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Data Brief

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DATA BRIEF

Medi-Cal Expansion under AHCA: Severe Coverage and Funding Loss unless State Backfills Billions in Federal Cuts

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The American Health Care Act (AHCA), currently being considered in Congress, would dismantle key elements of the Affordable Care Act (ACA) and would fundamentally change the way the federal government funds Medicaid by capping federal contributions. Among other changes, the bill would dramatically reduce federal funding for the ACA's largest health insurance expansion: the extension of Medicaid (called Medi-Cal in this state) eligibility to low-income adults. In this brief, we project the impact that the proposed cuts for the Medicaid expansion eligibility group under the AHCA would have on Medi-Cal enrollment, the state's budget, and the Medi-Cal funding that supports the state's healthcare system, over a ten-year period.

Key projections include:

- California would have to increase state General Fund spending by nearly $10 billion annually by 2027 in order to keep the ACA Medi-Cal expansion open to new enrollees. This is because the AHCA would cut federal funding for new enrollees in California by 40 percentage points beginning in 2020 and the state would receive this lower federal match for a growing share of enrollees each year.
- If California is not able to make up the lost federal funding and decides to continue eligibility only for individuals enrolled in the expansion as of the end of 2019 (after which federal funding would be reduced dramatically for any new Medi-Cal expansion enrollees), the state would experience severe coverage drops and healthcare funding losses compared to current law:
    - 3.7 million fewer Californians would be enrolled in Medi-Cal by 2027 because they would lose coverage when they have a break in eligibility;

- The state's healthcare system would lose nearly $25 billion in Medi-Cal funding annually by 2027, including $22 billion in federal funding; and
- The state's healthcare system would lose a cumulative total of $130 billion in federal and state Medi-Cal funding between 2020 and 2027.

- Certain parts of the state would be especially harmed if California is not able to fully maintain the Medi-Cal expansion due to the federal cuts.
  - For example, in the San Joaquin Valley, where residents have a high rate of enrollment in the Medi-Cal expansion, over 465,000 residents would be projected to lose Medi-Cal coverage in 2027 and the local healthcare system would lose more than $3 billion in Medi-Cal funding annually by 2027 if the state closes the expansion to new enrollees due to the federal cuts.
  - Other more rural parts of California would also face serious losses, as would Los Angeles.

Projections by county, Congressional District, California Senate District, and Assembly District are included in Appendix A of this brief.

California's potential coverage and funding losses due to the AHCA would extend beyond the estimates in this brief because of other provisions in the bill such as capping federal spending per enrollee, but the impacts of the Medicaid expansion provisions in the AHCA are the focus of this brief.

Background

California has experienced a historic drop in the state's uninsurance rate under the ACA, from 17.0% in 2013 to 7.1% in 2016.[1] Much of this progress is due to the ACA expansion of Medi-Cal, the state's Medicaid program, to citizen and qualified immigrant adults without minor children living at home with income at or below 138% of the Federal Poverty Level and to parents with income between 109% and 138% of the Federal Poverty Level (approximately $16,600 for a single individual and $33,900 for a family of four in 2017).

Nearly one in ten Californians, or 3.7 million adults ages 19 through 64, were enrolled in the Medi-Cal expansion in 2016. Enrollees are disproportionately people of color, comprising 71% of enrollment, compared to 62% of the state population of the same age. Nearly half (47%) are working, another 12% are actively looking for work, and some of the remaining adults are likely to have working spouses.[2] Workers in particular industries—including agriculture, restaurants, retail, auto repair, hair salons, private households, and building services—have higher-than-average rates of enrollment in the Medi-Cal expansion.[3] Medi-Cal expansion enrollment is higher in certain regions, including the San Joaquin Valley and northern parts of the state.[4]

Under the ACA, the federal government provides an enhanced match for expansion enrollees' costs, initially funding 100% of the expansion costs in 2014 through 2016 and phasing down to 90% by 2020. This compares to a 50% federal match for non-expansion Medi-Cal enrollees' costs. The AHCA[5] would drastically reduce federal funding for the Medicaid expansion beginning January 1, 2020. States would continue to receive the enhanced federal match (90% as of 2020) for costs for those who were enrolled in the expansion category as of Decmber 31, 2019, as long as those enrollees do not have a break in coverage of more than one month. After that time, the federal government

would reduce federal matching dollars for new enrollees who have a break in coverage of more than a month to 50%, which is California's matching rate for other populations.

Low-income individuals have frequent changes in income and a substantial share of Medi-Cal enrollees are expected to have a change in eligibility each year.[6] Often, enrollees who lose eligibility for Medi-Cal due to an increase in income become eligible again in the future as their income fluctuates. Additionally, many enrollees lose coverage at the time of redetermination for reasons unrelated to income or eligibility changes, including moving or encountering difficulties with the paperwork process. As of October 2016, 81% of Medi-Cal enrollees, on average, were approved for renewal of coverage during their annual redetermination of eligibility.[7]

The AHCA proposes to increase the frequency of eligibility determinations for expansion enrollees from annually to every six months beginning October 1, 2017. More frequent eligibility redetermination is known to be associated with a higher percentage of individuals having a break in coverage. This is related not only to the fluctuations in income made more visible by more frequent eligibility redeterminations but it is also due the administrative barrier it creates for individuals who in fact are eligible.

Under California law, the state's adoption of the optional Medicaid expansion is contingent on the level of federal funding provided. If the federal match for the Medicaid expansion falls below 90%, that reduction "shall be addressed in a timely manner through the annual state budget or legislative processes" in accordance with the state law.[8] Therefore, if the AHCA is enacted, soon after the California legislature must determine how and whether the state will maintain the Medi-Cal expansion.

