How the Senate Health Care Bill Affects Low-Income Californians

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H.R. 1628, which Senate Republicans retitled as the "Better Care Reconciliation Bill," drastically changes how our Medi-Cal program is funded. The bill also reduces the subsidies available to many lower-income people on Covered California.

Provisions Affecting Medi-Cal

The brunt of the cuts imposed by the Senate bill would be felt in California by Medi-Cal beneficiaries. A number of cost-cutting measures would force the state to drastically reduce its Medi-Cal program due to declining federal dollars. The bill also imposes additional barriers on Medi-Cal beneficiaries, making it tougher to get bills covered and stay on care.

1. Imposes a Per Capita Cap on Medi-Cal Expenditures

Rather than continuing the guarantee of federally matched funds that have existed since the beginning of the Medicaid program, section 133 puts a per capita cap on payments to the state to provide Medi-Cal services and allows for program growth only as tied to the Consumer Price Index. This is even more severe than the House version of the bill, which tied rate increases to the Medical Consumer Price Index that has a higher growth rate than the general Consumer Price Index. If the cost of providing care exceeds the Consumer Price Index that it used (which it most certainly will), California will be left with a massive shortfall. Using the House version of the bill with the medical Consumer Price Index, DHCS predicted California's share to grow to an additional $5.3 billion by 2027. The Senate version would be even costlier.

Additionally, for states whose per capita rates higher than other states, an additional penalty is imposed. This additional penalty encourages states to cut benefits to keep the cost per beneficiary down. While California's overall per capita rate is low, our per capita rate for seniors and persons with disabilities is higher than many other states, and the Senate bill pulls these populations out into a separate category for measuring per capita caps. Faced with such a cap on the cost of providing care, California will be forced to cut services as the cost of providing medical care vastly outpaces the Consumer Price Index. Section 134 offers state the option of doing a block grant instead, which would further allow the state to cut benefits and impose costs on adult beneficiaries.

2. Allows the State to Eliminate the Medi-Cal Expansion

Section 126 allows California to opt out of Medi-Cal expansion, leaving 3.5 million low-income Californians without coverage – presuming the California Legislature agreed. The expansion group is adults under age 65 who are not pregnant nor on Medicare.

3. **Reduces Federal Funds to California for Medi-Cal Expansion Adults**

For those states that choose to keep covering the expansion population, Section 126 would drastically cut federal financial participation. Under the current ACA provision, federal matching assistance percentage (FMAP) for expansion adults will be 90% in 2020 and after. Proposed Section 126 would reduce the FMAP by 5% every year after 2020 (85% in 2021, 80% in 2022, 75% in 2023) and then in 2024 it would reduce to California's regular FMAP rate of 50% - a 40% reduction overall. This would be a tremendous financial burden on the California budget.

4. **Reduces Enhanced Funding for In-Home Supportive Services**

Section 125 cuts an enhanced 6% FMAP starting January 1, 2020 for home and community-based attendant services that allows seniors and persons with disabilities who need extra assistance in order to be able to stay in their homes and avoid being institutionalized.

5. **Allows the State to Reduce Benefits for Medi-Cal Expansion Adults**

Like the previous House bill, Section 126 would also end the ACA's requirement that expansion adults get a minimum level of essential health benefits (EHBs) on Dec. 31, 2019. California aligned Medi-Cal covered services of the expansion adults with that of all other adult Medi-Cal beneficiaries, including certain mental health and substance abuse services not previously available. By reducing the requirement to cover services, this proposed provision would mean that Medi-Cal expansion adults would not be guaranteed all Medi-Cal covered services, such as certain mental and behavioral health services, if state law also changes. California does not distinguish benefits according to populations, so is more likely to cut benefits to the entire Medi-Cal population than to reduce benefits to specific populations.

6. **Allows the State to Require Twice-a-Year Renewals for Medi-Cal Expansion Adults**

Medi-Cal beneficiaries are already required to report changes that affect their eligibility, such as when their income goes up. Section 130 would allow states to require an additional eligibility redetermination every year and provides a 5% FMAP increase for the quarter the renewal is done to incentivize additional renewals. Whenever Medi-Cal beneficiaries are required to fill out additional paperwork, some inevitably lose coverage. To prevent this loss, 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. Thus, the semi-annual reporting requirement doubles the amount of time that county workers must spend processing each ongoing Medi-Cal expansion adult case, resulting in many people losing their Medi-Cal only to have it reinstated later.

