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House Republican Health Bill Would Effectively End ACA Medicaid Expansion

Provision Would Shift Hundreds of Billions in Unaffordable Costs to States

By Matt Broaddus and Edwin Park

The American Health Care Act (AHCA), which the House passed on May 4, would cut federal Medicaid spending by $834 billion over ten years by both radically restructuring federal Medicaid financing and ending enhanced federal funding for the Affordable Care Act's (ACA) Medicaid expansion, Congressional Budget Office estimates show. New CBPP state-level estimates show that the AHCA's cost shift to states would require them to come up with tens of billions more in annual funding from their own budgets in order to maintain their expansions. In practice, states very likely wouldn't be able to absorb these additional costs. The House Republican proposal would thus effectively end the Medicaid expansion now in effect in most or all of the 31 states and Washington, D.C. and preclude other states from adopting the expansion. As a result, the 11 million newly eligible low-income adults who have enrolled in Medicaid under the expansion would be at severe risk of becoming uninsured.[1]

Some Senate Republicans are reportedly considering phasing out federal funding for the expansion more slowly.[2] But while described by some as a compromise, that approach would have no effect on the AHCA's ultimate impact on low-income adults, states, and hospitals and other health care providers that have benefited from the ACA's Medicaid expansion. Delaying or phasing in the cost shift to the states under the AHCA would not stop the eventual end of the expansion and steep reductions in Medicaid enrollment. The bill still would reverse the historic gains in health coverage and access to care that have been made under the expansion.

[1] The AHCA also fundamentally alters the financing structure of Medicaid by converting the program to a per capita cap or block grant, shifting additional costs to states and threatening coverage for all Medicaid enrollees. For more detailed projections of the AHCA's impact on Medicaid financing and enrollment, see Congressional Budget Office, March 23, 2017, https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628.pdf. For more on the bill's overall effects on Medicaid, see "House Health Care Bill Ends Medicaid as We Know It," Center on Budget and Policy Priorities, updated May 25, 2017, http://www.cbpp.org/research/health/house-health-care-bill-ends-medicaid-as-we-know-it.

[2] Rachana Pradhan, "GOP Idea for Phasing Out Medicaid Expansion Could Backfire," PoliticoPro, May 18, 2017.

End of Medicaid Expansion Would Reverse Historic Health Coverage Gains

The ACA gave states the option, starting in 2014, to extend Medicaid coverage to low-income adults with income under 138 percent of the federal poverty line ($24,600 for a family of four in 2017[3]). Louisiana was the most recent state to adopt the expansion, joining 30 other states and Washington, D.C. in July 2016. The federal government finances health coverage for these adults at an *enhanced matching rate*, paying for at least 90 percent of expansion costs on a permanent basis.[4] The results have been striking. The uninsured rate among non-elderly adults in Medicaid expansion states has been cut in half — falling from 18.4 percent in 2013 to 9.2 percent in 2016.[5]

Under the AHCA, however, starting on January 1, 2020, the federal government would pay only the regular Medicaid matching rate — which averages 57 percent — rather than 90 percent for any new expansion enrollees. (Those already enrolled as of the end of 2019 would continue to receive the enhanced matching rate as long as they remain continuously enrolled.) States that want to continue enrolling low-income adults in expanded Medicaid coverage after 2019 thus would have to pay 2.8 to 5 times more from their own funds for each new enrollee, relative to current law. This higher cost would also apply to current enrollees who leave Medicaid for a month or more when their income rises but later seek to reenroll when they fall on hard times.

Most adult Medicaid enrollees see their incomes fluctuate and thus use the program for relatively short spells, so the higher state costs would apply to most of a state's expansion program within just two or three years. Moreover, while under the ACA, states must redetermine eligibility for expansion adults annually, the AHCA would require them to do so every six months starting in October 2017, which would accelerate the declines in enrollment. More frequent eligibility redeterminations have been found to lead many *eligible* people to experience coverage gaps if, for example, they move and don't receive their redetermination paperwork in time.

CBO estimates that more than two-thirds of those enrolled in the Medicaid expansion at the end of 2019 would fall off the program by the end of 2021 and that *fewer than 5 percent would remain on Medicaid by the end of 2024*.[6]

By eliminating the enhanced federal funding for new enrollees, the AHCA would require states either to sharply increase their own spending or to end the expansion. States' costs for the expansion population would more than triple by 2021; they would increase by an estimated $20.6 billion, or 206 percent, across the expansion states in 2021 alone. The higher costs would range

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[3] Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, https://aspe.hhs.gov/poverty-guidelines.

