What Does the American Health Care Act (AHCA) Mean for Medi-Cal?

May 11, 2017

On May 4, 2017, the House passed a version of the American Health Care Act (AHCA) that would gut our Medi-Cal program and add additional hurdles for low-income Californians trying to enroll or keep their Medi-Cal. Below is a summary of the major provisions that would affect the Medi-Cal program based on the amendments that were included by the House. While changes are expected in the Senate, the current bill's foundation would completely destabilize our Medi-Cal program. Defeating the bill entirely must be the goal as any compromise would result in millions of low-income Californians losing health coverage.

I. Mandatory Provisions of the AHCA that Would Affect Medi-Cal

1. Imposes a Spending Cap on all Medi-Cal Population Categories

Section 121 of the AHCA uses "per capita caps" to shift significant costs to the states. Per capita caps drastically change funding to the Medi-Cal program as a whole. Instead of the current system of using a combination of state and federal funds to pay for actual costs, the proposed per capita cap system would give California a set amount of money per person. The per capita cap rate would use California's 2016 Medi-Cal spending across five categories—children, elderly adults, persons who have a disability, expansion adults, and "other"—as a baseline index, and then increase that by an amount tied to the medical consumer price index.

Contrary to its proponents' claims, per capita caps would seriously undermine California's ability to operate the Medi-Cal program. California's Department of Health Care Services (DHCS) called the AHCA per capita cap proposal a "fundamental change" and "a massive and significant fiscal shift from the federal government to the states."[1] Because the medical consumer price index will not keep pace with actual rises in costs,[2] and because Medicaid is already an extremely lean program for which costs have risen much more slowly than private insurance,[3] California would have to pay the full amount of the difference between the per capita cap and the actual cost of health coverage. DHCS analyzed its current

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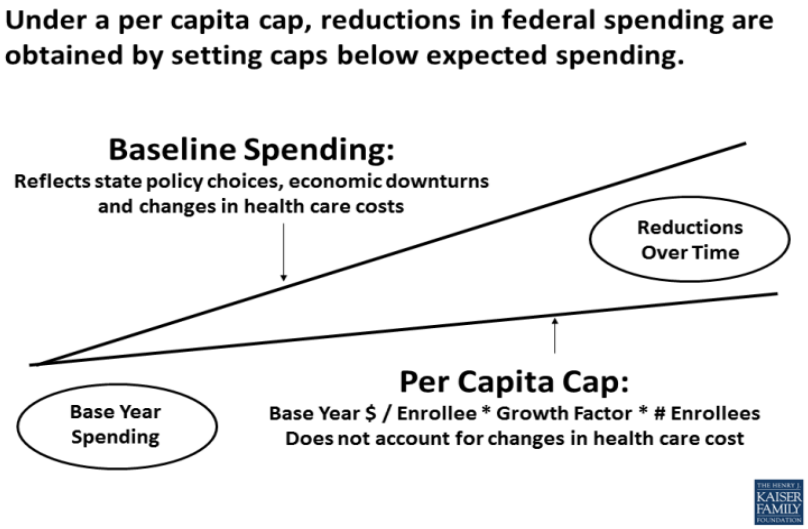
[1] Jennifer Kent & Mari Cantell, Department of Health Care Services, "Memo to Diana Dooley: Summary and Preliminary Fiscal Analysis of the Medicaid Provisions in the Federal American Health Care Act" at pp. 1, 4 (Mar. 21, 2017), http://www.dhcs.ca.gov/Documents/3.21.17_AHCA_Fiscal_Analysis.pd.pdf (emphasis in the original; hereinafter "DHCS Memo").

[2] Congressional Budget Office, "American Health Care Act: Budget Reconciliation Recommendations of the House Committees on Ways and Means and Energy and Commerce" at p. 10 (Mar. 13, 2017), https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf.

[3] CBPP Frequently Asked Question About Medicaid, http://www.cbpp.org/research/health/frequently-asked-questions-about-medicaid.

spending compared to the amount that would be allowed under the per capita cap system.[4] They projected that by 2027, California would have to repay the federal government $5.3 billion in that year alone for exceeding the cap.

