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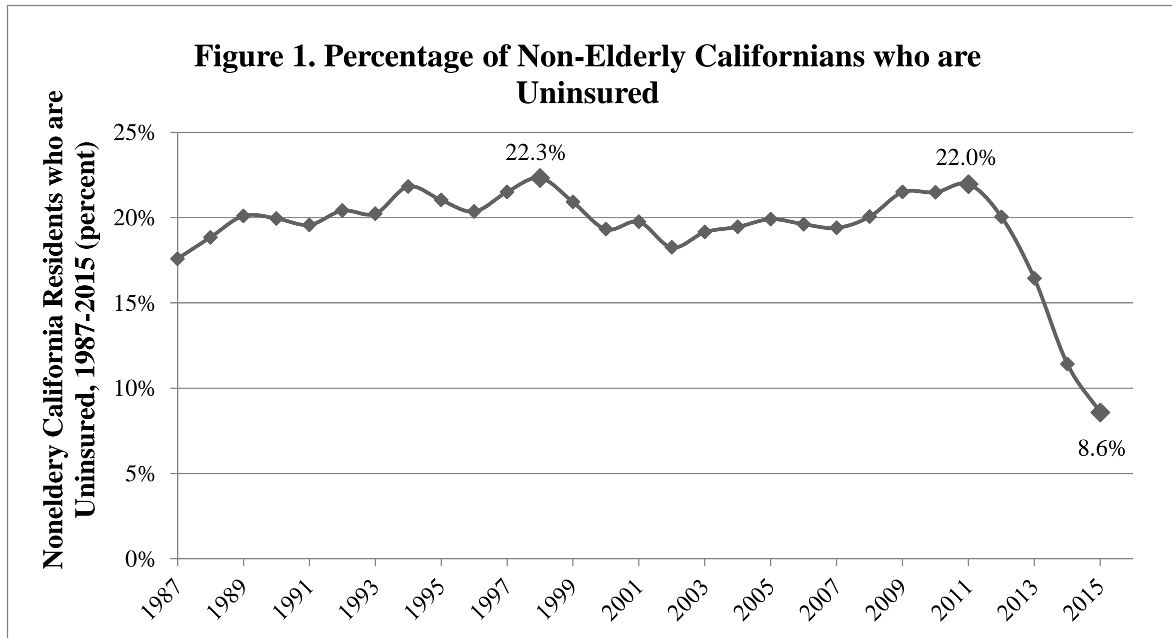
Informational Hearing: The American Health Care Act in California: What's at Stake.
March 24, 2017 - 2:30 pm

