assigns an industry code based on the 2017 North American Industry Classification System (NAICS) code published by the Executive Office of the President, Office of Management and Budget (OMB).

Source: KHI analysis of U.S. Census Bureau 2019 American Community Survey Public Use Microdata Sample.

Figure 1.2. **Industries with the Highest Percentage of Employed Kansans Potentially Eligible for Medicaid if Expanded, 2019**



Note: Kansans who are employed and potentially eligible for Medicaid if expanded = 139,470 adults age 19 to 64 with family income at or below 138 percent FPL. There are 1,446,468 Kansans defined as employed. Public and private-sector employees are included for each industry. The Census Bureau classifies survey responses from individuals about the types of businesses or activities they are doing and assigns an industry code based on the 2017 North American Industry Classification System (NAICS) code published by the Executive Office of the President, Office of Management and Budget (OMB).

Source: KHI analysis of U.S. Census Bureau 2019 American Community Survey Public Use Microdata Sample.

The employers of the 139,470 working Kansas adults potentially eligible for Medicaid if expanded represent many different industries that are the lifeblood of communities. The top five occupations by the number employed who are potentially eligible for Medicaid if expanded are cashiers, waiters and waitresses, nursing assistants, janitors and building cleaners, and cooks. *Figure 1.3* shows the total employment in each occupation and the number and percent employed who are potentially eligible for Medicaid if expanded.

Figure 1.3. **Top Five Occupations of Medicaid Expansion Eligible Kansans, 2019**

Occupation	Total Employment	Employees Eligible for Medicaid if Expanded	
		Number	Percentage
Cashiers	26,243	5,858	22.3%
Waiters and Waitresses	24,416	5,733	19.3%
Nursing Assistants	22,548	5,250	25.4%
Janitors and Building Cleaners	19,223	4,712	23.6%
Cooks	23,552	4,536	22.3%

Note: Kansans who are employed and potentially eligible for Medicaid if expanded = 139,470 adults age 19 to 64 with family income at or below 138 percent FPL. There are 1,446,468 Kansans defined as employed. Occupations are coded using the 2018 Census Occupation Code List, which is based on the 2018 Standard Occupational Classification maintained by the U.S. Department of Labor's Bureau of Labor Statistics.

Source: KHI analysis of the U.S. Census Bureau 2019 American Community Survey Public Use Microdata Sample.

Figure 1.4 (page 6) lists the top occupations for those potentially eligible for Medicaid if expanded in the industries that either employ the most Medicaid expansion eligible Kansans or the industries with the highest percentage of employees potentially eligible for Medicaid if expanded. For some occupations in these industries, a high percentage of those employed are potentially eligible for Medicaid if expanded. For example, more than a quarter (26.4 percent) of waiters and waitresses in the Accommodation and Food Services industry and nearly half (47.7 percent) of home health aides in the Health Care and Social Assistance industry are potentially eligible for Medicaid if expanded.

Figure 1.4. **Occupations of Medicaid Expansion Eligible Kansans, by Industry, 2019**

Industry	Occupation	Total Employment	Employees Eligible for Medicaid if Expanded	
			Number	Percentage
Accommodation and Food Services	Waiters and Waitresses	21,701	5,733	26.4%
	Cooks	13,830	3,243	23.4%
	Food Service Managers	9,821	2,262	23.0%
	Driver/Sales	3,125	1,743	55.8%
	Fast Food and Counter Workers	6,966	1,610	23.1%
	Remaining Occupations	44,043	8,106	18.4%
Wholesale Trade	Cashiers	18,051	4,519	25.0%
	Retail Salesperson	22,018	3,548	16.1%
	Stockers and Order Fillers	9,135	1,754	19.2%
	First-Line Supervisor of Retail Sales Workers	29,086	1,322	4.5%
	Customer Service Representatives	5,593	1,005	18.0%
	Remaining Occupations	60,788	7,345	12.1%
Educational Services	Teaching Assistants	17,578	3,699	21.0%
	Secondary School Teachers	14,608	1,735	11.9%
	Postsecondary Teachers	10,561	1,706	16.2%
	Elementary and Middle School Teachers	28,247	1,238	4.4%
	Secretaries and Administrative Assistants Except Legal, Medical and Executive	4,841	1,186	24.5%
	Remaining Occupations	63,015	7,484	11.9%
Health Care and Social Assistance	Nursing Assistants	22,045	4,792	21.7%
	Childcare Workers	8,260	2,020	24.5%
	Home Health Aides	3,001	1,430	47.7%
	Licensed Practical and Licensed Vocational Nurses	7,565	1,094	14.5%
	Personal Care Aides	7,251	898	12.4%
	Remaining Occupations	156,433	7,523	4.8%
Manufacturing	Printing Press Operators	4,112	2,064	50.2%
	Other Assemblers and Fabricators	13,041	1,992	15.3%
	Miscellaneous Production Workers Including Equipment Operators and Tenders	10,134	1,685	16.6%

Figure 1.4 (continued). **Occupations of Medicaid Expansion Eligible Kansans by Industry, 2019**

Industry	Occupation	Total Employment	Employees Eligible for Medicaid if Expanded	
			Number	Percentage
Manufacturing (*continued*)	Remaining Occupations	156,022	10,208	6.5%
Agriculture, Forestry, Fishing, and Hunting	Farmers, Ranchers and Other Agricultural Managers	19,270	2,165	11.2%
	Remaining Occupations	16,595	2,363	14.2%
Administration and Support and Waste Management	Janitors and Building Cleaners	7,104	1,862	26.2%
	Landscaping and Groundskeeping Workers	6,041	1,546	25.6%
	Remaining Occupations	35,273	3,739	10.6%
Remaining Industries	All Occupations	591,314	34,851	5.9%
Total		1,446,468	139,470	9.6%

