



**Changes Proposed to the Affordable Care Act  
and Medicaid Could Cost the District \$1 Billion  
or More Each Year**

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**Audit Team:**

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A Report by the Office of the District of Columbia Auditor  
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The Honorable Jack Evans  
Chairman, Committee on Finance and Revenue  
Council of the District of Columbia  
1350 Pennsylvania Ave., N.W.  
Washington, DC 20004

Dear Chairman Evans:

Shortly after the 2016 Presidential Election, you asked the Office of the District of Columbia Auditor (ODCA) to investigate the possible fiscal impact the proposed policies of then President-Elect Trump and the incoming Congress with respect to the Affordable Care Act (ACA) and Medicaid might have on the District. You asked ODCA to examine how repeal of the ACA, its Medicaid expansion, or a block grant of the Medicaid program could affect the flow of federal funds to the District and its ability to administer Medicaid and other local health programs, such as the District's health exchange, known as DC Health Link.

This letter report provides ODCA's response to those questions. We have examined current and previous plans proposed by the President Trump, his nominee to lead the U.S. Department of Health and Human Services (HHS), and Republican leaders in Congress to repeal or alter the ACA or to modify the current structure of Medicaid, with Republicans in the new Congress beginning their most recent push for ACA repeal on January 4, 2017. We also consulted with policy and program experts in the District's Department of Health Care Finance (DHCF) and Health Benefit Exchange Authority (HBX). The experts gave us the latest information on enrollment and costs, as well as their estimates of how ACA repeal or Medicaid alteration plans would affect the District. Additionally, we reviewed research by other experts on the impact these plans would have at the national and state level, including the District. Last, we consulted with health policy experts at the Kaiser Family Foundation, a leading healthcare think tank.

What follows is a brief summary of four findings that I believe answer your questions. The findings are supported by additional detail in the report, and may be helpful in your oversight of the District's revenues and finances:

1. The District would lose \$563 million in federal funding in Fiscal Year (FY) 2018 alone if Congress repealed the ACA's Medicaid expansion. Even using conservative growth estimates, the District could lose more than \$1 billion annually by FY 2028.
2. Separately, the District could lose \$1.9 billion annually by FY 2028 through the conversion of Medicaid into a per capita allotment, and \$2.1 billion through the conversion of Medicaid into a block grant.
3. The repeal of the ACA would require the District to take further legislative and regulatory action to continue operating its health benefits exchange, DC Health Link.
4. Repeal of the ACA or significant changes to Medicaid could leave tens of thousands of District residents without insurance unless the District stepped in to fill the gap.

## Background

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The **Patient Protection and Affordable Care Act of 2010 (ACA)**, also known as Obamacare, overhauled many aspects of the U.S. health insurance industry. Among its largest components are:

- The creation of state-specific “exchanges”—marketplaces that allow individuals without employer-provided health insurance and small businesses to purchase private health insurance.
- A federally-financed expansion of the Medicaid program that increased the eligibility threshold to 133 percent of the federal poverty level (FPL) and allowed lower-income adults without children (a population largely excluded from Medicaid in the past) to apply<sup>1</sup>.
- Federal tax credits and cost sharing subsidies for lower-income individuals and families to purchase insurance coverage for themselves.<sup>2</sup>

The law also includes an “individual mandate” requiring all Americans above a certain income level to carry insurance or face a tax penalty. It allows young adults to stay on their parents’ insurance until age 26, and prohibits insurance companies from denying coverage due to pre-existing conditions.

### DC Healthcare Alliance

Across the country, the District was among the first to take action to implement many of the key components of the ACA. Prior to passage of the ACA in 2010, the District had in place a locally-funded health insurance program for individuals who did not have access to any other options, including Medicaid and Medicare. The program, called the DC Healthcare Alliance, began in 2001 and had enrolled approximately 55,000 residents as of 2009. The Alliance covered District residents with an income below 200 percent of the FPL, including adults without children and undocumented immigrants—groups typically excluded from Medicaid.

After Congress passed the ACA in 2010, the Department of Health and Human Services (HHS) granted the District a waiver allowing it to use provisions in the new law to expand its Medicaid program to cover individuals up to 200 percent of the poverty level. The waiver allowed the District to shift many of the enrollees in the Alliance program (approximately 32,000 residents) to the newly expanded Medicaid program and to take advantage of the Federal Medical Assistance Percentage (FMAP)—the term for the federal share of payments under Medicaid. FMAP payments reduce the District’s local fund cost to provide many of these individuals with health insurance. In general, the District’s FMAP is 70 percent, meaning that for each standard Medicaid enrollee the District pays 30 percent of the costs and the

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<sup>1</sup> Prior to the expansion of the Medicaid program, only select disadvantaged populations (primarily pregnant women, parents with children, individuals with disabilities, senior citizens, and caretaker relatives) from 0 to approximately 44 percent of the FPL (which is \$11,880 for an individual in 2016) were eligible to enroll in Medicaid. The expansion allowed all Americans who fell below 133 percent of the FPL to enroll, regardless of disadvantaged status.