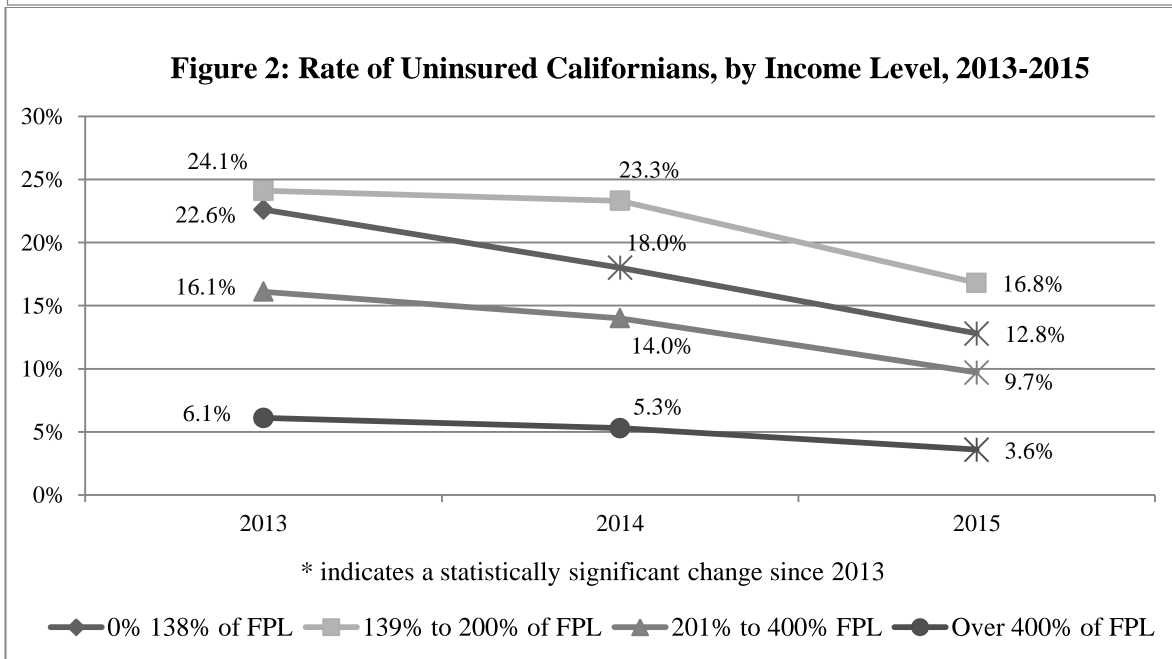
Background

Purpose. The federal Patient Protection and Affordable Care Act (ACA), approved on March 23, 2010, was the most transformative legislative action the U.S. health care system had seen in 40 years. The passage of the ACA meant sweeping changes to health care coverage in this country, including establishing more generous eligibility rules and federal funding for California's Medicaid (Medi-Cal) program, providing federally funded premium and cost-sharing subsidies offered through California's Health Benefit Exchange (known as Covered California), and imposing new requirements on health insurers that made it easier for individuals with pre-existing conditions to obtain coverage. The coverage expansions alone led to 20 million newly insured individuals in this country, including over 5 million Californians. In San Diego County over 250,000 low-income adults enrolled in expanded Medi-Cal and over 130,000 gained subsidies under the ACA.

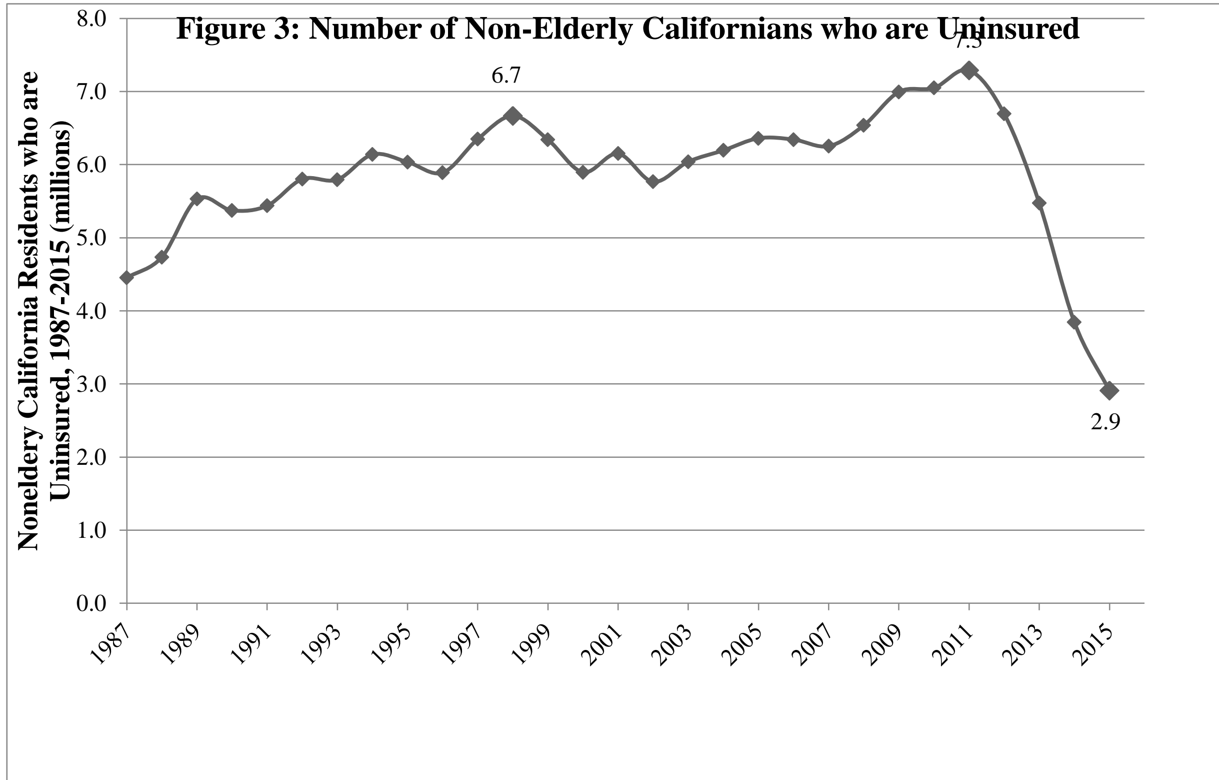
President Trump and the Republican leadership of the 115th Congress announced their intentions to repeal and replace the ACA, and have taken steps to defund major components of the ACA through the introduction of the American Health Care Act (AHCA) on March 6, 2017. In addition to making major changes to core health coverage provisions of the ACA, the AHCA would also enact new Medicaid changes, including a total conversion of federal Medicaid financing. In addition to the coverage impact, DHCS' preliminary fiscal estimate of the AHCA is that it represents a significant shift of costs from the federal government to states resulting in nearly $6 billion in costs to California in 2020, growing to $24.3 billion by 2027. The General Fund share is estimated to be $4.3 billion in 2020, increasing to $18.6 billion in 2027. Three House committees have passed the AHCA and it is anticipated that a full House Floor vote will take place on March 23rd, which is the 7th anniversary of the passage of the ACA. The purpose of this hearing is to inform policymakers and the public about the impact that the AHCA would have on California if enacted.