Other Related Provisions in AHCA

In addition to drastically reducing funding for the Medicaid expansion, the AHCA also proposes to change the way Medicaid is funded by capping federal spending per enrollee. The Center on Budget and Policy Priorities estimates that federal Medicaid funding would decrease by $116 billion nationally over ten years under the AHCA's proposed per capita caps.[9] This is in addition to the reductions projected for the Medicaid expansion. Under the AHCA, states would no longer be required to offer Medicaid benefits that meet the ACA standard for essential health benefits, which could put the state's expanded mental health and substance use services benefits at risk. The AHCA would also make other cuts to Medicaid including but not limited to: eliminating retroactive eligibility,[10] ending hospital presumptive eligibility,[11] and discontinuing federal Medicaid payments for individuals while citizenship or immigration status is being verified. In addition, the AHCA proposes to reduce federal funding levels for the Community First Choice Option, under which California currently receives enhanced federal funding for In-Home Supportive Services (IHSS) provided to certain seniors and individuals with disabilities. Evaluating the specific impacts of these changes is outside the scope of this brief, but these proposals pose further risks to Californians' coverage, the state budget, and the state's healthcare system.

It is also outside the scope of this brief to estimate the impact to California providers of repealing the Disproportionate Share Hospital (DSH) funding cuts or increasing funding for certain Federally Qualified Health Centers, as proposed under the AHCA, which could offset the Medi-Cal funding losses to the healthcare system to a limited extent. Nationally, the Congressional Budget Office projects that the AHCA would cut Medicaid spending by $880 billion between 2017 and 2026, while DSH payments would increase by $43 billion and funding for the Community Health Center Program would increase by $422 million over the ten-year period.[12]

By 2027, California would need to spend an additional $10 billion annually to maintain the Medi-Cal expansion under the AHCA

In order for California to keep the Medi-Cal expansion, including allowing new enrollment by any eligible applicant, the state would have to contribute billions in additional funding each year in order to make up for the loss in federal funding under the AHCA. In 2020, the first year in which the state would receive the traditional federal match (50%) for new enrollees, the state would have to provide an additional $1.4 billion, compared to under current law.[13]

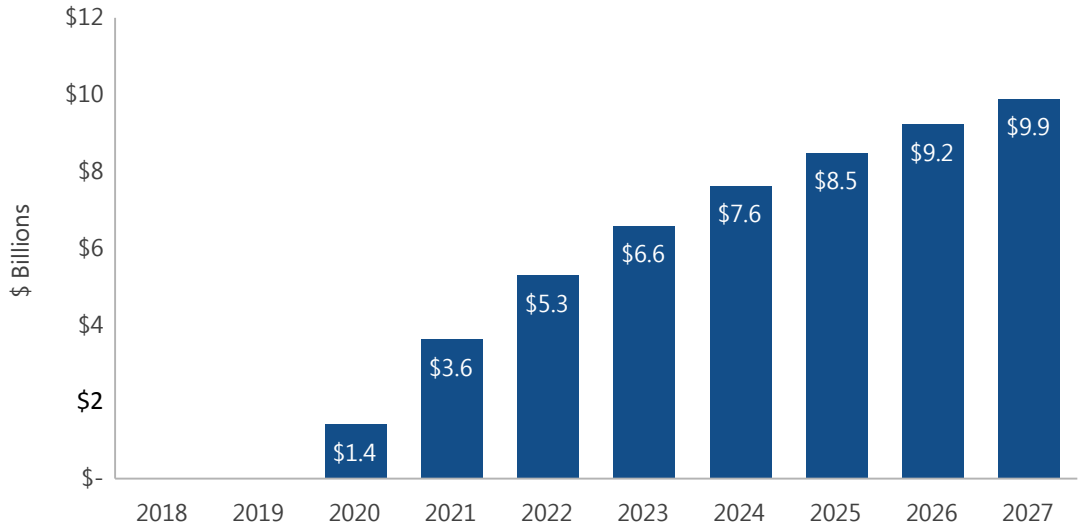
As individuals who enrolled prior to 2020 lose coverage over time and as the state receives the enhanced federal match for an ever-declining share of enrollment, the amount that the state would have to contribute would quickly grow. In addition, the total costs for the expansion population would grow over time as the state population grows and as healthcare costs grow.[14]

By 2027, the state would have to contribute $9.9 billion to keep the expansion (Exhibit 1), above and beyond the General Fund contributions the state would be required to pay for the costs of expansion enrollees under current law. Throughout this brief, enrollment and costs are projected from 2018 through 2027 to assess the impacts that the AHCA would have over a ten-year period.

In order to fund the additional costs it would incur to maintain the expansion, the state would likely have to raise new revenues or reduce spending in other programs. As a point of comparison for how significant it would be for California to raise

Exhibit 1: Projected Increase in General Fund Spending Needed to Maintain Medi-Cal Expansion under AHCA, 2018-2027

Assumes expansion enrollment continues for all eligible applicants and that total enrollment grows slightly with population over the ten-year period



Source: Authors' analysis (see Appendix B for details on methodology)
Note: These estimates solely reflect the additional state funding needed to make up for the lost federal funding for the expansion. These estimates do not include any additional state funding required to make up for federal funding loss due to the proposed caps on per capita spending or any other Medicaid cuts proposed in the AHCA.

$9.9 billion in new revenues by 2027, all corporate tax revenues collected by the state are projected to total $10.8 billion in Fiscal Year 2017-2018.[15] Reducing spending by $9.9 billion by 2027 would also be challenging for the state. In comparison, General Fund spending for the University of California and California State University combined is projected at $7.1 billion in Fiscal Year 2017-2018.[16] If California cannot make up all of the lost federal funding in order to fully maintain the expansion, the Legislature would face difficult choices such as reducing eligibility, capping enrollment, cutting benefits, or closing the program entirely to new enrollees.

