House Republican Budget Plan: State-by-State Impact of Changes in Medicaid Financing

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Introduction

The large and growing federal deficit has intensified calls for entitlement reform. Two prominent deficit commissions, the President's National Commission on Fiscal Responsibilities and Reform and the Bipartisan Policy Center Debt Reduction Task Force, have made broad proposals to reduce the deficit. The Obama administration also made recommendations. Recently, Congressman Paul Ryan, the Chairman of the House Budget Committee, has made a comprehensive proposal for deficit reduction, including major changes to Medicare and Medicaid. The Republican proposal, passed by the House on April 15, 2011 along a party line vote, would significantly reduce federal Medicaid spending and fundamentally alter the current entitlement structure and financing of the Medicaid program.

In this paper, we focus on the Medicaid provisions in the House Budget Plan, which would have significant implications for the populations served by the program, providers, states and localities, and would affect Medicaid's ability to maintain its current roles in the health system. In this analysis we will focus on the effect of the House Budget Plan for Medicaid on spending, enrollment, states and some providers.

The House Budget Plan includes two major provisions relevant to Medicaid. First, it would repeal the Affordable Care Act (ACA), which includes a major expansion of Medicaid with mostly federal funding to nearly all non-elderly individuals, including adults without dependent children, up to 138 percent of poverty. The repeal of ACA would result in substantial reductions in currently-projected Medicaid enrollment and federal spending. Second, the House Budget Plan would convert existing Medicaid financing from open-ended, matched federal spending for eligible individuals to a block grant under which federal spending is capped annually by state and is distributed based on a formula rather than actual costs. In exchange for capped federal spending, the proposal would give states additional flexibility to design their Medicaid programs although any federal requirements are not defined. The block grant would start in 2013 and grow annually with population growth and with inflation (CPI-U).[2] Since these growth levels are below the expected growth in Medicaid spending, the federal government would realize significant savings.
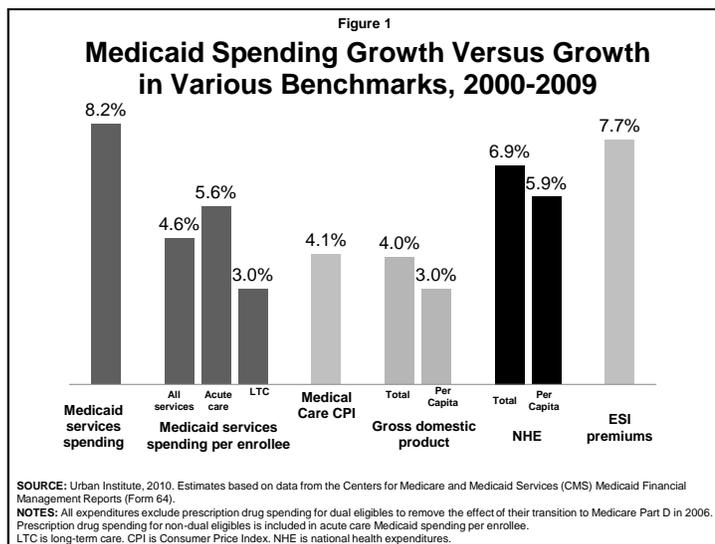
With federal spending reduced compared to current law projections, the House Budget Plan is expected to result in federal savings of $1.4 trillion over the 2012 to 2022 period with approximately $610 billion in savings resulting from the repeal of ACA and an additional $750 billion in savings from converting Medicaid to a block grant and limiting federal spending growth rates. The Congressional Budget Office concluded that although "states would have additional flexibility to design and manage their Medicaid programs and might achieve greater efficiencies in the delivery of care than they do under current law,

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[1] Authors are based at the Urban Institute.

[2] Starting in 2022, the Medicaid block grant payments would be reduced to exclude projected spending for acute care services or Medicare premiums and cost sharing paid by Medicaid. These payments would be replaced with Medical Savings Accounts. This change is outside the projection period in this analysis.

the large projected reduction in federal payments would probably require states to reduce payments to providers, curtail eligibility for Medicaid, provide less extensive coverage to beneficiaries, or pay more themselves than would be the case under current law."[3] Further, the fact that federal funds will no longer adjust to expanding enrollment will make it more difficult for states to respond during recessions.

In the face of reduced federal dollars, program cuts are likely because states have held rates of increase in spending per enrollee below those of other payers. As shown in Figure 1, from 2000 to 2009, Medicaid spending per enrollee increased by 4.6 percent overall, 5.6 percent for acute care, and 3.0 percent for long-term care. The 4.6 percent increase in Medicaid spending per enrollee was slightly above the medical care CPI and GDP during this period, but it was considerably below the growth rate for national health expenditures (both overall and per capita) and also below the growth rate for employer-sponsored health insurance premiums. Medicaid has achieved its relatively low growth rate through a variety of policies, including strict controls on provider payment rates, widespread use of managed care, expansion of home and community-based services as an alternative to institutional-ization, and a variety of policies intended to control prescription drug spending.[4] Growth in Medicaid spending has been largely driven by medical cost inflation and growth in enrollment, particularly during the recession from 2007 to 2009. While states would gain additional flexibility under the House proposed block grant, reductions in Medicaid spending growth much below levels experienced in the past seem difficult to achieve.

Figure 1

Medicaid Spending Growth Versus Growth in Various Benchmarks, 2000-2009

SOURCE: Urban Institute, 2010. Estimates based on data from the Centers for Medicare and Medicaid Services (CMS) Medicaid Financial Management Reports (Form 64).
NOTES: All expenditures exclude prescription drug spending for dual eligibles to remove the effect of their transition to Medicare Part D in 2006. Prescription drug spending for non-dual eligibles is included in acute care Medicaid spending per enrollee.
LTC is long-term care. CPI is Consumer Price Index. NHE is national health expenditures.

This analysis provides national and state-by-state estimates of changes in federal spending under the House Budget Plan. We estimate the impact of the changes due to both the elimination of the ACA and to the conversion to a block grant. The analysis also provides estimates of potential reductions in spending for hospitals, the largest category of Medicaid spending by service type.

The analysis then examines the potential impact on changes in enrollment under various scenarios. First, we assume that states make proportional reductions across population groups. We model these reductions using current law Medicaid spending growth per enrollee and then, assuming states could achieve significant efficiencies, using a somewhat lower growth rate. Second, we provide estimates of a scenario in which states achieve efficiencies in per capita spending growth and largely protect enrollment for the aged and disabled on Medicaid, thereby disproportionately distributing enrollment reductions to children and non-disabled adults. In another scenario we estimate the amount that state spending would have to increase in order to maintain enrollment as projected under current law without accounting for the Medicaid expansion in ACA.

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[3] Congressional Budget Office. *Long-Term Analysis of a Budget Proposal by Chairman Ryan.* April 5, 2011 (Corrected April 8, 2011).
[4] Holahan, John and Alshadye Yemane. 2009. "Enrollment Is Driving Medicaid Costs—But Two Targets Can Yield Savings." *Health Affairs* 28(5): 1453-1465.

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Methods

To develop state estimates of the House Budget Plan for Medicaid, we first needed to construct baselines of federal and state Medicaid spending by state both including the ACA and assuming the repeal of the ACA. These estimates are consistent with state levels of spending by age group and for acute and long-term care, and they are adjusted to agree with CBO numbers at the national level between 2012 and 2021. Second, we needed to create state-by-state estimates of Medicaid spending under the House Budget Plan, comparing this to the baselines both with and without the ACA to assess changes due to the ACA repeal and due to the conversion to a block grant. Deriving estimates of the implications for spending, enrollment, states and hospital spending all require specific assumptions. We note that some state estimates are subject to uncertainty because of sample size. Thus estimates of increases due to ACA in smaller states are less reliable than in larger states.

<u>**Methods for Developing Baseline Estimates**</u>

State Expenditures Baseline. We constructed our baseline estimates by starting with the Medicaid Statistical Information System (MSIS) data for 2007 (the most recent year available at the start of this analysis). MSIS includes national and state-by-state data on Medicaid spending. For consistency with CBO national estimates, we inflated the national 2007 MSIS figures on spending for each eligibility group (children, adults, individuals with disabilities, and the elderly) to agree with CBO estimates of national spending by eligibility group for 2012. We then made the same upward or downward adjustment in percentage terms for each individual state that we did for the national estimates; this step preserves the agreement with CBO projections at the national level but maintains state-by-state variation from the MSIS.

The Pre-ACA Baseline. For the period 2012 through 2021, we grew the estimates at the same baseline growth rate underlying CBO projections over this period. The CBO did not publish a pre-ACA or no reform baseline. However, the CBO published, on March 30, 2011, revised estimates of the impact of the Affordable Care Act for 2012 through 2021.[5] These changes from the current law (ACA) baseline begin in 2014. By subtracting these expenditure and enrollment estimates from the ACA baseline (March 2011 CBO Medicaid baseline), we estimated our pre-ACA baseline. We then inflated the adjusted MSIS figures described above at the same rate as the pre-ACA baseline for 2012 through 2021. This meant that each state would grow at the same rate over time. These procedures mean that high spending states would have the same relative difference for each eligibility group compared with lower spending states throughout the projection period. Thus, Massachusetts will have a high level of spending in its baseline because of their current polices and Texas will have a low level of spending in its baseline because of their current policies. But their baselines will grow at the same rate as each other and all other states.

