NHeLP
NATIONAL HEALTH LAW PROGRAM

Protect Medi-Cal Funding Series
Medi-Cal Affordability
Issue Brief #5 in a 12-Part Series

Medi-Cal provides a long-term investment in the health of Californians. Medi-Cal coverage and services are tailored to meet the unique needs of low-income individuals and families, and costs less per beneficiary than employer-based insurance.[1] The American Health Care Act (AHCA) passed by House Republicans would seriously jeopardize the health and financial security of more than 13 million Californians—one third of the state's residents—who rely on Medi-Cal each year.[2] The AHCA cuts federal Medicaid spending by $834 billion over ten years and imposes a cap on Medicaid funding for states.[3] In addition, the recently released White House budget proposes to further cut federal Medicaid spending by as much as $1.3 trillion over the next decade.[4] The loss of billions of dollars in federal Medicaid funding will invariably lead to cuts in services and the loss of affordable coverage. This issue brief explains why Medi-Cal is so critical to helping low-income people to afford health care, and it explains how low-income Californians would be harmed by Medicaid funding caps and cuts.

Why Medicaid is important for ensuring access to affordable care:

- **Medi-Cal provides strong affordability protections for low-income Californians.** Consistent with federal law, Medi-Cal does not charge premiums to low-income households (below $30,240 for family of three) because even small premiums keep people from signing up for Medicaid, increase disenrollment, and shorten the length of enrollment in the program.[5] In California, Medi-Cal allows participating providers to charge small copays of $1 for most services, up to $5 for non-emergency use of the emergency room.[6] California has set strict limits on cost sharing in Medi-Cal because even small required payments reduce access to needed services.[7] Medi-Cal also prohibits providers from denying care to individuals below the poverty level if they cannot afford to pay.[8]

- **Medi-Cal cost sharing limits help the most vulnerable Californians access services they rely on.** Medi-Cal prohibits cost sharing for key services, such as emergency services, family planning services, pregnancy-related services, or preventive services. [9] Medi-Cal also completely exempts some vulnerable populations from cost sharing, including individuals who are inpatients at licensed facilities, and most children and adolescents.[10] These protections ensure that

low-income Medi-Cal enrollees do not need to choose between obtaining needed care and paying for other expenses like food or housing.

- **Medi-Cal's affordability protections improve health outcomes.** Medi-Cal enrollees are less likely to skip medications or delay care due to cost.[11] Lower out-of-pocket costs improve access to primary and preventive care and increase likelihood of treatment for chronic conditions like diabetes and mental health conditions.[12]

- **Medi-Cal improves people's financial security.** Because Medi-Cal limits out-of-pocket costs for health care, when low-income Californians get Medi-Cal, their out-of-pocket spending on health care decreases.[13] As a result, Medi-Cal sharply reduces medical bankruptcies and interactions with debt collection agencies.[14] In addition, Medi-Cal enrollees have more money to ensure they meet other basic needs, such as securing stable housing, and buying healthy food.

How funding cuts would make Medicaid less affordable:

- **Funding cuts would pressure California to increase cost sharing to maximum legal limits.** Funding caps reduce federal Medicaid funding and shift costs onto California. Faced with less money to provide the same Medi-Cal coverage, California could be tempted to increase cost sharing to reduce utilization and push costs onto enrollees, even though studies show state savings from premiums and cost sharing in Medicaid (and CHIP) are limited and increase pressures on safety net providers, such as community health centers and hospitals, while also discouraging people from using both essential and non-essential services.[15] The resulting barriers to care are tied to worse health outcomes and more expensive care needs down the road, especially for populations with higher health risks, like seniors and people with disabilities.[16]

- **Funding cuts would likely erode Medi-Cal affordability protections.** With less federal funding under caps, California could also attempt to reverse long-standing affordability standards. California may seek to impose premiums and eliminate cost sharing limits. Several states have already aggressively sought exceptions to Medicaid's rules prohibiting premiums. These states have requested permission to charge premiums, terminate people for failure to pay, and lock them out for six months after termination. Budget gaps resulting from funding caps and cuts would motivate California to also seek exceptions to the existing rules. California could also attempt to roll back rules requiring providers to treat patients in poverty who cannot afford copayments.

