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Joint Informational Hearing
Subject: The American Health Care Act: What Will it Cost Californians?
Assembly Health and Budget Subcommittee No. 1 on Health and Human Services

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In 2014, California rolled out its implementation of the Affordable Care Act. Not only did we expand Medi-Cal, our state Medicaid program, by allowing adults up to 138% of the federal poverty level who were previously ineligible to enroll, we also made key program simplifications that led to more than 14 million being covered by Medi-Cal.

The idea behind the program simplifications was "no wrong door". We created a single application for insurance affordability programs so that someone wouldn't have to know whether they should get Covered California, Medi-Cal, Healthy Families, or AIM for pregnant women. They would just apply and get on coverage in the appropriate program. Many of our programs have been consolidated under Medi-Cal, so enrollees have the same networks regardless of what program they are in.

We also simplified the application process. Many of the verifications that were needed – citizenship, immigration status, identity, income, are now largely handled with electronic databases that can verify the information in real time. This means that people can apply even when they don't have all of their documents in hand, often get an instant eligibility result, and can begin using care. Finally, California also opened up other channels of enrolling, such as through the hospital presumptive eligibility program. This program allows patients to supply minimum information about income eligibility (later filling out the rest of the application), and immediately get approved for care without worrying about going into debt or bankruptcy due to large hospital bills.

The proposed American Health Care Act attempts to undo this program simplification so that our guiding principal of "no-wrong door" becomes "no right door" for Californians living in poverty.

The AHCA would stop the hospital presumptive eligibility so that adults cannot get fast-tracked onto care when they need it most. In this age of disinformation and alternative facts, many people still do not know that they are Medi-Cal eligible until they are screened for it when getting emergency care. The AHCA would end the rule that allows Medi-Cal applicants to submit older bills when applying for care if they would have been eligible at the time – this is an important tool against medical debt that is often used when people get hospital care but cannot apply until they are stable enough to submit an application weeks later.

The AHCA would impose a new requirement that citizenship or immigration status must be proven prior to getting care or the federal government won't pay. California verifies citizenship and immigration status electronically through federal databases – when these databases are not functioning properly, it is not the fault of the applicant and we should not make them delay care while sorting out this documentation. A decade ago, when California implemented a stricter citizenship documentation requirement mandated by Congress, the result was that administrative costs went up and some people experienced delays in accessing care, but no savings were found by rooting out suspected fraud.

The AHCA would also make some applicants renew their Medi-Cal twice a year, rather than one time as we do for all other health coverage programs, just in the hopes that some people will not turn in their paperwork and lose their coverage. The administrative burden of having a different renewal process for some groups of people also presents other challenges that will drive up workload.

The new AHCA amendments allow States to impose a work requirement – putting more conditions on receiving health care and ignoring the reality that many Medi-Cal recipients are working. For many recipients who are not working, it is their health that prevents and only by securing their access to health care can we get them back in the workforce.

The AHCA would also eliminate enhanced funding to the Community First Care program that allows some of our sickest Medi-Cal recipients to get home-based care rather than forcing them into institutions. This cut is not only cruel, but it can be more expensive in the long run.

The AHCA lowers the cap on home equity by $250,000 for people who need nursing home care. This means that some seniors in parts of California with high home prices would be forced to sell their homes and spend down before getting the care they need.

As other speakers will explain, the AHCA also imposes a per capita cap on Medicaid spending, meaning that over time, California will have less money for its entire Medi-Cal program. New amendments, specifically block grants, give states the option of taking a lump sum of money to cover children and parents that is further capped in exchange for so-called "flexibility." This option is only viable if California creates a different Medi-Cal program that is less than the program we have now. In other words, rather than integrating many of our low-income health programs into Medi-Cal, we will be turning Medi-Cal into a variety of programs with different benefits for different people – some people would get full benefits, while children and parents would get a pared down program. This is not the flexibility we seek in California. Furthermore, the block grant option does not undo many of the most administratively burdensome pieces of federal Medicaid dollars, such as the additional barriers to enrollment I mentioned earlier.

Finally, as will be discussed in more detail, the AHCA seeks to phase out the Medi-Cal expansion by squeezing federal dollars out of it, putting the coverage of 3-4 million Californians on Medi-Cal at risk and with no affordable alternatives.

To sum up, the American Health Care Act proposes saving money by cutting millions of very low-income Americans off of Medi-Cal. It also aims to save money by preventing eligible Americans from getting Medi-Cal by enacting additional barriers to enrollment and has provisions that push low-income seniors who are very sick out of their homes. And what do we get for all of these savings? A tax cut for the richest Americans. If saving money by taking care away from the poor to give tax cuts to the rich is what American Health Care is, then we've really lost our way.

In closing, I am certain that others here will speak more eloquently as to the personal effects of the ACA. As a legal services advocate, however, one of the most profound changes the ACA brought is that we would no longer need to tell adults without dependent children that Medi-Cal couldn't help them, no matter how poor they were, until they were too sick to work.

One client that will always haunt me is one who came to Western Center with an early diagnosis of colon cancer. There were not programs or resources in her county that could help her get the treatment she needed and Medi-Cal had denied her as she was not yet disabled. Finally, when her cancer had progressed to stage 4, she was able to get on Medi-Cal.

I would hope that as a society we would not want to return to a time of such needless human suffering.