U.S. Health Reform — Monitoring and Impact

# The Impact of Per Capita Caps on Federal and State Medicaid Spending

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# INTRODUCTION

On March 6, 2017, House Republican leaders introduced the American Health Care Act (AHCA) as a replacement for the Affordable Care Act (ACA).[1] If passed, the law would repeal many components of the ACA, substitute a number of alternative policies, and make substantial revisions to Medicaid financing. The bill would allow states to continue covering the population made eligible for Medicaid under the ACA's expansion, but it would phase out the higher federal contribution (i.e., the 90 percent federal matching rate) that the ACA provided to finance the cost of care for the new Medicaid population. Also, it would impose a per capita cap on the rest of the Medicaid program. A per capita cap sets limits on federal Medicaid contributions per enrollee and defines an annual growth rate for those limits in order to gradually reduce federal Medicaid spending over time. Such a policy fundamentally alters the nature of federal financing of Medicaid, shifting from an open-ended entitlement, where the federal government commits to paying for a set percentage of the expenses a state may incur under the program, to a limited federal allotment that would not respond to increased spending beyond a preset target per enrollee.

In this paper, we analyze the effect of two per capita cap approaches: that in the AHCA and that in Speaker of the House Paul Ryan's "Better Way" health care plan, released in June 2016.[2] We estimate the effect of each of these per capita caps on federal and state spending from 2019 to 2028. Our approach is similar to that used in a previous analysis of the 2012 House Republican budget plan.[3]

The Better Way proposal would increase federal spending per Medicaid enrollee each year by general inflation (using the consumer price index, or CPI), but the AHCA legislation would increase federal spending per enrollee by the medical care component of CPI, which has a higher historical growth rate than general CPI. However, the AHCA would phase out the expansion matching rate by 2020, earlier than the Better Way plan would. We account for differences in the two proposals' growth rates and phaseout schedules in our analysis. We analyze both proposals to show the sensitivity of our results to the effect of small differences in these parameters.

Our main findings are as follows:

- We estimate that between 2019 and 2028, the Better Way proposal would reduce federal Medicaid spending by $841 billion, or 18.1 percent. The AHCA would reduce federal spending by $457 billion, or 9.8 percent. This main estimate is considerably lower than the March 13, 2017, Congressional Budget Office (CBO) estimate,[4] which assumed that many states would cut enrollment; our estimates do not assume enrollment cuts, but they are discussed below. This is not because we do not think there will be coverage losses; it would be difficult for all or most states to increase taxes or cut benefits or reduce already low reimbursement rates sufficient to offset losses of federal funds. We do not model enrollment changes in this exercise because it is too difficult to make judgments about decisions individual states would make. For instance, cutting enrollment reduces federal payments in addition to reducing states' own spending. However, we do provide a sensitivity to our main results, assuming some retraction of the ACA eligibility expansion.

- About 29 percent of the Better Way plan's reduction in federal spending would be attributable to phasing out

the ACA's higher Medicaid expansion rate. This phaseout would account for 57 percent of the AHCA's reduction in federal spending. Thus, federal spending cuts under the AHCA would fall very heavily on states that expanded Medicaid under the ACA.

- If states increase their Medicaid spending to cover lost federal revenue, state Medicaid spending would increase by 29.7 percent under the Better Way plan and by 16.1 percent under the AHCA. Increases would be largest in low-income expansion states such as Kentucky, West Virginia, Montana, New Mexico and Oregon.

- If states choose to reduce their Medicaid spending in proportion to federal spending reductions by cutting benefits and/or lowering provider reimbursement—but not by reducing enrollment—total Medicaid spending on beneficiaries would decline by $1.4 trillion under the Better Way plan and by $734 billion under the AHCA.

- All states are affected by these policy changes. The greatest effects are felt by states that saw the largest coverage gains under the ACA, and the smallest effects by those that did not expand Medicaid under the ACA. Low-income expansion states are particularly affected. States with 50 percent federal matching rates are also significantly affected by the phaseout of the 90 percent federal matching rate.

- States could cut coverage for the expansion population, but that would reduce federal payments as well as their own spending. An estimated 13.5 million enrollees would qualify for the higher expansion match in 2019. Alternatively, states could cut other eligibility groups.

- If all expansion states, except those that had a pre-ACA expansion for childless adults, dropped coverage for enrollees, 8 million enrollees would lose Medicaid coverage in 2028, and federal savings would increase to $735 billion between 2019 and 2028. Those who would have been eligible for Medicaid before the ACA are assumed to maintain the coverage.

# BACKGROUND

Under Medicaid's current open-ended matching rate structure, states receive federal matching payments based on total expenditures in their program. Federal matching rates are higher for low-income states than for high-income states, ranging from 75 percent in Mississippi to 50 percent in 12 states including California and New York. This means that the federal government pays Mississippi 75 percent of the total costs the state incurs on behalf of its Medicaid enrollees; the federal government pays New York for half of the costs it incurs in its program.

The aggregate amount of federal payments to a state can be higher in high-income states than in low-income states, despite the less generous matching rates for the former. If a state has higher health care costs or chooses to develop a more generous program with broader eligibility and/or benefit standards, that state will receive higher aggregate federal program contributions because the federal government pays a set percentage of the state's total expenses. Thus, higher-income states that cover more of their low-income populations, have broader benefit packages, more extensive long-term care programs, and/or higher provider reimbursement rates can receive higher federal payments per enrollee than states that have less generous programs but higher federal matching rates.

Block grants and per capita caps are two frequently discussed policy strategies for ending the open-ended entitlement nature of the Medicaid program and for slowing the growth in aggregate federal spending. A block grant is a fixed total federal contribution to a state's Medicaid program based on the state's own aggregate historical level of spending multiplied by a predefined growth rate.

Per capita cap approaches also aim to slow federal spending on Medicaid, but they differ structurally from block grants in important ways. Per capita caps set federal contributions for specific enrollment groups based on historical federal spending per enrollee in a given state, and that amount increases each successive year by a predetermined growth rate. For example, total spending per enrollee in each state for each Medicaid-eligible group (e.g., children without disabilities, nonelderly adults without disabilities, people with disabilities, elderly people) could be calculated for base year 2016, the state's federal matching rate applied, and that total divided by the number of enrollees of that type in 2017. That per-enrollee spending level would be increased by a set growth rate—in this example, the CPI. Per capita caps for each state would then be calculated as the federal allotment per enrollee (for each type of enrollee) multiplied by the number of enrollees of that particular type in the state in that year.

In both the block grant and per capita cap scenarios, the growth rates in the formula for allocating federal dollars are set below the expected growth in Medicaid spending under current law (i.e., below the baseline rate of growth) to ensure federal budgetary savings from the change. How far below the baseline the growth rate is set will determine the reduction in federal payments to states, which affects the extent to which states must either raise new revenues to replace them or change the benefits and eligibility rules to reduce total spending on the program. In addition, unexpected economic changes (e.g., recession), changes in health care needs (e.g., an infectious disease outbreak), aging of the population, and advances in technology (e.g., emergence of an expensive new treatment for a serious medical condition) would place additional financial pressures on state governments under these approaches.[5]

Unlike block grants, per capita caps would protect states against unexpected enrollment increases occurring during a period of recession or another emergency unexpectedly increasing the size of the Medicaid-eligible population. Per capita allotments would stay fixed in bad economic times, but the total federal allotment would increase with greater enrollment. Thus, states would not be penalized during downturns. However, if the predetermined growth rates are insufficient to provide services at current levels, states would still have to choose between increasing state revenue, reducing benefits, and lowering provider payment rates. Under a per capita cap, addressing a shortfall by reducing enrollment would cause a further reduction in federal funding, making it an undesirable—but potentially unavoidable—option over

time. Thus, allotments under both block grants and per capita caps are set based on current levels of expenditures, the former on total program spending and the latter on spending per enrollee. Although each allows the size of federal contributions to grow by a preset growth rate, both lock in current expenditure disparities across states. Low spending states that have historically provided narrower benefits or lower provider payment levels cannot "catch up"—that is, they would not be able to develop more generous programs. States would also have limited ability to extend optional eligibility to groups more expensive on average than current enrollees.

