U.S. Health Reform—Monitoring and Impact

The Impact of the AHCA on Federal and State Medicaid Spending and Medicaid Coverage: An Update

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of health reform. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at **www.rwjf.org** and **www.healthpolicycenter.org**.

EXECUTIVE SUMMARY

On May 4, 2017, the House of Representatives passed the American Health Care Act (AHCA) as a replacement for the Affordable Care Act (ACA). The bill is now being debated in the Senate. The AHCA would allow states to continue covering new enrollees who became eligible for Medicaid under the ACA expansion but would eliminate the 90 percent federal matching rate for the expansion population. The federal matching rate for new enrollees would fall to a state's traditional federal matching rate, which ranges from 50 percent in the highest-income states to 75 percent in the lowest-income states. In addition, the AHCA would introduce a per capita cap on federal Medicaid spending. This would set limits on federal Medicaid spending per enrollee in each state and define an annual national growth rate for these limits to reduce federal Medicaid spending over time.

We estimate that between 2019 and 2028, the AHCA would reduce federal Medicaid spending by $373.6 billion, or 8.2 percent if program eligibility was not changed. In this scenario, most of the reduction in federal spending ($272.6 billion) would be attributable to the combined effects of the reduction in the matching rate and the effect of the per capita caps on the ACA expansion population. Additional reductions would be attributable to the per capita caps on the traditional Medicaid population ($52.0 billion) and the reduced federal matching rate for spending on pre-ACA expansion populations in seven states ($49.0 billion). One way in which states can accommodate the decrease in federal contributions is by generating new state revenues to offset the federal cuts—but *not* by reducing enrollment (Scenario 1). This approach would increase state spending by $371.1 billion.[1] Theoretically, states could also keep eligibility at current law levels by cutting benefits and/or provider payment rates by an equivalent amount, although that would be both politically and practically challenging.

AHCA Medicaid changes would have the greatest impact on states that have experienced the largest enrollment increases under the ACA. These states include Kentucky, Oregon, Nevada, New Mexico, and West Virginia. Other states with large enrollment increases and 50 percent match rates under the traditional program would also face substantial federal funding cuts because their federal match rates would fall the furthest; these states include New Jersey, Colorado, and Washington.

Many states may have no choice but to eliminate coverage of the expansion population because they would be unable to substantially increase their own spending. Moreover, they have limited scope to cut benefits and provider payment rates. Cuts to benefits such as dental, vision, and hearing coverage do not yield much savings. Provider payment rates are already very low in most states. Thus, the likelihood of enrollment cuts seems high, particularly among low-income states.

Instead, if states respond to the matching rate reduction by eliminating coverage of the expansion population (Scenario 2), the reduction in federal spending could be as high as $803.2 billion, or 17.5 percent, over 10 years. States would save only $78.0 billion in state dollars over 10 years by dropping coverage for the expansion population, because they would have paid only 10 percent of the costs of the expansion population. In the aggregate, these state savings would be more than offset by increased state spending because of the per capita caps imposed on the traditional Medicaid population and increased state spending in seven states on their pre-ACA expansion populations. These factors would lead to a net state spending *increase* of $20.5 billion.

If states not only eliminate coverage of the expansion population but also further reduce enrollment in response to the per capita caps and the reduced matching rate on the pre-ACA expansion population, federal spending would fall by

$938.3 billion between 2019 and 2028. State spending would fall by $78.0 billion in this scenario.

If all states eliminate coverage for their expansion populations under the AHCA, 12.0 million people—20 percent of nonelderly Medicaid enrollees—would lose their coverage in 2022. If states cut enrollment further in order that they not increase their own spending on pre-ACA eligible populations beyond current law levels, they would have to cut an additional 2.8 million Medicaid enrollees, and a total of 14.8 million people—24.9 percent of nonelderly enrollees—would lose Medicaid coverage (Scenario 3). With these additional enrollment cuts, states could avoid spending more money and compensate for the AHCA per capita caps and reduced federal match rate on pre-ACA expansion populations without cutting provider payment rates or benefits.

In 2028, 12.7 million people would lose Medicaid coverage if all states eliminated eligibility for the ACA expansion group, and an additional 951,000 people would lose Medicaid if the states cut enrollment further to offset the per capita caps and lower match rate on the pre-ACA expansion population, resulting in total Medicaid coverage losses of about 13.6 million people. If states cut enrollment to maintain their current spending on the pre-ACA expansion population, the per capita caps' effects on coverage would be weaker in 2028 than in 2022 because the caps become less binding over the 10-year budget window. (This may not be true after 2028, however, as explained below.)

We calculate Medicaid coverage losses in each state under Scenario 3 in 2022. Arkansas, Colorado, Kentucky, Nevada, New Jersey, New Mexico, North Dakota, Oregon, and West Virginia would have to cut Medicaid nonelderly coverage by more than 40 percent by 2022. Massachusetts, New York, and Arizona, which had broader Medicaid eligibility before the ACA, would see smaller but still substantial reductions in coverage—from 19.0 to 27.9 percent—to maintain their current state spending on pre-ACA eligible populations. States that did not expand Medicaid under the ACA or before it would sustain the smallest coverage cuts, compensating for the AHCA per capita caps alone.

Our estimates are very sensitive to the projections of Medicaid spending growth under current law and to the per capita cap growth rates for each eligibility category under the AHCA. For example, if future technological innovations lead to greater increases in per capita Medicaid spending under current law than those projected by the Congressional Budget Office (CBO), our estimates of federal funding losses, increased state financing burdens, and coverage losses are too low. Likewise, if the AHCA is modified to tighten the per capita caps, allowing federal funding to grow at a slower rate or computing per capita caps starting in an earlier base year, the effects of the per capita caps would be larger than those estimated here, reducing federal funds, increasing state financial burdens, and resulting in more coverage losses. Moreover, we do not take account of variation in state health care spending growth; in reality, per capita caps would be more binding in some states than in others.

In practice, different states would certainly respond in different ways to AHCA's Medicaid changes. While some states might take one of these approaches alone, others may respond in a combination of approaches, for example cutting enrollment while raising revenue each to a lesser degree than any of these specific scenarios. We provide the three scenarios included in this analysis as illustrations of potential state responses and their ramifications without attempting to predict which state would respond in which particular manner.

Three important policy issues related to per capita caps cannot be reflected in these estimates but should be considered in a full analysis of impacts. First, currently there are substantial disparities across states in state and federal funding of Medicaid, both for acute care and for long-term services and supports. Under a per capita cap structure, current low-spending states could spend more per enrollee in the future but would not receive matching federal funds for the increase, leaving them at a permanent funding disadvantage. Second, after the current 10-year budget window, the elderly population (ages 65 and older) will become older on average as the baby boom generation—now the "young" elderly—ages, and the average health care needs of this population will increase significantly.[3] Thus, in the future, per capita caps could limit necessary funding for the elderly population while reducing additional funds available to cover some of the costs of nonelderly, nondisabled enrollees; we estimate that this shifting of funds across groups is likely to occur in the first 10-year budget window. Third, per capita caps would constitute a substantial structural change from the current open-ended federal matching grant approach of Medicaid. The growth rates associated with the per capita caps for each eligibility group would likely become straightforward levers that policymakers could tighten to achieve additional federal savings. This could leave the program more susceptible to federal funding cuts in the future.

INTRODUCTION

The American Health Care Act (AHCA) passed the U.S. House of Representatives on May 4, 2017, and is now under debate in the Senate. The bill would eliminate much of the Affordable Care Act (ACA), ending the individual and employer mandates, eliminating other revenue sources, restructuring premium tax credits and eliminating cost-sharing subsidies, and substantially altering the financing of the Medicaid program. Specifically, the bill would allow states to continue covering the population made eligible for Medicaid under the ACA expansion but with substantially lower federal funding support. States would continue to receive the higher federal contribution—the 90 percent federal matching rate—for people who have already enrolled by the end of calendar year 2019 and have not experienced a gap in coverage. But as of January 1, 2020, the expansion matching rate for new enrollees would revert to each state's traditional matching rate. In addition, the bill would impose per capita caps on Medicaid payments, ending the program's open-ended matching grant structure.

The bill that passed the House differs slightly from the earlier one that was introduced on March 6 but never voted upon. In our previous report, we estimated the impact of the March 6 bill on federal spending and found that the combination of the reduction in the federal matching rate and the introduction of per capita caps would reduce federal Medicaid spending by $457 billion, or 9.8 percent, from 2019 to 2028.[4] This estimate is much lower than the March 23, 2017, estimate produced by the Congressional Budget Office (CBO) ($834 billion) because the CBO estimate assumed that many states would cut Medicaid enrollment in response to the new bill.[5] In this new paper, we update our earlier work, modeling the version of the bill that was passed by the House on May 4, 2017, and we expand our analysis to include the potential impacts of cuts to federal Medicaid funding on Medicaid enrollment.

The per capita cap is intended to slow federal spending on Medicaid. Per capita caps set federal contributions for specific enrollment groups based on historical federal spending per enrollee in each state. That amount is increased each year by a predetermined national growth rate. For example, under the AHCA, total (state plus federal) spending per enrollee in each state for each Medicaid eligibility group (children, Medicaid expansion adults, other nondisabled adults, people with disabilities, and elderly people) would be calculated for the base year of 2016. The per-enrollee spending level would increase by the set growth rate each year. Federal allotments given to each state would then be calculated as the federal spending cap per enrollee for each type of enrollee in each year, multiplied by the number of enrollees of that type in that state in that year. If states spend more than the capped federal allotment, their spending would not be matched. If they reduce spending to match the capped federal growth rate, they would fully draw down the federal matching funds and not spend additional unmatched state dollars. If they spend less than that amount, the federal allotment would be reduced below the capped amount.

