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Senate Health Bill Can't Be Fixed Latest Changes Do Not Affect Bill's Core Features

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Prior versions of congressional legislation to repeal and replace the Affordable Care Act (ACA) would all cause more than 20 million people to lose coverage and make coverage worse or less affordable for millions more, according to Congressional Budget Office (CBO) estimates. The amended version of the Senate bill released July 13 maintains the same core structural features, and thus would have the same harmful impacts.

In broad outline, the bill continues to do the following:

- **End the Affordable Care Act (ACA)'s expansion of Medicaid to low-income adults.**
- **Cap and cut federal Medicaid funding for seniors, people with disabilities, and families with children.**
- **Increase premiums and deductibles for millions of moderate-income people who buy health insurance through the ACA marketplaces.**
- **Undermine the ACA's individual market reforms by weakening key consumer protections for people with pre-existing conditions and eliminating the ACA's individual mandate, which helps ensure a balanced individual market risk pool.**
- **Provide hundreds of billions of dollars in tax cuts for high-income households, drug companies, and other corporations.**

Taken individually, none of the changes to the Senate bill would meaningfully reduce the coverage losses CBO estimated for prior versions of the bill. And some would further eliminate or weaken consumer protections, especially for individuals for pre-existing conditions. Moreover, as discussed further below, even if — as expected — the Senate makes additional changes, the bill's major flaws would remain. In particular, even with the savings from dropping two of the bill's high-income tax cuts, there is still not enough money available to change the basic impact of the bill on Americans' health insurance and health care.

TABLE 1

Changes to Senate Bill Have Little Impact on Its Five Core Features

Changes Made	Long-Run Impact
Ending the ACA Medicaid Expansion	
Add \$45 billion for treating opioid use disorders in lieu of Medicaid expansion	Funding insufficient to address opioid epidemic and expansion enrollees with opioid use disorders would still lose access to other needed mental and physical health care
Capping and Cutting Federal Medicaid Funding	
Small changes such as additional funding for uncompensated care in non-expansion states, cap exemption for certain public health emergencies	No meaningful changes to the bill's total Medicaid cuts, which CBO predicted would rise to 35 percent of federal Medicaid funding by 2036
Increasing Premiums and Deductibles for Marketplace Consumers	
Allow the use of Health Savings Accounts (HSAs) to pay premiums for individual market coverage	Mostly a tax break for upper-income people; would do little to help low- and moderate-income people afford coverage
Increase funding for market stabilization	Grants amount to about 10 percent of bill's cuts to coverage programs, yet are supposed to offset those cuts <u>and</u> lower sticker price premiums <u>and</u> undo the damage from allowing insurers to discriminate against people with pre-existing conditions
Undermining the ACA's Individual Market Reforms	
Allow insurers to charge higher premiums or deny coverage to people with pre-existing conditions in some plans (Cruz amendment)	Would raise premiums substantially for people with pre-existing conditions, making coverage unaffordable for many – with funding for high-risk pools insufficient to avoid harm
Cutting Taxes for High-Income Households and Corporations	
Do not repeal ACA's 3.8 percent tax on high-income households' unearned income ("net investment income tax") and 0.9 percent Hospital Insurance payroll tax on these households	Bill would still cut taxes by \$400 billion (including new HSA tax breaks), largely benefiting drug companies, insurers and high-income people

Changes to Senate Bill Do Not Meaningfully Reduce Its Damage

The major changes included in the updated text of the Senate bill would do little or nothing to mitigate the harm the bill would do, and some would exacerbate problems in the bill. These changes include:

- **Adding funding for opioid use disorders.** The bill includes an additional \$45 billion to fund treatment for opioid use disorders.¹ That funding is intended to compensate for the bill's elimination of the ACA Medicaid expansion, which has dramatically increased access to

¹ Robert King, "Senate Bill Adds Opioid Money, HSA Changes to Health Bill to Woo Holdouts," *Washington Examiner*, June 29, 2017, <http://www.washingtonexaminer.com/senate-adds-opioid-money-hsa-changes-to-health-bill-to-wooholdouts/article/2627422>.