Advocates of block grants and per capita caps claim that these strategies would create incentives for states to become more efficient. These types of policies typically offer states flexibility to make programmatic changes—for example, eliminating some categories of benefits currently required under federal law. The more limited federal support could encourage them to implement more efficient management of health care. Some governors and state legislators have expressed interest in more flexibility to impose premiums and cost-sharing requirements on Medicaid enrollees, to introduce health savings accounts and similar arrangements, and to institute work requirements on enrollees. However, it is not clear whether these types of strategies would lower state spending on the program. States already constrain spending relatively aggressively, and spending growth for Medicaid is below that of other programs and low relative to gross domestic product or inflation.[6] Lowering the rate of growth per enrollee relative to current law would be difficult.

# WHAT WE MODELED

In this brief, we model two per capita cap proposals: the Better Way proposal and the AHCA proposal. The Better Way plan includes the following provisions:

- The per capita cap basis for federal payments begins in 2020.

- The base year for calculating per-enrollee costs is 2019.

- For people eligible for Medicaid under pre-ACA rules, the federal match rate is computed according to traditional rules.

- For people eligible for Medicaid under the ACA expansion, the federal match rate is 90 percent in 2020 (as under the ACA) but phases down to the rate computed by traditional rules for all expansion enrollees in 2023.

- After the base year, each state's per capita caps increase by the percentage growth in CPI in that year relative to 2019. We assume average CPI growth of 2.4 percent per year over 10 years, consistent with the CBO.[7]

The AHCA proposal includes the following provisions:

- The per capita cap basis for federal payments begins in 2020.

- The base year for calculating per-enrollee costs is 2016.

- For people eligible for Medicaid under pre-ACA rules, the federal match rate is computed according to traditional rules.

- For people eligible for Medicaid under the ACA expansion who enrolled by the end of 2019 and maintain that

coverage without gaps, the federal match rate is 90 percent until they disenroll or experience a gap in enrollment.

- States can choose whether or not to maintain Medicaid eligibility for the ACA expansion population. If a state chooses to maintain eligibility for the expansion population, any new enrollees in that eligibility category

after January 1, 2020, will receive the state's matching rate computed according to traditional rules.

- After the base year, each state's per capita caps increase by the percentage growth in the medical component of CPI (M-CPI) in that year relative to 2016. We assume M-CPI growth of 3.7 percent per year, consistent with the CBO.[8]

# METHODS

We estimate Medicaid enrollment and costs for 2019 using the Health Insurance Policy Simulation Model (HIPSM). We use 2016 Medicaid enrollment data from monthly enrollment snapshots by the Centers for Medicare & Medicaid Services to ensure that the increase in Medicaid enrollment under the ACA matches administrative data for each state; we grow this enrollment to 2019 assuming that Medicaid growth under current law will be driven largely by population changes. Most of the new enrollees in our model were previously uninsured, but some who had private coverage were also simulated to switch to Medicaid. (Additional details about our methodology are available in Appendix B of an earlier publication.)[9] These results represent our best estimate of health coverage in 2019 under the ACA. Our national estimates differ from those of the Congressional Budget Office. CBO does not publish state-level estimates of coverage, so it is difficult to identify the sources of difference. Baseline CBO Medicaid enrollment numbers are generally higher because the CBO relies more on administrative data and counts limited-benefit populations. Notably, limited-benefit populations and certain other groups (e.g., under the AHCA, individuals receiving care through the Indian Health Service or receiving premium assistance for employer coverage) are excluded from the per capita caps.

Despite these differences, per capita cap analyses based on CBO and HIPSM data have produced similar estimates of federal savings. Most recently, an external analysis of the AHCA based on the CBO baseline estimated that the proposal would shift about $370 billion to states between 2018 and 2027.[10] Our corresponding estimate for 2019 to 2028 is $457 billion (Table 3). The difference in federal spending for 2028 was about $50 billion (Figure 1), so the two independent estimates are quite close.

Estimated Medicaid spending in 2019 is based on the latest publicly available Medicaid Statistical Information System (MSIS) data, which is from 2011 or 2012, depending on the state. We compute average costs in each state for elderly people, nonelderly people with disabilities, Medicaid expansion adults, other nondisabled adults, and nondisabled children. The costs are then grown to 2019 using the overall Medicaid growth rates projected by CBO. We also adjust spending to control for

the difference in health care risk between pre-ACA and ACA Medicaid enrollees in each state.

Several types of Medicaid spending are excluded from the per capita cap analysis presented here. These include disproportionate share hospital payments, certain 1115-based supplemental payments (delivery system reform incentive payments, uncompensated care pools, designated state health care programs), and spending on limited-benefit Medicaid recipients (such as those receiving only family planning services). We exclude these spending categories to the extent that MSIS data allow. Without more recent administrative data comparable to MSIS, we could not incorporate any state-specific differences in spending or growth occurring after 2011 or 2012.

To make our estimates more consistent with CBO scores, we assumed that growth in enrollment and costs per person from 2019 to 2028 would be consistent with the January 2017 CBO baseline.[11] For each year through 2027, we computed projected CBO growth in both enrollment and per capita costs for four groups of Medicaid enrollees: elderly people, people with disabilities, nondisabled adults, and nondisabled children. We used the average growth rates for each group to extrapolate the growth from 2019 to 2028.

Our current-law scenario starts from our 2019 estimates and assumes that both enrollment and per capita costs grow according to CBO projections. Per capita cap scenarios assume that enrollment would grow according to CBO projections, but per capita costs would grow at the capped amount.

Our estimates are the best possible under the data constraints. The available Medicaid spending and enrollment data on which we base our estimates of future coverage and spending levels is several years old. We had to assume that spending and enrollment in all states would grow over time by the same rates under current law, which is unlikely. But the major drivers of our estimates are the difference between current enrollment and spending growth rate projections by the CBO and the growth allowed under the proposed policy alternatives, and those are known.

### State Decisions on Medicaid Expansion Population

We assume that no new states would expand Medicaid under the ACA and that states that have already expanded Medicaid under the ACA would maintain that expanded eligibility. Thus, we also assume that Medicaid expansion states would maintain eligibility for the expanded population with lower match rates after the shift to a per capita cap structure. We estimate that 13.5 million adults would be in the expansion group and qualify for the higher federal matching rate in 2019; this group would include adults in some states that expanded Medicaid eligibility before January 1, 2014. In reality, many states may choose to restrict eligibility for the expansion (and for other eligibility groups) after 2019 in order to reduce their financial exposure, given lower federal contributions. We discuss the implications of enrollment cuts later in the paper.

### CBO Growth Rates

Table 1 provides background data showing the CBO projections we use to project Medicaid spending enrollment and spending per enrollee under current law.[12] Overall Medicaid spending is projected to grow between 2019 and 2027 (extrapolated using the same average growth rates for 2028) by 5.5 percent per year. Annual increases are slightly higher for adults and lower for the other eligibility groups. Average annual growth in Medicaid enrollment is estimated at 1.2 percent overall. Enrollment is estimated to increase more for the elderly population (2.8 percent per year) because of the retirement of the baby boom generation. Enrollment among people with disabilities is projected to grow by 1.4 percent per year. Child enrollment declines slightly (0.1 percent), and adult enrollment increases by 2.2 percent annually. Spending per enrollee is projected to increase by 4.3 percent per year. The estimated increase in spending per enrollee per year is 1.8 percent for elderly people, 3.5 percent for people with disabilities, 4.7 percent for children, and 4.5 percent for adults.

Table 2 shows that the average annual growth rate in GDP is projected to be 3.9 percent. The increase in the CPI is projected to be 2.4 percent.[13] The medical component of the CPI is estimated to be 3.7 percent per year over this period.[14]

### Table 1: Average CBO Medicaid growth rates by eligibility group, 2019 – 2027

|  | Average Annual Growth in Federal Medicaid Spending | Average Annual Growth in Medicaid Enrollment by Eligibility Group | Average Federal Spending on Benefits Per Enrollee |
|---|---|---|---|
| Elderly | 4.6% | 2.8% | 1.8% |
| Disabled | 4.9% | 1.4% | 3.5% |
| Children | 4.6% | -0.1% | 4.7% |
| Adults | 6.8% | 2.2% | 4.5% |
| Total | 5.5% | 1.2% | 4.3% |

SOURCE: "Detail of Spending and Enrollment for Medicaid for CBO's January 2017 Baseline." Washington DC: Congressional Budget Office, January 2017. https://www.cbo.gov/sites/default/files/recurringdata/51301-2017-01-medicaid.pdf.

