



P.O. Box 60
Jefferson City, MO 65102

573/893-3700
www.mhanet.com



The American Health Care Act Fails to Restore Parity in Medicaid Spending for Nonexpansion States

Mat Reidhead
Vice President of Research
and Analytics

Lawmakers in the U.S. Senate are again faced with a difficult decision on the repeal and replacement of the Patient Protection and Affordable Care Act. A recent article from *The Washington Post* asserts that “the most powerful bloc in the Senate, based on the size and clout of its members, are the Republicans who come from states that took advantage of the 2010 health law’s federal expansion of Medicaid to provide insurance to millions of lower-income Americans.” It goes on to say that “they are certain to become the driving force in whatever happens in the Senate’s consideration of health-care legislation.”¹

This analysis is designed to inform senators from nonexpansion states during deliberations on the House of Representatives’ version of the AHCA. *The Washington Post* notes that there are 20 members of the coalition representing Senate Republicans from expansion states. There are 32 Republican senators representing nonexpansion states.

The findings of this study suggest that the opportunity cost surrounding the decision not to expand Medicaid far outweighs the compensatory relief funding written into the AHCA for the 19 remaining nonexpansion states.

The House of Representatives did acknowledge the divide between expansion and nonexpansion states, and took action to close this gap. **However, this analysis suggests that the compensatory measures for nonexpansion states in the AHCA falls more than \$680 billion short of providing true equity and fairness in the system for states that opted out of Medicaid expansion.**

Executive Summary

The AHCA is projected to reduce federal spending on Medicaid by \$834 billion between 2017 and 2026. While the House of Representatives wrote assurances into the AHCA to restore equity in Medicaid spending for the 19 remaining states that have opted out of Medicaid expansion under the current law, little is known on the extent to which those compensatory provisions will return states to a level playing field with respect to federal spending on the program. This policy brief seeks to illuminate such questions using historical expenditures data and the Congressional Budget Office's scoring of the AHCA as passed by the House of Representatives on May 4, 2017.

The analysis suggests that by 2025, these states will have foregone an additional \$683.9 billion in net federal outlays for Medicaid, compared to states that have opted to expand the program under the existing law. **These estimates project that federal spending on Medicaid in expansion states by 2025 will be \$1,936 per capita compared to \$1,158 in nonexpansion states — a relative difference of 67 percent.**

The disparate findings for nonexpansion states in future federal funding under the AHCA hold true after accounting for restored disproportionate share funding, allocating 92.8 percent of the total projected cuts to expansion states, and distribution of the \$10 billion safety-net fund to nonexpansion states.

Background

The landmark June 2012 Supreme Court decision on the states' option to expand Medicaid under the ACA posed a difficult dilemma. Lawmakers could reject federal funds, while subsidizing expansion in other states, or accept enhanced federal matching funds to expand health coverage to thousands of lower-income constituents.

The opportunity cost for the 19 remaining states opting to forego expansion has been high. According to the Centers for Medicare & Medicaid Services' expenditure reports, **expansion states received an additional \$113.6 billion in federal Medicaid outlays during the first two years of expansion.**

Since that time, the expansion decision has become a purple phenomenon, with many traditionally conservative swing and red states adopting full expansion or tailored conservative models under Section 1115 waivers. In addition, new research shows that increased Medicaid spending in expansion states was borne almost entirely by federal funding, and changes in state spending resulting from "woodwork" or other expansion-induced effects were largely insignificant.² Finally, 4.5 million non-elderly uninsured adults in nonexpansion states would gain coverage with expanded Medicaid, and more than half of those (59 percent) fall into the coverage gap and are not eligible for subsidized coverage through marketplace enrollment.³

The AHCA, passed by the U.S. House of Representatives on May 4, 2017, proposes significant changes to the Medicaid delivery system.⁴ Beginning in 2020, the bill would sunset the enhanced federal match rate of 90 percent for expansion beneficiaries, typically individuals between traditional Medicaid eligibility and 138 percent of the federal poverty level. The bill also includes provisions requiring continuous enrollment for grandfathered beneficiaries of the Enhanced Federal Medical Assistance Percentage — the CBO estimates that more than 95 percent of expansion beneficiaries would churn out of the program by 2025 under this provision.⁵ Most significantly, the AHCA caps federal spending on the program in 2020 by converting inflation-adjusted spending into capped funding models for states. The baseline year used to determine the per capita amounts for each state is 2016 — three years after the enactment of Medicaid expansion. **Altogether, the CBO estimates that the AHCA would reduce federal outlays for Medicaid by \$834 billion between 2017 and 2026.**⁶

While the AHCA does include compensatory provisions to nonexpansion states through a \$10 billion safety-net fund and a portion of \$31.2 billion in restored Medicaid DSH cuts, these provisions fall far short of achieving equity among the states.

