Top 10 Changes to Medicaid Under The Senate's Revised ACA Repeal Bill

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On July 13, Senate Republicans introduced a revised version of the Better Care Reconciliation Act (BCRA 2.0) to repeal the ACA and eliminate the current financing structure of Medicaid. This bill, like the initial BCRA, is a "discussion draft" and not the final version the Senate is likely to vote on. Regardless, it highlights the Senate's desire to make drastic cuts and changes to Medicaid. Overall, the Senate bill is even worse than the House-passed American Health Care Act and the revisions failed to alleviate the drastic cuts to, and financial restructuring, of Medicaid. Even if minor changes are made before the actual vote, BCRA strikes a death blow to Medicaid as we know it. This fact sheet addresses how BCRA 2.0 impacts Medicaid.

1. **Implements a Per Capita Cap (PCC).** Since 1965, Medicaid has operated as a federal-state partnership where states receive on average 63% of the costs of Medicaid from the federal government. The federal share is based on actual costs of providing services, and lower income states receive more federal funding. BCRA limits the federal contribution to states, based on a state's historical expenditures inflated at a rate that is projected to be less than the yearly growth of Medicaid health care costs.[1] Beginning January 1, 2020, funding for state Medicaid programs will shrink over time, resulting in states cutting coverage and services for all beneficiaries. And starting in 2025, states would be limited to an even stingier growth rate than in the initial PCC years. BCRA also imposes a penalty on states that spend above the national mean, starting in 2022. This penalty would be imposed even if a state spends more because care is more costly due to geography or other factors or because enrollees are older or sicker than in another state. If a state spends 25% more than the national mean for a particular eligibility group (e.g. seniors or people with disabilities), it would be lose .5-2% of its aggregate cap amount for the applicable group for that year. BCRA 2.0 did not make any changes to these provisions except to allow states expanding Medicaid between July 1, 2015 and September 30, 2016 to use fewer quarters of fiscal data to determine a target PCC so that it could calculate a separate PCC for the expansion population.

2. **Repeals Medicaid Expansion.** BCRA effectively repeals the Medicaid expansion on January 1, 2024. The Medicaid expansion enhanced match from the ACA remains at 90% through 2020 but then reduces 5% each year for 3 years (85% in 2021, 80% in 2022, and 75% in 2023). In 2024, a state would only receive its regular FMAP if it wanted to continue covering these enrollees. It also requires those in the Medicaid expansion population to submit eligibility renewal paperwork every six months just to stay on Medicaid, beginning October 1, 2017. If states that have not yet expanded want to expand, they would only get the state's "regular" FMAP even while other states that have expanded could get a higher match through 2023. BCRA 2.0 did not make any changes to these provisions.

3. **Allows Work Requirements in Medicaid.** BCRA allows states to impose work requirements on people who are not disabled, elderly, or pregnant Medicaid enrollees. Currently, nearly 8 in 10 Medicaid enrollees are part of a working family. Another 14% of Medicaid enrollees are currently looking for work. Yet, BCRA would allow states to require work as a condition of eligibility, including enrollees who are caring for a parent or spouse and both parents in a two-parent household. Individuals receiving mental health or substance use disorder services who are eligible through Medicaid expansion (rather than a disability category) would be required to work as a condition of receiving treatment, which could undermine their progress and recovery. Medicaid coverage makes it easier to find and sustain work and should not be denied to those who need care before being able to work. BCRA 2.0 did not make any changes to these provisions.

4. **Allows States to Operate Medicaid as a Block Grant for Certain Populations.** In addition to requiring all states to operate within fixed caps, BCRA also gives states the option to operate their Medicaid program as a block grant for people who are not elderly, disabled, pregnant adults. BCRA 2.0 allows states to include Medicaid expansion enrollees in the block grant so a state could have a block grant for the following groups: (1) all non-elderly non-disabled adults including expansion adults; (2) only expansion adults; or (3) only non-elderly, non-disabled non-expansion adults. States would be locked in for a five-year period, and the growth rate would be lower than the initial per capita cap growth rate (although by 2025, both the PCC and block grant growth rates would be the same).

5. **Repeals Mandatory Medicaid Coverage for Children ages 6-18**. The ACA requires states to provide Medicaid coverage to all children from birth to age 19 whose family incomes are under 133% of the Federal Poverty Level (FPL). Prior to the ACA, coverage for this group extended to only 100% FPL. BCRA lowers the eligibility level for children ages 6-19 from 133% FPL back to 100% FPL. This means that (in some states) children may lose their Medicaid and can only be

enrolled in CHIP or be uninsured. These children may get fewer benefits at greater cost than on Medicaid and may not receive the services they need to correct or ameliorate their medical or mental health conditions. BCRA 2.0 did not make any changes to these provisions.