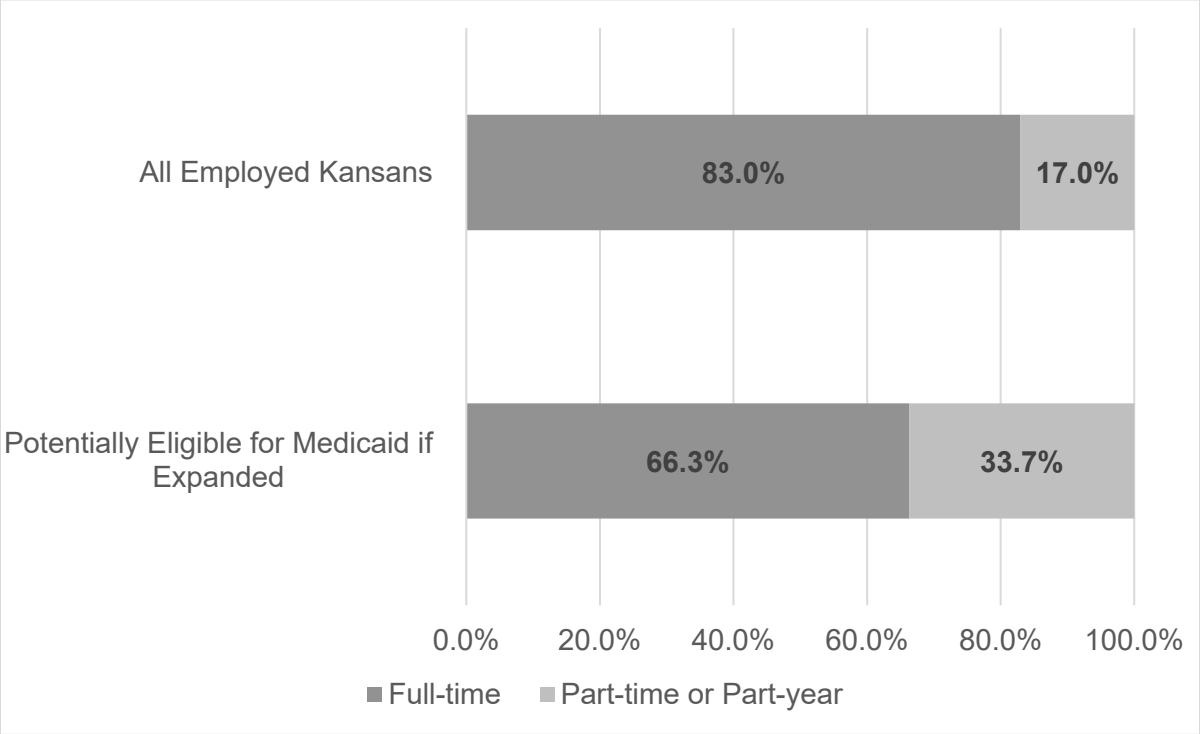
Note: Kansans who are employed and potentially eligible for Medicaid if expanded = 139,470 adults age 19 to 64 with family income at or below 138 percent FPL. There are 1,446,468 Kansans defined as employed. Occupations are coded using the 2018 Census Occupation Code List, which is based on the 2018 Standard Occupational Classification maintained by the U.S. Department of Labor's Bureau of Labor Statistics.

Source: KHI analysis of the U.S. Census Bureau 2019 American Community Survey Public Use Microdata Sample.

Type of Employment

The ACA considers working 30 hours or more per week for at least 24 weeks per year as full-time, and less than 30 hours per week as part-time. Part-year is defined as an individual working more than 30 hours per week for less than 24 weeks in a year. Examples of part-year workers include those who were unemployed for part of the prior year or work seasonally (e.g., during the holidays). Nearly two-thirds (66.3 percent) of employed Kansans potentially eligible for Medicaid if expanded worked full-time. The remaining 33.7 percent worked part-time or part-year. Additionally, employed Kansans potentially eligible for Medicaid if expanded were more likely to work part-time or part-year compared to all employed Kansans (33.7 percent compared to 17.0 percent, respectively). *Figure 1.5* (page 8) shows full-time or part-time status for all employed Kansans and employed Kansans potentially eligible for Medicaid if expanded.

Figure 1.5. **Employed Kansans by Full-Time or Part-Time Employment Status and Potential Eligibility for Medicaid if Expanded, 2019**



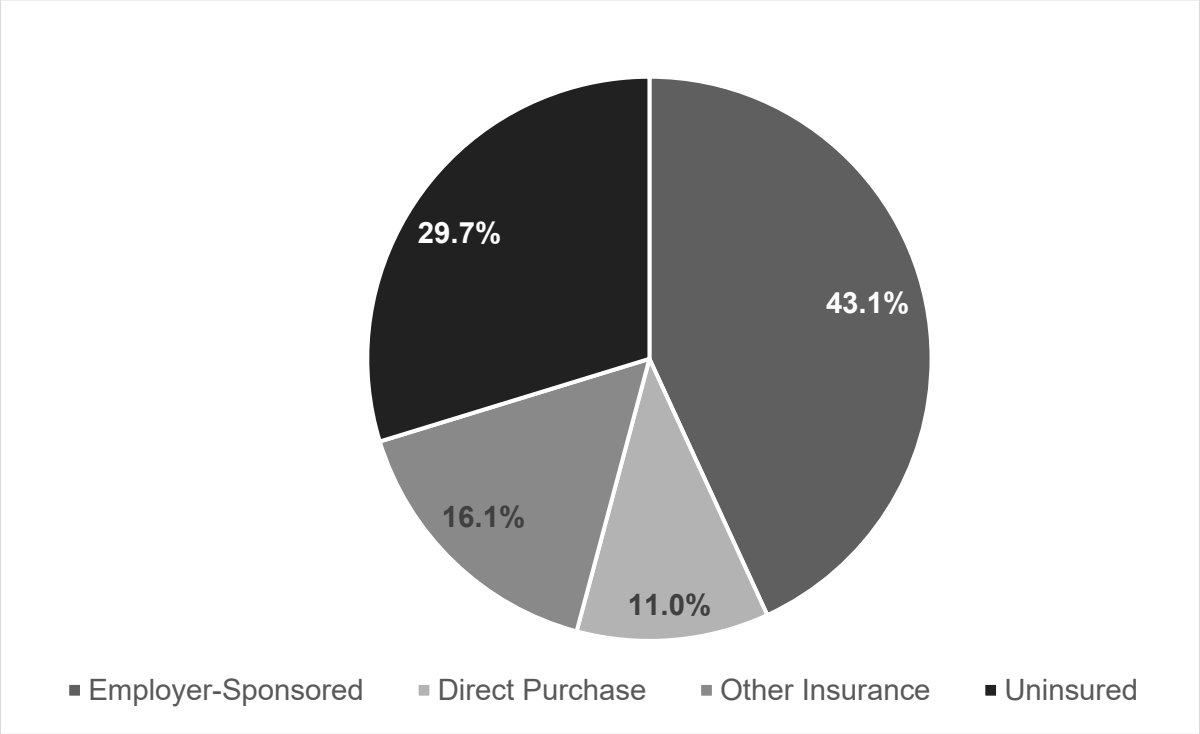
Note: Kansans who are employed and potentially eligible for Medicaid if expanded = 139,470 adults age 19 to 64 with family income at or below 138 percent FPL. There are 1,446,468 Kansans defined as employed. Full-time is defined as 30 hours or more per week for at least 24 weeks in a year. Part-time is defined as less than 30 hours per week. Part-year is defined as 30 hours or more per week for less than 24 weeks a year.