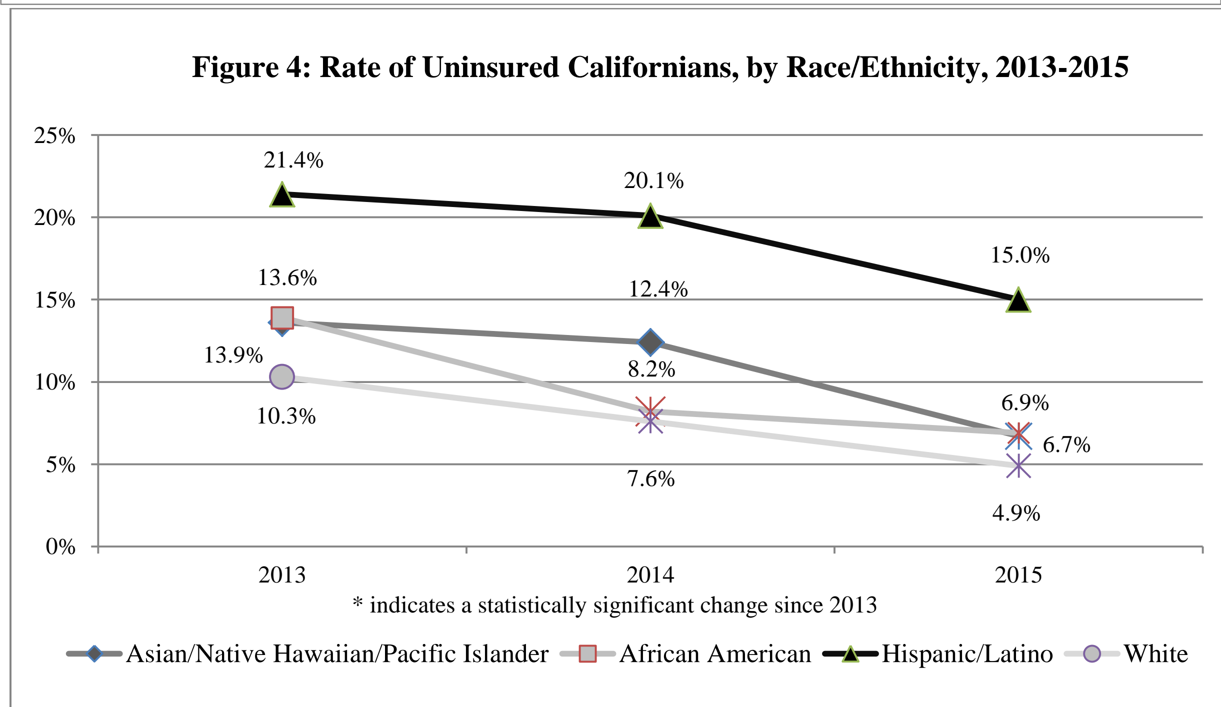
Decline in uninsured from the ACA. California has seen a remarkable decline in the number of people without health insurance coverage as a result of the ACA, as shown in Figures 1 and 2 below. Most notably, the percentage of Californians under age 65 without insurance declined from 22% in 2011 to 8.6% in 2015 (from 7.3 million in 2011 to 2.9 million in 2015). California experienced the largest percentage point decline in the uninsured rate of any state, according to the US Census Bureau. The federal Centers for Disease Control and Prevention has indicated a further fall to 7.1% in the first nine months of 2016.





The decline in uninsured as a result of the ACA crosses the major race/ethnic and income groups in California, as shown in the Figures 3 and 4 below:





Medi-Cal in California. Medi-Cal is administered by the Department of Health Care Services, with Medi-Cal eligibility determined primarily by county social service departments. As a joint federal–state program, federal matching funds are available to the state for the provision of health care services for most low-income persons. Medicaid spending is determined by three principle components: who is eligible for coverage, the rates health plans, health care providers, and health facilities are paid, and what benefits enrollees receive. In June 2016, there were 13.6 million individuals enrolled in Medi-Cal, comprising 34.5% of the state's population. Medi-Cal enrollment varies by county, with a low of 16.9% in Placer County to a high of 55.1% in Tulare County. San Diego County has a Medi-Cal enrollment of 901,691 people or 27% of the county's population. The Governor's 2017-18 budget assumes average monthly enrollment in Medi-Cal of 14.3 million individuals.

Medicaid and the per capita cap proposal in the AHCA. Medicaid is currently an entitlement for certain low-income individuals who meet eligibility criteria. States receive a fixed matching percentage of federal funds (referred to as the Federal Matching Assistance Percentage or FMAP) of at least 50% to up to 95% FMAP for each dollar they spend in state (or local government) funds. The matching rate varies by state, by population, and in some cases, by type of service. California's base FMAP is typically at 50%. In return for receipt of federal Medicaid matching funds, states have to cover certain population groups (for example, children and pregnant women at or below 133% of the FPL) and cover certain benefits (for example, physician and hospital services).

