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Senate Health Bill Would Put Coverage Out of Reach for Millions of Low-Income People

By Tara Straw

The Senate's Better Care Reconciliation Act (BCRA) — like its House-passed counterpart, the American Health Care Act (AHCA) — would effectively end the Affordable Care Act's (ACA) Medicaid expansion for adults with incomes below 138 percent of the poverty line, which has expanded coverage to 11 million people. While some Republican members of Congress have claimed that people losing Medicaid expansion coverage could purchase insurance in the individual market, the Congressional Budget Office (CBO) determined that most of those losing Medicaid coverage would end up uninsured, as would many low-income people currently insured through the ACA marketplaces.[1] Likewise, the Senate bill wouldn't help people in the Medicaid "coverage gap" — those with incomes below the poverty line in states that have not expanded Medicaid — obtain affordable coverage.

That's because the Senate bill would force poor and near-poor consumers to choose between paying premiums equal to 2 percent of income for plans with $6,300 deductibles or paying far higher premiums for plans that would still have several-thousand-dollar deductibles. Neither choice is tenable for low-income people, and they would likely go without insurance, CBO concludes.

Low-income people would also face several other major but less-discussed barriers to coverage under the Senate bill.

- **Waivers would erode the value of coverage, increase out-of-pocket costs, and create *de facto* pre-existing condition exclusions.** Waiving benefit requirements, as the Senate bill's expansion of state waivers encourages, could end coverage of certain necessary services. In particular, the services most likely to be excluded are maternity care, mental health and substance use disorder treatment, rehabilitative and habilitative services, and pediatric dental care, CBO writes. This would force people to pay out of pocket for these uncovered services, with no limitation on maximum out-of-pocket spending. For people who need these types of care, costs could balloon, compared to required coverage under current law in the marketplace or comprehensive Medicaid coverage.

[1] Unless otherwise noted, all references to CBO are to Congressional Budget Office, "H.R. 1628, Better Care Reconciliation Act of 2017," June 26, 2017, https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52849-hr1628senate.pdf.

- **The waiting period penalty would burden many low-income families.** As a substitute for the individual mandate, the Senate bill creates a six-month waiting period for people who have a gap in coverage of more than 63 days within the last year. This penalty would disproportionately affect low-income people, who are more likely to experience gaps in coverage and so would be more likely to face lengthy lock-outs.
- **More employed people would be barred from help getting affordable coverage.** Today, people who have an offer of employer-sponsored coverage are still able to enroll in Medicaid if they are otherwise eligible; for people seeking marketplace coverage, an employer offer only disqualifies a person from claiming a premium tax credit if the employer offer is affordable and meets minimum standards. But the Senate bill would exclude *anyone* with an employer offer of coverage from receiving a tax credit, no matter how inadequate or expensive the benefit is.
- **Eliminating the repayment caps would make accepting the tax credit a major financial risk.** The lowest-income people receive the most generous tax credits to purchase coverage in the marketplace. These advance credits are based on verified projections of income, filing status, and household size. If a person's eligibility changes during the year and she becomes eligible for a smaller tax credit, she must repay some of the difference. However, a person with income below 200 percent of the poverty line is protected from having to repay more than $300 (if filing as single) or $600 (for all others). The Senate bill would remove these caps and make a person liable for repayment of any and all excess credit, even if they were not at fault. The risk of having to repay large amounts as a result of small income fluctuations could deter some low-income people from signing up for coverage in the first place.

All told, the uninsured rate for non-elderly adults with income below 200 percent of the poverty line would nearly double under the Senate bill, reaching 33 percent, CBO determined.

Marketplace Coverage Would Be Unaffordable

The Senate bill cuts premium tax credits and eliminates cost-sharing subsidies that reduce deductibles, copays, and coinsurance for lower-income marketplace consumers. As a result, low-income consumers would face deductibles that are extremely high compared to their incomes or would have to pay unaffordable premiums for plans that would still have several-thousand-dollar deductibles.

