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State-by-State Coverage and Government Spending Implications of the American Health Care Act

Linda J. Blumberg, Matthew Buettgens, John Holahan, Bowen Garrett, and Robin Wang

Timely Analysis of Immediate Health Policy Issues

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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 tax revenue sources, restructuring premium tax credits and eliminating cost-sharing subsidies, and substantially altering the financing of the Medicaid program.[1] Some changes, such as the repeal of the ACA's mandates, would be made immediately; others would be implemented in the coming years.

We analyze the coverage effects of AHCA implementation on the nation and on specific states in 2022, which we consider a full-implementation year. We also provide estimates of the effects of the AHCA on federal funds for Medicaid and nongroup tax credits and cost-sharing assistance and state funds for Medicaid in 2022. We assume that states would respond to the proposed Medicaid changes by (1) eliminating their ACA Medicaid expansions; (2) maintaining pre-ACA expansions at the lower matching rate, in the seven states that implemented such expansions; and (3) increasing their own spending as necessary to compensate for federal funding cuts because of the lower match rate on pre-ACA expansions and the new per capita caps. Our analysis is based on the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) 2017.

This analysis differs from a recently released analysis of the effects of the AHCA on the Medicaid program under three different scenarios of state responses.[2] First, the current analysis is based on a full microsimulation analysis of the cost and coverage effects of the AHCA, including all types of coverage in the nonelderly population. The earlier analysis focused exclusively on the Medicaid program and did not take behavioral effects into account (e.g., reversal of Medicaid "welcome mat effects" from eliminating broad outreach and enrollment assistance, or individuals obtaining other types of coverage after losing Medicaid). Second, Medicaid spending in this report includes all Medicaid and CHIP program spending for nonelderly people; the earlier report did not include CHIP spending (because it would not be subject to the bill's per capita caps) but did include Medicaid spending for elderly people. HIPSM is a model of the nonelderly population alone.

Our main findings are as follows:

- The number of nonelderly, uninsured people would increase by 23.0 million in 2022 under the AHCA relative to current law (Summary Table). This number would grow after 2022 because the AHCA premium tax credits would grow more slowly than the projected growth in health care costs, making nongroup insurance coverage increasingly expensive over time. Our estimate is very similar to that of the Congressional Budget Office (CBO); although they use different data and methods and find a 21 million person increase in the uninsured in 2022, our estimated percent increase in the uninsured population because of the AHCA is almost identical to theirs (approximately 75 percent).[3]
- The number of people with private nongroup coverage would be 5.8 million lower under the AHCA (Table 2); this is very close to the CBO longer-run estimate of 6 million fewer people with nongroup coverage. The number of people enrolled in Medicaid would be 16.4 million lower than under current law.
- Of the 23.0 million person increase in the uninsured under the AHCA in 2022, 12.0 million would have incomes below 138 percent of the federal poverty level (FPL), 6.3 million would have incomes between 138 and 400 percent of FPL, and 4.7 million would have incomes above 400 percent of FPL (Table 1).

- Changes in coverage under the AHCA would vary considerably across states. The share of the population that is uninsured would increase in every state under the AHCA, with the largest percent increases in those states that saw the greatest coverage increases under the ACA. California's uninsurance rate would increase from 9.0 percent under current law to 21.2 percent under the BCRA, Nevada's from 14.6 percent to 25.4 percent under the AHCA. The uninsured share of the Alaska nonelderly population would increase from 15.4 percent to 24.1 percent. The uninsured share in West Virginia would increase from 5.0 percent to 19.6 percent. In Ohio, 6.5 percent would be uninsured in 2022 under current law, but 17.7 percent would be uninsured under the AHCA; in Pennsylvania, 6.0 percent would be uninsured in 2022 under current law, but 17.3 percent would be uninsured under the AHCA (Summary Table).

- Medicaid and Children's Health Insurance Program (CHIP) enrollment would fall the most in states that expanded Medicaid under the ACA, such as Arkansas (44.8 percent fewer nonelderly Medicaid enrollees), West Virginia (50.9 percent fewer), Kentucky (52.4 percent fewer), New Mexico (46.4 percent fewer), Nevada (42.9 percent fewer), and Colorado (47.8 percent fewer) (Table 2).

- Nongroup insurance coverage would fall the most in states with especially high ACA Marketplace enrollment, such as Florida (47.8 percent fewer nongroup enrollees), Maine (47.2 percent fewer), Wisconsin (42.9 percent fewer), Delaware (41.7 percent fewer), and Utah (41.8 percent fewer) (Table 2).

- Changes in employer coverage would be small, with roughly 0.6 percent fewer people covered through employers. However, the changes would vary across states depending on the number of people who moved from employer coverage to Medicaid under the ACA eligibility expansion and from employer to nongroup coverage in response to the availability of tax credits and cost-sharing assistance (Table 2).

- Most (55.4 percent) of those who would become uninsured because of the AHCA are non-Hispanic white. More than half of these newly uninsured adults have a high school education or less, and approximately 71 percent are in families with at least one full-time worker (Table 4).

- Federal funding for Medicaid would be $105.4 billion lower in 2022 under the AHCA than under the ACA (a 27.2 percent decline), and federal funding for premium tax credits and cost-sharing reductions would fall by $25.0 billion that year (a 55.0 percent decline) (Table 6).
  - Federal funding drops on these two programs would vary considerably across states. For example, Texas would see federal funding decrease by 8.9 percent, South Dakota 9.3 percent, Alaska 41.9 percent, Nevada 44.3 percent, and Kentucky 57.9 percent.
  - Large-population states that expanded Medicaid would also see substantial losses in federal funding. Pennsylvania would lose $6.0 billion, Ohio $6.3 billion, and Michigan $5.0 billion.

- State spending on Medicaid would increase by $1.2 billion in 2022 to compensate for federal funding decreases from the per capita caps and, in seven states, the reduced match rate for pre-ACA Medicaid expansion populations (Table 7). In aggregate, these increased costs offset state savings from eliminating the ACA Medicaid expansions.
  - State funding effects will vary substantially across the country. States with pre-ACA expansions (Arizona, Delaware, Hawaii, Maine, Massachusetts, New York, Vermont) would have to increase their own spending by 6.4 percent (Maine) to 21.8 percent (Massachusetts) to maintain those expansions with fewer federal funds, depending upon the state and the size of its expansion. Other states with large ACA expansions would spend less if those expansions were eliminated, but these states would also see larger increases in their uninsured populations (e.g., California, Oregon, Maryland).

Summary Table: Effects of the American Health Care Act on the Uninsured and Federal Health Care Spending for the Nonelderly, 2022 (Numbers of People in Thousands, Dollars in Millions)

