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Congressional Republicans' Budget Plans Are Likely to Cut Health Coverage

By Allison Orris and Sarah Lueck

This spring, House Republicans are expected to release an annual budget resolution that calls for large health care cuts, and Medicaid and the Affordable Care Act's (ACA) marketplace coverage are likely to be prime targets. House Republican leaders are calling for cutting the deficit and making the Trump tax cuts permanent, while saying they will shield certain areas of the budget (Medicare, Social Security, and military spending) from cuts. To do all these things at once, it is highly likely they will propose cuts in health programs that provide coverage to millions of people.

It may take time for the details of this agenda to become clear. Later this year the House Energy and Commerce and Ways and Means committees, which have jurisdiction over health coverage programs, could advance legislation with specific proposals that seek to hit the spending-cut targets the budget resolution is likely to include. But past Republican budgets and recent lawmaker statements offer clues to what's ahead. For example, budgets put forward by the Trump Administration,¹ by the Republican Study Committee,² and, late last year, by former director of the Trump Office of Management and Budget Russell Vought,³ all included large health care cuts. Leaders of the House Energy and Commerce Committee have also expressed support for proposals that would harm enrollees, states, and providers.⁴

With too many households already facing significant health and economic insecurity, policymakers should reject policies like those outlined below, which would eliminate or weaken people's coverage and their ability to afford health care. Large racial and ethnic disparities in uninsured rates persist, due in large part to long-standing structural racism and systemic inequities that have resulted in

¹ Peggy Bailey *et al.*, "Health Proposals in the President's Budget Would Reduce Health Insurance Coverage and Access to Care," CBPP, February 16, 2018, <https://www.cbpp.org/research/health/health-proposals-in-presidents-budget-would-reduce-health-insurance-coverage-and>.

² Republican Study Committee, "Blueprint to Save America: Fiscal Year 2023 Budget," https://banks.house.gov/uploadedfiles/rsc_2023_budget_final_version.pdf.

³ Center for Renewing America, "A Commitment to End Woke and Weaponized Government: 2023 Budget Proposals," December 7, 2022, <https://americarenewing.com/wp-content/uploads/2021/04/Budget-Center-for-Renewing-America-FY23.pdf>.

⁴ Mike Lillis, "Democrats vow fierce fight if GOP cuts Medicaid," *The Hill*, March 5, 2023, <https://thehill.com/homenews/house/3882349-democrats-vow-fierce-fight-if-gop-cuts-medicaid/>.

fewer educational, employment, and other economic opportunities for people of color — limiting their access to health coverage. Restricting coverage, particularly in Medicaid, would exacerbate inequities. Rather than disrupting coverage, Congress should take steps such as closing the Medicaid “coverage gap,” which leaves millions of people without an affordable path to coverage, and extending and improving financial assistance for people enrolling in the ACA marketplaces.

Medicaid

Nearly 85 million people are currently covered by Medicaid, which provides low-cost, efficient health care to low-income children, adults, people with disabilities, and seniors.⁵ Protecting Medicaid is just as critical as protecting Medicare and Social Security in upcoming negotiations, but lawmakers have started to float various proposals that would cut the program and increase the number of people without coverage. Some proposals would, over the next decade, cut Medicaid spending by as much as one-third, or cut Medicaid, the Children’s Health Insurance Program, and marketplace spending by nearly half, which would take coverage away from millions of people.⁶ Congress should reject all of these proposals, including those that would threaten the ACA Medicaid expansion, take coverage away from people who don’t document that they meet a work requirement, cap the federal government’s commitment to sharing the cost of Medicaid with states, or otherwise shift more costs to states.

- **Undermining or rescinding the ACA Medicaid expansion.** Rep. Cathy McMorris Rodgers, chair of the House Energy & Commerce Committee, has questioned both the Medicaid expansion itself (as did the Center for Renewing America budget, which would entirely repeal the ACA expansion⁷) and the increased matching rate for expansion adults.⁸ Changes to those policies would undo the tremendous benefits of the ACA’s Medicaid expansion to low-income adults.

States that expanded coverage have cut their uninsured rate by roughly half and have shrunk the gap in coverage between white adults and adults of color.⁹ As of March 2022, 17.8 million people were enrolled in the Medicaid expansion group.¹⁰ Many of these people are individuals

⁵ Centers for Medicare & Medicaid Services (CMS), “November 2022 Medicaid & CHIP Enrollment Data Highlights,” <https://www.medicare.gov/medicaid/national-medicare-chip-program-information/downloads/november-2022-medicare-chip-enrollment-trend-snapshot.pdf>.

