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June 29, 2017

Little-Noticed Medicaid Changes in Senate Health Plan Would Worsen Coverage, Reduce State Flexibility, and Raise Uncompensated Care Costs

By Jessica Schubel

The Senate Republicans' Better Care Reconciliation Act (BCRA) includes most of the House-passed bill's Medicaid provisions and cuts Medicaid even more deeply in the long run. Like the House bill, the Senate bill would radically restructure Medicaid financing and effectively phase out the Affordable Care Act's (ACA) Medicaid expansion, cutting federal Medicaid spending by $772 billion over ten years and enrollment by 15 million low-income people by 2026.[1] It would also make other, little noticed, changes that together would cut Medicaid spending by *another* $29 billion, significantly affecting coverage and financial security for over 70 million low-income Americans — including children, pregnant women, seniors, and people with disabilities — while reducing state flexibility and increasing hospitals' uncompensated care costs.[2] The bill would:

- **Roll back Medicaid coverage for children ages 6 to 18.** The ACA raised Medicaid's minimum income eligibility limit for these children from 100 to 133 percent of the poverty line, the level already in place for children under 6. This change enables all children with family incomes below 133 percent of the poverty line — regardless of age — to be covered by Medicaid, a better coverage option for these children than the Children's Health Insurance Program (CHIP), which provides somewhat narrower coverage and carries higher out-of-pocket costs.[3] The Senate plan, like the House bill, would take a step backwards by lowering Medicaid eligibility for children ages 6 to 18 level back to 100 percent of poverty, potentially affecting about 1.5 million children in 21 states.[4]

[1] Congressional Budget Office, "Cost Estimate of the Better Care Reconciliation Act of 2017," June 26, 2017, https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52849-hr1628senate.pdf.

[2] Congressional Budget Office, "Cost Estimate of the Better Care Reconciliation Act," and enrollment data from the Centers for Medicare & Medicaid Services available at https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.

[3] When the ACA's 5 percent income disregard is applied, the effective income limit is 138 percent of the poverty line.

[4] Kaiser Commission on Medicaid and the Uninsured, "Aligning Children's Eligibility: Moving the Stairstep Kids to Medicaid," August 2013, https://kaiserfamilyfoundation.files.wordpress.com/2013/08/8470-aligning-eligibility-for-children.pdf.

- **Make it harder for seniors and people with disabilities to get care in their homes and communities.** Though the Senate bill encourages states to provide more home- and community-based services (HCBS), it would have the opposite effect. HCBS, a lower-cost alternative to institutional care, help people with daily living activities like bathing and getting dressed. Instead of giving states more incentives to provide these services, the Senate bill eliminates a financial incentive in the ACA for states to do so, affecting the eight states that have taken advantage of this incentive plus others that might do so in the future.
- **Reduce states' flexibility to design and finance their programs to meet the needs of their residents.** States can now cover people with incomes just above the levels Medicaid typically covers. Michigan, for example, has used this flexibility to provide coverage to nearly 2,000 children and pregnant women in Flint, Michigan who may have been affected by the recent lead crisis. The Senate bill not only ends this option but it ends it *sooner* than the House-passed bill. The Senate bill would also limit states' ability to finance their share of Medicaid through taxes on health care providers.
- **Increase the likelihood of medical bankruptcy for low-income people and increase hospitals' uncompensated care costs.** The Senate bill would repeal an ACA provision requiring state Medicaid programs to help people pay medical bills they incurred in the three months before enrolling in Medicaid if they were Medicaid-eligible during that period. The bill would also remove an ACA option enabling states to enroll uninsured adults in Medicaid immediately if they need acute medical care. These changes would not only harm Medicaid beneficiaries, but increase uncompensated care costs for hospitals, particularly safety net hospitals that treat a disproportionate share of the most vulnerable people.
- **Make it harder for adults enrolled through the expansion to stay covered by allowing states to redetermine their eligibility every six months or even more frequently.** States now redetermine eligibility for expansion adults once a year. More frequent eligibility redeterminations lead significant numbers of *eligible* people to lose coverage or experience coverage gaps, because they often have recently moved and didn't get their redetermination paperwork in time. Coverage gaps could harm both adults and their families, such as by ending treatment for opioid addiction prematurely or creating greater financial instability.

Table 1 shows how these changes would affect individual state Medicaid programs.