If California closes expansion to new enrollees, 3.7 million fewer Californians would be in the Medi-Cal Expansion by 2027 under AHCA

Under a different scenario, California may decide to maintain the expansion for existing enrollees but close the program to new enrollment once the enhanced federal match ends for those enrollees in 2020. In this case, the number of existing enrollees in the Medi-Cal expansion would quickly diminish, as most of those enrollees would lose Medi-Cal in the first several years due to increase in income or the loss of coverage for other reasons such as bureaucratic hurdles. Taking into account the current Medi-Cal renewal rate for annual redeterminations and that the AHCA would require redeterminations every six months for expansion enrollees, we assume in this analysis that 35% of pre-2020 enrollees would remain in the program in 2022 and only 6% of enrollees would remain in 2026. (See Appendix B for details on methodology and a comparison to the relatively similar assumptions used by the Congressional Budget Office.)

Under current law, 3.7 million enrollees would be projected to be enrolled in the expansion in 2020, growing to 3.8 million in 2027 due to population growth. This does not include the additional Californians who enrolled due to the "welcome mat" effect in which some Californians who had been eligible for Medi-Cal nonetheless only enrolled after the expansion, as a result of ACA policy changes such as improved outreach and streamlined enrollment procedures. Under the AHCA, 725,000 fewer individuals would be enrolled in the Medi-Cal expansion in 2020 after losing coverage and 3.7 million fewer individuals would be enrolled in 2027 (Exhibit 2, page 6). By 2027, only 158,000 individuals would be projected to continue to be enrolled in the expansion. That is 96% less than would be projected to be enrolled under current law.

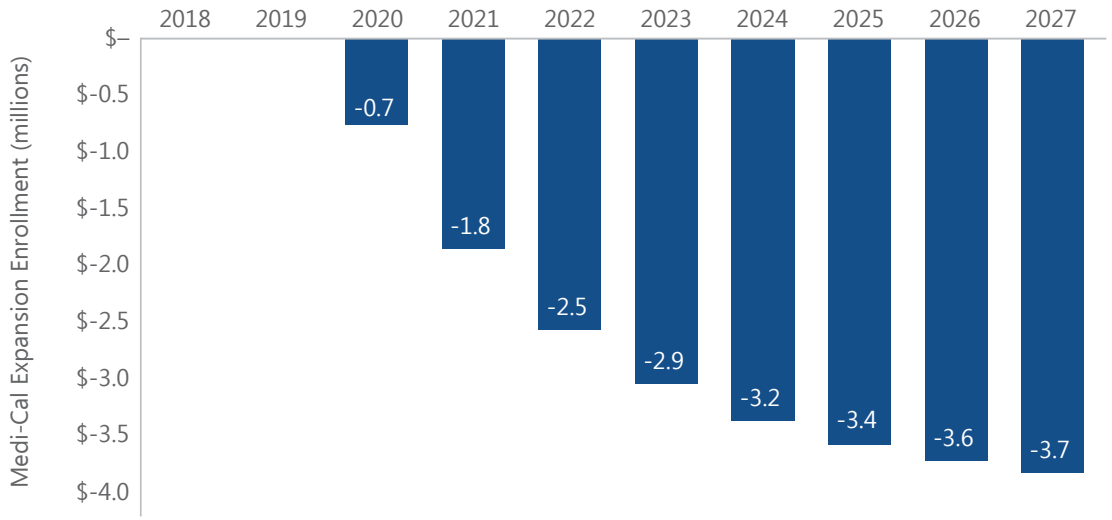
The positive benefits of having Medicaid coverage have been well documented. According to a Kaiser Family Foundation review of the literature, "most research demonstrates that Medicaid expansion positively impacts access to care, utilization of services, the affordability of care, and financial security among the low-income population."[17] One study found that Medicaid expansions to adults in three states were associated with a 6.1% decline in the relative risk of death over a five-year period.[18]

If California ends new enrollment in expansion, the healthcare system would lose $25 billion in annual Medi-Cal funding by 2027

As Medi-Cal enrollment falls, the healthcare system in the state would lose billions in funding, compared to what it would receive under current law. Most of the lost funding would be federal. In 2020, insurers, providers, and other parts of the healthcare system serving Medi-Cal patients would receive $3.5 billion less Medi-Cal funding than they would be projected to receive under current law, with most ($3.2 billion) of that being lost federal funds. By 2027, the annual decrease in funding would be $24.7 billion, including $22.3 billion in lost federal funds (Exhibit 3, page 6).

Exhibit 2: Projected Decrease in Medi-Cal Expansion Enrollment under AHCA relative to current law, 2018-2027