- **Funding cuts would lead to more uncompensated care and worse outcomes.** With less federal Medicaid funding available under a per capita cap or other cut, California could seek to add increased premiums, copayments, or other forms of cost-sharing to Medi-Cal to save money. But these cost increases will certainly to lead individuals to drop out of coverage due to unaffordable premiums or delay care due to high out-of-pocket costs.[17] As a result, these uninsured individuals or Medi-Cal enrollees will appear in the health care system with more advanced illness and emergency conditions, resulting in uncompensated care costs, which harm the entire system. When consumers skip or delay treatment due to unaffordable cost sharing they experience worse health outcomes and often need more expensive treatments later.[18] These negative effects on health care are largest among individuals with greater health care needs.[19]

- **Funding cuts will increase health disparities.** Individuals of color are more likely to be low-income and enrolled in Medi-Cal.[20] Weakening the affordability protections in Medi-Cal will reduce their access to care and worsen health disparities. California's lower-income communities and communities of color will see a reduction in their health security and an increase in debt and medical bankruptcies.[21] Communities of color are already likely to have lower health status than their white counterparts.[22] Making access to care less affordable is likely to widen this gap.

ENDNOTES

[1] *See* TERESA COUGHLIN ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, WHAT DIFFERENCE DOES MEDICAID MAKE? 4, 7 (2013), http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8440-what-difference-does-medicaid-make2.pdf (Nationally, employer-based coverage would cost 28% more than covering the same individual with Medicaid).
[2] CAL. DEP'T HEALTH CARE SERVS., MEDI-CAL MONTHLY ENROLLMENT FAST FACTS 1 (2017) (enrollment as of December, 2016 at 13.5 Million), http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Fast_Facts_December_2016.pdf
[3] CONG. BUDGET OFFICE, COST ESTIMATE: H.R. 1628, THE AMERICAN HEALTH CARE ACT, AS PASSED BY THE HOUSE OF REPRESENTATIVES ON MAY 4, 2017 (2017), https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf.
[4] EDWIN PARK, CTR. ON BUDGET AND POLICY PRIORITIES, TRUMP BUDGET CUTS MEDICAID EVEN MORE THAN HOUSE BILL, SHOWING DANGER OF PER CAPITA CAP (May 23, 2017), http://www.cbpp.org/blog/trump-budget-cuts-medicaid-even-more-than-house-health-bill-showing-danger-of-per-capita-cap .
[5] *See* 42 U.S.C. §§ 1396o, 1396o-1; *see also* SAMANTHA ARTIGA *ET AL.,* KAISER FAMILY FOUND., THE EFFECTS OF PREMIUMS AND COST SHARING ON LOW-INCOME POPULATIONS: UPDATED REVIEW OF RESEARCH FINDINGS 3 (2017) ("Numerous studies find that premiums increase disenrollment from Medicaid and CHIP among adults and children, shorten lengths of Medicaid and CHIP enrollment, and deter eligible adults and children from enrolling in Medicaid and CHIP."), http://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings; DAVID MACHLEDT & JANE PERKINS, NAT'L HEALTH LAW PROG., MEDICAID PREMIUMS AND COST SHARING (2014), http://www.healthlaw.org/publications/search-publications/Medicaid-Premiums-Cost-Sharing. Enrollees in some Medi-Cal programs for higher income individuals and families may pay a small premium.
[6] *See* CAL. WELF. & INST. CODE § 14134 (establishing maximum Medi-Cal copayments). Cost sharing is the portion of expenses for healthcare services and supplies not covered by the insurer that the patient must pay out-of-pocket. Types of cost sharing include deductibles, copayments, and coinsurance. A deductible is the amount a patient must pay out-of-pocket before the insurer covers any expenses during a given benefit period. Following payment of the deductible, most patients have copayments or coinsurance for the remainder of the coverage period. A copayment is a flat amount paid upon receipt of care, and coinsurance is a percentage amount paid upon receipt of care. *See* Marisa Elena Domino et al., *Increasing Time Costs and Copayments for Prescription Drugs: An Analysis of Policy Changes in a Complex Environment*, 46 HEALTH SERVS. RES. 900 (2011); ARTIGA *ET AL., supra,* note 5 at 4.
[7] *See* ARTIGA *ET AL., supra,* note 5 at 4-5; MACHLEDT & JANE PERKINS, *supra*, note 5 at 2; LEIGHTON KU ET AL., CTR. ON BUDGET & POLICY PRIORITIES, THE EFFECTS OF COPAYMENTS ON THE USE OF MEDICAL SERVICES AND PRESCRIPTION DRUGS IN UTAH'S MEDICAID PROGRAM (2004), www.cbpp.org/files/11-2-04health.pdf.
[8] CAL. WELF. & INST. CODE § 14134(a)(8).
[9] *See id.* §§ 14134(a)(6), (9).
[10] *Id.* § 14134(a)(6).
[11] Benjamin Sommers et al., *Changes in Utilization and Health among Low-Income Adults after Medicaid Expansion or Expanded Private Insurance*, 176 JAMA INT. MED. 1501 (2016). *Cf.,* CAL. HEALTH CARE FOUND., READY OR NOT: CONSUMER FACE NEW HEALTH INSURANCE CHOICES (2003) (low-income and chronically ill Californians three times more likely to skip and appointment or not fill a prescription due to cost),

