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House Republican Proposals to Radically Overhaul Medicaid Would Shift Costs, Risks to States

Proposals Would End the Medicaid Expansion and Endanger Coverage for Millions of Children, Seniors, and People with Disabilities

By Edwin Park, Matt Broaddus, Jesse Cross-Call, and Jessica Schubel

House Republicans released a document last week outlining plans for sweeping health care legislation.[1] The document shows that the starting point for House Republican proposals remains the Affordable Care Act (ACA) "repeal and delay" legislation that President Obama vetoed last year — a bill that would increase the number of uninsured by 32 million people, according to Congressional Budget Office (CBO) estimates.[2] Moreover, in the case of Medicaid, the document shows that House Republicans plan to pursue cuts that go far beyond those in last year's repeal bill. On top of effectively ending the ACA's Medicaid expansion, which has extended coverage to 11 million low-income adults, House Republicans intend to use ACA repeal legislation to fast track their longstanding proposal to convert Medicaid to a per capita cap or block grant. That proposal would shrink federal Medicaid funding over time, result in even deeper funding cuts when needs increase, and ultimately place coverage for tens of millions more Americans at risk.[3]

[1] House Republicans released these major health proposals as part of their recess packet for Republican members. https://gallery.mailchimp.com/301a28247b80ab82279e92afb/files/5c7c3226-a149-4842-ab43-707b7b4720fc/Healthcare_Policy_Brief.pdf?utm_source=HouseGOP%20Staff%20List&utm_campaign=ccecba1704-EMAIL_CAMPAIGN_2017_02_16&utm_medium=email&utm_term=0_f9e806e009-ccecba1704-132524909. For a discussion of the non-Medicaid proposals, see Jacob Leibenluft, *et al.*, "House Republicans Would Reverse ACA Coverage Gains, and Radically Overhaul Medicaid, New Talking Points Confirm," Center on Budget and Policy Priorities, February 17, 2017, http://www.cbpp.org/research/health/house-republicans-would-reverse-aca-coverage-gains-and-radically-overhaul-medicaid.

[2] Congressional Budget Office, "How Repealing Portions of the Affordable Care Act Would Affect Health Insurance Coverage and Premiums," January 2017, https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/reports/52371-coverageandpremiums.pdf.

[3] Edwin Park, "Medicaid Per Capita Cap Would Shift Costs and Risks to States and Harm Millions of Beneficiaries," February 24, 2017, http://www.cbpp.org/research/health/medicaid-per-capita-cap-would-shift-costs-and-risks-to-states-and-harm-millions-of.

The House Republican proposals would effectively end the Medicaid expansion now in effect in 31 states and Washington, D.C. by phasing out all of the enhanced federal funding that states now receive for covering the expansion population. This would force expansion states to find at least *$32 billion* more in state funds in 2019 alone (assuming the reduction took effect in that year) to continue covering this group. Few, if any, states could absorb such new costs.

In seven states, the reduced federal funding for the expansion would cause the expansion to end automatically as a result of provisions in those states' laws. And other expansion states would almost certainly drop or substantially scale back their expansions, reversing historic gains in health coverage and access to care.

The changes outlined in the document also show that House Republicans intend to make even more damaging changes to Medicaid. In addition to essentially undoing the Medicaid expansion, they would convert the underlying Medicaid program to a per capita cap or a block grant to states. This radical overhaul of the federal-state Medicaid funding partnership would shift substantial costs and fiscal risks to the states, ultimately forcing them to institute cuts that could endanger coverage for tens of millions of children, pregnant women, seniors, and people with disabilities.