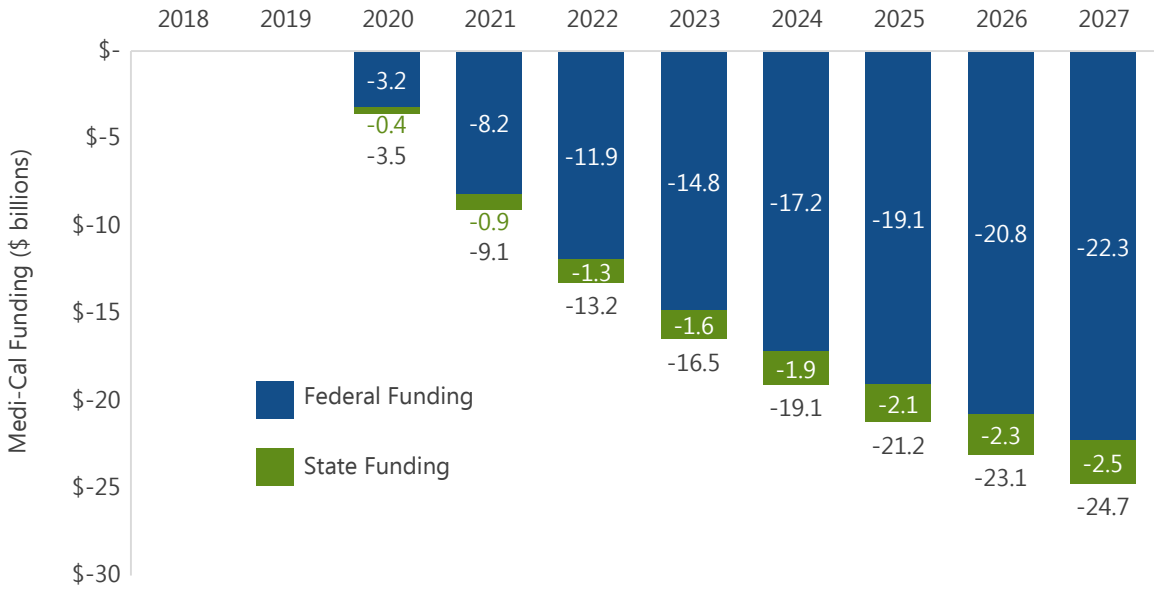
Assumes only existing enrollees who maintain continuous enrollment would be eligible for Medi-Cal expansion under AHCA beginning in 2020



Source: Authors' analysis (see Appendix B for details on methodology)
Note: These estimates solely reflect the enrollment loss due to the Medicaid expansion provisions in the AHCA. These estimates do not include any enrollment loss that would occur due to the proposed caps on per capita spending or any other Medicaid cuts proposed in the AHCA.

Exhibit 3: Projected Decrease in Federal and State Medi-Cal Expansion Funding under AHCA relative to current law, 2018-2027

Assumes only existing enrollees who maintain continuous enrollment would be eligible for Medi-Cal expansion under AHCA beginning in 2020



Source: Authors' analysis (see Appendix B for details on methodology)
Notes: Federal and state funding projections may not sum to total due to rounding. These estimates solely reflect the funding loss due to the Medicaid expansion provisions in the AHCA. These estimates do not include any funding loss that would occur due to the proposed caps on per capita spending or any other Medicaid cuts proposed in the AHCA.

This federal and state funding loss would create financial instability for healthcare providers due to the increase in uncompensated care.[19] Safety net providers, including public hospitals and public and non-profit clinics, would be especially harmed by the reduction in Medi-Cal funding. This reduction in funding would also be of special concern to California counties which, since 1933, have had an obligation to provide indigent healthcare to residents under state law.[20]

A previous study estimated that 209,000 jobs would be lost in California under the partial ACA bill passed by Congress in late 2015 and vetoed by President Obama. That bill would have repealed the Medicaid expansion and marketplace subsidies, repealed the ACA tax increases for high-income families and insurers, and repealed the individual and employer mandates. Out of the 209,000 projected lost jobs, 135,000 were estimated to be in the healthcare industry and the remainder would be in other industries within the state due to the spillover effect as healthcare workers spend less in their local communities. The job loss estimates reflect the net effect of federal healthcare spending losses and the limited economic gains associated with the proposed tax cuts.[21]

Based on the differences between the 2015 ACA repeal bill and the AHCA,[22] we estimate that under the AHCA, California would lose 209,000 jobs or more by approximately 2024, with the exact timing dependent on how much federal funding California loses for individual market subsidies.

Some California regions would be especially hard hit by Medi-Cal expansion coverage and funding loss

The Medi-Cal coverage and funding losses would be felt in every corner of the state. However, some regions of the state would be especially hard hit. As examples:

- In the San Joaquin Valley,[23] 11.2% of the total population is enrolled in the Medi-Cal expansion, higher than the statewide enrollment rate of 9.4%.[24] More than 465,000 residents in the Valley, or 9.7% of the region's population, would be projected to lose Medi-Cal coverage in 2027 and local healthcare systems would lose more than $3.1 billion in Medi-Cal funding annually by 2027 if the state closes the expansion to new enrollees due to the federal cuts under the AHCA (see Appendix Exhibit A1).
- In Los Angeles County, more than 1.1 million out of 10.2 million residents have enrolled in the Medi-Cal expansion. More individuals have enrolled in that county alone than have enrolled in the expansion in any state except California.[25] Under the AHCA, not only would more than 1.1 million residents lose their Medi-Cal coverage by 2027, but the local healthcare system would lose $7.8 billion annually (see Appendix Exhibit A1).

Projections of Medi-Cal coverage and funding losses by county, congressional district, California Senate district, and California Assembly district are provided in Appendix A.

Conclusion

California would face severe coverage and funding losses due to the Medicaid expansion cuts proposed in the AHCA. The state has made historic coverage gains under the ACA, in part due to the enrollment of 3.7 million Californians in Medi-Cal under the expansion. In order to maintain these gains and continue to enroll all eligible applicants in the Medi-Cal expansion, the state would have to increase funding by nearly $10 billion annually by 2027 to backfill the massive federal funding cuts to the program proposed under the AHCA. This does not take into account the impact of the proposed

caps on per capita spending or any other Medicaid cuts proposed in the AHCA.

