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CBPP STATEMENT

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Greenstein: House Republican Health Plan Seriously Flawed

The House Republican health plan is seriously flawed. Because it would repeal or severely weaken health reform's coverage expansions, force people to rely instead on a badly flawed tax credit to buy coverage in a largely unregulated individual market, weaken or end key measures to protect consumers in that market, and restructure and substantially cut Medicaid over time, millions of Americans would likely lose their existing health coverage — with many of them likely ending up uninsured or underinsured.

The Medicaid changes raise particular concern. Not only would the plan bar any more states from taking health reform's Medicaid expansion, but it would sharply reduce the federal share of Medicaid costs for beneficiaries covered under the expansion in states that have taken it — likely driving many such states to drop it in coming years. On top of that, the plan would force each state to accept the conversion of its Medicaid program to a block grant or to a program with rigid caps on federal funding provided per beneficiary (i.e., a "per capita cap"). While this part of the plan lacks full detail, the budget that the House Budget Committee's Republican majority adopted in March includes a virtually identical proposal — and it was designed to shrink federal Medicaid funding for states by *$1 trillion* over the next ten years. That would almost certainly prompt states to impose substantial Medicaid cuts to offset their large federal funding losses.

The plan also proposes ill-advised changes in Medicare that would adversely affect millions of people who are older or have disabilities, particularly 65- and 66-year-olds, who would be ineligible for Medicare in the future because the plan would raise Medicare's eligibility age from 65 to 67.

Overall, the plan would represent an enormous step backward for our country, reversing historic progress in expanding health coverage under the Affordable Care Act (ACA). Its problematic provisions include the following:

- **Repealing or undermining health reform's major coverage expansions.** The millions who gained health coverage through health reform's marketplaces and subsidies would lose their current coverage. In addition, many who gained coverage through the ACA's Medicaid expansion would likely see their states drop the expansion over time. Millions more who would have gained coverage in the future under the ACA would likely remain uninsured, as the plan would bar any more states from taking the Medicaid expansion.

  The plan also eliminates health reform's individual mandate, which would result in fewer people purchasing coverage. And since healthier people would be the ones most likely to drop coverage in the absence of the mandate, the pool of people buying coverage in the individual market would grow sicker on average and, thus, costlier to insure (especially since the plan would leave in place the ACA's

prohibition against insurers denying coverage to people with pre-existing conditions). That would push up premiums in the individual insurance market, especially for comprehensive coverage. (For more, see "Repealing the Affordable Care Act" and "No Individual Mandate".)

- **Creating a flawed tax credit to buy individual-market coverage.** The plan lacks essential details; for example, it doesn't specify the amounts of the refundable tax credits with which people would buy coverage in the individual market, though those amounts likely would be considerably smaller than the ACA's marketplace subsidies. Various House Republicans have suggested that the plan provides tax credits that enable people to buy *catastrophic* health coverage, rather than the more comprehensive coverage that the ACA's marketplaces and subsidies provide. The plan also notes that the credits would only be large enough to buy a typical pre-ACA individual market plan; such plans, however, often charged very high deductibles and lacked key benefits, such as prescription drug coverage.

  In addition, the tax credit would *not* vary by income or by the cost of decent-quality coverage that's available in a local area. Nor would it account for the substantially higher premiums that people who have pre-existing health conditions and couldn't maintain continuous coverage would face. And the plan wouldn't replace health reform's cost-sharing subsidies, which help people with marketplace coverage and incomes below 250 percent of the poverty line pay their deductibles and co-payments.

  All of that almost certainly would leave many fewer people with coverage — and among those with coverage, more people who have skimpy plans and are underinsured. (For more, see "Health Insurance Subsidies".)