[4] Under the ACA, the federal government financed 100 percent of the cost of states' Medicaid expansions to low-income adults for 2014 through 2016. From 2017 through 2020, the federal matching rate declines each year, stabilizing at 90 percent in perpetuity.

[5] Robin Cohen, Emily Zammitti, and Michael Martinez, "Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2016," National Center for Health Statistics, May 2017, https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201705.pdf.

[6] Congressional Budget Office, "American Health Care Act," March 13, 2017, https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf.

from an estimated 104 percent increase in state funding for the expansion population in West Virginia to a 262 percent increase in Massachusetts. (See Table 1.)

By 2023, states would see a four-fold increase in costs relative to current law: costs would increase by $35 billion, or by 304 percent, across the expansion states — ranging from an estimated 157 percent increase in West Virginia to a 357 percent increase in Massachusetts. The cost shift would grow progressively larger over time.[7] (See Table 2.)

Moreover, eight states have laws that *effectively require their Medicaid expansions to end* if federal financial support for the expansion falls. In these states, expansion would thus end in 2020.[8] And in practice, few if any states could absorb the large cost shifts that would result from the AHCA. As a result, most or all other expansion states would likely freeze enrollment for new enrollees, as the AHCA would allow, with their expansions virtually disappearing within a few years. This would reverse the historic gains in health coverage and access to care under the expansion.

Delaying Expansion-Related Provision Won't Keep Expansion Intact

Phasing in the AHCA's sharp reduction in the federal matching rate for the Medicaid expansion population over several years, or delaying the reduction, as some Senate Republicans reportedly are considering,[9] would not keep the AHCA from eventually ending the expansion and causing millions of low-income people to lose Medicaid coverage.

Under the AHCA, implementing the lower matching rate starting in 2020 would result in only an estimated 100,000 of the 11.1 million low-income adults currently enrolled in the Medicaid expansion — or only about 1 percent — remaining at the enhanced expansion matching rate by the end of 2027. Starting implementation in 2020 but phasing down the expansion matching rate for new enrollees over several years would ultimately produce the *exact* same result as under the AHCA: just 100,000 people would remain at the enhanced expansion matching rate by 2027. Delaying implementation until 2022 would only modestly increase the number of grandfathered enrollees receiving the expansion match to 300,000 of the total 11.1 million current Medicaid expansion enrollees — fewer than 3 percent of them — by the end of 2027.[10] (See Figure 1.)

Moreover, by 2025, the cost shift to states would be almost as large under the delayed implementation approach as under the current version of the AHCA. In states that chose to freeze their expansion enrollment, enrollment would fall by more than 66 percent by 2023 and by more than 90 percent by 2025.

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[7] CBPP estimates based on Centers for Medicare & Medicaid Services (CMS) Medicaid spending data, CMS projections of health care cost growth among the Medicaid expansion population, states' federal fiscal year 2017 Medicaid matching rates, and CBO estimates of Medicaid enrollment churn over time.

[8] These eight states are Arkansas, Illinois, Indiana, Michigan, Montana, New Hampshire, New Mexico, and Washington. Reduced federal funding would trigger immediate or eventual termination of the Medicaid expansion in these states without additional action by state policymakers. Laws in these states generally either require the expansion to end if the federal Medicaid matching rate decreases or require the state to act to prevent an increase in state Medicaid costs.

[9] Stephanie Armour and Kristina Peterson, "Senate Conservatives Look to Cut Medicaid," *Wall Street Journal*, May 14, 2017, https://www.wsj.com/articles/senate-conservatives-look-to-slash-medicaid-1494759603.

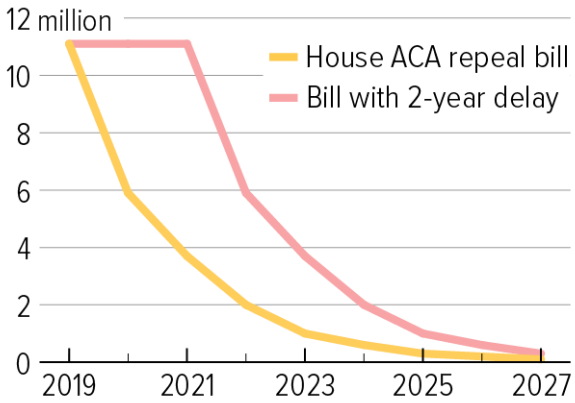
[10] CBPP calculation based on CMS Medicaid expansion population enrollment estimates and CBO estimates of Medicaid enrollment churn over time.

