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Changes to Medicaid Expansion in the American Health Care Act:
State-by-State Estimates of the Coverage and Fiscal Impact

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The House currently is considering the American Health Care Act (AHCA), a bill to repeal and replace the Affordable Care Act (ACA). Among other things, the bill would phase out enhanced federal funding for the expansion of Medicaid to low-income adults with income below 138 percent of the federal poverty line. Currently, more than 14 million low-income parents and adults without children are covered under expansion in 32 states (including the District of Columbia).[1] The remaining 19 states have not yet expanded Medicaid and would be precluded from receiving enhanced federal funding to do so under the AHCA.[2] In this analysis, we provide state-by-state estimates of the impact of the loss of enhanced federal funding on coverage and federal Medicaid expenditures in the expansion states.

I. Key Results

Assuming expansion states limit coverage to those for whom enhanced federal funding is available, there will be significant impacts on both coverage and federal Medicaid funding in short order.

- **The loss of coverage under the House bill due to changes in expansion financing could rapidly reach 14 million**. If expansion states limit their coverage of adults to those for whom enhanced federal funding is available ("grandfathered" individuals), the AHCA will rapidly result in large coverage losses. In fiscal year (FY) 2020, an average of 4.6 million fewer people would be enrolled than under current law. The coverage losses would reach 8.9 million in FY 2021, 11.6 million in FY 2022, 13 million in FY 2023, and 13.9 million in FY 2024. In FY 2024, this means that fewer than 5 percent of the original grandfathered enrollees will remain in Medicaid.

- **By FY 2026, the 32 states with Medicaid expansion will lose a third of their federal Medicaid expenditures.** As the availability of enhanced funding for expansion adults dwindles, these states will lose a substantial share of their federal Medicaid funding. As early as FY 2020, they will see an 11 percent drop in their total federal Medicaid expenditures. The loss would more than double by FY 2022 and it would exceed 30

[1] Of the more than 14 million individuals covered by Medicaid expansion, more than 3 million would have qualified under the Medicaid eligibility rules in place prior to Medicaid expansion. Some early (pre-ACA) expansion states receive an incremental increase in the federal match for these enrollees while others receive the regular Medicaid matching rate, rather than the enhanced matching rate, for the cost of providing services to these "already-eligible" adults.

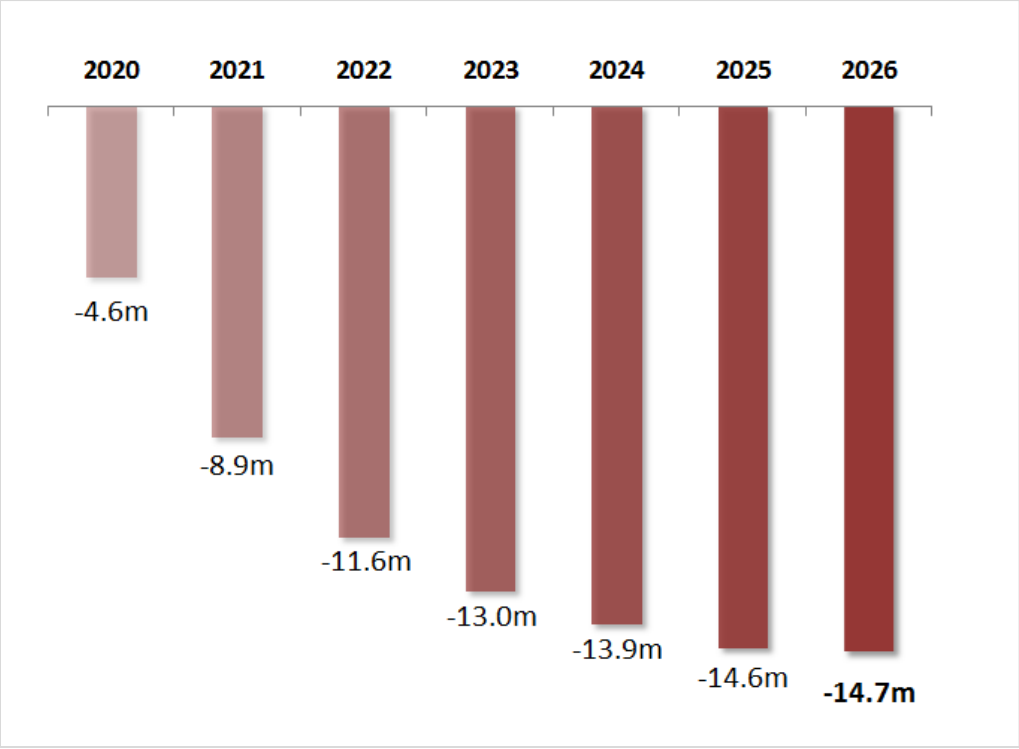
[2] The provision precluding non-expansion states from receiving enhanced federal funding if they adopt an expansion in the future is included in the Manager's Amendment to AHCA released on March 20th, 2017. See https://rules.house.gov/bill/115/hr-1628.

percent in FY 2024 and beyond. Over the FY 2020 – FY 2026 period, expansion states would, on average, see a drop of 26 percent in federal Medicaid expenditures.