⁶ Edwin Park, “Center for Renewing America Budget Plan Would Cut Federal Medicaid Spending By One-Third, Repeal Affordable Care Act’s Coverage Expansions,” Georgetown Center for Children and Families (CCF), February, 27, 2023, <https://ccf.georgetown.edu/2023/02/27/center-for-renewing-america-budget-plan-would-cut-federal-medicare-spending-by-one-third-repeal-affordable-care-acts-coverage-expansions/>; Edwin Park, “House Republican Study Committee Budget Plan Includes Draconian Medicaid Cuts,” CCF, January 31, 2023, <https://ccf.georgetown.edu/2023/01/31/house-republican-study-committee-budget-plan-includes-draconian-medicare-cuts/>.

⁷ Center for Renewing America, *op. cit.*

⁸ Lillis, *op. cit.*

⁹ Inna Rubin, Jesse Cross-Call, and Gideon Lukens, “Medicaid Expansion: Frequently Asked Questions,” CBPP, June 16, 2021, <https://www.cbpp.org/research/health/medicaid-expansion-frequently-asked-questions>.

¹⁰ CMS, Quarterly Medicaid Enrollment Data – New Adult Group, January – March 2022 Medicaid MBES Enrollment, <https://www.medicare.gov/medicaid/national-medicare-chip-program-information/medicaid-chip-enrollment-data/medicaid-enrollment-data-collected-through-mbes/index.html>.

with disabilities who do not receive Supplemental Security Income and are thus not automatically eligible through the mandatory disability-related pathway, which relies on an extremely narrow definition of disability.¹¹

Medicaid expansion coverage has improved access to care, health, and financial security for enrollees.¹² Medicaid expansion has reduced uncompensated care burdens and improved hospital operating margins, particularly for rural and safety net hospitals.¹³ States have also realized budget savings, revenue gains, and overall economic growth as a result of the expansion, in part because the federal government pays 90 percent of the cost of the Medicaid expansion, rather than matching state costs at the regular Medicaid matching rate (or FMAP), which ranges from 50 to 78 percent in fiscal year 2023.¹⁴

The Congressional Budget Office (CBO) estimated that reducing the Medicaid expansion federal matching rate to the regular Medicaid matching rate would save the federal government \$44 billion in 2024 and \$604 billion from 2024-2032.¹⁵ A cut of this magnitude would likely lead some states to drop the Medicaid expansion.

If that happens, the fallout would not be limited to the millions of adults who would lose coverage; large numbers of children would likely lose coverage as well, since children are more likely to gain coverage when their parents are covered.¹⁶ Undermining the Medicaid expansion by lowering the matching rate would increase uncompensated care for states and providers and leave millions nationwide without an affordable health care option. States that keep the expansion would likely shift costs to providers by lowering their payment rates.

- **Taking Medicaid coverage away from people who don't document they meet a work requirement would put millions of people's health care at risk and perpetuate health inequities.** So-called “work requirements” — which are included in the Center for Renewing

¹¹ MaryBeth Musumeci and Kendal Orgera, “People with Disabilities Are at Risk of Losing Medicaid Coverage Without the ACA Expansion,” KFF, November 2, 2020, <https://www.kff.org/medicaid/issue-brief/people-with-disabilities-are-at-risk-of-losing-medicaid-coverage-without-the-aca-expansion/>.

¹² Madeline Guth, Rachel Garfield, and Robin Rudowitz, “The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020,” KFF, March 17, 2020, <https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/>; Madeline Guth and Meghana Ammula, “Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021,” KFF, May 6, 2021, <https://www.kff.org/medicaid/report/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021/>.

¹³ Meghana Ammula and Madeline Guth, “What Does the Recent Literature Say about Medicaid Expansion? : Economic Impacts on Providers,” KFF, January 18, 2023, <https://www.kff.org/medicaid/issue-brief/what-does-the-recent-literature-say-about-medicaid-expansion-economic-impacts-on-providers/>.

¹⁴ These matching rates do not reflect higher matching rates made available through the Families First Coronavirus Response Act, as amended by the Consolidated Appropriations Act, 2023.

¹⁵ CBO, “Reduce Federal Medicaid Matching Rates,” Options for Reducing the Deficit, 2023-2032 – Volume I: Larger Reductions, December 7, 2022, <https://www.cbo.gov/budget-options/58624>.