The version of the AHCA that passed the House on May 4, 2017, differs slightly from the one we previously modeled. It retains the per capita cap and drops the 90 percent match rate to the regular match rate in 2020 for enrollees in the newly eligible group. In addition, the per capita caps for adults and children would grow by the medical care component of the consumer price index (MCPI) as in the earlier bill. But in the new bill, the per capita caps for elderly people and people with disabilities would grow by the MCPI plus 1 percent as opposed to MCPI. If actual spending per enrollee in the elderly and disabled groups grows by less than the cap, the savings to states can be applied to any overages for adults and children.

The ACA included a special provision for states that had expanded Medicaid eligibility to adults with incomes at least 100 percent of the federal poverty level (FPL) before the ACA (Arizona, Delaware, Hawaii, Maine, Massachusetts, New York, and Vermont). Beginning in 2014, the federal government would pay an increasing share of the costs for this population, eventually equaling the new ACA match rate in 2019 and later years. The AHCA would cap this higher matching rate at the 2017 level through 2019, and then eliminate it for new enrollees. For example, New York's match rate under the ACA would be 86 percent in 2017 and 2018, 93 percent in 2019, and 90 percent in 2020; its match rate under the AHCA would be 86 percent from 2017 to 2019, and 50 percent beginning in 2020. In these pre-ACA expansion states, state spending would have to increase relative to the ACA for beneficiaries in the expansion population to maintain the same coverage and benefits.

To summarize, the AHCA bill passed by the House of Representatives includes the following changes to Medicaid funding:

- Per capita caps would be imposed on federal payments beginning in 2020.
- The base year for calculating per-enrollee costs under the caps would be 2016.
- For people eligible for Medicaid under pre-ACA rules, the federal match rate would be 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 matching rate would remain at 90 percent until they disenroll or experience a gap in enrollment.
- If a state chooses to maintain eligibility for its ACA or pre-ACA expansion populations, spending on any new enrollees would receive the state's matching rate computed according to traditional rules.
- After the base year and through 2019, each state's per capita caps for all eligibility categories increase by the percentage growth in the MCPI. Beginning in 2020, the caps for elderly people and people with disabilities grow by MCPI plus one percentage point each year, while the caps for other children and adults grow by MCPI. To the extent that spending increases above the caps for some eligibility groups but not for others, excess allotted federal funds for one eligibility group can be shifted to help cover the costs of another for which the per capita cap is binding.
- The MCPI is projected to grow by 3.7 percent per year, according to CBO; thus, the MCPI plus 1 percent would be 4.7 percent.

This analysis updates our previous analysis to be consistent with the bill that passed the House on May 4, 2017. We provide estimates for three scenarios of state responses to AHCA changes to the Medicaid program. In Scenario 1, states increase their own Medicaid program spending, consistent with the new rules, by raising new revenues to offset federal funding cuts. In Scenario 2, states drop coverage for their ACA Medicaid expansion populations but increase their own spending to offset federal funding reductions for other eligibility groups. In Scenario 3, states drop coverage for their ACA expansion populations and make additional enrollment cuts in response to per capita caps and the reduced matching rate on pre-ACA eligible populations.

METHODS

Our methods are explained in detail in our previous report.[4] The key points are as follows:

- 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 (CMS) to ensure that the increase in Medicaid enrollment under the ACA matches administrative data for each state. We grow enrollment to 2019, assuming that Medicaid growth under current law will be driven largely by population increases.
- Our baseline results reflect our best estimate of health coverage in 2019 under the ACA. Our national estimates differ from those produced by the Congressional Budget Office. Baseline CBO Medicaid enrollment numbers are generally higher because the CBO relies on different data sources and, moreover, assumes that additional states would adopt the Medicaid expansion.
- Our estimate of 2019 Medicaid spending is based on the latest publicly available Medicaid Statistical Information System (MSIS) data; these data are from 2011 or 2012 depending on the state. We compute average costs for each of the five AHCA Medicaid per capita cap groups – elderly people, nonelderly people with disabilities, Medicaid expansion adults, other nondisabled adults, and nondisabled children. Costs are then grown to 2019 using the overall Medicaid growth rates projected by CBO. Per capita costs for the expansion population are estimated using pre-ACA adult per capita costs adjusted for the difference in health care risk between new and pre-ACA eligible adult populations.
- Several types of Medicaid spending are excluded from the per capita cap analysis, to the extent that MSIS data permit. These include disproportionate share hospital payments, certain 1115 waiver–based supplemental payments, and spending on limited-benefit Medicaid recipients. None of these components of spending are subject to the per capita caps under the AHCA.
- To make our estimates more consistent with CBO, we assume that growth in costs per person would be consistent with the January 2017 CBO baseline. Our current-law scenario starts from our 2019 estimates and assumes that both enrollment and per capita costs grow according to CBO projections but without any additional states expanding Medicaid eligibility. Our per capita cap scenarios assume that enrollment would grow according to CBO projections, but per capita costs would grow at the capped amount, except when we assume states increase their own spending to offset federal funding reductions.

One caveat to this analysis is that we use Medicaid spending and enrollment data that are several years old. Ideally we would have the most current data from each state, but this is not feasible; our estimates are the best possible using the most recent data available. The one exception to the above is

Massachusetts. Because of a separate analysis done for that state, we had access to Massachusetts-specific data and the state's growth projections.[3] However, the major driver of our estimates is the difference between current enrollment and spending growth projections by CBO and the growth allowed under the proposed policy alternatives, and these differences are known.

A second caveat is that the AHCA would permit states to accept a block grant option. We assume that no states would do this because the growth rates for a block grant would be significantly lower than those for a per capita cap, making this far less attractive to states than per capita caps. A third caveat is that this analysis assumes that all states would see enrollment and spending growth at the same CBO projected rates. In reality, this would not be the case. Some states' enrollment and spending would grow faster, and we have underestimated the impact of, say, the per capita cap on their programs. Other states would grow slower, and we may have overstated the effects, though these are likely to be small.

Fourth, we do not assume that any additional states would expand Medicaid if current law remained unchanged. Because we are producing state-specific estimates and would have had to assign Medicaid expansion to particular states, we only included the 32 states (including the District of Columbia) that have already expanded Medicaid under the ACA in our estimates of the expansion population. In contrast, CBO assumes that several additional states would expand Medicaid eligibility if the ACA continues.

The CBO growth rates for enrollment, spending per enrollee, and overall spending were provided in our last paper. The relevant growth rates are as follows:[4]

- MCPI is estimated to grow by 3.7 percent per year from 2019 to 2028; thus, MCPI plus 1 percent growth is estimated to be 4.7 percent.
- CBO projections of Medicaid per capita spending growth under current law are 1.8 percent for elderly people, 3.5 percent for people with disabilities, 4.7 percent for children, and 4.5 percent for nonelderly adults.
- CBO projections of enrollment growth are 2.8 percent for elderly people, 1.4 percent for people with disabilities, -0.1 percent for children, and 2.2 percent for adults. The adult enrollment growth rate reflects an anticipated increase in the number of states expanding Medicaid under the ACA. Because we chose not to model any additional expansion, we reduced adult enrollment growth to 0.9 percent per year, consistent with population growth for that age group. These national average growth rates are applied to each state.
- CBO expects MCPI plus 1 percent to exceed per capita Medicaid spending growth for elderly people and people with disabilities, providing a cushion that states can apply to losses of federal funds resulting from per capita caps on Medicaid spending for children and nonelderly adults. This cushion would grow over the 10-year budget window because the projected increase in the number of elderly and disabled enrollees exceeds that of children and adults; this reduces the impact that per capita caps will have in each successive year. As we explain in the discussion section, this cushion may disappear after the first 10-year budget window because of the aging of the elderly population.

RESULTS

In this paper, we model the new AHCA Medicaid per capita cap components as outlined above. We model three scenarios of state decisions. In Scenario 1, we assume states do not cut enrollment. Instead, they raise new revenues to compensate for the federal cuts. We estimate the loss of federal funds from 2019 to 2028, assuming no enrollment cuts; states would increase their own Medicaid spending by the amount needed to fully offset the loss of federal dollars and keep their programs intact.[1]

However, many states would not be able to substantially increase their own spending because that would require large revenue increases or cuts to other parts of their budgets. As an alternative to raising revenue to replace federal cuts, states could, at least theoretically, reduce benefits and/or provider payment rates to offset the cuts. Unlike enrollment cuts, reducing benefits or payment rates would not further reduce federal funds.

However, either of these alternatives would be difficult. States have limited room to reduce Medicaid spending per enrollee. Cutting optional benefits, such as prescription drug coverage, mental health and substance use disorder treatment, and home and community-based waiver services, would pose political challenges. Prescription drugs are central to modern medical care. Hospital inpatient care, emergency room care, and physician services could increase if prescription drugs are not available, thereby reducing or even eliminating savings from cutting the benefit. Mental health and substance use disorder treatment are vital to reducing violent behavior and alcohol and opiate addiction, both problems of great concern

to the governors of most states. Home and community-based services have helped slow growth in Medicaid spending on nursing home care; eliminating benefits for the former would lead to offsetting increases in the latter. Optional services such as dental, vision, and hearing care services could be cut, but they would yield little savings. Cutting provider payment rates could generate savings to states, but rates in virtually every state are already relatively low, and providers are likely to resist further reductions. To avoid spending more state dollars on their Medicaid programs, many states would have to reduce enrollment in response to the shortfall of federal dollars.