Notably, the federal savings from cutting the Medicaid expansion, in combination with the provision to convert virtually the entire Medicaid program to a per capita cap or block grant, would help pay for the AHCA's large tax cuts for people with very high incomes, drug companies, insurance companies, and other industries. People at the top of the income scale would receive multi-million-dollar tax cuts even as 23 million more people became uninsured and millions more were left without access to needed care.[11]

FIGURE 1

Delaying End of Higher Federal Funding for ACA Medicaid Expansion Enrollees Wouldn't Mitigate Eventual Harm

ACA Medicaid expansion enrollees who are eligible for continued enhanced federal funding rate



Note: ACA = Affordable Care Act. The ACA provided enhanced federal funding to cover the costs of Medicaid enrollees under the ACA's Medicaid expansion. The House-passed ACA repeal bill would lower that federal funding rate for expansion enrollees in 2020. Some Senate Republicans are considering delaying that provision for two years.

Source: CBPP analysis, Based on Centers for Medicare & Medicaid Services data and Congressional Budget Office assumptions about enrollment

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[11] Chye-Ching Huang and Brandon DeBot, "House Health Bill: Tax Cuts for Wealthy, Insurers, and Drug Companies Paid for by Low- and Middle Income Families," Center on Budget and Policy Priorities, updated May 22, 2017, http://www.cbpp.org/research/federal-tax/house-health-bill-tax-cuts-for-wealthy-insurers-and-drug-companies-paid-for-by.

TABLE 1

Cutting Enhanced Matching Rate for Medicaid Expansion Would Be a Very Large Cost Shift to States in 2021

State	2021, federal $ for expansion group (in $millions)		2021, 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**	**89,942.0**	**69,363.2**	**9,993.6**	**30,572.4**	**20,616.7**	**206%**
Alaska**	150.0	112.1	16.7	54.6	37.9	227%
Arizona	2,854.4	2,429.8	317.2	741.8	424.6	134%
Arkansas	1,533.1	1,336.3	170.3	367.1	196.8	116%
California	22,594.0	16,882.8	2,510.4	8,221.6	5,711.2	227%
Colorado	1,523.6	1,138.3	169.3	554.6	385.3	228%
Connecticut	1,529.2	1,137.6	169.9	561.5	391.5	230%
Delaware	521.3	387.4	57.9	191.9	133.9	231%
DC	384.4	335.4	42.7	91.7	49.0	115%
Hawaii	638.9	490.7	71.0	219.2	148.2	209%
Illinois	3,512.5	2,647.7	390.3	1,255.1	864.8	222%
Indiana	1,576.3	1,323.7	175.1	427.7	252.6	144%
Iowa	907.2	714.7	100.8	293.3	192.5	191%
Kentucky	3,278.8	2,873.9	364.3	769.2	404.9	111%
Louisiana**	2,647.8	2,184.0	294.2	758.0	463.8	158%
Maryland	1,971.7	1,473.3	219.1	717.5	498.4	227%
Massachusetts	3,952.7	2,802.0	439.2	1,589.8	1,150.7	262%
Michigan	3,683.0	3,100.5	409.2	991.7	582.5	142%
Minnesota	1,965.0	1,468.2	218.3	715.1	496.8	228%
Montana**	439.4	371.6	48.8	116.7	67.9	139%
Nevada	1,022.5	858.9	113.6	277.3	163.7	144%