- **In some states, the size of the losses is even greater, exceeding 40 percent of federal Medicaid funds.** For some states with particularly significant expansion populations (relative to the size of the rest of their Medicaid programs), the drop in federal Medicaid funding will be even greater. By FY 2026, Kentucky, Montana, Oregon and Washington are expected to lose 40 percent or more of their federal Medicaid funding.

It is possible that some states, particularly those with higher per capita incomes and a strong history of coverage, may seek to use their own funds to maintain coverage and prevent a sharp increase in their uninsured rates and the size of the uncompensated care burden faced by their providers. For most states, however, it is likely that the rapid diminution of enhanced federal funding will translate into large coverage losses. Prior to the ACA, when states did have some flexibility to expand coverage to low-income parents at the "regular" Medicaid matching rate, only a handful did so.

Figure 1. Estimated Decrease in Enrollment Assuming Coverage is Maintained Only for "Grandfathered" Expansion Adults, FY 2020-2026



II. Changes to Enhanced Funding in the AHCA

The ACA provided enhanced funding for states to cover low-income adults, who had income above pre-ACA Medicaid eligibility levels but below 138 percent of the federal poverty level ($16,643 for a single individual and $28,180 for a family of three in fiscal year 2017). Under the ACA, the federal government pays all but a small share of the cost of expanding Medicaid to low-income adults – 95 percent in 2017, dropping gradually over time to 90 percent. If the AHCA is adopted, the federal government, in general, would reduce its contribution from this enhanced funding level to the "regular" Medicaid matching rate, which varies from 50 percent to 73 percent among current expansion states. States would continue to receive 90 percent federal funding for the individuals enrolled in Medicaid on December 31, 2019 until they have a break in coverage for more than 30 days. If a state wanted to cover new enrollees or grandfathered adults who churn off and back onto Medicaid, it would need to do so at the much lower regular federal Medicaid matching rate.

III. State-by-State Estimates

This analysis is based on state-level projections of Medicaid spending and enrollment developed by Manatt Health. To model the impact of grandfathering enhanced funding for beneficiaries enrolled as of December 31, 2019, we use Congressional Budget Office (CBO) assumptions that less than one-third of grandfathered enrollees remain in Medicaid by the end of 2022, and that less than 5 percent remain by the end of 2024. These assumptions are consistent with recent state experiences with grandfathering enrollment of low-income adults, particularly when taking into account that AHCA would require more frequent renewals of coverage for expansion adults.[3]

The estimates are intended primarily to illustrate the fiscal and coverage impact of the changes to enhanced federal funding for Medicaid expansion included in AHCA. They are not intended to address all of the provisions of the bill that would affect federal Medicaid expenditures, such as elimination of the individual mandate.[4] Moreover, unlike CBO, which is charged with evaluating the impact of legislation on the federal budget, we do not estimate the share of low-income adults residing in states that would drop expansion or elect not to pursue an expansion as a result of the AHCA. The focus of this analysis is state-by-state estimates, showing the expected fiscal and coverage impact on each state assuming it continues expansion coverage just for those adults for whom enhanced federal funding is available.[5]

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[3] Deborah Bachrach, Jocelyn Guyer, April Grady, Ariel Levin, and Allison Orris, *Medicaid Expansion and Enhanced Match: How Proposals to Grandfather Medicaid Enrollees Could Impact States*, prepared for the State Health Reform Assistance Network, March 2017, http://www.statenetwork.org/wp-content/uploads/2017/03/State-Network-Grandfathered-Medicaid-Enhanced-Match-March-2017.pdf.

[4] One exception is that the estimates take into account the impact of the per capita cap provisions on expenditures in each state.

[5] Although not captured in these estimates, a few states, such as Minnesota and the District of Columbia, also take advantage of a state option in the ACA to coverage low-income adults above 138 percent of the federal poverty line at the regular Medicaid matching rate. Under the AHCA, they would lose the ability to do so, generating a significantly larger fiscal impact and greater loss of coverage than modeled here.

