UPDATED
Top 10 Changes to Medicaid Under The Graham-Cassidy Bill: Implications for California

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Republican Senators Lindsey Graham, Bill Cassidy, Dean Heller and Ron Johnson (hereinafter "Graham-Cassidy") on Sept. 14 introduced a bill to repeal the Affordable Care Act (ACA) and eliminate the current financing structure of Medicaid. Thanks to the ACA, the uninsured rate in California continues to drop, from 8.6 % in 2015 to 7.3 % in 2016. This bill, extremely similar but in some ways worse than the failed Better Care Reconciliation Act (BCRA 2.0), highlights these Senators' desire to dismantle Medicaid. Like BCRA and AHCA before it, the Graham-Cassidy bill would strike a death blow to Medi-Cal as we know it. While the Congressional Budget Office (CBO) has not yet scored the fiscal and coverage impact of the bill, similar bills have been found to result in major coverage and funding cuts. Like previous proposals, the Graham-Cassidy proposal would cause 32 million people - at least 6.7 million Californians - to lose coverage and will undermine key protections for Medi-Cal beneficiaries. California also stands to face $4.4 billion in additional costs to California in 2020, growing to $22.5 billion in 2026 for the state to maintain current coverage levels. Since the bill does not continue the block grants in 2027, the impact that year alone would grow to $53.1 billion. From a cumulative perspective, the impact to California between 2020 and 2026 would be $85.7 billion. From **2020 through 2027, the impact would total $138.8 billion in federal funding cuts**. This fact sheet explains how the Graham-Cassidy bill negatively impacts Medi-Cal.

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. Graham-Cassidy 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 lower growth rate than in the initial PCC years. Graham-Cassidy also imposes a penalty on states that spend above the national mean, starting in 2020 (two years earlier than BCRA). 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 unless the state is a "low density" state (less than 15 individuals per square mile).

California impact: The state stands to be a big loser in the Medicaid financial restructuring scheme of the Graham-Cassidy's PCC proposal. Through cuts to Medi-Cal, California estimates it will lose a total of $35.2 billion from 2020 and 2027. California would be disproportionately impacted by a Medicaid cap because the state already spends much less per Medicaid enrollee than most other states. Moreover, the federal government already pays only 50% of Medicaid costs in California. Thus, if health care costs in one area increase—for example, due to public health emergencies like an opioid epidemic or a natural disaster—the state will have very little room to balance those costs against expenses in other areas. In addition, the number of low-income seniors and people with disabilities in California is growing faster than the national average. California's over-65 population is expected to be 87% higher in 2030 than in 2012, an increase of more than 4 million people. The cost of health care services, on average, doubles between age 70 and age 90. Thus, as California's population lives longer, it will be difficult for California to keep its costs under the capped amount, resulting in deeper cuts to Medicaid over time. If California does not raise taxes or cut other budget items to maintain Medi-Cal, the state could be forced to cut Medi-Cal eligibility, benefits, or payments to hospitals and physicians.

2. **Repeals (and block grants) Medicaid Expansion Option after 2020**. Graham-Cassidy goes a step further than prior Senate bills by eliminating the ACA's Medicaid expansion starting in 2020, offering in its place only a smaller, temporary block grant that states could use for health coverage or any other health care purposes, with no guarantee of coverage or financial assistance for individuals. This essentially reduces the FMAP to 0% for any state that covers Medicaid expansion enrollees after 2020 (except Native Americans who meet certain "grandfathering" requirements). Even if a state wanted to continue covering Medicaid expansion enrollees, it could not get any federal matching funding (even at the traditional rate) and would have to pay 100% of the costs. Instead, Graham-Cassidy sets up a new block grant for states to help pay for health coverage for consumers who would have been covered by Medicaid expansion, as well as those who would have received tax credits and cost-sharing reductions, among other factors. But the block grant funding is set at 17% less than current funding. The block grant would not only cut overall funding for the Medicaid expansion but also redistribute the reduced federal funding across states, based on their share of low-income residents rather than their actual spending needs, thereby punishing states that have adopted the Medicaid expansion. The bill's block grant would not only be inadequate to replace the

ACA's Medicaid expansion (and the marketplace subsidies) but the funding would disappear altogether after 2026.