medication-assisted treatment for opioid use disorders, and perhaps to compensate for waivers that would allow private plans to exclude coverage for substance use treatment.²

Not only would \$45 billion fall short of what experts estimate is needed for opioid treatment,³ but *replacing health insurance coverage with grant funding for treatment would always fall short as a response to the opioid epidemic*. Opioid use disorder is often accompanied by other physical and mental health needs, including depression and anxiety. That means people struggling with opioid use disorder need access to physical and mental health care, not just treatment for their addiction, if they are to successfully recover.⁴ As Senator Bill Cassidy noted last month, “if a separate fund would bifurcate opioid addiction from physical health, ... that would be bad medicine.”⁵

- **Increasing funding for state innovation grants.** The revised Senate bill adds \$70 billion in funding for “long term state stability and innovation” grants, on top of \$62 billion for these grants in the earlier version (with an additional \$50 billion available for payments to insurers from 2018 to 2021). Republicans argue that these funds would not only drive down sticker price marketplace premiums but also accomplish other objectives, including assisting the millions of people losing Medicaid expansion coverage under the bill, compensating for the bill’s cuts to tax credits and higher deductibles for moderate-income consumers, and undoing the damage done by the Cruz amendment’s removal of additional consumer protections (discussed below). However:
 - The grants are an order of magnitude too small to achieve these goals. From 2022 to 2026, they amount to about 10 percent of the bill’s cuts to federal Medicaid funding and marketplace subsidies. Importantly, the bill zeroes out funding for these grants altogether after 2026.
 - The grants are also poorly designed to help compensate for the bill’s cuts. Unlike Medicaid and marketplace subsidies, which adjust based on need, the state grants are essentially a block grant, which would not adjust for recessions, demographic shifts, or other changes in costs. Likewise, the allocation of these grants would be left entirely to the Secretary of Health and Human Services’ discretion, meaning states would have no guarantee of their future funding amounts and could not depend on these funds. States would also have to make increasingly large matching payments to draw down these funds.
 - The same money cannot pay for reinsurance to lower sticker-price premiums, supplemental assistance for people losing Medicaid expansion coverage, help with out-of-

² Lisa Clemans-Cope *et al.*, “Medicaid Coverage of Effective Treatment for Opioid Use Disorder,” Urban Institute, updated June 2017, http://www.urban.org/sites/default/files/publication/90461/2001287_medicaid_coverage_of_effective_treatment_for_opioid_use_disorder_1.pdf.

³ Emily Gee and Richard Frank, “Senate’s Opioid Fund Cannot Substitute for Coverage,” Center for American Progress, June 20, 2017, <https://www.americanprogress.org/issues/healthcare/news/2017/06/20/434708/senates-opioid-fundcannot-substitute-health-coverage/>.

⁴ Peggy Bailey, “Extra Opioid Funding Wouldn’t Undo Senate Health Bill’s Harm,” Center on Budget and Policy Priorities, June 30, 2017, <http://www.cbpp.org/blog/extra-opioid-funding-wouldnt-undo-senate-health-bills-harm>.

⁵ Susannah Luthi, Michelle M. Stein, and Erin Raftery, “Separate Opioid Fund Could Limit Care for Addicts, Experts Warn,” Inside Health Policy, June 14, 2017.

pocket costs for moderate-income consumers, *and* payments to insurers to try to offset the damage done by the Cruz amendment. Yet the revised Senate bill relies on its state grants to somehow achieve all four purposes. Meanwhile, in its score of the initial Senate bill, CBO assumed that most of the state grant money would be used for reinsurance. If that funding were redirected to other purposes, silver plan premiums for an unsubsidized 64-year-old would increase by about \$6,000 instead of the \$5,200 CBO estimated.