http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20T/PDF%20TAReadyOrNot.pdf.

[12] *Id. See also,* Katherine Baicker et al., *The Oregon Experiment – Effects of Medicaid on Clinical Outcomes*, 368 NEJM 1713 (2013) (Medicaid reduces depression and increases treatment initiation for diabetes); JUDITH DEY ET AL.,OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION, BENEFITS OF MEDICAID EXPANSION FOR BEHAVIORAL HEALTH, 2 (Mar. 28, 2016).

[13] *See, e.g.,* Ezra Golberstein *et al., California's Early ACA Expansion Increased Coverage And Reduced Out-Of-Pocket Spending For The State's Low-Income Population*, 34 HEALTH AFF. 1688, 1691 (2015), http://content.healthaffairs.org/content/34/10/1688.

[14] *See, e.g.,* MUNIRA Z. GUNJA *ET AL*., COMMONWEALTH FUND, INSURANCE COVERAGE, ACCESS TO CARE, AND MEDICAL DEBT SINCE THE ACA: A LOOK AT CALIFORNIA, FLORIDA, NEW YORK, AND TEXAS (2017), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2017/mar/1935_gunja_coverage_access_four_largest_states_ib.pdf; LUOJIA HU ET AL., NAT'L BUREAU OF ECON. RESEARCH, THE EFFECT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT MEDICAID EXPANSIONS ON FINANCIAL WELL-BEING (2016), http://www.nber.org/papers/w22170; Katherine Baicker et al. *supra* note 6.

[15] ARTIGA *ET AL., supra,* note 5 at 4-5; *see also* Emmett B. Keeler, *Effects of Cost Sharing on Use of Medical Services and Health*, 8 MED. PRACTICE MANAGEMENT 317 (1992), *available at* http://www.rand.org/pubs/reprints/RP1114.html.

[16] Sujha Subramanian, *Impact of Medicaid Copayments on Patients with Cancer*, 49 MED. CARE 842 (2011); Amitabh Chandra et al., *Patient Cost-Sharing and Hospitalization Offsets in the Elderly*, 100 AM. ECON. REV. 193 (2010).

[17] *See, e.g.,* ARTIGA *ET AL., supra,* note 5 at 3-4.

[18] *See* sources cited *supra* note 12.

[19] *See* ARTIGA *ET AL., supra,* note 5 at 4.

[20] *See* CAL. DEP'T HEALTH CARE SERVS., *supra,* note 2 at 3 (80% of Medi-Cal enrollees are people of color).

[21] *See* CONSUMER FIN. PROT. BUREAU, FINDINGS FROM THE CFPB'S SURVEY OF CONSUMER VIEWS ON DEBT CONSUMER EXPERIENCES WITH DEBT COLLECTION (2017) ("Medical debt is the most common type of past-due bill or payment for which consumers reported being contacted [by debt collection agencies]."), https://s3.amazonaws.com/files.consumerfinance.gov/f/documents/201701_cfpb_Debt-Collection-Survey-Report.pdf; Christina Lamontagne, *NerdWallet Health Finds that Medical Bankruptcy Accounts for Majority of Personal Bankruptcies*, NERDWALLET HEALTH BLOG (Mar. 26 2014), https://www.nerdwallet.com/blog/health/medical-bankruptcy/.

[22] *See, e.g.,* Zinzi D Bailey, *et al., Structural Racism and Health Inequities in the USA: Evidence and Interventions,* 389 LANCET 1453 (2017).