# Issue Brief

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# CBO Scores House Passed Health Care Reform Bill; HR 1628

The Congressional Budget Office released its cost and impact evaluation of the recently passed American Health Care Act (HR 1628) by the House of Representatives. A copy is available at https://www.cbo.gov/publication/52752.

## COMMENT

While the House bill is intended to repeal and replace the Affordable Care Act, its future remains cloudy and uncertain. The issue of limiting/reducing Medicaid, covering prior existing conditions, essential health benefits and other issues in HR 1628 are controversial to say the least. At this juncture, we must also await Senate action, which is not clear as to when such may occur.

The CBO report is short — some 41 pages. A great deal of discussion centers on what may happen to the insurance markets and their future stability. Those discussions are limited in the material that follows.

## DEFICIT CHANGES AND REVENUE CHANGES

- Basically, CBO says the passed version of H.R. 1628 would reduce the cumulative federal deficit over the 2017-2026 period by $119 billion.
- However, that amount is $32 billion less than the estimated net savings for the version of H.R. 1628 that was posted on the House Committee on Rules website on March 22, 2017, incorporating manager's amendments 4, 5, 24, and 25. (CBO issued a cost estimate for that earlier version of the legislation on March 23, 2017.)
- CBO and the Joint Committee on Taxation estimate that, over the 2017-2026 period, enacting H.R. 1628 would reduce direct spending by $1.111 trillion and reduce revenues by $992 billion, for a net reduction of $119 billion.
- The largest savings would come from reductions in outlays for Medicaid and from the replacement of the ACA's subsidies for non-group health insurance with new tax credits for non-group health insurance.
- The largest increases in the deficit would come from repealing or modifying tax provisions in the ACA that are not directly related to health insurance coverage — such as repealing a surtax on net investment income, repealing annual fees imposed on health insurers, and reducing the income threshold for determining the tax deduction for medical expenses.

## EFFECTS ON HEALTH INSURANCE COVERAGE

- CBO and JCT estimate that, in 2018, 14 million **more** people would be uninsured under H.R. 1628 than under current law.
- The increase in the number of uninsured people relative to the number projected under current law would reach 19 million in 2020 and 23 million in 2026. In 2026, an estimated 51 million people under age 65 would

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be uninsured, compared with 28 million who would lack insurance that year under current law.

## STABILITY OF THE HEALTH INSURANCE MARKET

"The market for insurance purchased individually with premiums not based on one's health status—that is, non-group coverage without medical underwriting — would be unstable if, for example, the people who wanted to buy coverage at any offered price would have average health care expenditures so high that offering the insurance would be unprofitable."

CBO and the JCT also estimate that about one-sixth of the population reside in areas in which the non-group market would start to become unstable beginning in 2020. That instability would result from market responses to decisions by some states to waive two provisions of federal law permitted under H.R. 1628.

- One type of waiver would allow states to modify the requirements governing essential health benefits, which set minimum standards for the benefits that insurance in the non-group and small-group markets must cover.
- A second type of waiver would allow insurers to set premiums on the basis of an individual's health status if the person had not demonstrated continuous coverage; that is, the waiver would eliminate the requirement for what is termed community rating for premiums charged to such people. CBO and JCT anticipate that most healthy people applying for insurance in the non-group market in those states would be able to choose between premiums based on their own expected health care costs (medically underwritten premiums) and premiums based on the average health care costs for people who share the same age and smoking status and who reside in the same geographic area (community-rated premiums). By choosing the former, people who are healthier than average would be able to purchase non-group insurance with relatively low premiums.

Community-rated premiums would rise over time, and people who are less healthy (including those with preexisting or newly acquired medical conditions) would ultimately be unable to purchase comprehensive non-group health insurance at premiums comparable to those under current law, if they could purchase it at all — despite the additional funding that would be available under H.R. 1628 to help reduce premiums. As a result, the non-group markets in those states would become unstable for people with higher-than-average expected health care costs.