- **Expanding tax benefits for Health Savings Accounts (HSAs).** Prior versions of the Senate bill already dramatically expanded the tax sheltering opportunities HSAs offer by nearly doubling the annual contribution limits. The latest version of the bill would further expand HSA tax breaks by allowing people to pay health insurance premiums out of HSAs. That would enable individual market consumers to avoid taxes on the income used to pay premiums, at a reported cost of \$60 billion over ten years.⁶

This provision would do little to mitigate the large increases in out-of-pocket costs for moderate-income consumers under the Senate bill. Many low- and moderate-income people could not afford to make substantial HSA contributions in the first place, and many would likely also find it too complex and burdensome to funnel premium contributions through HSAs. But, even if they did, their tax savings would offset only a small portion of their increase in out-of-pocket costs under the Senate bill. For example, CBO's estimates imply that a 64-year-old with income of \$56,800 would have to pay about \$11,600 more in premiums for the same plan she has today, even taking into account her tax savings from paying premiums through an HSA. Meanwhile, a 40-year-old with income of \$26,500 would see tax savings of less than \$400 from paying her premiums through an HSA, but would see her deductible jump from under \$1,000 to more than \$6,000 due to other provisions in the Senate bill.⁷

The largest benefits from expanded HSA tax breaks would go to people at much higher income levels who are most likely to already have health insurance, because they are in higher marginal income tax brackets and so avoiding tax on their premiums is worth more to them. For example, the ability to pay premiums out of pre-tax dollars would be worth \$2,800 for a 60-year-old earning \$250,000. Higher-income people also realize most of the benefits from the current tax breaks for HSAs and from the expansion of those tax breaks already in the Senate bill: about 70 percent of HSA contributions come from households with incomes over \$100,000.⁸

- **Allowing insurers to discriminate based on pre-existing conditions.** While the previous version of the Senate bill already largely removed protections for people with pre-existing conditions, Senate Republicans have added the so-called "Cruz Amendment" that would

⁶ Robert King, "Senate Bill Adds Opioid Money, HSA Changes to Health Bill to Woo Holdouts," *Washington Examiner*, June 29, 2017, <http://www.washingtonexaminer.com/senate-adds-opioid-money-hsa-changes-to-health-bill-to-wooholdouts/article/2627422>.

People with employer plans already have the option to pay the employee share of health insurance premiums with pre-tax dollars. (On the other hand, people with employer plans are not eligible for the premium tax credits available to moderate-income marketplace consumers.)

⁷ Examples draw on the examples provided by CBO for the Senate bill. To calculate tax savings from paying premiums through an HSA, we assume that consumers contribute to HSAs up to the (Senate bill's) contribution limits.

⁸ Edwin Park, "Senate GOP Adding Another High-Income Tax Break to Health Bill," Center on Budget and Policy Priorities, June 29, 2017, <http://www.cbpp.org/blog/senate-gop-adding-another-high-income-tax-break-to-health-bill>.

further roll back protections. It would allow insurers that offer at least one “community-rated” plan (that is, a plan where premiums would not vary based on health status) to offer additional plans subject to “medical underwriting” (plans for which insurers could vary premiums based on health history or deny coverage outright to people with expensive pre-existing conditions).⁹ Under such a system, healthier people would naturally gravitate toward underwritten plans, which would offer them lower premiums. Meanwhile, the community-rated plans would disproportionately enroll people with expensive pre-existing conditions, and insurers would price them accordingly.¹⁰

This “adverse selection” means that, *in practice, people with pre-existing conditions would face sharply higher premiums because of their health status, whether they purchased “underwritten” or “community-rated” plans.* While lower-income people would be partially protected from higher premiums by the Senate bill’s subsidies, people with pre-existing conditions with incomes over 350 percent of the poverty level (about \$42,000 for a single adult) would face high, sometimes unaffordable premiums, with no financial assistance.

The bill attempts to address this concern by dedicating up to \$70 billion of its state grant funding (the entire increase relative to the original Senate bill) to insurers that offer these underwritten plans, with the goal of reducing the costs of covering high-risk individuals who purchase community-rated plans. This approach is similar to high-risk pools that have proven unsuccessful in the past. That funding would likely be highly inadequate and would likely do little to mitigate the additional severe harm to people with pre-existing conditions resulting from the Cruz amendment. And it would not address the fact — also true in the underlying bill — that people might not have access to plans that offer the benefits that they need, if states waive certain Essential Health Benefits.