¹⁶ Julie L. Judson and Asako S. Moriya, “Medicaid Expansion for Adults Had Measurable ‘Welcome Mat’ Effects on their Children,” *Health Affairs* 36, No. 9 (2017), 1643-1651, <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.0347>.

America's budget plan and in House Freedom Caucus¹⁷ and Republican Study Committee debt ceiling negotiation demands,¹⁸ and have recently been touted by other policymakers¹⁹ — would impose burdensome new reporting obligations that are unlikely to increase the number of people who work for pay.²⁰

The majority of adult Medicaid enrollees are already working, often in low-paying jobs that do not provide health coverage. Those who aren't currently working are often only temporarily between jobs or have health issues or disabilities that limit their employment (though not necessarily permanently).²¹ These requirements take coverage away from people who need it, including people who are working or who meet exemption criteria but aren't able to navigate the maze of reporting requirements. When someone loses health coverage that helps them manage a chronic condition, they can face more difficulties getting or keeping a job, adverse health outcomes, and increased financial instability as households have to use their limited resources for medicine or health care.

Previous experiments with similar policies led to large numbers of people losing coverage. Before a court ordered Arkansas to stop its experiment, for example, more than 18,000 people — nearly 1 in 4 individuals who were subject to the new rules — lost their coverage in just the first seven months of that state's work requirement policy.²² Some of these people were working but either didn't meet the required number of hours or had difficulty reporting their hours; others were exempt because they had disabilities or caregiving responsibilities but had difficulty claiming those exemptions due to red tape. A study by Harvard researchers found no evidence that the Arkansas policy increased employment, but it did find that people who lost

¹⁷ Lindsey McPherson, "Freedom Caucus lays out debt limit, spending demands," *CQ News*, March 10, 2023, https://plus.cq.com/doc/news-7684210?0&utm_medium=newsletter&utm_source=hbmorning; Emily Brooks, "Freedom Caucus lays out spending cut demands for debt limit," *The Hill*, March 10, 2023, <https://thehill.com/business/budget/3893956-freedom-caucus-lays-out-spending-cut-demands-for-debt-limit/>.

¹⁸ Memo from the Republican Study Committee (RSC) Policy Team to RSC Member Offices Re: Debt Limit Policy Memo, March 7, 2023, https://hern.house.gov/uploadedfiles/hern_rsc_debt_limit_memo_03082023.pdf.

¹⁹ Lillis, *op. cit.*; Joseph Zeballos-Roig, "Matt Gaetz has a big demand for the debt ceiling fight," *Semafor*, February 3, 2023, <https://www.semafor.com/article/02/03/2023/matt-gaetz-debt-ceiling-fight>. See also Arkansas Department of Human Services, "Governor Sarah Huckabee Sanders Directs DHS to Add Work Requirement to Medicaid Program," February 15, 2023, <https://humanservices.arkansas.gov/news/governor-sarah-huckabee-sanders-directs-dhs-to-add-work-requirement-to-medicaid-program/>.

²⁰ LaDonna Pavetti *et al.*, "Expanding Work Requirements Would Make it Harder for People to Meet Basic Needs: Would Do Little to Improve Long-Term Work Opportunities and Outcomes," CBPP, March 15, 2023, <https://www.cbpp.org/research/poverty-and-inequality/expanding-work-requirements-would-make-it-harder-for-people-to-meet>.

²¹ Rachel Garfield *et al.*, "Work Requirements Among Medicaid Adults: Implications of Economic Downturn and Work Requirements," Kaiser Family Foundation (KFF), February 11, 2021, <https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/>; Kristin F. Butcher and Diane Whitmore Schanzenbach, "Most Workers in Low-Wage Labor Market Work Substantial Hours, in Volatile Jobs," CBPP, July 24, 2018, <https://www.cbpp.org/research/poverty-and-inequality/most-workers-in-low-wage-labor-market-work-substantial-hours-in>.

²² Jennifer Wagner and Jessica Schubel, "States' Experiences Confirm Harmful Effects of Medicaid Requirements," CBPP, updated November 18, 2020, <https://www.cbpp.org/research/health/states-experiences-confirm-harmful-effects-of-medicaid-work-requirements>.

Medicaid coverage under the policy became uninsured.²³ These results are hardly a basis for extending work reporting requirements to all states.