Source: KHI analysis of the U.S. Census Bureau 2019 American Community Survey Public Use Microdata Sample.

Section 2. Employer-Sponsored Insurance in Kansas

Employer-sponsored insurance (ESI) is the most common source of health insurance coverage for employed Kansans potentially eligible for Medicaid if expanded (43.1 percent), and many of the employed and potentially eligible for Medicaid if expanded are uninsured (29.7 percent) (*Figure 2.1*, page 9). However, there are differences in insurance status for those who are employed full-time compared to those working part-time or part-year. Those working full-time are more likely than those working part-time or part-year to have ESI (44.6 percent compared to 40.2 percent, data not shown) and are less likely to have direct-purchase coverage like the ACA marketplace (8.9 percent compared to 15.1 percent, data not shown).

Figure 2.1. **Insurance Coverage for Employed Kansans Potentially Eligible for Medicaid if Expanded, 2019**



Note: Kansans who are employed and potentially eligible for Medicaid if expanded = 139,470 adults age 19 to 64 with family income at or below 138 percent FPL. The estimated number who are employed with employer-sponsored coverage is not a unique count of ESI plans. Some with employer-sponsored insurance are a spouse or dependent of someone with an ESI plan through their employer. Other insurance coverage includes Military or TRICARE and public sources of coverage (Medicaid, Medicare and the U.S. Department of Veterans Affairs).

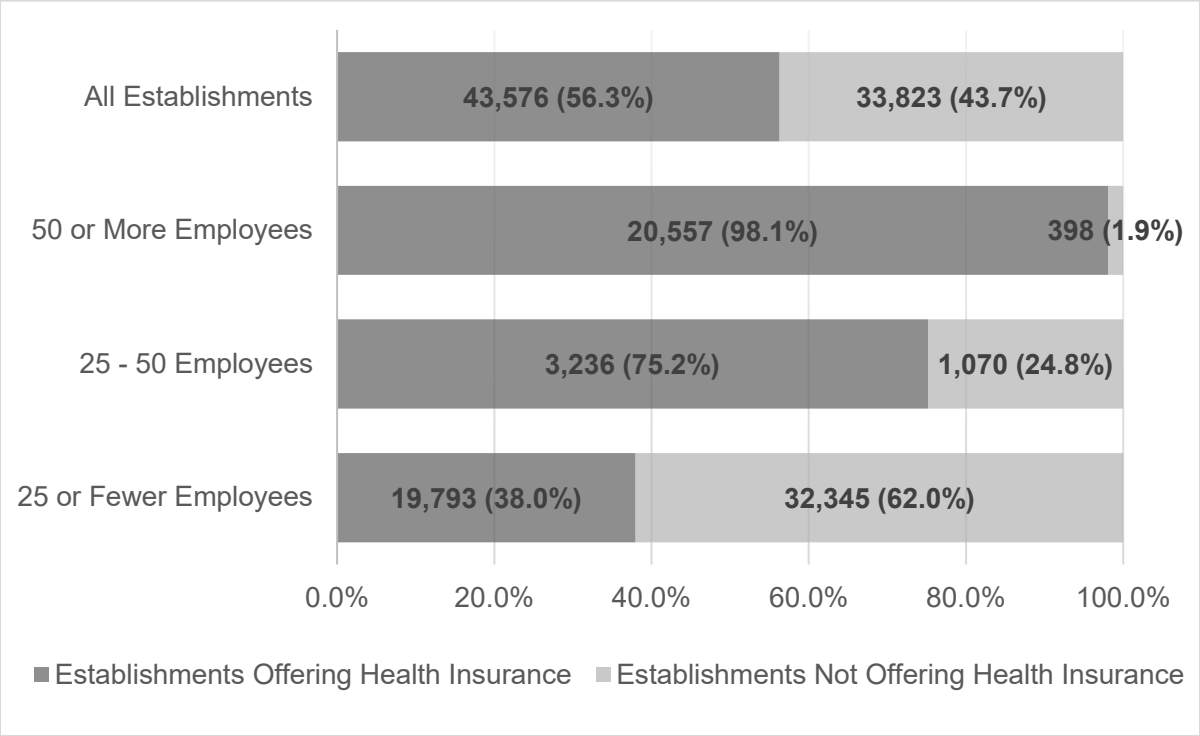
Source: KHI analysis of U.S. Census Bureau 2019 American Community Survey Public Use Microdata Sample files.

Employers are not required to offer health insurance coverage to their employees, but the ACA created several incentives to encourage employers to do so. Employers with 50 or more full-time employees that do not offer minimum essential coverage that is affordable to at least 95 percent of their employees incur a tax penalty if at least one of their employees enrolls in ACA marketplace coverage and receives a subsidy. Employers with 50 or fewer employees are exempt from the tax penalty, and some employers with 25 or fewer employees may receive a tax credit to reduce the cost of providing health insurance to their employees.

Data from the Agency for Healthcare Research and Quality's Medical Expenditure Panel Survey show that of the 77,399 private-sector establishments in Kansas, 56.3 percent (43,576 establishments) offered health insurance, with large employers (50 or more full-time employees) the most likely to offer insurance (98.1 percent offer health insurance) and small employers (25 or fewer full-time employees) the least likely to offer insurance (38.0 percent offer health

insurance). *Figure 2.2* shows the total number of private-sector establishments and the percentage that offer health insurance by the number of employees.

Figure 2.2. **Private-Sector Establishments that Offer Health Insurance by Firm-Size, 2019**



