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What to Look for in CBO's Analysis of House-Passed Health Bill Score Will Show Challenges Senate Faces in Fixing Bill

By Jacob Leibenluft

On Wednesday, the Congressional Budget Office (CBO) will release its analysis of the House-passed bill to repeal the Affordable Care Act (ACA) and its impacts on health coverage, Medicaid, the cost of private insurance, and the deficit. Because the House took the unusual step of voting on the bill (the American Health Care Act, or AHCA) before CBO scored it, the score will primarily set the stage for the Senate debate. We expect the score will continue to show, as did CBO's analysis of earlier versions of the bill,¹ that the AHCA would result in millions of people losing coverage, sharp cuts to Medicaid, and increased premiums and out-of-pocket costs for many of those who purchase insurance on their own — especially lower-income people and older people. And a careful analysis of the score will show that the Senate cannot undo these harmful effects without revamping the bill's entire structure — namely, deep cuts to coverage that pay for tax breaks for the wealthy, pharmaceutical companies, and insurers.

What to Look for in the CBO Score

How many more would be uninsured compared to current law? CBO estimated that two earlier versions of the AHCA would result in 24 million more people without health coverage by 2026. There's been a lot of speculation about how much that number may change in CBO's forthcoming estimate.

The most relevant question, however, isn't how the latest version of the House bill compares to the old one; it's how the House bill compares to current law, if Congress leaves the ACA intact. The uninsured rate remained at a historic low — 9.0 percent — last year, and states that expanded Medicaid under the ACA have cut their non-elderly uninsured rate by more than half since 2010, according to new data from the Centers for Disease Control.² The latest House bill would largely or entirely reverse that progress, because it retains the key elements of the House bill's earlier versions: deep Medicaid cuts of \$839 billion over ten years that would reduce enrollment by 14 million by 2026, sharply reduced subsidies for the individual market, and immediate elimination of the ACA's individual mandate.

¹ Congressional Budget Office, "American Health Care Act," March 13, 2017, <https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf>.

² Robin A. Cohen, Emily P. Zammitti, and Michael E. Martinez, "Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2016," National Center for Health Statistics, May 2017, <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201705.pdf>.

The uncertainty around the bill's coverage effects largely revolves around changes to the individual market — in particular, the impact of the MacArthur amendment, which would enable states to apply for waivers to allow insurers to charge people with pre-existing conditions more or offer plans that do not cover minimum standards known as “Essential Health Benefits.” That amendment could change not just how many people get covered, but who gets covered — potentially increasing the number of healthy people with coverage at the expense of those with more serious health needs, the very people who need coverage the most. Importantly, that means the question isn't simply how many people are uninsured compared to the ACA, but also *who* these uninsured are.

For those who maintain private individual market coverage, how much would they pay — and what would they get? When CBO released its first score of the AHCA, House Speaker Paul Ryan initially touted its estimate that “sticker price” premiums would fall slightly by the end of the decade. In fact, this statistic was deeply misleading.³ First, it reflected that older people would drop out of the market because they couldn't afford insurance. Older people pay higher premiums, so when they drop coverage, average sticker price premiums fall. Second, it ignored the fact that the tax credits that help families pay for insurance would shrink by thousands of dollars, meaning the amount many people actually pay for their premiums would *rise* substantially. Moreover, lower-income people would no longer receive financial assistance with their deductibles and other out-of-pocket costs. Finally, it did not take into account that the AHCA allows insurers to offer skimpier plans with higher deductibles and out-of-pocket costs, so people would get much less in return when they buy insurance.⁴ The MacArthur amendment, which would let states waive standards for what health plans cover, could sharply exacerbate this shift toward skimpier coverage.⁵ When looking at the new score, the key questions are, what would people — especially low-income, older, and sicker people — actually pay out of pocket, and what kind of coverage would they get in return?