## EFFECTS ON PREMIUMS AND OUT-OF-POCKET PAYMENTS

CBO and JCT say that for single policyholders, H.R. 1628 would tend to increase such premiums before 2020, relative to those under current law—by an average of about 20 percent in 2018 and 5 percent in 2019, as the funding provided by the act to reduce premiums had a larger effect on pricing.

Starting in 2020, however, average premiums would depend in part on any waivers granted to states and on how those waivers were implemented and, in part, on what share of the funding available from the Patient and State Stability Fund was applied to premium reduction.

People living in states modifying the EHBs who used services or benefits no longer included in the EHBs would experience substantial increases in out-of-pocket spending on health care or would choose to forgo the services.

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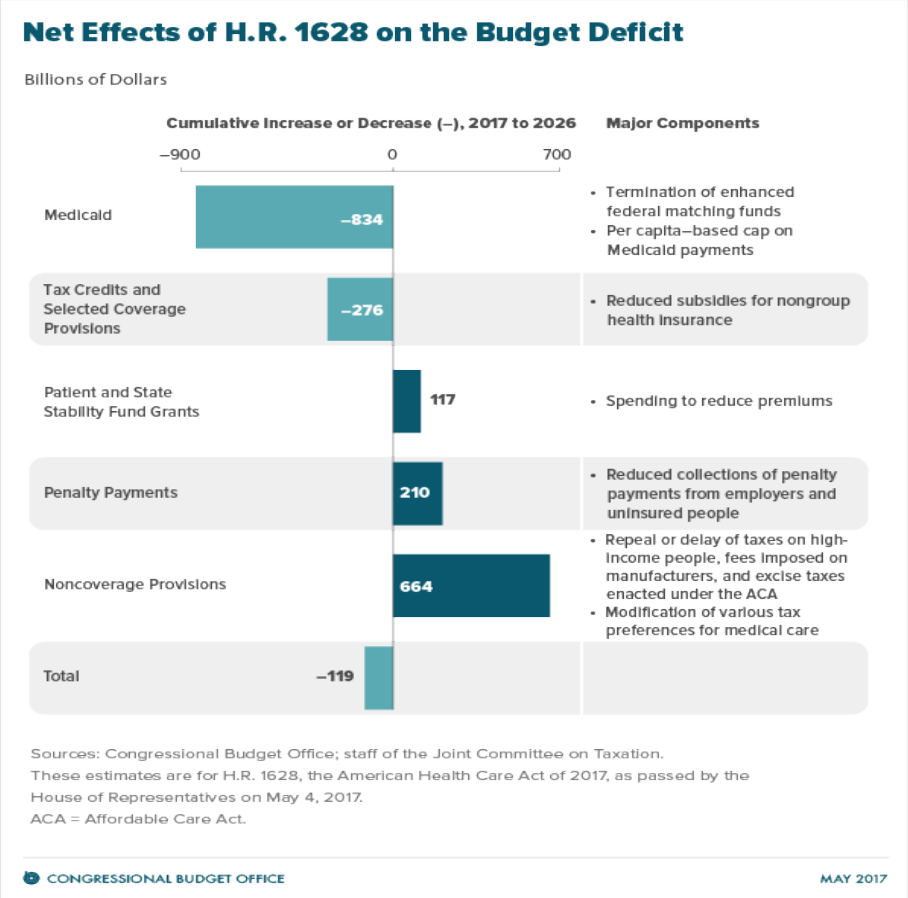
The ACA's ban on annual and lifetime limits on covered benefits would no longer apply to health benefits not defined as essential in a state. As a result, for some benefits that might be removed from a state's definition of EHBs but that might not be excluded from insurance coverage altogether, some enrollees could see large increases in out-of-pocket spending because annual or lifetime limits would be allowed. That could happen, for example, to some people who use expensive prescription drugs. Out-of-pocket payments for people who have relatively high health care spending would increase most in the states that obtained waivers from the requirements for both the EHBs and community rating.




*Analysis provided for MHA by Larry Goldberg, Goldberg Consulting*

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