Under current law, people with income below 150 percent of the poverty line receive cost-sharing reduction subsides that increase the share of costs their plans pay and lower their average deductibles for a silver plan in 2017 to only $255.[2] People with incomes between 150 and 200 percent of the poverty line have average deductibles of $809, and people with incomes between 200 and 250 percent of the poverty line have deductibles of $2,904, compared to an average deductible

[2] Matthew Rae, Gary Claxton, and Larry Levitt, "Impact of Cost Sharing Reductions on Deductibles and Out-of-Pocket Limits," Kaiser Family Foundation, March 22, 2017, http://www.kff.org/health-reform/issue-brief/impact-of-cost-sharing-reductions-on-deductibles-and-out-of-pocket-limits/.

of $3,609 in unsubsidized silver plans. The average deductible in bronze plans, which don't qualify for cost-sharing subsidies, is $6,105.[3]

The Senate bill eliminates cost-sharing reductions that lower deductibles while also cutting tax credits, which would make silver plans unaffordable and push consumers toward lesser bronze plans. Low-income marketplace consumers' deductibles would therefore increase ten-fold or more if they wanted to maintain their current premium, and low-income people currently covered by Medicaid expansion (usually with no premium) would have to pay 2 percent of their income in premiums to buy a plan with a $6,105 deductible. In addition, bronze plans typically cover only one or two health care services with no or low cost-sharing before meeting the deductible, compared to the plans available to low-income consumers today, which cover seven or more common health care services (such as generic prescription drugs and primary care visits) with no or minimal cost-sharing prior to meeting the deductible.[4]

Alternatively, if a low-income consumer wanted to purchase even a silver plan, with an average deductible of $3,609, her premium would increase dramatically. For example, under current law in 2020, a person of any age with income at the poverty line would pay about $264 per year, or 2 percent of income, in premiums to obtain silver plan coverage — with the premium tax credit covering the remainder.[5] Under the Senate bill, a 60-year-old at that income would need to pay an average of $2,200, or 17 percent of income, to maintain her silver-level coverage.[6] A 25-year-old would see her premiums more than double to get silver coverage ($264 to $697). People with incomes below 200 percent of the poverty line would pay an average of 177 percent more in premiums under the Senate bill for silver plan coverage compared to what they pay for such coverage today.[7]

Evaluating consumers' options under the Senate bill, CBO reaches a blunt conclusion: "despite being eligible for premium tax credits, few low-income people would purchase any plan."

This would be the case, too, for people today who live in states that have not expanded Medicaid coverage and are in the "coverage gap" — not qualifying for Medicaid but with income below the poverty line, contrary to the claim of Texas Sen. John Cornyn, whose state hasn't expanded

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[3] Gary Claxton *et al.*, "Premiums under the Senate Better Care Reconciliation Act," Kaiser Family Foundation, June 2017, http://www.kff.org/health-reform/issue-brief/premiums-under-the-senate-better-care-reconciliation-act/.

[4] Centers for Medicare & Medicaid Services, "Data Brief: 2016 Median Marketplace Deductible $850, with Seven Health Services Covered Before Deductible on Average," July 12, 2016, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-07-12.html.

[5] In the lower 48 states, the federal poverty line is estimated to be approximately $12,600 for a household of one in 2019, the figure used to determine 2020 premium tax credit eligibility. The poverty line will be approximately $15,750 in Alaska and $14,500 in Hawaii.

[6] The methodology is the same as that in Aviva Aron-Dine and Tara Straw, "Senate Bill Still Cuts Tax Credits, Increases Premiums and Deductibles for Marketplace Consumers," Center on Budget and Policy Priorities, revised June 25, 2017, http://www.cbpp.org/research/health/senate-bill-still-cuts-tax-credits-increases-premiums-and-deductibles-for.

[7] Gary Claxton *et al.*, "Premiums under the Senate Better Care Reconciliation Act."

Medicaid.[8] These people would be newly eligible for tax credits under the Senate bill but would still end up uninsured. As CBO explains:

> [E]ven with the net [bronze] premium of $300 shown in the illustrative examples for a person with income at 75 percent of the [federal poverty line] ($11,400 in 2026), the deductible would be more than half their annual income. The net premium of a silver plan for a 40-year-old would be about 15 percent of their annual income, and the deductible would be more than one-third of their annual income. Many people in that situation would not purchase any plan, CBO and [the Joint Committee on Taxation] estimate….

