# How the Senate Health Care Bill Affects Low-Income Californians

***Revised July 14, 2017 to include July 13 Senate Amendments***

*The July 13 amendments are noted in italics. The sections have been renumbered to reflect the current version.*

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 132 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 are 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 133 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.

*The July 13 amendments allow for an exception to the per capita caps, but only if a public health emergency is declared by the HHS Secretary.*

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

Section 125 allows California to opt out of the 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 125 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 state budget.

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

Section 124 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.

*A new section, 132(b), allocates $8 billion in funding to states that apply for 4-year demonstration project waivers allowing for payment adjustments for home and community-based services. However, these projects will be awarded on a competitive basis with priority given to the 15 states with lowest population density (i.e. <u>not</u> California). Even for states who are awarded the extra funding, the amount is nowhere near what current Medicaid provisions cover for these populations.*

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

Like the previous House bill, Section 125 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.

*The July 13 amendments create a new fund for state grants for substance abuse treatment services (Section 202). Such grants would not address the need for opioid treatments or fill the hole in the Medi-Cal budget created by other provisions in the bill. Nor do the opioid funds address the fact that other provisions of the bill would cause current Medi-Cal beneficiaries to lose access to core health services due to funding cuts or by excluding substance abuse treatment from the essential health benefits.*

### 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 129 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 130 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 health coverage due to unemployment will 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 that they are Medi-Cal eligible or have problems applying for Medi-Cal and need assistance. Section 127 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.

*The July 13 amendments exclude persons over 65 or persons who are receiving Medi-Cal on the basis of a disability from this provision.*

### 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 124 eliminates hospital presumptive eligibility.

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

Section 124 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.

*This provision is no longer in the July 13 amended version.*

### 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 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).

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

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

Section 102 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.

***7. Encourages the Purchase of Catastrophic Plans that Lead to Medical Debt***

*Sections 102(e) and 208 of the July 13 version would allow for premium tax credits to be used to purchase catastrophic plans. These plans, while attractive to low-income consumers due to their low premiums, make basic health care unaffordable and out of reach due to their high deductibles and out-of-pocket maximums.*

***8. Imposes a 6-month Waiting Period for People Who Were Previously Uninsured***

*Instead of an individual mandate, which would be repealed by Section 104, Section 206 would impose a 6-month waiting period for anyone applying during open enrollment or special enrollment who did not have coverage for a period of 63 days or more in the previous 12 months (or just 60 days prior to applying).*

***9. Allows States to Waive Consumer Protections or Change Plan Benefits***

*Section 207 gives states broad leeway to change or reduce the required essential health benefits in plans offered on the Exchange or to eliminate consumer protections such as lifetime and annual limits through a Section 1332 waiver. California state law currently prevents many such changes, so no waiver could be obtained without also changing our law.*

## Harms to Low-income Californians Who Do Not Qualify for Subsidies

*Section 301 of the July 13 version—the so-called "Cruz Amendment" which is now part of the full bill—would give $70 billion to health insurance companies that offer at least one ACA compliant plan on the market. The money would be then used to underwrite off-Exchange plans that base premiums on pre-existing conditions. These off-Exchange plans would not have to meet any other ACA requirements for*

*Exchange plans, such as covering EHBs, making such plans ostensibly cheaper but without any guaranteed coverage. People with pre-existing conditions or who need or want more health coverage would choose the ACA-compliant plans for more comprehensive coverage. That means ACA-compliant plans will become more and more expensive to cover. These non-compliant plans would still be subject to California's state health insurance laws.*