States have the option to cover additional groups or provide additional optional benefits and still receive federal Medicaid matching funds. If medical care costs increase, health plan and health provider rates are increased, or Medicaid enrollment increases, federal spending increases automatically as long as the required state/local match in spending increases. Federal Medicaid spending follows state spending, and is not capped per person or in aggregate. Total Medicaid spending nationally in 2015 was $346 billion in federal funds, with a match of $205 billion in state/local funds. California's Medi-Cal spending in 2016-17 is estimated to be $100 billion, consisting of $66 billion in federal funds, $19.6 in General Fund, and $16.7 in other non-federal funds (provider taxes and county funds through intergovernmental transfers and certified public expenditures).

Under the AHCA, beginning in 2020, the federal government would limit the amount of reimbursement it provides to states. This provision is referred to as a "per capita cap." A per capita cap would be a fundamental change to Medicaid financing. The per capita limit would be set by calculating the average per-enrollee cost of medical services for most enrollees who received full Medicaid benefits in 2016 for each state. The federal Secretary of the Department of Health and Human Services (HHS) would then inflate the average per-enrollee costs for each state by the growth in the consumer price index for medical care services (CPI-M). The final limit on federal reimbursement for each state for 2020 and after would be the average cost per enrollee for five specified groups of enrollees (the elderly, disabled people, children, newly eligible adults, and all other adults), reflecting growth in the CPI-M from 2016 multiplied by the number of enrollees in each category in that year.

Any state with spending higher than their specified targeted aggregate amount would receive reductions to their Medicaid funding for the following fiscal year. The limit on federal reimbursement would reduce federal spending because Medicaid spending would grow on a per-enrollee basis at a faster rate than the CPI-M. According to CBO's projections, Medicaid spending would grow at an average annual rate of 4.4% for Medicaid and 3.7% for the CPI-M over the 2017-2026 period.

With less Medicaid reimbursement, states would need to decide whether to commit more of their own resources to finance the program or whether to reduce spending by cutting payments to health care providers and health plans, eliminating optional services, restricting eligibility for enrollment, or (to the extent feasible) arriving at more efficient methods for delivering services. CBO anticipates that states would adopt a mix of those approaches, which would result in additional savings to the federal government.

A Medicaid per capita cap provides greater funding certainty to the federal government, and shifts the risk for health care cost increases to the states. For example, when new drugs and treatments are introduced, disease outbreaks occur, medical technology improves, chronic condition prevalence increases, or when people live longer and progressively require more medical care, states would be "on the hook" for cost increases.

In addition, a per capita cap would lock in California's low payment rate structure. California is one of the lower state per capita spending states, mainly due to its provider rates being far below what other payors pay. A per capita cap would lock in this historical amount so that any provider or plan rate increases would come from reductions in Medi-Cal spending in other areas (such as eligibility or benefits) because the per capita amount is a capped amount of money.

DHCS preliminary estimate of the per capita proposal in the AHCA is that California will be responsible for a state share of approximately $680 million in 2020, growing to $5.3 billion by 2027.

	Per Capita Impact	
	FY 2020	**FY 2027**
Total Expenditures Subject to the Cap	$94,888,686,184	$155,848,068,021
Total Allowed Expenditures Under the Cap	$93,819,883,742	$146,753,343,274
Total Expenditures Over the Cap	$1,068,802,442	$9,094,724,747
Federal Repayment Above Cap	**$679,192,987**	**$5,284,654,126**

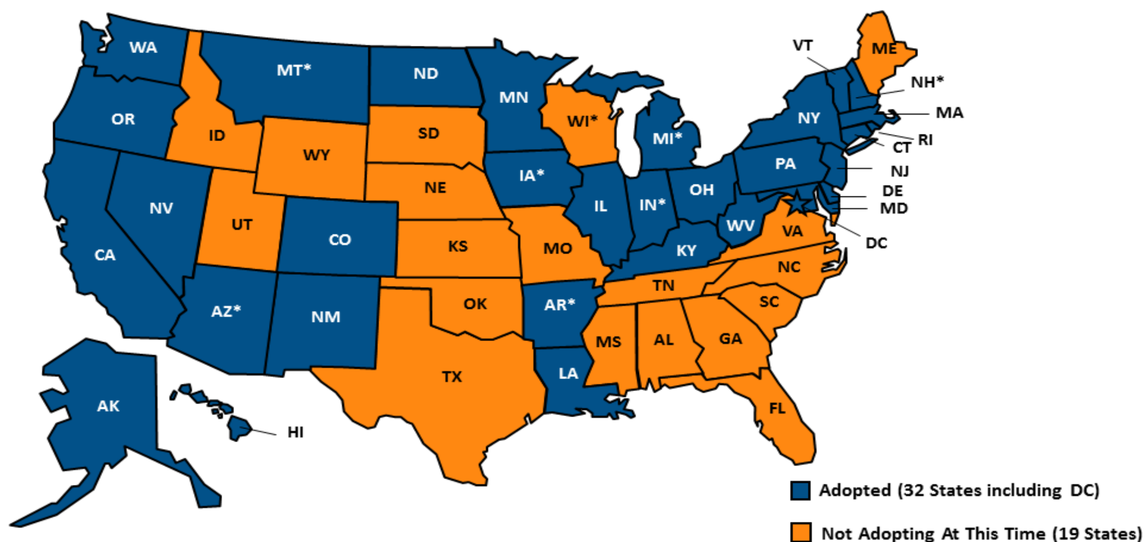
DHCS indicates, to the extent that state Medicaid programs are subject to an aggregate spending limit, this will have a devastating and chilling effect on provider or plan rate increases or any future supplemental payments (including quality assurance fees) because these additional costs will almost always be guaranteed to exceed the allowed trend factors and require states to fund these additional costs at 100% (in state funds).