The federal savings from these Medicaid cuts would apparently be used, under the House Republican proposal, to help pay for tax cuts for high earners, drug companies, insurers, and other industries — which would be provided by repealing revenue measures that were included in the ACA to help finance its coverage expansions. People at the top of the income scale would receive multi-million-dollar tax cuts even as vulnerable groups lost coverage and were left without access to needed care.[4]

House Republican Document Reaffirms Plans to End Medicaid Expansion

The House Republican document is clear about its intention to end the Medicaid expansion, noting: "Obamacare's Medicaid expansion for able-bodied [adult] enrollees would be repealed in its current form." Rather than eliminating Medicaid coverage for the expansion population outright, however, the document proposes repealing the *enhanced federal matching rate* for this group, under which the federal government pays 90 percent or more of a state's costs in covering the expansion population. After "a limited period of time," if states wanted to continue enrolling low-income adults under the Medicaid expansion, they would have to do so at their regular matching rate — requiring them to pay an average of 43 percent of the cost, instead of 10 percent or less.

In practice, this would end the Medicaid expansion. States would be allowed to continue covering the expansion population, but only if they paid between *four and seven times their current expansion costs* in 2019 — that is, a 300 to 600 percent increase — assuming the reduction in the expansion matching rate took effect that year, and between 2.8 and 5 times their costs under current law after that.[5] In

[4] Brandon DeBot, Chye-Ching Huang, and Chuck Marr, "ACA Repeal Would Lavish Medicare Tax Cuts on 400 Highest-Income Households," Center on Budget and Policy Priorities, January 12, 2017, http://www.cbpp.org/research/federal-tax/aca-repeal-would-lavish-medicare-tax-cuts-on-400-highest-income-households.

[5] The House document suggests there would be a transition to the lower matching rate, but the nature and timing of that transition are left unclear. This analysis focuses on the impact of the House proposal when fully in effect, which we assume — based on the prior vetoed Republican ACA repeal legislation — would be in 2019.

2019 alone, the 32 expansion states (including the District of Columbia) would have to find *more than $32 billion* in additional funds to continue the expansion.

Reducing the Expansion Match Rate Would Automatically End Expansion in Seven States

In Arkansas, Illinois, Indiana, Michigan, New Hampshire, New Mexico, and Washington, reduced federal funding would "trigger" immediate or eventual termination of the Medicaid expansion, without additional action by state policymakers. Laws in these states either explicitly require the expansion to end if the federal Medicaid matching rate decreases, or they require the state to take action to prevent an increase in state Medicaid costs. These triggers would cause the low-income people enrolled in the expansion in these seven states — 2.6 million adults as of the end of 2015 — to lose their current health coverage.[6]

Reducing the Matching Rate Would Force Other States to End or Curb the Expansion

Faced with dramatically reduced federal funding for the Medicaid expansion, the remaining 24 expansion states and the District of Columbia would likely have no choice but to drop the expansion (or to significantly curtail it, if that is permitted). Table 1 shows that if Congress lowered the federal Medicaid expansion matching rate to the regular matching rate in 2019, Medicaid expansion states would have to contribute at least $32 billion more from their own budgets just in fiscal year 2019 to continue the expansion.[7] That would be extremely unlikely, for several reasons:

- **A $32 billion cost increase is large relative to states' total Medicaid spending and budgets.** As noted, lowering the expansion matching rate to a state's regular Medicaid matching rate would require states to pay four to seven times their current-law costs for the Medicaid expansion in 2019. If a comparable cost shift had occurred in 2015, it would increase *total* Medicaid costs for expansion states by more than one-fifth, requiring them to

[6] See Robin Rudowitz *et al.*, "What Coverage and Financing Is at Risk under a Repeal of the ACA Medicaid Expansion?," Kaiser Family Foundation, December 2016, http://kff.org/medicaid/issue-brief/what-coverage-and-financing-at-risk-under-repeal-of-aca-medicaid-expansion/.