We followed a similar procedure for state-by-state Medicaid spending on Medicare premiums, disproportionate share hospital payments (DSH), and administration. We inflated national spending for these items to 2012 to agree with 2012 CBO estimates for the nation, and grew each individual state's spending on these items from 2007 to 2012 by that same rate. For the period 2012 through 2021, we grew the estimates at the same growth rate used by CBO for these services over this period, again using the same growth rate for each state but preserving state differences in levels of spending for these items.

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[5] Elmendorf, Douglas W. 2011. CBO's Analysis of the Major Health Care Legislation Enacted in March 2010. Congressional Testimony. Washington DC: Congressional Budget Office.

Simulating the impact of the ACA on States. The final step was to simulate the impact of the ACA. We used the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) to simulate the impact of the ACA in 2014 to get estimates of the increase in Medicaid enrollment and expenditures in every state. These were then grown at the same rate as CBO's current law (ACA) baseline for both enrollment and expenditures. If HIPSM estimates at the national level exceeded CBO's ACA baseline data in any year, then each state was adjusted proportionally downward. The end result is that each state will grow under the ACA at the same rate as CBO's current law baseline, though from different starting points. The impact of the ACA relative to the CBO baseline will reflect state specific effects. For example, Alabama currently has lower Medicaid eligibility levels for adults and will have a much bigger relative expansion under ACA than New York, which currently extends Medicaid eligibility to adults at relatively higher incomes. The HIPSM identifies Medicaid enrollees by eligibility pathways. Thus, the model applies differential federal match rates for current, expansion, and new eligibles as specified under the law. It is assumed in our modeling effort that states would drop those with incomes above 138% FPL who are eligible through Sections 1115 or 1931 from their Medicaid programs and that these individuals would enroll in private coverage through exchanges.[6]

The model data set then is consistent with state levels of spending for each group with relative differences being maintained throughout the projection period. The baseline national data also agrees with the current law (ACA) baseline at the national level between 2012 and 2021.

Methods for Developing House Budget Plan Spending Estimates for Medicaid

The House Budget Plan would repeal ACA and convert Medicaid to a block grant starting in 2013 with federal spending allocated to states based on current expenditures that grow annually at a single national rate. The repeal of ACA is estimated by taking the difference between the current law baseline and the baseline assuming ACA repeal. To estimate spending under the House Budget block grant proposals and to hit the target savings of $750 billion over the 2012 to 2021 period as specified in the House Budget Resolution, we assume that after the repeal of ACA the Medicaid baseline would increase by the CPI-U and by the CBO's projection of Medicaid enrollment growth prior to reform, approximately 2.6 percent per year.[7] We assume this growth rate would be applied to 2010 spending, and projected forward to 2021.[8] We compared state-by-state federal spending under the House Budget Plan to baseline spending both with and without ACA.

To demonstrate the implications of a reduction in federal Medicaid spending on service providers, we examined how the changes in federal Medicaid spending would translate to changes in payments to hospitals, the largest single Medicaid provider*.* Decreases in Medicaid spending will translate to decreased revenue sources for providers, as fewer Medicaid dollars will flow through the health system. We calculate the share of Medicaid spending in each state attributable to hospitals and assume that this share remains constant through 2021. We then assume state policy changes to reduce Medicaid spending result in proportionate reductions in spending on all services. These cuts could come through reductions in payments and benefits. They could also come via eligibility reductions. States would have to make very deep cuts in other services to avoid proportionate reductions in hospital spending.

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[6] There are other optional categories which could be affected, but they are more difficult to identify using our model.

[7] Congressional Budget Office. March 2010 Medicaid Baseline; this low growth rate occurs because the increase in the CPI is low in the early years because of continuing slow economic growth, yet Medicaid enrollment is projected to decline slowly because of some albeit slow economic growth.

[8] With lags in data availability, this is the most recent year that could be as a baseline to establish a block grant in 2013.

We used our analysis of state-by-state federal Medicaid spending under the House Budget Plan to estimate the potential implications for enrollment in state Medicaid programs under different possible scenarios (described in detail below).

Results

Medicaid Spending Under the House Budget Plan

Total Changes in Federal Spending. Figure 2 shows projections for federal spending under three scenarios. Under current law, including the effects of ACA, federal Medicaid spending will total $4.0 trillion over the 2012 to 2021 period. With the repeal of ACA, total federal spending for Medicaid over the same period would be $3.4 trillion. Total spending under the House Budget Plan would be $2.7 trillion. Spending under the House Budget Plan is a $1.4 trillion or 34% reduction over the 2012 to 2021 period compared to current law (with ACA). After accounting for the repeal of ACA, the House Budget Plan represents a $750 billion or 22% reduction in federal Medicaid spending over the 2012 to 2021 period. Thus, the reduction in federal spending under the House Budget Plan that is attributable to the repeal of ACA would be $610 billion and the reduction attributable to the block grant would be $750 billion over the 2012 to 2021 period.

Figure 2

Federal Medicaid Spending for Years 2012-2021

Note: The House block grant does not come into effect until 2013 but begins growing from 2010 expenditure levels.
Source: Urban Institute estimates prepared for the Kaiser Commission on Medicaid and the Uninsured, May 2011.
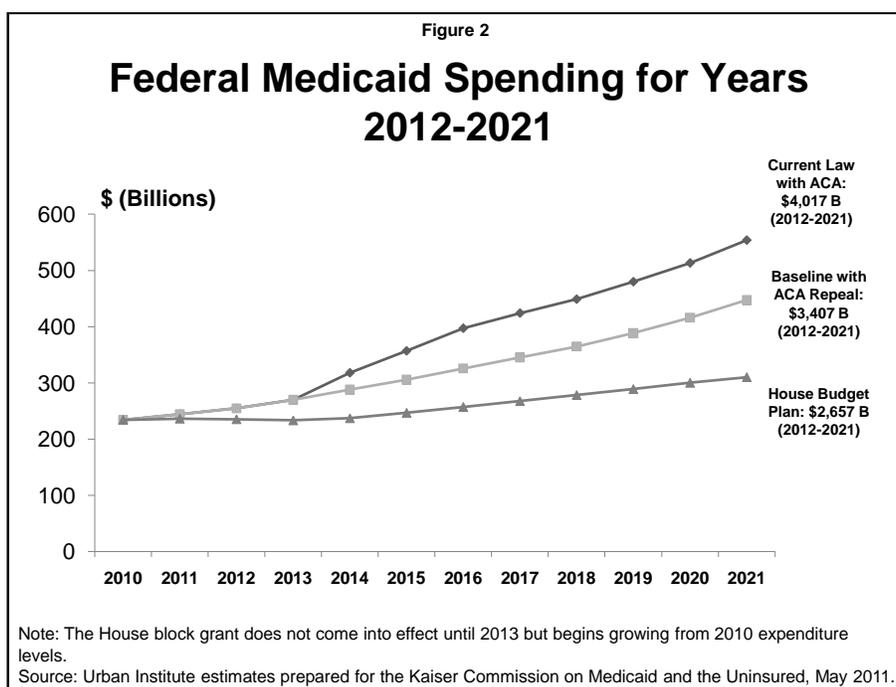
Changes in Federal Spending by State. Table 1 shows cumulative federal spending from 2012 to 2021 by state under current law and under the House Budget Plan. For the U.S. spending under the ACA is $4.0 trillion dollars. Not surprisingly, given their relatively large populations, the largest spending is in New York ($461.9 billion) followed by California ($394.4 billion). As noted above, the plan is expected to reduce federal Medicaid spending by $1.4 trillion over the 2012 to 2012 period. Under the methods used in this analysis, states will experience different percentage reductions in federal spending under the House Budget Plan largely due to the repeal of ACA (Figure 3). The reduction relative to the ACA is greatest in states where the ACA would have the largest impact and smaller in states with greater coverage in the baseline.

Figure 3
% Reduction in Federal Spending Under House Budget Plan Compared to Current Law Baseline with ACA, 2012 - 2021

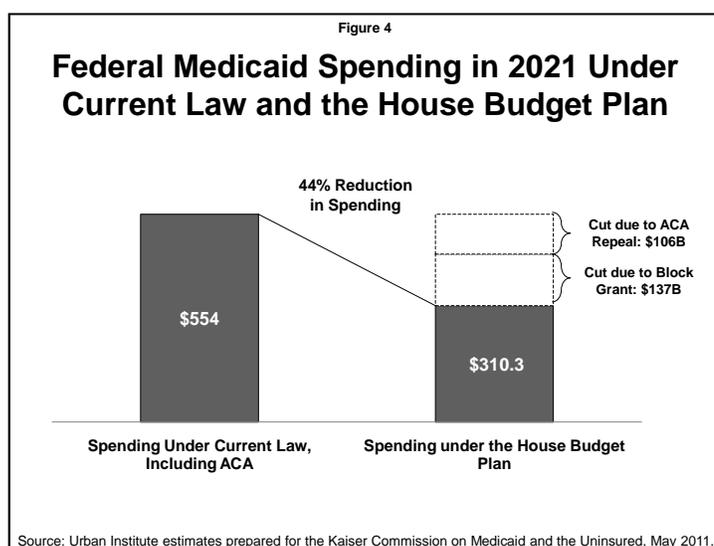| State	% Reduction
Wyoming	44.4%
Florida	43.7%
Alaska	41.6%
Colorado	41.4%
Georgia	41.4%
Oregon	41.1%
Nevada	40.9%
Delaware	40.2%
West Virginia	39.5%
Louisiana	39.5%
North Carolina	39.3%
Texas	38.4%
Maryland	37.9%
South Carolina	37.6%
North Dakota	37.2%
Arkansas	37.0%
Virginia	36.3%
Tennessee	35.8%
Utah	35.8%
Hawaii	34.8%
New Mexico	34.8%
Arizona	34.6%
Idaho	33.9%
US TOTAL	33.9%
New Hampshire	33.4%
Montana	33.3%
Alabama	33.1%
Connecticut	32.9%
South Dakota	32.9%
Ohio	32.9%
Wisconsin	32.5%
Nebraska	31.8%
Kentucky	31.7%
Illinois	31.7%
Mississippi	31.4%
Indiana	31.4%
Missouri	31.4%
Pennsylvania	31.2%
California	31.0%
Oklahoma	30.7%
Kansas	30.6%
New Jersey	30.6%
New York	30.6%
Maine	29.7%
Massachusetts	28.9%
Michigan	28.9%
Rhode Island	27.6%
Iowa	26.6%
District of Columbia	26.4%
Minnesota	26.3%
Vermont	25.8%
Washington	25.7%