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	Under current matching rules	If matching rate reduced*	Under current matching rules	If matching rate reduced*		
New Hampshire	314.1	234.5	34.9	114.4	79.5	228%
New Jersey	3,202.8	2,393.2	355.9	1,165.4	809.6	227%
New Mexico	1,581.4	1,392.8	175.7	364.3	188.6	107%
New York	13,570.8	9,664.4	1,507.9	5,414.2	3,906.3	259%
North Dakota	267.7	199.7	29.7	97.7	68.0	229%
Ohio	4,148.7	3,413.2	461.0	1,196.5	735.5	160%
Oregon	3,069.5	2,574.3	341.1	836.3	495.2	145%
Pennsylvania	2,185.3	1,649.6	242.8	778.5	535.7	221%
Rhode Island	511.8	385.7	56.9	182.9	126.1	222%
Vermont	344.9	255.7	38.3	127.5	89.2	233%
Washington	3,443.2	2,565.1	382.6	1,260.6	878.0	230%
West Virginia	766.2	678.1	85.1	173.3	88.1	104%

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 ensure that state costs do not increase, meaning that federal funding cuts would end the expansion even without additional action by state policymakers.

* The American Health Care Act would reduce the federal matching rate for the low-income adult Medicaid expansion group to states' standard Medicaid matching rate.

** Medicaid expansion group expenditure totals are not available for Alaska, Louisiana, and Montana, so CBPP generates estimates based on available state-level data and adjusted national-level averages.

Sources: CBPP analysis using Centers for Medicare & Medicaid Services (CMS) 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 fiscal year 2021 standard matching rates are identical to those for federal fiscal year 2017 and that expansion enrollment remains steady in each state

TABLE 2

Cutting Enhanced Matching Rate for Medicaid Expansion Would Be an Even Bigger Cost Shift to States in 2023

State	2023, federal $ for expansion group (in $millions)		2023, 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**	**103,554.5**	**68,605.9**	**11,506.0**	**46,454.5**	**35,015.2**	**304%**
Alaska**	173.5	106.8	19.3	86.0	66.7	346%
Arizona	3,244.7	2,579.4	360.5	1,025.8	665.3	185%
Arkansas	1,773.9	1,427.5	197.1	543.4	346.3	176%
California	26,141.7	16,090.0	2,904.6	12,956.3	10,051.7	346%
Colorado	1,762.6	1,085.1	195.8	873.4	677.5	346%
Connecticut	1,766.3	1,085.4	196.3	877.2	680.9	347%
Delaware	592.5	382.9	65.8	275.4	209.6	318%
DC	444.3	358.7	49.4	134.9	85.6	173%
Hawaii	734.7	484.7	81.6	331.7	250.0	306%
Illinois	4,060.4	2,547.8	451.2	1,963.7	1,512.6	335%
Indiana	1,802.2	1,391.9	200.2	610.6	410.4	205%
Iowa	1,048.3	712.5	116.5	452.3	335.8	288%
Kentucky	3,793.7	3,081.1	421.5	1,134.1	712.6	169%
Louisiana**	3,063.5	2,247.2	340.4	1,156.7	816.3	240%
Maryland	2,281.3	1,404.1	253.5	1,130.7	877.2	346%
Massachusetts	4,482.4	2,705.2	498.0	2,275.3	1,777.3	357%
Michigan	4,257.3	3,238.9	473.0	1,491.5	1,018.4	215%
Minnesota	2,273.4	1,399.3	252.6	1,126.8	874.2	346%
Montana**	508.5	389.0	56.5	175.9	119.5	211%
Nevada	1,183.1	895.0	131.5	419.5	288.1	219%
New Hampshire	363.3	223.6	40.4	180.1	139.7	346%
New Jersey	3,705.7	2,280.8	411.7	1,836.6	1,424.9	346%

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	Under current matching rules	If matching rate reduced*	Under current matching rules	If matching rate reduced*		
New Mexico	1,829.7	1,497.8	203.3	535.2	331.9	163%
New York	15,416.0	9,319.6	1,712.9	7,809.3	6,096.4	356%
North Dakota	309.5	190.4	34.4	153.5	119.1	346%
Ohio	4,791.6	3,513.2	532.4	1,810.8	1,278.4	240%
Oregon	3,551.5	2,679.9	394.6	1,266.2	871.6	221%
Pennsylvania	2,523.5	1,593.5	280.4	1,210.3	929.9	332%
Rhode Island	592.2	370.3	65.8	287.7	221.9	337%
Vermont	391.1	253.3	43.5	181.2	137.8	317%
Washington	3,979.2	2,446.4	442.1	1,974.9	1,532.8	347%
West Virginia	886.5	731.4	98.5	253.6	155.1	157%

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 ensure that state costs do not increase, meaning that federal funding cuts would end the expansion even without additional action by state policymakers.

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