Justifications for work requirements rest on false assumptions about people who participate in Medicaid and about why people are out of work or are paid low wages. They ignore the realities for people in the low-paid labor market, who frequently lack paid sick and family leave, experience health issues and disabilities that affect employment, and encounter ongoing labor market discrimination. These proposals appeal to stereotypes about people based on their race, gender, class, or health status, and aren't supported by research or experience. Finally, administrative burdens, including those embedded in work requirements, fall disproportionately on people of color, who are more likely to rely on Medicaid for health coverage.²⁴

- **Capping federal Medicaid funding (via a “per capita cap” or block grant) is the same as a cut and would shift costs to states, force them to scale back benefits and services, and harm enrollees and the providers who serve them.** The Republican Study Committee budget proposes to cut Medicaid by converting it to a block grant.²⁵ The chair of the House Energy and Commerce Subcommittee on Health, Rep. Brett Guthrie, has discussed capping Medicaid spending, which could refer to either a block grant or a Medicaid per capita cap, a policy he supported during Republican efforts to repeal the ACA.²⁶ Either policy would radically restructure Medicaid financing in order to cut the federal government’s spending on the program.²⁷

Today, the federal government picks up a fixed percentage of states’ total Medicaid costs, which gives them the certainty they need to run their programs because they receive more funding when costs rise.²⁸ In contrast, under a *per capita cap*, states would receive a fixed amount of federal funding on a per-enrollee basis; if average per capita costs were higher than the capped amount, the state would have to pay the full amount of those additional costs.²⁹ (See Figure 1.) Costs could rise for a variety of reasons, including increased incidence of health

²³ Benjamin Sommers *et al.*, “Medicaid Work Requirements – Results from the First Year in Arkansas,” *New England Journal of Medicine*, September 2019, Vol. 318, No. 11, <https://www.nejm.org/doi/full/10.1056/NEJMSr1901772>.

²⁴ Jennifer Wagner, Farah Erzouki, and Jennifer Sullivan, “States Can Reduce Medicaid’s Administrative Burdens to Advance Health and Racial Equity,” CBPP, July 19, 2022, <https://www.cbpp.org/research/health/states-can-reduce-medicoids-administrative-burdens-to-advance-health-and-racial>.

²⁵ Republican Study Committee, *op. cit.*

²⁶ Peter Sullivan, “Debt ceiling fight looms over Medicare, Medicaid,” *Axios*, January 13, 2023, <https://www.axios.com/2023/01/13/debt-ceiling-fight-medicare-medicoid>.

²⁷ In addition to capped funding proposals, both the Republican Study Committee and the Center for Renewing America budget also propose harmful reductions to the FMAP that also undermine the federal government’s support for Medicaid. The Republican Study Committee plan would cut the matching rate to 50 percent for all states; the Center for Renewing America budget would significantly reduce the federal Medicaid matching rate for a segment of states by eliminating the so-called “FMAP floor,” which ensures that no state’s FMAP drops below 50 percent.

²⁸ CBPP, “Medicaid Per Capita Cap Would Shift Costs to States,” updated February 7, 2023, <https://www.cbpp.org/research/health/medicaid-per-capita-cap-would-shift-costs-to-states>.

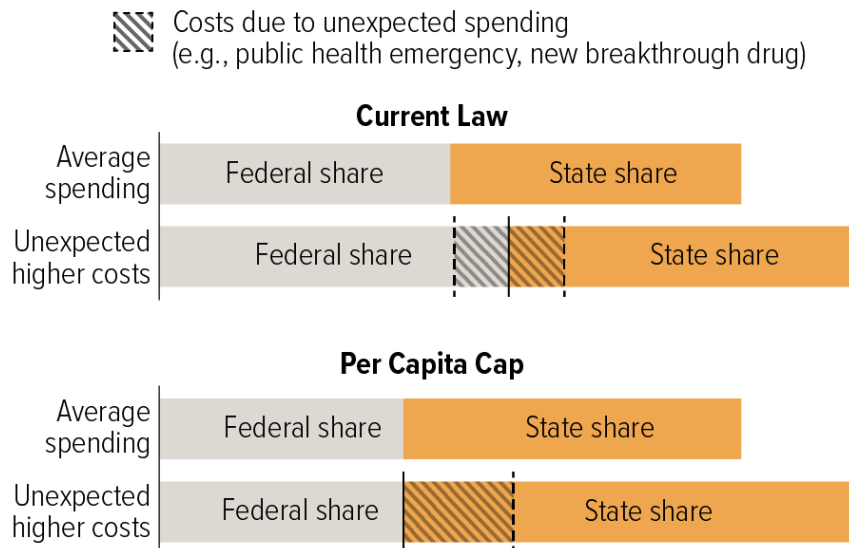
²⁹ Edwin Park, “Medicaid Per Capita Cap Would Shift Costs and Risks to States and Harm Millions of Beneficiaries,” CBPP, revised February 27, 2017, <https://www.cbpp.org/research/health/medicaid-per-capita-cap-would-shift-costs-and-risks-to-states-and-harm-millions-of>.

conditions, such as substance use conditions, or newly available treatments that improve health or save lives but increase costs. In periods when the cap is inadequate, the state would bear the additional costs.