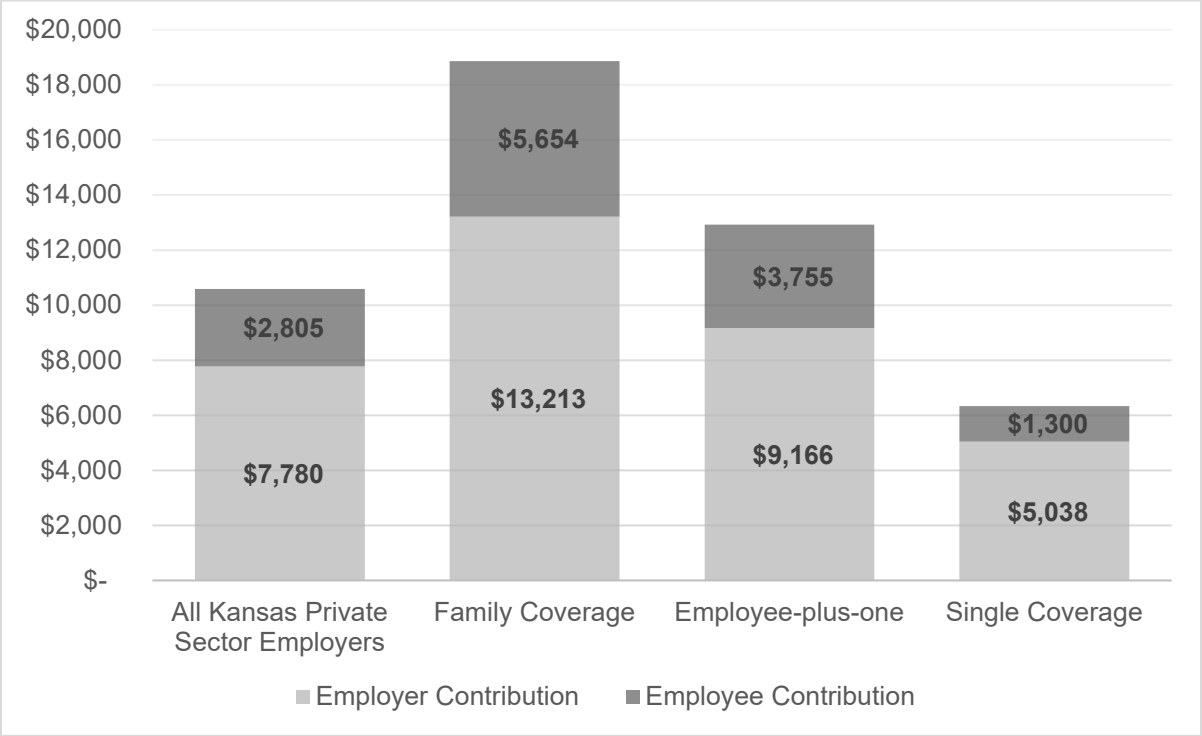
Note: There are 77,399 private-sector establishments in Kansas, of which 20,955 have 50 or more employees, 4,306 have between 25 and 50 employees and 52,138 have 25 or fewer employees. Private-sector establishments are those that engage in any economic activity other than that of government. In this data, the private-sector excludes the unincorporated, self-employed with no-employees. The self-employed with employees and the incorporated, self-employed with no employees are included.

Source: KHI analysis of the 2019 Medical Expenditure Panel Survey's Insurance Component.

There are generally three types of employer-sponsored coverage offered to employees: single or employee only, family, and employee plus one – which may include a spouse or child. The total premium and the amount covered by the employer and the employee varies by the type of coverage the employee selects. Family plans, which can cover a spouse and children up to age 26, are on average the most expensive followed by employee plus one and then single coverage. Because the ACA penalizes employers with more than 50 employees if they do not offer affordable coverage – defined as not costing more than 9.83 percent of the employee's income in 2021 (based on the cost of the lowest price single coverage offered) – and one of their employees receives a subsidy through the ACA marketplace, many employers that offer health insurance have increased their contributions for lower-income employees. *Figure 2.3*

(page 11) shows the average employer and employee share of the annual premium by plan type. Employees who switch to Medicaid would most likely save the entire premium contribution for themselves and their employer as well as any copays or deductibles that are required by their employer-sponsored plan.

Figure 2.3. **Kansas Private-Sector Employer and Employee Average Annual Premium Contributions by Type of Coverage, 2019**



Note: Private-sector establishments are those that engage in any economic activity other than that of government. In this data, the private-sector excludes the unincorporated, self-employed with no-employees. The self-employed with employees and the incorporated, self-employed with no employees are included. Single coverage only covers the employee. Employee-plus-one coverage covers a spouse or child in addition to the employee. Family coverage can cover an employee's spouse and/or all dependent children up to age 26.

Source: KHI analysis of the 2019 Medical Expenditure Panel Survey's Insurance Component.

Section 3. Financial and Non-Financial Impacts of Medicaid Expansion for Employers

Financial Impact

Prior research indicates that some employed individuals who would qualify for Medicaid if expanded are likely to move from their current employer-sponsored insurance (ESI) to Medicaid. Further, all individuals with incomes from 100 to 138 percent of FPL who purchased health insurance through the ACA marketplace would be required to move from marketplace

coverage to Medicaid. Research from Medicaid expansions prior to the ACA indicates that the marginal take-up rates of Medicaid among newly eligible individuals ranged from 15 to 24 percent, and the Urban Institute has estimated that 13 percent of adults who had ESI prior to becoming eligible for Medicaid via the ACA expansion enrolled in Medicaid.[1,2] While expansion appears to have had minimal impact on the overall rate of private insurance enrollment in states that expanded Medicaid, any transitions from ESI to Medicaid can result in savings to employers.[3-5]

A subset of employed Kansans with ESI will likely switch to Medicaid once eligible, leading to savings for some Kansas employers due to reduced premium contributions and lesser or no tax penalties. This analysis estimates that overall private-sector employers in Kansas would save between $37.1 million and $71.4 million per year from reduced premium contributions, and between $2.4 million and $9.1 million in reduced tax penalties. *Figure 3.1* (page 13) shows a low estimate and high estimate of the savings estimated for private-sector employers from their employees enrolling in Medicaid instead of ESI or ACA marketplace coverage by industry groupings. A brief description of the methodology used is provided here, and a detailed discussion of the methodology is included in *Appendix A*.

To estimate the savings for private-sector employers from reduced premium contributions, demographic, insurance and income data from the American Community Survey (ACS) was used to estimate that on average 5.7 percent of the 616,262 private-sector Kansas employees enrolled in an ESI plan who are not self-employed would potentially be eligible for Medicaid if expanded (a total of 35,374). Then based on experience in other states, it was estimated that between 13 and 25 percent of those 35,374 employees would switch to Medicaid if expanded (between 4,599 and 8,843). Multiplying the assumed number who would switch by the statewide average employer premium contribution for each industry yields a low estimated savings (based on 13 percent of eligible employees switching) and a high estimated savings (based on 25 percent of eligible employees switching) to employers from not paying premiums for employees who would potentially switch their insurance coverage to Medicaid if expanded.

In addition to premium savings, employers with 50 or more full-time or full-time equivalent employees could avoid tax penalties if Medicaid was expanded. A penalty is assessed on large employers if at least one employee enrolls in marketplace coverage and receives a premium tax credit. If Medicaid is expanded, everyone with family income between 100 and 138 FPL who applies for marketplace coverage would be enrolled in Medicaid and employers would no longer

be penalized for those employees enrolling in marketplace coverage. Employers are penalized a different amount depending on whether they offer health insurance coverage at all, or instead do not offer affordable health insurance coverage that meets minimum coverage requirements.