- **Table 1. Estimated Decrease in Medicaid Enrollment Assuming Coverage is Maintained Only for "Grandfathered" Enrollees**

  Table 1 shows the number of low-income adults expected to lose coverage in expansion states if they limit enrollment just to those grandfathered individuals for whom they receive the enhanced matching rate. In short order, "grandfathered" individuals are expected to leave Medicaid as they get jobs, experience changes in family circumstances or lose coverage due to paperwork requirements at renewal. Even if they again fall below 138 percent of the federal poverty line, they will have lost their grandfathered status and be unable to regain coverage. This "churning," or movement on and off coverage, is a well-documented dynamic that will likely accelerate under the AHCA due to provision requiring that expansion adults renew their coverage every six months, rather than once a year as now required.

- **Table 2. Estimated Decrease in Federal Medicaid Funds Assuming Expansion Adult Coverage is Maintained Only for "Grandfathered" Enrollees**

  Table 2 provides estimates of how much each state would lose in federal Medicaid expenditures in FY 2020, FY 2022, FY 2026 and over the FY 2020 – FY 2026 period if they restrict enrollment to grandfathered individuals for whom they receive enhanced funding. The loss of federal funds is presented as a share of each state's total federal Medicaid expenditures under current law in each of these periods. The states in which the loss of expansion funds represents a particularly high share of total federal Medicaid expenditures often are those that had a relatively low income thresholds for adults prior to the ACA.[6] In others, it may be because the "gap" between the state's regular Medicaid matching rate and the enhanced matching rate is particularly sizeable, increasing the impact of expenditures on expansion adults relative to other populations.

III. Conclusion

As policymakers continue their deliberations on the AHCA, it will be important to take the state-specific impact of the Medicaid changes into account. The 32 states with Medicaid expansion are facing significant reductions in federal Medicaid funding. Many are unlikely to be able to replace the lost federal funds, and, as a result, will experience sharp drops in coverage and a rise in the uncompensated care burden faced by their providers.

[6] Prior to the ACA, states could secure regular Medicaid matching funds to expand coverage for low-income parents above historic levels, though only a handful took up the option. States were precluded from covering most non-disabled, non-pregnant adults in the absence of a Medicaid 1115 waiver.

Table 1. Estimated Decrease in Medicaid Enrollment Assuming Coverage Is Maintained Only for "Grandfathered" Expansion Adults Under the AHCA, FY 2020-2026 (thousands)

State	Expansion Adult Enrollment Under Current Law	Decrease in Enrollment Assuming Expansion Adult Coverage is Maintained Only for "Grandfathered" Enrollees**						
	2019*	2020	2021	2022	2023	2024	2025***	2026***
All Expansion States	**14,737**	**-4,598**	**-8,907**	**-11,581**	**-13,030**	**-13,936**	**-14,570**	**-14,663**
Alaska	12	-3	-7	-9	-10	-11	-12	-12
Arizona	433	-115	-257	-347	-398	-432	-457	-465
Arkansas	296	-95	-180	-233	-262	-280	-292	-293
California	3,491	-890	-1,990	-2,671	-3,038	-3,265	-3,422	-3,443
Colorado	415	-107	-237	-318	-361	-388	-407	-409
Connecticut	202	-62	-121	-158	-178	-190	-199	-200
Delaware	64	-16	-36	-49	-56	-60	-63	-63
District of Columbia	64	-16	-36	-49	-55	-60	-62	-63
Hawaii	110	-28	-63	-84	-95	-103	-107	-108
Illinois	679	-193	-399	-526	-595	-637	-667	-670
Indiana	366	-203	-273	-317	-341	-356	-366	-368
Iowa	149	-46	-90	-117	-131	-141	-147	-148
Kentucky	445	-113	-253	-340	-387	-416	-436	-438
Louisiana	397	-101	-226	-304	-346	-371	-389	-391
Maryland	238	-61	-136	-182	-207	-222	-233	-234
Massachusetts	393	-100	-224	-301	-342	-368	-385	-387
Michigan	628	-187	-374	-490	-552	-591	-617	-621
Minnesota	207	-53	-118	-158	-180	-194	-203	-204
Montana	72	-18	-41	-55	-63	-67	-70	-71
Nevada	209	-56	-124	-167	-191	-207	-219	-223
New Hampshire	51	-13	-29	-39	-44	-48	-50	-50
New Jersey	557	-142	-318	-426	-485	-521	-546	-549
New Mexico	241	-61	-137	-184	-210	-225	-236	-237
New York	2,234	-1,074	-1,569	-1,877	-2,045	-2,150	-2,224	-2,236
North Dakota	20	-5	-11	-15	-17	-18	-19	-19
Ohio	690	-213	-415	-540	-608	-650	-679	-683
Oregon	548	-193	-345	-439	-491	-524	-549	-554
Pennsylvania	627	-200	-381	-493	-553	-591	-617	-620
Rhode Island	60	-15	-34	-46	-52	-56	-58	-59
Vermont	63	-16	-36	-48	-54	-59	-61	-62
Washington	599	-154	-344	-463	-528	-570	-600	-606
West Virginia	180	-46	-102	-137	-156	-168	-176	-177