Medi-Cal, the "optional expansion" and the AHCA. Prior to the ACA, Medi-Cal eligibility was mainly restricted to low-income families with children, seniors and persons with disabilities, and pregnant women. As part of the ACA, beginning January 1, 2014, the state expanded Medi-Cal eligibility to include additional low-income populations—primarily childless adults who did not previously qualify for the program. In California, the two principle groups included in the Medicaid eligibility expansion are non-disabled adults ages 18-64 without minor children and with incomes 0-138% FPL (up to $16,394 for an individual and $22,108 for a couple), and parents and caretaker relatives with incomes between 109-138% FPL (from $21,974 to $27,821 for a family of 3 in 2016/parents with incomes below 109% were previously effectively Medi-Cal eligible). The expansion also covers legal immigrants subject to the five year bar from federal Medicaid funding (who are currently proposed to shift from Medi-Cal to Covered California coverage in 2018).

In June 2016, 3.7 million individuals received coverage through this Medi-Cal expansion. This enrollment is projected to increase in the state's 2016-17 budget year to 3.9 million individuals, and the Governor's January 2017-18 Budget projects a total of 4.1 million individuals for the budget year. This expansion is referred to by the Brown Administration as the "optional expansion" because the 2012 Supreme Court decision in *National Federation of Independent Business v. Sebelius* made the Medicaid expansion optional for states. Total projected enrollment in Medi-Cal for 2016-17 was 14.3 million, meaning the ACA mandatory expansion of 3.9 million individuals in 2016-17 represents 27.2% of overall Medi-Cal enrollment.

As shown in the map below, California is one of 32 states that implemented the Medicaid expansion.

Current Status of State Medicaid Expansion Decisions



NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. *AR, AZ, IA, IN, MI, MT, and NH have approved Section 1115 waivers. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.
SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated October 14, 2016.
http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

Federal funds pay for nearly all of the cost of the Medi-Cal optional expansion. California's historical FMAP for Medicaid services is generally 50%, meaning for every dollar the state spends, the federal government provides one dollar in federal matching funds. By contrast, the benefit cost of the Medi-Cal expansion was funded entirely by federal funds for the first three years of the ACA implementation (2014-16). The FMAP percentage declined to 95% as of January 1, 2017, and will decrease to 94% in 2018, 93% in 2019, and to 90% in 2020 and thereafter.

	2015-2016	**2016-2017**	**2017-2018**
Total Medi-Cal spending (all fund sources)	$ 91 billion	$ 100 billion	$ 102.6 billion
Medi-Cal Optional Expansion (total funds)	$20.3 billion	$20 billion	$18.9 billion
Medi-Cal Optional Expansion (federal funds)	$ 19.9 billion	$ 19.2 billion	$ 17.3 billion
Medi-Cal Optional Expansion (state funds)	$396.6 million	$888.4 million	$1.6 billion
Medi-Cal Optional Expansion Enrollment	3.4 million	3.9 million	4.1 million
General Fund for Overall Medi-Cal Budget	$ 17.7 billion	$ 19.6 billion	$ 19.1 billion
Total General Fund/Overall State Budget	$ 115.6 billion	$ 122.5 billion	$ 122.5 billion

The AHCA and Medi-Cal expansion. The AHCA would discontinue the enhanced 90% federal funding for the optional expansion for new enrollment beginning January 1, 2020. Enrollment as of December 31, 2019 of individuals who do not have more than a one month gap in coverage would continue to receive enhanced FMAP funding. New enrollment after January 1, 2020 would be at state option, and would be at the state's regular FMAP (typically 50% in California) instead of the enhanced 90% FMAP.

CBO projects, on the basis of historical data (and taking into account the increased frequency of eligibility redeterminations required by the AHCA), that fewer than one-third of those enrolled as of December 31, 2019, would have maintained continuous eligibility two years later. Under the legislation, CBO estimates the higher FMAP would apply for fewer than 5% of newly eligible enrollees by the end of 2024.

DHCS preliminary fiscal estimate indicates the shift of optional expansion enrollees to a 50% FMAP represents the most significant cost shift to states, especially those that have expanded their Medicaid programs (such as California). DHCS estimates this will cost $4.8 billion in 2020, and grow to over $18.5 billion in 2027. The General Fund share would be about $3.3 billion in 2020, increasing to $13 billion in 2027.