Figure 3.1. **Estimated Annual Private-Sector Employer Savings by Industry**

Industry	Low Estimate	High Estimate
Agriculture, Fishing, Forestry and Construction	$2.3 million	$4.7 million
Mining and Manufacturing	$6.4 million	$13.6 million
Retail Trade, Other Services	$14.9 million	$29.9 million
Professional Services	$6.5 million	$13.2 million
All Other	$9.4 million	$19.1 million
Total Kansas Private-Sector Employers	$39.6 million	$80.6 million

Note: The savings for employer premium contributions were calculated by multiplying the assumed number of employees with employer-sponsored insurance who would switch to Medicaid by the average employer premium in each industry. The average premium per industry and a detailed discussion of the methodology for calculating the reduction in tax penalties for large employers is included in the appendix. Estimated savings are not net of any additional taxes that may be incurred. Retail Trade, Other Services include employees of establishments classified as Retail Trade; Administrative and Support and Waste Management; Arts, Entertainment and Recreation; Accommodation and Food Services; and Other Services, Except Public Administration. Professional Services include employees of establishments classified as Information; Professional, Management, Scientific and Technical Services; Educational Services; and Health Care and Social Assistance. All Other includes employees of establishments classified as Utilities; Wholesale Trade; Transportation and Warehousing; Finance, Insurance and Real Estate; and Management of Companies and Enterprises.

Source: KHI analysis of the U.S. Census Bureau 2019 American Community Survey Public Use Microdata Sample and the 2019 Medical Expenditure Panel Survey's Insurance Component.

In Kansas, like the United States as a whole, a majority of private-sector establishments have 10 employees or less. However, more than two-thirds of private-sector employment is concentrated in the approximately 25 percent of businesses with 50 or more employees. These large employers are more likely to offer health insurance to their employees. Thus, most savings to private-sector employers from some of their employees switching to Medicaid if expanded may be concentrated in relatively few employers within each industry. Employers can determine how much they may save from employees switching their insurance from ESI to Medicaid if expanded by calculating the number of employees potentially eligible, the average share of the premium paid by the employer per potentially eligible employee, and any tax penalties that would be avoided.

Figure 3.2 (page 14) shows hypothetical examples of how Medicaid expansion might create savings for businesses in the Accommodation and Food Services industry in Kansas for various firm sizes and numbers of employees potentially eligible for Medicaid if expanded. The savings

for companies offering affordable insurance to their employees reflect the average employer premium contribution for Retail and Other Services (which includes the Accommodation and Food Services industry) and the low and high end of the estimated range that Medicaid expansion eligible employees with ESI might newly enroll in Medicaid (either 13 or 25 percent). The savings for companies offering insurance that is not affordable for Medicaid expansion eligible employees are attributed to reduced tax penalties, assuming that between zero and all Medicaid expansion eligible employees were enrolled in an ACA marketplace plan. If Medicaid is expanded, all of these employees who would have enrolled through the ACA marketplace would be enrolled in Medicaid.

Figure 3.2. **Hypothetical Examples of Estimated Annual Savings for Individual Businesses**

Scenario	Offers Affordable Health Insurance to Employees	Offers Health Insurance, but it is not Affordable for Medicaid Expansion Eligible Employees
A. 100 employees, 5 are potentially eligible for Medicaid if expanded, 0 to 1 enroll	$0 – $7,058	$0 – $20,300
B. 200 employees, 50 are potentially eligible for Medicaid if expanded, 7 to 13 enroll	$49,407 – $91,756	$0 – $203,000
C. 50 employees, 25 are potentially eligible for Medicaid if expanded, 3 to 6 enroll	$21,175 – $42,349	$0 – $54,000
D. 10 employees, 7 are potentially eligible for Medicaid if expanded, 1 to 2 enroll	$7,058 – $14,116	$0

Note: The scenarios described assume a business in the Accommodations and Food Services industry. Savings for employer premium contributions were calculated by multiplying the assumed number of employees with employer-sponsored insurance who would switch to Medicaid if expanded by the average employer premium contribution in the Retail Trade, Other Services industry ($7,058), which includes Accommodations and Food Services. Tax penalties are assessed to large employers if an employee receives premium assistance through the ACA marketplace. The tax penalty amount depends on the number of employees who enroll.

Source: KHI analysis of the U.S. Census Bureau 2019 American Community Survey Public Use Microdata Sample and the 2019 Medical Expenditure Panel Survey's Insurance Component.

Non-Financial Impact

In addition to the financial implications for employers, Medicaid expansion also has the potential to impact non-financial outcomes, such as their employees' health and ability to work, as well as the overall labor market.

Prior to many states adopting Medicaid expansion in 2014, some thought that it would improve enrollee health, which could in turn lead to better work outcomes, such as a reduction in absenteeism (i.e., chronic or frequent absences from work) or higher productivity. Conversely, there also were concerns that Medicaid expansion — and other new coverage options created

by the ACA — would reduce the labor force by disentangling employment from health insurance, removing an incentive to be employed.

Emerging evidence indicates that, in general, Medicaid expansion has resulted in better health outcomes, improved self-reported ability to work and minimal changes to the labor market (*Figure 3.3*). The following sections describe these findings in more detail.

Figure 3.3. **The Impact of Medicaid Expansion on Non-Financial Outcomes**

	Hypotheses Prior to Expansion	Study Findings
Health Status	Medicaid coverage — like other types of health insurance coverage — will improve employee health by increasing access to care and receipt of needed services.	Expansion has improved self-reported health status, resulted in better management of some chronic diseases and earlier cancer diagnoses, and early evidence suggests reductions in mortality.
Ability to Work	Medicaid expansion will improve enrollees' ability to work, resulting in reduced absenteeism and higher productivity.	Expansion has resulted in improvements in self-reported ability to work, with minimal evidence of changes in rates of absenteeism.
Labor Market	Medicaid expansion will decrease the labor force by reducing job lock, lead to changes in the number of hours worked, result in earlier retirements and stifle wage growth. It may increase rates of self-employment.	Expansion has resulted in minimal changes to the overall size of the labor force, worked hours, early retirements, wages and changes in self-employment.

Source: KHI review of existing literature.

Impact on Health Status

By providing access to affordable health coverage, Medicaid expansion was expected to improve health outcomes for new enrollees. Due to the length of time it takes to measure health improvements following policy changes, findings in this area are still emerging. Thus far, expansion has resulted in improved self-reported health status, better management of some chronic diseases, earlier cancer diagnoses, and some reductions in mortality.