The cost to California would be magnified as the population ages, new treatments are released, and the state responds to disease outbreaks and epidemics, among other things.[5] DHCS also notes that the per capita cap funding structure would have a "devastating and chilling effect on provider or plan rate increases."[6]



Source: Kaiser Family Foundation[7]

2. Rolls Back the Medi-Cal Expansion

With the Affordable Care Act, in 2014 California expanded coverage to adults 19-64 year old not previously eligible for Medi-Cal, referred to as the adult expansion population.[8] Section 112 of the AHCA would effectively end the Medi-Cal expansion by (a) allowing California to opt out of coverage for the adult expansion population; (b) severely limiting federal funding for the expansion population and thus shifting significant cost burdens to make the adult expansion prohibitively expensive for California to cover; and (c) sunsetting the requirement for states to cover certain essential health benefits for the

[4] DHCS Memo, p. 2.
[5] CBPP, Per Capita Caps Would Shift Costs and Risks to States, http://www.cbpp.org/research/health/medicaid-per-capita-cap-would-shift-costs-and-risks-to-states-and-harm-millions-of; New England Journal of Medicine, Per Capita Caps in Medicaid – Lessons from the Past, http://www.nejm.org/doi/full/10.1056/NEJMp1615696#t=article
[6] DHCS Memo, p. 2.
[7] Kaiser Family Foundation, 5 Key Questions: Medicaid Block Grants & Per Capita Caps
[8] The expansion population is sometimes referred to as "childless adults." This is a misnomer because it also includes parents of Medi-Cal children who have too much income to qualify as caretaker relatives (109-138%FPL).

expansion population. If the AHCA becomes law, we are counting on the Governor and Legislature to stay the course and not leave 3.7 million low-income Californian adults without coverage.[9]

Section 112(b) of the AHCA would have a dramatic impact on California by reducing the federal Medical assistance percentage (FMAP) provided to California to provide Medi-Cal coverage to expansion adults. Currently, the federal government provides a standard FMAP of 50% to California for the traditional Medi-Cal adult population (*e.g.,* parents, caretaker relatives). The ACA guaranteed a higher federal contribution to the state to cover the cost of expanding Medi-Cal to the adult expansion population. 42 USC § 1396d(y)(1). Under the ACA, starting in 2017 the enhanced FMAP was reduced to 95% and will be reduced further each subsequent year until 2020, when the expansion's increased FMAP is set to level off permanently at 90%.

Under the current AHCA bill, starting on January 1, 2020, the federal government would limit the increased FMAP of 90% to *only* those expansion individuals who were enrolled in Medi-Cal by December 31, 2019 and who did not have a break in eligibility after that date. For Medi-Cal expansion adults who have a break in eligibility, California would only receive the standard FMAP of 50% as of 2020. The AHCA would increase such breaks in eligibility because it would require expansion adults to renew their Medi-Cal every six months. The increased frequency of renewal, in addition to the normal rates of churn in and out of Medi-Cal,[10] would make it progressively more difficult for California to continue to cover the 3.5 million expansion adults. California currently receives over $21 billion in federal funds to cover that population.[11] California could not make-up for a shortfall of decreased FMAP. Current estimates project the state would need to use $10[12] - $13[13] billion of the state's general fund just to make up what the AHCA cuts to FMAP for the expansion population. If California chose instead to stop the Medi-Cal expansion, 3.7 million adults would lose coverage by 2027.[14]

3. Ends Hospital Presumptive Eligibility and Presumptive Eligibility for Expansion Adults

Presumptive eligibility is a process that allows people to quickly enroll in Medi-Cal based on basic income information and later submit a complete application. Starting in 2014, Medi-Cal implemented the Hospital Presumptive Eligibility Rule which allowed hospitals to do a basic screen to get individuals covered who would then follow up with a complete application, presumably when they were in better

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[9] Laurel Lucia, Ken Jacobs, and Andrew Bindman, UC Berkeley Center for Labor Research and Education, "Data Brief: Medi-Cal Expansion under AHCA: Severe Coverage and Funding Loss unless State Backfills Billions in Federal Cuts" at p. 5 (March 2017), http://laborcenter.berkeley.edu/pdf/2017/Medi-Cal-Expansion-under-AHCA.pdf.
[10] *See* UC Berkeley Labor Center, "The Ongoing Importance of Enrollment Churn in Covered California and Medi-Cal," http://laborcenter.berkeley.edu/the-ongoing-importance-of-enrollment-churn-in-covered-california-and-medi-cal/
[11] Kaiser Family Foundation http://kff.org/report-section/what-coverage-and-financing-is-at-risk-under-a-repeal-of-the-aca-medicaid-expansion-appendix/
[12] UC Berkeley, Medi-Cal Expansion Under AHCA, p. 4. http://laborcenter.berkeley.edu/pdf/2017/Medi-Cal-Expansion-under-AHCA.pdf.
[13] DHCS Memo, p. 2.
[14] UC Berkeley, Medi-Cal Expansion Under AHCA, p. 4.

shape to do so. Section 111(1) of the AHCA eliminates hospital presumptive eligibility effective January 1, 2020.

