Protect Medi-Cal Funding 2025: Affordability

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California's Medicaid program (Medi-Cal) provides a critical 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 provides the most affordable coverage. If Medicaid cuts are enacted, states like California will lose billions of dollars in federal Medicaid funding, shifting financial responsibility for Medicaid services to the states and to enrollees. 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 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's affordability protections improve health outcomes.** Access to affordable health care, like Medi-Cal, improves individuals' health outcomes.[1] Medi-Cal enrollees are less likely to avoid regular doctor visits, skip medications, or delay care due to cost.[2] Lower out-of-pocket costs improve access to primary and preventive care and increase likelihood of treatment for chronic conditions like cardiovascular disease, diabetes, and mental health conditions.[3]

- **Medi-Cal improves people's financial security.** Because for most enrollees, Medi-Cal has no out-of-pocket costs, premiums, or co-payments, Medi-Cal enrollees retain more income for other expenses.[4] As a result, Medi-Cal sharply reduces medical bankruptcies and interactions with debt collection agencies while improving individuals' credit ratings.[5] In addition, Medi-Cal enrollees have more money to ensure they meet other basic needs, such as securing stable housing and buying healthy food.[6]

- **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 $39,975 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.[7] Similarly, as of 2023, Medi-Cal providers may not charge any out-of-pocket cost-sharing for services covered by

Medi-Cal.[8] This is important, because even small required payments reduce access to needed services.[9]

- **Medi-Cal copay limits help Californians access services they rely on.** Medi-Cal prohibits copays for ALL services, including important services such as emergency care, family planning services, pregnancy-related services, and preventive services.[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.

How federal 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 elect to impose cost sharing to reduce utilization and push costs onto enrollees, even though studies show state savings from premiums and cost sharing in Medicaid programs 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.[11] California itself noted, when it eliminated copays in Medi-Cal, that the copays imposed in the Medi-Cal program before 2023 did not generate revenue for the program, and the administrative burden required to track their collection would be substantial.[12] The barriers to care that result from cost-sharing on health care services are tied to worse health outcomes and more expensive care needs, especially for people with disabilities or chronic conditions.[13]

- **Funding cuts would likely erode Medi-Cal affordability protections.** With less federal funding, California could also attempt to reverse long-standing affordability standards. California may seek to re-impose cost sharing in Medi-Cal. In the previous Trump Administration, several states were permitted to charge Medicaid beneficiaries premiums up to 2% of household income (about $33.50/month for a single individual with income at 138% FPL).[14] Budget gaps resulting from funding caps and cuts could prompt California to also seek exceptions to the existing rules and require premiums to access care.

- **Funding cuts would lead to more uncompensated care and worse outcomes.** With less federal Medicaid funding available under a per capita cap, block grant or other cut, California could seek to add premiums, copayments, or

other forms of cost-sharing to Medi-Cal in order to save money. But these cost increases will certainly lead individuals to drop out of coverage due to unaffordable premiums or delay care due to high out-of-pocket costs.[15] As a result, 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 health care system.[16] When people skip or delay treatment due to unaffordable cost sharing they experience worse health outcomes and often need more expensive treatments later.[17] Thus overall health care costs do not decrease, rather costs shift from less expensive outpatient care (e.g. primary care and clinics) to expensive inpatient care (e.g. hospitalization).[18] These negative effects on health care are largest among individuals with greater health care needs.[19]

- **Funding cuts will increase health inequities.** People with disabilities as well as Black, Indigenous and People of Color (BIPOC) are more likely to be enrolled in Medi-Cal.[20] Weakening the affordability protections in Medi-Cal will reduce their access to care and worsen health disparities. California's low-income communities and BIPOC communities will see a reduction in their health security and an increase in debt and medical bankruptcies.[21] BIPOC communities are already likely to have poorer health status than their white counterparts; thus, ensuring affordable Medi-Cal coverage is likely to narrow these gaps.[22] Additionally, Medi-Cal covers services important to LGBTQI+ people, such as STI screening, culturally competent mental health services, and gender-affirming care, so increased premiums or cost-sharing could also make it harder for LGBTQI+ people to access those services.[23]