Overall Medicaid spending is projected to increase under current law by 5.5 percent per year on average over this period, and spending per enrollee is estimated to increase 4.3 percent per year on average. Increases in enrollment and per capita spending would vary across eligibility groups with the estimated differential growth rates. The financial effects of the two proposals on different states would depend upon the composition of their Medicaid populations by eligibility group. These differences may seem small—say, 4.3 percent projected per capita spending growth versus 3.7 percent annual increase in the M-CPI—but over time they become quite large and likely will force major policy changes.

### Table 2: Average Growth Rates in Gross Domestic Product and Consumer Price Index, 2019–2027

| | |
|---|---|
| GDP | 3.9 |
| CPI | 2.4 |
| M-CPI | 3.7 |

SOURCE: CBO Forecast, January 2017.
NOTES: GDP = gross domestic product; CPI = consumer price index; M-CPI = medical component of the CPI.

# RESULTS

*National Findings*

## Changes in Federal Spending Year by Year

In Figure 1, we chart federal spending for each year between 2019 and 2028 under current law, the Better Way plan, and the AHCA. The per capita cap does not take effect until 2020, so all three lines start at the same place in 2019. Federal spending under the Better Way plan grows slowly until 2023 as the ACA expansion match rate is phased out, and then grows by the specified CPI rate. Federal spending under the AHCA would be lower in 2020 than in 2019 because the per capita caps are based on 2016 costs, trended by M-CPI. As under the Better Way plan, spending growth would be slower as the federal match rate is phased out. By 2028, federal spending would be $574.1 billion under current law, $445.3 billion under the Better Way plan, and $519.3 billion under the AHCA.

## Ten-Year Estimates for the Better Way Proposal

Using the Better Way design, if states continue to spend on their Medicaid programs at current levels, a per capita cap would reduce federal Medicaid contributions by $841 billion, or 18.1 percent from 2019 to 2028 (Table 3). We estimate that 39 percent of these savings to the federal government result from restricting per capita spending growth to CPI, 32 percent result from using 2016 as the base year, and 29 percent result from entirely phasing out the higher ACA federal matching rate for the expansion population (Figure 2).

To fully offset this loss in federal contributions with increases in their own spending, states would have to increase their Medicaid expenditures by 29.7 percent. Such an increase in state spending would keep total government spending on Medicaid at current levels. However, states may not be able to raise revenues enough to do that.

## Figure 1: Impact of Alternative Medicaid Per Capita Cap Proposals on Total Federal Medicaid Spending , 2019-2028 (Billions $)
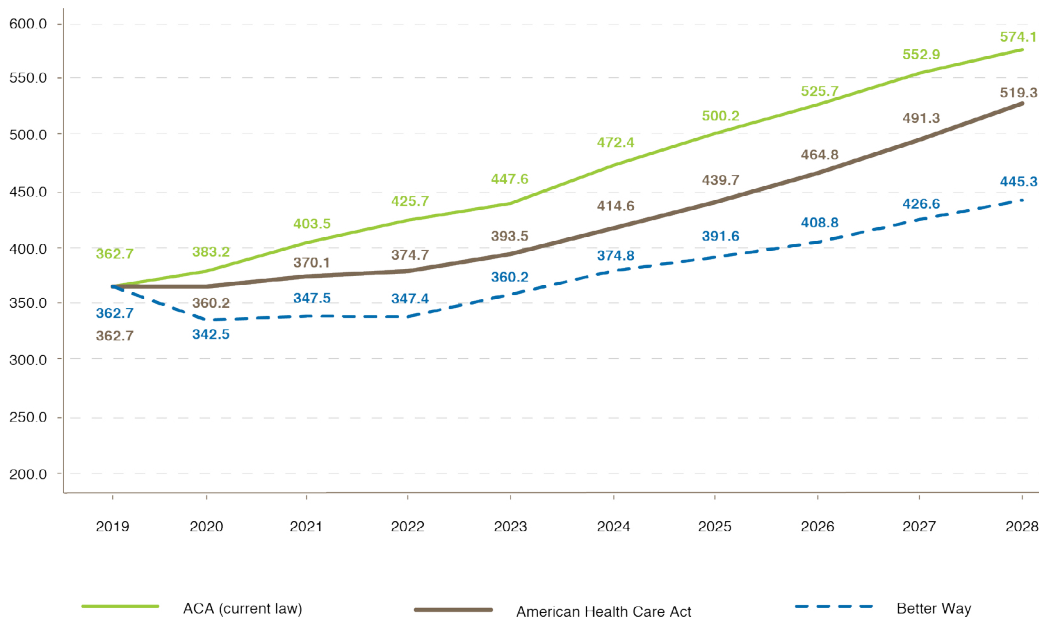


Source: Urban Institute Analysis using HIPSM 2017

If states instead reduced their spending proportionately to the reduced level of federal contributions (allowing them to draw down the full federal allotment but not spend any more), state government spending on Medicaid would fall by $511 billion over the 10-year period, and total government spending on the Medicaid program would fall by $1.4 trillion. States would have to cut benefits or provider payment rates to achieve the

$511 billion reduction. If states attempted to achieve these reductions by cutting enrollment that would further reduce their federal allotment, which is based on the number of enrollees in each eligibility category.

States have limited options to reduce spending. In principle, they could cut optional benefits such as prescription drug

## Table 3: Impact of Alternative Medicaid Per Capita Cap Proposals on Federal and State Medicaid Expenditures, 2019-2028 (Billions $)

| Better Way | | |
|---|---|---|
| **Scenario 1: States Increase Spending to Offset Federal Spending Decreases** | | |
| | Difference | Percent Change |
| Federal | -$841 | -18.1% |
| State | $841 | 29.7% |
| Total | $0 | 0.0% |
| **Scenario 2: States Decrease Spending Proportionate to Federal Spending Decrease** | | |
| | Difference | Percent Change |
| Federal | -$841 | -18.1% |
| State | -$511 | -18.0% |
| Total | -$1,352 | -18.1% |

| American Health Care Act | | |
|---|---|---|
| **Scenario 1: States Increase Spending to Offset Federal Decrease** | | |
| | Difference | Percent Change |
| Federal | -$457 | -9.8% |
| State | $457 | 16.1% |
| Total | $0 | 0.0% |
| **Scenario 2: States Decrease Spending Proportionate to Federal Spending Decrease** | | |
| | Difference | Percent Change |
| Federal | -$457 | -9.8% |
| State | -$277 | -9.8% |
| Total | -$734 | -9.8% |

Note: For the Better Way proposal, computation of the caps is based in 2016, caps grow by the overall CPI each year, and the ACA expansion match rate phases out from 2020 to 2023. For the AHCA bill, computation of the caps is based in 2016, caps grow by the medical CPI each year, and beginning in 2020, the expansion match rate is available for those enrolled before 2020 with no subsequent lapses in eligibility.

## Figure 2: Sources of Federal Savings from the Better Way Proposal, 2019-2028 (Billions $)



- Capping growth at CPI, $330.0 , 39%
- Setting the base year at 2016, $270.0 , 32%
- Phasing out the expansion match rate, $241.0 , 29%
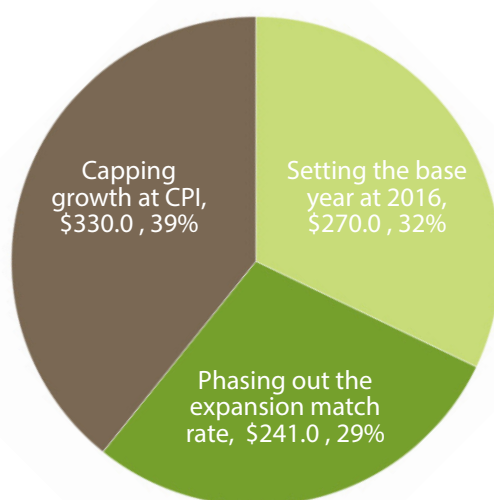
Source: Urban Institute Analysis using HIPSM 2017

coverage, mental health and substance use disorder treatment, and home- and community-based waiver services. However, prescription drugs would be politically difficult to cut, given their centrality to the delivery of medical care and the potential for increased hospitalizations or other service use if beneficiaries underuse prescription drugs because they lack coverage. Mental health and substance use disorder treatment and home- and community-based waiver services would also be difficult to cut because of the growing demand for these services. Eliminating optional Medicaid services, such as dental, vision, and hearing services, would yield little savings because these are not high spending categories. Reducing provider payment rates could offer some relief, but these rates are controlled fairly aggressively by many states, and providers are likely to resist any reductions.