[7] The $32 billion estimate is based on federal Medicaid spending for the expansion eligibility group for fiscal year 2015, the latest year for which administrative spending data are available. These data, however, only include the 28 states (and Washington, D.C.) that adopted the expansion prior to March 2015 (excluding Alaska, Louisiana, and Montana, which have adopted the expansion in the time since), making the $32 billion an underestimate of total costs to states. We trend these spending data to 2019 based on the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary's estimates for enrollment and per-beneficiary spending for the expansion group at the national level. We deem this the soundest method, but do arrive at estimates lower than if we had used growth rates based on the Congressional Budget Office (CBO) baseline. In comparing states' share of expansion costs in 2019, we assume that the regular Medicaid matching rate for each state in fiscal year 2019 is identical to the matching rate for 2017 (although some states' matching rates can change modestly from one year to the next**)**. Estimated federal savings from the reduction in the federal matching rate would likely be much larger than the $32 billion cost shift to states because, as discussed in the text, most or all states would drop the expansion entirely. However, a fraction of those losing coverage may be eligible for other federal assistance, with some offsetting cost.

find additional resources equivalent to their *total general fund spending* on corrections or about three-quarters of their general fund spending on higher education to maintain the expansion.[8]

- **Before the ACA, states largely declined opportunities to cover low-income parents at the regular match rate.** Prior to the ACA, states had the option to cover low-income parents with incomes up to 138 percent of the federal poverty line at their regular federal Medicaid matching rates. Only ten states did**.** The income-eligibility limit for parents in the typical (or median) state was only 64 percent of the poverty line in 2013, and only about one-third of states covered any parents at or above the poverty line.[9] The outlook for poor non-elderly, non-disabled adults who are not raising children would be even more grim. Prior to the ACA, only a small number of states sought and obtained waivers to cover non-elderly, non-disabled adults without dependent children at *any* income level; in most states, even those far below the poverty line were uninsured.
- **Under the House Republican proposals, states would also have to deal with other deep and growing Medicaid cuts.** Even if some expansion states could somehow make up for the large hole in their budgets left by terminating the enhanced match for the expansion, that change would be only part of the overall cost shift to state Medicaid programs that House Republicans are proposing, as discussed below.

Ending Expansion Would Reverse Gains in Coverage and Access to Care

The nation has experienced historic health coverage gains since the ACA's key coverage provisions took effect in 2014, and these gains have been greatest in states that have expanded Medicaid. The uninsured rate among adults aged 18 to 64 dropped from 15.8 percent to 7.3 percent in expansion states, as compared to a drop from 20.6 percent to 14.1 percent in non-expansion states, an Urban Institute survey found.[10] And the ten states with the largest health coverage gains

[8] This estimate is based on CMS state-level administrative spending data for 2015 — the most recent available. We compare states' Medicaid spending in total and for the expansion group under the matching rules that would apply in 2019 under current law to similar state Medicaid spending estimates assuming a reduction in the matching rate for the expansion group. Then, we evaluate states' increased Medicaid spending for the expansion group under a reduced matching rate as a share of states' total Medicaid spending. A comparable reduction in federal funds in 2015 would have required expansion states to increase their Medicaid spending by about $30 billion. Figures for state spending are from: National Association of State Budget Officers, "State Expenditure Report," 2016, https://www.nasbo.org/mainsite/reports-data/state-expenditure-report.

[9] Samantha Artiga and Elizabeth Cornachione, "Trends in Medicaid and CHIP Eligibility over Time," Kaiser Family Foundation, January 2016, http://kff.org/report-section/trends-in-medicaid-and-chip-eligibility-over-time-section-1-eligibility-trends-by-group-2016-update/. See also Martha Heberlein *et al.*, "Getting into Gear: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013," Kaiser Family Foundation, January 2013, http://kff.org/medicaid/report/getting-into-gear-for-2014-findings-from-a-50-state-survey-of-eligibility-enrollment-renewal-and-cost-sharing-policies-in-medicaid-and-chip-2012-2013/.

[10] Michael Karpman, Sharon Long, and Steven Zuckerman, "Taking Stock: Health Insurance Coverage Under the ACA as of March 2016," Urban Institute, May 25, 2016, http://hrms.urban.org/briefs/health-insurance-coverage-ACA-March-2016.html.

all are Medicaid expansion states, a recent Gallup poll found.[11] Ending the Medicaid expansion would cause at least 11 million people to lose their coverage. (See Table 2.)