California impact: Under Graham-Cassidy the state's Medi-Cal expansion would be at risk of elimination altogether and the financial impact to the state would be devastating. Starting in FY 2020, the federal funding cuts for the Medicaid Expansion in California would be $22.2 billion annually, growing to $32.6 billion in 2027. This means a combined reduction of more than $216.8 billion for the period of 2020-2027. The Medi-Cal Expansion has brought coverage to over 4 million low-income state residents. In addition, it has produced a $17 billion or greater investment in the state each year. That investment has directed an estimated $2.2 billion per year into California's health care safety net. Notwithstanding the effects of the per capita limits, repealing the Medi-Cal expansion along with the enhanced (or regular) federal funding means the state would need to spend many billions of additional state dollars to maintain health coverage for this population. Under this proposal the financial hit would be even greater than other Republican ACA repeal proposals to date because these cuts financially punish states like California who expanded Medicaid and gives these dollars to other states who refused to expand their Medicaid programs.

Since California law contains a "trigger" that directs the State to address the funding reduction through the State Legislature, determining what the state would do if Graham-Cassidy is enacted as currently proposed remains unclear. But if the State moved forward with a repeal of the Expansion, that alone would result in over 4 million low-income Californians loosing coverage.

3. **Allows Shorter Eligibility Periods for Medicaid Expansion Enrollees.** While states can continue Medicaid Expansion through December 31, 2019 with a 90% federal match, Graham-Cassidy allows states to require those in the Medicaid expansion population to submit eligibility renewal paperwork every six months just to stay on Medicaid, beginning October 1, 2017. This will certainly result in more eligible enrollees being knocked off Medicaid.

California impact: Medi-Cal beneficiaries are already required to report changes that affect their eligibility. Submitting new paperwork every six months will inevitably result in loss of coverage for many of the over 14 million people on the program. These requirements would also add administrative costs to the State since it would double the time that county workers would have to spend to process ongoing Medi-Cal beneficiaries' renewal applications. In other words, this new requirement is futile, will cost money to the state, and result in less people having the health coverage that they need.

4. **Allows Work Requirements in Medicaid.** Graham-Cassidy 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, Graham-Cassidy 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.

California impact: In California, almost half of Medi-Cal Expansion enrollees are currently working, and another 12% are actively looking for work. In 2015, almost one in five California workers between the ages of 18 and 65 was enrolled in Medi-Cal. Workers in agricultural, restaurant, and other service industry jobs are most likely to have coverage through Medi-Cal. Medi-Cal enrollees who are not engaged in paid labor may have an illness or disability that prevents them from working, may be engaged in unpaid work taking care of young children or children with disabilities, or may be looking for work but unable to find employment. Imposing a work requirement on these individuals is unlikely to result in changing their employment status. Rather, it could cause them to lose access to coverage they need, making them sicker and more likely to incur medical debt.

5. **Allows States to Operate Medicaid as a Block Grant for Certain Populations.** In addition to requiring all states to operate within fixed caps, Graham-Cassidy also gives states the option to operate their Medicaid program as a block grant as opposed to a PCC for people who are not elderly, disabled, pregnant 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).

California Impact: In California, block granting would have an even more harmful impact on the state's budget pressures than the PCC funding cuts. As a result, the state would face a growing budget deficit and look to cut eligibility, not only for the approximately 4 million expansion enrollees, but also for the "optional" Medicaid groups as well. Medicaid services would also be targeted for elimination or substantially rollback, and already extremely low provider rates could be slashed even further, jeopardizing access to care for those still on Medi-Cal.

6. **Repeals Presumptive Eligibility for Everyone**. In addition to repealing the Medicaid expansion, Graham-Cassidy prevents states from using "presumptive eligibility" and express lane eligibility after January 1, 2020. This includes repealing 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.

California Impact: California has long implemented presumptive eligibility for pregnant women, children, foster youth, individuals with breast and cervical cancer, and for family planning services and supplies. The state also implemented its ACA Hospital Presumptive Eligibility (HPE) program in January 2014 for expansion-eligible adults, as well as children under the age of 19, parents and caretaker relatives, pregnant women, and former foster youth up to age 26. In 2017-18 California's expenditures on HPE are estimated at nearly $400 million. Taking these critical pathways away to obtain immediate Medi-Cal coverage for eligible children, adults (including former foster youth), pregnant women and others they apply or end up in emergency rooms or hospitalized for treatment without insurance means they will more likely remain uninsured and in medical debt. In addition, hospitals are likely to experience financial losses, without Medi-Cal coverage upfront as these low-income uninsured individuals' will be unable to pay for their care in full.