Furthermore, Section 111(3) severely restricts the ability of states to use presumptive eligibility for expansion adults. As opposed to the ACA, which permits states to opt to use presumptive eligibility for all expansion adults, the AHCA limits the option to former foster youth under age 26.

While California never implemented presumptive eligibility for expansion adults beyond hospital presumptive eligibility and former foster youth, the statutory authority to do so presumably allowed CMS to approve temporary accelerated enrollment periods to address the Medi-Cal application backlog that built up when the Medi-Cal expansion rolled out in 2014. The elimination of this statutory authority would hamper the state's ability to address similar problems that might arise in the future.

4. Eliminates Periods of Retroactive Eligibility

Medi-Cal allows applicants to submit bills for three months prior to the month of application if an applicant would have been eligible in those months. For example, if a person is hospitalized at the end of March, remains hospitalized until April, and applies for Medi-Cal after receiving a bill in May, the person would have their bills covered in May (the month of application), as well as any bills in February, March, and April if that person would have been eligible all of those months had they known to apply.

This is an important tool to fight medical debt as many people do not know they are Medi-Cal eligible or have problems applying for Medi-Cal and need assistance. Section 114(b) of the AHCA would eliminate this protection so eligibility would only start in the month of application. This is particularly difficult for people who apply after a hospitalization. If the hospitalization started the month prior, those bills would no longer be covered. Currently, people often find out they are eligible for Medi-Cal through a medical catastrophe. Under this rule, these catastrophes would lead to bankruptcy.

This provision would go into effect for applications made on or after October 1, 2017.

5. Requires Two Renewal Periods Each Year to Stay on Medi-Cal

Medi-Cal beneficiaries are already required to renew their Medi-Cal benefits once a year or when they experience any changes that affect their eligibility, such as when their income goes up. As mentioned above, the AHCA further undermines the Medi-Cal expansion by requiring Medi-Cal expansion adults to go through a Medi-Cal renewal every six months starting October 1, 2017.

Whenever Medi-Cal beneficiaries are required to jump through hoops and fill out paperwork, some inevitably lose coverage. The Congressional Budget Office evaluated historical data along with the six-month redetermination requirement and projected that "*fewer than one-third* of those enrolled as of December 31, 2019, would have maintained continuous eligibility two years later."[15]

[15] CBO Report, page p. 10

Because people easily slip through the cracks during these renewal periods, the Medi-Cal program has several protections in place requiring counties to attempt to contact beneficiaries before cutting them off and allowing for a 90-day cure period where coverage can be reinstated back to the date lost, rather than starting over with a new application. Thus, the semi-annual reporting requirement doubles the amount of time that county workers must spend processing each ongoing Medi-Cal case, resulting in many people losing their Medi-Cal only to have it reinstated later.

The AHCA's twice-a-year reporting requirement is a method to get more people to fall into a one-month or more gap in coverage and would then be subject to the reduced federal matching rate under the rollback of the Medi-Cal expansion. In addition, California would be subjected to penalties if it claimed for any person who is over income at the time of service. On the other hand, the AHCA allows states to claim a higher match rate for the administrative work required to administer this additional six-month verification.

6. Reduces Federal Match Percentage for Home and Community-Based Attendant Services and Supports

Section 111(2) of the AHCA reduces the amount of federal money going to home and community-based services that keep low-income people with disabilities out of institutions so they can receive personal care at home. California has participated in this option that allows Medi-Cal beneficiaries to receive In-Home Supportive Services in lieu of nursing home care.

Our IHSS program is the largest in the country.[16] Recipients receive assistance with daily living activities, transportation to medical appointments, and protective supervision when appropriate. This provision would lower the federal funding that pays for the attendants that help these recipients to stay in their homes and communities. DHCS estimates that this AHCA provision "will increase state costs by about $400 million in 2020, growing annually."[17] If the state cannot sustain such in-home services because of the AHCA cuts, many of these recipients would have no choice but to move to a nursing home—a more expensive choice overall. This provision would go into effect January 1, 2020.