Health Status: Early evidence indicates that expansion improves self-reported health status and results in earlier cancer diagnoses and improvements in management of chronic diseases, with a handful of studies reporting reductions in mortality.[5-7] Thus far, most studies have relied on measures of self-reported health status, and studies with longitudinal data indicate that improvements in health associated with expansion have increased over time. While self-reported health status is a subjective measure of health, prior research has found associations between it and more objective measures (e.g., mortality).[6,7]

Medicaid expansion enrollees also have reported that Medicaid makes it easier to manage chronic conditions and that they no longer delay needed care due to cost, which can prevent a worsening of health conditions.[8-10] While these findings may be more likely to accrue to individuals who were previously uninsured, studies of Ohio Medicaid expansion enrollees indicate that reductions in unmet care needs also occurred for individuals who had health coverage prior to enrolling in Medicaid.[8,11]

Health Disparities: A few studies also have assessed the impact of expansion on health disparities, and while studies in this area are limited, initial findings suggest that expansion can reduce some racial/ethnic disparities in health outcomes, in addition to improvements in access to and utilization of care.[5,6]

Impact on Ability to Work

If access to health care through Medicaid improved the health of new enrollees, some believed Medicaid expansion also would improve work outcomes, including increases in productivity and decreases in absenteeism, for new Medicaid enrollees. To date, expansion has resulted in improvements in self-reported ability to work, with minimal evidence of changes in rates of absenteeism.

Self-Reported Ability to Work: When asked, Medicaid enrollees across multiple studies have shared that Medicaid supports or improves their ability to work.[9-13] This improved ability to work has been tied to the ability to access needed care, such as medications or treatment for chronic conditions, which previously prevented some enrollees from being able to work. In particular, enrollees with behavioral health needs (i.e., those with mental health and substance use disorders) are as likely — in one study, more so — to indicate that Medicaid expansion improved their ability to work.[11,13]

Most studies do not differentiate changes in ability to work for those who were uninsured prior to receiving Medicaid compared to those who were previously covered by ESI. While these benefits may accrue predominately to those who were previously uninsured and had to pay for all medical care out of pocket, benefits also may accrue to individuals whose ESI left them with high out-of-pocket costs (e.g., high-deductible health plans) and led them to avoid needed care.

Absenteeism: To date, few studies have examined the impact of Medicaid expansion on absenteeism, and those that have indicate mixed results. One study of expansion enrollees in Michigan found no reduction in absenteeism due to expansion, while one study found a

reduction in absenteeism for women who were overweight or obese following the implementation of the ACA but not for men.[12,14]

Other Factors Influencing Employment: While Medicaid can support the ability of enrollees to work, it is one of many factors influencing employment status. Other health and social barriers to employment, such as housing instability or caregiving responsibilities, can lead to an inability to seek and maintain employment.[10] Additionally, the ability to work can be impacted by local economic conditions and work opportunities.[11]

Medicaid programs across the U.S. have begun to address enrollee social risk factors (i.e., individual-level adverse social determinants of health) that ultimately impact health and the ability to work. For example, some have begun developing housing programs to provide temporary housing for their enrollees. For more information on how Medicaid programs are addressing enrollee social risk factors and social needs, see Medicaid and Social Needs: Do State-Based Interventions Decrease Medicaid Expenditures and Improve Enrollee Well-Being?

Impact on Labor Market

Given the strong tie between employment and health insurance in the U.S., some feared that Medicaid expansion would decrease the labor force by reducing employment lock (i.e., when individuals participate in the labor force exclusively to gain access to ESI) and job lock (i.e., when individuals refrain from switching jobs to maintain health insurance), resulting in earlier retirements, reductions in the number of hours worked and stifled wage growth. Conversely, some hypothesized that expansion may increase the number of individuals who are self-employed, due to new coverage options not tied to employment. Thus far, there have been minimal effects on the labor market following Medicaid expansion.

Labor Supply: Multiple studies have indicated minimal negative impacts on the labor force in states that have expanded Medicaid — contradicting initial fears of a reduced labor force — with some studies indicating a slight increase in labor supply and employment in expansion states.[4,11,15-22]

While expansion has generally had a minimal impact on labor supply, some studies have documented differences between groups, with some groups experiencing higher labor force participation after expansion. For example, individuals with disabilities living in expansion states were more likely to be employed in the first two years following expansion, and another study examining differences by race and gender found increased labor force participation for white

women, Hispanic women and Black men after expansion.[19,23] Further, one study documented higher total employment in some states that expanded Medicaid, with particular growth in the health care sector.[22] Findings from a study on "early" Medicaid expansions (i.e., expansions prior to 2014), however, indicated that low-income women with a high school degree were less likely to be employed following Medicaid expansion.[17]

For groups that increased workforce participation following expansion, studies have highlighted that this may be due to improved health conditions after obtaining Medicaid coverage, in addition to individuals no longer restricting their income to maintain Medicaid coverage.[11,23]

Retirement: Studies have also examined the impact of expansion on early retirements, given the assumption that expansion may induce retirements prior to age 65 due to an additional coverage option. Findings on the impact of expansion on retirements are mixed, however, with some indicating no increase in early retirements associated with Medicaid expansion, while others find increases only for specific populations (e.g., older women with less than a high school education).[24,25] Further, some have documented increases in retirements prior to age 62 attributed to the ACA generally, but it is not clear how much of this change was impacted by Medicaid expansion relative to other provisions in the ACA that increased non-employment coverage options, such as plans purchased via marketplaces.[26]

Worked Hours: Consistent with other pre-expansion concerns, some feared that decoupling insurance from employment would result in fewer hours worked. Multiple studies conducted since Medicaid was expanded have found minimal to no impact on hours worked, in addition to minimal changes in individuals transitioning from full-time employment to part-time employment.[4,15,16,18,19,24]

While Medicaid expansion does not appear to have resulted in fewer hours worked broadly, one study did find a reduction of weekly hours worked for white men in expansion states compared to white men in non-expansion states, with no reduction in hours for other populations.[19] Further, in interviews with Medicaid expansion enrollees in Minnesota, interviewees indicated that in order to avoid losing Medicaid coverage — which supported their ability to work — some would adjust their hours to not exceed income eligibility limits.[10] This highlights the importance of creating policies that blunt disincentives created by income-based insurance eligibility.

One option for individuals who lose Medicaid eligibility due to increased income is to purchase plans on the ACA marketplace, which would be accompanied by financial assistance (e.g., cost

sharing reduction subsidies and advance premium tax credits) based on income. While coverage may be subsidized, marketplace plans still include premiums and cost sharing not required by Medicaid. Indiana's Workforce Bridge Account reduces the disincentive by allowing individuals who lose their Medicaid eligibility due to increased income to qualify for up to $1,000 to cover costs associated with transitioning to commercial insurance, including for premiums and cost-sharing.[27]

Wages: Like fears around worked hours described above, some worried that Medicaid expansion would result in lower wages in order for individuals to not exceed the income threshold to qualify for Medicaid. The few studies that have examined changes in wages indicate minimal to no impact on wages due to Medicaid expansion.[18,21]

Self-Employment: Past research has indicated that entrepreneurship may be hampered by the tie between health insurance coverage and employment.[28] In other words, individuals may be less likely to start a business or become self-employed due to a fear of being uninsured. The rise of "gig work" or contracted labor (e.g., driving for Uber or Lyft), often grouped under self-employment, also has resulted in individuals working without traditional employee benefits. Elements of the ACA — such as Medicaid expansion or marketplace plans — may provide coverage options for these individuals.