Using historic and projected federal Medicaid spending data, this policy brief examines the potential impact of the Medicaid-related provisions of the AHCA for expansion and nonexpansion states between 2017 and 2025.

Results

Despite the disproportionate burden of the estimated reductions in federal spending on Medicaid under the AHCA, the \$10 billion in compensatory nonexpansion safety-net funding and early DSH relief, **states that have opted to expand Medicaid under the ACA are estimated to receive significantly larger shares of federal Medicaid spending under the AHCA.**

This is largely due to the extreme growth in Medicaid spending observed during the first two years of the program, and projected to continue until the major provisions of the AHCA are enacted in 2020.

On a per capita basis, net federal expenditures for full-expansion states increased 91 percent between 2013 and 2015, while partial-expansion (1115 waiver) states experienced 71 percent growth and nonexpansion states saw just a 13 percent increase. Combined, in 2015, Medicaid expansion states received \$1,578 per capita in federal Medicaid spending compared to \$753 per capita in nonexpansion states — a relative difference of 110 percent (Figure 1 and Table 1).

Figure 1: AHCA Per Capita Federal Net Medicaid Expenditures by Expansion Status

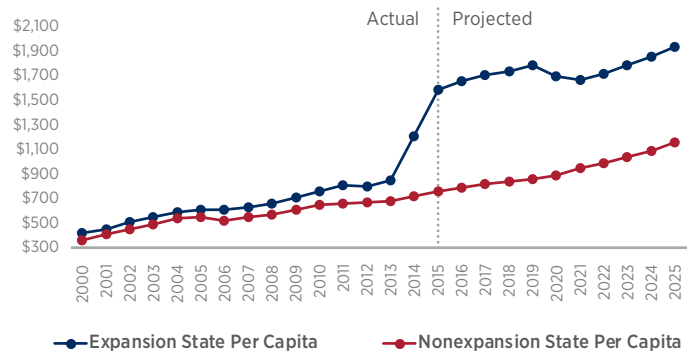


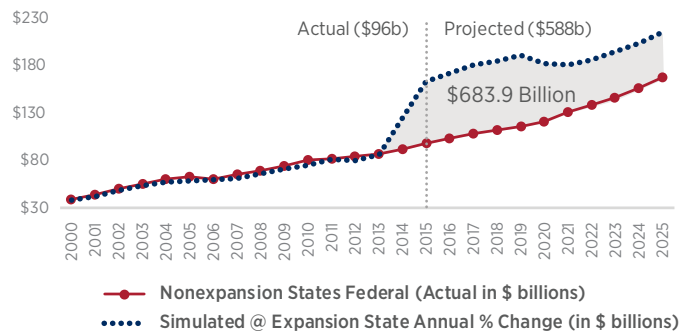
Table 1: Actual and Projected Net Federal Medicaid Expenditures Per Capita Under the AHCA by State Expansion Status

	ACTUAL			PROJECTED									
	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Nonexpansion States	\$681	\$716	\$753	\$785	\$819	\$841	\$859	\$882	\$949	\$988	\$1,031	\$1,089	\$1,158
Full Medicaid Expansion	\$855	\$1,231	\$1,616	\$1,694	\$1,756	\$1,784	\$1,837	\$1,741	\$1,718	\$1,763	\$1,835	\$1,908	\$2,000
% Difference Nonexpansion	26%	72%	114%	116%	114%	112%	114%	98%	81%	78%	78%	75%	73%
1115 Waiver Expansion	\$818	\$1,086	\$1,386	\$1,451	\$1,448	\$1,468	\$1,508	\$1,428	\$1,405	\$1,439	\$1,494	\$1,550	\$1,620
% Difference Nonexpansion	20%	52%	84%	85%	77%	75%	76%	62%	48%	46%	45%	42%	40%
All Expansion States	\$849	\$1,208	\$1,578	\$1,655	\$1,705	\$1,732	\$1,782	\$1,689	\$1,665	\$1,709	\$1,777	\$1,847	\$1,936
% Difference Nonexpansion	25%	69%	110%	111%	108%	106%	107%	92%	75%	73%	72%	70%	67%