Ending the expansion would also cut people off from critical health services. Since Louisiana's expansion took effect on July 1, 2016, for example, 1,193 people in the state have been diagnosed with diabetes and begun treatment, and 2,954 people in the state have been diagnosed with hypertension and begun treatment.[12] In addition, ending the expansion would unravel what has become a critical tool for providing mental health services and combatting substance abuse. In Ohio, over half of Medicaid expansion enrollees have used their coverage to access mental health or drug treatment services.[13]

The House Republican proposals would also cut off the possibility of gaining coverage for millions of people in the 19 states that haven't yet expanded Medicaid.

House Proposals Would Cap and Cut Federal Medicaid Funding for *All* States

Though short on details, the document House leaders released on February 16 makes clear they also intend to use ACA repeal as a vehicle for their longstanding proposal to convert Medicaid into a per capita cap or block grant and to shrink federal Medicaid funding, relative to need, over time. This radical change would put coverage for more than 63 million Medicaid beneficiaries at risk, in addition to the 11 million low-income adults who would stand to lose coverage under the expansion's repeal.

The federal government now pays a fixed percentage of states' Medicaid costs, varying by state between 50 and 75 percent. In contrast, under a per capita cap or a block grant, the federal government's contribution to Medicaid would be decoupled from the actual cost of providing health care. Instead, federal support would be capped, and limited either to a set amount per beneficiary (under a per capita cap) or to a fixed amount per state (under a block grant). The House GOP document appears to suggest states would have a choice between a per capita cap and a block grant. But either approach would dramatically alter federal Medicaid financing, shifting costs and risks to states and forcing states to decide who would lose coverage and how care would be rationed among the millions of families, seniors, and people with disabilities who rely on Medicaid.

Either a Per Capita Cap or a Block Grant Would Shift Costs to States

The primary purpose of capping federal Medicaid funding is to reduce federal Medicaid costs. Under either a per capita cap or block grant, this is accomplished by setting the cap for each state below the federal government's projected spending under current law and/or adjusting the cap from

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[11] Dan Witters, "Kentucky, Arkansas Post Largest Drops in Uninsured Rates," Gallup-Healthways Well-Being Index, February 8, 2017, http://www.gallup.com/poll/203501/kentucky-arkansas-post-largest-drops-uninsured-rates.aspx?g_source=Healthcare&g_medium=newsfeed&g_campaign=tiles.

[12] Louisiana Department of Health, http://ldh.louisiana.gov/HealthyLaDashboard/. Data are as of February 6, 2017.

[13] For more information on the adverse effect that ending the Medicaid expansion would have on states, see Jesse Cross-Call, "Repealing Health Reform's Medicaid Expansion Would Cause Millions to Lose Coverage, Harm State Budgets," Center on Budget and Policy Priorities, December 22, 2016, http://www.cbpp.org/research/health/repealing-health-reforms-medicaid-expansion-would-cause-millions-to-lose-coverage.

year to year by a rate below expected cost growth. Some proposals would initially set the cap based on states' current spending and then raise it each year by the overall inflation rate or less; historically, health costs (not only in Medicaid but in the U.S. health care system as a whole) have outpaced inflation, and as a result, the annual federal funding cuts would grow larger with each passing year. Other per capita cap proposals would achieve additional savings by setting the initial cap amounts below states' current or historical levels of federal Medicaid spending per beneficiary. While the new House document does not specify how much House Republicans would cut Medicaid over time, all past Republican proposals for Medicaid per capita caps or block grants have featured cuts to federal funding that grew deep over time.

Even comparatively small *percentage* cuts in federal funding would create large budget shortfalls for states, as federal Medicaid funding constitutes about 15 percent of state budgets, on average.[14] Moreover, once the caps on federal Medicaid funding were in place, it would likely be tempting for Congress to ratchet them down over time to produce savings to offset the cost of other legislative priorities that congressional leaders badly wanted to pass.