Urban Institute estimates the prepared for the Kaiser Commission on Medicaid and the Uninsured, May 2011

States that currently have lower uninsured rates, higher Medicaid eligibility levels and higher participation in Medicaid are expected to experience less of a change in Medicaid enrollment and spending as a result of ACA than the national average. These states would also achieve savings by shifting coverage for populations with incomes above 138 percent of the federal poverty line (FPL) from Medicaid to the new exchanges. For example, spending increases by only relatively small amounts in Massachusetts, Iowa, Minnesota, Vermont, and Washington. Several states have increases in spending in the ACA that are well above the national average. These include Colorado, Florida, Georgia, Louisiana, Nevada, Oregon and Texas. These states are estimated to have the largest increase in enrollment spending under ACA relative to the baseline because they have higher rates of uninsured and lower Medicaid eligibility levels. Thus, these states have the largest decrease in federal Medicaid spending due to the repeal of ACA under the House Budget Plan.

In this analysis, the House Budget Plan to block grant Medicaid would reduce Medicaid spending by $750 billion over the 2012 to 2021 period, or 22 percent relative to the baseline with the repeal of ACA. There is not substantial variation in the percentage reduction across states in our analysis. Essentially each group - the aged, disabled, adults, and children - would grow at slightly different rates specified in the CBO baseline. As a result, baseline growth in each state would be slightly different because of the composition of their populations. However, the plan would achieve a relatively uniform reduction in spending as a percent relative to the ACA repeal baseline because the state baselines are each projected to grow at the same rate assumed by the CBO. The House Budget Plan would also grow by a uniform, though lower, rate in every state.

In reality, the national CBO projections are an average across states. Some states actually would grow faster and others more slowly. States that would have experienced higher growth rates than the national average under current law would experience sharper reductions in federal spending, and vice versa. However, there is no basis for predicting differences in baseline spending growth across states and we do not do so.

Figure 4 and Table 2 show similar results for the year 2021. Largely due to enrollment growth under the ACA, Medicaid spending under current law increases each year; it is higher in 2021 in percentage terms that it is cumulatively over the 2012-2021 period. Thus in 2021 the House Budget Plan would cut spending by 44 percent relative to the current law baseline with ACA and 31 percent relative baseline with the repeal of ACA. Again, the reductions in federal spending under the House Budget Plan relative to the ACA are greatest in states with large coverage expansions and smallest in states where there is less of an expansion of coverage. States with large coverage expansions due to the ACA will see largest reductions. For example, Florida would see a 54 percent cut; Georgia, Nevada and Oregon 51 percent; Louisiana 50 percent; and Texas 49 percent.

Figure 4

Federal Medicaid Spending in 2021 Under Current Law and the House Budget Plan

44% Reduction in Spending

$554

$310.3

Cut due to ACA Repeal: $106B

Cut due to Block Grant: $137B

Spending Under Current Law, Including ACA

Spending under the House Budget Plan

Source: Urban Institute estimates prepared for the Kaiser Commission on Medicaid and the Uninsured, May 2011.
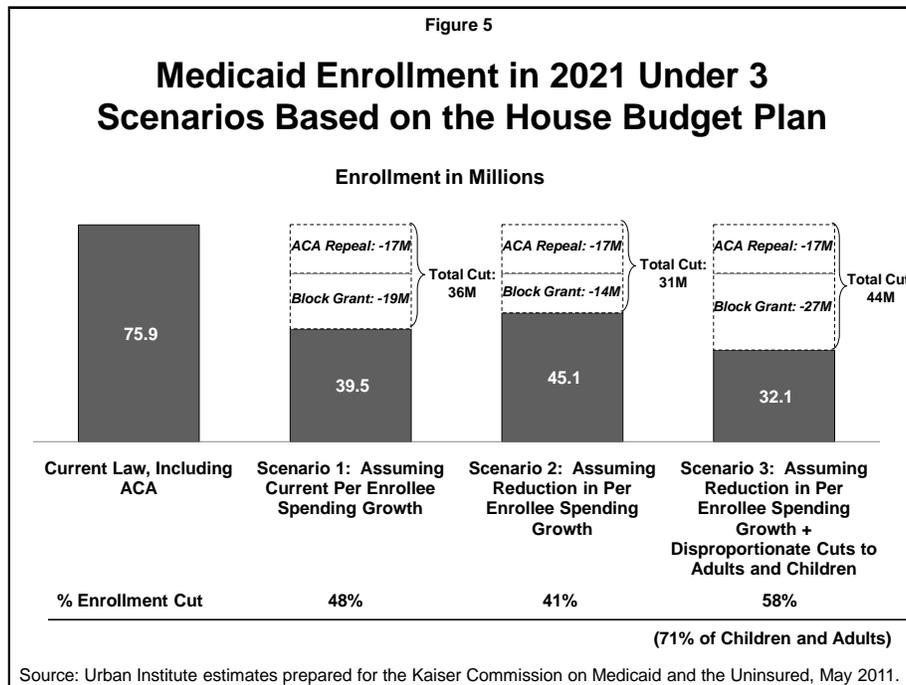
Impact on Hospitals. In Table 3 we look at the impact on hospitals, the largest Medicaid provider. Unlike previous tables, Table 3 includes both federal and state spending. Under current law, including ACA, Medicaid payments to hospitals would be $219 billion, about 25 percent of Medicaid spending, though this percentage varies among states. We project hospital spending in each state based on 2007 MSIS data and assumed the hospital share of the total remains the same. We then estimate reductions in hospital expenditures in 2021. This assumes that states would make equal reductions across all providers. Under the House Budget Plan, Medicaid payments to hospitals would fall by $84.3 billion in 2021 relative to the ACA, or 38 percent. Hospitals would see larger percentage reductions in those states with the largest increases in enrollment due to the ACA. Conversely, there would be smaller reductions, though still sizable, in states with smaller coverage expansions.

We then looked at the impact of the block grant relative to the pre-ACA baseline on hospitals. The effect would be about a 31 percent cut. Again, because both the baseline and the House Budget Plan grow at approximately the same rates, the cuts in hospital payments because of the block grant would be virtually the same in percentage terms across states. This is unlike the impact on hospital spending because of the ACA repeal, which varies in proportion to the extent to which states expand coverage and federal spending increases. Other providers such as physicians, nursing homes, and managed care plans will see reductions in the 31 percent range. For nursing homes in particular, this would be a significant cut since Medicaid accounts for over 40 percent of the nation's nursing home spending.

It is quite likely that states would disproportionally cut other services, particularly services that are now optional. As noted above, hospitals represent 25 percent of Medicaid expenditures and nursing homes represent 18 percent nationally. Services such as physician and clinic services, prescription drugs, institutional care for the intellectually disabled and mentally ill are also difficult to cut. It would thus require enormous cuts in remaining benefits to avoid substantial cuts in hospital and nursing home spending. Thus, these estimates may reflect an upper bound on potential reductions to hospitals under the House Budget Plan.

Implications for Medicaid Enrollment Under House Budget Plan

States will make different policy choices in the face of reduced federal spending for Medicaid. We examined the potential impact on enrollment in 2021 due to the reductions in federal spending from the repeal of ACA and the block grant under three possible scenarios: (1) per person spending would grow at rates equal to those projected under current law, and states make proportional reductions across all eligibility groups; (2) states can reduce per person spending growth (thus mitigating the size of the enrollment cuts), and states make proportional reductions across eligibility groups; and (3) states both reduce per person spending growth and protect the elderly and disabled (thus disproportionately distributing enrollment cuts to adults and children). In all of these scenarios, we assume that state spending is reduced by the same percentage as federal spending. Figure 5 summarizes the results from these scenarios.

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Figure 5

Medicaid Enrollment in 2021 Under 3 Scenarios Based on the House Budget Plan

Enrollment in Millions

Source: Urban Institute estimates prepared for the Kaiser Commission on Medicaid and the Uninsured, May 2011.