And despite provisions of the AHCA to restore parity in Medicaid spending for nonexpansion states, **this analysis suggests that they will not recover from their extremely disadvantaged starting point in 2020, when the major provisions of the AHCA are enacted.** The per capita federal spending for expansion states is projected to slow between 2016 and 2019; then experience a significant reduction between 2020 and 2021; however, by 2025, their per capita federal spending on Medicaid is still projected to be 67 percent higher than in nonexpansion states (Table 1).

By simulating the actual and projected federal Medicaid spending in nonexpansion states using annual percentage changes experienced in expansion states, it is estimated that nonexpansion states will have collectively foregone \$683.9 billion in federal Medicaid spending under the AHCA by 2025. This includes an actual difference of \$96 billion observed during the first two years of Medicaid expansion, and a projected additional \$588 billion between 2016 and 2025 (Figure 2).

Figure 2: AHCA Federal Net Medicaid Expenditures for Nonexpansion States (Actual vs. Simulated at Annual % Change for Expansion States)



Data and Sources

Historical state and federal Medicaid expenditures data at the state level for 2000-2015 were gathered from CMS-64 Expenditure Reports and served as the historical basis of projected Medicaid spending estimates.⁷ Projected total Medicaid expenditures for 2016-2025 for the U.S. were obtained from the CMS Office of the Actuary, National Health Expenditures Accounts files.⁸ Projected Medicaid budgetary effects of the AHCA between 2017 and 2025 were taken from the CBO and Joint Committee on Taxation analysis, Cost Estimate of the American Health Care Act as Passed by the House of Representatives on May 4, 2017.⁹ Projections for state-level total population and population living below 138 percent FPL, which are used to distribute the nonexpansion state safety-net fund between 2018 and 2022, were retrieved from the U.S. Census Bureau.¹⁰ Finally, information on state expansion decisions — full expansion, partial expansion under a Section 1115 waiver, or nonexpansion — were obtained from the Kaiser Family Foundation, Status of State Action on the Medicaid Expansion Report.¹¹ States opting to expand Medicaid in 2016 or later were kept in the nonexpansion group because historic federal expenditures data from CMS were only available through 2015, which captured the actual effects of the first two years of the program in expansion states.

Methods

To simulate the effects of the AHCA compared to the current law, net federal Medicaid expenditures were projected under the ACA status quo compared to the CBO-estimated \$834 billion reduction in federal outlays between 2017 and 2026. First, historical net federal expenditures data were gathered from the CMS-64 Expenditure Reports between fiscal years 2000

and 2015. These data include information on net federal outlays for the traditional and expanded Medicaid populations at the state level. Beginning in 2016 and carried through to 2025, each state's federal Medicaid expenditures were adjusted to reflect increased program spending estimates from the CMS Office of the Actuary, using actual expenditures from 2015 as a basis for projections. Beginning in 2017, the EFMAP for expansion state Title VIII ACA spending was reduced from 100 to 95 percent, and gradually reduced to 90 percent by 2020 as codified under the existing law.

Beginning in 2018, the provisions of the AHCA were distributed across states using the annual CBO scores for the program under the proposed law. Between 2018 and 2022, \$10 billion in nonexpansion state safety-net funding was distributed across nonexpansion states in proportion to each state's population under 138 percent FPL among all nonexpansion states. Medicaid DSH cuts provisioned under the ACA also were restored beginning in 2018, and redistributed to states in accordance with the annual CBO estimates and provisions of the AHCA.

To project the estimated impact of the major provisions of the AHCA for expansion and nonexpansion states, the total CBO estimates for reduced federal outlays on Medicaid were divided into reduced spending resulting from EFMAP attrition and other reductions. Because of the large estimated attrition from EFMAP beginning in 2020, a large majority of the reduced federal spending on Medicaid under the AHCA was distributed across expansion states in proportion to their actual share of federal spending on expanded Medicaid in 2015. As a result, this analysis estimates that expansion states would shoulder 92.8 percent of the total CBO-estimated reduction of \$834 billion between 2017 and 2026, while nonexpansion states would experience just 7.2 percent of the overall reduction.

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