<sup>2</sup> The Affordable Care Act provides two sets of benefits for lower- to middle-income individuals and families. The first is an advanceable and refundable tax credit designed to limit the cost of premiums to a fixed percentage of income. The second is a set of cost-sharing subsidies that reduce the total out-of-pocket cost of insurance. Both of these benefits exist on a sliding scale up to 400 percent of the FPL, with lower-income individuals receiving a larger benefit.

federal government pays 70 percent.<sup>3</sup> For childless adults up to 133 percent of the FPL, the federal government paid 100 percent of the costs through the end of 2016, but under the ACA that percentage will decline through 2020 when the federal government will pay 90 percent of each enrollee’s cost.<sup>4</sup> Under the ACA, the District subsequently converted its waiver covering childless adults between 134 and 200 percent of the FPL to a state plan amendment that further increases eligibility to 210 percent of the FPL. The federal government reimburses the District for these costs at the District’s FMAP rate of 70 percent.

The District could not accomplish the transition of all Alliance program enrollees, however, due to the federal prohibition on Medicaid eligibility for undocumented immigrants and a five-year waiting period for non-citizens with legal status. Therefore, the District continues to run the Healthcare Alliance, which enrolled 15,206 District residents—as of July 2016, the most recent data available—using local funds to provide insurance coverage to these vulnerable populations. Figure 1 below provides a brief summary of the District’s vulnerable populations and which program (Alliance or Medicaid) they were eligible for both pre- and post-ACA implementation.

**Figure 1: How various low-income District residents receive health insurance**  
Insurance Eligibility Status of Select Groups Pre-and Post-ACA Implementation and Amount of Federal Funding Received for Each Enrollee

Population	Income Level	Pre-ACA	Post-ACA
Parents/Disabled/Elderly	0-44% FPL	Medicaid (70% Federal)	Medicaid (70% Federal)
Parents/Disabled/Elderly	44-210% FPL	Alliance (0% Federal)	Medicaid (70% Federal)
Childless Adults	0-133% FPL	Alliance (0% Federal)	Medicaid (100%* Federal)
Childless Adults	133-210% FPL	Alliance (0% Federal)	Medicaid (70% Federal)
Undocumented Immigrants	0-200% FPL	Alliance (0% Federal)	Alliance (0% Federal)

Note: The FPL in 2016 was \$11,880 for an individual. Accordingly, all American citizens in the District who made less than \$24,948 in 2016 are eligible to participate in the District’s Medicaid expansion.

\* The federal match for the expansion population was 100 percent through the end of 2016 but will gradually decline each year to 90 percent in 2020.

Because of the expansion, the District’s Medicaid program is quite large and covers a significant portion of the District’s population. As of FY 2016, the District had a monthly average of 261,768 individuals with Medicaid coverage across all of the groups identified above. Of that, the expansion population accounted for 75,828, or 29 percent of the total. In sum, the District budgeted \$2.9 billion for its Medicaid program in FY 2017, \$2.2 billion of which represents federal FMAP payments for both the expansion and traditional Medicaid population. On average, the District pays approximately one-quarter of the cost for each enrollee in Medicaid.

### DC Health Benefit Exchange Authority

The District also quickly implemented another major component of the ACA known as the individual and small business health insurance exchanges.<sup>5</sup> The exchanges were designed to offer individuals and small

<sup>3</sup> See 42 U.S.C. 1396d(b).

<sup>4</sup> See 42 U.S.C. 1396d(y).

<sup>5</sup> The ACA provides for two types of exchange markets—individual and small business. The market for individuals sells insurance plans to individuals and families living in that state, while the small business market sells plans to

businesses a way to access health care plans from insurance companies. In March 2012, the District created the DC Health Benefit Exchange Authority (HBX), a quasi-governmental independent agency<sup>6</sup>, to oversee the development of the District's health insurance exchange program. The District's exchange opened for business on October 1, 2013, and as of December 4, 2016, covered 16,745 individual District residents and an additional 58,823 people through the small business marketplace. According to HHS, 1,224 low-income District residents served by the individual market received federal subsidies to help them purchase health insurance in the first quarter of 2016 at the average value of \$183/month. According to HBX, these subsidies will total an estimated \$3.5 million in FY 2017. The most recent data from HBX also suggests that enrollment of District residents will increase substantially in FY 2017. As of December 11, 2016, according to data provided by HBX, 19,263 District residents had signed up for benefits through DC Health Link for coverage beginning in FY 2017, representing a 17.4 percent increase over the 16,409 individuals who had selected a health plan at the same time last year.

### **ACA Success and Contentions**

From an insurance coverage perspective, the provisions of the ACA have been an unqualified success. According to HHS, the percentage of uninsured Americans nationally has dropped from 15.5 percent in 2010 to 9.4 percent in 2015. In the District, the percentage of residents without insurance fell by half during the same period, from 7.6 percent to 3.8 percent. That low rate puts the District in a tie with Vermont for the second lowest uninsured rate nationally, with only Massachusetts, at 2.8 percent, having fewer residents uninsured as a percentage of its total population.