If the state cannot find that additional $10 billion and decides to close the expansion to new enrollees, only 158,000 individuals would be enrolled in the expansion by 2027, compared to the 3.8 million who would be expected to be enrolled under current law. This drop in coverage would mean a loss of $25 billion in annual Medi-Cal funding to the California healthcare system, most of which would have come from the federal government. Between 2020 and 2027, $130 billion fewer Medi-Cal expansion dollars would flow to the healthcare system under the AHCA than would be provided under current law.

The coverage and funding losses that the state would experience under the AHCA would increase the number of uninsured, reduce Californians' access to care, destabilize healthcare providers' funding, and eliminate jobs in healthcare and other industries.

Appendix A: County and District Estimates

Appendix Exhibit A1. Projected Reduction in Federal and State Medi-Cal Expansion Funding under AHCA relative to current law, by County, 2027

Assumes only existing enrollees who maintain continuous enrollment would be eligible for Medi-Cal expansion under AHCA beginning in 2020

County	Projected loss in enrollment, 2027	Projected loss in enrollment as % of county population, 2027	Projected loss in Medi-Cal funding ($ millions), 2027
Alameda	(123,100)	6.7%	$ (829)
Alpine	(100)	8.8%	$ (1)
Amador	(2,600)	6.6%	$ (17)
Butte	(24,700)	10.2%	$ (167)
Calaveras	(4,000)	8.6%	$ (27)
Colusa	(1,700)	7.0%	$ (12)
Contra Costa	(72,500)	5.7%	$ (488)
Del Norte	(3,000)	10.9%	$ (20)
El Dorado	(12,800)	6.4%	$ (86)
Fresno	(116,900)	10.5%	$ (787)
Glenn	(2,700)	8.7%	$ (18)
Humboldt	(18,700)	13.3%	$ (126)
Imperial	(22,000)	10.3%	$ (148)
Inyo	(1,600)	8.4%	$ (11)
Kern	(95,800)	9.4%	$ (645)
Kings	(13,400)	8.1%	$ (90)
Lake	(8,800)	13.1%	$ (60)
Lassen	(2,000)	6.6%	$ (13)
Los Angeles	(1,162,100)	10.8%	$ (7,826)
Madera	(15,000)	8.4%	$ (101)
Marin	(14,600)	5.4%	$ (98)
Mariposa	(1,600)	8.7%	$ (11)
Mendocino	(12,300)	13.3%	$ (83)
Merced	(32,900)	10.5%	$ (222)
Modoc	(800)	8.7%	$ (5)
Mono	(1,300)	9.0%	$ (9)
Monterey	(37,500)	7.8%	$ (253)
Napa	(8,500)	5.6%	$ (57)
Nevada	(8,500)	8.2%	$ (57)
Orange	(260,400)	7.7%	$ (1,754)
Placer	(18,000)	4.1%	$ (121)
Plumas	(2,000)	10.5%	$(13)
Riverside	(205,900)	7.5%	$ (1,387)
Sacramento	(141,600)	8.3%	$ (954)

Appendix Exhibit A1 continued

County	Projected loss in enrollment, 2027	Projected loss in enrollment as % of county population, 2027	Projected loss in Medi-Cal funding ($ millions), 2027
San Benito	(4,700)	7.3%	$ (31)
San Bernardino	(225,100)	9.3%	$ (1,516)
San Diego	(259,600)	7.3%	$ (1,748)
San Francisco	(78,000)	8.1%	$ (525)
San Joaquin	(73,900)	8.6%	$ (498)
San Luis Obispo	(18,400)	6.2%	$ (124)
San Mateo	(48,300)	5.8%	$ (325)
Santa Barbara	(33,500)	6.9%	$ (225)
Santa Clara	(136,400)	6.3%	$ (918)
Santa Cruz	(23,000)	7.7%	$ (155)
Shasta	(17,200)	9.2%	$(116)
Sierra	(300)	9.6%	$ (2)
Siskiyou	(5,100)	11.5%	$ (34)
Solano	(33,700)	6.8%	$ (227)
Sonoma	(35,300)	6.5%	$ (238)
Stanislaus	(62,400)	10.1%	$ (420)
Sutter	(10,200)	9.4%	$ (69)
Tehama	(6,300)	9.3%	$ (43)
Trinity	(1,700)	12.8%	$ (11)
Tulare	(55,000)	10.5%	$ (371)
Tuolumne	(4,300)	7.9%	$ (29)
Ventura	(65,800)	7.3%	$ (443)
Yolo	(16,700)	6.6%	$ (112)
Yuba	(7,700)	9.1%	$ (52)
Total	**(3,672,000)**	**8.5%**	**$ (24,730)**

Source: Authors' analysis (see Appendix B for details on methodology)

Notes: Enrollment projections are rounded to nearest 100 enrollees; rows may not sum to total due to rounding. Projections assume that the reduction in enrollment and funding would be proportional to each county's current share of Medi-Cal expansion enrollment. These estimates solely reflect the enrollment and funding losses due to the Medicaid expansion provisions in the AHCA. These estimates do not include any enrollment or funding loss that would occur due to the proposed caps on per capita spending or any other Medicaid cuts proposed in the AHCA.