A few studies have examined the impact of Medicaid expansion on those who are self-employed. While Medicaid expansion has resulted in a decrease in the number of individuals who are self-employed and uninsured, thus far it has had minimal impact on the probability of individuals being self-employed or starting their own business.[29,30] One study examining differences by population did find an increase in self-employment for white women in states that expanded Medicaid, but similar increases were not found for other populations.[19] Given that few studies have examined this issue so far, it may represent an area for future research.

Section 4. Areas for Future Study

Medicaid expansion may lead to other impacts on employers, some of which were outside the scope of this review or have not been studied thus far. These other potential impacts on employers could be areas for future study, including — but not limited to — long-term changes in rates of self-employment; whether expansion influences new business startups and entrepreneurship; and whether expansion impacts employer premiums in the private insurance market.

Section 5. Conclusion

Nearly all Kansas industries employ Kansans who would potentially be eligible for Medicaid if expanded. Industries with a higher proportion of employees potentially eligible for Medicaid if expanded, such as Accommodation and Food Services, Administration and Support and Waste Management, Wholesale Trade, Agriculture, Forestry, Fishing and Hunting and Educational Services, would likely see more of an effect. This analysis estimates that private-sector employers in Kansas could save a total of $39.6 million to $80.6 million per year. Beyond the potential financial impact, there are non-financial impacts that employers likely will accrue. These include improved health and self-reported ability to work for employees who enroll in Medicaid, as well as minimal changes to the overall labor force.

Appendix A: Report Methodology

Data Analysis Methodology

Research Questions

- ☐ How many employed Kansans are eligible for Medicaid if expanded?
- ☐ Which industries employ the most Medicaid expansion eligible Kansans?
- ☐ How many Kansas employers offer health insurance to employees?
- ☐ What are the financial and non-financial effects of Medicaid Expansion on Kansas employers?

Study Population

- ☐ Kansas adults with family income less than or equal to 138 percent of the federal poverty level (FPL)
- ☐ Private-sector business establishments in Kansas

Data Sources

- ☐ U.S. Census Bureau's 2019 American Community Survey
- ☐ The Agency for Healthcare Research and Quality's 2019 Medical Expenditure Panel Survey's Insurance Component

Analytical Approach

Employment Profile

1. KHI estimated the number of adults age 19 to 64 with family income less than or equal to 138 percent FPL by employment and insurance status using the U.S. Census Bureau's American Community Survey 2019 1-year Public Use Microdata Sample.
2. Industries were classified using the Census Bureau's Industry Code list, which is based on the 2017 North American Industry Classification System (NAICS) published by the Executive Office of the President, Office of Management and Budget (OMB).
3. Occupation data describe the kind of work the person does on the job. These data are derived from responses to write-in questions that are auto-coded and clerically coded by

Census Bureau staff, using the Census Occupation Code List developed for Census Bureau household surveys.

4. Employment was defined as all civilians 16 years old and over who either (1) were "at work," that is, those who did any work at all during the reference week as paid employees, worked in their own business or profession, worked on their own farm, or worked 15 hours or more as unpaid workers on a family farm or in a family business; or (2) were "with a job but not at work," that is, those who did not work during the reference week but had jobs or businesses from which they were temporarily absent due to illness, bad weather, industrial dispute, vacation, or other personal reasons. Excluded from the employed are people whose only activity consisted of work around the house or unpaid volunteer work for religious, charitable, and similar organizations; also excluded are all institutionalized people and people on active duty in the United States Armed Forces.
    - Full-time: 30 hours per week or more, at least 24 weeks per year
    - Part-time: less than 30 hours per week
    - Part-year: 30 hours per week or more for less than 24 weeks per year
5. Because ACS respondents can report more than one type of insurance, KHI uses a standard hierarchy to assign health insurance coverage, as follows:
    - Medicaid and Medicare ("dual eligibles");
    - Medicaid or CHIP;
    - Medicare;
    - Employment-Based;
    - Military/TRICARE;
    - VA Health Care; and
    - Direct-Purchase.

Statewide Average Premiums

Statewide average premiums and the estimated number of employees enrolled in a plan with their employer were calculated from estimates in selected tables of the following 2019 Medical Expenditure Panel Survey Insurance Component table series:

1. II.A Private-Sector Data by Firm Size and State Establishment tables
2. II.B Private-Sector Data by Firm Size and State Employee tables
3. II.C Private-Sector Data by Firm Size and State Premium and Contribution tables
4. V.A Private-Sector Data by Industry Groupings and State Establishment tables
5. V.B Private-Sector Data by Industry Groupings and State Employee tables
6. V.C Private-Sector Data by Industry Groupings and State Premium and Contribution tables

Assessing Financial Impact

In 2021, for a company that does not offer minimum essential coverage or offers coverage to fewer than 95 percent of its full-time employees and their dependents, the penalty is $2,700 multiplied by the number of full-time employees minus 30. This penalty is assessed if at least one employee enrolls in ACA marketplace coverage and receives a premium tax credit for purchasing coverage through the ACA marketplace. Since it is unlikely that all employees in a company are potentially eligible for Medicaid if expanded, and at least one employee would enroll in ACA market place coverage, we assume that Medicaid expansion would not result in savings from reduced tax penalties for establishments that do not offer health insurance.

For a company that offers minimum essential coverage to at least 95 percent of its full-time employees and their dependents that is not affordable, the penalty is computed separately for each month and the amount of the penalty for the month equals the number of full-time employees who receive a premium tax credit for that month multiplied by 1/12 of $4,060. The penalty is the lesser of the amount calculated or the amount that would be owed if the employer did not offer coverage.

Employer Premium Contribution Savings

The following steps describe the methodology used to estimate premium contribution savings for private-sector employers in Kansas.

1. Determined the population of all private-sector employees (not self-employed) with employer-sponsored coverage using Medical Expenditure Panel Survey (MEPS) data. This is the number of employees enrolled in the ESI plan during a typical pay period. Dependents who may be enrolled with the employee on a family plan or employee-plus-one plan are not included in the count.

2. Multiplied the number of employees with an employer sponsored plan by the percent in each industry potentially eligible for Medicaid if expanded to determine an estimated number of private-sector employees (not self-employed) age 19 to 64 with family income at or below 138 percent FPL that are enrolled in an ESI plan.