However, portions of the ACA—particularly state exchanges, the Medicaid expansion, and the individual mandate—have been politically contentious. According to the New York Times, Republicans in Congress had made 62 attempts as of January 6, 2016, to repeal or replace all or parts of the ACA since its 2010 passage. Over the years, Congress also has debated the idea of altering the structure of other social safety net programs through block grants or other changes, particularly with respect to Medicaid. Despite maintaining majorities in both houses of Congress since the 2014 midterm elections, Republicans have been unable to overcome President Obama's veto to advance their agenda. But with President Trump's election and the retention of their congressional majority in the 2016 election, Republicans could implement many of the changes to the ACA and Medicaid that they have long advocated.

Many of these proposed changes, which will be discussed in detail in this report, would result in significantly lower federal government payments to states. In the District, repeal of the ACA's Medicaid expansion would result in the loss of \$563 million in federal funding in the first year alone. In addition, the conversion of Medicaid into a per capita allotment or block grant would result in the loss of tens of millions of dollars in the first few years following the change. Given the District's projected FY 2017 local source revenues of \$7.23 billion, if enacted, the policy proposals discussed in detail below could force

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businesses with 50 or fewer full-time employees that are located within the state. Like participating states, the District's marketplace, DC Health Link, contains both an individual and small business exchange. For the purposes of this report, "exchange" refers to both.

<sup>6</sup> The Health Benefits Exchange Authority is governed by an independent board of directors, appointed by the Mayor with the advice and consent of the District of Columbia Council. Four non-voting members are District of Columbia agency directors (from the Department of Health Care Finance, the Department of Health, the Department of Human Services, and the Department of Insurance, Securities and Banking). Employees of the authority are District of Columbia government employees.

the District government into a difficult choice: Either supplement reduced federal funding from local source revenues at great cost or cut service to many District residents. Repealing the ACA would also create significant issues for the District's locally-run health benefits exchange, which relies on many aspects of the law to function effectively. This report will detail a number of the proposed policies that congressional Republicans have offered on the ACA and Medicaid and how those changes may affect residents and District finances.

# Objectives, Scope, and Methodology

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## Objectives

The primary objectives of this report are to answer the following questions:

1. How much federal funding could the District lose for Medicaid each year over the next 10 years if the ACA's Medicaid expansion was repealed?
2. How much federal funding could the District lose for Medicaid each year over the next 10 years if the Medicaid program were transformed from a fee-for-service program into a per capita allotment or a block grant?
3. How would the repeal of the ACA affect DC Health Link, the District's health insurance exchange?
4. What effects might repeal of the ACA or proposed changes to Medicaid have on District residents if the District did not step in to replace lost federal funding?

## Scope

This report is focused on analyzing the effects of plans put forward by Republicans in Congress over the past year to repeal or replace elements of the ACA or to restructure the Medicaid program.

## Methodology

To accomplish these objectives, ODCA interviewed officials at the District's Department of Health Care Finance (DHCF) and the Health Benefits Exchange Authority (HBX) and requested recent data on Medicaid and DC Health Link enrollment from those agencies. We also reviewed prior research and analyses from leading health policy organizations and interviewed staff from the Kaiser Family Foundation, a leading health policy think tank in the District. We then took that information and used the details of the proposed policy revisions outlined in this report to project the potential change in federal spending for Medicaid to the District over the next decade. We also analyzed how the proposed policy changes would affect the District's insurance exchanges and how residents may be affected if the District government cannot or does not make up for declines in federal spending over the period examined.

Because this is an analysis and not an audit, ODCA did not conduct a data reliability assessment or otherwise verify the data collected from cited sources beyond ensuring that it was correctly transcribed in this report. Therefore, the numbers in this report should be regarded as unaudited figures. Further, because this analysis discusses prospective legislative changes to major federal programs, it should not be regarded as a definitive assessment of what will occur. Instead, it models possible scenarios based on the details of those proposals, historical trends, and future projections. The analysis, therefore, should be viewed as describing a set of potential outcomes based on conservative assumptions. ODCA did not conduct the examination as an audit as defined by the Government Accountability Office's Government Auditing Standards.

## Analysis Results

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### **1. The District would lose \$563 million in federal funding in FY 2018 alone if Congress repealed the ACA's Medicaid expansion. Even using conservative growth estimates, the District could lose more than \$1 billion annually by FY 2028.**

One common target for conservatives in the debate over the ACA has been the law's expansion of the federal Medicaid program to include nearly all adults at or below 133 percent of the FPL. In FY 2016, the FPL for an individual was \$11,880, meaning that the Medicaid expansion allowed individuals who make up to \$15,800 to qualify for Medicaid. In 2012, the Supreme Court ruled that the federal government could not require states to accept the Medicaid expansion, allowing each state to choose whether to accept the expansion—and the increased federal funds and obligations that accompanied it.<sup>7</sup> As of December 2016, 31 states and the District have agreed to the Medicaid expansion. The District's Medicaid program exceeds the minimum income threshold set in the ACA due to a state plan amendment the District obtained from the federal government and covers residents with incomes up to 210 percent of the FPL, or \$24,948. In FY 2016, the District's Medicaid program covered 261,768 individuals on average each month, including 75,828 in the expanded portion alone.