Scenario (1): Per Person Spending Growth Maintained. In this first scenario, Medicaid spending per enrollee would grow at rates equal to our estimates of the CBO baseline, if the ACA had not been enacted. We project this to be an average increase in spending per enrollee of 6.1 percent between 2012 and 2021, equivalent to growth in gross domestic product (GDP) plus 1.4 percentage points. These relatively high (compared to past trends) rates of spending per enrollee reflect faster growth in the aged and disabled than adults and children, again assuming no reform. (Without the compositional shift into a more expensive population, the assumed spending per enrollee change would be lower and a relatively low growth rate in comparison with that of other third party payers.) Under this assumption, all of the spending reductions would have to come from cuts in enrollment, and we assume that the cuts would be spread equally across all eligibility groups: the aged and disabled as well as the non-disabled adults and children. We estimated the cuts in enrollment by taking total (state and federal) projected Medicaid spending in a year with both the baseline and the House Budget Plan, dividing each by spending per enrollee for each year and deriving the change in the number of enrollees that could be covered at that spending level.

Figure 6 and Table 4 shows the results from our estimates under scenario (1). Under current law including ACA, average monthly Medicaid enrollment would be 75.9 million in 2021. Repealing the ACA in 2021 would reduce enrollment by about 17 million or 22 percent. Similar to changes in spending, the reductions in enrollment are greater in states with the greatest coverage expansions in the ACA, e.g. Florida, Georgia, Louisiana. Applying our assumptions about per person growth in Medicaid spending, the House Budget Plan would lead to an additional 19.4 million people being cut from Medicaid. Counting the impact of the ACA as well as the block grant, the result would be a cut of 36.4 million enrollees, a reduction of 48 percent. If states increase their spending, then the need for enrollment cuts would be much less. If there was no maintenance of effort and they spent less, they could cut state spending even more than federal spending and these enrollment estimates would be understated.

Figure 6
% Enrollment Cuts in 2021 Under House Budget Plan
Assuming Current Law Spending Per Enrollee and
Proportional Reductions Across Eligibility Groups

State	%
Oregon	56.1%
South Dakota	55.4%
Florida	55.1%
North Dakota	54.6%
Louisiana	54.5%
Nevada	54.5%
Georgia	54.1%
Alaska	53.7%
New Hampshire	53.6%
Kansas	53.5%
Idaho	53.4%
Colorado	53.3%
South Carolina	53.2%
Missouri	52.9%
Wyoming	52.8%
Utah	52.4%
Texas	52.1%
Montana	52.1%
Arkansas	52.0%
Nebraska	51.7%
West Virginia	50.9%
Ohio	50.8%
Oklahoma	50.6%
Virginia	50.1%
North Carolina	50.1%
Maryland	49.9%
Kentucky	49.7%
Indiana	49.6%
New Mexico	49.6%
Alabama	49.4%
Tennessee	48.6%
Pennsylvania	48.0%
US TOTAL	48.0%
Mississippi	48.0%
Hawaii	47.3%
California	47.2%
Illinois	46.9%
New Jersey	46.7%
Connecticut	46.1%
Michigan	46.0%
Wisconsin	43.7%
Washington	43.1%
District of Columbia	42.4%
Rhode Island	42.0%
Maine	41.5%
Delaware	40.6%
Minnesota	39.6%
Arizona	39.6%
Iowa	39.6%
New York	38.5%
Massachusetts	33.0%
Vermont	32.2%

Urban Institute estimates prepared for the Kaiser Commission on Medicaid and the Uninsured, May 2011

Scenario (2): Reductions in Per Person Spending. The second scenario is that states would achieve substantial efficiencies and reduce the rate of growth in spending per enrollee, which would mitigate the enrollment cuts. We assume that states could reduce the rate of growth in spending per enrollee to the growth in GDP (4.7%), or 1.4 percentage points lower than the previous assumption. Again, this is a lower reduction than it appears because of the compositional shift. By reducing spending per enrollee, less of the reductions need to come from enrollment cuts.[9] As in the first scenario, we estimated the cuts in enrollment by taking total (state and federal) projected Medicaid spending in a year in both the baseline and the House Budget Plan and dividing by the new and lower level of spending per enrollee, and deriving the change in the number of enrollees that could be covered at that spending level.

Table 4 also shows the estimates from scenario (2). Under these assumptions, states would still need to reduce enrollment by about 13.8 million under the House block grant proposal. Together with the impact of the ACA repeal, Medicaid enrollment would fall by 30.8 million under this assumption, a reduction of 41 percent. While most states cover children under Medicaid with higher incomes, there is significant variation in eligibility levels for adults across states. Most states do not cover childless adults through Medicaid. Over half of all states set eligibility for working parents below 100 percent of poverty, with 16 states below 50 percent of poverty. For many of these states, it would be extremely difficult to reduce eligibility levels by these amounts. Some states may cap enrollment and use waiting lists.

Scenario (3): Protections for the Aged and Disabled. The third scenario assumes that states would be relatively protective of the aged and disabled. In this scenario, we assume that states would reduce spending for these groups by 10 percent through benefit cuts and payment reductions. The remainder of the reduction in spending comes from spending on adults and children. We assume states reduce spending per enrollee to grow at the rate of GDP. The remainder comes from enrollment cuts. As in the other scenarios, we estimated the cuts in enrollment by taking total (state and federal) projected Medicaid spending in a year and calculating the number of adult and child enrollees that could be covered at that spending level.

Table 5 presents the enrollment impact under this scenario. Nearly all of the impact of the ACA would fall on adults and children, about 17 million, because the goal of the ACA is to primarily expand coverage for non-disabled adults.[10] The block grant itself would reduce coverage by almost 26.8 million adults and children, even assuming states were successful in controlling spending growth to the rate of increase in GDP. This would mean an overall reduction in enrollment of 58 percent and a reduction in enrollment of adults and children of 71 percent. Again, the biggest reductions would occur for states with largest coverage expansions in the ACA, but the reductions also depend on the amount of spending on the aged and disabled relative to adults and children. In states that have a large share of spending on the aged and disabled, a 10 percent reduction in spending yields more savings, thus the cuts that are necessary on adults and children are somewhat less. On the other hand, states that have relatively few adults and children covered by Medicaid, e.g. North Dakota, Kansas, would have to make greater

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[9] To slow growth rates further than assumed in this analysis would require high levels of cost sharing and substantial reductions in benefits. As discussed above, Medicaid per capita spending growth over the last decade has been lower than private payers due to strict controls of provider payment rates, widespread use of Medicaid managed care, expansion of home and community based services as alternatives to institutionalization and a variety of policies intended to control prescription drug spending. While states would gain more flexibility under the block grant, it is still difficult to see a rate of growth below the increase in GDP given historic trends in overall health care spending.

[10] Under the ACA, states could define the "medically frail" category of benchmark exempt enrollees to essentially extend the definition of disabled beyond the current SSI definition. That is outside the scope of this paper.

enrollment cuts to achieve sufficient savings or spend more of their own money. We cannot predict how these cuts would be distributed across adults and children, but the cuts are so large that a typical state would have to eliminate almost all coverage for adults to avoid any cuts for children.

Impact on State Spending to Preserve Eligibility. In this section we estimated how much of an increase in state expenditures would be necessary to ensure that there would be no enrollment reductions. All of the analysis summarized in Table 6 assumes repeal of the ACA and that states would only be attempting to offset the loss of federal revenues because of the block grant.

The results show that states would have to increase expenditures by a substantial amount to avoid enrollment cuts. Under the assumption that they cannot reduce spending per enrollee below GDP plus 1.4 percent, state spending would have to increase by $241 billion or 71 percent (Figure 7). The increases would tend to be greatest in states with higher federal matching rates. This occurs because the federal government is currently paying a high share of Medicaid spending in such states. If a high matching rate state chose to offset the loss of federal dollars, the increase in spending would be substantially greater than in a state with a lower matching rate.   If states were able to control spending to GDP growth, state expenditures would have to increase by $152 billion or 45 percent. Again, the increases are larger in states with higher matching rates.

Figure 7
Estimated Increase in State Spending in 2021 to Offset Medicaid Enrollment Reductions Under the House Budget Plan

$ billions

■ State Baseline Spending With ACA Repeal

▭ New State Spending to Maintain Medicaid Enrollment Under House Budget Block Grant

$240.8	$152.1
$339.2	$339.2
Assuming Current Per Enrollee Spending Growth	Assuming Reduction in Per Enrollee Spending Growth
71% Increase	**45% Increase**

Source: Urban Institute estimates prepared for the Kaiser Commission on Medicaid and the Uninsured, May 2011.

Conclusion

It is indisputable that the U.S. deficit is a serious matter and that entitlement programs need to be examined as part of a range of options. Both the President's National Commission on Fiscal Responsibilities and Reform and the Bipartisan Policy Center Debt Reduction Task Force made serious recommendations for reductions in Medicaid, including emphasis on better managing the care of Medicare and Medicaid dual eligibles and taking steps to reduce the gaming by states of the federal-state matching formula. The President has also put forth a proposal to achieve federal deficit reduction. The House Budget Plan goes much further than the President or either commission.

The House Budget Plan would repeal the ACA and convert Medicaid to a block grant with significant reductions in federal spending. This proposal would make fundamental changes to the financing structure of the program that could shift costs to states and could result in large reductions in enrollment and payments to providers such as hospitals. In aggregate, the proposal would reduce federal Medicaid spending by $1.4 trillion over the 2012 to 2021 period relative to spending under current law with ACA, a 34 percent reduction. The cuts in federal spending in the House Budget Plan would be greatest in the states that would benefit the most in terms of new coverage and new federal revenues from the ACA. These in general are in the south and mountain regions.