- **Changes to Medicaid that do nothing to limit the harm of the bill’s cuts.** The minor changes in the revised Senate bill’s Medicaid provisions do nothing to limit the harm the bill would cause, including reducing enrollment by 15 million people by 2026. The bill would still effectively eliminate Medicaid expansion in 31 states and the District of Columbia, leaving millions of low-income adults uninsured by phasing down federal funding for all expansion enrollees over three years starting in 2021. And it would still 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 that would rise each year by a slower rate than CBO’s current projection of Medicaid costs. The bill’s minor changes would:
 - *Give even more money to states that haven’t expanded Medicaid by increasing their allotments of disproportionate share hospital (DSH) payments.* DSH provides capped allotments for payments by states to hospitals that treat a disproportionate share of uninsured and Medicaid patients. The original Senate bill exempted non-expansion states from cuts in DSH payments scheduled for 2018-2025 and increased allotments for most non-

⁹ Caitlin Owens, “Senate Asks for CBO Score With, Without Cruz Proposal,” Axios, July 1, 2017, <https://www.axios.com/senate-asks-for-cbo-score-with-without-cruz-proposal-2451585212.html>.

¹⁰ Sarah Lueck, “Cruz Amendment Would Worsen Already Harmful Senate Health Bill for People with Medical Conditions,” Center on Budget and Policy Priorities, July 12, 2017, <https://www.cbpp.org/research/health/cruz-amendment-would-worsen-already-harmful-senate-health-bill-for-people-with>.

- expansion states in 2020-2023. The revised bill changes the formula to direct even more money to non-expansion states. Moreover, it creates an incentive for states to drop their expansions even before the enhanced federal match starts to phase down in 2021, because states that do so could escape the DSH cuts they would otherwise face and obtain additional funding.
- *Continue to pay lip service to the need for home- and community based services (HCBS).* The new bill would provide \$8 billion from 2020 through 2023 for a demonstration project providing states with 100 percent federal matching funds for “payment adjustments” that increase payments that would otherwise be provided for HCBS. This would allow a select number of states (the bill gives priority to the 15 states with the lowest population density) to increase payments for their existing HCBS programs, but it would do nothing to protect seniors and people with disabilities from the severe threat the per capita cap presents to HCBS. As states cope with increasing cuts in federal funds, they would likely cut payments to health care providers, restrict eligibility, and eliminate optional services, according to CBO. The largest share of Medicaid funding for optional services goes to provide HCBS to seniors and people with disabilities, including children with complex health care needs. At the same time, the bill would eliminate enhanced federal funding to promote further transition to HCBS by states, a cut of \$19 billion over ten years.
 - *Still leave states on the hook for Medicaid costs related to unanticipated cost increases and cost increases that the per capita cap doesn’t account for.* The new bill purports to protect states from higher costs related to public health emergencies by exempting that higher spending from the per capita cap. But it caps the total amount by which the per capita cap can be relaxed for emergencies, leaves the decision whether to grant an exemption entirely up to the Secretary’s discretion, and eliminates the exemption after 2024. It also continues to leave states responsible for 100 percent of all other unanticipated costs, including higher costs resulting from a costly new breakthrough medication or treatment. And it continues to leave states fully on the hook for the long-term impact of the aging of the population. Seniors’ per-beneficiary Medicaid costs will rise substantially as the baby boomers age and more seniors move from “young-old age” to “old-old age.” But under the Senate bill, each state’s funding per senior beneficiary would be based on the state’s spending per senior beneficiary in 2016 and thus wouldn’t adjust to reflect the rise in seniors’ per beneficiary costs.
 - *Allow states to expand the scope of the block grant option to expansion adults.* The new bill would allow states to include expansion adults in a block grant, in addition to other adults like parents. This change would *not* allow states to keep their current enhanced expansion funding: the block grant allocations would reflect the Senate bill’s reduction and eventual elimination of the enhanced federal match. Thus, expansion states would still be forced to drop their expansions.
 - **Retaining the ACA’s Medicare taxes.** The new version of the Senate legislation retains the ACA’s additional 0.9 percent Hospital Insurance payroll tax and its 3.8 percent tax on investment income for individuals with incomes over \$200,000 (couples with incomes over \$250,000).¹¹ This change is intended to respond to complaints that the Senate bill cuts taxes