Several recent bills in Congress have sought to repeal the ACA's expansion of Medicaid. Perhaps most significantly, both the House and Senate passed a bill titled, "Restoring Americans' Healthcare Freedom Reconciliation Act of 2015," which would have eliminated the ACA's Medicaid expansion on December 31, 2017. The legislation provided that, effective January 1, 2018, states could no longer receive federal funding to continue enrolling individuals eligible for coverage under the expanded program. Instead, states would only receive the FMAP for Medicaid expenditures for individuals eligible for the program prior to the passage of the ACA. While the bill did not prohibit the District from using local funds to provide health insurance comparable to Medicaid to the formerly covered expansion population, those individuals would no longer be eligible to enroll in Medicaid. President Obama vetoed the bill and Congress failed to override the veto. However, President Trump has publicly indicated a willingness to consider such a change and with Republicans in control of Congress, a similar bill could become law in 2017.

To date, several reviews have examined the effects a repeal of the Medicaid expansion program would have at the national level. The Congressional Budget Office produced a report in June 2015 that predicted total federal Medicaid spending would decrease by \$824 billion between 2016 and 2025 if the ACA were repealed. Repeal would also decrease the number of Americans who obtained their health insurance through Medicaid by an estimated 14 million over the same time period. Similarly, an analysis produced by the nonpartisan Kaiser Family Foundation estimated that up to 11 million Medicaid enrollees eligible under the Medicaid expansion could lose coverage if ACA provisions allowing states to expand coverage are repealed. In another analysis, the nonprofit Urban Institute focused on how repeal of Medicaid expansion would affect Americans who have health insurance through Medicaid or the

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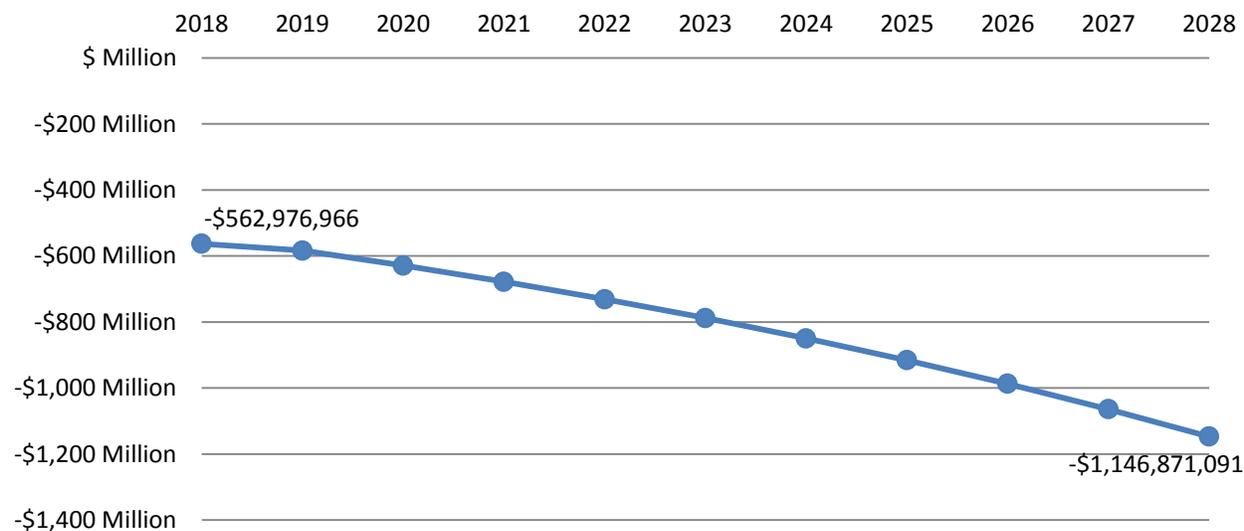
<sup>7</sup> See *National Federation of Independent Business et al. v. Sebelius*, 132 S.Ct. 2566 (2012). The Supreme Court ruled that mandating states enact the Medicaid expansion by threatening to withhold federal funds if they did not was not a legitimate use of Congress's power under the Spending Clause of the U.S. Constitution.

Children’s Health Insurance Program (CHIP). The bottom line: By 2019, 12.9 million Americans would lose their health insurance.

Meanwhile, DHCF concluded that the District would lose \$563 million in federal funds in FY 2018 alone if Medicaid expansion were repealed in FY 2017. That assessment is based on real costs from FY 2014 through FY 2016 and projections based on budgetary and historical trends for FY 2017 and FY 2018. DHCF’s analysis also notes that the federal government’s share of FMAP payments for the expanded Medicaid population will decrease from 100 percent to 90 percent between FY 2017 and FY 2020.<sup>8</sup> Separately, an issue brief from The Commonwealth Fund and the Milken Institute School of Public Health at The George Washington University found that a repeal of the ACA’s Medicaid expansion and tax credits would cost the District \$2.863 billion in federal funds between 2019 and 2023. That analysis, however, does not take into account the District’s additional expansion of the Medicaid program for individuals between 133 and 210 percent of the FPL.