	ACA Expansion FMAP Shift	
	FY 2020	**FY 2027**
Total ACA Expansion Enrollees	3,888,109	4,814,477
ACA Expansion Enrollees at 90% FMAP	2,187,297	1,839
ACA Expansion Enrollees at 50% FMAP	1,700,812	4,812,638
Total ACA Expansion Expenditures	$27,365,301,087	$46,454,019,990
ACA Expansion Expenditures at 90% FMAP	$15,394,640,767	$17,739,684
ACA Expansion Expenditures at 50% FMAP	$11,970,660,320	$46,436,280,306
Lost FFP Due to Shift to 50% FMAP	**$4,788,264,128**	**$18,574,512,122**

Note: The General Fund share of the FMAP shift is approximately 70%.

ACA health insurance requirements. Among many other provisions, the ACA made statutory changes affecting the regulation of and payment for certain types of private health insurance. Beginning in 2014, individuals were required to maintain health insurance or pay a penalty, with exceptions for financial hardship (if health insurance premiums exceed 8% of household adjusted gross income), religion, incarceration, and immigration status. Several insurance market reforms were required, such as prohibitions against health insurers imposing preexisting health condition exclusions. These reforms impose new requirements on states related to the allocation of insurance risk, prohibit insurers from basing eligibility for coverage on health status-related factors, allow the offering of premium discounts or rewards based on enrollee participation in wellness programs, impose nondiscrimination requirements, require insurers to offer coverage on a guaranteed issue and renewal basis, determine premiums based on adjusted community rating (age, family, geography and tobacco use).

Additionally, by 2014 either a state was required to establish separate exchanges to offer individual and small-group coverage or rely on the federal exchange referred to as healthcare.org. Exchanges allow for easy comparison of health insurance products and make available premium credits and subsidies to help those who qualify offset the costs of insurance coverage. An individual with income between 138% and 400% FPL ($16,394 and $47,080 annually) can qualify for advanced premium tax credits toward his or her premium costs based on age, income, family size and the region where the individual lives. In addition, depending upon income, consumers may qualify for subsidies toward their cost-sharing which limits the amount they pay when they access care. California established Covered California, as a state-based exchange that is operating as an independent government entity with a five-member Board of Directors.

Covered California. Covered California received more than $1 billion in federal grant funding for its launch; to build the information technology infrastructure; hire staff; undertake multicultural marketing, outreach and education efforts statewide; and work with community partners to educate target communities. Approximately 1.5 million people are enrolled in Covered California in 2017. In the fourth open enrollment period 412,000 new consumers enrolled and 1.3 million went through the renewal process. In 2016, Californians received federal funds in the amounts of $4.2 billion in advanced premium tax credits and over $700 million in cost sharing subsidies. Covered California is a self-sustaining entity funded through fees assessed on the participating health plans. Almost 90% of Covered California enrollees benefit from receiving federal subsidies to lower their premium costs.

Covered California plans and rates. Unlike other health benefit exchanges, Covered California is an "active purchaser," which means it selects plans and products to give uninsured Californians a mix of price and choice. In 2016, more than 90% of hospitals in California were available through at least one health insurance company, and about three-quarters (74%) were available through three or more companies. For 2017, Covered California is offering 11 health plans with new expanded options in Orange, San Francisco, and Santa Cruz counties. In addition, Covered California has required plans to lower co-payments for primary care visits and urgent care, saving consumers up to $55 per visit. Consumers in Silver, Gold and Platinum plans will pay a flat co-payment for emergency room visits without having to satisfy a deductible.

Until 2017, statewide weighted average rate increases were approximately 4%, a dramatic reduction from the trends that individuals faced in the years prior to the ACA. The modest rate increases negotiated for 2016 represented the second year of Covered California's success as an active purchaser. For 2017 rates the statewide weighted average change in rates is 13.2%, which is up considerably from approximately 4% in each of the previous two years. However, most consumers saw a much smaller increase or reduced rates if they switched to another plan.

Covered California indicates the rate increases for 2017 are a one-time adjustment due in large part to the end of federal programs, such as the reinsurance program, that helped keep rates low by supporting plans that had sicker enrollees and thus higher costs. With reinsurance expiring at the end of 2016, plans no longer receive reinsurance payments and have to adjust their rates to make up for those losses. It is estimated that the end of reinsurance added between 4% and 7% to rates in 2017. Additionally, the cost of health care continues to go up every year, with the cost of specialty drugs being a driver of those cost increases.

The AHCA insurance market changes. The AHCA changes the tax credit offered under the ACA by offering a flat tax based on age and income (the credit phases out for individuals making more than $75,000 per year). The proposed AHCA tax credits would range from $2,000 to $4,000 per individual. There would be no cost sharing subsidies available under the AHCA. The average subsidy under the AHCA would be about 60% of the average subsidy under the ACA, and the effect on Californians would vary. For older, lower income Californians, the proposed tax credit structure is a dramatic increase in the out-of-pocket costs for coverage. Eliminating the adjustment of subsidy based on where an individual lives will have major impact as well, especially for those who live in areas of the state with higher insurance costs. In Kern County, a 62 year old earning $30,000 a year would pay 8.3% of his or her income ($2,494 per

year or $208 per month) toward health insurance under the ACA, and under the AHCA he or she would pay more than 30% of his or her income ($9,182 a year or $765 per month). In Monterey County, a 62 year old earning $30,000 a year would also pay 8.3% of his or her income under the ACA, and under the AHCA would pay almost 60% of his or her income ($17,873 per year or $1,489 a month) toward health insurance. In San Diego County, a 62 year old earning $30,000 a year would also pay 8.3% of his or her income toward health insurance under the ACA, and under the AHCA would pay more than 26% of his or her income ($7,917 per year or $659 per month) toward health insurance. The proposed AHCA tax credits would be available for use outside of exchanges, unlike the ACA which limits the use of the tax credits to purchases through exchanges.