7. **Reduces Retroactive Eligibility to Two Months For Everyone But 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. Graham-Cassidy reduces retroactive coverage for most Medicaid beneficiaries to two months starting October 1, 2017. It requires states to maintain three months of retroactive coverage only for seniors and people with disabilities.

California Impact: Both before and after the enactment of the ACA, individuals who incur medical expenses in any of the three months prior to the month of Medi-Cal application can apply for coverage for those months by requesting the retroactive coverage before a year from the date of service. The process for requesting and determining retroactive coverage is fairly simple. This significant and longstanding legal entitlement has enabled millions of individuals to be insulated from significant medical debt due to medical bills incurred in the months just prior to applying for Medi-Cal. The loss of this available coverage could result in financial ruin for millions of individuals who will no longer get these months of coverage at the time of application, or during any gaps in coverage due to falling off coverage during the renewal process. It will also mean that hospitals and other health care providers will have to absorb more costs due to an absence of payer sources.

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. Graham-Cassidy 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.

California Impact: California has aligned the benefits the Medi-Cal Expansion population receives with the State's approved state plan benefits. This means that all Medi-Cal populations receive the same benefits. Since the State's essential health benefits benchmark plan for the private market offered additional mental health and substance use disorder services from those offered in Medi-Cal, as of January 1, 2014, the State added the additional benefits to the coverage received by all Medi-Cal populations, not just the Expansion. Without the EHB requirement for the Medi-Cal Expansion, Medi-Cal enrollees could lose these additional mental health and substance use disorder services, including individual and group psychotherapy, psychiatric consultations, and intensive outpatient treatment for substance use.

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, Graham-Cassidy repeals the 6% increase in funds established to cover these services, which CBO predicts will reduce federal supports to participating states by $19 billion.

California Impact: California was the first state approved to enact the Community First Choice Option, which allowed the State to take advantage of the 6% enhanced match to provide In-Home Supportive Services (IHSS) to certain Medi-Cal enrollees who otherwise would need institutional care. Over 500,000 Californians have received services through the Community First Choice Option since 2011. Taking up the option brought the State an estimated $573 million in additional federal funds during the first two years of implementation. Eliminating the enhanced match provided by the Community First Choice Option will place financial strain on California's already struggling IHSS program, requiring an estimated $400 million in additional state funds for the program by 2020. This loss of federal funds could cause the State to cut provider payment rates or curtail eligibility for IHSS.

10. **Reduces Provider Taxes.** Graham-Cassidy 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.

California Impact: California has three provider taxes that exceeded 5.5% of net patient revenues as of July 1, 2016. Provider fees/assessment have been a significant source of non-federal revenue in the Medi-Cal program for many years. If provider taxes are limited as proposed in the Graham-Cassidy bill, the state anticipates an immediate impact to at least California's provider fee on skilled nursing and other long-term care facilities, resulting in the need for increased state general fund of nearly $150 million. The state would also receive no relief from the scheduled DSH cuts, even though hospitals continue to experience uncompensated care costs, even if reduced. Decreases in uncompensated care costs resulting from the ACA insurance expansion will not match the DSH reductions because of the high number of people who will remain uninsured, low Medicaid reimbursement rates, and medical cost inflation. DSH reduction in California is already expected to amount to an increase in unmet uncompensated costs of at least $1.381 billion in 2019. To make matters worse, a rise in uncompensated care is extremely likely given the elimination of the Medicaid expansions and changes to Marketplace coverage and tax subsidy eligibility which will result in a wave of uninsured low and moderate income people. This would undoubtedly lead to even higher unmet uncompensated costs in the State.

Changing the financing of Medicaid from a guarantee (or "entitlement") to a per capita cap and block grant and imposing other cuts and 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. Not only will these cuts result in millions of low-income and vulnerable people losing Medi-Cal coverage and services, but these cuts create significant financial hardship for states which they cannot afford. Graham-Cassidy would decimate the Medi-Cal program.

ENDNOTES

[1] Graham-Cassidy'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.