Senate Health Care Bill Ends Medicaid as We Know It, With Even Bigger Cuts Than House Bill

The Senate's Better Care Reconciliation Act (BCRA) would radically restructure Medicaid financing and effectively end the Affordable Care Act's (ACA) Medicaid expansion, cutting federal Medicaid funding by $772 billion over ten years and reducing enrollment by 15 million people by 2026. The bill's other Medicaid changes would cut another $29 billion over ten years. Just like the House-passed bill, the BCRA would have a devastating effect on over 70 million people who rely on Medicaid, including over 30 million children and millions of seniors, people with disabilities, pregnant women, and low-income adults.

Capping Federal Medicaid Funding, with Cuts Growing Each Year

The BCRA would end Medicaid's federal-state financing partnership in which the federal government pays a fixed percentage of state Medicaid costs — on average, 64 percent today. Instead, beginning in 2020, federal funding would be capped at a set amount per beneficiary. This "per capita cap" would be based initially on the state's past federal Medicaid spending per beneficiary but would rise each year by a *slower* rate than the Congressional Budget Office's (CBO) current projection for Medicaid per beneficiary spending. That would cut federal Medicaid funding, with the cuts growing each year. (States would also have the option of converting Medicaid to a block grant for adults.) In fact, the Senate bill's Medicaid cuts in 2026 are *larger* than the House bill's because it lowers the growth rate for federal funding under the per capita cap below even the House bill's inadequate level starting in 2025. The federal funding cuts from the per capita cap would continue deepening in coming decades, rising to a 35 percent cut by 2036, according to CBO.

To compensate for these cuts, states would have to raise taxes, cut other budget areas like education, or — as is far likelier — cut Medicaid spending. Medicaid is highly efficient, with per-beneficiary costs that are lower than (and growing more slowly than) private insurance, so states would likely have to make cuts that seriously harm beneficiaries, like restricting eligibility, reducing services, cutting payments to providers, or a combination of all three approaches to rationing care.

Funding shortfalls would be even greater if health care costs grow more quickly than anticipated due to a public health emergency, costly new prescription drug, or changing demographics. And the certain increase in seniors' per beneficiary costs as the baby boomers age and more seniors move from "young-old age" to "old-old age" will deepen the shortfalls. All 32 states with available projections estimate that the share of their seniors who are 85 and older will rise between 2025 and 2035, in most cases by at least 25 percent. People in their 80s or 90s have more serious and chronic health problems and are likelier to require nursing home and other long-term services and supports. For example, seniors aged 85 and older incurred average Medicaid costs in 2011 that were more than 2.5 times higher than those aged 65 to 74. But under the BCRA, each state's funding per senior beneficiary would be based on the state's spending per senior beneficiary in 2016, so federal funding wouldn't adjust to reflect the rise in seniors' per beneficiary costs.

Faced with these cuts, many states would cut home- and community-based services, an optional benefit in Medicaid that enables people with serious health problems (including children with disabilities and special health care needs) to remain in their homes instead of a nursing home by helping them with daily living activities like bathing and dressing. Over half of state spending on optional services is for home- and community-based services, making them a likely target for cuts.

Ending the Medicaid Expansion

Like the House bill, the Senate health bill would effectively eliminate the ACA's Medicaid expansion in 31 states and the District of Columbia, leaving millions of low-income adults uninsured. Under the Senate bill, the federal share of spending for *all* expansion enrollees — not just new enrollees, as in the House bill — would fall from 90 percent under the ACA to 85 percent in 2021, 80 percent in 2022, 75 percent in 2023, and then to states' regular Medicaid matching rates (which average 57 percent) in 2024. At that point, states wanting to continue covering low-income adults in expanded Medicaid coverage would have to pay 2.8 to 5 times their current-law cost for each enrollee. At least nine states have laws that effectively require their Medicaid expansions to end if federal financial support for the expansion falls; most or all other states would ultimately have to end the expansions. The expansion now covers 11 million low-income adults who would have been ineligible for Medicaid, and likely uninsured, under pre-ACA rules.

Worsening Coverage, Reducing State Flexibility, and Increasing Uncompensated Care Burdens

The BCRA's other Medicaid changes haven't gained much notice but would cut an additional $29 billion over ten years and significantly affect coverage and financial security for millions of children, pregnant women, seniors, and people with disabilities, while also increasing hospitals' uncompensated care costs. These changes would:

- **Roll back Medicaid coverage for children ages 6-18.** The ACA raised Medicaid's minimum income limit for these children from 100 to 133 percent of the poverty line, allowing all children with family incomes below 133 percent of poverty, regardless of age, to receive Medicaid. That's a better coverage option than the Children's Health Insurance Program, which has narrower coverage and higher out-of-pocket costs. Like the House bill, the BCRA would lower eligibility back to 100 percent of poverty, potentially affecting about 1.5 million children in 21 states.
- **Make it harder for seniors and people with disabilities to get health care in their homes and communities.** The BCRA also would remove a financial incentive in the ACA for states to provide home- and community-based services, a lower-cost alternative to institutional care. This would threaten people's ability to stay in their homes and get care.
- **Allow states to impose onerous work requirements as a condition of eligibility on adult beneficiaries who are not elderly, disabled, or pregnant,** which current law does not allow. The work requirement could apply, for example, to a married mother of a young child, a former foster child attending college, or an individual caring for an aging parent. But the overwhelming majority of low-income adults on Medicaid already work. Nearly 8 in 10 non-disabled adults with Medicaid coverage live in working families, and nearly 60 percent are working themselves. Of those not working, more than one-third reported that illness or a disability was the primary reason, 28 percent reported that they were taking care of a family member, and 18 percent were in school.
- **Reduce state flexibility to design and finance their programs to meet their residents' needs.** Under current law, states can cover people with incomes just above the income levels Medicaid typically covers. Michigan, for example, has used this flexibility to provide coverage to nearly 2,000 children and pregnant women in Flint who may have been affected by the recent lead water crisis. The BCRA not only ends this option but it ends it *sooner* than the House-passed bill. The Senate bill would also limit state taxes on health care providers, which nearly every state uses to help finance Medicaid.
- **Increase the likelihood of medical bankruptcy for low-income people and increase hospitals' uncompensated care costs.** Like the House bill, the BCRA would repeal an ACA provision requiring state Medicaid programs to help people pay medical bills incurred in the three months before enrolling in Medicaid if they were eligible for Medicaid during that period. It would also remove an ACA option enabling states to enroll uninsured adults in Medicaid immediately if they need acute medical care. These changes would harm beneficiaries and raise uncompensated care costs for hospitals — particularly safety net hospitals, which treat a disproportionate share of the most vulnerable people.

Revised July 6, 2017