



Top 10 Changes to Medicaid Under The Senate's ACA Repeal Bill: Implications for California

By Kim Lewis¹

On June 26, Senate Republicans updated the bill to repeal the ACA and eliminate the current financing structure of Medicaid under the guise of the "[Better Care Reconciliation Act](#)" (BCRA). This bill is a revised version of the Senate discussion draft released on June 22 and is likely to change again in the coming days. Regardless, the bill highlights the Senate's desire to make drastic cuts and restructure Medicaid. Overall, the Senate bill is worse than the House-passed [American Health Care Act](#). Even if minor changes are made before the actual vote, BCRA strikes a death blow to Medicaid as we know it. The independent [Congressional Budget Office](#) (CBO) analysis found that the BCRA would cut \$772 billion from Medicaid. This means 15 million low-income people, including kids, seniors and people with disabilities, will lose their health coverage. In California, [4.1 million](#) people enrolled in the Medicaid Expansion could lose their coverage. The state's [own analysis](#) concludes that the current federal proposal represents a significant cost shift from the federal government resulting in nearly \$3 billion in costs to California in 2020, growing to \$30.3 billion by 2027. The [State General Fund share](#) is estimated to be \$3 billion in 2020, increasing to \$24.3 billion in 2027. This fact sheet addresses how BCRA impacts Medicaid, and what those impacts could mean for California.

- 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 caps the federal contribution to states, based on a state's historic expenditures inflated at a rate that is projected by the [CBO](#) to be less than the yearly growth of Medicaid health care costs. Beginning January 1, 2020, funding

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for state Medicaid programs will shrink over time, resulting in states cutting coverage and services for all beneficiaries. 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 lose .5-2% of its aggregate cap amount for the applicable group for that year.

California Impact: The state stands to be a big loser in the Medicaid financial restructuring scheme of the BCRA's PCC. And since the BCRA cost cap trend is significantly lower beginning in FY 2025, the impact to California will be even more catastrophic in the out years. The state estimates it will be responsible for an increased share of approximately \$2.6 billion in 2020, growing to \$11.3 billion by 2027. Cumulatively over the course of 2020 through 2027, the impact to California is estimated to be \$37.3 billion. 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 percent 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 doesn't 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 Medicaid Expansion. BCRA effectively repeals the Medicaid expansion on January 1, 2024. The Medicaid expansion enhanced match from the Affordable Care Act (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 Federal Medical Assistance Percentage (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.

California Impact: California's 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. Beginning in 2024, the federal matching rate will be reduced to a state's traditional 50% federal matching rate. This means that in order to maintain the expansion (notwithstanding the effects of the per capita limits) California would need to spend [five times as much](#) as originally estimated. By 2027 the cost to California would be \$18.0 billion (\$12.6 billion state general fund), and cumulatively from 2021 through 2027 it would be [\\$74.1 billion](#) (\$51.9 billion state general fund).

In addition, California law contains a "trigger" that directs the state to address the funding reduction through the State Legislature. It is not entirely clear when or how this proposal would go into effect if BCRA is enacted as currently proposed. But if the state moved forward with a repeal of the Expansion, over [4 million](#) low-income Californians stand to lose their coverage.

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.

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.

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, or 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). Block-granting Medicaid would strip away the current federal financial commitment to help vulnerable individuals and families who depend on the program. Fixed annual funding would leave states even less able to absorb higher unanticipated costs due to a public health emergency, a new but costly drug or treatment, or a faltering economy. States would have to cut eligibility or benefits or establish waiting lists to stay within capped funding. Eventually, that would mean lost coverage for tens of millions of people, and reduced services for seniors in nursing homes, people with disabilities, and families with children.

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. For example, almost [1 million children with special health care needs](#) in California rely on Medi-Cal for their care. Without Medi-Cal coverage or home and community-based long-term care services, the children with intensive or chronic needs could end up no longer able to live at home with their families.

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.

California Impact: The state currently covers all children [up to 266% FPL](#) through Medi-Cal. Thus, in California, children should not experience any disruptions in coverage as a result of this change, and will be able to stay in Medi-Cal. However, funding for CHIP is currently only authorized through September 30, 2017. Thus, if BCRA is enacted and Congress fails to reauthorize CHIP funding, California could face significant budget shortfalls, and might be forced to consider cutting 1.3 million children

off of coverage. The cap on Medicaid will also result in the state losing billions of federal dollars which could also jeopardize Medi-Cal coverage for these children when the state struggles to pay for services and seeks to rollback Medi-Cal eligibility due to budget restraints.

- 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.

California Impact: California implemented its [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. Approximately [25,000](#) individuals are offered coverage in Medi-Cal each month through this process. In 2017-18 California’s expenditures on HPE are estimated at nearly [\\$400 million](#). Taking away this critical pathway for eligible adults, children, and former foster youth to obtain immediate Medi-Cal coverage when they end up in emergency rooms or hospitalized for treatment without insurance means they will remain uninsured and in medical debt. In addition, those hospitals are likely to experience [financial losses](#), as the chances of these low-income uninsured individuals’ being able to pay for their care in full are very low.

- 7. Eliminates Retroactive Eligibility.** 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 repeals this coverage for all Medicaid beneficiaries starting October 1, 2017.

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. 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.

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," with enhanced federal funding, enables states to provide home and community-based attendant services and supports to eligible Medicaid enrollees under their State Medicaid Plan. CFC funds assist individuals with Activities of Daily Living (ADLs), habilitative services, and emergency back-up systems like electronic indicators. CFC also gives states the option to cover many of the costs of transitioning individuals from institutional care to supported community living, including rent deposits, moving expenses, and some nonmedical transportation. Some of these services complement the transition services. Effective January 1 2020, BCRA repeals the 6% increase in funds established to cover these services.

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, taking an estimated [\\$400 million in federal funds](#) from 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 and DSH Funding. BCRA reduces states' ability to use provider taxes to help pay the state's share of Medicaid. Provider taxes are an integral source of Medicaid financing governed by long-standing regulations. [All states but one](#) rely on provider taxes for revenue. BCRA proposes a phase down of the provider tax safe harbor threshold from 6.0 percent to 5.0 percent of net patient revenues over 5 years beginning in 2021. Cutting or eliminating these 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, BCRA requires only states that expanded Medicaid to cut to their Disproportionate Share Hospital (DSH) funding, while non-expansion states will not experience DSH cuts (and some non-expansion states will see a temporary increase in DSH funding). The DSH cuts continue for expansion states even after Medicaid expansion ends. Coupling restrictions on provider taxes and lower DSH funds for expansion states with per capita caps, states will be severely squeezed in their ability to maintain eligibility, services, and provider rates.

California Impact:

California has [3 provider taxes](#) that exceeded 5.5% of net patient revenues as of July 1, 2016. If provider taxes are limited as proposed in the BCRA, California would need to increase state funds by nearly [\\$150 million](#) to maintain current programs. 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 also clearly 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.

BCRA's changes to the financing of Medicaid from a guarantee (or "entitlement") to a per capita cap and other cuts to Medicaid threatens everyone in the state – enrollees who receive services, health care providers who provide care through Medi-Cal, 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 economy. These cuts create significant financial hardship for California and are devastating for low-income and vulnerable people throughout the state. Californians cannot afford these changes.