Appendix Exhibit A2. Projected Reduction in Federal and State Medi-Cal Expansion Funding under AHCA relative to current law, by Congressional District, 2027

Assumes only existing enrollees who maintain continuous enrollment would be eligible for Medi-Cal expansion under AHCA beginning in 2020

Congressional district	Projected loss in enrollment, 2027	Projected loss in Medi-Cal funding ($ millions), 2027	Congressional district	Projected loss in enrollment, 2027	Projected loss in Medi-Cal funding ($ millions), 2027
1	(69,400)	$ (467)	28	(90,400)	$ (609)
2	(62,800)	$ (423)	29	(100,700)	$ (678)
3	(61,900)	$ (417)	30	(70,700)	$ (476)
4	(44,600)	$ (300)	31	(82,400)	$ (555)
5	(56,100)	$ (378)	32	(86,900)	$ (585)
6	(78,600)	$ (529)	33	(34,600)	$ (233)
7	(55,800)	$ (376)	34	(115,600)	$ (779)
8	(81,400)	$ (548)	35	(87,500)	$ (589)
9	(76,300)	$ (514)	36	(76,200)	$ (513)
10	(78,000)	$ (526)	37	(98,800)	$ (665)
11	(52,400)	$ (353)	38	(63,200)	$ (426)
12	(67,700)	$ (456)	39	(54,900)	$ (370)
13	(75,900)	$ (511)	40	(91,000)	$ (613)
14	(54,200)	$ (365)	41	(78,100)	$ (526)
15	(44,900)	$ (302)	42	(53,400)	$ (360)
16	(101,400)	$ (683)	43	(88,700)	$ (598)
17	(44,600)	$ (301)	44	(97,500)	$ (657)
18	(34,700)	$ (233)	45	(38,200)	$ (257)
19	(74,600)	$ (502)	46	(85,100)	$ (573)
20	(65,200)	$ (439)	47	(76,200)	$ (513)
21	(93,900)	$ (632)	48	(55,900)	$ (376)
22	(73,800)	$ (497)	49	(39,800)	$ (268)
23	(66,700)	$ (449)	50	(54,800)	$ (369)
24	(53,300)	$ (359)	51	(90,900)	$ (612)
25	(63,200)	$ (426)	52	(37,200)	$ (250)
26	(57,600)	$ (388)	53	(59,300)	$ (399)
27	(75,100)	$ (506)	**Total**	**(3,672,000)**	**$ (24,730)**

Source: Authors' analysis (see Appendix B for details on methodology)

Notes: Enrollment projections are rounded to nearest 100 enrollees; rows may not sum to total due to rounding. Projections assume that the reduction in enrollment and funding would be proportional to each district's current share of Medi-Cal expansion enrollment. These estimates solely reflect the enrollment and funding losses due to the Medicaid expansion provisions in the AHCA. These estimates do not include any enrollment or funding loss that would occur due to the proposed caps on per capita spending or any other Medicaid cuts proposed in the AHCA.

Appendix Exhibit A3. Projected Reduction in Federal and State Medi-Cal Expansion Funding under AHCA relative to current law, by California Senate District, 2027

Assumes only existing enrollees who maintain continuous enrollment would be eligible for Medi-Cal expansion under AHCA beginning in 2020

CA Senate District	Projected loss in enrollment, 2027	Projected loss in Medi-Cal funding ($ millions), 2027
1	(70,800)	$ (477)
2	(86,700)	$ (584)
3	(66,800)	$ (450)
4	(94,700)	$ (638)
5	(105,700)	$ (712)
6	(105,700)	$ (712)
7	(55,800)	$ (376)
8	(94,700)	$ (638)
9	(95,700)	$ (645)
10	(70,800)	$ (477)
11	(88,700)	$ (598)
12	(119,600)	$ (806)
13	(46,900)	$ (316)
14	(139,600)	$ (940)
15	(76,800)	$ (517)
16	(92,700)	$ (624)
17	(73,800)	$ (497)
18	(113,700)	$ (765)
19	(82,800)	$ (557)
20	(125,600)	$ (846)
21	(114,700)	$ (772)
22	(114,700)	$ (772)
23	(98,700)	$ (665)
24	(129,600)	$ (873)
25	(73,800)	$ (497)
26	(40,900)	$ (275)
27	(64,800)	$ (436)
28	(84,700)	$ (571)
29	(82,800)	$ (557)
30	(143,600)	$ (967)
31	(98,700)	$ (665)
32	(88,700)	$ (598)
33	(127,600)	$ (859)
34	(112,700)	$ (759)
35	(122,600)	$ (826)
36	(53,800)	$ (363)
37	(54,800)	$ (369)
38	(82,800)	$ (557)
39	(51,800)	$ (349)
40	(122,600)	$ (826)
Total	**(3,672,000)**	**$ (24,730)**

Source: Authors' analysis (see Appendix B for details on methodology)

Notes: Enrollment projections are rounded to nearest 100 enrollees; rows may not sum to total due to rounding. Projections assume that the reduction in enrollment and funding would be proportional to each district's current share of Medi-Cal expansion enrollment. These estimates solely reflect the enrollment and funding losses due to the Medicaid expansion provisions in the AHCA. These estimates do not include any enrollment or funding loss that would occur due to the proposed caps on per capita spending or any other Medicaid cuts proposed in the AHCA.

Appendix Exhibit AA4: Projected Reduction in Federal and State Medi-Cal Expansion Funding under AHCA relative to current law, by California Assembly District

Assumes only existing enrollees who maintain continuous enrollment would be eligible for Medi-Cal expansion under AHCA beginning in 2020