Conclusion

The Medicaid program is designed to give California wide flexibility in designing and implementing its own Medi-Cal program to meet the particular health needs of its residents. The potential threats to the program on the federal level will not only result into devastating impacts on low-income individuals and families across the state, these threats will also make it necessary for California to impose additional cuts and erect barriers to access life-sustaining care in the future. While it remains unclear what the current 2025 Congress and Trump Administration will do with respect to the Medicaid program, such federal funding cuts that will make Medi-Cal less affordable must be rejected so low-income individuals and families have the access to quality affordable and comprehensive health care they need.

ENDNOTES

[1] *See, e.g.,* Renuka Tipirneni et al, *Health Insurance Affordability Concerns And Health Care Avoidance Among U.S. Adults Approaching Retirement*, 3 JAMA NETWORK OPEN 6, 8 (2020); Madeline Guth et al., Kaiser Family Found., *Understanding the Impact of Medicaid Premiums & Cost-Sharing: Updated Evidence from the Literature and Section 1115 Waivers* (2021), **https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers**.

[2] *See* Jennifer Tolbert et al, *Key Facts about the Uninsured Population*, Kaiser Family Found. (2024), available at https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.

[3] Jusung Lee et al, *The Impact of Medicaid Expansion on Diabetes Management*, 43 DIABETES CARE 1094 (2020); *see also* Centers for Disease Control and Prevention (CDC), *Health Equity Indicators Profiles: Health Care Access* (2023), **https://www.cdc.gov/dhdsp/health_equity/health-care-access.htm**; Judith Dey et al, Off. Ass't Sec'y Planning & Evaluation, *Benefits of Medicaid Expansion for Behavioral Health* (2016).

[4] *See* Cal. Dep't Health Care Servs., Medi-Cal Eligibility & Covered California - FAQ's, **https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/Medi-CalFAQs2014a.aspx** (last visited Jan. 30, 2025).

[5] *See* Guth et al., *supra,* note 1; *see also, e.g.*, Z Munira 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/issuebrief/2017/mar/1935_gunja_coverage_access_four_largest_states_ib.pdf**; Luojia Hu et al., Nat'l Bureau Econ. Res., *The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions On Financial Well-Being* (2016), **http://www.nber.org/papers/w22170**.

[6] *See* Caroline Danielson et al., Pub. Pol'y Inst. Cal., *The Impact of Health Insurance on Poverty in California* (2023), **https://www.ppic.org/publication/the-impact-of-health-insurance-on-poverty-in-california**.

[7] *See* 42 U.S.C. §§ 1396o, 1396o-1; *see also* Guth et al., *supra,* note 1 ("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."); David Machledt, Nat'l Health L. Prog., *What Makes Medicaid, Medicaid? — Affordability* (2023), **https://healthlaw.org/resource/what-makes-medicaid-medicaid-affordability**. Enrollees in some Medi-Cal programs for higher income individuals and families may pay a small premium.

[8] *See* Budget Act of 2022 (A.B. 204) (eliminating WIC § 14134); *see also* Letter from James S. Scott, Ctrs. Medicare & Medicaid Servs., to Jacey Cooper, Cal. Dep't Health Care Services, (Dec. 16, 2022) (federal approval of State Plan Amendment 22-0045, effectuating the elimination of copays in Medi-Cal), **https://www.medicaid.gov/medicaid/spa/downloads/CA-22-0045.pdf**. While California's legislature repealed the law that allowed providers to charge small copays for certain Medi-Cal services, some Medi-Cal beneficiaries still have a "share of cost," however, which could require them to pay out-of-pocket costs for care. *See* Cal. Dept. Health Care Servs., *Share of Cost (SOC)* (2022), **https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/32F2D4C6-B1D5-4A83-B325-92E2C579C243/share.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO**.