7. **Allows the State to Impose Work Requirements**

Starting in October 2017, Section 131 allows the state to impose work requirements on enrollees who are not pregnant, elderly, or disabled. The bill also increases the FMAP by 5% as an incentive for state that create these new requirements. We know that many people need Medi-Cal in order to be able to work – cutting of health care due to unemployment will only make it less likely that these adults can return to work.

8. **Eliminates Periods of Retroactive Eligibility**

Medi-Cal allows applicants to submit bills for up to 3 months prior to the month of application if an applicant would have been eligible in those months. 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 128 would eliminate this protection so eligibility would only start in the month of application. This is particularly difficult for people who apply during or after a hospitalization – if the hospitalization started the month prior, those bills could no longer be covered.

9. **Ends Hospital Presumptive Eligibility**

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 and then they would follow up with a complete application, presumably when they were better able to do so. Section 125 eliminates hospital presumptive eligibility.

10. **Lowers the Income Cap for Children Age 6-19**

Section 125 reverts the income cap for children age 6-19 from 133% FPL to 100% FPL starting January 1, 2020. Because Medi-Cal covers these children through Children's Health Insurance Program (CHIP) funds instead of Medicaid funds this may not immediately change coverage in California. However, the CHIP program itself is subject to reauthorization under this Congress prior to this provision taking effect.

11. **Defunds Planned Parenthood for One Year**

Section 124 prohibits the federal government from making any payments to Planned Parenthood for the provision of Medi-Cal services, despite the fact that the federal government already does not fund abortions. This would decrease access to important reproductive services for Medi-Cal beneficiaries. Should Planned Parenthood clinics close due to the financial stress, other uninsured and underinsured low-income Californians will lose access to birth control and preventive screening services.

Other provisions harming low-income Californians in Covered California

The Senate bill makes a number of changes to the individual market and subsidy structures offered through the Exchange. Here are the changes that will most affect lower-income Californians using Covered California.

1. **Cuts certain immigrant groups from Covered California**

Section 102 changes which immigrants are eligible for Covered California. Currently, all lawfully present immigrants can enroll, including those with incomes less than 100% FPL and who are only eligible for restricted-scope Medi-Cal. The Senate bill changes this to only "qualified" immigrants,[1] a definition currently used to determine eligibility for federal public benefits. This change would cause many

[1] See 8 U.S.C. § 1641 for the full list of qualified immigrants.

immigrants on temporary student or worker visas, immigrants in temporary protected status due to civil strife at home, immigrants waiting on visa petitions or adjustments, and immigrants with court orders allowing them to be in the U.S. to lose their Covered California coverage.

2. **Eliminates Cost-Sharing Reductions**

Section 207 ends cost-sharing reductions on December 31, 2019. Cost-sharing reductions are the additional subsidies on out-of-pocket costs, like copays, that lower-income enrollees get by enrolling in certain plans. Without these subsidies, lower-income Californians would not be able to afford to use their Covered California plans.

3. **Reduces Subsidies Overall**

Section 102 reduces tax subsidy eligibility from 400% FPL in the ACA, to only 350% FPL, meaning a family of four who currently makes $86,101 a year will no longer be eligible for tax subsidies. This section also makes several changes to how subsidies are calculated. One adjustment, which lowers the value of the benchmark premium will give everyone less purchasing power with their subsidies. The ACA set the benchmark premium at the second lowest cost silver plan; the Senate bill sets it at the median cost of a plan with 58% actuarial value (just below a Bronze plan).

4. **Changes Subsidy Structure So That Older Californians Would Have to Pay a Greater Percentage of Their Income**

The Senate bill combines the ACA's income-based subsidy structure with the House bill's age-based subsidy structure. In doing this, there are winners and losers. Younger Californians at higher income levels could potentially get more subsidies, while older Californians at all income levels would get less.

5. **Makes Anyone With an Offer Of Employer Coverage Ineligible, No Matter How Bad The Coverage**

Right now, just because an employee has an offer of employer coverage does not mean they can't get subsidies from Covered California. The employer coverage that is offered must be affordable to the employee and be at least roughly equivalent to a Bronze plan (known as the "minimum value" standard). If the plan the employer offered doesn't meet those tests, the employee can get subsides from Covered California instead. Section 102 would take away that protection and make any employer coverage, no matter how bad, preclude someone from getting subsidies.

6. **Ends the Repayment Cap During Reconciliation**

Section 101 eliminates the cap that lower income people pay during reconciliation if they miscalculated their income and owe money back for the advanced premium tax credits they received. Thus, a single person earning $18,000 a year could end up having to pay $1,500 or more instead of the $300 cap on reconciliation for people below 200% FPL if they misjudged their annual income and did not catch the error during the year.