7. Eliminates Funding to Planned Parenthood for One Year

AHCA Section 103 cuts Medicaid funding for one year to any non-profit provider who offers abortion services in addition to being primarily engaged in family planning and reproductive health services —or in other words, Planned Parenthood. DHCS identified that Planned Parenthood Affiliates of California serve over 600,000 Californians in either Medi-Cal or the Family Planning, Access, Care and Treatment Program (FPACT).[18] The cut for just one year of funding under the AHCA would cost over $400 million.[19]

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[16] DHCS Memo, p. 3.
[17] *Id.*
[18] DHCS Memo, p. 3.
[19] *Id.*

8. Lowers the Cap on Allowable Home Equity for Persons Needing Long Term Care

Medi-Cal beneficiaries who need nursing home or long term care in certain circumstances must have home equity below a certain limit. This rule is not used in many cases due to its exceptions, including those for persons planning on returning home and rules regarding spouses and dependent children living in the home.[20] Section 114(d) of the AHCA lowers the allowable limit from an indexed rate starting at $750,000, to an indexed rate starting at $500,000. This disproportionately deprives those Medi-Cal recipients who live in areas where housing of California with very high home prices of coverage for such care.

Section 114(d) goes into effect 180 days after it is passed, though if state legislation is required, the state is given until the first calendar quarter beginning after the close of the first session that begins after the AHCA is passed. Two-year sessions are counted as two separate sessions. In California, that would mean that the state law would need to be changed when the Legislature reconvenes in 2018.

9. Stops Medi-Cal for Lottery Winners

Section 114(a) of the AHCA contains provisions to ensure that winners of the lottery and other windfalls aren't "gaming the system" due to the lump sum rules in Medi-Cal that allow income to be counted only in the month it is received.[21] In addition to lottery winnings, winnings from gambling and liquid assets received from the estate of a deceased person are included. The section, which spans about 10% of the total length of the bill, allows for winnings above $80,000 to be attributed across many months, on in the case of winnings of more than $1,260,000, over a period of 10 years. Hardship exemptions are permitted and notice of loss of eligibility is required that includes the date when the person would be eligible again.

Not since the rhetoric of the "welfare queen" in the 1990s has so much legislative drafting been dedicated to such imagined benefits of misusing means-tested programs. The racially coded "welfare queen" myth is largely responsible for the gutting of our cash benefits programs and draconian program rules such as the "maximum family grant" rule that was only recently repealed in California. That rule punished children born after a family started receiving cash aid by not including additional aid for the later born children. There is no evidence that Californians on Medi-Cal win more than $80,000 from windfalls of any kind and then choose to remain on Medi-Cal. This provision of the AHCA will cost far more to implement than any savings it would achieve. This provision would go into effect January 1, 2020.

10. Funds Providers Rather than Provides Coverage

Section 113 of the AHCA reinstates the Disproportionate Share Hospital funds to hospitals that have a large number of Medi-Cal and uninsured patients after 2019. Section 115 provides funding to non-expansion states in a manner that incentivizes not covering the expansion adults that California and

[20] *See* Welf. & Inst. Code §§ 14006.15 and 140015.1(b).
[21] *See* Welf. & Inst. Code § 11157.

many other states are covering. While the non-expansion provisions would not affect California directly, both of these sections demonstrate a preference for reimbursing providers for the cost of uncompensated care rather than providing coverage to those who cannot afford it. When the cost of care is paid for in this manner, Californians without coverage will go without needed primary and specialty care and face medical debt, ruined credit, and bankruptcy. Provider funding is also less stable when it is not tied to the persons they serve having coverage.

II. Additional Provisions of the AHCA that May Affect Medi-Cal, Depending on How They Are Implemented

1. Lowers the Income Cap for Children Age 6-19

Section 111(1)(B) of the AHCA reverts the income cap for children age 6-19 from 133% FPL to 100% FPL starting in January of 2020. Because California's Children's Health Insurance Program (CHIP – formerly Healthy Families in California) has been fully integrated into Medi-Cal, California could use CHIP funds to cover this population as it did prior to this expansion. However, the CHIP program itself is subject to reauthorization under this Congress before this section would take effect. If this draft legislation is a preview of what to expect in terms of coverage, we cannot assume that CHIP would continue at current levels.