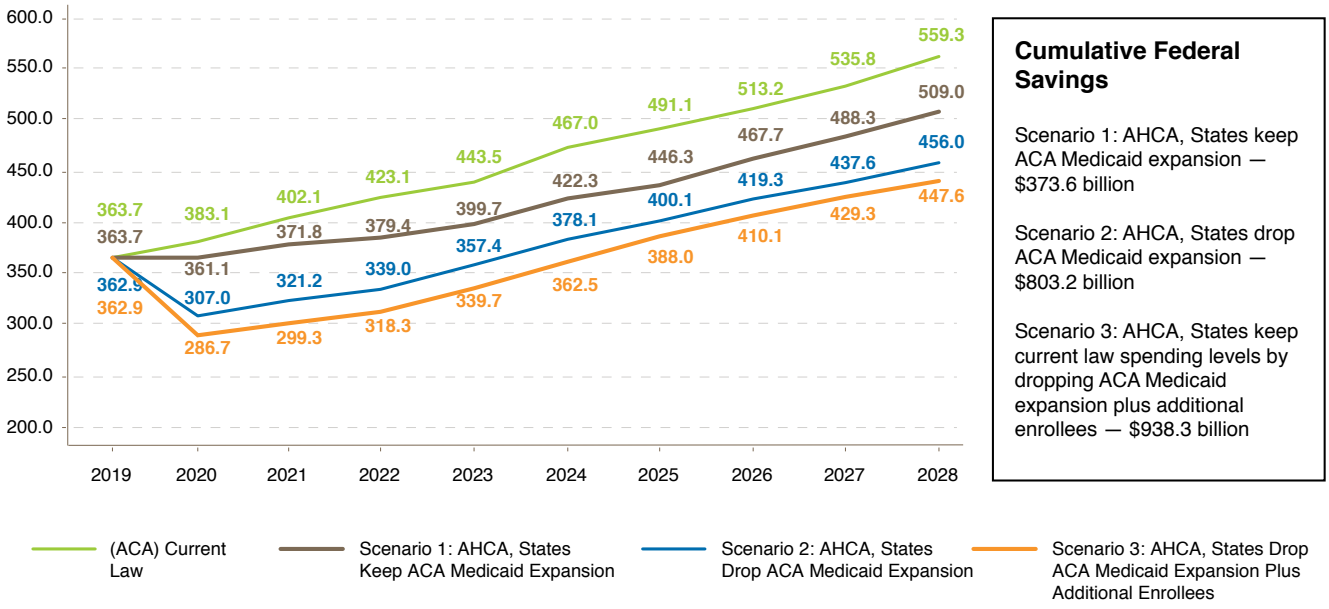
Thus, we present estimates for two additional scenarios that include enrollment cuts. In Scenario 2, states eliminate eligibility for their ACA expansion populations but increase state funds to offset the effects of federal cuts (i.e., per capita caps and reduced matching funds) on state populations eligible for Medicaid before the ACA. Simply put, this scenario assumes that Medicaid eligibility reverts to pre-ACA rules. We provide estimates of the coverage implications for each state if it does make that choice.

We estimate federal savings from the elimination of Medicaid eligibility for the ACA expansion group and from per capita caps and the reduced matching rates imposed on pre-ACA eligibility groups. We also estimate state savings from dropping the expansion population, as well as state spending increases required to offset the impacts of per capita caps on the remaining eligible population, and cost increases required to offset the reduced matching rate for the seven states that had expanded eligibility before the ACA.

Scenario 3 leads to larger Medicaid enrollment cuts than Scenario 2, and our analysis focuses on these potential enrollment effects. In Scenario 3, states would eliminate eligibility for their ACA expansion populations (if they expanded eligibility) and make additional enrollment cuts as necessary in response to the per capita caps and reduced matching rate on the pre-ACA expansion population. These enrollment cuts affect all states, not just those that expanded eligibility under the ACA, because all states are affected by the per capita caps. In Scenario 3, we focus on the implied enrollment effects by state in 2022 and in total over the 10-year budget window.

Figure 1 shows aggregate federal Medicaid spending under current law and under all three AHCA scenarios. The top line shows total federal Medicaid spending from 2019 to 2028 under current law using the CBO baseline growth rates; it does not include any additional expansion of Medicaid eligibility. We estimate that federal spending in 2028 would be $559.3 billion. Assuming no enrollment cuts under the AHCA (Scenario 1), federal spending would grow along the path of the second highest line, reaching $509.0 billion in 2028. Federal spending growth slows between 2020 and 2022 because people currently enrolled under the ACA expansion (with the higher matching rates) move out of the Medicaid program. States would then receive the lower traditional matching rate for any new enrollees. By 2022, the growth rate reflects the per capita cap growth rates of MCPI for adults and children and MCPI plus 1 percent for elderly people and people with disabilities.

Figure 1. Impact of AHCA on Total Federal Medicaid Spending Under Three State Response Scenarios, 2019–2028 (Billions $)



Cumulative Federal Savings

Scenario 1: AHCA, States keep ACA Medicaid expansion — $373.6 billion

Scenario 2: AHCA, States drop ACA Medicaid expansion — $803.2 billion

Scenario 3: AHCA, States keep current law spending levels by dropping ACA Medicaid expansion plus additional enrollees — $938.3 billion

Source: Urban Institute analysis using HIPSM 2017

The third highest line shows reduced federal spending if all 32 expansion states eliminate coverage of their expansion populations in response to the federal matching rate reduction beginning in 2020 (Scenario 2). In this case, federal spending would reach $456.0 billion by 2028. If states not only eliminate their ACA Medicaid expansions but also cut enrollment further to avoid increasing their own spending to offset federal losses from per capita caps and reduced federal matching payments for the pre-ACA expansion population (Scenario 3), federal spending would fall to $447.6 billion in 2028. Assuming no enrollment cuts, federal spending would fall by $373.6 billion from 2019 to 2028; assuming all states eliminate eligibility for the ACA expansion population, federal spending would fall by $803.2 billion; and assuming states cut enrollment further to avoid additional spending on pre-ACA eligibility groups, federal spending would fall by $938.3 billion.

These estimates are also displayed in Table 1. Under Scenario 1 (no enrollment cuts; states increase own spending), federal spending would fall by $373.6 billion, or 8.2 percent. State spending would increase by $371.1 billion to compensate for federal spending decreases.[1] Under Scenario 2 (all states that expanded eligibility under the ACA drop coverage for that group), federal spending would fall by $803.2 billion, or 17.5 percent. State spending would still have to increase by $20.5 billion; state savings from dropping the expansion population ($78.0 billion) are far less than the loss of federal dollars from per capita caps and the reduced matching rate on that population. Under Scenario 3 (further enrollment cuts), federal spending would fall by $938.3 billion, and state spending would fall by $78.0 billion.

Table 1. Impact of AHCA on Federal and State Medicaid Expenditures, 2019–2028 Under Three Different State Response Scenarios (Billions $)

Scenario 1: States Keep ACA Medicaid Expansion		
To Offset Decreases in Federal Spending, States Increase Their Own Spending		
	Difference	% Difference
Federal Spending	-$373.6	-8.2%
State Spending	$371.1*	13.2%
Total	-$2.5	0.0%
Scenario 2: States Drop ACA Medicaid Expansion		
Federal and State Governments Save by Cutting ACA Expansion Enrollment; States Increase Spending to Offset Per Capita Caps and Reduced Federal Match for Pre-ACA Expansion Populations		
	Difference	% Difference
Federal	-$803.2	-17.5%
State	$20.5	0.7%
Total	-$782.7	-10.6%
Scenario 3: States Drop ACA Medicaid Expansion and Additional Enrollees		
States Cut Enrollment of Pre-ACA Eligible Populations In Response to Per Capita Caps and Reduced Matching Rates for Pre-ACA Expansion Populations		
	Difference	% Difference
Federal	-$938.3	-20.5%
State	-$78.0	-2.8%
Total	-$1,016.3	-13.8%

Source: Urban Institute analysis using HIPSM 2017.

Notes: Per capita caps for spending on elderly people and people with disabilities grow by MCPI plus 1 percent per year; caps for nonelderly adults and children grow at MCPI. The base year is 2016.

*In Scenario 1, aggregate state spending does not increase as much as federal spending decreases because of the unique conditions in Massachusetts. As we estimated in a separate Massachusetts-specific analysis, the AHCA would lead to a loss of federal Section 1115 waiver funding for Massachusetts residents with income between 138 and 300 percent of FPL, in addition to the matching rate reduction on the ACA Medicaid expansion population. In this scenario, we assume that Massachusetts would eliminate its own spending on this population once the federal matching funds were eliminated. This reduction in state spending accounts for the Scenario 1 difference between decreased federal funding and increased state spending in the aggregate.

Table 2 shows the state-by-state effects of Scenario 1 on federal Medicaid spending. Federal Medicaid expenditures would fall by 8.2 percent from 2019 to 2028; however, states with large Medicaid expansion populations would see larger relative reductions in federal payments. For example, Kentucky would see a 12.5 percent decrease in federal spending, Nevada 12.8 percent, New Mexico 14.0 percent, and Oregon 15.1 percent. States that have large Medicaid expansion populations and a 50 percent traditional federal matching rate would see even larger percent reductions. For example, Colorado would see a federal spending decrease of 18.4 percent, New Jersey 19.1 percent, and Washington 18.2 percent. States that did not expand Medicaid at all would experience much smaller reductions in spending. For example, Florida and Texas would see reductions of about 1.4 and 2.1 percent respectively.