Note: Excludes the territories, and the impact of eliminating the state option to cover adults above 138 percent of the federal poverty line (which would affect the District of Columbia and Minnesota).

*Under current law, the vast majority of adults in this eligibility group receive enhanced federal match; only IN, NY, and OR have more than 10 percent of these adults receiving regular federal match.

**Decrease is relative to current law enrollment in each year. The number of "grandfathered" expansion adults with enhanced match reflects reductions consistent with Congressional Budget Office assumptions that less than one-third of those enrolled as of December 31, 2019, would have maintained continuous eligibility two years later, and that the enhanced federal matching rate would apply for less than 5 percent of expansion adults by the end of 2024.

***Because the decrease is relative to current law enrollment in each year (which increases over time), the 2025 and 2026 decreases may exceed 2019 enrollment in some states.

Source: Manatt Health analysis.

Table 2. Estimated Decrease in Federal Medicaid Funds Assuming Expansion Adult Coverage Is Maintained Only for "Grandfathered" Enrollees Under the AHCA, FY 2020-2026 (millions)

State	Estimated Federal Medicaid Funds for All Enrollees Under Current Law*				Decrease in Federal Medicaid Funds Assuming Expansion Adult Coverage Is Maintained Only for "Grandfathered" Enrollees**							
					2020		2022		2026		2020-2026	
	2020	2022	2026	2020-2026	$	% Decrease in All Federal Medicaid Funds	$	% Decrease in All Federal Medicaid Funds	$	% Decrease in All Federal Medicaid Funds	$	% Decrease in All Federal Medicaid Funds
All Expansion States	**$280,475**	**$309,120**	**$375,187**	**$2,281,901**	**-$29,939**	**-10.7%**	**-$79,528**	**-25.7%**	**-$119,869**	**-31.9%**	**-$599,486**	**-26.3%**
Alaska	$1,013	$1,130	$1,399	$8,390	-$47	-4.7%	-$118	-10.5%	-$183	-13.1%	-$904	-10.8%
Arizona	$11,048	$12,551	$16,188	$94,386	-$1,092	-9.9%	-$3,127	-24.9%	-$5,071	-31.3%	-$24,259	-25.7%
Arkansas	$4,484	$4,932	$5,961	$36,358	-$531	-11.8%	-$1,356	-27.5%	-$2,019	-33.9%	-$10,185	-28.0%
California	$57,178	$63,297	$77,407	$468,270	-$5,495	-9.6%	-$15,986	-25.3%	-$24,235	-31.3%	-$120,338	-25.7%
Colorado	$5,661	$6,257	$7,634	$46,262	-$652	-11.5%	-$1,887	-30.2%	-$2,878	-37.7%	-$14,245	-30.8%
Connecticut	$4,942	$5,426	$6,535	$39,965	-$461	-9.3%	-$1,251	-23.1%	-$1,873	-28.7%	-$9,396	-23.5%
Delaware	$1,555	$1,717	$2,087	$12,678	-$185	-11.9%	-$535	-31.2%	-$813	-39.0%	-$4,033	-31.8%
District of Columbia	$2,009	$2,173	$2,547	$15,878	-$92	-4.6%	-$311	-14.3%	-$484	-19.0%	-$2,355	-14.8%
Hawaii	$1,587	$1,745	$2,104	$12,855	-$158	-10.0%	-$469	-26.9%	-$707	-33.6%	-$3,519	-27.4%
Illinois	$11,164	$12,235	$14,684	$90,019	-$856	-7.7%	-$2,418	-19.8%	-$3,657	-24.9%	-$18,207	-20.2%
Indiana	$8,151	$8,929	$10,697	$65,658	-$1,117	-13.7%	-$1,993	-22.3%	-$2,777	-26.0%	-$14,862	-22.6%
Iowa	$3,424	$3,739	$4,452	$27,442	-$221	-6.4%	-$598	-16.0%	-$889	-20.0%	-$4,480	-16.3%