Of the $1.4 trillion reduction in federal Medicaid spending under the House Budget Plan, $610 billion is due to the repeal of the ACA, and $750 billion is due to the conversion of Medicaid financing to a block grant. The $750 billion reduction represents a 22 percent cut from what Medicaid spending would have been even without ACA

The repeal of ACA along with reductions in federal spending for Medicaid through the block grant would almost inevitably result in dramatic reductions in coverage and similarly dramatic increases in the number of uninsured in the country. Cuts in federal spending would result in large scale reductions in enrollment in Medicaid. This outcome would hold even if states were able to achieve substantial efficiencies by adopting policies to reduce the rate of growth in spending. We examined different scenarios for state responses to reduced federal Medicaid spending and estimate, depending on the specific underlying assumption, that enrollment reductions could range from 31 to 36 million if enrollment cuts were spread across all groups. Under the assumption that there were no cuts in eligibility and enrollment of the aged and disabled, 44 million adults and children, 58 percent of the total (or 71 percent of adults and children) could be cut even assuming efficiency gains. Most of the people who would lose Medicaid coverage would become uninsured. For example, in Urban Institute modeling of the Affordable Care Act, we found that 84 percent of new Medicaid enrollees would have otherwise been uninsured.[11]

To avoid enrollment cuts, states would be required to substantially increase their own Medicaid spending to make up for the loss in federal spending. The shift to state spending would be greatest in states that have higher federal Medicaid matching rates, as the federal government is currently paying a high share of Medicaid spending in such states.

We also showed that hospitals could potentially face major reductions in revenues under the House Budget Plan. By 2021, hospitals would face an annual loss of Medicaid revenue of $84 billion relative to the ACA. Some cuts in payments to hospital are inevitable if health care spending is to be reduced, but these reductions are of such a magnitude that they have quite serious implications. For example, the cuts facing hospitals would occur at the same time as a large number of Medicaid beneficiaries would become uninsured, requiring care they would have great difficulty paying for. The burdens of higher levels of uncompensated care facing hospitals would inevitably lead to increased spending by state and local governments.

From the federal perspective, capped financing at lower than anticipated levels will limit liability, make funding predictable and generate savings. In exchange for benefits to the federal budget, these changes could mean shifting costs and risk to states, localities, providers and beneficiaries. Medicaid currently plays a significant role in providing care to many low-income individuals including children, the elderly and individuals with disabilities, financing long-term services and provides support to safety net providers. Medicaid's ability to continue this role would be significantly compromised under this proposal, with no obvious alternative to take its place.

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[11] Buettgens, Matthew, Garrett, Bowen, and John Holahan. America Under the Affordable Care Act. Robert Wood Johnson Foundation. December 2010.

Table 1. Change in Federal Spending Under the House Budget Plan for Years 2012-2021

	Current Law Including ACA $(billions)	Spending Under House Budget Plan $(billions)	Total Reduction In Spending Under House Budget Plan Due to ACA Repeal and Block Grant		Baseline with ACA Repeal $(billions)	Spending Under House Budget Plan $(billions)	Reduction in Spending Under House Budget Plan Due to Medicaid Block Grant	
			Δ ($ billions)	Δ (%)			Δ ($ billions)	Δ (%)
US TOTAL	**4,017**	**2,657**	**1,361**	**34%**	**3,407**	**2,657**	**750**	**22%**
Connecticut	44.3	29.7	14.6	33%	37.9	29.7	8.2	22%
Maine	26.8	18.8	7.9	30%	24.3	18.8	5.5	23%
Massachusetts	109.4	77.7	31.7	29%	100.7	77.7	23.0	23%
New Hampshire	12.5	8.3	4.2	33%	10.4	8.3	2.1	20%
Rhode Island	19.3	14.0	5.3	28%	17.9	14.0	3.9	22%
Vermont	10.0	7.4	2.6	26%	9.5	7.4	2.1	22%
New England:	**222.3**	**156.0**	**66.3**	**30%**	**200.8**	**156.0**	**44.8**	**22%**
Delaware	12.8	7.6	5.1	40%	9.9	7.6	2.3	23%
District of Columbia	19.6	14.4	5.2	26%	18.5	14.4	4.1	22%
Maryland	64.6	40.1	24.5	38%	51.8	40.1	11.7	23%
New Jersey	87.5	60.7	26.8	31%	76.5	60.7	15.8	21%
New York	461.9	320.6	141.3	31%	409.6	320.6	89.0	22%
Pennsylvania	179.7	123.7	56.1	31%	159.1	123.7	35.4	22%
Middle Atlantic:	**826.2**	**567.2**	**259.0**	**31%**	**725.5**	**567.2**	**158.3**	**22%**
Illinois	143.5	98.0	45.4	32%	125.9	98.0	27.9	22%
Indiana	69.8	47.8	21.9	31%	61.8	47.8	13.9	23%
Michigan	111.5	79.2	32.3	29%	101.7	79.2	22.5	22%
Ohio	168.1	112.8	55.2	33%	144.7	112.8	31.8	22%
Wisconsin	62.2	42.0	20.2	32%	54.5	42.0	12.5	23%
East North Central:	**555.0**	**379.9**	**175.1**	**32%**	**488.5**	**379.9**	**108.6**	**22%**
Iowa	31.1	22.8	8.3	27%	29.4	22.8	6.6	22%
Kansas	27.9	19.4	8.6	31%	25.0	19.4	5.6	22%
Minnesota	62.3	46.0	16.4	26%	59.4	46.0	13.5	23%
Missouri	86.5	59.3	27.2	31%	74.9	59.3	15.6	21%
Nebraska	19.8	13.5	6.3	32%	17.5	13.5	4.0	23%
North Dakota	7.6	4.8	2.8	37%	6.2	4.8	1.4	23%
South Dakota	8.9	6.0	2.9	33%	7.7	6.0	1.8	23%
West North Central:	**244.2**	**171.8**	**72.4**	**30%**	**220.2**	**171.8**	**48.5**	**22%**
Florida	189.6	106.7	82.8	44%	137.7	106.7	30.9	22%
Georgia	115.1	67.5	47.6	41%	86.3	67.5	18.8	22%
North Carolina	155.4	94.3	61.1	39%	121.2	94.3	26.8	22%
South Carolina	66.6	41.5	25.0	38%	52.6	41.5	11.0	21%
Virginia	55.4	35.3	20.1	36%	45.5	35.3	10.2	22%
West Virginia	39.8	24.1	15.7	40%	31.0	24.1	6.9	22%
South Atlantic:	**621.8**	**369.4**	**252.4**	**41%**	**474.2**	**369.4**	**104.8**	**22%**
Alabama	58.0	38.8	19.2	33%	49.1	38.8	10.3	21%
Kentucky	68.8	47.0	21.8	32%	60.3	47.0	13.3	22%
Mississippi	51.7	35.4	16.2	31%	45.3	35.4	9.9	22%
Tennessee	106.6	68.5	38.2	36%	88.3	68.5	19.8	22%
East South Central:	**285.0**	**189.6**	**95.4**	**33%**	**242.9**	**189.6**	**53.3**	**22%**
Arkansas	50.4	31.8	18.7	37%	41.0	31.8	9.3	23%
Louisiana	88.6	53.6	35.0	40%	66.8	53.6	13.2	20%
Oklahoma	48.4	33.5	14.9	31%	43.2	33.5	9.7	22%
Texas	293.6	181.0	112.6	38%	230.4	181.0	49.4	21%
West South Central:	**481.0**	**299.9**	**181.2**	**38%**	**381.5**	**299.9**	**81.6**	**21%**
Arizona	99.5	65.1	34.4	35%	83.7	65.1	18.6	22%
Colorado	36.3	21.3	15.0	41%	27.2	21.3	6.0	22%
Idaho	17.6	11.6	6.0	34%	15.1	11.6	3.4	23%
Montana	10.9	7.3	3.6	33%	9.4	7.3	2.1	23%
Nevada	15.3	9.1	6.3	41%	11.6	9.1	2.5	22%
New Mexico	43.4	28.3	15.1	35%	36.7	28.3	8.3	23%
Utah	24.0	15.4	8.6	36%	19.9	15.4	4.5	23%
Wyoming	6.0	3.4	2.7	44%	4.4	3.4	1.0	23%
Mountain:	**253.1**	**161.4**	**91.6**	**36%**	**207.9**	**161.4**	**46.5**	**22%**
Alaska	12.9	7.5	5.4	42%	9.8	7.5	2.2	23%
California	394.4	272.2	122.2	31%	350.4	272.2	78.2	22%
Hawaii	13.9	9.0	4.8	35%	11.7	9.0	2.7	23%
Oregon	46.8	27.6	19.2	41%	35.7	27.6	8.1	23%
Washington	60.6	45.0	15.6	26%	57.9	45.0	12.9	22%
Pacific:	**528.6**	**361.4**	**167.2**	**32%**	**465.5**	**361.4**	**104.1**	**22%**

Source: Urban Institute estimates prepared for the Kaiser Commission on Medicaid and the Uninsured, May 2011.