Table 3 shows the increases in state spending required to fully offset the loss of federal dollars under Scenario 1. Alternatively, these estimates represent the value of benefit and/or payment rate cuts that would be necessary to offset the federal funding reductions. For each state, the increase is the same as the reduction in federal spending in Table 2 (except for Massachusetts).[1] However, the percent differences are greater for the states than for the federal government because the increases in state spending required to compensate for decreased federal funding are larger relative to the states' current spending. States with high traditional federal matching rates—usually low-income states—would have to make bigger percent increases in spending to fully offset the loss of federal dollars because those states' current spending levels are lower. For example, Kentucky would have to increase its spending by 45.9 percent, New Mexico by 49.4 percent, and Oregon by 43.5 percent. Arizona, Colorado, Delaware, Hawaii, Maryland, Michigan, Montana, Nevada, New Jersey, North Dakota, Washington, and West Virginia would each have to increase state spending by more than 20.0 percent. States that must make large percent increases in spending had a large coverage expansion, a high traditional federal matching rate, or both.

If states eliminate eligibility for their expansion populations but compensate for other federal funding losses under the AHCA (Scenario 2), federal spending would fall substantially more: $803.2 billion over 10 years, or 17.5 percent (Table 4). States with large expansion populations and 50 percent traditional federal matching rates would see substantial reductions in federal funds. For example, Colorado would see a federal spending reduction of 39.9 percent, New Jersey 41.6 percent, and Washington 39.2 percent. States with large expansion populations but higher traditional federal matching rates would also see substantial reductions. These large percent reductions in federal spending would occur in part because their pre-ACA Medicaid spending levels were low and their ACA expansion populations are large relative to their pre-ACA coverage base. For example, Kentucky would face a federal spending reduction of 42.6 percent, Nevada 35.7 percent, New Mexico 42.9 percent, and Oregon 43.6 percent. Arizona, Delaware, Hawaii, Illinois, Indiana, Iowa, Maryland, Michigan, Minnesota, Montana, New Hampshire, North Dakota, Ohio, Pennsylvania, Rhode Island, and West Virginia would see federal spending fall by over 20.0 percent.

Table 5 shows the net effect on state spending associated with eliminating coverage for the expansion population and offsetting losses on per capita caps and the reduced match rate on the pre-ACA expansion group. States with large ACA coverage expansions would reduce their own spending by the largest relative amounts; these include Kentucky (-14.0 percent), Oregon (-12.1 percent), New Mexico (-7.1 percent), and West Virginia (-9.8 percent). States that expanded Medicaid before the ACA would spend an additional $49 billion in total to compensate for the cut to federal matching rates for their pre-ACA expansion populations and the per capita caps applied to these eligible people; these states are Arizona ($6.9 billion), Delaware ($1.1 billion), Hawaii ($1.4 billion), Maine ($0.5 billion), Massachusetts ($10.4 billion), New York ($27.9 billion), and Vermont ($0.9 billion).

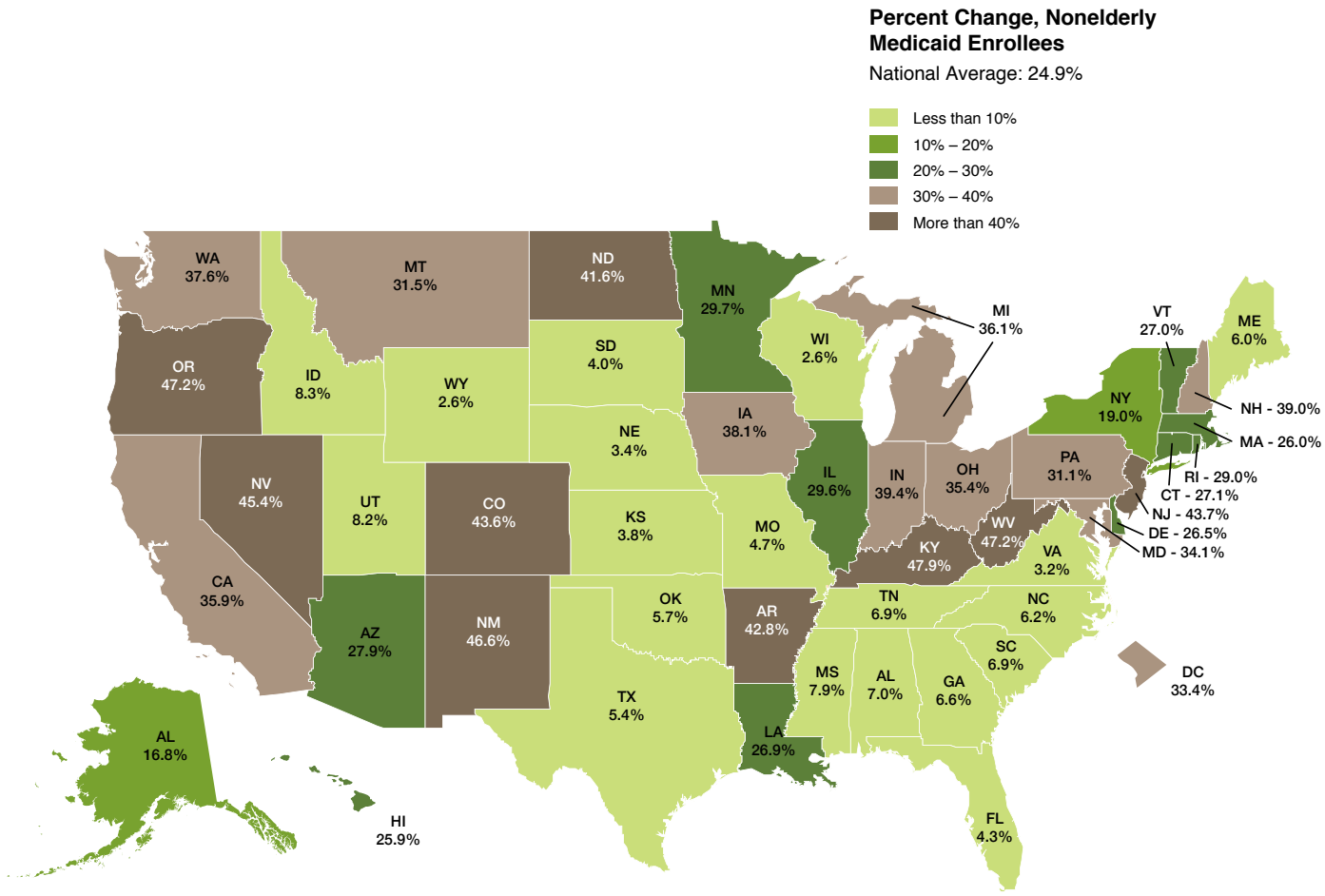
Table 6 shows how the effects would play out over time. Recall that the per capita caps increase by MCPI plus 1 percent for elderly people and people with disabilities and by MCPI for adults and children. At the same time, the number of elderly people and people with disabilities is projected to grow faster than the number of children and adults; this increases the likelihood that in the 10-year budget window, savings on elderly and disabled people can compensate for some of the state cost overages relative to the AHCA per capita caps on children and nonelderly adults. In Scenario 2, federal spending on the pre-ACA Medicaid-eligible population would decrease by $11.6 billion in 2020, but only by $0.4 billion in 2028. However, federal savings from dropping the expansion population increase each year because federal spending on that group grows under current law; thus, the reduction in federal spending on the expansion population would be $62.0 billion in 2020, but $95.8 billion in 2028. Finally, the reduced federal match rate and the per capita caps have increasing effects over time in the seven states that expanded Medicaid before the ACA. The reduction in federal spending in these states would be $0.8 billion in 2019 and $7.0 billion in 2028.

Table 7 shows coverage losses in 2022 under Scenario 2 (states drop their ACA expansion populations) and Scenario 3 (states drop their expansion populations and additional enrollees to offset the impacts of per capita caps and the lower match rate for those eligible under pre-ACA expansions). The first column of Table 7 shows coverage losses under Scenario 2, and the second column shows the additional coverage losses under

Scenario 3. In 2022, 12.0 million Medicaid enrollees currently eligible under the ACA expansion would lose their coverage in both Scenario 2 and Scenario 3. Another 2.8 million would lose their Medicaid coverage because of the impact of per capita caps and the lower match rate for pre-ACA expansion populations under Scenario 3; altogether, 14.8 million people would lose Medicaid coverage under Scenario 3. In 2022, 3.4 million people would lose coverage in California, 712,000 would lose coverage in Illinois, 737,000 in Michigan, 587,000 in New Jersey, 613,000 in Pennsylvania, and 594,000 in Washington. Among lower-income states, Kentucky would see coverage losses of 535,000, West Virginia 195,000, and Arkansas 313,000.

Table 7 also shows each state's Medicaid enrollment cut as a percentage of the baseline enrollment of nonelderly beneficiaries (these relative changes are also shown in Figure 2). In states with proportionally large Medicaid expansion populations, coverage losses among the expansion population would reduce total state nonelderly Medicaid enrollment by more than 40 percent; these states include Colorado (43.6 percent), Kentucky (47.9 percent), Nevada (45.4 percent), New Jersey (43.7 percent), North Dakota (41.6 percent), Oregon (47.2 percent), and West Virginia (47.2 percent). All but one of the states (Maine) that had expanded Medicaid eligibility before the ACA would see smaller but still substantial percent reductions in total nonelderly enrollment; these states include Arizona (27.9 percent), Delaware (26.5 percent), Hawaii (25.9 percent), Massachusetts (26.0 percent), New York (19.0 percent), and Vermont (27.0 percent) in 2022. Coverage losses from per capita caps alone in nonexpansion states are relatively small—for example, 4.3 percent in Florida and 5.4 percent in Texas.