There are no features of a per capita cap or block grant that would make it possible for states to absorb these cuts without cutting coverage. Medicaid is already efficient — covering people at substantially lower costs than private insurance and with slower growth in per-beneficiary costs over time — and its per-beneficiary costs are expected to continue to grow more slowly than private insurance in coming years.[15] In addition, states already have significant flexibility in how they run their Medicaid programs. The major new flexibility that the House Republican proposals would likely provide is flexibility to limit eligibility or cut benefits in ways that federal law doesn't currently permit,[16] such as:

- Cutting eligibility and benefits for seniors and people with disabilities, who account for about half of Medicaid spending. Medicaid finances half the nation's long-term services and supports (i.e., long-term care) and protects millions of low-income seniors from high out-of-pocket Medicare costs; and
- Restricting eligibility and benefits for the one-third of U.S. children — well over 30 million in total — who get health care through Medicaid. The Republican document says that states choosing a block grant would only have to cover "the most vulnerable elderly and disabled individuals," making no mention of children. Some children could lose coverage entirely.

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[14] Medicaid and CHIP Payment and Access Commission, "Medicaid's share of state budgets," https://www.macpac.gov/subtopic/medicaids-share-of-state-budgets/.

[15] See Teresa A. Coughlin *et al.*, "What Difference Does Medicaid Make? Assessing Cost Effectiveness, Access, and Financial Protection under Medicaid for Low-Income Adults," Kaiser Family Foundation, May 2013, http://kff.org/medicaid/issue-brief/what-difference-does-medicaid-make-assessing-cost-effectiveness-access-and-financial-protection-under-medicaid-for-low-income-adults/; Edwin Park *et al.*, "Frequently Asked Questions About Medicaid," Center on Budget and Policy Priorities, updated January 21, 2016, http://www.cbpp.org/research/health/frequently-asked-questions-about-medicaid; Medicaid and CHIP Payment and Access Commission, "Report to Congress on Medicaid and CHIP," June 2016, https://www.macpac.gov/wp-content/uploads/2016/06/Trends-in-Medicaid-Spending.pdf.

[16] Judith Solomon, "Caps on Federal Medicaid Funding Would Give States Flexibility to Cut, Stymie Innovation," Center on Budget and Policy Priorities, January 18, 2017, http://www.cbpp.org/research/health/caps-on-federal-medicaid-funding-would-give-states-flexibility-to-cut-stymie.

Others could lose access to the comprehensive pediatric benefits Medicaid now provides, and receive more limited coverage instead.

Either a Per Capita Cap or a Block Grant Would Shift Risk to States

Either a per capita cap or a block grant would eliminate Medicaid's crucial ability to automatically respond to increases in need. Instead, states would be fully responsible for bearing all additional costs that result from a public health emergency, a costly new prescription drug, changing demographics not accounted for in the formula for capped funding, or — in the case of a block grant — a recession. This means that the magnitude of the federal Medicaid funding cuts that states actually would experience could be considerably larger in any given year than the explicit cuts that would result from the failure of a per capita cap or block grant to keep up with anticipated increases in health care costs. It also means that the cuts could be deepest precisely when need is greatest.

Consider how a per capita cap or a block grant would perform in the face of the following health care challenges.