Using DHCF’s analysis as a baseline, ODCA modeled the amount of potential federal funding loss annually from FY 2019 through FY 2028. To do this, we obtained estimates of average annual enrollment growth of 1.6 percent and an estimate of annual service cost increases for Medicaid of 6.1 percent from the Centers for Medicare and Medicaid Service (CMS)’s National Health Expenditure Projections 2015-2025. We then used DHCF’s FY 2018 estimate and inflated it each year with CMS’ annual estimated 10-year increases to account for growth between FY 2019 through FY 2028, projecting how much federal funding the District could lose (relative to current law) over 10 years. That data is shown in Figure 2.

**Figure 2: Total estimated annual decrease in federal Medicaid spending to the District after ACA repeal relative to current law, by fiscal year.**



As the figure shows, the amount of federal Medicaid dollars lost by the District under ACA repeal would total approximately \$563 million in FY 2018, consistent with the analysis by DCHF. Given projected medical cost inflation and enrollment increases, however, the annual decrease in federal spending rises

<sup>8</sup>Under the Affordable Care Act, the actual amount the federal government pays to cover the expanded Medicaid population is 100 percent of costs through 2016, a number that decreases each year to 90 percent of costs in 2020.

quickly each year. In FY 2028, the District could potentially be receiving more than \$1.1 billion less in Medicaid payments from the federal government than if the ACA remained in effect.

**NOTE:** It should be emphasized that the estimates presented in Figure 2 are based on projections and assumptions, not guarantees. Actual decreases in federal funds to the District under a repeal of the ACA (or more specifically the Medicaid expansion) could be higher or lower depending on the rates of enrollment growth and medical cost inflation that occur. The CMS data represent national projections, which may differ from what the District experiences over the next decade. However, we believe that our estimates represent both accurate and somewhat conservative benchmarks based on the most reliable and updated information available from official federal government sources, such as CMS, and discussions with staff and data from DHCF.

Further, the projections are based on the assumption that the District government would choose to completely fill the gap left by the repeal of the Medicaid expansion. If Congress repeals the ACA's Medicaid expansion, the District presumably would not be required to provide a Medicaid-like insurance program for the expansion population. Indeed, if the District declined to provide services and funding, direct costs to the District would likely decrease. Quite simply, repeal of ACA would mean that the District would no longer be required to pay some of the cost for covering the expanded population as it does under current law. The District would have other options. It could, for instance, offer a benefits package that is less generous than Medicaid, potentially reducing costs from the baseline identified in Figure 2.

On the other hand, actual costs to the District could also be substantially more than Figure 2 indicates if the District decided to provide its own insurance system for the population currently served by the Medicaid expansion. Based on the ODCA's interviews with officials from the Department of Health Care Finance, there may also be other indirect costs to the District associated with the repeal of the Medicaid expansion. There would likely be an increase in costs to District hospitals as more uninsured individuals seek emergency room treatment. Likewise, the District could expect an increase in the use of other government-provided health services, such as mental and behavioral health and substance abuse prevention. By law, the District has a responsibility to provide those necessary services to vulnerable populations.

## **2. Separately, The District could lose \$1.9 billion annually in 2028 through the conversion of Medicaid into a per capita allotment, and \$2.1 billion through the conversion of Medicaid into a block grant.**

Distinct from the proposal to outright repeal the ACA's Medicaid expansion, Republicans in Congress have also expressed a desire to reform the Medicaid program and reduce the cost of the program to the federal government. In June 2016, Republicans in the House of Representatives, led by Speaker Paul Ryan, unveiled a plan titled, "A Better Way: Our Vision for a Confident America," which included a wide swath of reforms across a number of policy issues. In a white paper on healthcare, the plan called for giving states a choice between two types of Medicaid reform: Converting the program into a per capita allotment (under which states are given a certain amount of federal funding each year per enrollee in the program) and a block grant (under which states are given a fixed sum of federal dollars per year regardless of changes in enrollment). While the white paper did not contain specific legislative language, it provided many details on how states could shift to either the per-capita or block grant formula from

the current fee-for-service based system. The details allowed ODCA to model how those systems differ from current law and estimate how federal payments to the District would likely change over time.<sup>9</sup>

If Congress passed a bill with provisions similar to those contained in the House Republican white paper, the District would have a choice of whether to convert its Medicaid program into a per capita allotment or a block grant. Under the per capita allotment outlined in the plan, the District in FY 2019 would receive the same amount of money it receives today under current law (including funding for the Medicaid expansion), adjusted for inflation. In subsequent years, the District's allotment would be calculated based on the per capita allotment for each type of Medicaid beneficiary (aged, blind and disabled, children, and adults) and the number of enrollees in those four categories. The per capita allotment would be adjusted each year for inflation, and the per capita FMAP for the expansion population would gradually decrease from 90 percent to 70 percent, the District's standard FMAP level.<sup>10</sup> Under the block grant option, a state that opted out of the per capita allotment would receive a set amount of federal funds each year, regardless of enrollment changes. The House Republican plan does not specify whether the block grant option would increase each year with inflation. However for the purposes of our analysis, we assume it will.