- **Returning to much of the largely unregulated individual market before health reform.** Insurers could again charge higher premiums based on health status to people who haven't maintained continuous coverage for a period of time, which people of modest means often find hard to do. And insurance companies could again charge women higher premiums than men and older people much higher premiums than younger people (well beyond what the ACA allows). Insurers also could set total dollar limits on how much they'd cover in benefits each year and stop paying benefits when a beneficiary reaches the limit. Also, the plan would drop the ACA's limit on the total out-of-pocket costs that a beneficiary can incur, as well as the requirement that individual and small-group market insurers cover a comprehensive array of benefits. (For more, see "Market Rules and Consumer Protections" and "Little Protection for People with Pre-Existing Conditions".)

- **Converting Medicaid to a per capita cap or a block grant.** As noted, states would have to accept a per capita cap or a block grant. Both would shift significant costs to states over time, either by capping federal Medicaid spending per beneficiary at levels *below* the projected per-beneficiary levels — with the cuts growing larger each year — or by capping total federal funding for state Medicaid programs, with the block grant amounts failing to keep pace with expected growth in enrollment and health care costs over time. To compensate for the large federal funding losses, states would have to boost their own Medicaid spending substantially or, as is likelier, cut eligibility, benefits, and provider payments — causing millions of low-income Americans to lose Medicaid coverage altogether or lose various needed benefits. These cuts would come on top of other federal Medicaid funding cuts in the plan that likely would prompt many states that have adopted health reform's Medicaid expansion to drop it, since the GOP plan would sharply reduce over time the share of Medicaid expansion costs that the federal government covers.

  To cope with these Medicaid funding cuts, states would have to impose cuts that surely would harm beneficiaries, despite House leaders' blithe claims that states could use their enhanced flexibility to simply make their Medicaid programs more efficient. Medicaid per-beneficiary costs already are far

below those of private insurance, and such costs have grown considerably slower in Medicaid over the past 15 years than the costs of private insurance and Medicare.

Moreover, while the plan lacks full detail on its Medicaid changes, the budget that the House Budget Committee's GOP majority approved in March proposes to give states the same choice between a per capita cap and a block grant, with the option designed to cut federal Medicaid spending by about $1 trillion over the next ten years. If all states pursued a per capita cap, federal Medicaid funding cuts of this size would force states to cut Medicaid per-beneficiary spending by about *50 percent* by the tenth year, relative to current law (or to slash the number of low-income beneficiaries they serve). (For more, see "Commentary: Like a Block Grant, Medicaid Per Capita Cap Would Shift Costs to States and Place Beneficiaries at Risk" and "Medicaid Spending Per Beneficiary Would Shrink by Half Under House Budget's Per Capita Cap Option".)

- **Converting Medicare to premium support and making 65- and 66-year-olds ineligible.** By replacing Medicare's guarantee of health coverage with a flat payment (or voucher) for beneficiaries to buy private health insurance or traditional Medicare, the plan would likely shift costs to beneficiaries over time, because the amount of the premium-support voucher likely wouldn't keep pace with health care costs. Furthermore, the premium-support proposal could presage the gradual demise of traditional Medicare because, if insurance companies could design their plans under premium support to attract healthier enrollees and deter sicker ones (as would be likely), the pool of beneficiaries in traditional Medicare would grow older and sicker, on average, and hence much costlier to cover. The resulting increases in per-beneficiary costs in traditional Medicare could ultimately make that program unsustainable, thus leading eventually to full Medicare privatization.

  In addition, the plan would raise Medicare's eligibility age from 65 to 67 over time, compelling 65- and 66-year-olds who can't get employer-based coverage to buy coverage in the individual market. As noted, however, insurers in the individual market could charge much higher premiums to this age group than they can under the ACA. And insurers could discriminate against people with pre-existing conditions who couldn't maintain continuous coverage by raising their premiums further. Finally, 65- and 66-year-olds with limited incomes would have to try to buy coverage in the individual market with what would likely be a very modest tax credit that doesn't vary by income and isn't tied to the actual cost of coverage in their area. As a result, the tax credits almost certainly would be woefully inadequate to buy a plan with the comprehensive benefits that many 65- and 66-year-olds need, particularly those with chronic conditions. Consequently, many 65- and 66-year-olds would likely end up uninsured or underinsured — and forgo needed care.

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