### Ten-Year Estimates for the American Health Care Act

Government spending reductions from 2019 to 2028 would be lower under the AHCA than under the Better Way proposal.

If states continue to spend on the Medicaid program at current levels, federal spending would fall by $457 billion, or 9.8 percent, from 2019 to 2018 under the AHCA. Almost 57 percent of the reduction in federal spending is attributable to the proposal's phaseout of the higher matching rate for ACA Medicaid expansion population; 32 percent of the reduction is attributable to the use of 2016 as the base year for calculating the per capita caps, and the remaining 11 percent is attributable to limiting per-enrollee spending growth to M-CPI (Figure 3). Thus, a large majority of the reduced federal spending under the AHCA will come at the expense of states that expanded Medicaid under the ACA.

To offset the loss of federal spending and to keep total spending on the program constant, states would have to increase their spending by 16.1 percent. If states decreased their spending proportionately to the lower federal spending, they would save $277 billion over the 10 years, and Medicaid spending overall would fall by $734 billion.

### Figure 3: Sources of Federal Savings from the AHCA, 2019-2028 (Billions $)
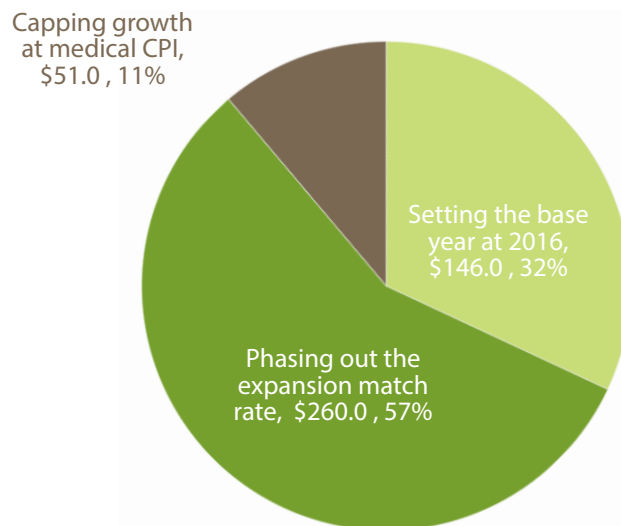


Source: Urban Institute Analysis using HIPSM 2017

However, in a per capita cap financing environment, states could make any number of decisions beyond the scenarios described here. They could increase their spending somewhat, without completely offsetting the loss of federal dollars. They could decrease their own spending more or less than proportionately to the decrease in federal spending. The difficulties states face in cutting spending were discussed above. Actual decisions will vary considerably across states and over time and are likely to be a function of each state's revenue base, political preferences, economic conditions, and local health care needs.

*State-Specific Findings*

### Changes in Federal Spending

Table 4 shows the reduction in federal Medicaid spending in each state under the Better Way and AHCA approaches, assuming states would fully draw down the capped federal funds but not cut enrollment. The results show that the effects of both proposals are largest for states that adopted the ACA Medicaid expansion and have seen particularly large increases in Medicaid coverage. In addition, the loss of the 90 percent

federal matching rate for the expansion population will lead to larger federal funding decreases for states with the highest per capita incomes. For example, a higher-income state would see their federal matching rate on the expansion population fall from 90 percent to the traditional 50 percent—a larger decline than for a lower-income state, whose matching rate would fall from 90 percent to, say, 70 percent.

Under the Better Way approach, 17 states would see their federal Medicaid payments fall by more than 20 percent compared with current law. Colorado (27.3 percent), New Jersey (27.8 percent) and Washington (27.1 percent) would see reductions of more than 25 percent. California (19.2 percent) and New York (19.8 percent) would experience somewhat smaller percent reductions in federal Medicaid payments because they already implemented significant coverage expansions before the ACA, yet both states would be affected significantly by the

large reductions in federal matching rates for their expansion populations. States that did not adopt the Medicaid expansion would experience smaller percent reductions in federal funds as a result of the per capita cap. For example, Florida would see a 12.5 percent decrease in federal Medicaid payments, and Texas would see a 13.2 percent decrease.

The percent reductions in federal funds are slightly lower under the AHCA, but the two per capita cap proposals affect states in similar ways. Under the AHCA proposal, Colorado, New Jersey, and Washington would see decreases of about 20 percent in federal Medicaid spending, and Delaware, Hawaii, Illinois, Maryland, New Hampshire, North Dakota, Oregon, and Rhode Island would each lose 14 to 19 percent, relative to current levels. Texas would lose $15 billion in federal funds over 10 years (a 4.5 percent loss), and Florida would lose $7 billion (a 3.6 percent loss).

## Table 4: Impact of Alternative Medicaid Per Capita Cap Proposals on Federal Medicaid Expenditures by State, 2019-2028 (Billions $)

| | ACA (Current Law) | Better Way | | | American Health Care Act | | |
|---|---|---|---|---|---|---|---|
| | | Spending | Difference | % Change | Spending | Difference | % Change |
| **National** | **4,648** | **3,807** | **-841** | **-18.1%** | **4,191** | **-457** | **-9.8%** |
| Alabama | 47 | 41 | -6 | -12.7% | 45 | -2 | -3.8% |
| Alaska | 13 | 10 | -2 | -18.8% | 11 | -1 | -10.7% |
| Arizona | 153 | 122 | -31 | -20.3% | 134 | -19 | -12.3% |
| Arkansas | 50 | 43 | -7 | -14.6% | 47 | -3 | -5.9% |
| California | 401 | 324 | -77 | -19.2% | 356 | -45 | -11.1% |
| Colorado | 76 | 55 | -21 | -27.3% | 60 | -15 | -20.1% |
| Connecticut | 65 | 53 | -12 | -19.1% | 58 | -7 | -10.9% |
| Delaware | 16 | 13 | -4 | -22.7% | 14 | -2 | -15.0% |
| District of Columbia | 21 | 17 | -3 | -15.8% | 19 | -2 | -7.3% |
| Florida | 205 | 179 | -26 | -12.5% | 197 | -7 | -3.6% |
| Georgia | 106 | 92 | -14 | -13.0% | 101 | -4 | -4.2% |
| Hawaii | 18 | 14 | -4 | -23.4% | 15 | -3 | -15.7% |
| Idaho | 26 | 23 | -3 | -13.1% | 25 | -1 | -4.3% |
| Illinois | 158 | 122 | -36 | -22.6% | 135 | -24 | -14.9% |
| Indiana | 94 | 78 | -16 | -17.1% | 86 | -8 | -8.7% |
| Iowa | 38 | 31 | -7 | -18.1% | 34 | -4 | -9.8% |
| Kansas | 26 | 23 | -3 | -12.3% | 25 | -1 | -3.4% |
| Kentucky | 111 | 87 | -24 | -21.8% | 96 | -16 | -14.0% |
| Louisiana | 103 | 85 | -19 | -18.0% | 93 | -10 | -9.7% |
| Maine | 23 | 20 | -3 | -12.8% | 22 | -1 | -3.9% |
| Maryland | 84 | 64 | -20 | -23.8% | 70 | -14 | -16.3% |
| Massachusetts | 113 | 91 | -22 | -19.3% | 100 | -13 | -11.1% |
| Michigan | 174 | 143 | -31 | -18.1% | 157 | -17 | -9.8% |
| Minnesota | 98 | 78 | -20 | -20.2% | 86 | -12 | -12.2% |
| Mississippi | 51 | 45 | -6 | -12.4% | 50 | -2 | -3.5% |
| Missouri | 87 | 76 | -11 | -12.4% | 84 | -3 | -3.5% |