Under either scenario, the District would almost certainly lose a significant amount of federal funding over time relative to the current funding structure. While the amount the District would receive in the first year of either scenario would be the same or similar to the funds it receives under current law, the allotments would likely grow substantially slower than current annual increases. The primary reason for this is that the "Better Way" plan shifts from paying states based on a fixed percentage of costs incurred to pre-determining federal payments to states and adjusting the amount each year for inflation. Under the per capita plan, the amount also shifts based on the number of projected enrollees in the program. Under both plans, however, the District would get less money because the annual Medicaid cost increases are projected to significantly outpace inflation. The CMS projects that annual cost increases in Medicaid under current law will average 6.1 percent between 2015 and 2025. By comparison, the Federal Reserve Bank of Cleveland estimates that annual inflation (as measured in the rise in the price of goods, also known as the Consumer Price Index—CPI) will average 1.75 percent annually over the same period. Thus, under the House Republican plan, each year the District would see an increase in federal funds but over time would receive less and less relative to the current law as the inflation gap increases.

To model what this could look like, ODCA analyzed the House Republican plan and used additional information and projections to extrapolate how fast federal funding could grow under the per capita allotment and block grant scenarios relative to what would likely happen if no changes to the Medicaid program occurred. We first obtained data on the District's current FY 2017 budgeted Medicaid funding, including both local fund and federal payments. Then, as with the previous modelling of the effects of ACA repeal, we estimated annual enrollment growth in Medicaid of 1.6 percent (assuming eligibility for individuals is the same as it is currently under the Medicaid expansion, as the House plan indicates,

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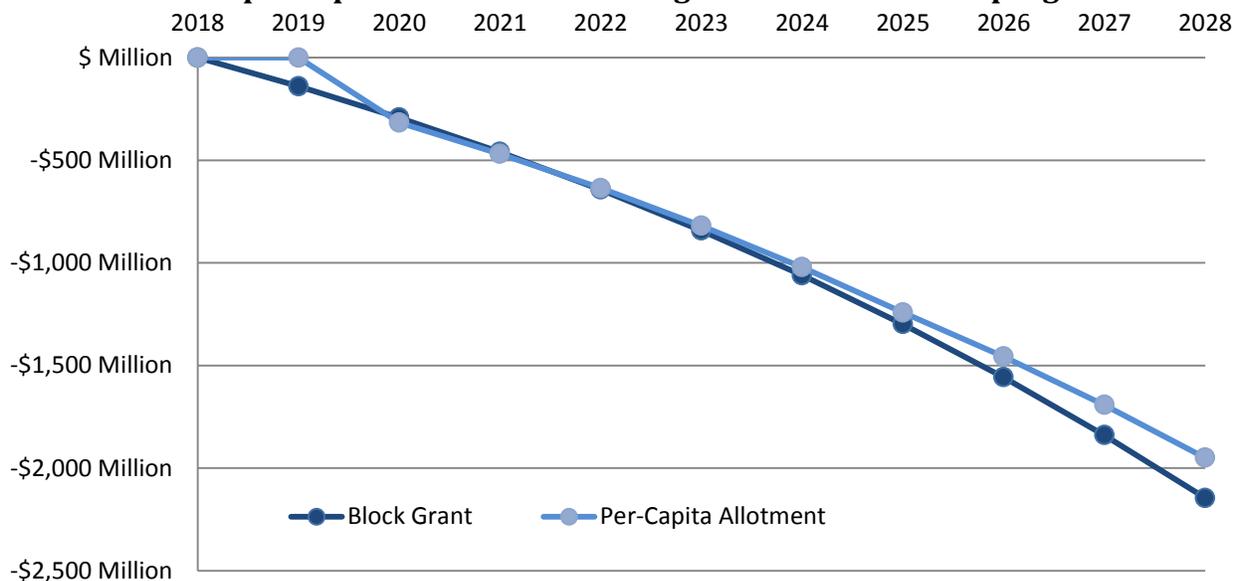
<sup>9</sup> Two important details to note from the proposal: The changes would happen gradually over several years (unlike the plan to repeal the Medicaid expansion noted above) and the House Republican Medicaid restructuring plan would not directly and immediately eliminate the Medicaid expansion. Instead, the plan (under both the per capita allotment and block grant) would gradually reduce federal financing for the expansion population to encourage states to shift those enrollees off of Medicaid and onto private health insurance.)

<sup>10</sup> According to the "Better Way" plan, the conversion of Medicaid to a per capita allotment would not itself invalidate the ACA's Medicaid expansion. Instead, over time the FMAP would be phased down from the 90 percent currently in the law "until it reached a state's normal FMAP level." The plan does not specify how long this phase-down would take, however. For the purposes of our analysis, we project it will occur over a five- year period.

using data from CMS’s National Health Expenditure Projections. We also obtained the previously noted estimates for both annual Medicaid cost increases under current law from CMS and annual CPI inflation from the Cleveland Fed.

Using these data and projections, Figure 3 shows the change in total projected federal Medicaid funding relative to current law for the District under a per capita allotment and a block grant beginning in FY 2019.