6. **Repeals Presumptive Eligibility for the Medicaid Expansion Population and Hospital Presumptive Eligibility for Everyone**. In addition to repealing the Medicaid expansion, BCRA prevents states from using "presumptive eligibility" for Medicaid expansion adults after January 1, 2020. Further, BCRA repeals the ability of states to permit their hospitals to use presumptive eligibility for pregnant women, children, individuals with breast and cervical cancer, and for family planning services and supplies to obtain immediate Medicaid coverage when they end up in emergency rooms or hospitalized for treatment without insurance means they will end up with medical debt. BCRA 2.0 did not make any changes to these provisions.

7. **Eliminates Retroactive Eligibility for Everyone Except Seniors and People with Disabilities.** Medicaid currently provides coverage up to three months before the month an individual applies for coverage. This "retroactive coverage" protects individuals from medical expenses they incurred before they apply for Medicaid. An individual may not be able to apply for Medicaid immediately due to hospitalization, a disability, or other circumstances. Retroactive coverage provides that critical coverage and ensures providers get reimbursed for their costs and that low-income individuals do not end up facing severe medical debt or bankruptcy due to these medical expenses. BCRA 2.0 restored retroactive eligibility for seniors and people with disabilities but continues to eliminate it for all other Medicaid enrollees starting October 1, 2017.

8. **Repeals Essential Health Benefits (EHBs) for Medicaid Expansion Beneficiaries**. Under the ACA, states that expanded coverage to non-pregnant childless adults had to provide coverage in at least the 10 "essential health benefit" categories. BCRA repeals this requirement, effective December 31, 2019, resulting in beneficiaries losing services such as mental health and substance use disorder services and some no cost preventive health services. BCRA 2.0 did not make any changes to these provisions.

9. **Repeals Enhanced Funding for States for Community First Choice (CFC) Attendant Supports.** Established under the ACA, the "Community First Choice Option" provides states enhanced federal funding for home and community-based attendant services and supports to eligible Medicaid enrollees under their State Medicaid Plan. CFC services assist individuals with Activities of Daily Living (ADLs), habilitative services, and emergency back-up systems like electronic indicators. Some of these services complement the transition services. Effective January 1, 2020, BCRA repeals the 6% increase in funds established to

cover these services, which CBO predicts will reduce federal supports to participating states by $19 billion. BCRA 2.0 adds $8 billion in funding to increase reimbursement for HCBS services, which amounts to only roughly 4% of the $202 billion projected reduction in federal support for HCBS due to per capita caps.

10. **Reduces Provider Taxes and DSH Funding.** BCRA reduces states' ability to use provider taxes to help pay the state's share of Medicaid. Cutting or eliminating provider taxes is a substantial cost shift to states and threatens access to care for millions of Medicaid enrollees. It also undermines state flexibility to administer the Medicaid program without doing anything to achieve programmatic efficiencies or improve quality. Further, states that expanded Medicaid will face significant cuts to their Disproportionate Share Hospital (DSH) funding. The DSH cuts continue for expansion states even after Medicaid expansion ends. BCRA 2.0 provides a temporary bump in DSH allotments for some non-expansion states. The initial BCRA calculated the average ratio of DSH funding to Medicaid beneficiaries in each state. Non-expansion states with an allotment below that ratio would have their allotment temporarily increased up to the national average. BCRA 2.0 would calculate the ration of DSH funding to uninsured people, rather than to Medicaid beneficiaries. This would result in states such as Florida receiving higher DSH payments. And if a state drops the Medicaid expansion before January 1, 2021 the state would be considered a "non-expansion state" for the purposes of retaining their DSH allotment (exempting them from future cuts) and the bump. So this change provides an additional financial incentive to drop the expansion. Overall, coupling restrictions on provider taxes and lower DSH funds for non-expansion states with per capita caps, states will be severely squeezed in their ability to maintain eligibility, services, and provider rates.

Changing the financing of Medicaid from a guarantee (or "entitlement") to a per capita cap and these other changes to Medicaid threatens everyone -- enrollees who receive services, health care providers who provide care through Medicaid, families who live and work without the worry of providing expensive care to a child with a debilitating illness or an older adult who needs home care or nursing home care, and all communities which benefit from the jobs created and the federal dollars flowing into our state economies. These cuts create significant financial hardship for states and are devastating for low-income and vulnerable people everywhere. No one can afford these changes. BCRA 2.0 does nothing to address these concerns.

ENDNOTES

[1] CBO Cost Estimate at 11. BCRA's growth rate from the state's base year through 2019 is the medical component of the Consumer Price Index (CPI-M). For 2019-2025, the growth rate would be CPI-M plus 1% for elderly enrollees

and enrollees with disabilities and CPI-M for adults and children. Beginning in 2025, the growth rate would lower to the "regular" CPI which grows even slower than CPI-M and does not include long term care costs.