## Table 4: Continued...

| | ACA (Current Law) | Better Way | | | American Health Care Act | | |
|---|---|---|---|---|---|---|---|
| | | Spending | Difference | % Change | Spending | Difference | % Change |
| **National** | **4,648** | **3,807** | **-841** | **-18.1%** | **4,191** | **-457** | **-9.8%** |
| Montana | 31 | 25 | -6 | -18.1% | 28 | -3 | -9.9% |
| Nebraska | 17 | 15 | -2 | -12.2% | 17 | -1 | -3.3% |
| Nevada | 36 | 28 | -8 | -22.3% | 31 | -5 | -14.6% |
| New Hampshire | 17 | 13 | -4 | -22.8% | 14 | -3 | -15.1% |
| New Jersey | 148 | 107 | -41 | -27.8% | 117 | -31 | -20.6% |
| New Mexico | 69 | 53 | -16 | -22.8% | 59 | -11 | -15.2% |
| New York | 436 | 351 | -85 | -19.6% | 386 | -50 | -11.4% |
| North Carolina | 152 | 132 | -19 | -12.8% | 146 | -6 | -4.0% |
| North Dakota | 9 | 7 | -2 | -23.6% | 8 | -1 | -15.9% |
| Ohio | 219 | 179 | -40 | -18.3% | 197 | -22 | -10.0% |
| Oklahoma | 52 | 45 | -7 | -12.7% | 50 | -2 | -3.8% |
| Oregon | 90 | 68 | -21 | -24.0% | 75 | -15 | -16.4% |
| Pennsylvania | 181 | 147 | -33 | -18.4% | 162 | -18 | -10.2% |
| Rhode Island | 23 | 18 | -5 | -22.6% | 20 | -3 | -14.8% |
| South Carolina | 61 | 54 | -8 | -12.4% | 59 | -2 | -3.5% |
| South Dakota | 9 | 8 | -1 | -12.8% | 9 | 0 | -4.0% |
| Tennessee | 101 | 87 | -13 | -13.4% | 96 | -5 | -4.6% |
| Texas | 326 | 283 | -43 | -13.2% | 312 | -15 | -4.5% |
| Utah | 31 | 27 | -4 | -13.2% | 30 | -1 | -4.5% |
| Vermont | 14 | 11 | -3 | -21.4% | 12 | -2 | -13.5% |
| Virginia | 61 | 53 | -8 | -12.7% | 59 | -2 | -3.8% |
| Washington | 100 | 73 | -27 | -27.1% | 80 | -20 | -19.9% |
| West Virginia | 40 | 33 | -7 | -18.1% | 36 | -4 | -9.8% |
| Wisconsin | 65 | 58 | -7 | -11.2% | 64 | -1 | -2.0% |
| Wyoming | 5 | 5 | -1 | -12.1% | 5 | 0 | -3.1% |

Source: Urban Institute analysis using HIPSM 2017.

Note: For the Better Way proposal, computation of the caps is based in 2016, caps grow by the overall CPI each year, and the ACA expansion match rate phases out from 2020 to 2023. For the AHCA bill, computation of the caps is based in 2016, caps grow by the medical CPI each year, and beginning in 2020, the expansion match rate is available for those enrolled before 2020 with no subsequent lapses in eligibility.

## Changes in State Spending

Table 5 shows the amount that each state's Medicaid spending would have to increase in order to fully offset the reductions in federal Medicaid spending under each per capita cap proposal. Such increases would be necessary to avoid cuts in benefits and provider payments. Table 6 also shows how much states could decrease their own spending in proportion to the decrease in federal spending.

To preserve current total Medicaid spending under either the Better Way or AHCA approach, low-income expansion states would have to increase state spending by large percentages. States including West Virginia, Kentucky, New Mexico, Oregon, Montana, and Nevada would have to increase their Medicaid spending from 58 percent to 82 percent under the Better Way plan, and from 34 percent to 55 percent under the AHCA. These low-income states have high traditional federal matching rates, which means that federal spending represents a large share of their total Medicaid spending; thus, a reduction in federal spending for these states has comparatively large effects. States with lower traditional matching rates are already spending large amounts of their own dollars on their Medicaid programs, so compensating for federal losses from per capita caps requires smaller percentage increases in spending. For example, California would have to increase state Medicaid spending by 24.6 percent under the Better Way approach, and by 13.8 percent under the AHCA. For New York, corresponding increases would be 24.2 percent and 14.1 percent.

States that did not expand Medicaid under the ACA would face smaller percentage increases to replace lost federal funding. For example, Florida would have to increase its own contributions by 17.9 percent under the Better Way plan and 5.1 percent under the AHCA; corresponding increases for Texas are 18.8 percent and 6.4 percent.

**Table 5: State Increases in Spending, Assuming Full Offset of Federal Funding Reductions, 2019-2028 (Billions $)**

| | ACA (Current Law) | Better Way | | | American Health Care Act | | |
|---|---|---|---|---|---|---|---|
| | | Spending | Difference | % Change | Spending | Difference | % Change |
| National | 2,832 | 3,673 | 841 | 29.7% | 3,289 | 457 | 16.1% |
| Alabama | 22 | 28 | 6 | 27.1% | 24 | 2 | 8.1% |
| Alaska | 11 | 13 | 2 | 22.4% | 12 | 1 | 12.7% |
| Arizona | 63 | 95 | 31 | 49.0% | 82 | 19 | 29.8% |
| Arkansas | 19 | 26 | 7 | 39.3% | 22 | 3 | 15.8% |
| California | 321 | 399 | 77 | 24.0% | 366 | 45 | 13.8% |
| Colorado | 45 | 66 | 21 | 45.7% | 60 | 15 | 33.7% |
| Connecticut | 52 | 64 | 12 | 23.8% | 59 | 7 | 13.6% |
| Delaware | 10 | 14 | 4 | 38.1% | 12 | 2 | 25.2% |
| District of Columbia | 7 | 11 | 3 | 43.8% | 9 | 2 | 20.2% |
| Florida | 143 | 169 | 26 | 17.9% | 151 | 7 | 5.1% |
| Georgia | 55 | 68 | 14 | 25.2% | 59 | 4 | 8.1% |
| Hawaii | 12 | 17 | 4 | 33.8% | 15 | 3 | 22.7% |
| Idaho | 10 | 14 | 3 | 33.1% | 11 | 1 | 10.8% |
| Illinois | 116 | 151 | 36 | 30.9% | 139 | 24 | 20.4% |
| Indiana | 36 | 52 | 16 | 43.9% | 45 | 8 | 22.4% |
| Iowa | 22 | 29 | 7 | 31.1% | 26 | 4 | 16.9% |
| Kansas | 20 | 23 | 3 | 16.3% | 21 | 1 | 4.5% |
| Kentucky | 30 | 54 | 24 | 81.6% | 45 | 16 | 52.3% |
| Louisiana | 41 | 60 | 19 | 45.4% | 51 | 10 | 24.6% |
| Maine | 14 | 17 | 3 | 20.6% | 15 | 1 | 6.2% |
| Maryland | 57 | 77 | 20 | 34.7% | 71 | 14 | 23.7% |
| Massachusetts | 98 | 120 | 22 | 22.2% | 110 | 13 | 12.8% |
| Michigan | 67 | 99 | 31 | 46.6% | 84 | 17 | 25.3% |
| Minnesota | 76 | 96 | 20 | 25.9% | 88 | 12 | 15.7% |
| Mississippi | 19 | 25 | 6 | 33.6% | 21 | 2 | 9.4% |
| Missouri | 53 | 64 | 11 | 20.3% | 56 | 3 | 5.7% |
| Montana | 9 | 15 | 6 | 61.7% | 12 | 3 | 33.7% |
| Nebraska | 14 | 16 | 2 | 14.8% | 15 | 1 | 3.9% |
| Nevada | 14 | 22 | 8 | 57.6% | 19 | 5 | 37.8% |
| New Hampshire | 12 | 16 | 4 | 32.5% | 14 | 3 | 21.5% |
| New Jersey | 85 | 126 | 41 | 48.2% | 116 | 31 | 35.9% |
| New Mexico | 19 | 35 | 16 | 81.9% | 30 | 11 | 54.6% |
| New York | 353 | 439 | 85 | 24.2% | 403 | 50 | 14.1% |
| North Carolina | 79 | 98 | 19 | 24.7% | 85 | 6 | 7.6% |
| North Dakota | 6 | 8 | 2 | 35.2% | 7 | 1 | 23.8% |
| Ohio | 98 | 138 | 40 | 40.7% | 120 | 22 | 22.3% |
| Oklahoma | 29 | 36 | 7 | 22.6% | 31 | 2 | 6.8% |
| Oregon | 30 | 52 | 21 | 70.6% | 45 | 15 | 48.3% |
| Pennsylvania | 125 | 158 | 33 | 26.7% | 143 | 18 | 14.8% |
| Rhode Island | 17 | 22 | 5 | 31.1% | 20 | 3 | 20.5% |
| South Carolina | 26 | 33 | 8 | 29.8% | 28 | 2 | 8.4% |
| South Dakota | 8 | 9 | 1 | 14.8% | 8 | 0 | 4.6% |
| Tennessee | 53 | 67 | 13 | 25.1% | 58 | 5 | 8.6% |