CA Assembly District	Projected loss in enrollment, 2027	Projected loss in Medi-Cal funding ($ millions), 2027
1	(45,900)	$ (309)
2	(50,800)	$ (342)
3	(53,800)	$ (363)
4	(36,900)	$(248)
5	(44,900)	$ (302)
6	(22,900)	$ (154)
7	(54,800)	$ (369)
8	(47,900)	$ (322)
9	(48,900)	$ (329)
10	(29,900)	$ (201)
11	(39,900)	$ (269)
12	(44,900)	$ (302)
13	(57,800)	$ (389)
14	(38,900)	$ (262)
15	(35,900)	$ (242)
16	(13,000)	$ (87)
17	(53,800)	$ (363)
18	(59,800)	$ (403)
19	(35,900)	$(242)
20	(39,900)	$ (269)
21	(66,800)	$ (450)
22	(22,900)	$ (154)
23	(46,900)	$ (316)
24	(22,900)	$ (154)
25	(31,900)	$ (215)
26	(58,800)	$ (396)
27	(56,800)	$ (383)
28	(23,900)	$ (161)
29	(28,900)	$ (195)
30	(52,800)	$ (356)
31	(75,800)	$ (510)
32	(62,800)	$ (423)
33	(64,800)	$ (436)
34	(43,900)	$ (295)
35	(42,900)	$ (289)
36	(58,800)	$ (396)
37	(31,900)	$ (215)
38	(27,900)	$ (188)
39	(61,800)	$ (416)
40	(49,900)	$ (336)
41	(30,900)	$ (208)
42	(41,900)	$ (282)
43	(44,900)	$ (302)
44	(36,900)	$ (248)
45	(41,900)	$ (282)
46	(53,800)	$ (363)
47	(67,800)	$(457)
48	(51,800)	$ (349)
49	(54,800)	$ (369)
50	(23,900)	$ (161)
51	(60,800)	$ (410)
52	(57,800)	$ (389)
53	(73,800)	$ (497)
54	(43,900)	$ (295)
55	(30,900)	$ (208)
56	(60,800)	$ (410)
57	(45,900)	$ (309)
58	(49,900)	$ (336)
59	(91,700)	$ (618)
60	(43,900)	$ (295)
61	(54,800)	$ (369)
62	(47,900)	$ (322)
63	(60,800)	$ (410)
64	(79,800)	$ (537)
65	(48,900)	$ (329)
66	(24,900)	$ (168)
67	(40,900)	$ (275)
68	(31,900)	$ (215)
69	(68,800)	$ (463)
70	(44,900)	$ (302)
71	(45,900)	$ (309)
72	(50,800)	$ (342)
73	(20,900)	$ (141)
74	(22,900)	$ (154)
75	(38,900)	$ (262)
76	(32,900)	$ (222)
77	(21,900)	$ (148)
78	(24,900)	$ (168)
79	(43,900)	$ (295)
80	(67,800)	$ (457)
Total	**(3,672,000)**	**$ (24,730)**

Source: Authors' analysis (see Appendix B for details on methodology)

Notes: Enrollment projections are rounded to nearest 100 enrollees; rows may not sum to total due to rounding. Projections assume that the reduction in enrollment and funding would be proportional to each district's current share of Medi-Cal expansion enrollment. These estimates solely reflect the enrollment and funding losses due to the Medicaid expansion provisions in the AHCA. These estimates do not include any enrollment or funding loss that would occur due to the proposed caps on per capita spending or any other Medicaid cuts proposed in the AHCA.

Appendix B: Methodology

This analysis uses September 2016 Medi-Cal expansion enrollment data from the California Health and Human Services (CHHS) Department Open Data Portal[26] for full-scope enrollees and from the California Department of Health Care Services (DHCS) for restricted-scope enrollees.[27] Under current policy, enrollment is assumed to grow at the same rate that the California population ages 20-64 is projected to grow.[28]

Under the AHCA scenario in which California only continues the expansion for individuals enrolled prior to January 1, 2020, enrollment grows with population growth through 2019, then decreases beginning in 2020 as enrollees lose eligibility. Using California's current 81% renewal rate[29] and applying that percentage once in 2020, and twice per year in subsequent years to reflect the AHCA proposal that redeterminations occur every six months, we assume that enrollment deteriorates as follows: 81% of 2019 enrollment remains in 2020, 53% in 2021, 35% in 2022, 23% in 2023, 15% in 2024, 10% in 2025, 6% in 2026, and 4% in 2027. These assumptions are relatively similar to the Congressional Budget Office's national estimate that under the AHCA "…fewer than one-third of those enrolled as of December 31, 2019, would have maintained continuous eligibility two years later… [and] the higher federal matching rate would apply for fewer than 5 percent of newly eligible enrollees by the end of 2024."[30]

This analysis uses DHCS budget estimates for the cost per enrollee. The 2016 cost per full-scope enrollee is based on a weighted average of the Fiscal Year 2016-2017 managed care and fee-for-service per member per month estimates for expansion enrollees in DHCS's Medi-Cal Estimates.[31] The Fiscal Year 2016-2017 estimate is used for 2016 because it is assumed to be more indicative of long-term trends given that the cost per expansion enrollee has decreased substantially since 2014. It appears from the budget estimates that costs per enrollee are leveling off. Given the downward trend in cost until this year, to be conservative, it is assumed that costs per enrollee grow by only 2% in 2017 through 2019. In 2020 and beyond, costs per enrollee are assumed to grow at the national rate of growth projected by the CBO for non-disabled non-elderly adults in their January 2017 baseline estimates for Medicaid.[32] The 2016 cost per restricted-scope enrollee is based on Fiscal Year 2015-2016 per member per month estimates for enrollees Permanently Residing Under Color of Law (PRUCOL) in DHCS's Medi-Cal Estimates.[33] The restricted-scope costs per enrollee are assumed to grow at the same rate as full-scope costs.