	ACA (Current Law)			AHCA (House Bill)				
State	Number Uninsured	Percent Nonelderly Uninsured	Federal Spending	Number Uninsured	Percent Nonelderly Uninsured	Increase in Number Uninsured	Change in Federal Spending	Percent Change in Federal Spending
Alabama	545	13.3%	$5,329	682	16.6%	138	-$1,045	-19.6%
Alaska	111	15.4%	$1,543	173	24.1%	63	-$647	-41.9%
Arizona	828	13.4%	$14,270	1,185	19.2%	357	-$3,262	-22.9%
Arkansas	183	7.1%	$4,483	531	20.6%	348	-$1,451	-32.4%
California	3,082	9.0%	$39,143	7,308	21.2%	4,226	-$14,782	-37.8%
Colorado	429	9.0%	$7,302	977	20.5%	548	-$3,625	-49.6%
Connecticut	174	5.9%	$5,513	481	16.4%	307	-$2,052	-37.2%
Delaware	72	9.0%	$1,403	127	16.1%	56	-$368	-26.2%
District of Columbia	29	5.0%	$1,759	88	15.2%	59	-$445	-25.3%
Florida	2,459	15.0%	$23,920	3,806	23.2%	1,347	-$7,190	-30.1%
Georgia	1,878	19.1%	$10,048	2,183	22.2%	304	-$966	-9.6%
Hawaii	101	7.9%	$1,358	157	12.3%	56	-$316	-23.3%
Idaho	210	14.0%	$2,831	307	20.5%	97	-$558	-19.7%
Illinois	1,027	9.2%	$15,220	2,015	18.1%	988	-$4,925	-32.4%
Indiana	542	9.4%	$8,449	1,155	20.1%	613	-$2,898	-34.3%
Iowa	173	6.6%	$3,330	397	15.1%	224	-$834	-25.0%
Kansas	343	13.6%	$2,499	441	17.5%	98	-$310	-12.4%
Kentucky	234	6.3%	$10,709	756	20.5%	522	-$6,204	-57.9%
Louisiana	342	8.9%	$7,672	732	19.0%	390	-$2,608	-34.0%
Maine	74	7.4%	$1,933	130	12.9%	56	-$382	-19.8%
Maryland	411	7.6%	$8,206	913	17.0%	502	-$3,517	-42.9%
Massachusetts	239	4.3%	$9,169	329	6.0%	90	-$1,659	-18.1%
Michigan	516	6.5%	$14,458	1,468	18.4%	952	-$4,988	-34.5%
Minnesota	393	8.3%	$7,316	781	16.4%	388	-$1,875	-25.6%
Mississippi	396	16.0%	$4,437	456	18.4%	61	-$586	-13.2%
Missouri	596	11.6%	$8,674	869	17.0%	273	-$1,429	-16.5%
Montana	84	10.0%	$2,219	179	21.4%	95	-$826	-37.2%
Nebraska	178	11.1%	$1,780	275	17.1%	97	-$370	-20.8%
Nevada	420	14.6%	$3,598	728	25.4%	308	-$1,593	-44.3%
New Hampshire	61	5.7%	$1,431	172	16.1%	112	-$564	-39.4%
New Jersey	650	8.7%	$13,125	1,598	21.3%	949	-$6,640	-50.6%
New Mexico	181	9.9%	$7,064	491	26.9%	310	-$3,662	-51.8%
New York	1,300	7.9%	$35,818	2,510	15.2%	1,210	-$8,908	-24.9%
North Carolina	1,316	14.6%	$16,742	1,834	20.4%	518	-$4,395	-26.3%

Summary Table: Continued...

State	ACA (Current Law)			AHCA (House Bill)				
	Number Uninsured	Percent Nonelderly Uninsured	Federal Spending	Number Uninsured	Percent Nonelderly Uninsured	Increase in Number Uninsured	Change in Federal Spending	Percent Change in Federal Spending
North Dakota	51	8.8%	$748	113	19.6%	63	-$338	-45.3%
Ohio	610	6.5%	$17,238	1,664	17.7%	1,054	-$6,293	-36.5%
Oklahoma	605	17.6%	$5,104	751	21.8%	145	-$811	-15.9%
Oregon	279	8.3%	$7,429	774	23.1%	495	-$3,883	-52.3%
Pennsylvania	620	6.0%	$16,925	1,790	17.3%	1,169	-$5,967	-35.3%
Rhode Island	53	6.2%	$2,167	150	17.6%	97	-$961	-44.4%
South Carolina	604	14.8%	$6,589	809	19.8%	205	-$1,380	-20.9%
South Dakota	95	12.9%	$881	120	16.4%	26	-$81	-9.3%
Tennessee	726	12.9%	$10,539	1,058	18.7%	332	-$2,728	-25.9%
Texas	5,098	20.4%	$32,857	5,979	24.0%	881	-$2,932	-8.9%
Utah	341	11.6%	$3,511	558	19.1%	218	-$548	-15.6%
Vermont	23	4.7%	$1,077	61	12.5%	38	-$290	-27.0%
Virginia	1,050	13.4%	$6,480	1,428	18.2%	378	-$952	-14.7%
Washington	520	8.4%	$8,858	1,262	20.5%	743	-$4,457	-50.3%
West Virginia	71	5.0%	$3,670	280	19.6%	209	-$1,810	-49.3%
Wisconsin	391	8.1%	$5,358	636	13.3%	246	-$1,008	-18.8%
Wyoming	69	13.8%	$567	88	17.5%	19	-$120	-21.1%
Total	30,780	11.1%	$432,748	53,759	19.4%	22,979	-$130,441	-30.1%

Source:Urban Institute analysis, HIPSM 2017.

Note: Federal spending includes Medicaid & CHIP, nongroup premium tax credits, and cost-sharing reductions (the last only under the ACA).

Background

The American Health Care Act would allow states to continue covering the population made eligible for Medicaid under the ACA expansion but would provide substantially lower federal funding. States would continue to receive the higher federal contribution—95 percent of total costs in 2017, falling to 90 percent beginning in 2020—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.

Current law limits nongroup and fully insured small-group premium variation to no more than 3-to-1 (i.e., a 64-year-old cannot be charged more than three times the premium charged the youngest adult for the same coverage). The AHCA eliminates that limit, proposing a 5-to-1 ratio and permitting states to use even higher ratios through waivers. Individuals who experience coverage gaps of more than 62 days would be charged a 30 percent premium surcharge for 12 months if they enroll in nongroup health insurance. Actuarial value standards for nongroup insurance coverage would be eliminated beginning in 2020. Additional incentives to use Health Savings Accounts would be provided (beyond those currently available) by increasing the annual tax-free contribution limit and making other changes.

The AHCA would change the advanced premium tax credits provided under the ACA beginning in 2018, with a temporary two-year change that would shift assistance from older adults to younger adults. Beginning in 2020, the bill would eliminate ACA cost-sharing assistance to low-income people, and it would replace the tax credits tied to income and available premiums with tax credits that vary only with age (the credits would begin phasing out at incomes between $75,000 and $115,000). The maximum credit for a 64-year-old in 2020 would be $4,000, and the maximum for an 18-year-old would be $2,000. Thus, the premium for a 64-year-old would be five times that of an 18-year-old of the same

income, but the tax credit for the older person would only be twice that for the younger one.

States could apply for waivers to

1. shift higher premiums to older adults, having 64-year-olds pay premiums more than five times the premium of an 18-year-old;
2. change or eliminate the ACA essential health benefit requirements; and/or
3. permit insurers to charge enrollees higher premiums based on their health status if they have not maintained continuous insurance coverage (as an alternative to the 30 percent premium surcharge for having a gap in coverage).

A Patient and State Stability Fund would be established to provide funding to states for several potential uses. For most uses, states would have to provide matching funds to draw down their federal allotment. Possible uses of the funds include reinsurance, high-risk pools, cost-sharing assistance, and promotion of preventive care. A new federal "invisible risk-sharing program" would be established by the Centers for Medicare & Medicaid Services (CMS) as part of the Patient and State Stability Fund; this program would act as reinsurance for nongroup insurers enrolling individuals with at least one of a list of health conditions; the list would be developed outside of the legislation. No state matching funds are required for the invisible risk-sharing program.

Data and Methods

Our primary source of data for the demographic and economic characteristics of Americans is the American Community Survey (ACS). Estimates of pre-ACA health coverage come from the 2013 ACS. We apply edits to the ACS coverage variables.[4] The ACS has a sample size large enough to make state-level analysis possible. We estimate eligibility for Medicaid on the 2013 ACS using the Urban Institute's pre-ACA Medicaid eligibility model for 2013.[5]

We estimate health coverage under both the ACA and AHCA using the Health Insurance Policy Simulation Model (HIPSM). We first calibrate the model to reproduce early 2017 state-by-state enrollment data from the Marketplaces and Medicaid.[6] We then benchmark the uninsured rate and employer-sponsored insurance coverage with the most recent available survey data, particularly the National Health Interview Survey.