## Table 5: Continued...

| | ACA (Current Law) | Better Way | | | American Health Care Act | | |
|---|---|---|---|---|---|---|---|
| | | Spending | Difference | % Difference | Spending | Difference | % Difference |
| **National** | **2,832** | **3,673** | **841** | **29.7%** | **3,289** | **457** | **16.1%** |
| Texas | 230 | 273 | 43 | 18.8% | 244 | 15 | 6.4% |
| Utah | 13 | 17 | 4 | 31.5% | 15 | 1 | 10.7% |
| Vermont | 9 | 12 | 3 | 34.0% | 11 | 2 | 21.5% |
| Virginia | 61 | 69 | 8 | 12.7% | 63 | 2 | 3.8% |
| Washington | 60 | 87 | 27 | 44.9% | 80 | 20 | 33.0% |
| West Virginia | 12 | 19 | 7 | 62.2% | 16 | 4 | 33.8% |
| Wisconsin | 45 | 52 | 7 | 16.2% | 46 | 1 | 2.9% |
| Wyoming | 5 | 6 | 1 | 12.1% | 6 | 0 | 3.1% |

Source: : Urban Institute analysis using HIPSM 2017.

Note: For the Better Way proposal, computation of the caps is based in 2016, caps grow by the overall CPI each year, and the ACA expansion match rate phases out from 2020 to 2023. For the AHCA bill, computation of the caps is based in 2016, caps grow by the medical CPI each year, and beginning in 2020, the expansion match rate is available for those enrolled before 2020 with no subsequent lapses in eligibility.

## Table 6: State Decreases in Spending, Assuming States Just Fully Draw Down Capped Federal Allotment, 2019-2028 (Billions $)

| | ACA (Current Law) | Better Way | | | American Health Care Act | | |
|---|---|---|---|---|---|---|---|
| | | Spending | Difference | % Change | Spending | Difference | % Change |
| **National** | **2,832** | **2,321** | **-511** | **-18.0%** | **2,555** | **-277** | **-9.8%** |
| Alabama | 22 | 19 | -3 | -12.7% | 21 | -1 | -3.8% |
| Alaska | 11 | 9 | -2 | -18.8% | 9 | -1 | -10.7% |
| Arizona | 63 | 51 | -13 | -20.3% | 56 | -8 | -12.3% |
| Arkansas | 19 | 16 | -3 | -14.6% | 17 | -1 | -5.9% |
| California | 321 | 260 | -62 | -19.2% | 286 | -36 | -11.1% |
| Colorado | 45 | 33 | -12 | -27.3% | 36 | -9 | -20.1% |
| Connecticut | 52 | 42 | -10 | -19.1% | 46 | -6 | -10.9% |
| Delaware | 10 | 8 | -2 | -22.7% | 8 | -1 | -15.0% |
| District of Columbia | 7 | 6 | -1 | -15.8% | 7 | -1 | -7.3% |
| Florida | 143 | 125 | -18 | -12.5% | 138 | -5 | -3.6% |
| Georgia | 55 | 47 | -7 | -13.0% | 52 | -2 | -4.2% |
| Hawaii | 12 | 10 | -3 | -23.4% | 11 | -2 | -15.7% |
| Idaho | 10 | 9 | -1 | -13.1% | 10 | 0 | -4.3% |
| Illinois | 116 | 89 | -26 | -22.6% | 98 | -17 | -14.9% |
| Indiana | 36 | 30 | -6 | -17.1% | 33 | -3 | -8.7% |
| Iowa | 22 | 18 | -4 | -18.1% | 20 | -2 | -9.8% |
| Kansas | 20 | 17 | -2 | -12.3% | 19 | -1 | -3.4% |
| Kentucky | 30 | 23 | -6 | -21.8% | 26 | -4 | -14.0% |
| Louisiana | 41 | 34 | -7 | -18.0% | 37 | -4 | -9.7% |
| Maine | 14 | 12 | -2 | -12.8% | 14 | -1 | -3.9% |
| Maryland | 57 | 44 | -14 | -23.8% | 48 | -9 | -16.3% |
| Massachusetts | 98 | 79 | -19 | -19.3% | 87 | -11 | -11.1% |
| Michigan | 67 | 55 | -12 | -18.1% | 61 | -7 | -9.8% |
| Minnesota | 76 | 61 | -15 | -20.2% | 67 | -9 | -12.2% |
| Mississippi | 19 | 17 | -2 | -12.4% | 18 | -1 | -3.5% |
| Missouri | 53 | 46 | -7 | -12.4% | 51 | -2 | -3.5% |
| Montana | 9 | 7 | -2 | -18.1% | 8 | -1 | -9.9% |

## Table 6: Continued...

| | ACA (Current Law) | Better Way | | | American Health Care Act | | |
|---|---|---|---|---|---|---|---|
| | | Spending | Difference | % Difference | Spending | Difference | % Difference |
| **National** | **2,832** | **2,321** | **-511** | **-18.0%** | **2,555** | **-277** | **-9.8%** |
| Nebraska | 14 | 13 | -2 | -12.2% | 14 | 0 | -3.3% |
| Nevada | 14 | 11 | -3 | -22.3% | 12 | -2 | -14.6% |
| New Hampshire | 12 | 9 | -3 | -22.8% | 10 | -2 | -15.1% |
| New Jersey | 85 | 61 | -24 | -27.8% | 68 | -18 | -20.6% |
| New Mexico | 19 | 15 | -4 | -22.8% | 16 | -3 | -15.2% |
| New York | 353 | 284 | -69 | -19.6% | 313 | -40 | -11.4% |
| North Carolina | 79 | 69 | -10 | -12.8% | 76 | -3 | -4.0% |
| North Dakota | 6 | 5 | -1 | -23.6% | 5 | -1 | -15.9% |
| Ohio | 98 | 80 | -18 | -18.3% | 88 | -10 | -10.0% |
| Oklahoma | 29 | 25 | -4 | -12.7% | 28 | -1 | -3.8% |
| Oregon | 30 | 23 | -7 | -24.0% | 25 | -5 | -16.4% |
| Pennsylvania | 125 | 102 | -23 | -18.4% | 112 | -13 | -10.2% |
| Rhode Island | 17 | 13 | -4 | -22.6% | 14 | -2 | -14.8% |
| South Carolina | 26 | 22 | -3 | -12.4% | 25 | -1 | -3.5% |
| South Dakota | 8 | 7 | -1 | -12.8% | 8 | 0 | -4.0% |
| Tennessee | 53 | 46 | -7 | -13.4% | 51 | -2 | -4.6% |
| Texas | 230 | 199 | -30 | -13.2% | 219 | -10 | -4.5% |
| Utah | 13 | 11 | -2 | -13.2% | 13 | -1 | -4.5% |
| Vermont | 9 | 7 | -2 | -21.4% | 8 | -1 | -13.5% |
| Virginia | 61 | 53 | -8 | -12.7% | 59 | -2 | -3.8% |
| Washington | 60 | 44 | -16 | -27.1% | 48 | -12 | -19.9% |
| West Virginia | 12 | 10 | -2 | -18.1% | 11 | -1 | -9.8% |
| Wisconsin | 45 | 40 | -5 | -11.2% | 44 | -1 | -2.0% |
| Wyoming | 5 | 5 | -1 | -12.1% | 5 | 0 | -3.1% |

Source: : Urban Institute analysis using HIPSM 2017.