Moreover, because per capita cap proposals are aimed at cutting Medicaid, they typically set the cap to grow more slowly than expected growth in per-enrollee costs, leaving states to pay an increasing share of Medicaid costs over time as the cap becomes less and less adequate. Even a per capita cap proposal that generated only modest projected savings in the early years could result in very large savings over time. (And actual savings could be larger than projected savings if costs grow more quickly than anticipated.)

FIGURE 1

Medicaid Per Capita Cap Would Squeeze State Budgets



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Under a *block grant*, states would receive a fixed dollar amount from the federal government. Here too, states would be responsible for *all* Medicaid costs that exceed the fixed amount and would be at risk for *both* population growth and rising per-person costs. Because block grants also are intended to produce significant federal savings, Medicaid block grants would give states considerably less federal funding each year than they would receive under the current financing system. That is typically accomplished by basing a state's initial block grant amount on its current or historical spending and then increasing it annually at a slower rate than the

currently projected annual growth in federal Medicaid spending. The resulting federal funding cuts would thus grow steadily larger each year.³⁰

Both a per capita cap and a block grant would create uncertainty for states by shifting the risks for unanticipated costs to states, meaning states would not automatically receive additional funding when a health care crisis, medical advances such as costly new treatments, or other circumstances lead to higher Medicaid costs. States would be responsible for 100 percent of all costs above the per capita cap or block grant amount. In stark contrast to the current Medicaid financing structure, both policies would fail to automatically protect states during an economic downturn, when demand for Medicaid tends to increase.

Under a block grant, funding is fixed at the block grant level even if the number of people eligible for and enrolling in the program grows. With a per capita cap structure, states would get additional funding as the number of enrollees increases during a downturn, but insufficient per-enrollee caps on funding would mean that when more people enroll, the funding shortfall the state would have to make up would grow.

Under either a per capita cap or block grant, states would face increasing budget pressure over time, as federal cuts grow and capped funding levels become increasingly inadequate. Because states must balance their budgets annually, they would be forced to raise taxes, cut other parts of the budget, or cut Medicaid. Those cuts could leave more people uninsured, significantly weaken benefits, and reduce already inadequate Medicaid provider payment rates, making it more difficult for people with Medicaid to find care.

To take just one example of how enrollees could be affected: although only 11 percent of Medicaid enrollees are eligible based on a disability,³¹ they account for 34 percent of Medicaid spending,³² making their care or eligibility a potential target for budget cuts. This is particularly likely because states are not required to provide many of the home- and community-based services that people with disabilities often use, such as personal care services or adult day care.

- **Limiting state provider taxes would also shift costs to states and weaken Medicaid.** Republicans have previously considered legislation to restrict states' ability to use taxes on health care providers — such as hospitals and nursing facilities as well as managed care plans — to help finance state Medicaid programs.³³ The Republican Study Committee budget seeks

³⁰ Edwin Park, “Medicaid Block Grant Would Slash Federal Funding, Shift Costs to States, and Leave Millions More Uninsured,” CBPP, November 30, 2016, <https://www.cbpp.org/research/health/medicaid-block-grant-would-slash-federal-funding-shift-costs-to-states-and-leave>.

³¹ KFF, “Medicaid Enrollees by Enrollment Group: 2019,” <https://www.kff.org/medicaid/state-indicator/distribution-of-medicaid-enrollees-by-enrollment-group/?dataView=1¤tTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

³² KFF, “Medicaid Spending by Enrollment Group: 2019,” <https://www.kff.org/medicaid/state-indicator/medicaid-spending-by-enrollment-group/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

³³ Edwin Park, “Limiting State Provider Taxes Would Shift Costs to States and Weaken Medicaid,” CBPP, updated March 16, 2016, <https://www.cbpp.org/research/health/limiting-state-provider-taxes-would-shift-costs-to-states-and-weaken-medicaid>.