When simulating the AHCA, we included the following major provisions that would take effect beginning in 2020: repeal of the enhanced federal match rate for ACA Medicaid expansion population, introduction of Medicaid per capita caps, repeal of the ACA premium tax credits and cost-sharing reductions, introduction of new age-based premium tax credits for nongroup coverage, repeal of the ACA individual and employer mandates, introduction of a 30 percent premium surcharge for people who forgo health coverage, the Patient and State Stability Fund, and the federal invisible risk-sharing program.

We assume that ACA Medicaid expansion states would cut eligibility back to 2010 levels. Seven states covered adults up to at least 100 percent of FPL before the ACA was enacted; we assume that they would return to those eligibility thresholds. But to do so, they likely would need to negotiate a new Medicaid waiver with CMS. Also, our model predicts that the additional enrollment under the ACA of people who were already eligible for Medicaid—variously called the "woodwork" or "welcome mat" effect—would reverse under the AHCA, leading to a loss of several million Medicaid enrollees. The AHCA lacks many of the ACA provisions that encouraged increased enrollment, and it includes new potential barriers to enrollment such as requiring more frequent income determination.

We assume that both the stability fund and the risk-sharing program would be used to provide reinsurance. They would not be targeted to any group but would decrease premiums by a uniform percentage. We did not see any basis for anticipating individual state decisions on using their stability fund allotments.

We assume that no states would take the Medicaid block grant option, which would provide less federal funding over time than the per capita cap option. We also did not model any state waivers of essential health benefits or modified community rating. Models that only produce national estimates can make broad assumptions about the percentage of states that would choose a given option, but we find little to no basis for predicting what individual states would choose. Even under broad assumptions, both CBO and the CMS Office of the Actuary emphasized that the impossibility of predicting state waiver and stability fund decisions added considerable uncertainty to their results. We show results state by state, so we made a consistent set of assumptions to make state results comparable.

Additional details about our methodology are available in Appendix B of an earlier report.[7]

Results

National Distribution of Insurance Coverage

Table 1 shows the effects of the AHCA on the national distribution of health insurance coverage for the total nonelderly population and for three income groups in 2022: people with incomes below 138 percent of FPL, those with incomes between 138 and 400 percent of FPL, and those with incomes at or above 400 percent of FPL. We estimate that the number of uninsured people would be 23.0 million higher under the AHCA than under the ACA; of these uninsured people, 12.0 million people have incomes below 138 percent of FPL. Although 14.9 million fewer low-income people would have Medicaid under the AHCA, approximately 2.8 million would have access to and enroll in employer-based coverage, and roughly an equal number would gain nongroup coverage as lose it. Plus, 6.3 million additional people with incomes between 138 and 400 percent of FPL would be uninsured, and 4.7 million additional higher-income people would be uninsured.

Approximately 5.8 million fewer people would have private nongroup insurance. The bulk of that decrease—4.3 million people—would come from the income group eligible for ACA tax credits and cost-sharing reductions, people with incomes between 138 and 400 percent of FPL.

Employer-sponsored insurance would decrease modestly under the AHCA (816,000 fewer people would have employer coverage nationally), yet the underlying dynamics of this small net change are important (not shown in the table). First, elimination of the individual mandate would lead to some coverage losses among people who were uninsured before the ACA. Second, some people who would lose their Medicaid coverage would take employer-based insurance offers under the AHCA, but many do not have such offers and even those who do would generally receive less comprehensive coverage at a higher out-of-pocket cost compared with Medicaid. Third, the ACA individual mandate not only led some previously uninsured people to enroll in employer coverage for the first time, but it also seems to have halted the secular decline in employer-based insurance. Thus, eliminating the mandate is expected to restart that trend in declining employer coverage, even in higher-income groups. Finally, the AHCA would eliminate the employer mandate, but we do not expect the effects of this to be significant.

State-by-State Changes in the Distribution of Health Insurance Coverage

Table 2 shows the absolute change and percent change in each type of health insurance coverage attributable to the AHCA for the nonelderly population in each state. Changes in coverage under the AHCA would vary considerably across states depending on whether they had expanded Medicaid under the ACA or before it, whether nongroup Marketplace and other nongroup coverage enrollment was high after ACA reforms, and how many people losing Medicaid or nongroup coverage would have access to employer-based insurance.

Medicaid enrollment would fall by the largest percentages in states that expanded Medicaid under the ACA, such as Arkansas (44.8 percent fewer nonelderly Medicaid enrollees), Colorado (47.8 percent fewer), Nevada (42.9 percent fewer), New Mexico (46.4 percent fewer), North Dakota (42.6 percent fewer), and Oregon (42.6 percent fewer). States that did not expand Medicaid would also lose coverage but to a lesser extent, because of the elimination of outreach and enrollment efforts associated with the ACA and the reversal of the so-called "welcome mat" effect. Such states include Alabama (6.2 percent fewer nonelderly Medicaid enrollees), Mississippi (6.2 percent fewer), Missouri (8.5 percent fewer), North Carolina (11.5 percent fewer), and South Carolina (8.3 percent fewer).

Nongroup insurance coverage would fall the most in states with especially high enrollment in ACA marketplaces, such as Florida (-47.8 percent), Maine (-47.2 percent), and Utah (-41.8 percent). Changes in employer coverage would be small (-0.6 percent) but would vary across the states as a function of cutbacks in the Medicaid expansion population and losses of nongroup coverage.

The number of uninsured people would increase in every state under the AHCA, with the largest increases in states with large populations and states with the largest coverage increases under the ACA (Table 2 and additional detail on the uninsured in Table 3). For example, the uninsurance rate in Florida would increase from 15.0 percent under the ACA to 23.2 percent under the AHCA, a 54.8 percent increase (1.3 million additional uninsured people). The number of uninsured people in Pennsylvania would almost triple, from 6.0 percent to 17.3 percent of the state's nonelderly population (1.2 million people). The share of uninsured people in Ohio would increase from 6.5 percent to 17.7 percent (1.1 million people). In Arkansas, the share of uninsured people would increase from 7.1 percent to 20.6 percent (348,000 people). States that did not expand Medicaid under the ACA and did not have high nongroup enrollment would see the smallest percent increases in the number of uninsured people.

Characteristics of Uninsured People

Table 4 shows the characteristics of uninsured people under the ACA and the AHCA, along with the characteristics of people who would become newly uninsured because of the AHCA. The number of newly uninsured people under the AHCA (24.5 million people) is not equal to the difference between the number of uninsured under the AHCA and the ACA (53.8 million – 30.8 million = 23.0 million) because the latter is a net calculation that takes into account that fewer people uninsured under the ACA would become insured under the AHCA.

A comparison of uninsured people under the ACA and under the AHCA (the first two sets of columns) shows that a larger share of the nonelderly uninsured population would be non-Hispanic white under the AHCA than under current law. Under the ACA, 37.1 percent of the uninsured are estimated to be non-Hispanic white in 2022, compared with 45.2 percent under the AHCA. Roughly 55.4 percent of people who would become newly uninsured because of the AHCA would be non-Hispanic white (far right column).

A slightly higher percentage of adults uninsured would have at least some college education under the AHCA (38.9 percent versus 34.1 percent), but more than half (55.0 percent) of those who would become uninsured because of the AHCA would have a high school education or less. Approximately 71 percent of those who would become uninsured because of the AHCA live in families with at least one full-time worker. Another 9.7 percent have a part-time worker in the family.