Figure 2. Percent Reduction in Medicaid Nonelderly Enrollment, if States Drop ACA Expansion and Cut Other Enrollees to Compensate for Per Capita Caps and Reduced Federal Match on Pre-ACA Expansion Population.



Source: Urban Institute analysis using HIPSM 2017

Table 8 shows total national coverage losses under Scenario 3 by year, with a large initial coverage loss of 14.8 million in 2020. Coverage losses decline over time because of the weakening effects of per capita caps over the 10-year window. For example, coverage losses are 13.6 million in 2028, compared with 14.8 million in 2020, and only 951,000 enrollees would be dropped because of the per capita caps and pre-ACA expansion matching rate reductions in 2028. However, as discussed below, the coverage loss effects of per capita caps could increase in later years; we do not estimate those here.

CONCLUSION

In this analysis, we show that the AHCA as passed by the House of Representatives would reduce federal Medicaid spending by $373.6 billion, or 8.2 percent, from 2019 to 2028, if all states accommodated the federal spending reductions resulting from the per capita caps and lower federal matching rates for the expansion populations by increasing their own spending but not by cutting enrollment. Alternatively, states could potentially offset federal losses by cutting benefits and/or provider payment rates. States with the largest enrollment expansions under the ACA would experience the largest reductions in federal payments and would face the largest increases in their own spending (or the largest benefit/payment rate cuts) to offset the federal losses.

Reducing provider payment rates or benefits would prove challenging, however. Provider payment rates are already fairly low in most states, and hospitals and physician groups would strongly oppose any reductions. Optional services such as dental, vision, and hearing services are not expensive, so eliminating coverage for them would yield little savings. Cutting more expensive services such as prescription drugs would be difficult because they are often essential to medical treatment, and lack of drug coverage could increase hospital and physician costs. Cuts to mental health and substance use disorder services could also be counterproductive, given the growing need for these services across the country.

Thus, many states may choose to reduce Medicaid eligibility to accommodate the changes in the AHCA. Lower-income states are more likely to do this because they would have to make comparatively larger spending increases to preserve their current programs. Under a per capita cap, dropping enrollees reduces federal payments more than cuts to benefits and provider payments would. We estimate that federal spending would fall by $803.2 billion, including savings from per capita caps and savings on the pre-ACA expansion population ($702.2 billion) from dropping the expansion population alone), assuming states eliminate Medicaid eligibility for the ACA expansion population but maintain enrollment for other groups. However, states save very little ($78.0 billion) relative to the lost federal dollars ($702.2 billion) by dropping ACA expansion enrollees, and these savings would be more than offset by increased spending to compensate for federal funding losses on other Medicaid-eligible groups.

We estimate that if Medicaid expansion states drop their expansions and all states cut Medicaid enrollment in order to offset federal losses due to the per capita caps and the lower pre-ACA match rates, 14.8 million nonelderly Medicaid enrollees would lose their coverage in 2022—12.0 million from the expansion population and 2.8 million from other eligibility categories. The percent reductions are significantly greater in states that saw the largest coverage increases as a result of the ACA Medicaid expansion. Several states would see nonelderly Medicaid coverage fall by more than 40 percent. However, the impact of the per capita caps weakens over the 10-year window because of the higher spending growth rate for elderly people and people with disabilities; this population is expected to grow faster nationwide than children and nonelderly adults. Thus, from 2019 to 2028, the per capita caps become less burdensome, and coverage and funding losses from the elimination of ACA expansion eligibility grow. However, this would not necessarily be true after 2028.

Our estimates are very sensitive to the projections of Medicaid spending growth under current law and to the per capita cap growth rates for each eligibility category under the AHCA. For example, if future technological innovations lead to greater increases in per capita Medicaid spending under current law than those projected by CBO, our estimates of federal funding losses, increased state financing burdens, and coverage losses are too low. Likewise, if the AHCA is modified to tighten the per capita caps, allowing federal funding to grow at a slower rate or computing per capita caps starting in an earlier base year, the effects of the per capita caps would be larger than those estimated here, reducing federal funds, increasing state financial burdens, and resulting in more coverage losses. Moreover, we do not take account of variation in state health care spending growth, but per capita caps would be more binding in some states than in others.

Our analysis indicates that over the next 10 years, per capita caps would have a smaller effect on federal funding changes and Medicaid coverage than changes to the ACA expansion population would. However, we must consider three other

important policy issues related to per capita caps that cannot be reflected in these estimates. First, there are substantial disparities in state and federal funding of Medicaid, both for acute care and for long-term services and supports. For example, states that do not provide many optional benefits to their enrollees or pay providers less per service not only spend less per beneficiary, but they also draw down fewer federal matching dollars than they otherwise would. The current structure of the Medicaid program allows states to change such health care investment decisions in the future and catch up to states spending more. Under a per capita cap structure, current low-spending states could still spend more per enrollee in the future, but they would not see those additional funds matched with federal dollars, leaving them at a permanent funding disadvantage.[4,7]

Second, beyond the 10-year budget window, the elderly population (ages 65 and older) will become older on average as the baby boom generation—now the "young" elderly—ages, and the average health care needs of this population will increase significantly.[3] Per capita caps for elderly people set in 2016 and growing by MCPI plus 1 percent may not reflect the average health care costs of this population as it becomes more expensive to insure. Thus, per capita caps for the elderly population—projected here as nonbinding over the next 10 years—could become increasingly constraining after 2028. In the future, the caps could limit necessary funding for elderly people while leaving fewer additional funds to cover the costs of nonelderly, nondisabled enrollees, for whom the caps would be binding even in the near term.

Third, per capita caps would constitute a substantial structural change from the current open-ended federal matching grant approach of Medicaid. The growth rates associated with the eligibility group–specific per capita caps would likely become straightforward levers that policymakers could tighten to achieve additional federal savings. This could leave the program more susceptible to future federal funding cuts.

ENDNOTES

1. In Scenario 1, aggregate state spending does not increase as much as federal spending decreases because of the unique conditions in Massachusetts. As we estimated in a separate Massachusetts-specific analysis, the AHCA would lead to a loss of federal Section 1115 funding for Massachusetts residents with income between 138 and 300 percent of FPL, in addition to the matching rate reduction on the ACA Medicaid expansion population. In this scenario, we assume that Massachusetts would eliminate its own spending on this population once the federal matching funds were eliminated. This reduction in state spending accounts for the Scenario 1 difference between decreased federal funding and increased state spending in the aggregate. Urban Institute. *Modeling the Impacts of the American Health Care Act on Massachusetts*. Boston: Blue Cross Blue Shield of Massachusetts Foundation; 2017. https://bluecrossmafoundation.org/publication/modeling-impacts-american-health-care-act-massachusetts.
2. This estimate is higher than the Congressional Budget Office's estimate because our 10-year budget window goes from 2019 to 2028 while CBO's window goes from 2017 to 2026. The years 2017 and 2018 are before the largest reductions in federal funding would take place. This difference in years more than offsets the fact that the Congressional Budget Office also assumes additional states would have adopted the ACA's Medicaid expansion under current law, which we do not assume here. Congressional Budget Office. *Cost Estimate: H.R. 1628, American Health Care Act of 2017*. Washington: Congressional Budget Office, 2017. https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf. Published May 24, 2017.
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Table 2: Impact of AHCA on Federal Medicaid Expenditures by State, 2019–2028

Scenario 1: States Keep Medicaid Expansion by Increasing Own Spending to Offset Federal Cuts (Billions $)

	Federal Medicaid Spending		Difference Between AHCA and ACA				
	ACA (Current Law)	AHCA	Change in Spending on ACA Expansion Population Because of Reduced Match Rate and Per Capita Caps	Change in Spending on Traditional Medicaid Population Because of Per Capita Caps	Change in Spending on Pre-ACA Expansion Population Because of Reduced Match Rate and Per Capita Caps	Total Difference	% Difference
National	4,581.9	4,208.3	-272.6	-52.0	-49.0	-373.6	-8.2%
Alabama	46.8	46.0	0.0	-0.8	n.a.	-0.8	-1.6%
Alaska	12.3	11.3	-0.9	-0.2	n.a.	-1.1	-8.5%
Arizona	149.9	133.8	-7.2	-2.0	-6.9	-16.1	-10.8%
Arkansas	49.7	47.5	-1.9	-0.4	n.a.	-2.3	-4.6%
California	395.6	358.7	-33.6	-3.3	n.a.	-37.0	-9.3%
Colorado	73.8	60.2	-13.1	-0.5	n.a.	-13.6	-18.4%
Connecticut	63.8	57.9	-5.5	-0.5	n.a.	-5.9	-9.3%
Delaware	16.0	13.8	-1.0	-0.1	-1.1	-2.2	-13.7%
District of Columbia	20.4	19.3	-0.9	-0.2	n.a.	-1.1	-5.5%
Florida	202.2	199.3	0.0	-2.9	n.a.	-2.9	-1.4%
Georgia	104.2	102.2	0.0	-2.0	n.a.	-2.0	-1.9%
Hawaii	17.7	15.0	-1.1	-0.1	-1.4	-2.6	-14.9%
Idaho	25.7	25.3	0.0	-0.5	n.a.	-0.5	-1.8%
Illinois	155.1	135.1	-18.2	-1.8	n.a.	-20.0	-12.9%
Indiana	92.3	85.6	-6.1	-0.6	n.a.	-6.7	-7.3%
Iowa	37.3	34.2	-2.8	-0.3	n.a.	-3.1	-8.2%
Kansas	25.9	25.6	0.0	-0.3	n.a.	-0.3	-1.3%
Kentucky	108.3	94.8	-12.6	-0.9	n.a.	-13.5	-12.5%
Louisiana	100.9	92.9	-6.5	-1.5	n.a.	-8.0	-7.9%
Maine	22.5	21.9	0.0	-0.2	-0.5	-0.6	-2.9%
Maryland	81.6	69.9	-11.1	-0.7	n.a.	-11.7	-14.4%
Massachusetts	119.0	106.3	0.0	-2.4	-10.4	-12.8	-10.7%
Michigan	171.1	157.0	-13.0	-1.2	n.a.	-14.1	-8.2%
Minnesota	96.1	86.1	-9.2	-0.9	n.a.	-10.0	-10.4%
Mississippi	50.8	50.1	0.0	-0.7	n.a.	-0.7	-1.4%

Table 2. Continued...