to “effectively” eliminate them³⁴ while the Center for Renewing America’s proposal seeks to eliminate them entirely.³⁵

In the past, some states misused provider taxes by taxing providers, using the tax proceeds to draw down federal matching funds, and then fully reimbursing providers for their contributions. The federal government rightly clamped down on these abuses and set standards for provider taxes, and it continues to provide guidance and oversee state compliance with these standards.³⁶

Now, provider taxes are used in 48 states and the District of Columbia to help finance provider reimbursement adjustments needed to keep pace with increases in health costs, to avert Medicaid benefit cuts, and to expand Medicaid benefits, including supporting the ACA Medicaid expansion.³⁷ Restricting or ending states’ ability to use these revenues would create a hole in state budgets and have serious consequences for Medicaid enrollees. Limiting provider taxes would also remove a critical way that states support their programs, and it is unlikely that states could fill the gap, which would result in benefit cuts, eligibility cuts, or limits on access for Medicaid beneficiaries.

Marketplace Premium Tax Credits

Republicans have also floated proposals that would eliminate³⁸ or scale back the financial assistance that helps millions of people afford premiums, deductibles, and other cost-sharing in the ACA marketplaces.

Congress recently acted to reduce people’s costs for buying health coverage through the ACA marketplaces by improving the federal premium tax credit. These enhancements, which went into effect for the first time in 2021 and are available through 2025 under current law, ensure that people with low incomes can get a plan that requires either no premium or very modest costs. The changes also eliminated a cap on eligibility for the credit so that people with incomes at or above four times the poverty level (about \$54,000 for an individual and \$111,000 for a family of four) are protected from paying more than 8.5 percent of their income toward premiums. As a result of these changes, premiums are now more affordable for millions of low-, moderate-, and middle-income households.

Some Republicans are looking at undoing these enhancements. House Budget Committee Chair Jodey Arrington has floated, on a list of “sensible solutions to the debt crisis,” a proposal to bring

³⁴ Republican Study Committee, *op. cit.*

³⁵ Center for Renewing America, *op. cit.*

³⁶ CMS, “Health Care-Related Taxes and Hold Harmless Arrangements Involving the Redistribution of Medicaid Payments,” February 17, 2023, <https://www.medicaid.gov/federal-policy-guidance/downloads/cib021723.pdf>.

³⁷ Medicaid and CHIP Payment and Access Commission, “Health Care-Related Taxes in Medicaid,” May 2021, <https://www.macpac.gov/wp-content/uploads/2020/01/Health-Care-Related-Taxes-in-Medicaid.pdf>; KFF, “States With At Least One Provider Tax in Place: SFY 2004 - SFY 2022,” <https://www.kff.org/medicaid/state-indicator/states-with-at-least-one-provider-tax-in-place/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

³⁸ Center for Renewing America, *op. cit.*

back the eligibility cap of 400 percent of poverty.³⁹ This would mean, for example, that two 60-year-old married people with household income of \$75,000 a year would see their yearly premium costs rise from about \$6,000 to about \$23,000 on average if the cap were brought back in 2023. A family of four with income of about \$120,000 a year would see premiums rise from about \$10,000 to nearly \$18,000 per year.⁴⁰

In other words, bringing back the 400 percent cap would remove an important financial protection for middle-income people who face a high premium burden because they are older or live in high-cost areas and lack access to employer coverage and contributions. Moreover, imposing a cap would not impact very many high-income people; as incomes rise relative to premium costs, the amount of premium tax credits naturally phases out.

³⁹ House Budget Committee Republicans, “The Debt Limit and Fiscal Restraint” [Press release], February 8, 2023, <https://mailchi.mp/budgetgop.housecommunications.gov/chairman-arrington-announces-budget-committee-roster-461535?e=62a56cb896>.

⁴⁰ KFF, “Health Insurance Marketplace Calculator,” <https://www.kff.org/interactive/subsidy-calculator/#state=&zip=&income-type=dollars&income=120000&people=4&alternate-plan-family=&adult-count=2&adults%5B0%5D%5Bage%5D=40&adults%5B0%5D%5Btobacco%5D=0&adults%5B1%5D%5Bage%5D=40&adults%5B1%5D%5Btobacco%5D=0&child-count=2&children%5B0%5D%5Bage%5D=10&children%5B0%5D%5Btobacco%5D=0&children%5B1%5D%5Bage%5D=5&children%5B1%5D%5Btobacco%5D=0>.