What happens to the budget? There has been significant attention to the possibility that after last-minute tweaks to the bill, it may increase rather than reduce the deficit over ten years — which could create procedural complications for the bill moving forward. But while that's possible, it's much more likely that the bill will still achieve some modest deficit reduction.

But whatever the bottom-line deficit number, the core issue around the bill's fiscal effects remains the tradeoff between health coverage and high-income tax cuts. CBO's estimates of the bill's savings due to the cuts to coverage and its costs due to the tax cuts will illustrate the magnitude of the bill's redistribution from lower- and moderate-income Americans to the wealthy.

³ Jacob Leibenluft, “CBO: Millions Would Pay More for Less Under House GOP Health Plan,” Center on Budget and Policy Priorities, March 13, 2017, <http://www.cbpp.org/blog/cbo-millions-would-pay-more-for-less-under-house-gop-health-plan>.

⁴ For an estimate of the total cost increase before the most recent changes, see: Aviva Aron-Dine and Tara Straw, “House GOP Health Bill Still Cuts Tax Credits, Raises Costs by Thousands of Dollars for Millions of People,” Center on Budget and Policy Priorities, March 22, 2017, <http://www.cbpp.org/research/health/house-gop-health-bill-still-cuts-tax-credits-raises-costs-by-thousands-of-dollars>.

⁵ Aviva Aron-Dine, Edwin Park, and Jacob Leibenluft, “Amendment to House ACA Repeal Bill Guts Protections for People with Pre-Existing Conditions,” Center on Budget and Policy Priorities, updated April 27, 2017, <http://www.cbpp.org/research/health/amendment-to-house-aca-repeal-bill-guts-protections-for-people-with-pre-existing>.

What Senators Should Be Asked After the CBO Score Is Released

Immediately upon House passage of the AHCA, Senate Republicans made clear that the bill would undergo changes before any consideration began. The key question now is not how senators view the House bill or its score — but what they intend to do going forward.

In particular, senators should be asked:

Will you commit not to vote on a bill unless there is a CBO score on that actual piece of legislation? The anticipation around CBO's release this week — and the uncertainty around what it may say — underscore the extraordinary nature of the House voting on a bill of the AHCA's magnitude without a score. Several senators expressed discomfort with the House's choice to rush a vote without knowing how major changes to the bill would affect how much the bill would cost, how many people it would cover, and what it would mean for people with pre-existing conditions.⁶ Now, the question is how the Senate will proceed — and whether they will follow the long-standing precedent (including from passage of the ACA) of holding hearings and waiting for updated CBO scores before proceeding on major legislation.

Speaker Ryan and others defended the House's decision to vote by noting that CBO had scored the bill at one point — neglecting to mention that CBO had never evaluated a major change crucial to securing the bill's passage. The release of the CBO score this week is a chance for senators to commit not to vote for a bill unless CBO has scored *the version of the bill they are actually voting on*.

Will you commit not to vote for a bill that CBO estimates will add to the uninsured? If not, what level of coverage loss is acceptable to you? President Trump and some Republican senators have pledged that at least as many people should have coverage under the AHCA *as do under current law*. That should be the metric by which a Senate bill is judged — not how it compares to the House bill. If senators will not commit to oppose any bill that results in increasing the number of uninsured, they should be asked what level of coverage loss is acceptable.

If you believe the House bill is flawed, which of its major components do you intend to change or jettison? Several Senate Republicans have been clear that they do not like the House bill — whether because it would result in too many people losing coverage, undermine the ACA's Medicaid expansion and convert the program to a per capita cap or block grant, raise individual market costs for older people or those in higher-cost states, or remove protections for people with pre-existing conditions.