Other provisions of the AHCA will impact the cost of health insurance by changing the ACA incentives to encourage participation in health insurance. For example, the AHCA reduces the penalty associated with the individual mandate and instead establishes a 30% surcharge on premiums for individuals who have significant gaps in their coverage. This will serve as an incentive for unhealthy people to keep coverage and could serve as a disincentive for young, healthy people to enroll if there is a gap in coverage. The AHCA also eliminates the ACA actuarial value (AV) requirements which establish standards for the type of coverage health insurers can sell. These AV requirements determine the amount of health care services the plan pays versus the amount the patient pays through co-payments and deductibles. The AHCA creates a Patient and State Stability Fund that would provide $15 billion in 2018 and 2019 and $10 billion annually for 2020 through 2026.

CBO analysis of the AHCA. The CBO and the staff of the Joint Committee on Taxation (JCT) released an estimate of the budgetary effects of the AHCA on March 13, 2017. In 2017, the elimination of the individual mandate would result in about four million additional people becoming uninsured. CBO and JCT estimate that in 2018, 14 million more people would be uninsured under the AHCA than under the ACA, including five million fewer with coverage under Medicaid and two million few people with employment-based coverage. In 2026, an estimated 52 million would be uninsured compared to 28 million who would lack insurance under the ACA.

Federal Spending. The AHCA would reduce federal deficits by $337 billion over the 2017-2026 period. The largest savings would come from reductions in outlays for Medicaid and from the elimination of the ACA subsidies for nongroup health insurance. Provisions affecting Medicaid would decrease spending by $880 billion over the 2017-2026 period, reducing Medicaid enrollment by 17% (14 million) by 2026 relative to the ACA. The largest costs would come from repealing many of the ACA tax requirements including the Hospital Insurance payroll tax rate for high-income taxpayers, a surtax on those taxpayers' net investment income, and annual fees imposed on health insurers, and from the establishment of a new tax credit for health insurance. The CBO estimates that Medicare spending would increase by $43 billion over the 2018-2020 period. The CBO estimates eliminating Prevention and Public Health Fund funding would reduce direct spending by $9 billion over the 2017-2026 period. The CBO estimates an increase in direct spending for the Community Health Center Program of $422 million over the 2017-2026 period.

Medicaid. Beginning in 2020 the AHCA would terminate the enhanced federal matching rate for new enrollees under the ACA Medicaid expansion (from 90% to 50-75% for newly eligible adults enrolled after December 31, 2019) and place a per capita-based cap on federal payments resulting in a 25% reduction in funding by 2026 compared to Medicaid funding projects under the ACA. CBO projects that some states that have expanded their Medicaid programs would no longer offer that coverage, reducing the share of the newly eligible population residing in a state with expanded eligibility to about 30% in 2026. States could maintain the higher matching rate for those Medicaid enrollees who maintain continuous coverage but CBO projects that fewer than one-third of those enrolled as of December 31, 2019 would have maintained continuous coverage two years later, and the higher federal matching rate would apply for fewer than 5% of newly eligible enrollees by the end of 2024. CBO estimates a $7 billion decrease in direct spending over the 2017-2026 period associated with treating lottery winnings as income, decreasing the three month retroactive eligibility period, eliminating federal payments for services provided to applicants with unsatisfactory evidence of citizenship or nationality, and eliminating a state's option to increase the amount of home equity allowable for individuals applying for long-term services and supports.

Insurance Coverage. The CBO analysis indicates that the nongroup market would probably be stable in most areas under either the ACA or the AHCA. The AHCA would tend to increase average premiums in the nongroup market prior to 2020 and lower average premiums thereafter, relative to the ACA. Changes in the way the nongroup market would function under the AHCA would make it harder to compare health plans, making shopping on the basis of price more difficult. Total federal subsidies for nongroup health insurance would be significantly smaller under the AHCA (by 2020, 60% of the average subsidy under the ACA and by 2026, 50% of the average subsidy under the ACA). The CBO and JCT estimate that the Patient and State Stability Fund Grants would exert substantial downward pressure on premiums in the nongroup market in 2020 and later years and help encourage participation by health insurers. The analysis indicates that over time fewer employers would offer health insurance due to elimination of the penalties and because tax credits would be available to higher income individuals. By 2026, CBO and JCT project, premiums in the nongroup market would be 20-25% lower for a 21 year old and 8-10% lower for a 40 year old, but 20-25% higher for a 64 year old compared to the ACA.