Distribution of Federal Tax Credits

and Cost-Sharing Reductions by Income

Table 5 shows how federal funding to assist with the costs associated with private nongroup insurance coverage would be distributed across different income groups under the ACA and under the AHCA. The ACA provides tax credits for the purchase of nongroup insurance based on a sliding income scale; the level of assistance takes into account the cost of coverage available in the person's area of residence. These tax credits are available to people with incomes between 100 percent of FPL (138 percent of FPL in Medicaid expansion states) and 400 percent of FPL. The ACA also provides subsidies to reduce deductibles, out-of-pocket maximums, and other cost-sharing requirements for people with incomes below 250 percent of FPL who also are eligible for premium tax credits. The AHCA would eliminate the ACA premium tax credits and cost-sharing subsidies and replace them with premium tax credits that vary with age but not with income (phasing out at high incomes) or with the local cost of insurance coverage. The AHCA would not provide any cost-sharing assistance. As we and others have shown,[8] the AHCA tax credits tend to increase net premiums for older adults and younger people living in high-insurance-cost areas, but lower them for young people living in low-insurance-cost areas.

ACA tax credits are heavily concentrated in low-income populations; two-thirds of the credits go to people with incomes between 100 and 200 percent of FPL.[9] All ACA tax credits go to people with incomes below 400 percent of FPL. Approximately 96 percent of ACA cost-sharing assistance goes to families with incomes between 100 and 200 percent of FPL.

By design, the AHCA tax credits are spread more broadly across the income distribution. Approximately 28.5 percent of the age-based tax credits would go to people with incomes at or above 400 percent of FPL, who would be ineligible for tax credits under the ACA. Approximately one-third of the tax credits would go to those with incomes below 200 percent of FPL, roughly half the lowest-income share receiving ACA tax credits. About half as many people would receive tax credits under the AHCA as under the ACA because fewer people would be enrolled in nongroup insurance coverage. This coverage disparity stems from the AHCA elimination of the individual mandate, higher financial burdens for many families in the absence of income-based tax credits, and lack of connection between federal assistance and local policy costs.

Federal Funding for Tax Credits and Medicaid, by State

Table 6 provides estimates of federal funding for Medicaid, tax credits, and cost-sharing reductions that would flow to each state under the ACA in 2022, compared with the federal funding for Medicaid and tax credits under the AHCA in the same year (the AHCA would not provide cost-sharing reductions). Total federal funding would fall by 30.1 percent ($130.4 billion) in 2022.

Percent changes in federal funding would vary considerably by state depending on whether the state expanded Medicaid under the ACA, whether the state had a pre-ACA Medicaid expansion, how many people enrolled in the ACA marketplaces (Table 6). Federal spending would fall significantly in each state, ranging from an 8.9 percent drop in Texas to a 57.9 percent drop in Kentucky. Even states that did not expand Medicaid would lose federal funding under the AHCA because of the bill's per capita caps and the reversal of the "welcome mat" effect.

State Funding for Medicaid, by State

Table 7 provides estimates of the effect of the AHCA on state Medicaid spending. States that expanded Medicaid under the ACA would spend less on the expansion population after dropping that eligibility category, but states would have to increase spending to compensate for per capita caps, and the seven pre-ACA expansion states would spend more because of the lower federal match rate under the AHCA. To the extent that the reversal of the "welcome mat" effect and the elimination of the individual mandate lower enrollment, states' spending would also be reduced. Net changes in each state's spending would therefore be a function of the size of these countervailing changes. Nationally, state spending on Medicaid would increase by $1.2 billion in 2022, less than 1 percent of current spending. States that expanded eligibility under the ACA—and would therefore see the most coverage losses—would decrease spending the most. States that expanded before the ACA and states that would be hit hardest by the new per capita caps would increase their spending the most.

Changes in 2022 state Medicaid spending under the AHCA would range from a 23.9 percent ($692 million) decrease in spending for Kentucky to a 21.8 percent increase ($1.2 billion) in Massachusetts. Kentucky saw a large eligibility expansion under the ACA and is expected to save significantly once eligibility for that group is eliminated. Massachusetts expanded eligibility before the ACA and is expected to maintain that expansion but at a significantly lower federal match rate under the AHCA. New York, a large-population state that expanded Medicaid before the ACA, is estimated to face a cost increase of $2.8 billion (11.2 percent) in 2022; Texas, a large-population state that did not expand Medicaid, is estimated to face a cost increase of $2.1 billion (10.5 percent) in 2022 because of the AHCA's per capita caps.

Discussion

If enacted, the House of Representatives' version of the AHCA would make fundamental changes to the U.S. health care financing system. Changes to the Medicaid program would reduce federal funds to the low-income populations of all states ($105.4 billion nationally in 2022), and federal financial assistance for the purchase of private nongroup insurance would fall significantly in almost every state ($25.0 billion nationally in 2022). The number of uninsured people would increase by about 23 million people in

Comparison of Urban Institute Estimates of Coverage Implications of the AHCA and the BCRA

We estimate that an additional 23.0 million people would be uninsured due to the House of Representative's American Health Care Act as compared to an additional 24.7 million people uninsured due to the Senate's Better Care Reconciliation Act. Why do we find that the Senate bill would reduce coverage by more than the House bill? The most significant factors are:

- The actuarial value of the plans offered under the BCRA would be lower than those offered under the AHCA, as the latter did not eliminate the ACA's out-of-pocket maximum standard. By tying premium tax credits to a 58 percent actuarial value and allowing that value to be as low as 54 percent (due to permissible variation), the BCRA results in higher out-of-pocket limits and makes nongroup coverage less attractive. Plans with lower actuarial value would lead to lower take-up, as the return for the premium is lower.
- The AHCA would offer tax credits to middle and some upper-middle income taxpayers who would be more likely to purchase coverage as a result; the BCRA limits tax credits to those with incomes below 350 percent of FPL. Also, the BCRA's high percent of income tax credit caps make that bill's tax credits have lower value for many of those with incomes below 350 percent of FPL as well.
- The AHCA provides a significantly larger amount of federal funds for reinsurance than does the BCRA; this funding lowers nongroup insurance premiums further and thus increases purchase.
- The AHCA's premium surcharge for not maintaining continuous enrollment is not particularly effective relative to the ACA's individual mandate, but it would be more effective than the BCRA's 6-month waiting period.
- Lower enrollment in nongroup coverage leads to greater adverse selection under the BCRA, which drives premiums higher than under the AHCA.

2022, roughly 80 percent of that increase among people with incomes below 400 percent of FPL. The private nongroup market would shrink by 5.8 million people, and Medicaid enrollment would fall by almost 16.4 million people.

This dramatic increase in uninsurance would be driven by (1) the elimination of the individual mandate, and to a much smaller degree the elimination of the employer mandate; (2) the reduction in the federal matching rates for Medicaid expansion populations, which likely will cause all states to drop eligibility for that group; (3) elimination of cost-sharing assistance, which would make practical access to care unaffordable for many low-income people currently receiving assistance; and (4) structural change in tax credits, which would increase net premiums for older people and people living in higher-insurance-cost areas.

Coverage and funding effects would vary considerably across states. The differences are largely attributable to population size, Medicaid expansion decisions, and enrollment in the ACA nongroup marketplaces. States that saw the largest coverage gains under the ACA would face the largest coverage losses, the largest federal funding losses, and the largest state cost increases. The seven states that expanded Medicaid before the ACA would face large cost increases if they choose to maintain those expansions at the lower federal match rate under the AHCA.

The AHCA would affect some population subgroups more than others. For example, it would increase the number of uninsured non-Hispanic white people the most. Most newly uninsured people would have a high school education or less, and the large majority would be members of working families.

We estimate that full ACA repeal without replacement would leave just about the same number of people uninsured as the AHCA would (data not shown). The combination of the per capita caps imposed on the Medicaid program and the changes to the private nongroup insurance market make the AHCA less a substitute for the ACA than a reversal. In addition, the AHCA would fundamentally alter the federal financing of the Medicaid program, changing it from an open-ended federal matching grant to a program with federal funding limited to a specified trend. This straightforward approach would allow policymakers to achieve additional federal savings by lowering the annual federal funding rate increases. This practice would put financial pressure on state governments, on health care providers, and ultimately on households.