But just tweaking the House bill won't solve those problems. Instead, senators should be asked about their positions on the following planks of the AHCA that are driving the coverage losses and cost increases that CBO's analysis will confirm:

⁶ See, for example: "Sen. McCain: I 'Don't Approve' of Passing Health Care Bill With No CBO Score," Yahoo! News, May 5, 2017, https://www.yahoo.com/news/m/94a42869-5c9e-3b74-95d2-46cf1d016685/ss_sen.-mccain%3A-i-%27don%27t.html; Kimberly Leonard, "Susan Collins: 'More questions than answers' about Obamacare repeal 'consequences,'" *Washington Examiner*, May 4, 2017, <http://www.washingtonexaminer.com/susan-collins-more-questions-than-answers-about-obamacare-repeal-consequences/article/2622185>; and Abigail Abrams, "Lindsey Graham: House GOP Health Care Bill 'Should Be Viewed With Caution,'" *TIME*, May 4, 2017, <http://time.com/4767461/lindsey-graham-republican-health-care-bill-obamacare-repeal-ahca/>.

- Repealing the Medicaid expansion. Some senators have expressed concern about the AHCA's effective repeal of the Medicaid expansion,⁷ which now provides coverage for 11 million people. Delaying or more gradually phasing out the end of the expansion won't change the fact that millions of people will eventually lose coverage, and those who need it in the future won't be able to get it. Senators should be asked to clearly state whether they believe the expansion should end or continue.
- Ending the Medicaid program as we know it through a per capita cap or block grant. The AHCA's deep cuts to Medicaid⁸ go well beyond repealing the Medicaid expansion by converting federal funding to Medicaid to a per capita cap or block grant, under which the amount of federal funding states receive would be capped and would grow more slowly than actual state Medicaid costs. That would result in large and growing federal Medicaid funding shortfalls over time, which in turn would force states to cut eligibility, services, provider payments, or a combination of all three. Senators who express concerns about the House bill's impact on older people and people with pre-existing conditions should be asked whether they will commit to drop the radical restructuring of Medicaid, which would jeopardize coverage and services for the most vulnerable, including those who require Medicaid-funded long-term services and supports to stay at home.
- Dismantling the ACA's individual market reforms, which make insurance affordable for people with pre-existing conditions. The ACA made it possible for people with pre-existing conditions to access affordable coverage, through a combination of new rules that prevent insurers from charging sicker people more, a requirement to buy coverage or pay a penalty that keeps healthy people in the market, and tax credits and cost-sharing subsidies. The AHCA undoes this basic structure, leaving a choice between two bad options: (1) keeping protections for people with pre-existing conditions, but making coverage unaffordable for millions of people as premiums rise and tax credits fall or (2) removing those protections to lower premiums for healthy people, but putting coverage all but out of reach for sicker and older people. Senators should be asked which they prefer, or whether they will support restoring the features of the ACA that keep coverage broadly affordable.
- Cutting coverage to pay for tax cuts for the wealthy and corporations. The AHCA's fundamental structure will be reflected in the CBO score: large tax breaks for the wealthy, pharmaceutical companies, and insurance companies that are paid for by deep cuts to health coverage. The Senate must undo the AHCA's cuts to Medicaid and tax credits to avoid causing millions of people to lose coverage and raising costs substantially for those who buy insurance. But within the bounds of a bill that needs to reduce the deficit, those cuts to coverage and affordability can't be reversed as long as the bill includes the tax cuts for the wealthy. Ultimately, senators need to be asked whether they are willing to walk away from the House bill's basic structure and its tax cuts — or they'll find that there is no way to structure legislation that doesn't dramatically reduce coverage.

⁷ See, for example: "GOP Senators Say House Health Care Draft Lacks Key Protections for Medicaid Expansion Population," March 6, 2017, <https://www.portman.senate.gov/public/index.cfm/2017/3/gop-senators-say-house-health-care-draft-lacks-key-protections-for-medicaid-expansion-population>.

⁸ Edwin Park, "Toomey-Lee Proposal Would Significantly Expand House Bill's Already Deep Medicaid Cuts," Center on Budget and Policy Priorities, May 18, 2017, <http://www.cbpp.org/research/health/toomey-lee-proposal-would-significantly-expand-house-bills-already-deep-medicaid>.