TABLE 1

Coverage Options for a Single Adult with Income at the Poverty Line, 2020

	ACA		BCRA
	Medicaid in Expansion States	ACA Marketplace in Non-Expansion States	
Typical Premiums	$0	$264/month	$264/month
Typical Deductibles	$0	Less than $500	More than $6,000
Benefits Covered	Essential health benefits + services like non-emergency medical transportation	Essential health benefits	States can let plans drop coverage for essential health benefits
Availability of Coverage	When needed	Open enrollment, or if people lose coverage or have a major life change	Extra six-month waiting period for people with a gap in coverage
Impact of Employer Coverage	Qualifies based on income, regardless of an employer offer	Subsidy available unless individual has an *affordable* employer offer	Subsidy not available if the individual has *any* employer offer, even if not affordable

[8] Statement of U.S. Senator John Cornyn, "Cornyn: Health Care Status Quo Isn't Working," July 10, 2017, https://www.cornyn.senate.gov/content/news/cornyn-health-care-status-quo-isn%E2%80%99t-working.

Medicaid Waivers Can't Solve the Problems Created by Massive Federal Medicaid Cuts

Trump Administration officials are reportedly trying to win support for the Senate Republican health bill by offering waivers of Medicaid rules that would give states funds to supplement the coverage that would be available to low-income people in the private insurance market. This approach wouldn't come close to filling the big gap between what Medicaid covers and what would be covered under the Senate bill. Moreover, the Administration is making promises it can't keep, because any waiver that would come even close to filling the gap would likely violate the rule that doesn't allow the federal government to spend more under a waiver than it would otherwise.

The Administration is suggesting that states could provide a so-called "cost-sharing wrap" to supplement the coverage poor- and near-poor people could buy in the private market and pay for the wrap by using the funds states currently spend on expansion to obtain federal matching funds through a Medicaid waiver.

Any wrap that states could afford to provide under a waiver would either cover far fewer people, leave people with far higher deductibles and cost sharing than they have today, or more likely, both. And that's before taking into account other benefits low-income people would lose because they're covered in Medicaid but not in commercial plans: services such as non-emergency medical transportation and personal care services that help adults with special needs.

Moreover, any state relying on the promise of a waiver in lieu of expansion would be taking a big risk. Medicaid waivers are granted and renewed at the discretion of the Secretary of Health and Human Services (HHS), based on whether they promote the objectives of the Medicaid statute, and they're granted for periods of only five years. The current HHS Secretary thus can't make any guarantees about waivers after 2022, as the Senate bill's cuts to expansion funding (and the cuts resulting from the Medicaid per capita cap) continue to deepen.

Judith Solomon, "Waivers Can't Solve the Problems Created by Massive Federal Medicaid Cuts," Center on Budget and Policy Priorities, July 15, 2017, https://www.cbpp.org/blog/waivers-cant-solve-the-problems-created-by-massive-federal-medicaid-cuts.

Waivers Could Disproportionately Hurt Low-Income People

CBO estimates that states with about half of the nation's population would take up "section 1332" waivers that the Senate bill would dramatically expand, primarily to eliminate or weaken the ACA requirement that insurers cover essential health benefits. People living in those states could experience substantial increases in out-of-pocket spending on health care or would lose access to certain services entirely.

The benefits at risk, according to CBO, include: maternity care, mental health and substance use disorder treatment, rehabilitative and habilitative services, and pediatric dental care. CBO notes that out-of-pocket costs associated with maternity care and mental health and substance use services could increase "by thousands of dollars" since annual and lifetime limits on out-of-pocket spending would not apply to non-covered benefits. Once the benefit standards are waived, plans could engage in a race to the bottom on coverage of particular services. People with certain health conditions — such as pregnancy or substance use disorders — would face a *de facto* pre-existing condition exclusion since no plan would cover their needed care as a standard covered benefit and

instead could offer unaffordable riders for targeted conditions.[9] The benefit losses would be even more notable for people who lose access to Medicaid, which covers services that low-income people need that are not covered by private insurance, such as non-emergency transportation.

Waiving the core consumer protections would particularly harm low-income people, since they tend to report being in poorer health. Poor adults are five times likelier to report being in fair or poor health than higher-income people. Low-income people have higher rates of heart disease, diabetes, stroke, and other chronic conditions and are three times likelier than higher-income people to have activity limitations due to chronic illness than higher-income people.[10] The Ohio Department of Medicaid found that 27 percent of expansion enrollees had been diagnosed with at least one chronic medical condition and nearly one-third screened positive for depression or anxiety disorders. In addition, one-third had been diagnosed with substance abuse or dependence.[11] In addition to out-of-pocket increases due to lower premium subsidies and loss of cost-sharing reductions, people with health care needs who live in states that use waivers to eliminate or substantially alter the essential health benefits requirement could see their out-of-pocket payments rise further.