Table 2. Change in Federal Spending Under House Budget Plan for 2021

	Current Law Including ACA $(billions)	Spending Under House Budget Plan $(billions)	Total Reduction In Spending Under House Budget Plan Due to ACA Repeal and Block Grant Δ ($ billions)	Δ (%)	Baseline with ACA Repeal $(billions)	Spending Under House Budget Plan $(billions)	Reduction in Spending Under House Budget Plan Due to Medicaid Block Grant Δ ($ billions)	Δ (%)
US TOTAL	**553.8**	**310.3**	**243.5**	**44%**	**447.5**	**310.3**	**137.1**	**31%**
Connecticut	6.1	3.5	2.6	43%	5.0	3.5	1.5	31%
Maine	3.6	2.2	1.4	39%	3.2	2.2	1.0	31%
Massachusetts	14.8	9.1	5.7	38%	13.2	9.1	4.1	31%
New Hampshire	1.7	1.0	0.8	44%	1.4	1.0	0.4	29%
Rhode Island	2.6	1.6	1.0	38%	2.4	1.6	0.7	31%
Vermont	1.3	0.9	0.5	36%	1.3	0.9	0.4	31%
New England:	**30.2**	**18.2**	**12.0**	**40%**	**26.4**	**18.2**	**8.2**	**31%**
Delaware	1.8	0.9	0.9	50%	1.3	0.9	0.4	31%
District of Columbia	2.6	1.7	1.0	36%	2.4	1.7	0.8	31%
Maryland	9.0	4.7	4.3	48%	6.8	4.7	2.1	31%
New Jersey	12.1	7.1	5.0	41%	10.1	7.1	3.0	30%
New York	63.0	37.5	25.5	41%	53.9	37.5	16.5	31%
Pennsylvania	24.6	14.4	10.1	41%	21.0	14.4	6.5	31%
Middle Atlantic:	**113.0**	**66.3**	**46.8**	**41%**	**95.5**	**66.3**	**29.2**	**31%**
Illinois	19.6	11.4	8.2	42%	16.5	11.4	5.0	31%
Indiana	9.5	5.6	3.9	41%	8.1	5.6	2.5	31%
Michigan	15.2	9.3	5.9	39%	13.4	9.3	4.1	31%
Ohio	23.1	13.2	10.0	43%	19.0	13.2	5.8	31%
Wisconsin	8.5	4.9	3.6	42%	7.2	4.9	2.3	32%
East North Central:	**76.0**	**44.4**	**31.6**	**42%**	**64.1**	**44.4**	**19.8**	**31%**
Iowa	4.2	2.7	1.5	36%	3.9	2.7	1.2	31%
Kansas	3.8	2.3	1.5	41%	3.3	2.3	1.0	31%
Minnesota	8.4	5.4	3.0	36%	7.8	5.4	2.4	31%
Missouri	11.9	6.9	4.9	42%	9.8	6.9	2.9	30%
Nebraska	2.7	1.6	1.1	42%	2.3	1.6	0.7	31%
North Dakota	1.1	0.6	0.5	47%	0.8	0.6	0.3	32%
South Dakota	1.2	0.7	0.5	43%	1.0	0.7	0.3	31%
West North Central:	**33.2**	**20.1**	**13.2**	**40%**	**28.9**	**20.1**	**8.8**	**31%**
Florida	26.9	12.5	14.4	54%	18.1	12.5	5.6	31%
Georgia	16.2	7.9	8.3	51%	11.3	7.9	3.4	30%
North Carolina	21.8	11.0	10.8	49%	15.9	11.0	4.9	31%
South Carolina	9.3	4.9	4.5	48%	6.9	4.9	2.1	30%
Virginia	7.7	4.1	3.6	46%	6.0	4.1	1.9	31%
West Virginia	5.6	2.8	2.8	50%	4.1	2.8	1.3	31%
South Atlantic:	**87.5**	**43.2**	**44.4**	**51%**	**62.2**	**43.2**	**19.1**	**31%**
Alabama	8.0	4.5	3.5	43%	6.5	4.5	1.9	30%
Kentucky	9.4	5.5	3.9	42%	7.9	5.5	2.4	31%
Mississippi	7.1	4.1	2.9	42%	6.0	4.1	1.8	31%
Tennessee	14.8	8.0	6.8	46%	11.6	8.0	3.6	31%
East South Central:	**39.3**	**22.2**	**17.1**	**44%**	**31.9**	**22.2**	**9.7**	**31%**
Arkansas	7.0	3.7	3.3	47%	5.4	3.7	1.7	31%
Louisiana	12.5	6.3	6.2	50%	8.8	6.3	2.5	29%
Oklahoma	6.6	3.9	2.7	40%	5.7	3.9	1.7	31%
Texas	41.1	21.1	19.9	49%	30.2	21.1	9.1	30%
West South Central:	**67.2**	**35.0**	**32.2**	**48%**	**50.0**	**35.0**	**15.0**	**30%**
Arizona	13.7	7.6	6.1	44%	10.9	7.6	3.3	30%
Colorado	5.1	2.5	2.6	52%	3.6	2.5	1.1	31%
Idaho	2.4	1.4	1.1	44%	2.0	1.4	0.6	31%
Montana	1.5	0.8	0.7	43%	1.2	0.8	0.4	31%
Nevada	2.2	1.1	1.1	51%	1.5	1.1	0.5	30%
New Mexico	6.0	3.3	2.7	45%	4.8	3.3	1.5	31%
Utah	3.3	1.8	1.5	46%	2.6	1.8	0.8	31%
Wyoming	0.9	0.4	0.5	54%	0.6	0.4	0.2	31%
Mountain:	**35.0**	**18.9**	**16.1**	**46%**	**27.2**	**18.9**	**8.3**	**31%**
Alaska	1.8	0.9	0.9	52%	1.3	0.9	0.4	31%
California	53.9	31.8	22.1	41%	46.1	31.8	14.3	31%
Hawaii	1.9	1.1	0.9	45%	1.5	1.1	0.5	31%
Oregon	6.6	3.2	3.4	51%	4.7	3.2	1.5	31%
Washington	8.2	5.3	2.9	36%	7.6	5.3	2.3	31%
Pacific:	**72.4**	**42.2**	**30.2**	**42%**	**61.2**	**42.2**	**19.0**	**31%**

Source: Urban Institute estimates prepared for the Kaiser Commission on Medicaid and the Uninsured, May 2011.

Table 3. Potential Impact of House Budget Plan on Federal and State Medicaid Payments to Hospitals, 2021

	Medicaid Payments to Hospitals Under Current Law Including ACA $(billions)	Medicaid Payments to Hospitals Under House Budget Plan $(billions)	Effect of House Budget Plan on Medicaid Payments to Hospitals due to ACA Repeal and Block Grant		Medicaid Payments to Hospitals Under Baseline with ACA Repeal $(billions)	Medicaid Payments to Hospitals Under House Budget Plan $(billions)	Effect of House Budget Plan on Medicaid Payments to Hospitals due to Block Grant	
			Δ ($ billions)	Δ (%)			Δ ($ billions)	Δ (%)
US TOTAL	**219,122**	**134,854**	**84,269**	**38%**	**194,320**	**134,854**	**59,467**	**31%**
Connecticut	1,687	1,082	605	36%	1,558	1,082	476	31%
Maine	683	444	239	35%	644	444	201	31%
Massachusetts	5,991	4,177	1,813	30%	6,074	4,177	1,897	31%
New Hampshire	355	220	135	38%	310	220	90	29%
Rhode Island	936	612	325	35%	881	612	269	31%
Vermont	223	161	63	28%	232	161	71	31%
New England:	**9,876**	**6,695**	**3,181**	**32%**	**9,699**	**6,695**	**3,003**	**31%**
Delaware	590	368	222	38%	534	368	166	31%
District of Columbia	1,148	750	398	35%	1,085	750	334	31%
Maryland	4,467	2,624	1,842	41%	3,805	2,624	1,180	31%
New Jersey	4,613	2,965	1,648	36%	4,216	2,965	1,251	30%
New York	26,756	17,754	9,002	34%	25,522	17,754	7,768	30%
Pennsylvania	9,371	5,963	3,408	36%	8,640	5,963	2,677	31%
Middle Atlantic:	**46,944**	**30,424**	**16,520**	**35%**	**43,801**	**30,424**	**13,377**	**31%**
Illinois	13,080	8,259	4,821	37%	11,877	8,259	3,618	30%
Indiana	2,936	1,826	1,109	38%	2,646	1,826	820	31%
Michigan	6,732	4,300	2,432	36%	6,198	4,300	1,898	31%
Ohio	7,342	4,455	2,887	39%	6,425	4,455	1,970	31%
Wisconsin	2,507	1,610	896	36%	2,355	1,610	745	32%
East North Central:	**32,597**	**20,451**	**12,146**	**37%**	**29,502**	**20,451**	**9,051**	**31%**
Iowa	1,091	767	324	30%	1,110	767	343	31%
Kansas	1,115	700	414	37%	1,011	700	311	31%
Minnesota	3,094	2,062	1,032	33%	2,997	2,062	935	31%
Missouri	4,918	3,026	1,892	38%	4,293	3,026	1,268	30%
Nebraska	803	494	309	38%	718	494	224	31%
North Dakota	185	106	79	43%	155	106	49	32%
South Dakota	417	254	164	39%	370	254	116	31%
West North Central:	**10,531**	**6,642**	**3,889**	**37%**	**9,546**	**6,642**	**2,904**	**30%**
Florida	12,784	6,842	5,942	46%	9,923	6,842	3,080	31%
Georgia	7,177	3,885	3,292	46%	5,561	3,885	1,676	30%
North Carolina	6,031	3,361	2,670	44%	4,843	3,361	1,482	31%
South Carolina	2,662	1,495	1,167	44%	2,131	1,495	636	30%
Virginia	2,801	1,684	1,118	40%	2,433	1,684	749	31%
West Virginia	1,106	598	507	46%	865	598	266	31%
South Atlantic:	**32,561**	**17,866**	**14,696**	**45%**	**25,755**	**17,866**	**7,889**	**31%**
Alabama	1,520	913	607	40%	1,303	913	390	30%
Kentucky	3,128	1,909	1,219	39%	2,751	1,909	842	31%
Mississippi	2,331	1,413	918	39%	2,036	1,413	622	31%
Tennessee	5,947	3,471	2,476	42%	5,006	3,471	1,536	31%
East South Central:	**45,487**	**25,571**	**19,916**	**44%**	**36,851**	**25,571**	**11,279**	**31%**
Arkansas	1,425	800	625	44%	1,163	800	362	31%
Louisiana	3,944	2,143	1,801	46%	3,007	2,143	864	29%
Oklahoma	2,539	1,580	960	38%	2,282	1,580	702	31%
Texas	16,139	9,211	6,928	43%	13,151	9,211	3,940	30%
West South Central:	**69,536**	**39,306**	**30,230**	**43%**	**56,453**	**39,306**	**17,147**	**30%**
Arizona	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
Colorado	2,024	1,143	881	44%	1,646	1,143	503	31%
Idaho	610	362	248	41%	525	362	163	31%
Montana	343	206	137	40%	299	206	93	31%
Nevada	876	502	374	43%	721	502	219	30%
New Mexico	2,437	1,471	966	40%	2,131	1,471	660	31%
Utah	1,482	851	631	43%	1,228	851	377	31%
Wyoming	302	163	139	46%	237	163	74	31%
Mountain:	**6,049**	**3,554**	**2,495**	**41%**	**5,141**	**3,554**	**1,587**	**31%**
Alaska	671	376	295	44%	546	376	170	31%
California	23,731	15,070	8,660	36%	21,807	15,070	6,737	31%
Hawaii	756	471	285	38%	687	471	215	31%
Oregon	2,254	1,244	1,010	45%	1,807	1,244	563	31%
Washington	3,981	2,717	1,265	32%	3,925	2,717	1,208	31%
Pacific:	**31,393**	**19,879**	**11,515**	**37%**	**28,772**	**19,879**	**8,893**	**31%**