3. Assume eligible ESI enrollees switch at a rate of between 13 percent and 25 percent. Multiply each enrollment estimate by the average employer premium contribution. The average employer premium contribution is weighted by the employer premium contribution for each plan type (single, employee-plus-one or family) and the number of employees enrolling in each plan type.

Figure A.1. **Premium Savings Calculation Source Data**

Industry	ESI Enrollment (MEPS)	Percent Potentially Eligible for Medicaid if Expanded (ACS)	Average Employer Premium Contribution
All Other	137,262	5.5%	$9,015
Professional Services	157,063	4.1%	$7,365
Retail Trade, Other Services	150,511	10.3%	$7,058
Mining and Manufacturing	112,005	5.0%	$7,790
Agriculture, Fishing, Forestry and Construction	59,447	4.4%	$6,531
Kansas Private-Sector Employers	616,262	5.7%	$7,780

Reduction in ACA Employer Tax Penalties

The ACS data show that of the 45,130 private-sector employees age 19 to 64 with family income between 100 and 138 percent FPL in Kansas, 15,001 are uninsured and 5,129 are enrolled in marketplace coverage, which potentially would result in a tax penalty.

1. Of these 45,130 Kansans, it is estimated that 46 percent (20,760) work for large companies with 50 or more employees based on a 2012 study by Jackson Hewitt. Of those Kansans working for large companies, it is estimated from MEPS national calculations that 95.2 percent (19,763) work at firms offering health insurance.

2. To estimate the penalty for firms not offering affordable insurance, the same assumptions are applied to the 5,129 Kansans age 19 to 64 with family income between 100 and 138 percent FPL who are enrolled in marketplace coverage. Of them, 43.8 percent (2,246) work at large firms (50 or more employees) offering health insurance and would trigger a tax penalty for their employer.

3. Assuming each marketplace enrollee receives a premium tax credit for the full year, the maximum penalty assessed in 2021 is the lesser of $4,060 for each marketplace enrollee with income between 100-138 FPL employed at a large firm offering health insurance (2,246) or the penalty for not offering health insurance ($2,700 * Number of Employees – 30). The high estimate assumes all 2,246 enrollees are spread evenly across 2,246 companies. The low estimate assumes the ACA marketplace enrollees are concentrated at an average of 50 ACA enrollees per firm.

4. Because the few large employers not offering health insurance may still be penalized if employees not eligible for Medicaid if expanded enroll in ACA marketplace coverage, we assume no savings from reduced tax penalties for large employers that do not offer health insurance.

Figure A.2. **Estimated Reduction in Premiums and ACA Employer Tax Penalties from Medicaid Expansion by Industry**

Industry	Reduced Premium Contributions		Tax Penalty A: Offers Health Insurance that is not Affordable		Tax Penalty B: Does Not Offer Health Insurance
	Low	High	Low	High	
Agriculture, Fishing, Forestry and Construction	$2,207,453	$4,244,061	$108,000	$467,602	$0
Mining and Manufacturing	$5,624,638	$10,814,496	$756,000	$2,832,283	$0
Retail Trade, Other Services	$14,215,157	$27,338,630	$702,000	$2,579,813	$0
Professional Services	$6,215,695	$11,952,729	$324,000	$1,269,460	$0
All Other	$8,897,422	$17,103,031	$540,000	$1,969,974	$0
Kansas Private-Sector Employers	$37,155,362	$71,452,620	$2,430,000	$9,119,132	$0

Literature Review Methodology

A limited scope literature review was conducted to address the following research questions:

- ☐ What are non-cost impacts on employers of Medicaid expansion, items such as employee health, productivity and absenteeism?
- ☐ What is the effect of Medicaid expansion on small business startups and entrepreneurism?

The literature review included peer-reviewed literature and grey literature (i.e., research not published in peer-reviewed journals, such as research reports, government reports, etc.)

Peer-reviewed literature searches were conducted in the PubMed.gov database, using the advanced search function and Medical Subject Headings [MeSH] where relevant. See *Figure A.3* (page A-7) for the search combinations used.

Figure A.3. **PubMed Search Combinations**

Search Combinations
(Medicaid expansion) AND (Entrepreneur)
(Medicaid expansion) AND (small business)
(Medicaid expansion) AND (employee productivity)
(Medicaid expansion) AND (efficiency[MeSH Terms])
(Medicaid expansion) AND (absenteeism[MeSH Terms])
(Medicaid expansion) AND (job satisfaction[MeSH Terms])
(Medicaid expansion) AND (occupational health[MeSH Terms])
(Medicaid expansion) AND (employee health)
(Medicaid expansion) AND (work)

Definitions of MeSH terms:

- ☐ *Absenteeism:* Chronic absence from work or other duty.
- ☐ *Job Satisfaction:* Personal satisfaction relative to the work situation.
- ☐ *Occupational Health:* The promotion and maintenance of physical and mental health in the work environment.
- ☐ *Efficiency:* Ratio of output to effort and or resources, or the ratio of effort and or resources produced to energy expended.

The PubMed search resulted in a total of 224 articles for title and abstract review, after removing duplicates and excluding articles published prior to January 1, 2014. Snowball sampling (i.e., reviewing the reference list of a study to identify other relevant studies) and the "cited by" tool in Google Scholar were also used to identify relevant articles not found in the PubMed search. Titles and abstracts were then reviewed to identify whether the studies were relevant to the research question(s). After title and abstract review, a final set of 17 peer-reviewed articles were reviewed in full by the project team.

In addition to peer-reviewed literature, targeted websites were searched for grey literature pertaining to the research questions. Targeted organization websites included:

- ☐ Center for Health Care Strategies (CHCS)
- ☐ Commonwealth Fund

- ☐ Families USA
- ☐ Institute for Medicaid Innovation
- ☐ Kaiser Family Foundation (KFF)
- ☐ Medicaid and CHIP Payment and Access Commission (MACPAC)
- ☐ National Academy for State Health Policy (NASHP)
- ☐ National Conference of State Legislatures (NCSL)
- ☐ RAND Corporation
- ☐ Urban Institute

Grey literature from the organizations above were included if they contained findings relevant to the research questions and were published after January 1, 2014. Google searches using search terms similar to those from the PubMed review were conducted to ensure other relevant articles were not missed, in addition to snowball sampling and the Google cited by feature. A total of 13 grey literature documents were reviewed in full by the project team.

Relevant findings from the 30 articles reviewed in full were extracted into the following table shell and then synthesized for the report.

EndNote Citation	Topic(s)	Methods Summary	Relevant Findings

Limitations: Many of the findings in the *Non-Financial Impact* section rely on data from the early years of expansion; as more information becomes available, a more complete picture of the impact on health, the ability to work and the labor market will become available. Further, much of the ability to work and health outcomes data is self-reported in surveys and interviews and may be influenced by social-desirability bias.

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