Note: For the Better Way proposal, computation of the caps is based in 2016, caps grow by the overall CPI each year, and the ACA expansion match rate phases out from 2020 to 2023. For the AHCA bill, computation of the caps is based in 2016, caps grow by the medical CPI each year, and beginning in 2020, the expansion match rate is available for those enrolled before 2020 with no subsequent lapses in eligibility.

If states reduce their spending by the same percentages as the federal reductions (Table 6)—that is, spending just enough to fully draw down the federal allotment—the largest percent decrease in state spending would occur in states with the largest ACA coverage increases under the ACA (e.g., Colorado, New Mexico, New Jersey, Oregon, and Washington). The smallest reductions would occur in states that did not expand coverage (e.g., Florida, Texas, Mississippi, Missouri, and Wyoming).

### Changes in Total Medicaid Spending

Table 7 provides estimates of the changes in total Medicaid expenditures (state and federal) for the two proposals, assuming that states would reduce their Medicaid spending proportionate to the federal government's reduction. These estimates are the sum of the reductions in federal and state spending shown in Tables 4 and 6. The largest percent reductions in total government spending on the program would occur in ACA expansion states. States with 50 percent federal matching rates also would experience large reductions. For example, California, Colorado, Maryland, Massachusetts, New Jersey, New York, and Washington, all 50 percent matching rate states, would have above average reductions in spending.

### Potential Impacts on Coverage

The effect of these per capita caps on eligibility and enrollment is uncertain. If states reduce enrollment to address the federal spending shortfall, their federal allotment would also be reduced because it is spending per enrollee multiplied by enrollment. Some states may nonetheless discontinue coverage for the expansion population in response to the federal matching rate cut and the per capita cap. This is probably more likely in lower-income states that face larger cost increases relative to their current spending. The number of adults covered by the higher ACA federal match rate in 2019 is shown in Table 8. We cannot predict state decisions, but the coverage of nearly 13.5 million expansion adults would be at risk.[15] In some

## Table 7: Impact of Alternative Medicaid Per Capita Cap Proposals on Federal and State Medicaid Expenditures by State, 2019-2028 (Billions $)

| | Better Way | | American Health Care Act | |
|---|---|---|---|---|
| | Difference in Total Spending | % Change in Total Spending | Difference in Total Spending | % Change in Total Spending |
| **National** | **-1,352** | **-18.1%** | **-734** | **-9.8%** |
| Alabama | -9 | -12.7% | -3 | -3.8% |
| Alaska | -4 | -18.8% | -2 | -10.7% |
| Arizona | -44 | -20.3% | -27 | -12.3% |
| Arkansas | -10 | -14.6% | -4 | -5.9% |
| California | -139 | -19.2% | -80 | -11.1% |
| Colorado | -33 | -27.3% | -24 | -20.1% |
| Connecticut | -22 | -19.1% | -13 | -10.9% |
| Delaware | -6 | -22.7% | -4 | -15.0% |
| District of Columbia | -4 | -15.8% | -2 | -7.3% |
| Florida | -44 | -12.5% | -13 | -3.6% |
| Georgia | -21 | -13.0% | -7 | -4.2% |
| Hawaii | -7 | -23.4% | -5 | -15.7% |
| Idaho | -5 | -13.1% | -2 | -4.3% |
| Illinois | -62 | -22.6% | -41 | -14.9% |
| Indiana | -22 | -17.1% | -11 | -8.7% |
| Iowa | -11 | -18.1% | -6 | -9.8% |
| Kansas | -6 | -12.3% | -2 | -3.4% |
| Kentucky | -31 | -21.8% | -20 | -14.0% |
| Louisiana | -26 | -18.0% | -14 | -9.7% |
| Maine | -5 | -12.8% | -1 | -3.9% |
| Maryland | -34 | -23.8% | -23 | -16.3% |
| Massachusetts | -41 | -19.3% | -23 | -11.1% |
| Michigan | -44 | -18.1% | -24 | -9.8% |
| Minnesota | -35 | -20.2% | -21 | -12.2% |
| Mississippi | -9 | -12.4% | -2 | -3.5% |
| Missouri | -17 | -12.4% | -5 | -3.5% |
| Montana | -7 | -18.1% | -4 | -9.9% |
| Nebraska | -4 | -12.2% | -1 | -3.3% |
| Nevada | -11 | -22.3% | -7 | -14.6% |
| New Hampshire | -6 | -22.8% | -4 | -15.1% |
| New Jersey | -65 | -27.8% | -48 | -20.6% |
| New Mexico | -20 | -22.8% | -13 | -15.2% |
| New York | -155 | -19.6% | -90 | -11.4% |
| North Carolina | -29 | -12.8% | -9 | -4.0% |
| North Dakota | -4 | -23.6% | -2 | -15.9% |
| Ohio | -58 | -18.3% | -32 | -10.0% |
| Oklahoma | -10 | -12.7% | -3 | -3.8% |
| Oregon | -29 | -24.0% | -20 | -16.4% |
| Pennsylvania | -56 | -18.4% | -31 | -10.2% |
| Rhode Island | -9 | -22.6% | -6 | -14.8% |

## Table 7: Continued...

| | Better Way | | American Health Care Act | |
|---|---|---|---|---|
| | Difference in Total Spending | % Change in Total Spending | Difference in Total Spending | % Change in Total Spending |
| **National** | **-1,352** | **-18.1%** | **-734** | **-9.8%** |
| South Carolina | -11 | -12.4% | -3 | -3.5% |
| South Dakota | -2 | -12.8% | -1 | -4.0% |
| Tennessee | -21 | -13.4% | -7 | -4.6% |
| Texas | -74 | -13.2% | -25 | -4.5% |
| Utah | -6 | -13.2% | -2 | -4.5% |
| Vermont | -5 | -21.4% | -3 | -13.5% |
| Virginia | -15 | -12.7% | -5 | -3.8% |
| Washington | -43 | -27.1% | -32 | -19.9% |
| West Virginia | -9 | -18.1% | -5 | -9.8% |
| Wisconsin | -12 | -11.2% | -2 | -2.0% |
| Wyoming | -1 | -12.1% | 0 | -3.1% |

Source: Urban Institute analysis using HIPSM 2017.

Note: For the Better Way proposal, computation of the caps is based in 2016, caps grow by the overall CPI each year, and the ACA expansion match rate phases out from 2020 to 2023. For the AHCA bill, computation of the caps is based in 2016, caps grow by the medical CPI each year, and beginning in 2020, the expansion match rate is available for those enrolled before 2020 with no subsequent lapses in eligibility.

## Table 8: Number of Adults Covered by Medicaid Expansion, 2019

| National | 13,452,000 |
|---|---|
| **Alaska** | **14,000** |
| Arizona | 517,000 |
| Arkansas | 284,000 |
| California | 3,139,000 |
| Colorado | 415,000 |
| Connecticut | 164,000 |
| Delaware | 57,000 |
| District of Columbia | 44,000 |
| Hawaii | 92,000 |
| Illinois | 636,000 |
| Indiana | 403,000 |
| Iowa | 177,000 |
| Kentucky | 473,000 |
| Louisiana | 301,000 |
| Maine | 44,000 |
| Maryland | 288,000 |
| Massachusetts | 504,000 |

| National | 13,452,000 |
|---|---|
| Michigan | 659,000 |
| Minnesota | 278,000 |
| Montana | 65,000 |
| Nevada | 230,000 |
| New Hampshire | 69,000 |
| New Jersey | 553,000 |
| New Mexico | 262,000 |
| New York | 1,212,000 |
| North Dakota | 30,000 |
| Ohio | 743,000 |
| Oregon | 389,000 |
| Pennsylvania | 567,000 |
| Rhode Island | 57,000 |
| Vermont | 61,000 |
| Washington | 546,000 |
| West Virginia | 179,000 |

Source: Urban Institute analysis using HIPSM 2017.

states, other eligibility groups also may be in danger of losing coverage.