- **The opioid epidemic.** As the opioid epidemic has intensified in states around the country, substance use treatment services covered by Medicaid expanded to meet growing need. This occurred not only due to the Medicaid expansion, but also because of how Medicaid currently works. When demand for treatment rose, federal funding automatically rose to cover more than half the cost. Likewise, the federal government partnered with states that chose to improve services, covering more than half the cost of expanding or improving treatment options. Under either a per capita cap or a block grant, states would have had to cover the entire cost of rising need on their own. And rather than being able to invest in improving care, many states would have been forced to scale back or ration substance use treatment as the need increased, or to weaken Medicaid coverage for other groups.
- **The introduction of Sovaldi.** The introduction of Sovaldi, a new drug regimen that cures Hepatitis C, has dramatically improved the quality of life for people with the disease. But it has also imposed large unexpected costs on state Medicaid programs. In calendar year 2014, state Medicaid programs incurred $1.3 billion in total Medicaid costs (before applying any Medicaid rebates) related to Sovaldi, even though only about 2 percent of Medicaid beneficiaries nationwide with Hepatitis C had received this medication.[17] Under current law, the federal government has covered more than half of that cost, on average, leaving states with still significant, but not insurmountable, demands on their budgets. Under a per capita cap or a block grant, however, states would bear the full cost of Sovaldi or any other new drug or prescription-drug price spike that affects Medicaid beneficiaries.
- **The aging baby-boom generation.** As the population ages, a larger share of Medicaid beneficiaries will be seniors and people with disabilities, whose average health care spending is about five times higher than that of children and other adults. Some per capita cap proposals claim to address this issue by setting separate caps for seniors and other beneficiary groups. But as the baby boomers age, a growing share of seniors will move from "young-old age" to

[17] See U.S. Senate Finance Committee, "The Price of Sovaldi and the Impact on the U.S. Health Care System," December 2015, https://www.finance.senate.gov/download/the-price-of-sovaldi-and-its-impact-on-the-us-health-care-system-full-report&download=1.

"old-old age." People in their 80s or 90s have more serious and chronic health care problems and are more likely to require costly nursing home and other long-term care than younger seniors. In 2011 (the latest year for which these data are available), seniors aged 85 and older incurred average Medicaid costs more than 2.5 times higher than those of beneficiaries aged 65 to 74.[18] Under current law, federal funding automatically rises when per-person Medicaid costs increase; but under a per capita cap or a block grant, states would be responsible for all of the increase.

Either a Per Capita Cap or a Block Grant Would Likely Impede, Rather than Enhance, State Innovation

While proponents often promote per capita caps and block grants as a way to give states greater flexibility and help them reduce health care costs, shifting costs to states would actually *reduce* state flexibility to institute reforms that can improve the quality of care and lower costs down the road. Today, the federal government is partnering with states to make *upfront investments* designed to reduce long-term health care costs, while improving health care quality. Under a per capita cap or block grant that squeezes federal funding, however, it would become considerably more difficult for states to find the resources for such investments. The innovations states are now making include:

- **Delivery system reform waivers.** Nine states are using waivers to advance delivery system reforms that leverage federal funding to create systems where Medicaid providers are paid based on their success in delivering high-quality, efficient care.[19]
- **Substance use disorder waivers.** States are also using waivers to transform how they provide substance use disorder treatment, including expanding the services Medicaid covers and leveraging federal funding to improve care coordination.
- **Home- and community-based waivers.** States can use waivers to receive federal matching funds to provide long-term services and supports to seniors and people with disabilities in their homes and communities, rather than in nursing homes. More than 275 of these waivers are active nationwide, serving over 1 million individuals, according to the Centers for Medicare & Medicaid Services.[20]
- **Health homes**. The ACA created a new option for states to improve care coordination for people with chronic conditions, including severe mental illness and opioid dependency. States implementing health homes are seeing promising results in reducing costs, such as fewer emergency room visits, while improving quality of care.

Under either a per capita cap or a block grant, these investments and innovations by states would no longer be matched with federal dollars. While it's unclear whether the proposal the House is contemplating would allow states to maintain federal funding for innovations already underway, Table 3 shows some of the types of state programs that could be at risk — and that would become more difficult to initiate going forward under a per capita cap or block grant.

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[18] CBPP analysis of fiscal year 2011 Medicaid Statistical Information System data.

[19] CMS, "Medicaid and CHIP: Strengthening Coverage, Improving Health," January 2017, https://www.medicaid.gov/medicaid/program-information/downloads/accomplishments-report.pdf.