Waiting Period Penalty Would Lock Consumers Out of Coverage

The Senate Republican health bill includes a six-month waiting period penalty for people who have gaps in coverage and then attempt to enroll in health insurance in the individual market. Beginning in 2019, people seeking to buy coverage in the individual market would generally be required to show they had health coverage during the prior 12 months, without a gap of more than 63 days. If they had a gap, or could not demonstrate they had coverage for an adequate length of time, they would be subject to a waiting period of at least six months following an open or special enrollment period. During the waiting period, they couldn't use covered benefits, nor would they be charged premiums.[12]

Gaps in coverage can occur for many different reasons. People may face financial hardships that lead them to miss premium payments, such as an expensive car repair and reduced work hours that swamp a modest-income family's monthly budget. Or someone may leave a job with health benefits and fail to secure new coverage before a couple of months have passed because they are unaware

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[9] Thomas Huelskoetter and Emily Gee, "Senate Repeal Bill Would Still Eviscerate Coverage and Protections for People with Pre-Existing Conditions," Center for American Progress, June 9, 2017, https://www.americanprogress.org/issues/healthcare/news/2017/06/09/433871/senate-repeal-bill-still-eviscerate-coverage-protections-people-pre-existing-conditions/.

[10] Steven H. Woolf *et al.,* "How are Income and Wealth Linked to Health and Longevity?" Urban Institute and VCU Center on Society and Health, April 2015, http://www.urban.org/sites/default/files/publication/49116/2000178-How-are-Income-and-Wealth-Linked-to-Health-and-Longevity.pdf.

[11] Ohio Department of Medicaid, "Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly," January 15, 2017, http://medicaid.ohio.gov/portals/0/resources/reports/annual/group-viii-assessment.pdf.

[12] For a complete explanation of the continuous coverage requirement, see Sarah Lueck, "Waiting Period Penalty in Senate Republicans' Health Bill Would Lock People Out of Coverage, Provide Little Benefit to the Risk Pool," Center on Budget and Policy Priorities, July 5, 2017, http://www.cbpp.org/research/health/waiting-period-penalty-in-senate-republicans-health-bill-would-lock-people-out-of.

that there is a deadline or expect they will soon find a new job with health benefits. The Senate bill's waiting period penalty would leave many people uninsured for lengthy periods of time, possibly leaving them facing an illness without the protection of health care coverage.

This waiting period penalty would hit low-income people particularly hard because they are more likely to have gaps in coverage or be uninsured so would be more likely to be subjected to the penalty. In 2016, according to the Commonwealth Fund, 28 percent of low-income people said they had a gap in coverage within the last year or were currently uninsured, compared to 10 percent of higher-income people.[13] This means that low-income people are more likely to face enrollment delays, even if they are prepared to bear the heavy financial cost of coverage.

People with an Offer of Employer-Sponsored Coverage Would Be Excluded Entirely

The Senate bill blocks anyone with an offer of employer-sponsored coverage from receiving a tax credit to purchase marketplace coverage, which would disproportionately hurt the lowest-income working families. Today, an income-eligible person can receive Medicaid despite having an offer of employer-sponsored coverage. In the marketplace, someone with an offer of employer-sponsored coverage is not eligible for a premium tax credit, with two important exceptions. A person may still qualify for assistance if the employer offer does not meet the minimum value standard of covering at least 60 percent of expected health costs, or if the plan is unaffordable, meaning the employee-only offer costs more than 9.5 percent of income. The Senate bill eliminates these exceptions and would bar more people from premium help.

This restriction may be a frequent barrier to coverage. The Urban Institute estimates that 81 percent of those who would be newly uninsured under the Senate bill have a worker in the family.[14] In 2014, according to the Kaiser Family Foundation, 30 percent of people with income under 100 percent of the poverty line had an employer offer of coverage, but only 12 percent enrolled, presumably because many found coverage hard to afford or had a more affordable offer, such as Medicaid. But under the Senate bill, any offer of employer-based coverage — even an unaffordable one offered to someone well below the poverty line who was formerly Medicaid eligible — would disqualify a low-income person from the Senate tax credit.[15]

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[13] Commonwealth Fund, "Biennial Health Insurance Survey, 2003-2016," http://www.commonwealthfund.org/publications/blog/2017/mar/~/link.aspx?_id=ACBDD468952747D9A38A47C6161F0629&_z=z.