Limited growth rates in the federal premium tax credits would make private nongroup coverage less affordable over time. This would encourage states to adopt other policies included in the AHCA but not modeled in this analysis; these measures include waivers of essential health benefit requirements, waivers to allow health status rating, and waivers to permit age rating bands broader than the 5-to-1 ratio. Such policies could lower

premiums for young and healthy people, but at the expense of greater financial burdens and increased barriers to care for older people and people with health problems. These changes likely would drive uninsurance upward over time. The AHCA would place increasing financial burdens on families, particularly those with low and middle incomes and those with health problems.

Table 1. The Distribution of Health Insurance Coverage Under the ACA and the AHCA, 2022 (Thousands of People)

Panel A. All Nonelderly		ACA		AHCA		Change from ACA	
Insured	**Total Insured**	**245,894**	**88.9%**	**222,915**	**80.6%**	**-22,979**	**-8.3%**
	Total Medicaid & CHIP	**69,864**	**25.3%**	**53,506**	**19.3%**	**-16,358**	**-5.9%**
	Expansion Eligible Adults	13,031	4.7%	0	0.0%	-13,031	-4.7%
	Other Adults	11,642	4.2%	10,962	4.0%	-680	-0.2%
	Children	35,078	12.7%	32,759	11.8%	-2,320	-0.8%
	Non-elderly with Disability	10,112	3.7%	9,785	3.5%	-327	-0.1%
	Employer	**148,110**	**53.5%**	**147,293**	**53.2%**	**-816**	**-0.3%**
	Total Nongroup	**19,302**	**7.0%**	**13,498**	**4.9%**	**-5,805**	**-2.1%**
	With Tax Credits	9,810	3.5%	7,135	2.6%	-2,675	-1.0%
	Other Nongroup	9,492	3.4%	6,362	2.3%	-3,130	-1.1%
	Medicare and other public	**8,617**	**3.1%**	**8,617**	**3.1%**	**0**	**0.0%**
Uninsured		**30,780**	**11.1%**	**53,759**	**19.4%**	**22,979**	**8.3%**
Total		**276,674**	**100.0%**	**276,674**	**100.0%**	**0**	**0.0%**

Panel B. Nonelderly with Income Under 138% FPL		ACA		AHCA		Change from ACA	
Insured	**Total Insured**	**81,383**	**83.2%**	**69,377**	**70.9%**	**-12,005**	**-12.3%**
	Total Medicaid & CHIP	**54,822**	**56.0%**	**39,977**	**40.8%**	**-14,845**	**-15.2%**
	Expansion Eligible Adults	13,031	13.3%	0	0.0%	-13,031	-13.3%
	Other Adults	8,879	9.1%	8,217	8.4%	-662	-0.7%
	Children	23,781	24.3%	22,913	23.4%	-868	-0.9%
	Non-elderly with Disability	9,131	9.3%	8,847	9.0%	-284	-0.3%
	Employer	**18,553**	**19.0%**	**21,395**	**21.9%**	**2,841**	**2.9%**
	Total Nongroup	**3,907**	**4.0%**	**3,905**	**4.0%**	**-2**	**0.0%**
	With Tax Credits	2,620	2.7%	1,954	2.0%	-666	-0.7%
	Other Nongroup	1,287	1.3%	1,951	2.0%	664	0.7%
	Medicare and other public	**4,101**	**4.2%**	**4,101**	**4.2%**	**0**	**0.0%**
Uninsured		**16,482**	**16.8%**	**28,488**	**29.1%**	**12,005**	**12.3%**
Total		**97,865**	**100.0%**	**97,865**	**100.0%**	**0**	**0.0%**

Table 1: Continued...

Panel C. Nonelderly with Income of 138%-400% FPL		ACA		AHCA		Change from ACA	
Insured	Total Insured	85,516	87.8%	79,209	81.3%	-6,307	-6.5%
	Total Medicaid & CHIP	**13,486**	**13.8%**	**12,006**	**12.3%**	**-1,480**	**-1.5%**
	Expansion Eligible Adults	0	0.0%	0	0.0%	0	0.0%
	Other Adults	2,352	2.4%	2,345	2.4%	-8	0.0%
	Children	10,596	10.9%	9,146	9.4%	-1,451	-1.5%
	Non-elderly with Disability	537	0.6%	515	0.5%	-22	0.0%
	Employer	**59,983**	**61.6%**	**59,460**	**61.1%**	**-523**	**-0.5%**
	Total Nongroup	**9,488**	**9.7%**	**5,184**	**5.3%**	**-4,304**	**-4.4%**
	With Tax Credits	7,190	7.4%	3,147	3.2%	-4,043	-4.2%
	Other Nongroup	2,298	2.4%	2,037	2.1%	-261	-0.3%
	Medicare and other public	**2,559**	**2.6%**	**2,559**	**2.6%**	**0**	**0.0%**
Uninsured		**11,857**	**12.2%**	**18,164**	**18.7%**	**6,307**	**6.5%**
Total		**97,373**	**100.0%**	**97,373**	**100.0%**	**0**	**0.0%**

Panel D. Nonelderly with Income Above 400% FPL		ACA		AHCA		Change from ACA	
Insured	Total Insured	78,995	97.0%	74,328	91.3%	-4,666	-5.7%
	Total Medicaid & CHIP	**1,557**	**1.9%**	**1,524**	**1.9%**	**-33**	**0.0%**
	Expansion Eligible Adults	0	0.0%	0	0.0%	0	0.0%
	Other Adults	411	0.5%	401	0.5%	-11	0.0%
	Children	701	0.9%	700	0.9%	-1	0.0%
	Non-elderly with Disability	445	0.5%	423	0.5%	-21	0.0%
	Employer	**69,573**	**85.4%**	**66,438**	**81.6%**	**-3,135**	**-3.8%**
	Total Nongroup	**5,908**	**7.3%**	**4,409**	**5.4%**	**-1,498**	**-1.8%**
	With Tax Credits	0	0.0%	2,035	2.5%	2,035	2.5%
	Other Nongroup	5,908	7.3%	2,375	2.9%	-3,533	-4.3%
	Medicare and other public	**1,957**	**2.4%**	**1,957**	**2.4%**	**0**	**0.0%**
Uninsured		**2,441**	**3.0%**	**7,107**	**8.7%**	**4,666**	**5.7%**
Total		**81,436**	**100.0%**	**81,436**	**100.0%**	**0**	**0.0%**

Source:Urban Institute analysis, HIPSM 2017.