Kentucky	$8,966	$9,861	$11,914	$72,692	-$1,079	-12.0%	-$3,178	-32.2%	-$4,859	-40.8%	-$24,003	-33.0%
Louisiana	$6,347	$6,968	$8,388	$51,310	-$603	-9.5%	-$1,768	-25.4%	-$2,709	-32.3%	-$13,367	-26.1%
Maryland	$6,291	$6,947	$8,453	$51,320	-$464	-7.4%	-$1,354	-19.5%	-$2,063	-24.4%	-$10,217	-19.9%
Massachusetts	$10,190	$11,182	$13,456	$82,339	-$662	-6.5%	-$1,919	-17.2%	-$2,870	-21.3%	-$14,364	-17.4%
Michigan	$13,851	$15,193	$18,233	$111,771	-$1,482	-10.7%	-$4,006	-26.4%	-$6,024	-33.0%	-$30,144	-27.0%
Minnesota	$7,438	$8,212	$9,989	$60,659	-$488	-6.6%	-$1,330	-16.2%	-$2,032	-20.3%	-$10,076	-16.6%
Montana	$1,591	$1,756	$2,131	$12,961	-$200	-12.6%	-$573	-32.6%	-$875	-41.1%	-$4,329	-33.4%
Nevada	$3,085	$3,503	$4,497	$26,304	-$357	-11.6%	-$1,035	-29.6%	-$1,650	-36.7%	-$7,969	-30.3%
New Hampshire	$1,218	$1,349	$1,650	$9,981	-$119	-9.8%	-$336	-24.9%	-$506	-30.6%	-$2,525	-25.3%
New Jersey	$9,396	$10,332	$12,491	$76,185	-$1,024	-10.9%	-$3,071	-29.7%	-$4,645	-37.2%	-$23,066	-30.3%
New Mexico	$5,128	$5,660	$6,879	$41,794	-$605	-11.8%	-$1,718	-30.3%	-$2,649	-38.5%	-$13,040	-31.2%
New York	$37,920	$41,523	$49,817	$305,493	-$5,787	-15.3%	-$12,472	-30.0%	-$18,007	-36.1%	-$93,295	-30.5%
North Dakota	$758	$832	$998	$6,120	-$56	-7.4%	-$156	-18.8%	-$232	-23.3%	-$1,168	-19.1%
Ohio	$17,015	$18,638	$22,334	$137,064	-$1,404	-8.3%	-$3,721	-20.0%	-$5,640	-25.3%	-$28,121	-20.5%
Oregon	$7,693	$8,540	$10,565	$63,411	-$1,684	-21.9%	-$4,209	-49.3%	-$6,356	-60.2%	-$31,837	-50.2%
Pennsylvania	$16,540	$18,078	$21,558	$132,759	-$1,221	-7.4%	-$3,295	-18.2%	-$4,937	-22.9%	-$24,759	-18.6%
Rhode Island	$1,730	$1,899	$2,284	$13,983	-$121	-7.0%	-$348	-18.3%	-$526	-23.0%	-$2,618	-18.7%
Vermont	$1,265	$1,396	$1,690	$10,297	-$120	-9.5%	-$336	-24.1%	-$506	-29.9%	-$2,528	-24.5%
Washington	$8,485	$9,453	$11,782	$70,352	-$1,217	-14.3%	-$3,646	-38.6%	-$5,668	-48.1%	-$27,706	-39.4%
West Virginia	$3,351	$3,667	$4,382	$26,945	-$337	-10.1%	-$1,006	-27.4%	-$1,529	-34.9%	-$7,574	-28.1%

Note: Excludes Medicaid expenditures for DSH, Medicare premiums, administrative costs, the Vaccines for Children program, and the territories.

*Includes both expansion and non-expansion enrollees.

**Reflects the impact of AHCA provisions that would impose per capita caps on federal Medicaid funds starting in FY 2020 and eliminate enhanced federal match for expansion adults enrolling after 2019; excludes the impact of eliminating the state option to cover adults above 138 percent of the federal poverty line (which would affect the District of Columbia and Minnesota). The number of "grandfathered" expansion adults with enhanced match reflects reductions consistent with Congressional Budget Office assumptions that less than one-third of those enrolled as of December 31, 2019, would have maintained continuous eligibility two years later, and that the enhanced federal matching rate would apply for less than 5 percent of expansion adults by the end of 2024.

Source: Manatt Health analysis.