[20] *Ibid.*

TABLE 1

Cutting Enhanced Matching for the Medicaid Expansion Group Would Be a Huge Financial Loss for States

State	2019, federal $ for expansion group (in $millions)		2019, state $ for expansion group (in $millions)		Additional state costs to maintain expansion (in $millions)	Increase in state costs to maintain expansion
	Under current matching rules	If matching rate reduced*	Under current matching rules	If matching rate reduced*		
Expansion states**	**78,217.4**	**46,160.2**	**5,887.3**	**37,944.5**	**32,057.2**	**545%**
Alaska**	**	**	**	**	**	**
Arizona	2,596.2	1,932.9	195.4	858.7	663.3	339%
Arkansas	1,375.0	1,030.4	103.5	448.1	344.6	333%
California	20,264.4	10,894.9	1,525.3	10,894.9	9,369.6	614%
Colorado	1,366.6	735.0	102.9	734.4	631.6	614%
Connecticut	1.373.4	738.4	103.4	738.4	635.0	614%
Delaware	474.3	276.4	35.7	233.6	197.9	554%
DC	345.0	259.7	26.0	111.3	85.3	329%
Hawaii	575.9	340.1	43.3	279.1	235.7	544%
Illinois	3,152.6	1,739.0	237.3	1,650.9	1,413.6	596%
Indiana	1,427.2	1,024.2	107.4	510.4	403.0	375%
Iowa	814.4	496.9	61.3	378.9	317.6	518%
Kentucky	2,940.8	2,228.0	221.3	934.1	712.7	322%
Louisiana**	**	**	**	**	**	**
Maryland	1,768.4	950.8	133.1	950.8	817.7	614%
Massachusetts	3,601.7	1,936.4	271.1	1,936.4	1,665.3	614%
Michigan	3,305.7	2,315.8	248.8	1,238.8	989.9	398%
Minnesota	1,762.4	947.5	132.7	947.5	814.9	614%
Montana**	**	**	**	**	**	**
Nevada	917.1	637.7	69.0	348.4	279.4	405%
New Hampshire	281.7	151.5	21.2	151.5	130.3	614%
New Jersey	2,872.6	1,544.4	216.2	1,544.4	1,328.2	614%
New Mexico	1,418.3	1,084.8	106.8	440.3	333.5	312%

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State	2019, federal $ for expansion group (in $millions)		2019, state $ for expansion group (in $millions)		Additional state costs to maintain expansion (in $millions)	Increase in state costs to maintain expansion
	Under current matching rules	If matching rate reduced*	Under current matching rules	If matching rate reduced*		
New York	12,349.4	6,639.4	929.5	6,639.4	5,709.9	614%
North Dakota	240.2	129.1	18.1	129.1	111.0	614%
Ohio	3,726.3	2,497.0	280.5	1,509.7	1,229.3	438%
Oregon	2,753.1	1,908.5	207.2	1,051.8	844.6	408%
Pennsylvania	1,963.1	1,093.0	147.8	1,017.9	870.1	589%
Rhode Island	459.0	251.8	34.6	241.8	207.2	600%
Vermont	314.3	184.0	23.7	153.9	130.2	551%
Washington	3,091.0	1,661.8	232.7	1,661.8	1,429.2	614%
West Virginia	687.2	530.5	51.7	208.4	156.7	303%

Shaded states are "trigger states" — those states with laws that either trigger termination of the expansion if the enhanced federal Medicaid matching rate decreases, or require the state to take steps to not increase state costs, meaning that federal funding cuts would end the expansion even without additional action by state policymakers.

* House Republican proposals would reduce the federal matching rate for the low-income adult Medicaid expansion group to states' standard Medicaid matching rate.

** Alaska, Louisiana, and Montana have expanded Medicaid but are not included in this analysis as relevant data are not available yet.

Source. CBPP analysis using Centers for Medicare & Medicaid Services administrative spending data, Department of Health and Human Services federal matching rate data, and CMS Office of the Actuary health care cost projections. It is assumed that states' federal FY2019 standard matching rates are identical to those for federal FY2017.