	Federal Medicaid Spending		Difference Between AHCA and ACA				
	ACA (Current Law)	AHCA	Change in Spending on ACA Expansion Population Because of Reduced Match Rate and Per Capita Caps	Change in Spending on Traditional Medicaid Population Because of Per Capita Caps	Change in Spending on Pre-ACA Expansion Population Because of Reduced Match Rate and Per Capita Caps	Total Difference	% Difference
National	4,581.9	4,208.3	-272.6	-52.0	-49.0	-373.6	-8.2%
Missouri	86.0	84.9	0.0	-1.1	n.a.	-1.1	-1.3%
Montana	30.2	27.7	-1.9	-0.6	n.a.	-2.5	-8.3%
Nebraska	17.2	17.0	0.0	-0.2	n.a.	-0.2	-1.2%
Nevada	35.3	30.8	-4.1	-0.4	n.a.	-4.5	-12.8%
New Hampshire	16.4	14.2	-2.1	-0.1	n.a.	-2.2	-13.5%
New Jersey	143.8	116.3	-26.7	-0.8	n.a.	-27.5	-19.1%
New Mexico	67.4	58.0	-7.7	-1.7	n.a.	-9.4	-14.0%
New York	429.6	383.3	-16.2	-2.3	-27.9	-46.3	-10.8%
North Carolina	150.1	147.6	0.0	-2.5	n.a.	-2.5	-1.6%
North Dakota	8.8	7.5	-1.3	0.0	n.a.	-1.3	-14.8%
Ohio	214.5	196.1	-17.2	-1.3	n.a.	-18.5	-8.6%
Oklahoma	51.4	50.5	0.0	-0.8	n.a.	-0.8	-1.6%
Oregon	87.2	74.0	-12.6	-0.5	n.a.	-13.1	-15.1%
Pennsylvania	178.2	162.4	-14.7	-1.1	n.a.	-15.8	-8.8%
Rhode Island	22.5	19.6	-2.6	-0.2	n.a.	-2.9	-12.8%
South Carolina	60.9	60.1	0.0	-0.8	n.a.	-0.8	-1.4%
South Dakota	9.0	8.8	0.0	-0.2	n.a.	-0.2	-1.7%
Tennessee	98.9	96.6	0.0	-2.3	n.a.	-2.3	-2.3%
Texas	323.2	316.3	0.0	-6.9	n.a.	-6.9	-2.1%
Utah	31.0	30.4	0.0	-0.6	n.a.	-0.6	-1.9%
Vermont	13.9	12.2	-0.6	-0.1	-0.9	-1.7	-12.3%
Virginia	60.5	59.5	0.0	-0.9	n.a.	-0.9	-1.6%
Washington	97.6	79.9	-17.0	-0.8	n.a.	-17.8	-18.2%
West Virginia	39.3	35.9	-3.3	-0.2	n.a.	-3.5	-8.8%
Wisconsin	64.4	63.9	0.0	-0.5	n.a.	-0.5	-0.7%
Wyoming	5.3	5.3	0.0	-0.1	n.a.	-0.1	-1.1%

Source: Urban Institute analysis using HIPSM 2017.

Notes: n.a. = not applicable. Only seven states expanded Medicaid eligibility before the ACA. Per capita caps for spending on elderly people and people with disabilities grow by MCPI plus 1 percent per year; caps for nonelderly adults and children grow at MCPI. The base year is 2016.

Table 3: State Costs of Offsetting Loss of Federal Dollars Under AHCA by State, 2019–2028

Scenario 1: States Keep Medicaid Expansion by Increasing Own Spending to Offset Federal Cuts (Billions $)

	State Medicaid Spending			
	ACA (Current Law)	AHCA	Difference	% Difference
National	2,805.4	3,176.4	371.1	13.2%
Alabama	21.9	22.6	0.8	3.5%
Alaska	10.5	11.5	1.1	10.1%
Arizona	62.3	78.4	16.1	25.9%
Arkansas	18.6	20.9	2.3	12.2%
California	321.1	358.0	37.0	11.5%
Colorado	44.8	58.4	13.6	30.4%
Connecticut	51.7	57.6	5.9	11.5%
Delaware	9.7	11.9	2.2	22.7%
District of Columbia	7.4	8.5	1.1	15.0%
Florida	141.8	144.7	2.9	2.0%
Georgia	53.8	55.8	2.0	3.7%
Hawaii	12.3	15.0	2.6	21.3%
Idaho	10.2	10.7	0.5	4.6%
Illinois	114.7	134.7	20.0	17.4%
Indiana	36.4	43.1	6.7	18.4%
Iowa	22.0	25.0	3.1	13.9%
Kansas	19.6	20.0	0.3	1.7%
Kentucky	29.4	42.9	13.5	45.9%
Louisiana	40.6	48.7	8.0	19.7%
Maine	14.0	14.7	0.6	4.6%
Maryland	57.1	68.8	11.7	20.6%
Massachusetts	87.4	97.7	10.3	11.8%
Michigan	67.2	81.3	14.1	21.0%
Minnesota	75.8	85.8	10.0	13.2%
Mississippi	18.8	19.5	0.7	3.9%
Missouri	52.7	53.8	1.1	2.1%
Montana	9.0	11.5	2.5	27.6%
Nebraska	14.3	14.5	0.2	1.5%
Nevada	13.9	18.4	4.5	32.6%

Table 3. Continued...

	State Medicaid Spending			
	ACA (Current Law)	AHCA	Difference	% Difference
National	2,805.4	3,176.4	371.1	13.2%
New Hampshire	11.7	13.9	2.2	18.9%
New Jersey	84.6	112.1	27.5	32.5%
New Mexico	19.0	28.4	9.4	49.4%
New York	351.7	398.0	46.3	13.2%
North Carolina	78.0	80.5	2.5	3.2%
North Dakota	6.0	7.3	1.3	21.7%
Ohio	97.8	116.2	18.5	18.9%
Oklahoma	28.9	29.7	0.8	2.8%
Oregon	30.2	43.4	13.1	43.5%
Pennsylvania	124.7	140.5	15.8	12.6%
Rhode Island	16.6	19.4	2.9	17.5%
South Carolina	25.4	26.2	0.8	3.3%
South Dakota	7.8	7.9	0.2	2.0%
Tennessee	52.6	54.9	2.3	4.4%
Texas	227.5	234.4	6.9	3.0%
Utah	13.1	13.7	0.6	4.5%
Vermont	8.8	10.5	1.7	19.3%
Virginia	60.5	61.4	0.9	1.6%
Washington	60.0	77.8	17.8	29.6%
West Virginia	11.6	15.1	3.5	29.8%
Wisconsin	44.6	45.1	0.5	1.1%
Wyoming	5.3	5.4	0.1	1.1%

Source: Urban Institute analysis using HIPSM 2017.

Notes: Per capita caps for spending on elderly people and people with disabilities grow by MCPI plus 1 percent per year; caps for nonelderly adults and children grow at MCPI. The base year is 2016. In Scenario 1, aggregate state spending does not increase as much as federal spending decreases because of the unique conditions in Massachusetts. As we estimated in a separate Massachusetts-specific analysis, the AHCA would lead to a loss of federal Section 1115 waiver funding for Massachusetts residents with income between 138 and 300 percent of FPL, in addition to the matching rate reduction on the ACA Medicaid expansion population. In this scenario, we assume that Massachusetts would eliminate its own spending on this population once the federal matching funds were eliminated. This reduction in state spending accounts for the Scenario 1 difference between decreased federal funding and increased state spending in the aggregate.