[14] Linda J. Blumberg *et al.*, "State-by-State Coverage and Government Spending Implications of the Better Care Reconciliation Act," Urban Institute, June 2017, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf438332.

[15] Michelle Long *et al.,* "Trends in Employer-Sponsored Insurance Offer and Coverage Rates, 1999-2014," Kaiser Family Foundation, March 21, 2016, http://kff.org/private-insurance/issue-brief/trends-in-employer-sponsored-insurance-offer-and-coverage-rates-1999-2014/.

For example, consider a Nevadan who works full-time at the state's minimum wage of $7.25, earning about $14,500 per year.[16] Today, her employer offers single coverage with a $150 per month premium ($1,800 per year) and a $1,500 deductible, making her combined out-of-pocket contribution $3,300, or nearly a quarter of her income. She can't afford that insurance, but with income that is roughly 115 percent of the poverty line, she would also qualify for Medicaid expansion coverage with no premium or deductible. If the Senate bill were fully implemented today, she would likely lose Medicaid coverage and her employer offer of coverage would make her ineligible for other assistance. She would almost certainly end up uninsured.

The result would be similar in a non-expansion state like Kansas. A 35-year-old woman who works full-time at the state's $7.25 per hour minimum wage would earn $14,500 per year. She's offered coverage at work for a $300 per month premium with a $2,000 deductible. Under current law, her premium would be considered unaffordable and she would qualify for a $4,800 premium tax credit that reduces her marketplace premium to $25 per month with a deductible of less than $500. Under the Senate bill, any offer of employer-sponsored coverage — even an unaffordable one — would prohibit her from claiming the credit.

Tax Credit Could Put the Lowest-Income People in Financial Jeopardy

Another little-noticed provision threatens to put low-income people in financial jeopardy for innocent or unavoidable errors in the calculation of the premium tax credit. Since this provision would take effect in 2018, it would affect consumers' decisions on marketplace enrollment as early as the upcoming November 1 start of the open enrollment period.

Under current law, the premium tax credit is paid directly to the insurer in advance based on a projection of the year's income, then reconciled on the tax return at the end of the year based on actual income. A person who got too little tax credit during the year can claim the additional amount on their tax return; a person who claimed too much credit needs to repay it, up to a cap. The Senate Republicans' plan would eliminate the cap and force repayment of the entire amount. This could wallop people who have low incomes, are older, or live in high-cost areas since they have the highest tax credits, and therefore have the most exposure to potential repayment obligations. It could also hurt people whose income fluctuates, like those who are self-employed, or people who have changes in the family during the year, such as a divorce or older child who gets a job and can no longer be claimed as a dependent.

In many cases, an overpayment of advance credits is the result of a change in circumstances that couldn't be predicted when initial eligibility was determined. For example, a person may get a higher-paying job, use retirement savings for a necessary home repair, or need to file taxes separately from a spouse due to marital separation. Any of these may change the family's income or composition and require a recalculation of the allowable credit. In many cases, even if the change is reported in a timely way, an excess credit may already have been awarded. Some people, such as those who need to file taxes separately from their spouse, may lose eligibility for the credit entirely at tax filing, after it's already been used throughout the year.

[16] In Nevada for fiscal year 2018, the minimum wage is $7.25 (the federal minimum) for a person who is offered qualified health benefits from their employer and $8.25 for someone who is not. For full-time annual earnings, we estimate someone working 40 hours per week for 50 weeks.

The current income-based cap on repayment limits liability to $300 for a single person (or $600 for others) with income below 200 percent of the poverty line. But the Senate bill would eliminate this cap and expose people to thousands of dollars in tax liability, since lower-income people generally get the largest credits.

Absent a requirement to have coverage — which the bill also would eliminate — many people would be unwilling to take the risk of repayment. A freestanding proposal eliminating the caps on repayment amounts would deter 250,000 people each year from enrolling in coverage, the Joint Committee on Taxation estimated.[17] On top of this, the Senate bill creates a 25 percent tax penalty for an erroneous claim of the premium tax credit, compounding the risk of using the credit and guaranteeing that more people will be uninsured.

[17] Tara Straw, "Ways and Means Proposal Would Weaken Health Reform and Put Many Families at Financial Risk," Center on Budget and Policy Priorities, March 14, 2016, http://www.cbpp.org/research/health/ways-and-means-proposal-would-weaken-health-reform-and-put-many-families-at.