**Figure 3: Total estimated annual decrease in federal Medicaid spending to the District under a per capita allotment or block grant of the Medicaid program**



As Figure 3 shows, both options result in a significant loss of federal funding over the next decade. The losses in both scenarios start out relatively low, with the District receiving \$317 million less in federal dollars under a per capita allotment in FY 2020 and \$293 million less under a block grant. However, because of the difference in projected Medicaid cost increases and projected inflation, the losses compound over 10 years. Under a per capita allotment, ODCA estimates that the District could lose more than \$1.9 billion in federal funding per year by FY 2028, while under a block grant those losses could total \$2.1 billion annually by FY 2028. Over the course of the 10-year period from FY 2019 through FY 2028, we estimate that the District could lose \$9.6 billion under the per capita allotment scenario and \$10.3 billion under a Medicaid block grant. **NOTE:** The results presented in Figure 3 should not be taken as a certainty. They are based on projections using the information on policy changes contained in the House Republican plan and the most accurate estimates of program growth and inflation available. Actual federal funding losses to the District could be lower or higher, depending on the specifics of final policy changes, cost inflation, and enrollment growth.

As with the repeal of the Medicaid expansion, the conversion of Medicaid to a per capita allotment or a block grant would also likely have additional indirect effects on the District, many of which are difficult to quantify at this time. These include higher numbers of uninsured District residents seeking emergency treatment at District hospitals or mental health services through the Department of Behavioral Health (DBH).

### **3. The repeal of the Affordable Care Act would require the District to take further legislative and regulatory action to continue operating DC Health Link, its health benefits exchange.**

The United States has historically relied on employers to provide health insurance for employees (in contrast with many other countries where the government guarantees health insurance to its citizens). Self-employed Americans or those without job-based coverage have often found it difficult to obtain quality, affordable health insurance. Over the years, the federal government has established several programs to expand accessibility of health insurance to specific subsets of Americans least likely to have insurance: Medicare for senior citizens, Medicaid for low-income individuals and individuals with disabilities, and the Children's Health Insurance Program (CHIP) for children.

The ACA was designed to close most of the remaining gaps in insurance coverage. For instance, one key provision enabled states to create exchanges allowing individuals to directly purchase health insurance plans outside of the traditional employer-based health insurance system. Through the exchanges, individual Americans and small businesses can choose among numerous plans that offer different levels of insurance coverage at varying costs. Federal tax credits and cost sharing subsidies exist for lower- and middle-income individuals to reduce the cost of insurance.

As of December 2016, the District's health exchange, known as DC Health Link, enrolled 16,745 District residents and 58,823 employees of small businesses in the marketplace. Of the 16,745 individuals getting insurance through the marketplace, about 1,200 of them fall below 400 percent of the FPL, making them eligible for federal tax subsidies to purchase insurance. In total, those District residents will have received tax subsidies of about \$2.8 million in 2016 and will receive \$3.5 million in 2017, according to the HBX. According to data from the Kaiser Family Foundation, the District actually has the smallest portion of individual enrollees who qualify for federal tax subsidies—just 13 percent—compared to the nationwide average of 83 percent. One reason so few individuals qualify for subsidies is because the District's Medicaid program covers residents up to 210 percent of the FPL; in other states Medicaid typically only covers individuals and families up to 133 percent of the FPL.

As discussed, President Trump's official position and at least one plan proposed in Congress would repeal the ACA, including the language governing the regulation of the state insurance exchanges. HBX, which operates DC Health Link, was established by local law. The Health Benefit Exchange Authority Establishment Act of 2011 establishes HBX as an independent body with the statutory authority to set up and regulate the District's exchange. Therefore, unless Congress passes something that pre-empts state law, the District could continue providing a health insurance marketplace. If the ACA is repealed or changed, local law would require technical adjustments to eliminate references to the ACA.

That said, there are several provisions in the ACA that have a direct impact on the operation of the District's exchange. Most significantly within the ACA, there is the "individual mandate" requiring nearly all Americans to carry health insurance or pay a tax penalty.<sup>11</sup> This requirement exists only in the ACA, and if the law is repealed, there would be no requirement for individuals to purchase health insurance. If that occurs, many health researchers and insurers predict that the exodus of participants from the individual market could trigger what is commonly called a "death spiral," in which healthy individuals

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<sup>11</sup> There are some exemptions from the individual mandate. Individuals with qualifying religious exemptions and those whose income is too low to require them to file federal income taxes are not required to pay the tax penalties under the mandate. See *26 U.S. Code § 5000A*.

conclude they do not need insurance and decide not to purchase it. In that event, the number of healthy individuals in the insurance pool would likely drop dramatically. In turn, insurance companies can be expected to increase prices for the remaining participants, driving more individuals out of the market. With no individual mandate in place, DC Health Link—and its enrollees—would likely be significantly affected.

Repeal of the ACA would also eliminate federal tax credits and cost sharing subsidies for lower-income participants in the individual marketplace. As mentioned, about 1,200 District residents receive these subsidies, and their total projected value in FY 2017 is \$3.5 million. Without them, many of their recipients may not be able to afford health insurance through DC Health Link, reducing insurance coverage of the District's population.