¹¹ Richard Rubin and Siobhan Hughes, “Some Senators in Health Talks Would Keep Tax on Investment Income,” *Wall Street Journal*, updated June 29, 2017, <https://www.wsj.com/articles/some-senators-in-health-talks-would-keep-tax-on-investment-income-1498757176>.

on the wealthy even as it increases costs for low- and middle-income people. But even without repeal of these taxes, *the Senate bill would still spend about \$400 billion on tax cuts* (counting the additional HSA tax breaks described above). And these tax cuts would still mostly benefit upper-income people and pharmaceutical companies, insurers, and other corporations — even as the bill imposed deep cuts in health coverage. For example, the tax break to drug companies in 2022 would roughly equal the savings from the bill’s reduction in tax credits and subsidies that help low- and moderate-income families in 20 states and the District of Columbia *combined*.¹²

Further Changes to Bill Are Likely — But Can’t Undo the Harm It Would Cause

In the coming days, CBO will release an analysis illustrating the coverage, cost, and deficit impact of the current version of the Senate bill. However, the Senate is expected to make additional changes, either through piecemeal amendments or a manager’s amendment. The final coverage and cost impact of these changes may not be scored before a vote, allowing Senate Republican leaders to falsely claim that last-minute changes have finally “fixed” the bill’s major harms. But given its structure, there is no way they can undo the harm of the bill:

- **Even if the Cruz amendment is dropped or modified, the bill still removes or substantially weakens protections for people with pre-existing conditions.** The bill already allowed states to waive important protections for people with pre-existing conditions, including standards for what services plans have to cover. That means plans could once again carve out key services, such as maternity care or mental health or substance use treatment, and could go back to placing annual and lifetime limits on coverage.¹³ That could make coverage and care unaffordable for people with pre-existing conditions or other serious health needs — even though the bill technically retains the ACA’s prohibition on charging higher premiums based on health status.

As a result, even if the Cruz amendment drops out due to procedural reasons or opposition from moderate senators — or if it is adjusted — people with pre-existing conditions would still risk finding affordable care out of reach.

- **There is not enough money available to meaningfully reduce the number of people losing coverage.** As discussed above, there is little reason to imagine that the changes in the newest version of the Senate bill would significantly change CBO’s estimate that it would cause 22 million people to lose coverage in 2026. Furthermore, there is no reason to believe that further changes to the bill would make much additional progress.

Of the approximately \$430 billion available from the combination of the deficit reduction in the original Senate bill and the removal of repeal of the Medicare taxes, the new bill already allocates \$175 billion to the opioid fund, additional stabilization money and expanded HSAs,

¹² Brandon DeBot, “Wealthy, Corporations Still Win Big Under Revised Senate GOP Health Bill,” Center on Budget and Policy Priorities, July 13, 2017, <https://www.cbpp.org/blog/wealthy-corporations-still-win-big-under-revised-senate-gop-health-bill>.

¹³ Sarah Lueck, “If Senate Republican Health Bill Weakens Essential Health Benefits Standards, It Would Harm People With Pre-Existing Conditions,” Center on Budget and Policy Priorities, June 12, 2017, <http://www.cbpp.org/research/health/if-senate-republican-health-bill-weakens-essential-health-benefits-standards-it>.

which, as explained above, will not meaningfully reduce coverage losses. Even if changes surrounding the Cruz amendment do *not* have a significant fiscal cost — which may not be the case — that would leave only about \$250 billion available to offset \$1.2 trillion in cuts to coverage. Thus, even if that money went directly to offsetting coverage losses (rather than delaying some of the harmful provisions or addressing discrete or state-specific issues, as seems more likely), it could only address a small fraction of them.