Table 4: Impact of AHCA on Federal Medicaid Expenditures by State, 2019–2028

Scenario 2: States Drop ACA Expansion Population But Increase Their Own Spending to Compensate for Per Capita Caps and Reduced Federal Match on Pre-ACA Expansion Population (Billions $)

	Federal Medicaid Spending		Difference Between AHCA and ACA				
	ACA (Current Law)	AHCA	Change in Spending on ACA Expansion Population Because of Dropping Eligibility	Change in Spending on Traditional Medicaid Population Because of Per Capita Caps	Change in Spending on Pre-ACA Expansion Population Because of Reduced Match Rate and Per Capita Caps	Total Difference	% Difference
National	4,581.9	3,778.7	-702.2	-52.0	-49.0	-803.2	-17.5%
Alabama	46.8	46.0	0.0	-0.8	n.a.	-0.8	-1.6%
Alaska	12.3	10.3	-1.9	-0.2	n.a.	-2.1	-16.9%
Arizona	149.9	117.0	-24.0	-2.0	-6.9	-32.9	-22.0%
Arkansas	49.7	42.5	-6.9	-0.4	n.a.	-7.2	-14.6%
California	395.6	318.0	-74.3	-3.3	n.a.	-77.6	-19.6%
Colorado	73.8	44.4	-28.9	-0.5	n.a.	-29.4	-39.9%
Connecticut	63.8	51.3	-12.1	-0.5	n.a.	-12.5	-19.7%
Delaware	16.0	12.4	-2.4	-0.1	-1.1	-3.6	-22.4%
District of Columbia	20.4	16.8	-3.4	-0.2	n.a.	-3.6	-17.6%
Florida	202.2	199.3	0.0	-2.9	n.a.	-2.9	-1.4%
Georgia	104.2	102.2	0.0	-2.0	n.a.	-2.0	-1.9%
Hawaii	17.7	13.6	-2.6	-0.1	-1.4	-4.1	-23.1%
Idaho	25.7	25.3	0.0	-0.5	n.a.	-0.5	-1.8%
Illinois	155.1	113.1	-40.2	-1.8	n.a.	-42.0	-27.1%
Indiana	92.3	71.6	-20.1	-0.6	n.a.	-20.7	-22.4%
Iowa	37.3	29.7	-7.3	-0.3	n.a.	-7.6	-20.3%
Kansas	25.9	25.6	0.0	-0.3	n.a.	-0.3	-1.3%
Kentucky	108.3	62.2	-45.2	-0.9	n.a.	-46.1	-42.6%
Louisiana	100.9	81.2	-18.2	-1.5	n.a.	-19.7	-19.5%
Maine	22.5	21.9	0.0	-0.2	-0.5	-0.6	-2.9%
Maryland	81.6	56.5	-24.5	-0.7	n.a.	-25.2	-30.8%
Massachusetts	119.0	106.3	0.0	-2.4	-10.4	-12.8	-10.7%
Michigan	171.1	128.0	-41.9	-1.2	n.a.	-43.0	-25.2%
Minnesota	96.1	75.0	-20.2	-0.9	n.a.	-21.1	-21.9%
Mississippi	50.8	50.1	0.0	-0.7	n.a.	-0.7	-1.4%
Missouri	86.0	84.9	0.0	-1.1	n.a.	-1.1	-1.3%
Montana	30.2	23.4	-6.2	-0.6	n.a.	-6.8	-22.4%

Table 4. Continued...

	Federal Medicaid Spending		Difference Between AHCA and ACA				
	ACA (Current Law)	AHCA	Change in Spending on ACA Expansion Population Because of Reduced Match Rate and Per Capita Caps	Change in Spending on Traditional Medicaid Population Because of Per Capita Caps	Change in Spending on Pre-ACA Expansion Population Because of Reduced Match Rate and Per Capita Caps	Total Difference	% Difference
National	4,581.9	4,208.3	-272.6	-52.0	-49.0	-373.6	-8.2%
Nebraska	17.2	17.0	0.0	-0.2	n.a.	-0.2	-1.2%
Nevada	35.3	22.7	-12.2	-0.4	n.a.	-12.6	-35.7%
New Hampshire	16.4	11.6	-4.7	-0.1	n.a.	-4.8	-29.1%
New Jersey	143.8	84.0	-59.0	-0.8	n.a.	-59.8	-41.6%
New Mexico	67.4	38.5	-27.2	-1.7	n.a.	-28.9	-42.9%
New York	429.6	363.6	-35.9	-2.3	-27.9	-66.0	-15.4%
North Carolina	150.1	147.6	0.0	-2.5	n.a.	-2.5	-1.6%
North Dakota	8.8	6.0	-2.8	0.0	n.a.	-2.8	-32.1%
Ohio	214.5	162.5	-50.8	-1.3	n.a.	-52.1	-24.3%
Oklahoma	51.4	50.5	0.0	-0.8	n.a.	-0.8	-1.6%
Oregon	87.2	49.1	-37.5	-0.5	n.a.	-38.0	-43.6%
Pennsylvania	178.2	142.3	-34.8	-1.1	n.a.	-35.9	-20.1%
Rhode Island	22.5	16.4	-5.9	-0.2	n.a.	-6.1	-27.1%
South Carolina	60.9	60.1	0.0	-0.8	n.a.	-0.8	-1.4%
South Dakota	9.0	8.8	0.0	-0.2	n.a.	-0.2	-1.7%
Tennessee	98.9	96.6	0.0	-2.3	n.a.	-2.3	-2.3%
Texas	323.2	316.3	0.0	-6.9	n.a.	-6.9	-2.1%
Utah	31.0	30.4	0.0	-0.6	n.a.	-0.6	-1.9%
Vermont	13.9	11.2	-1.6	-0.1	-0.9	-2.6	-19.0%
Virginia	60.5	59.5	0.0	-0.9	n.a.	-0.9	-1.6%
Washington	97.6	59.3	-37.5	-0.8	n.a.	-38.3	-39.2%
West Virginia	39.3	26.9	-12.2	-0.2	n.a.	-12.4	-31.5%
Wisconsin	64.4	63.9	0.0	-0.5	n.a.	-0.5	-0.7%
Wyoming	5.3	5.3	0.0	-0.1	n.a.	-0.1	-1.1%

Source: Urban Institute analysis using HIPSM 2017.

Notes: n.a. = not applicable. Only seven states expanded Medicaid eligibility before the ACA. Per capita caps for spending on elderly people and people with disabilities grow by MCPI plus 1 percent per year; caps for nonelderly adults and children grow at MCPI. The base year is 2016.

Table 5: Impact of AHCA on State Medicaid Expenditures by State, 2019–2028

Scenario 2: States Drop ACA Expansion Population But Increase Their Own Spending to Compensate for Per Capita Caps and Reduced Federal Match on Pre-ACA Expansion Population (Billions $)

	State Medicaid Spending		Difference Between AHCA and ACA				
	ACA (Current Law)	AHCA	Change in Spending on ACA Expansion Population Because of Dropping Eligibility	Change in Spending on Traditional Medicaid Population Because of Per Capita Caps	Change in Spending on Pre-ACA Expansion Population Because of Reduced Match Rate and Per Capita Caps	Total Difference	% Difference
National	2,805.4	2,825.9	-78.0	49.5	49.0	20.5	0.7%
Alabama	21.9	22.6	0.0	0.8	n.a.	0.8	3.5%
Alaska	10.5	10.4	-0.2	0.2	n.a.	0.0	-0.1%
Arizona	62.3	68.5	-2.7	2.0	6.9	6.2	10.0%
Arkansas	18.6	18.2	-0.8	0.4	n.a.	-0.4	-2.1%
California	321.1	316.2	-8.3	3.3	n.a.	-4.9	-1.5%
Colorado	44.8	42.2	-3.2	0.5	n.a.	-2.7	-5.9%
Connecticut	51.7	50.8	-1.3	0.5	n.a.	-0.9	-1.7%
Delaware	9.7	10.7	-0.3	0.1	1.1	1.0	10.1%
District of Columbia	7.4	7.2	-0.4	0.2	n.a.	-0.2	-2.9%
Florida	141.8	144.7	0.0	2.9	n.a.	2.9	2.0%
Georgia	53.8	55.8	0.0	2.0	n.a.	2.0	3.7%
Hawaii	12.3	13.6	-0.3	0.1	1.4	1.2	9.8%
Idaho	10.2	10.7	0.0	0.5	n.a.	0.5	4.6%
Illinois	114.7	112.1	-4.5	1.8	n.a.	-2.7	-2.3%
Indiana	36.4	34.7	-2.2	0.6	n.a.	-1.6	-4.5%
Iowa	22.0	21.4	-0.8	0.3	n.a.	-0.6	-2.5%
Kansas	19.6	20.0	0.0	0.3	n.a.	0.3	1.7%
Kentucky	29.4	25.3	-5.0	0.9	n.a.	-4.1	-14.0%
Louisiana	40.6	40.2	-2.0	1.5	n.a.	-0.5	-1.2%
Maine	14.0	14.7	0.0	0.2	0.5	0.6	4.6%
Maryland	57.1	55.0	-2.7	0.7	n.a.	-2.1	-3.6%
Massachusetts	87.4	97.7	0.0	-0.1	10.4	10.3	11.8%
Michigan	67.2	63.7	-4.7	1.2	n.a.	-3.5	-5.2%
Minnesota	75.8	74.4	-2.2	0.9	n.a.	-1.4	-1.8%
Mississippi	18.8	19.5	0.0	0.7	n.a.	0.7	3.9%
Missouri	52.7	53.8	0.0	1.1	n.a.	1.1	2.1%
Montana	9.0	8.9	-0.7	0.6	n.a.	-0.1	-1.2%

Table 5. Continued...