Rolling Back Children's Medicaid Coverage

Before the ACA, state Medicaid programs had to cover children under age 6 with family incomes below 133 percent of the poverty line. They didn't, however, have to cover older children and teenagers with family incomes above the poverty line, and only a minority of states did so.[5] This split in children's coverage between Medicaid and CHIP, known as "stairstep" eligibility, sometimes disrupted care when children moved between the two programs. Moreover, it caused children in the same family to have different coverage sources (Medicaid versus CHIP), with different benefit packages, providers, and cost-sharing.

[5] Kaiser Commission on Medicaid and the Uninsured, "Where Are States Today? Medicaid and CHIP Eligibility Levels for Children and Non-Disabled Adults," March 2013, https://kaiserfamilyfoundation.files.wordpress.com/2013/04/7993-03.pdf.

The ACA simplified this system: it eliminated "stairstep" eligibility by requiring state Medicaid programs to cover *all* children up to age 18 with incomes below 133 percent of poverty. Accordingly, 21 states moved nearly 1.5 million children from CHIP to Medicaid by January 1, 2014.[6] On average, about 28 percent of children enrolled in CHIP moved to Medicaid, though in some states (like Mississippi, Oregon, and Utah), more than half did so, and California and New Hampshire moved their entire CHIP population into Medicaid.[7]

In addition to eliminating the burden on families that different sources of coverage can create, ending stairstep eligibility strengthened benefit and cost-sharing protections for low-income children. All children in families with incomes below 133 percent of the poverty line now have guaranteed access to a strong set of comprehensive and preventive health services — such as screenings, hearing, vision, dental, mental health, and developmental services — under Medicaid's mandatory Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. EPSDT ensures that children have access to services to treat emerging conditions such as mental illness. (In 2015, 12.5 percent of adolescents aged 12 to 17 experienced a major depressive episode.)[8] Medicaid also provides greater cost-sharing protection than CHIP for children and their families, with no premiums and modest co-payments.

The Senate bill would roll back these stronger benefits and cost-sharing protections. Parents would once again have to deal with additional challenges when managing their children's health because in many families, children would have different sources of coverage.

Making It Harder for Seniors and People with Disabilities to Get Home-Based Care

The Senate bill would eliminate an ACA incentive for states to promote HCBS, which offer an alternative to nursing homes and other institutions by providing patient-centered services that help people perform daily activities. In 2013, for the first time in Medicaid's history, the majority of Medicaid spending on long-term care was for HCBS, and the share has steadily increased since then.[9]

The ACA furthered this progress by giving states new incentives and options to implement HCBS programs. One such option is Community First Choice (CFC), which provides personal attendant services, like help with bathing and getting dressed. CFC also allows states to help beneficiaries cover the costs of transitioning from a nursing home back to their home or community by helping cover the first month's rent and utilities or paying for bedding and basic kitchen supplies.

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[6] States continue to receive the CHIP federal matching rate for these children.

[7] Kaiser Commission on Medicaid and the Uninsured, "Aligning Children's Eligibility: Moving the Stairstep Kids to Medicaid?" Prior to the ACA, some states had acted to avoid "stairstep" eligibility by taking up an option to cover CHIP-eligible children in Medicaid. Children in those states weren't affected by this transition.

[8] Substance Abuse and Mental Health Administration, "Key Substance Use and Mental Health Indicators: Results from the 2015 National Survey on Drug Use and Health," September 2016, https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2015Rev1/NSDUH-FFR1-2015Rev1/NSDUH-FFR1-2015Rev1/NSDUH-National%20Findings-REVISED-2015.pdf.

[9] Centers for Medicare & Medicaid Services, "Medicaid and CHIP: Strengthening Coverage, Improving Health," January 2017, https://www.medicaid.gov/medicaid/program-information/downloads/accomplishments-report.pdf.