2. Reduces Mandatory Benefits for Expansion Population

Section 112(c) of the AHCA would end the ACA requirement that Medicaid covers the enumerated essential health benefits (EHBs) for the expansion population. California, like most states, aligned its Medi-Cal covered services for the newly eligible adult expansion population to the traditional benefits. If California chose to maintain Medi-Cal coverage for the adult expansion group, it could attempt to cut costs incurred by the decreased FMAP by cutting the covered services to be less than the EHBs starting on January 1, 2020. While this may save Medi-Cal program money in the short term, it would have a similar impact on the greater California economy as un- or underinsured persons seek, delay, or avoid needed care they cannot afford. A 2016 Kaiser Family Foundation report noted that, "[t]hough the uninsured are typically billed for medical services they use, when they cannot pay these bills, the costs may become bad debt or uncompensated care for providers."

In addition to financial costs, being un- or underinsured has a serious impact on health outcomes, "[b]ecause people without health coverage are less likely than those with insurance to have regular outpatient care, they are more likely to be hospitalized for avoidable health problems and to experience declines in their overall health." *Id.*

3. Allows States to Impose a Work Requirement for Adults Who Are Not Disabled, Elderly, or Pregnant

The amended Section 117 of the AHCA provides a framework by which states may impose work requirements for many adults in order to continue receiving Medicaid. Work requirements could not be imposed on persons who are disabled, elderly, or pregnant, with exemptions for persons under 19 years old, in a 60-day post-partum period, the only caretaker relative of a child under 6, or a married or head of householder under 20 and in secondary school or a program directly related to employment. States would receive an additional 5% in the federal contribution (FMAP) in order to offset the costs of administering a work requirement. States would be allowed to start implementing such requirements starting in October of 2017.

Simply stated, work requirements are not an appropriate condition for receiving health care. Many Medi-Cal recipients are already working,[22] and of those that are not, many cannot work due to chronic health conditions or illnesses that may not rise to Medi-Cal's strict definition of disability. Enrollees should not be punished for health statuses that prevent them from maintaining steady work. Furthermore, low-income Californians already have work requirements if they are participating in cash programs such as CalWORKs and local General Assistance programs.

4. Gives States the Option of Seeking a Block Grant in Lieu of the Per Capita Cap

The amended Section 121(i) of the AHCA gives states the option of taking a 10-year block grant for Medicaid recipients who are not elderly, disabled, or expansion adults (*e.g.,* children and parents) starting in 2020. Such block grants could waive many of the required Medicaid services (including EPSDT services for children), eligibility rules, cost-sharing limits, and delivery system model. Applications for such block grants would be subject to minimum federal scrutiny in order to be approved.[23] While currently there is no political will in California to cut services to children and parents, the budgetary pressure imposed by the per capita cap could change the landscape.

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[22] More than half of California's Medi-Cal expansion population are either working or actively looking for work. UC Berkeley Labor Center and UCLA Center for Health Policy Research, ACA Repeal in California: Who Stands to Lose? at 2. Nationally, nearly 8 in 10 non-disabled adults with Medicaid coverage live in working families, and nearly 60 percent are working themselves. Edwin Park, Judith Solomon, and Hannah Katch, Center on Budget and Policy Priorities, "Updated House ACA Repeal Bill Deepens Damaging Medicaid Cuts for Low-Income Individuals and Families" (Mar. 21, 2017), pp. 3-4, http://www.cbpp.org/sites/default/files/atoms/files/3-21-17health2.pdf. *See also* Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Kaiser Family Foundation, Understanding the Intersection of Medicaid and Work" (Feb. 15, 2017), http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.

[23] *See* Sara Rosenbaum, Health Affairs Blog, "The House Manager's Medicaid Amendments: The State Block Grant Option" (Mar. 21, 2017), http://healthaffairs.org/blog/2017/03/21/the-house-managers-medicaid-amendments-the-state-block-grant-option/. *See generally* Robin Rudowitz, Kaiser Family Foundation, "5 Key Questions: Medicaid Block Grants & Per Capita Caps" (Jan. 31, 2017), http://kff.org/medicaid/issue-brief/5-key-questions-medicaid-block-grants-per-capita-caps/.