	Federal Medicaid Spending		Difference Between AHCA and ACA				
	ACA (Current Law)	AHCA	Change in Spending on ACA Expansion Population Because of Reduced Match Rate and Per Capita Caps	Change in Spending on Traditional Medicaid Population Because of Per Capita Caps	Change in Spending on Pre-ACA Expansion Population Because of Reduced Match Rate and Per Capita Caps	Total Difference	% Difference
National	2,805.4	2,825.9	-78.0	49.5	49.0	20.5	0.7%
Nebraska	14.3	14.5	0.0	0.2	n.a.	0.2	1.5%
Nevada	13.9	13.0	-1.4	0.4	n.a.	-0.9	-6.7%
New Hampshire	11.7	11.3	-0.5	0.1	n.a.	-0.4	-3.5%
New Jersey	84.6	78.8	-6.6	0.8	n.a.	-5.8	-6.8%
New Mexico	19.0	17.7	-3.0	1.7	n.a.	-1.3	-7.1%
New York	351.7	377.8	-4.0	2.3	27.9	26.1	7.4%
North Carolina	78.0	80.5	0.0	2.5	n.a.	2.5	3.2%
North Dakota	6.0	5.7	-0.3	0.0	n.a.	-0.3	-4.5%
Ohio	97.8	93.4	-5.6	1.3	n.a.	-4.4	-4.5%
Oklahoma	28.9	29.7	0.0	0.8	n.a.	0.8	2.8%
Oregon	30.2	26.6	-4.2	0.5	n.a.	-3.7	-12.1%
Pennsylvania	124.7	122.0	-3.9	1.1	n.a.	-2.8	-2.2%
Rhode Island	16.6	16.2	-0.7	0.2	n.a.	-0.4	-2.4%
South Carolina	25.4	26.2	0.0	0.8	n.a.	0.8	3.3%
South Dakota	7.8	7.9	0.0	0.2	n.a.	0.2	2.0%
Tennessee	52.6	54.9	0.0	2.3	n.a.	2.3	4.4%
Texas	227.5	234.4	0.0	6.9	n.a.	6.9	3.0%
Utah	13.1	13.7	0.0	0.6	n.a.	0.6	4.5%
Vermont	8.8	9.7	-0.2	0.1	0.9	0.9	10.0%
Virginia	60.5	61.4	0.0	0.9	n.a.	0.9	1.6%
Washington	60.0	56.7	-4.2	0.8	n.a.	-3.4	-5.6%
West Virginia	11.6	10.5	-1.4	0.2	n.a.	-1.1	-9.8%
Wisconsin	44.6	45.1	0.0	0.5	n.a.	0.5	1.1%
Wyoming	5.3	5.4	0.0	0.1	n.a.	0.1	1.1%

Source: Urban Institute analysis using HIPSM 2017.

Notes: n.a. = not applicable. Only seven states expanded Medicaid eligibility before the ACA. Per capita caps for spending on elderly people and people with disabilities grow by MCPI plus 1 percent per year; caps for nonelderly adults and children grow at MCPI. The base year is 2016.

Table 6: Federal Medicaid Savings, 2019–2028 (Billions $)

Scenario 2: States Drop ACA Expansion Population But Increase Their Own Spending to Compensate for Per Capita Caps and Reduced Federal Match on Pre-ACA Expansion Population (Billions $)

			Difference Between AHCA and ACA			
	ACA (Current Law)	AHCA	Change in Spending on ACA Expansion Population Because of Dropping Eligibility	Change in Spending on Traditional Medicaid Population Because of Per Capita Caps	Change in Spending on Pre-ACA Expansion Population Because of Reduced Match Rate and Per Capita Caps	Total Difference
2019	363.7	362.9	0.0	0.0	-0.8	-0.8
2020	383.1	307.0	-62.0	-11.6	-2.5	-76.1
2021	402.1	321.2	-65.3	-11.3	-4.3	-80.9
2022	423.1	339.0	-69.2	-10.0	-4.8	-84.1
2023	443.5	357.4	-73.3	-7.6	-5.2	-86.0
2024	467.0	378.1	-77.1	-6.3	-5.5	-88.9
2025	491.1	400.1	-81.9	-3.3	-5.9	-91.1
2026	513.2	419.3	-86.7	-1.4	-5.9	-93.9
2027	535.8	437.6	-90.9	-0.6	-6.6	-98.1
2028	559.3	456.0	-95.8	-0.4	-7.0	-103.2

Source: Urban Institute analysis using HIPSM 2017.

Notes: n.a. = not applicable. Only seven states expanded Medicaid eligibility before the ACA. Per capita caps for spending on elderly people and people with disabilities grow by MCPI plus 1 percent per year; caps for nonelderly adults and children grow at MCPI. The base year is 2016.

Table 7: Number of Medicaid Enrollees Losing Coverage

Scenario 2: States Drop ACA Expansion (Billions $), and

Scenario 3: States Drop ACA Expansion Population and Cut Enrollment of Pre-ACA Eligible Populations to Compensate for Per Capita Caps and Reduced Federal Match on Pre-ACA Expansion Population (Billions $)

	2022 (Thousands of People)			
	Number of Newly Eligible Expansion Enrollees Losing Coverage* (Scenarios 2 and 3)	Number of Additional Nonelderly Adults Losing Coverage (Scenario 3)	Total Number of Enrollees Losing Coverage (Scenario 3)	Percentage of All Nonelderly Medicaid Enrollees (Scenario 3)
National	12,017.2	2,786.2	14,803.3	24.9%
Alabama	0.0	54.5	54.5	7.0%
Alaska	14.2	3.4	17.6	16.7%
Arizona	240.3	223.2	463.5	27.9%
Arkansas	291.6	21.7	313.3	42.8%
California	3,224.5	156.9	3,381.4	35.9%
Colorado	426.3	17.8	444.2	43.6%
Connecticut	168.3	11.3	179.6	27.1%
Delaware	26.5	20.7	47.2	26.5%
District of Columbia	45.3	5.8	51.1	33.4%
Florida	0.0	131.5	131.5	4.3%
Georgia	0.0	110.8	110.8	6.6%
Hawaii	38.2	27.0	65.2	25.9%
Idaho	0.0	19.9	19.9	8.3%
Illinois	653.0	58.7	711.7	29.6%
Indiana	413.8	29.1	443.0	39.4%
Iowa	181.4	9.6	191.1	38.1%
Kansas	0.0	12.9	12.9	3.8%
Kentucky	486.3	49.0	535.4	47.9%
Louisiana	309.6	77.1	386.7	26.9%
Maine	0.0	15.1	15.1	6.0%
Maryland	295.5	17.2	312.7	34.1%
Massachusetts	0.0	355.4	355.4	26.0%
Michigan	677.1	60.3	737.4	36.1%
Minnesota	285.9	20.1	305.9	29.7%
Mississippi	0.0	48.1	48.1	7.9%
Missouri	0.0	39.8	39.8	4.7%
Montana	66.3	20.5	86.7	31.5%

Table 7. Contintued...

	2022 (Thousands of People)			
	Number of Newly Eligible Expansion Enrollees Losing Coverage* (Scenarios 2 and 3)	Number of Additional Nonelderly Adults Losing Coverage (Scenario 3)	Total Number of Enrollees Losing Coverage (Scenario 3)	Percentage of All Nonelderly Medicaid Enrollees (Scenario 3)
National	12,017.2	2,786.2	14,803.3	24.9%
Nebraska	0.0	6.9	6.9	3.4%
Nevada	235.9	21.5	257.4	45.4%
New Hampshire	71.2	2.7	74.0	39.0%
New Jersey	568.5	18.6	587.1	43.7%
New Mexico	268.7	49.5	318.1	46.6%
New York	422.9	315.8	738.7	19.0%
North Carolina	0.0	107.5	107.5	6.2%
North Dakota	31.2	0.7	31.9	41.6%
Ohio	763.2	51.5	814.7	35.4%
Oklahoma	0.0	35.0	35.0	5.7%
Oregon	399.6	22.4	422.0	47.2%
Pennsylvania	582.7	30.0	612.7	31.1%
Rhode Island	58.5	5.3	63.8	29.0%
South Carolina	0.0	49.3	49.3	6.9%
South Dakota	0.0	4.6	4.6	4.0%
Tennessee	0.0	83.9	83.9	6.9%
Texas	0.0	224.0	224.0	5.4%
Utah	0.0	26.5	26.5	8.2%
Vermont	25.5	16.9	42.5	27.0%
Virginia	0.0	28.2	28.2	3.2%
Washington	561.1	32.6	593.7	37.6%
West Virginia	184.1	11.2	195.4	47.2%
Wisconsin	0.0	22.5	22.5	2.6%
Wyoming	0.0	1.5	1.5	2.6%

Source: Urban Institute analysis using HIPSM 2017.

Notes: Per capita caps for spending on elderly people and people with disabilities grow by MCPI plus 1 percent per year; caps for nonelderly adults and children grow at MCPI. The base year is 2016.

* Applies to both Scenario 2 and Scenario 3. Number of additional nonelderly losing coverage applies only to Scenario 3.

Table 8: Number of Medicaid Enrollees Losing Coverage

Scenario 2: States Drop ACA Expansion, and

Scenario 3: States Drop ACA Expansion Population and Cut Enrollment of Pre-ACA Eligible Populations to Compensate for Per Capita Caps and Reduced Federal Match on Pre-ACA Expansion Population

	2019–2028 (Thousands of People)			
	Number of Newly Eligible Expansion Enrollees Losing Coverage* (Scenarios 2 and 3)	Number of Additional Nonelderly Adults Losing Coverage (Scenario 3)	Total Number of Enrollees Losing Coverage (Scenario 3)	Percentage of All Nonelderly Medicaid Enrollees (Scenario 3)
2019	0.0	72.9	72.9	0.1%
2020	11,803.7	3,030.1	14,833.8	25.2%
2021	11,910.0	3,052.3	14,962.3	25.3%
2022	12,017.2	2,786.2	14,803.3	24.9%
2023	12,125.3	2,376.2	14,501.5	24.4%
2024	12,234.5	2,063.6	14,298.0	23.8%
2025	12,344.6	1,592.9	13,937.4	23.0%
2026	12,455.7	1,248.8	13,704.5	22.5%
2027	12,567.8	1,132.7	13,700.5	22.3%
2028	12,680.9	950.9	13,631.7	22.0%

Source: Urban Institute analysis using HIPSM 2017.

Notes: Per capita caps for spending on elderly people and people with disabilities grow by MCPI plus 1 percent per year; caps for nonelderly adults and children grow at MCPI. The base year is 2016.

* Applies to both Scenario 2 and Scenario 3. Number of additional nonelderly losing coverage applies only to Scenario 3.

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