Table 2. Absolute Difference and Percent Difference In Insurance Coverage (by Type of Coverage) Between ACA and AHCA, by State, 2022 (Thousands of People)

	Employer		Nongroup		Medicaid & CHIP		Uninsured	
State	Difference	Percent Change from ACA	Difference	Percent Change from ACA	Difference	Percent Change from ACA	Difference	Percent Change from ACA
Alabama	-20	-0.9%	-59	-22.3%	-58	-6.2%	138	25.3%
Alaska	-23	-5.9%	3	9.5%*	-43	-28.9%	63	56.5%
Arizona	-113	-3.7%	-65	-19.1%	-179	-10.1%	357	43.1%
Arkansas	92	7.7%	-10	-8.5%	-430	-44.8%	348	190.1%
California	898	5.4%	-588	-23.8%	-4,536	-39.8%	4,226	137.1%
Colorado	60	2.4%	27	9.5%*	-635	-47.8%	548	127.8%
Connecticut	4	0.2%	-48	-27.5%	-263	-34.3%	307	176.7%
Delaware	-18	-3.9%	-18	-41.7%	-20	-10.4%	56	77.9%
District of Columbia	-5	-1.6%	-2	-5.9%	-52	-29.4%	59	202.4%
Florida	66	0.9%	-1,034	-47.8%	-379	-10.3%	1,347	54.8%
Georgia	-166	-3.3%	-183	-26.0%	45	2.4%	304	16.2%
Hawaii	-21	-2.8%	-10	-19.8%	-25	-8.8%	56	54.9%
Idaho	-14	-1.8%	-49	-31.4%	-34	-11.1%	97	46.2%
Illinois	-191	-3.0%	-182	-27.8%	-616	-22.2%	988	96.2%
Indiana	-53	-1.6%	-54	-17.8%	-506	-36.0%	613	113.2%
Iowa	-43	-2.6%	-8	-5.9%	-173	-28.7%	224	129.5%
Kansas	-51	-3.4%	-46	-26.1%	-1	-0.3%	98	28.7%
Kentucky	181	10.1%	11	8.5%*	-714	-52.4%	522	223.2%
Louisiana	19	1.0%	-15	-6.3%	-394	-30.0%	390	113.9%
Maine	1	0.2%	-44	-47.2%	-13	-5.1%	56	75.2%
Maryland	23	0.7%	-61	-22.2%	-463	-37.0%	502	122.1%
Massachusetts	38	1.2%	-123	-35.7%	-6	-0.3%	90	37.8%
Michigan	-86	-1.9%	-195	-36.3%	-671	-30.5%	952	184.5%
Minnesota	-125	-4.1%	-45	-16.1%	-217	-23.2%	388	98.8%
Mississippi	-6	-0.5%	-12	-9.8%	-42	-6.2%	61	15.3%
Missouri	-84	-2.9%	-99	-27.5%	-90	-8.5%	273	45.8%
Montana	-4	-1.1%	-9	-12.5%	-81	-33.5%	95	113.1%
Nebraska	-44	-4.5%	-50	-33.7%	-3	-1.2%	97	54.8%
Nevada	-16	-1.0%	-21	-13.6%	-271	-42.9%	308	73.4%
New Hampshire	-12	-1.7%	-17	-25.7%	-82	-38.4%	112	183.8%
New Jersey	-162	-3.5%	-148	-33.1%	-639	-38.9%	949	146.0%
New Mexico	72	10.3%	-12	-15.4%	-370	-46.4%	310	171.7%
New York	28	0.3%	-696	-56.9%	-543	-11.3%	1,210	93.1%
North Carolina	-46	-1.0%	-232	-30.5%	-239	-11.5%	518	39.3%

Table 2: Continued...

State	Employer		Nongroup		Medicaid & CHIP		Uninsured	
	Difference	Percent Change from ACA	Difference	Percent Change from ACA	Difference	Percent Change from ACA	Difference	Percent Change from ACA
North Dakota	-17	-4.7%	-9	-17.3%	-37	-42.6%	63	123.8%
Ohio	-92	-1.7%	-64	-14.8%	-898	-34.8%	1,054	172.8%
Oklahoma	-52	-3.0%	-83	-36.5%	-10	-1.3%	145	24.0%
Oregon	-35	-2.0%	-42	-19.3%	-418	-42.6%	495	177.1%
Pennsylvania	-156	-2.5%	-235	-34.1%	-779	-31.1%	1,169	188.6%
Rhode Island	27	5.8%	-15	-29.7%	-109	-40.6%	97	184.2%
South Carolina	-21	-1.0%	-108	-35.4%	-75	-8.3%	205	33.9%
South Dakota	-15	-3.6%	-14	-20.4%	3	2.2%	26	27.0%
Tennessee	72	2.6%	-82	-21.7%	-322	-20.7%	332	45.7%
Texas	-441	-3.5%	-525	-30.3%	85	1.8%	881	17.3%
Utah	-83	-4.5%	-122	-41.8%	-13	-3.4%	218	64.0%
Vermont	0	0.1%	-15	-43.2%	-23	-15.5%	38	165.3%
Virginia	-183	-3.9%	-212	-34.3%	17	1.7%	378	36.0%
Washington	6	0.2%	-14	-4.3%	-735	-42.4%	743	143.0%
West Virginia	63	8.9%	-5	-9.0%	-267	-50.9%	209	296.4%
Wisconsin	-57	-1.9%	-157	-42.9%	-32	-3.3%	246	62.9%
Wyoming	-7	-2.4%	-11	-25.6%	-1	-1.1%	19	27.3%
Total	-816	-0.6%	-5,805	-30.1%	-16,358	-23.4%	22,979	74.7%

Source:Urban Institute analysis, HIPSM 2017.

**Note: The reported insurance coverage data in Alaska, Colorado, and Kentucky had much larger numbers of people with incomes below 138 percent of the FPL reporting private non-group insurance coverage prior to the ACA. This may have been the result of misreporting of coverage, but we have no way of knowing that for sure, so we did not reassign their coverage. Under the ACA, these individuals enroll in Medicaid under the ACA expansion. Under the AHCA they lose that Medicaid coverage and re-enroll in nongroup insurance as they had done prior to 2014 according to their self-report of coverage. These anomalies are the reason why nongroup coverage appears to increase instead of decrease in these states under the AHCA -- the only states where that finding occurs.*

Table 3. Uninsured by State in 2022 (Thousands of People)

State	ACA	As a Percent of State Nonelderly population	AHCA	As a Percent of State Nonelderly population	Difference	Percent Change from ACA
Alabama	545	13.3%	682	16.6%	138	25.3%
Alaska	111	15.4%	173	24.1%	63	56.5%
Arizona	828	13.4%	1,185	19.2%	357	43.1%
Arkansas	183	7.1%	531	20.6%	348	190.1%
California	3,082	9.0%	7,308	21.2%	4,226	137.1%
Colorado	429	9.0%	977	20.5%	548	127.8%
Connecticut	174	5.9%	481	16.4%	307	176.7%
Delaware	72	9.0%	127	16.1%	56	77.9%
District of Columbia	29	5.0%	88	15.2%	59	202.4%
Florida	2,459	15.0%	3,806	23.2%	1,347	54.8%
Georgia	1,878	19.1%	2,183	22.2%	304	16.2%
Hawaii	101	7.9%	157	12.3%	56	54.9%
Idaho	210	14.0%	307	20.5%	97	46.2%
Illinois	1,027	9.2%	2,015	18.1%	988	96.2%
Indiana	542	9.4%	1,155	20.1%	613	113.2%
Iowa	173	6.6%	397	15.1%	224	129.5%
Kansas	343	13.6%	441	17.5%	98	28.7%
Kentucky	234	6.3%	756	20.5%	522	223.2%
Louisiana	342	8.9%	732	19.0%	390	113.9%
Maine	74	7.4%	130	12.9%	56	75.2%
Maryland	411	7.6%	913	17.0%	502	122.1%
Massachusetts	239	4.3%	329	6.0%	90	37.8%
Michigan	516	6.5%	1,468	18.4%	952	184.5%
Minnesota	393	8.3%	781	16.4%	388	98.8%
Mississippi	396	16.0%	456	18.4%	61	15.3%
Missouri	596	11.6%	869	17.0%	273	45.8%
Montana	84	10.0%	179	21.4%	95	113.1%
Nebraska	178	11.1%	275	17.1%	97	54.8%
Nevada	420	14.6%	728	25.4%	308	73.4%
New Hampshire	61	5.7%	172	16.1%	112	183.8%
New Jersey	650	8.7%	1,598	21.3%	949	146.0%
New Mexico	181	9.9%	491	26.9%	310	171.7%
New York	1,300	7.9%	2,510	15.2%	1,210	93.1%
North Carolina	1,316	14.6%	1,834	20.4%	518	39.3%

Table 3: Continued...