On March 13, 2017, CBO released its official cost estimate for the AHCA, predicting that several states would reduce coverage, including some that would have expanded Medicaid in the future.[16] This would decrease the number of Medicaid enrollees by 14 million by 2026. CBO also assumed that these cuts would begin in 2018, two years before the cap takes effect. As a result, their savings estimates are much larger than ours, $880 billion from 2017 to 2026.

We estimate the impact of the AHCA assuming that all states would repeal Medicaid expansion except for states that covered

childless adults with incomes up to 100 percent of the federal poverty level before the ACA was passed (Arizona, Delaware, District of Columbia, Hawaii, Maine, Massachusetts, Minnesota, New York, and Vermont). All other states in Table 8 are assumed to reduce eligibility levels to pre-ACA standards. This reduces enrollment by about 8 million by 2026 and increases federal savings to $735 billion from 2019 to 2028 (data not shown). We did not estimate enrollment reductions for other Medicaid populations.

### Locking in State Expenditure Differences

As previously discussed, per capita caps are based on spending per enrollee in a base year (2019 under the Better Way proposal and 2016 under the AHCA). Under current law, states vary widely in spending per Medicaid enrollee. The new federal allotments calculated under the Better Way plan and the AHCA would reflect current state variation in federal spending. Figures 4 and 5 show some of the state differences in federal Medicaid expenditures per enrollee for elderly people and children in 2017.[17] For example, Connecticut spends nearly four times as much as Utah per elderly enrollee ($12,267 versus $3,772), and Vermont spends almost three times as much as Wisconsin per child enrollee ($3,510 versus $1,320). The same growth rates in

### Figure 4: Medicaid Federal Expenditures per Enrollee, Elderly, 2017
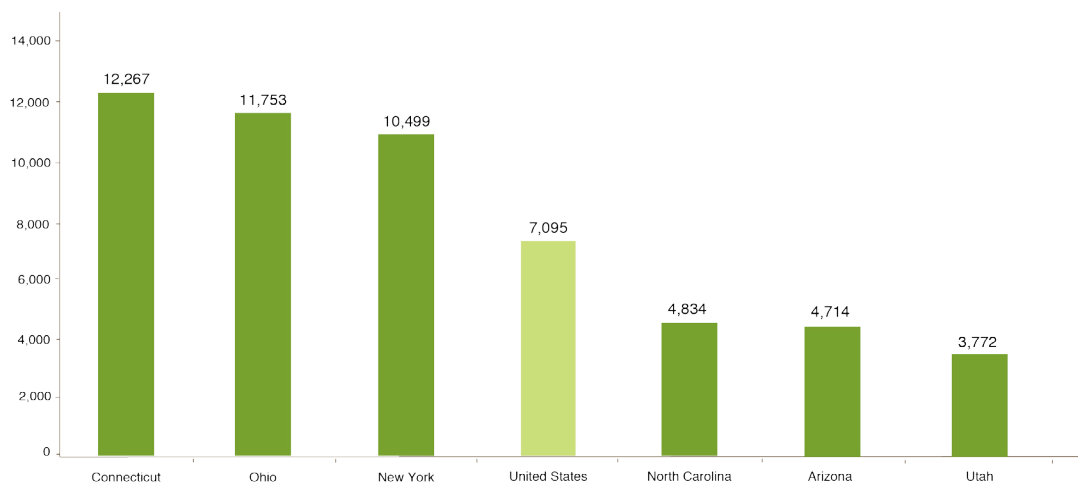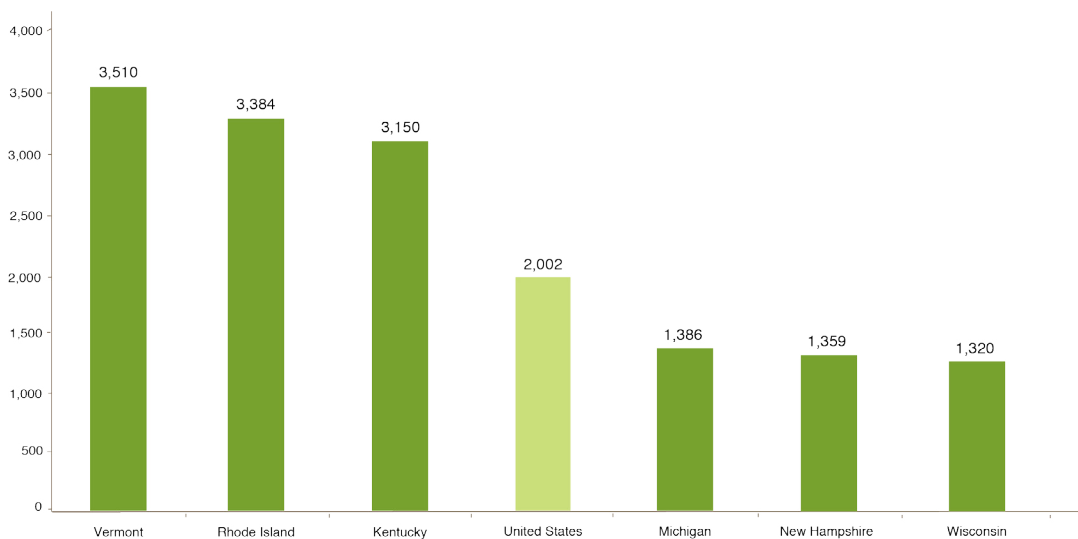


### Figure 5: Medicaid Federal Expenditures per Enrollee, Children, 2017

Source: Holahan, J., Buettgens, M. "Block Grants and Per Capita Caps: The Problem of Funding Disparities among States." Washington DC: The Urban Institute, September 2016. http://www.urban.org/sites/default/files/publication/83921/2000912-Block-Grants-and-Per-Capita-Caps-the-Problem-of-Funding-Disparities-among-States.pdf.

# SUMMARY AND CONCLUSION

federal payments would apply to all states, thus locking in these differences in perpetuity.

In this paper, we have shown that the Better Way per capita cap proposal would reduce federal spending on Medicaid by $841 billion dollars between 2019 and 2028, an 18.2 percent reduction. The AHCA per capita cap plan would reduce federal spending by somewhat less: $457 billion, or 9.8 percent. If states reduce their spending proportionately to the federal decrease, $1.4 trillion less would be spent on Medicaid beneficiaries under the Better Way approach, and $734 billion less would be spent under the AHCA over the 10-year period. The differences in the two estimates show how sensitive federal savings are to differences in parameters such as growth rates.

Under a per capita cap policy, states have two options for reducing spending that would not also reduce federal payments: cutting benefits or cutting provider payment rates. Reducing enrollment (by cutting expansion populations or other eligibility groups) would lower both state spending and federal reimbursement. But reducing either provider payment rates or benefits would prove challenging. Provider payment rates are already controlled fairly aggressively by states, and hospitals and physician groups would strongly oppose any

reductions.[13] Optional Medicaid services, such as dental, vision, and hearing services, are not "big ticket" items, so eliminating coverage for them would yield little savings. Cutting prescription drugs—another optional high-cost benefit— would be difficult because they are essential to medical treatment and because lack of drug coverage could increase hospital and physician costs. Cuts to home- and community- based waiver services, mental health and substance use disorder care, and other optional benefits would also be challenging, given the growing demand for these services.

Some states may choose to reduce enrollment rather than increase spending to cover the ACA expansion population and other Medicaid-eligible groups. Lower-income states are more likely to make this decision because they would have to make comparatively larger percent increases in spending compared with higher-income states. We have estimated that, if all expansion states, except those that had a pre-ACA expansion for childless adults, dropped coverage for enrollees who would not have been eligible for Medicaid before the ACA, this could reduce enrollment by about 8 million and increase federal spending reductions to $735 billion. This is less than the CBO estimated, largely because the CBO baseline assumed that more states would have expanded Medicaid in the future;

# ENDNOTES

1. The two House bills constituting the AHCA were reported out of the House Energy and Commerce and House Ways and Means committees on March 9, 2017. See: House GOP. American Health Care Act website. https://housegop.leadpages.co/healthcare/. Updated March 13, 2017.

2. Office of the Speaker of the House. *A Better Way: Report from the Health Care Reform Task Force*. Washington: Office of the Speaker of the House; 2016. http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf. Published June 22, 2016.

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