In this case, the Council would have a viable option. It could pass a local version of the individual mandate and other provisions as long as the ACA repeal does not prohibit the District or states from doing so. The bill that President Obama vetoed—the “Restoring Americans’ Healthcare Freedom Reconciliation Act of 2015”—would have repealed both the individual mandate and federal tax and cost sharing subsidies, but contained no provisions preventing enactment of local legislation to accomplish similar goals. Therefore, if a similar bill passes Congress, the Council could adopt an individual mandate and create local tax subsidies funded with new local dollars, keeping the District's state exchange alive and potentially preventing an exodus of enrollees.

#### **4. Repeal of the Affordable Care Act or significant changes to Medicaid could leave more than 100,000 District residents without insurance unless the District stepped in to fill the gap.**

In addition to the fiscal impact, the repeal of the ACA could mean that tens of thousands of District residents lose their health insurance. According to a recent analysis by the Urban Institute, 32,000 District residents would lose health insurance as a result of a repeal of the ACA in FY 2019. In our analysis, this estimate seems low. Using the most recent enrollment figures, 75,828 District residents had healthcare under the Medicaid expansion program in September 2016 and 75,568 individuals were enrolled in DC Health Link. Without the ACA, the federal government would not provide funds for Medicaid services to District citizens up to 133 percent of the FPL or subsidies for lower-income enrollees in DC Health Link. In addition, without the threat of tax penalties under the individual mandate provision, healthy participants in DC Health Link might conclude it would be cheaper not to purchase insurance, a development that could drive up prices and force more District residents out of the exchange. Whether through an instantaneous or phased repeal, more than 100,000 District residents could lose their health insurance within a few years.

Separately, the conversion of Medicaid to a per capita allotment or a block grant could also lead to tens of thousands District residents losing health coverage or realizing reductions in the quality of their coverage. As projected in Figure 3, under a Medicaid per capita allotment the District could lose approximately \$1.9 billion per year in federal funding by FY 2028. Under a block grant program, the loss could be \$2.1 billion because of enrollment growth and significant differences between the rate of projected Medicaid inflation and the standard consumer price inflation. According to ODCA's analysis of DHCF provided data, the projected average cost per enrollee in the District's Medicaid program in FY 2017 is \$10,475.79. Using CMS's estimate of annual Medicaid cost growth of 6.1 percent, the average cost per enrollee in FY 2028 could be \$20,093.51. Given the District's FMAP rate of 70 percent, the

federal per-enrollee share could be \$14,065.46. According to our calculations, this means that—without altering the structure of the District’s Medicaid program at all—federal funding under a per capita allotment would support 138,618 fewer enrollees in FY 2028. Similarly, reductions under a block grant could mean 152,565 fewer enrollees supported by federal payments. In that scenario, in order to continue providing the same breadth and level of coverage, the District would need to increase its financial support or find ways to reduce the cost of coverage per enrollee in Medicaid.

### **Additional Economic Consequences**

The potential loss of health insurance for so many District residents would also produce side effects on the District’s economy. More residents, for example, would likely turn to hospitals for what is commonly called “uncompensated care,” a situation in which hospitals are required to treat but not compensated for treating individuals unwilling or unable to pay. According to the American Hospital Association (AHA), uncompensated care accounted for \$35.7 billion in costs for U.S. hospitals in 2015, the most recent data available. The AHA data also shows that uncompensated care costs, as a percentage of total expenses, decreased from 6.1 percent in 2012 to 4.2 percent in 2015 after years of ranging between 5.3 percent and 6.2 percent. According to HHS, a significant portion of this cost reduction is due to increased coverage offered through the ACA, particularly Medicaid expansion.

There would be other indirect economic costs to the District as well. A recent report by the Commonwealth Fund and Milken Institute School of Public Health at The George Washington University found that the District could lose 8,200 jobs from a repeal of the ACA’s tax credits and Medicaid expansion as the decline in federal funds leads to lower economic activity and employment. In addition, there would also likely be an increase in the number of employees missing work due to illness, since fewer residents would have health insurance to cover preventative care. This, in turn, would put a burden on District businesses. These costs, however, are difficult to measure due to uncertainty around the number of uninsured and the overall health of the population.

## Conclusion

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The repeal of the Affordable Care Act or the conversion of Medicaid into a per capita allotment or block grant would be very costly to the District and pose significant challenges for District policymakers. We estimate that the District could lose more than \$1.1 billion annually by FY 2028 from a repeal of the Medicaid expansion. Separately, the conversion of Medicaid into a per capita allotment could cost the District \$1.9 billion in federal funds in FY 2028 while the conversion of the program to a block grant could cost \$2.1 billion in that same year. In addition, the repeal of the ACA would cost District residents millions of dollars each year in lost federal tax credits, perhaps making the cost of health insurance unaffordable for them.

Given the magnitude of these possible losses, it is clear that the District could not readily supplement the lost federal funding to maintain the level of coverage for residents who currently benefit from the ACA and the Medicaid expansion program. The most recent quarterly revenue estimate from the District's Office of the Chief Financial Officer (OCFO) projects that the District will bring in \$7,227,500,000 in local source revenues in FY 2017. And while OCFO projects the District's local source revenues will grow in coming years, the size of the potential decreases in federal assistance suggests that the District would face a significant fiscal burden, likely requiring additional sources of revenue.

Sincerely,



Kathleen Patterson  
District of Columbia Auditor

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