State	ACA	As a Percent of State Nonelderly population	AHCA	As a Percent of State Nonelderly population	Difference	Percent Change from ACA
North Dakota	51	8.8%	113	19.6%	63	123.8%
Ohio	610	6.5%	1,664	17.7%	1,054	172.8%
Oklahoma	605	17.6%	751	21.8%	145	24.0%
Oregon	279	8.3%	774	23.1%	495	177.1%
Pennsylvania	620	6.0%	1,790	17.3%	1,169	188.6%
Rhode Island	53	6.2%	150	17.6%	97	184.2%
South Carolina	604	14.8%	809	19.8%	205	33.9%
South Dakota	95	12.9%	120	16.4%	26	27.0%
Tennessee	726	12.9%	1,058	18.7%	332	45.7%
Texas	5,098	20.4%	5,979	24.0%	881	17.3%
Utah	341	11.6%	558	19.1%	218	64.0%
Vermont	23	4.7%	61	12.5%	38	165.3%
Virginia	1,050	13.4%	1,428	18.2%	378	36.0%
Washington	520	8.4%	1,262	20.5%	743	143.0%
West Virginia	71	5.0%	280	19.6%	209	296.4%
Wisconsin	391	8.1%	636	13.3%	246	62.9%
Wyoming	69	13.8%	88	17.5%	19	27.3%
Total	30,780	11.1%	53,759	19.4%	22,979	74.7%

Source:Urban Institute analysis, HIPSM 2017.

Table 4. Characteristics of Uninsured and Those Losing Coverage Under the AHCA, 2022 (Thousands of People)

Characteristics	Uninsured under ACA		Uninsured under AHCA		Newly uninsured under AHCA	
	Number of Uninsured	Percent of Total Uninsured	Number of Uninsured	Percent of Total Uninsured	Number of Uninsured	Percent of Total Newly Uninsured
Race & Ethnicity						
White, non-Hispanic	11,412	37.1%	24,311	45.2%	13,541	55.4%
Hispanic	12,590	40.9%	17,486	32.5%	5,343	21.8%
Black, non-Hispanic	3,996	13.0%	6,783	12.6%	3,053	12.5%
Asian & Pacific Islander	1,616	5.2%	3,061	5.7%	1,511	6.2%
Other	1,167	3.8%	2,119	3.9%	1,013	4.1%
Gender						
Male						
Subtotal	**16,809**		**28,443**		**12,372**	
0-18	1,888	11.2%	3,904	13.7%	2,092	16.9%
19-34	7,354	43.7%	11,412	40.1%	4,305	34.8%
35-54	5,837	34.7%	10,072	35.4%	4,502	36.4%
55-64	1,731	10.3%	3,055	10.7%	1,472	11.9%
Female						
Subtotal	**13,971**		**25,316**		**12,090**	
0-18	1,784	12.8%	3,672	14.5%	1,956	16.2%
19-34	5,241	37.5%	9,114	36.0%	4,110	34.0%
35-54	5,122	36.7%	9,166	36.2%	4,302	35.6%
55-64	1,824	13.1%	3,364	13.3%	1,722	14.2%
Education (Age 19-64)						
Subtotal	**27,108**		**46,183**		**20,413**	
Less than High School	6,699	24.7%	9,320	20.2%	2,909	14.3%
High School	11,154	41.1%	18,883	40.9%	8,318	40.7%
Some College	5,862	21.6%	10,772	23.3%	5,216	25.6%
College Graduate	3,393	12.5%	7,208	15.6%	3,970	19.4%
Working Status						
No Worker in Family	6,547	21.3%	10,824	20.1%	4,749	19.4%
Part-Time in Family	2,636	8.6%	4,795	8.9%	2,377	9.7%
Full-Time in Family	21,598	70.2%	38,140	70.9%	17,335	70.9%
Total	30,780	100.0%	53,759	100.0%	24,461	100.0%

Source:Urban Institute analysis, HIPSM 2017.

Table 5. Distribution of Tax Credits and Cost-Sharing Reductions by Income Relative to the Federal Poverty Level (FPL), 2022 ($Million)

Income Group	ACA Tax Credits		ACA Cost-Sharing Reductions		AHCA Tax Credits	
	Amount	Percent	Amount	Percent	Amount	Percent
0-100 FPL	$544	1.4%	$25	0.4%	$2,509	12.2%
100-200 FPL	$25,964	66.9%	$6,409	95.6%	$4,526	22.1%
200-300 FPL	$8,349	21.5%	$270	4.0%	$4,496	21.9%
300-400 FPL	$3,930	10.1%	$0	0.0%	$3,128	15.3%
400-500 FPL	$0	0.0%	$0	0.0%	$2,530	12.3%
500-600 FPL	$0	0.0%	$0	0.0%	$1,550	7.6%
600 FPL +	$0	0.0%	$0	0.0%	$1,754	8.6%
Total	**$38,787**	**100.0%**	**$6,704**	**100.0%**	**$20,493**	**100.0%**

Source:Urban Institute analysis, HIPSM 2017.

Table 6. Federal Spending on the Nonelderly Under the ACA and the AHCA, 2022 ($Million)

State	ACA			AHCA			Difference in 2022	
	Medicaid & CHIP	Tax Credits & Cost-Sharing Reductions	Total Federal Spending	Medicaid & CHIP	Tax Credits	Total Federal Spending	Total Change in Federal Spending	Percent change from ACA
Alabama	$4,279	$1,050	$5,329	$3,881	$403	$4,284	-$1,045	-19.6%
Alaska	$1,427	$116	$1,543	$838	$58	$896	-$647	-41.9%
Arizona	$13,311	$959	$14,270	$10,643	$366	$11,009	-$3,262	-22.9%
Arkansas	$4,286	$197	$4,483	$2,893	$139	$3,032	-$1,451	-32.4%
California	$33,708	$5,435	$39,143	$22,073	$2,288	$24,361	-$14,782	-37.8%
Colorado	$7,100	$202	$7,302	$3,289	$388	$3,677	-$3,625	-49.6%
Connecticut	$5,103	$410	$5,513	$3,285	$177	$3,462	-$2,052	-37.2%
Delaware	$1,311	$92	$1,403	$1,001	$34	$1,035	-$368	-26.2%
District of Columbia	$1,750	$9	$1,759	$1,297	$17	$1,314	-$445	-25.3%
Florida	$16,819	$7,101	$23,920	$14,509	$2,221	$16,730	-$7,190	-30.1%
Georgia	$8,348	$1,699	$10,048	$8,083	$998	$9,081	-$966	-9.6%
Hawaii	$1,288	$70	$1,358	$984	$58	$1,042	-$316	-23.3%
Idaho	$2,457	$373	$2,831	$2,081	$192	$2,273	-$558	-19.7%
Illinois	$14,017	$1,202	$15,220	$9,771	$524	$10,295	-$4,925	-32.4%
Indiana	$7,911	$539	$8,449	$5,242	$309	$5,551	-$2,898	-34.3%
Iowa	$3,158	$171	$3,330	$2,340	$156	$2,496	-$834	-25.0%
Kansas	$2,097	$402	$2,499	$1,973	$216	$2,189	-$310	-12.4%
Kentucky	$10,496	$213	$10,709	$4,347	$158	$4,505	-$6,204	-57.9%
Louisiana	$7,035	$637	$7,672	$4,622	$442	$5,064	-$2,608	-34.0%
Maine	$1,566	$366	$1,933	$1,442	$109	$1,551	-$382	-19.8%

Table 6: Continued...