Reproductive Services. CBO estimates that provisions of the AHCA targeting Planned Parenthood Federation of America and its affiliates and clinics would reduce direct spending by $178 million in 2017 and by $234 million over the 2017-2026 period and that 15% of people who reside in areas without other health care clinics or medical practitioners would lose access to care. Direct spending in Medicaid would increase by $17 million in 2017 and by $77 million over the 2017-2026 period because of an increase in the number of births. Overall direct spending would be reduced by $156 million over the 2017-2026 period.

Additional proposals. The Trump Administration has proposed regulatory measures that would also impact the ACA. For example, in February, HHS and the Centers for Medicare and Medicaid Services (CMS) issued a "Market Stabilization Rule" that would amend standards relating to special enrollment periods, guaranteed availability, and the timing of the annual open enrollment period in the individual market for the 2018 plan year; standards related to network adequacy and essential community providers for qualified health plans; and the rules around AV

requirements. Comments were due on the proposal on March 7, 2017. Additionally, CMS Administrator Seema Verma and HHS Secretary Tom Price have indicated a willingness to facilitate expedited approval of Section 1115 demonstration waiver applications to reshape Medicaid. Specifically, suggesting that states may consider policies imposing work requirements for certain able-bodied, adult beneficiaries, "Health Savings Account-like features," and various cost-sharing policies common in commercial insurance, such as premium payments and emergency room co-payments. The House Congressional leadership has announced the introduction of four new bills that would 1) eliminate anti-trust protection for insurance providers 2) allow small businesses to pool together and purchase plans across state lines, 3) prevent "abusive" lawsuits, and 4) establish the Self-Insurance Protection Act.

Potential AHCA amendments. A series of amendments to the AHCA are under discussion and could potentially be adopted this week. These amendments would:

- Prevent states that have not expanded Medicaid under the ACA as of March 1, 2017 from doing so at the enhanced FMAP rate.
- Beginning October 1, 2017, provide states the option of instituting a work requirement in Medicaid for expansion adults as a condition of receiving coverage.
- Increase the annual inflation factor for the elderly and disabled from the Medicaid per capita cap from CPI-U Medical to CPIU Medical +1.
- Starting in Fiscal Year 2020, create a new option for states to opt to receive a block grant for providing health care for their traditional adult and children populations served in the per capita allotment.
- Appropriate $1 billion to the federal HHS for an American Health Care Implementation Fund to implement the law's major provisions.
- Beginning in 2017 (one year earlier than the prior draft), repeal the ACA's taxes on medical devices, medications, health insurance, tanning, and capital gains, among others, and delay implementation of the ACA's Cadillac tax by one additional year, moving implementation to 2026.
- Reduce the qualifying adjusted gross income threshold for the Medical Expense Deduction from 10% to 5.8% – lower than the pre-ACA level of 7.5%.
- Prohibit the federal government from reimbursing New York state for payments made by counties.
- Eliminate essential health benefits requirements in the individual and small group markets.

What's at stake. Millions of Californians lives will be affected by the significant structural changes being proposed by the AHCA and other actions being taken at the federal level to undo the ACA. As pointed out by the CBO and others, many of the gains in insurance coverage under the ACA will be reversed. While some higher income individuals will have access to tax credits and some may see lower premiums, health insurance for many more will be even less affordable. Premiums will be higher for many and copayments and deductibles will be higher. Insurance coverage will be less comprehensive. Reductions in federal funding to state budgets will have dramatic effects on the ability of states to finance health care for its residents. Without the security of health care coverage fewer people are able to participate in the work force. Declines

in employment will have additional effects on the local economy as well, indirectly impacting food and retail industries.

Conclusion. Prior to the enactment of the major ACA coverage expansions, over 40 million Americans (including seven million Californians) were uninsured. The consequences of a lack of insurance are dire. The federal Institute of Medicine put it succinctly: uninsured people are more likely to receive too little medical care and receive it too late; as a result, they are sicker and die sooner. The repeal of the enhanced FMAP for new enrollment in the Medicaid expansion in 2020 and the cost-sharing subsidies, along with the imposition of the per capita Medicaid proposal and changes in the advanced premium tax credits would have a devastating impact on the California state budget and Californians who rely on the ACA for health insurance coverage. The AHCA represents a significant shift of costs from the federal government to states, which DHCS estimates will result in nearly $6 billion in costs to California in 2020, growing to $24.3 billion by 2027, with a General Fund share estimated to be $4.3 billion in 2020, increasing to $18.6 billion in 2027. The loss of this financing would be a significant blow to these major program expansions which are critical pieces that provide foundational support necessary to make the popular mandates on insurers work without destabilizing the entire health insurance market. An insurance market without stability will also have significant impacts on those Americans and Californians who are not dependent on Medi-Cal and Covered California for their health coverage. The loss of funding for the ACA will not only substantially affect California's GDP and employment rates, but its ramifications will be deeply felt on a local and individual level in terms of economic and health status for our residents.