[9] *See* Guth et al., *supra,* note 1; Machledt, *supra*, note 7 at 4.

[10] *Supra* note 8.

[11] Guth et al., *supra,* note 1; Salam Abdus et al., *Children's Health Insurance Program Premiums Adversely Affect Enrollment, Especially among Lower-Income Children*, 33 HEALTH AFF. 1353 (2014); Leighton Ku & Teresa A. Coughlin, *Sliding-Scale Premium Health Insurance Programs: Four States' Experiences*, 36 INQUIRY 471 (1999); Bill J. Wright et al., *The Impact of Increased Cost-sharing on Medicaid Enrollees*, 24 H HEALTH AFF. 1106 (2005); Samantha Artiga & Molly O'Malley, Kaiser Family Found., *Increasing Premiums and Cost-sharing in Medicaid and SCHIP: Recent State Experiences* (2005), **https://www.kff.org/medicaid/issue-brief/increasing-premiums-and-costsharing-in-medicaid**.

[12] *See* Cal. Dep't Health Care Servs., *Proposed Trailer Bill Legislation: Copayments in the Medi-Cal Program* (2022), **https://www.dhcs.ca.gov/Documents/Budget-Highlights-Add-Docs/FS/DHCS-Copayments-Fact-Sheet.pdf**.

[13] *See, e.g.,* Amitabh Chandra et al., *The Health Costs of Cost Sharing,* 139 Q. J. ECON. 2037 (2024); Nuriel Moghavem et al., *The Impact of Medical Insurance on Health Care Access and Quality for People with Multiple Sclerosis in the United States,* 30 J. MULTIPLE SCLEROSIS 299 (2023).

[14] *See* Machledt, *supra*, note 7 at 3.

[15] *See* Tolbert et al., *supra*, note 2; Samantha Artiga et al., Kaiser Family Found., *The Effects Of Premiums And Cost Sharing On Low-Income Populations: Updated Review Of Research Findings* (2017).

[16] California Dep't Health Care Access & Info. (HCAI), *Statewide Health Care Spending Target Approval is Key Step Towards Improving Health Care Affordability for Californians* (2024), **https://hcai.ca.gov/statewide-health-care-spending-target-approval-is-key-step-towards-improving-health-care-affordability-for-californians**.

[17] Jen Joynt et al., Cal. Health Care Found., *The 2024 CHCF California Health Policy Survey*, 27–28 (2024).

[18] HCAI, *supra*, note 15.

[19] *See* Luna Lopes et al., Kaiser Family Found., *Americans' Challenges with Health Care Costs* (2024), **https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs**; Artiga et al., supra, note 14.

[20] Cal. Health Care Found., *Medi-Cal Facts and Figures Essential Source of Coverage for Millions* 5–7 (2024), **https://www.chcf.org/wp-content/uploads/2024/06/MediCalFactsFiguresAlmanac08052024.pdf**.

[21] *See* Consumer Fin. Protection Bureau (CFBP), *Findings from the CFPB's Survey of Consumer Views on Debt Consumer Experiences with Debt Collection* 21 (2017) ("Medical debt is the most common type of past-due bill or payment for which consumers reported being contacted [by debt collection agencies].").

[22] Latoya Hill et al., Kaiser Family Found., *Health Coverage by Race and Ethnicity, 2010-2022* (2024); Eric T. Roberts et al., *Racial and Ethnic Disparities in Health Care Use and Access Associated With Loss of Medicaid Supplemental Insurance Eligibility Above the Federal Poverty Level*, 183 JAMA INTERN. MED. 534 (2023); *see also* Zinzi D Bailey, et al., *Structural Racism and Health Inequities in the USA: Evidence and Interventions*, 389 LANCET 1453 (2017).

[23] *See* Richard S. Henry et al., *Health Conditions, Access to Care, Mental Health, and Wellness Behaviors in Lesbian, Gay, Bisexual, and Transgender Adults*, 2020 INT'L J. OF CHRONIC DISEASES 4 (2020).