State	ACA			AHCA			Difference in 2022	
	Medicaid & CHIP	Tax Credits & Cost-Sharing Reductions	Total Federal Spending	Medicaid & CHIP	Tax Credits	Total Federal Spending	Total Change in Federal Spending	Percent change from ACA
Maryland	$7,851	$355	$8,206	$4,441	$248	$4,688	-$3,517	-42.9%
Massachusetts	$8,571	$597	$9,169	$7,308	$202	$7,510	-$1,659	-18.1%
Michigan	$13,643	$815	$14,458	$9,070	$401	$9,470	-$4,988	-34.5%
Minnesota	$7,052	$264	$7,316	$5,206	$235	$5,441	-$1,875	-25.6%
Mississippi	$4,029	$408	$4,437	$3,590	$261	$3,851	-$586	-13.2%
Missouri	$7,601	$1,073	$8,674	$6,737	$508	$7,245	-$1,429	-16.5%
Montana	$2,018	$202	$2,219	$1,258	$136	$1,394	-$826	-37.2%
Nebraska	$1,349	$432	$1,780	$1,256	$154	$1,410	-$370	-20.8%
Nevada	$3,242	$356	$3,598	$1,813	$191	$2,004	-$1,593	-44.3%
New Hampshire	$1,335	$96	$1,431	$798	$69	$867	-$564	-39.4%
New Jersey	$12,431	$694	$13,125	$6,071	$414	$6,485	-$6,640	-50.6%
New Mexico	$6,965	$99	$7,064	$3,325	$77	$3,402	-$3,662	-51.8%
New York	$33,994	$1,824	$35,818	$26,238	$671	$26,910	-$8,908	-24.9%
North Carolina	$13,307	$3,435	$16,742	$11,299	$1,048	$12,347	-$4,395	-26.3%
North Dakota	$688	$60	$748	$354	$56	409	-$338	-45.3%
Ohio	$16,649	$589	$17,238	$10,473	$472	10,945	-$6,293	-36.5%
Oklahoma	$4,319	$785	$5,104	$4,031	$262	4,293	-$811	-15.9%
Oregon	$7,121	$308	$7,429	$3,313	$233	3,547	-$3,883	-52.3%
Pennsylvania	$15,379	$1,547	$16,925	$10,397	$562	10,958	-$5,967	-35.3%
Rhode Island	$2,109	$58	$2,167	$1,160	$45	1,205	-$961	-44.4%
South Carolina	$5,486	$1,103	$6,589	$4,804	$405	5,209	-$1,380	-20.9%
South Dakota	$735	$146	$881	$711	$88	799	-$81	-9.3%
Tennessee	$9,455	$1,083	$10,539	$7,309	$502	7,811	-$2,728	-25.9%
Texas	$28,748	$4,109	$32,857	$27,724	$2,201	29,925	-$2,932	-8.9%
Utah	$2,943	$568	$3,511	$2,719	$244	2,962	-$548	-15.6%
Vermont	$993	$84	$1,077	$754	$33	787	-$290	-27.0%
Virginia	$5,013	$1,467	$6,480	$4,833	$695	5,528	-$952	-14.7%
Washington	$8,470	$388	$8,858	$3,990	$411	4,401	-$4,457	-50.3%
West Virginia	$3,510	$161	$3,670	$1,803	$57	1,860	-$1,810	-49.3%
Wisconsin	$4,368	$989	$5,358	$4,051	$298	4,349	-$1,008	-18.8%
Wyoming	$410	$158	$567	$385	$63	448	-$120	-21.1%
Total	**$387,249**	**$45,498**	**$432,748**	**$281,814**	**$20,493**	**$302,307**	**-$130,441**	**-30.1%**

Source:Urban Institute analysis, HIPSM 2017.

Table 7. State Medicaid & CHIP Spending on the Nonelderly Under the ACA and the AHCA, 2022 ($Million)

State	ACA	AHCA	Difference in 2022	
			Amount	Percent Change
Alabama	$1,896	$2,022	$126	6.6%
Alaska	$957	$945	-$12	-1.3%
Arizona	$5,630	$6,224	$594	10.5%
Arkansas	$1,573	$1,478	-$95	-6.1%
California	$27,172	$24,667	-$2,505	-9.2%
Colorado	$4,183	$3,473	-$710	-17.0%
Connecticut	$3,790	$3,561	-$229	-6.0%
Delaware	$789	$893	$104	13.2%
District of Columbia	$632	$659	$27	4.3%
Florida	$11,520	$11,387	-$133	-1.2%
Georgia	$4,193	$4,768	$575	13.7%
Hawaii	$913	$1,036	$123	13.4%
Idaho	$952	$973	$22	2.3%
Illinois	$10,143	$10,209	$66	0.7%
Indiana	$2,986	$2,953	-$34	-1.1%
Iowa	$1,807	$1,830	$23	1.3%
Kansas	$1,524	$1,617	$93	6.1%
Kentucky	$2,901	$2,209	-$692	-23.9%
Louisiana	$3,447	$3,371	-$77	-2.2%
Maine	$956	$1,017	$61	6.4%
Maryland	$5,511	$4,974	-$537	-9.7%
Massachusetts	$5,658	$6,890	$1,231	21.8%
Michigan	$5,308	$5,296	-$12	-0.2%
Minnesota	$5,671	$5,797	$126	2.2%
Mississippi	$1,453	$1,583	$130	8.9%
Missouri	$4,502	$4,588	$86	1.9%
Montana	$747	$714	-$33	-4.4%
Nebraska	$1,115	$1,179	$64	5.7%
Nevada	$1,300	$1,200	-$100	-7.7%
New Hampshire	$927	$889	-$38	-4.1%

Table 7: Continued...

State	ACA	AHCA	Difference in 2022	
			Amount	Percent Change
New Jersey	$6,976	$6,373	-$602	-8.6%
New Mexico	$2,176	$1,799	-$377	-17.3%
New York	$25,487	$28,333	$2,846	11.2%
North Carolina	$6,791	$6,760	-$31	-0.5%
North Dakota	$410	$387	-$23	-5.6%
Ohio	$7,329	$7,081	-$248	-3.4%
Oklahoma	$2,428	$2,651	$223	9.2%
Oregon	$2,438	$2,119	-$319	-13.1%
Pennsylvania	$9,629	$9,525	-$104	-1.1%
Rhode Island	$1,522	$1,295	-$227	-14.9%
South Carolina	$2,288	$2,422	$134	5.8%
South Dakota	$633	$693	$60	9.4%
Tennessee	$4,820	$4,453	-$366	-7.6%
Texas	$19,615	$21,673	$2,058	10.5%
Utah	$1,212	$1,334	$122	10.1%
Vermont	$620	$699	$79	12.8%
Virginia	$4,878	$5,251	$374	7.7%
Washington	$4,963	$4,341	-$622	-12.5%
West Virginia	$1,000	$830	-$170	-17.0%
Wisconsin	$2,959	$3,119	$160	5.4%
Wyoming	$402	$420	$18	4.5%
Total	**$228,728**	**$229,956**	**$1,228**	**0.5%**

Source:Urban Institute analysis, HIPSM 2017.

NOTES

1 See: American Health Care Act of 2017, H.R. 1628, 115th Cont. (2017) https://www.congress.gov/bill/115th-congress/house-bill/1628. An excellent summary of the components of the AHCA can be found at: Kaiser Family Foundation, May 2017. Summary of the American Health Care Act. http://files.kff.org/attachment/Proposals-to-Replace-the-Affordable-Care-Act-Summary-of-the-American-Health-Care-Act

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6 Effectuated enrollment for 2017 was not available at the time the model was calibrated, so we used Marketplace plan selections from the open enrollment report, discounted by the attrition between plan selections and effectuated enrollment observed in 2016.

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9 A small percentage of tax credits go to those below 100 percent of FPL. These families qualify for the tax credits (even though they have lower incomes) through a provision of the law that grants Marketplace assistance to recent immigrants who would otherwise be ineligible for Medicaid because of their immigration status.

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ABOUT THE AUTHORS & ACKNOWLEDGMENTS

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