To encourage states to take up this option, the ACA gives them an enhanced federal match of 6 additional percentage points for CFC services and supports. (For example, a state whose regular Medicaid matching rate is 50 percent would be reimbursed for 56 percent of the CFC services it provides.) The additional federal funds allow states to strengthen their HBCS programs by reinvesting the additional funding and providing new or more comprehensive benefits. The Senate plan would eliminate the enhanced federal match for CFC services beginning in 2020, cutting federal funding by $19 billion over the next ten years.[10] This proposal places the CFC program in jeopardy in the eight states that have taken it up and makes it less likely that other states will adopt it.[11]

Reducing State Flexibility to Design and Finance Medicaid

States have considerable flexibility in designing and financing their Medicaid programs. The ACA enhanced state flexibility by allowing states to cover people with incomes above 133 percent of poverty, and two states have taken advantage of this option. The District of Columbia adopted it to create a pathway to Medicaid coverage for adults with incomes up to 200 percent of poverty who had been enrolled in its solely state-funded health coverage program. Michigan adopted it to provide coverage to nearly 2,000 children and pregnant women in Flint, Michigan who may have been affected by the recent lead water crisis.[12]

The Senate bill would eliminate this state option after December 31, 2017, placing coverage at risk for those enrolled through the option. While any loss of coverage is harmful, it would be particularly devastating for the children, pregnant women, and their unborn children in Flint who would lose access to vital lead screening and treatment services.

The Senate bill would also restrict state taxes on health care providers and health plans. Every state except Alaska uses provider taxes to help finance its share of Medicaid costs.[13] The federal government has imposed three tests to prevent improper financing arrangements. Provider taxes must be "broad based," meaning that they must apply to *all* providers in a given category (e.g., all hospitals or all nursing homes). They must be applied on a "uniform basis," meaning each provider must pay the same rate regardless of whether the provider serves many, few, or no Medicaid beneficiaries.[14] Finally, the revenues they raise may not exceed 6 percent of the providers' net revenues from treating patients. The Senate bill would phase down this 6-percent limit each year starting in fiscal year 2021, until it reaches 5 percent in fiscal year 2025.

The reduction would have a significant effect on states. Twenty-eight states have at least one provider tax that exceeds 5.5 percent of net patient revenues, which means that starting in fiscal year

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[10] Congressional Budget Office, "Cost Estimate of the Better Care Reconciliation Act of 2017."

[11] Centers for Medicare & Medicaid Services, "Medicaid and CHIP: Strengthening Coverage, Improving Health."

[12] Michigan Department of Health and Human Services, "Flint Waiver Progress Report," June 27, 2017, http://www.michigan.gov/documents/mdhhs/Flint_Waiver_Report-Web-FINAL_534902_7.pdf.

[13] Kaiser Family Foundation, "States and Medicaid Provider Taxes and Fees," June 23, 2017, http://www.kff.org/medicaid/fact-sheet/states-and-medicaid-provider-taxes-or-fees/.

[14] For more information on provider taxes, see Edwin Park, "Limiting State Provider Taxes Would Shift Costs to States and Weaken Medicaid," Center on Budget and Policy Priorities, March 16, 2016, http://www.cbpp.org/health/limiting-state-provider-taxes-would-shift-costs-to-states-and-weaken-medicaid.

2023, they would have to find another revenue source for Medicaid. More states would be affected as the threshold phases down to 5 percent.[15]

This provider tax limit would hit states even as the Senate bill imposed growing federal Medicaid funding cuts by converting Medicaid to a per capita cap that did not keep pace with rising Medicaid costs. Since states likely could not replace all the lost provider tax revenue by raising their income taxes, for example, they couldn't maintain their *current* Medicaid spending, let alone raise it to offset the growing federal cuts. As a result, states would have to make even deeper cuts to Medicaid eligibility, benefits, and provider payments. The Congressional Budget Office estimates that this provision would reduce federal spending by $5 billion over ten years.[16]

Reducing Financial Security for Low-Income People and Increasing Hospitals' Uncompensated Care Costs

The Senate plan would repeal two provisions that protect low-income people from debt and reduce hospitals' uncompensated care — one enacted as part of the ACA, the other a longstanding Medicaid protection. These changes would likely drive more low-income people into bankruptcy due to medical costs and would raise uncompensated care costs for hospitals.

The first change would end Medicaid payments for medical costs that beneficiaries incurred up to three months before enrolling in Medicaid if they were eligible for Medicaid during that period. This retroactive coverage helps prevent medical bankruptcy. It also reimburses hospitals and other safety net providers for care they have provided during the period, helping them continue to meet their daily operating costs and maintain quality of care. While this protection may only affect a small number of individuals, the amounts can be significant. For example, data from Indiana showed that, on average, individuals with medical bills incurred before enrolling owed $1,561 to providers, which Medicaid would pay.[17] The Congressional Budget Office estimated that the Senate bill's repeal of this Medicaid protection would result in a loss of $5 billion of federal funding over the next ten years.[18]