TABLE 2

Nearly 11 Million Newly Eligible People Enrolled in Medicaid Expansion in 2015

State	Total Expansion Enrollment	Newly Eligible Expansion Enrollment*
Expansion states**	**14,054,100**	**10,728,200**
Alaska	8,500	8,500
Arizona	413,000	105,700
Arkansas	291,600	266,700
California	3,466,100	3,466,100
Colorado	347,800	346,200
Connecticut	201,000	187,000
Delaware	61,300	10,100
DC	62,000	62,000
Hawaii	107,500	34,300
Illinois	671,100	654,400
Indiana	361,700	222,400
Iowa	146,300	136,100
Kentucky	439,000	439,000
Louisiana**	**	**
Maryland	260,200	260,200
Massachusetts	410,900	0
Michigan	613,800	579,400
Minnesota	208,500	207,700
Montana**	**	**
Nevada	187,100	187,100
New Hampshire	49,000	48,800
New Jersey	532,900	532,900
New Mexico	235,400	235,400
New York	2,276,900	285,600
North Dakota**	**	**
Ohio	665,900	618,200
Oregon	546,400	474,800
Pennsylvania	603,300	548,000
Rhode Island	59,300	59,300
Vermont	60,700	0
Washington	592,100	577,400
West Virginia	175,000	175,000

Shaded states are "trigger states" — those states with laws that either trigger termination of the expansion if the enhanced federal Medicaid matching rate decreases, or require the state to take steps to not increase state costs, meaning that federal funding cuts would end the expansion even without additional action by state policymakers.

* "Newly eligible" refers to those low-income adults made eligible for Medicaid under the Affordable Care Act's option for states to expand coverage to those adults with income up to 138 percent of the federal poverty line.

** Louisiana, Montana, and North Dakota have expanded Medicaid, but expansion enrollment data are not yet available for these states.

Source. Kaiser Family Foundation

TABLE 3

Per Capita Cap or Block Grant Could Endanger Medicaid Innovations in Nearly Every State

State	Delivery System Reform Waiver	Substance Use Disorder Waiver	Home and Community-Based Services Waiver/s	Health Homes[1]
Alabama	X		X	X
Alaska			X	
Arizona[2]	X			
Arkansas			X	
California	X	X	X	
Colorado			X	
Connecticut			X	X
Delaware			X	
District of Columbia			X	X
Florida			X	
Georgia			X	
Hawaii[2]				
Idaho			X	
Illinois[3]		X	X	
Indiana[3]		X	X	
Iowa			X	X
Kansas	X		X	
Kentucky			X	
Louisiana			X	
Maine			X	X
Maryland		X	X	X
Massachusetts	X	X	X	
Michigan[3]		X	X	
Minnesota			X	X
Missouri		X	X	X
Mississippi			X	
Montana			X	
Nebraska			X	
Nevada			X	
New Hampshire	X		X	
New Jersey	X		X	X
New Mexico	X		X	X
New York	X		X	X
North Carolina			X	X
North Dakota			X	
Ohio			X	X

TABLE 3

Per Capita Cap or Block Grant Could Endanger Medicaid Innovations in Nearly Every State

State	Delivery System Reform Waiver	Substance Use Disorder Waiver	Home and Community-Based Services Waiver/s	Health Homes[1]
Oklahoma			X	X
Oregon	X		X	
Pennsylvania			X	
Rhode Island[2]	X			X
South Carolina			X	
South Dakota			X	X
Tennessee			X	
Texas	X		X	
Utah			X	
Vermont[2]	X			X
Virginia		X	X	
Washington	X		X	X
Wisconsin			X	X
West Virginia[3]		X	X	X

Source: CBPP analysis using health home and sections 1115 and 1915(c) waiver data from the Centers for Medicare & Medicaid Services.

[1] Authorized under section 2703 of the ACA.

[2] Arizona, Hawaii, Rhode Island, and Vermont offer HCBS through their section 1115 waivers rather than through section 1915(c) waivers.

[3] Under consideration at Centers for Medicare &Medicaid Services as of the date of this paper.