Enrollment and funding losses by county and district are projected assuming that the reduction in enrollment and funding would be proportional to each county and district's current share of Medi-Cal expansion enrollment. For each county and district, enrollment estimates under the AHCA scenario in which the expansion is closed to new enrollees are 96% of the projected enrollment under current law in 2027. The current share of Medi-Cal expansion enrollment by county is based on DHCS data published in a UC Berkeley brief.[34] The current share of Medi-Cal expansion enrollment by Congressional district is based on DHCS data.[35] The current share of Medi-Cal expansion enrollment by California Senate and Assembly district is based on estimates developed by UC Berkeley researchers.[36]

Endnotes

[1] Centers for Disease Control and Prevention (CDC), National Health Interview Survey. 2016 uninsurance rate is for January through September 2016.

[2] Dietz M, Lucia L, Kominski GF, and Jacobs K, ACA Repeal in California: Who Stands to Lose? UC Berkeley Center for Labor Research and Education and UCLA Center for Health Policy Research, December 2016.

[3] Lucia L, Dietz M, and Jacobs K, Which California Industries would be Most Affected by ACA Repeal and Medicaid Cuts in California? UC Berkeley Center for Labor Research and Education, February 2017.

[4] Lucia L, et al., February 2017.

[5] Analysis of the AHCA in this brief is based on bill language dated March 6, 2017.

[6] Dietz M, Graham-Squire D, and Jacobs K, The Ongoing Importance of Enrollment Churn in Covered California and Medi-Cal, UC Berkeley Center for Labor Research and Education, April 2014.

[7] California Department of Health Care Services, Medi-Cal Renewals by County, October 2016.

[8] California Welfare & Institutions Code § 14103

[9] Park E, Aron-Dine A, and Broaddus M, House Republican Health Plan Shifts $370 Billion in Medicaid Costs to States, Center on Budget and Policy Priorities, March 8, 2017.

[10] This provision would disallow submitting bills for reimbursement for the three months prior to application for individuals that would have been eligible.

[11] Hospital presumptive eligibility is a policy that allows hospitals to provide temporary Medicaid benefits to applicants who appear eligible for Medicaid based on a simplified Medicaid application process.

[12] Congressional Budget Office, American Health Care Act Cost Estimate, March 13, 2017.

[13] Throughout this brief, all findings are reported in nominal dollars.

[14] This analysis assumes that the increased frequency of redeterminations accelerates the shift of enrollees from the enhanced federal match (90%) group to the traditional federal match (50%) group, but that the overall level of enrollment remains roughly the same as new enrollees enter the program and as individuals re-enroll due to regaining eligibility or because they were in fact eligible when they lost coverage. This assumption may overstate enrollment under this scenario to some extent if the six-month redetermination proposal under the AHCA results in lower average enrollment.

[15] California Governor Jerry Brown, California's 2017-2018 Governor's Budget, January 10, 2017.

[16] California Governor Jerry Brown, California's 2017-2018 Governor's Budget, January 10, 2017.

[17] Antonisse L, Garfield R, Rudowitz R, and Artiga S, The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review, Kaiser Family Foundation, February 22, 2017.

[18] Sommers BD, Baicker K, and Epstein AM, Mortality and Access to Care Among Adults after State Medicaid Expansions, New England Journal of Medicine 367 (11): p. 1025-1034 (2012).

[19] Buettgens M, Blumberg LJ, and Holahan J, The Impact on Health Care Providers of Partial ACA Repeal through Budget Reconciliation, Urban Institute, January 5, 2017.

[20] California Welfare & Institutions Code § 17000

[21] Lucia L and Jacobs K, California's Projected Economic Losses under ACA Repeal, UC Berkeley Center for Labor Research and Education, December 2016.

[22] The AHCA tax cut provisions are similar to the provisions in the 2015 bill, but the AHCA would phase out the Medicaid expansion more gradually than the 2015 bill, and it would replace the marketplace subsidies with tax credits with about half of the total value nationwide, according to Congressional Budget Office estimates. Congressional Budget Office, March 13, 2017.

[23] Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, and Tulare County are included in these San Joaquin Valley estimates.

[24] Lucia L and Jacobs K, Fact Sheet: Projected Economic Losses under ACA Repeal in California's San Joaquin Valley, UC Berkeley Center for Labor Research and Education, January 2017.

[25] Dietz et al., December 2016.

[26] California Department of Health and Human Services, Open Data Portal, Statewide Medi-Cal Certified Eligible Individuals, by Aid Code, 2012 – 2016. CHHS data for September 2016 for aid codes 7U, L1, M1 and P3 is included for full-scope enrollees.

[27] California Department of Health Care Services (DHCS) Research and Analytic Studies Division, Medi-Cal Monthly Enrollment Fast Facts, September 2016. DHCS data for September 2016 for aid code M2 is used for restricted-scope enrollees.

[28] California Department of Finance, Population Projections (Baseline 2016): Total Population by Sex and Age Group: 2010-2060 (5-year increments), March 2017.

[29] California Department of Health Care Services, Medi-Cal Renewals by County, October 2016.

[30] Congressional Budget Office, March 13, 2017.

[31] California DHCS, November 2016 Medi-Cal Estimate, Regular Policy Change 18, January 2017.

[32] Congressional Budget Office, Detail of Spending and Enrollment for Medicaid for CBO's January 2017 Baseline.

[33] California DHCS, May 2015 Medi-Cal Estimate, Regular Policy Change 211, May 2015.

[34] Dietz et al., December 2016.

[35] California DHCS, Medi-Cal Certified Eligibility Counts by Aid Code Groups and Congressional District, October 2016.

[36] Estimates by Jonathan Palisoc, Miranda Dietz, and Laurel Lucia, UC Berkeley Center for Labor Research and Education. California Senate and Assembly District estimates of current expansion enrollment are based on extrapolations from the American Community Survey data on Medi-Cal enrollment overall by congressional district and August 2016 DHCS data on Medi-Cal enrollment by county.

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