Source: Urban Institute estimates prepared for the Kaiser Commission on Medicaid and the Uninsured, May 2011.

Table 4. Change in Enrollment Under House Budget Plan, Assuming Cuts are Spread Among All Groups, 2021

State	Enrollment Under Current Law Including ACA (thousands)	Reduction in Enrollment Due to House Budget Plan to Repeal ACA		Reduction in Enrollment Due to House Budget Plan to Block Grant Medicaid		Total Reduction in Enrollment under House Budget Plan			
Growth rate:				GDP+1.4%	GDP	GDP+1.4%		GDP	
	(thousands)	Δ (thousands)	Δ (%)	Δ (thousands)	Δ (thousands)	Δ (thousands)	Δ (%)	Δ (thousands)	Δ (%)
US TOTAL	**75,851**	**16,984**	**22%**	**19,404**	**13,816**	**36,388**	**48%**	**30,800**	**41%**
Connecticut	662	131	20%	175	124	305	46%	255	38%
Maine	395	50	13%	114	82	164	42%	132	33%
Massachusetts	1,437	15	1%	460	332	475	33%	346	24%
New Hampshire	199	59	30%	47	33	107	54%	92	46%
Rhode Island	228	32	14%	64	46	96	42%	77	34%
Vermont	158	1	1%	49	35	51	32%	37	23%
New England:	**3,080**	**287**	**9%**	**910**	**651**	**1,198**	**39%**	**939**	**30%**
Delaware	213	26	12%	61	44	86	41%	69	33%
District of Columbia	192	26	14%	55	40	81	42%	66	34%
Maryland	1,007	254	25%	249	179	503	50%	432	43%
New Jersey	1,204	240	20%	323	226	562	47%	465	39%
New York	5,639	518	9%	1,653	1,173	2,171	39%	1,691	30%
Pennsylvania	2,674	594	22%	690	495	1,283	48%	1,088	41%
Middle Atlantic:	**10,929**	**1,657**	**15%**	**3,028**	**2,153**	**4,685**	**43%**	**3,810**	**35%**
Illinois	2,965	640	22%	751	533	1,391	47%	1,173	40%
Indiana	1,339	326	24%	339	243	665	50%	569	42%
Michigan	2,336	473	20%	602	429	1,075	46%	902	39%
Ohio	2,846	773	27%	671	479	1,445	51%	1,252	44%
Wisconsin	1,174	185	16%	327	237	513	44%	423	36%
East North Central:	**10,660**	**2,398**	**22%**	**2,689**	**1,919**	**5,086**	**48%**	**4,317**	**40%**
Iowa	528	56	11%	153	109	209	40%	166	31%
Kansas	515	157	31%	118	84	275	53%	241	47%
Minnesota	881	86	10%	263	189	349	40%	276	31%
Missouri	1,415	425	30%	323	225	748	53%	650	46%
Nebraska	326	87	27%	82	59	169	52%	146	45%
North Dakota	102	32	31%	24	17	56	55%	49	48%
South Dakota	178	57	32%	41	30	99	55%	87	49%
West North Central:	**3,946**	**900**	**23%**	**1,005**	**716**	**1,905**	**48%**	**1,616**	**41%**
Florida	4,261	1,419	33%	930	668	2,349	55%	2,087	49%
Georgia	2,482	789	32%	553	390	1,342	54%	1,179	48%
North Carolina	2,232	573	26%	544	388	1,118	50%	961	43%
South Carolina	1,313	403	31%	296	207	699	53%	611	47%
Virginia	1,177	310	26%	280	200	590	50%	510	43%
West Virginia	537	146	27%	127	91	273	51%	237	44%
South Atlantic:	**12,002**	**3,640**	**30%**	**2,731**	**1,945**	**6,371**	**53%**	**5,586**	**47%**
Alabama	1,203	298	25%	296	208	594	49%	506	42%
Kentucky	1,112	289	26%	265	189	553	50%	477	43%
Mississippi	986	226	23%	247	176	473	48%	402	41%
Tennessee	1,903	464	24%	460	328	924	49%	792	42%
East South Central:	**5,204**	**1,277**	**25%**	**1,266**	**899**	**2,543**	**49%**	**2,176**	**42%**
Arkansas	961	271	28%	228	164	499	52%	435	45%
Louisiana	1,633	535	33%	356	244	891	55%	778	48%
Oklahoma	970	258	27%	233	166	491	51%	425	44%
Texas	5,916	1,702	29%	1,380	970	3,082	52%	2,672	45%
West South Central:	**9,479**	**2,766**	**29%**	**2,197**	**1,545**	**4,963**	**52%**	**4,311**	**45%**
Arizona	1,741	209	12%	480	340	689	40%	549	32%
Colorado	798	242	30%	184	131	426	53%	373	47%
Idaho	300	91	30%	69	50	160	53%	141	47%
Montana	159	45	28%	38	27	83	52%	72	45%
Nevada	367	117	32%	83	59	200	54%	176	48%
New Mexico	685	170	25%	170	122	340	50%	292	43%
Utah	438	128	29%	102	73	230	52%	200	46%
Wyoming	108	31	29%	26	19	57	53%	50	46%
Mountain:	**4,596**	**1,032**	**22%**	**1,155**	**822**	**2,187**	**48%**	**1,855**	**40%**
Alaska	170	51	30%	40	29	91	54%	80	47%
California	13,395	2,491	19%	3,835	2,746	6,326	47%	5,237	39%
Hawaii	282	59	21%	75	54	133	47%	112	40%
Oregon	755	249	33%	175	126	424	56%	375	50%
Washington	1,353	175	13%	407	291	583	43%	467	34%
Pacific:	**15,955**	**3,025**	**19%**	**4,523**	**3,240**	**7,549**	**47%**	**6,265**	**39%**

NOTE: GDP+1.4% is equivalent to 6.1%; true growth in spending per enrollee for each eligibility group is actually lower. The 6.1% reflects a shift to a more expensive population because of faster growth in the aged and disabled in the baseline.

Source: Urban Institute estimates prepared for the Kaiser Commission on Medicaid and the Uninsured, May 2011.