The second change would bar states from immediately enrolling uninsured adults (other than pregnant women) into temporary Medicaid coverage while they complete the Medicaid eligibility determination process. Before the ACA, states had the option to provide immediate temporary Medicaid coverage to pregnant women and children to improve their access to timely care. The ACA extended this option, called presumptive eligibility, to help enroll uninsured adults newly eligible for Medicaid under the ACA's Medicaid expansion. Uninsured adults can enroll immediately in coverage by answering a set of questions at the hospital or other safety net provider. If the individual appears eligible, the hospital can make a "presumptive" eligibility determination, which helps prevent a delay in care while the state conducts a full eligibility determination. During this temporary coverage period, providers (including hospitals, doctors, and pharmacies) receive full

[15] Kaiser Family Foundation.

[16] Congressional Budget Office, "Cost Estimate of the Better Care Reconciliation Act of 2017."

[17] July 29, 2016 letter from the Centers of Medicare and Medicaid Services to the state of Indiana, available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf.

[18] Congressional Budget Office, "Cost Estimate of the Better Care Reconciliation Act of 2017."

Medicaid reimbursement for services they provide, even if the individual is later found ineligible for Medicaid. The Senate bill's repeal of this option would delay reimbursement for hospitals providing needed care for people who may be eligible for expansion coverage.

Making it Harder for Expansion Adults to Stay Covered

Medicaid requires most beneficiaries to renew their coverage once a year. Many beneficiaries do not complete renewals on time and lose coverage despite remaining eligible, for reasons that include changes in address and lack of time to comply with processes that can be confusing and may require documentation that beneficiaries may not have on hand. Beneficiaries often re-apply for Medicaid after a short break in coverage.

Increasing the frequency of renewals can reduce enrollment and cause more breaks in coverage. In 2003, Washington State began requiring children to renew eligibility every six months and made other process changes; the number of children participating in Medicaid fell by 30,000 over the next two years. When the state restored 12-month eligibility, children's enrollment *rose* back by 30,000 within a year.[19]

The Senate plan would allow states, starting in October 2017, to renew Medicaid eligibility every six months or even more frequently for expansion enrollees. This change would leave more people with coverage gaps, which would be particularly harmful for adults undergoing treatment for cancer or substance use disorder.

[19] Georgetown Center for Children and Families, "Program Design Snapshot: 12-Month Continuous Eligibility," March 2009, http://ccf.georgetown.edu/wp-content/uploads/2012/03/CE-program-snapshot.pdf.

TABLE 1

Senate Plan Would Require Changes in Every State's Medicaid Program

State	Potentially Affected by Change in Children's Medicaid Coverage	End of Optional Coverage for People Over 133% of Poverty	End of Enhanced Match for Community First Choice (Home- and Community-Based Services)	End of Retroactive Coverage & Presumptive Eligibility	Potentially Affected by More Frequent Renewals for Expansion Adults	Have at Least 1 Provider Tax Over 5.5% of Net Patient Revenue
Alabama	X			X		X
Alaska				X	X	
Arizona	X			X	X	
Arkansas				X	X	X
California	X		X	X	X	X
Colorado	X			X	X	
Connecticut			X	X	X	X
Delaware	X			X	X	
District of Columbia		X		X	X	
Florida	X			X		X
Georgia	X			X		X
Hawaii				X	X	
Idaho				X		
Illinois				X	X	
Indiana				X	X	X
Iowa				X	X	
Kansas	X			X		
Kentucky				X	X	
Louisiana				X	X	
Maine				X		
Maryland			X	X	X	X
Massachusetts				X	X	X
Michigan		X		X	X	

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Minnesota				X	X	
Missouri				X		X
Mississippi	X			X		X
Montana			X	X	X	
Nebraska				X		X
Nevada	X			X	X	X
New Hampshire	X			X	X	
New Jersey				X	X	X
New Mexico				X	X	
New York	X	X	X	X	X	
North Carolina	X			X		X
North Dakota	X			X		X
Ohio				X	X	X
Oklahoma				X		X
Oregon	X		X	X	X	X
Pennsylvania	X			X	X	X
Rhode Island				X	X	X
South Carolina				X		
South Dakota				X		
Tennessee	X			X		X
Texas	X		X	X		
Utah	X			X		X
Vermont				X	X	X
Virginia				X		

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Washington			X	X	X	X
Wisconsin		X		X		X
West Virginia	X			X	X	X
Wyoming	X			X		X