Table 5. Change in Enrollment Under House Budget Plan, Assuming Disproportionate Share of Spending Reductions Fall on Adults and Children, 2021

| | Enrollment Under Current Law Including ACA | Enrollment of Adults and Children Under Current Law Including ACA | Reduction in Enrollment Due to House Budget Plan to Repeal ACA | | Reduction in Enrollment Due to House Budget Plan to Block Grant Medicaid | Total Reduction in Enrollment under House Budget Plan | | |
| | | | | | | | Δ (%) | |
	(thousands)	(thousands)	Δ (thousands)	Δ (%)	Δ (thousands)	Δ (thousands)	Total	Adults & Children
US TOTAL	**75,851**	**61,284**	**16,984**	**28%**	**26,791**	**43,775**	**58%**	**71%**
Connecticut	662	532	131	25%	302	432	65%	81%
Maine	395	281	50	18%	175	225	57%	80%
Massachusetts	1,437	845	15	2%	539	553	8%	65%
New Hampshire	199	162	59	37%	68	127	64%	79%
Rhode Island	228	163	32	19%	95	127	55%	77%
Vermont	158	117	1	1%	72	74	47%	63%
New England:	**3,080**	**2,101**	**287**	**14%**	**1,237**	**1,524**	**49%**	**73%**
Delaware	213	177	26	14%	67	93	44%	53%
District of Columbia	192	144	26	18%	81	107	56%	74%
Maryland	1,007	807	254	31%	380	634	63%	79%
New Jersey	1,204	902	240	27%	574	814	68%	90%
New York	5,639	4,475	518	12%	2,705	3,224	57%	72%
Pennsylvania	2,674	1,925	594	31%	1,026	1,620	61%	84%
Middle Atlantic:	**10,929**	**8,431**	**1,657**	**20%**	**4,819**	**6,477**	**59%**	**77%**
Illinois	2,965	2,461	640	26%	885	1,525	51%	62%
Indiana	1,339	1,105	326	29%	453	778	58%	70%
Michigan	2,336	1,890	473	25%	831	1,304	56%	69%
Ohio	2,846	2,308	773	34%	1,150	1,923	68%	83%
Wisconsin	1,174	888	185	21%	601	786	67%	89%
East North Central:	**10,660**	**8,652**	**2,398**	**28%**	**3,796**	**6,193**	**58%**	**72%**
Iowa	528	414	56	14%	273	329	62%	79%
Kansas	515	415	157	38%	182	339	66%	82%
Minnesota	881	678	86	13%	445	531	60%	78%
Missouri	1,415	1,143	425	37%	384	809	57%	71%
Nebraska	326	269	87	32%	118	205	63%	76%
North Dakota	102	83	32	38%	49	81	79%	98%
South Dakota	178	149	57	38%	52	109	61%	73%
West North Central:	**3,946**	**3,152**	**900**	**29%**	**1,476**	**2,377**	**60%**	**75%**
Florida	4,261	3,411	1,419	42%	1,281	2,700	63%	79%
Georgia	2,482	2,062	789	38%	546	1,335	54%	65%
North Carolina	2,232	1,766	573	32%	682	1,255	56%	71%
South Carolina	1,313	1,088	403	37%	354	757	58%	70%
Virginia	1,177	920	310	34%	414	724	61%	79%
West Virginia	537	385	146	38%	172	319	59%	83%
South Atlantic:	**12,002**	**9,631**	**3,640**	**38%**	**3,423**	**7,063**	**59%**	**73%**
Alabama	1,203	886	298	34%	340	639	53%	72%
Kentucky	1,112	799	289	36%	299	588	53%	74%
Mississippi	986	737	226	31%	329	555	56%	75%
Tennessee	1,903	1,456	464	32%	485	948	50%	65%
East South Central:	**5,204**	**3,878**	**1,277**	**33%**	**1,432**	**2,709**	**52%**	**70%**
Arkansas	961	776	271	35%	360	631	66%	81%
Louisiana	1,633	1,322	535	40%	549	1,084	66%	82%
Oklahoma	970	800	258	32%	277	535	55%	67%
Texas	5,916	4,969	1,702	34%	1,524	3,226	55%	65%
West South Central:	**9,479**	**7,868**	**2,766**	**35%**	**2,621**	**5,388**	**57%**	**68%**
Arizona[1]	1,741	1,515	209	14%	345	554	32%	37%
Colorado	798	674	242	36%	287	529	66%	79%
Idaho	300	248	91	37%	104	196	65%	79%
Montana	159	129	45	35%	55	99	63%	77%
Nevada	367	306	117	38%	118	234	64%	77%
New Mexico	685	593	170	29%	188	357	52%	60%
Utah	438	386	128	33%	114	242	55%	63%
Wyoming	108	93	31	34%	39	70	65%	76%
Mountain:	**4,596**	**3,943**	**1,032**	**26%**	**1,135**	**2,167**	**47%**	**55%**
Alaska	170	147	51	35%	43	94	55%	64%
California	13,395	11,535	2,491	22%	6,285	8,776	66%	76%
Hawaii	282	235	59	25%	85	143	51%	61%
Oregon	755	622	249	40%	221	471	62%	76%
Washington	1,353	1,091	175	16%	540	716	53%	66%
Pacific:	**15,955**	**13,630**	**3,025**	**22%**	**6,987**	**10,012**	**63%**	**73%**

[1]*Estimates in spending and enrollment reductions in Arizona may be low because the state reports an unusually low share of enrollment and expenditures for the aged and disabled; this means the cuts reported in Table 3 are mostly from adults and children and thus, the cuts in Table 4 are similar. Assumes per enrollee spending growth at GDP.*

Source: Urban Institute estimates prepared for the Kaiser Commission on Medicaid and the Uninsured, May 2011.

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Table 6. Impact of House Block Grant Proposal on State Expenditures to Maintain Medicaid Enrollment, 2021

	State Expenditures Under Baseline with ACA Repeal	New State Spending to Avoid Enrollment Cuts Due to Ryan Block Grant			
		Assuming Cuts Spread Equally Across Eligibility Groups			
Growth rate:		GDP+1.4%		GDP	
	($ billions)	Δ ($ billions)	Δ (%)	Δ ($ billions)	Δ (%)
US TOTAL	**339.2**	**240.8**	**71%**	**152.1**	**45%**
Connecticut	5.0	3.1	61%	1.9	39%
Maine	1.8	1.5	88%	1.0	56%
Massachusetts	13.2	8.2	63%	5.3	40%
New Hampshire	1.4	0.8	58%	0.5	35%
Rhode Island	2.1	1.4	64%	0.9	41%
Vermont	0.9	0.6	76%	0.4	48%
New England:	**24.3**	**15.6**	**64%**	**9.9**	**41%**
Delaware	1.3	0.8	62%	0.5	40%
District of Columbia	1.0	1.1	103%	0.7	65%
Maryland	6.8	4.2	62%	2.7	40%
New Jersey	10.1	6.0	59%	3.7	37%
New York	53.8	32.8	61%	20.6	38%
Pennsylvania	17.4	11.9	68%	7.6	43%
Middle Atlantic:	**90.4**	**56.8**	**63%**	**35.8**	**40%**
Illinois	16.2	10.0	61%	6.3	39%
Indiana	4.5	3.9	87%	2.5	55%
Michigan	8.8	6.8	77%	4.3	49%
Ohio	11.6	9.4	81%	5.9	51%
Wisconsin	4.9	3.8	78%	2.5	50%
East North Central:	**46.0**	**33.9**	**74%**	**21.4**	**47%**
Iowa	2.3	1.9	83%	1.2	52%
Kansas	2.2	1.7	77%	1.1	49%
Minnesota	7.8	4.9	62%	3.1	40%
Missouri	5.7	4.6	80%	2.8	50%
Nebraska	1.6	1.2	77%	0.8	49%
North Dakota	0.5	0.4	86%	0.3	55%
South Dakota	0.6	0.5	84%	0.3	54%
West North Central:	**20.6**	**15.2**	**73%**	**9.6**	**46%**
Florida	14.6	10.1	70%	6.5	44%
Georgia	6.2	5.3	85%	3.3	53%
North Carolina	8.7	7.5	86%	4.8	55%
South Carolina	3.0	2.9	100%	1.8	62%
Virginia	5.9	3.7	62%	2.3	39%
West Virginia	1.4	1.7	118%	1.1	75%
South Atlantic:	**39.8**	**31.2**	**79%**	**19.7**	**50%**
Alabama	3.0	2.8	94%	1.8	58%
Kentucky	3.4	3.5	103%	2.2	65%
Mississippi	1.9	2.4	127%	1.5	80%
Tennessee	6.4	5.5	86%	3.5	55%
East South Central:	**14.7**	**14.2**	**97%**	**9.0**	**61%**
Arkansas	2.0	2.3	115%	1.5	73%
Louisiana	3.5	3.5	100%	2.2	61%
Oklahoma	2.9	2.6	90%	1.7	57%
Texas	20.6	15.2	74%	9.5	46%
West South Central:	**29.0**	**23.7**	**82%**	**14.8**	**51%**
Arizona[1]	5.7	5.0	89%	3.2	56%
Colorado	3.6	2.2	61%	1.4	39%
Idaho	0.9	0.9	103%	0.6	66%
Montana	0.6	0.6	98%	0.4	63%
Nevada	1.5	0.9	61%	0.6	38%
New Mexico	2.0	2.1	106%	1.3	68%
Utah	1.1	1.1	105%	0.7	67%
Wyoming	0.6	0.4	62%	0.2	40%
Mountain:	**15.8**	**13.2**	**83%**	**8.3**	**53%**
Alaska	1.3	0.8	63%	0.5	40%
California	45.9	28.4	62%	18.1	39%
Hawaii	1.3	0.9	70%	0.6	45%
Oregon	2.8	2.3	83%	1.5	53%
Washington	7.3	4.6	63%	2.9	40%
Pacific:	**58.6**	**37.0**	**63%**	**23.5**	**40%**

SOURCE: Urban Institute estimates prepared for the Kaiser Commission on Medicaid and the Uninsured, May 2011.

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