2017 HEALTH CARE REFORM: CBO PROJECTS FISCAL AND COVERAGE IMPACTS OF AMERICAN HEALTH CARE ACT
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The Republican health care plan to repeal and replace Obamacare, titled the “American Health Care Act” (AHCA), was released by House Republicans on Monday, March 6th. It was swiftly scheduled for markup on Wednesday, March 8th, and approved by both the Ways and Means Committee and the Energy and Commerce Committee on March 9th along party lines. On March 13th, the nonpartisan Congressional Budget Office (CBO) released its highly anticipated scoring of the AHCA. Many commentators have observed that several of CBO’s findings will make the legislation a tougher sell for Republicans — in particular, its finding that the AHCA would result in a dramatic and near immediate increase in the number of Americans who will be uninsured.

The AHCA. The AHCA is largely similar to a draft version that was leaked to the press a couple weeks ago but with a number of significant modifications, including the addition of income-based phaseouts for the new health care coverage credit, delayed effective dates for several key provisions, and the removal of a provision that many likened to the so-called “Cadillac” tax on high-cost employer plans.

The AHCA is currently structured as two “Committee Prints” — one from the Energy and Commerce Committee (Title I; Subtitles A through D) and one from the Ways and Means Committee (no Title, with unnumbered subtitles that are referred to throughout this article by subtitle name and Sec. number). Except as otherwise noted, all of the provisions below are to the Ways and Means portion.

ACA Repeal. The AHCA would repeal virtually all of the Affordable Care Act (ACA, or Obamacare), including the following tax provisions:

- The individual mandate under Code Sec. 5000A — by making the penalty amounts zero, effective for months beginning after Dec. 31, 2015 (i.e., retroactive for 2016). (Repeal and Replace of Health-Related Tax Policy, Sec. 5)

✓ Observation: Title I, Subtitle D — Patient Relief and Health Insurance Market Stability, Sec. 133, would modify the Public Health and Services Act (PHSA) to allow insurers to charge a 30% penalty on top of the monthly premium rate for a year if a policyholder didn’t have creditable coverage for a period of at least 63 consecutive days during the applicable “look-back period.” This provision, titled “Continuous Health Coverage Incentive,” is often viewed by some as a counterpart to the individual mandate in that it encourages, but doesn’t require, a taxpayer to obtain and continue health insurance coverage.

- The employer mandate under Code Sec. 4980H — by reducing the penalty amounts to zero, effective for months beginning after Dec. 31, 2015 (i.e., retroactive for 2016). (Repeal and Replace of Health-Related Tax Policy, Sec. 6)

- The premium tax credit under Code Sec. 36B would be repealed for coverage months that begin after Dec. 31, 2019. The credit would also be subject to a number of amendments, generally effective for tax years beginning after Dec. 31, 2017, including: (i) removing the repayment limits for excess advance payments effective for tax years beginning after Dec. 31, 2017; (ii) modifying the definition of a “qualified health plan” to include “catastrophic-only” plans and certain plans not offered through an Exchange; and (iii) modifying the applicable percentage tables in Code Sec. 36B(b)(3) (which essentially determine a taxpayer’s eligibility for the premium tax credit based on the percentage of income that the cost of health insurance premiums represents, for taxpayers with household incomes of 100% to 400% of the federal poverty line) to also take into account the taxpayer’s age. (Repeal and Replace of Health-Related Tax Policy, Secs. 1 - 3)
The 3.8% net investment income tax (NIIT) under Code Sec. 1411, effective for tax years beginning after Dec. 31, 2017. (Repeal of Net Investment Income Tax, Sec. 1)

The 0.9% additional Medicare tax under Code Sec. 3101(b)(2), effective with respect to remuneration received after, and tax years beginning after, Dec. 31, 2017. (Repeal and Replace of Health-Related Tax Policy, Sec. 14)

The higher floor for medical expense deductions under Code Sec. 213(a), effective for tax years beginning after Dec. 31, 2017. Thus, the 7.5% floor that was previously in place would be restored. The AHCA would also extend the relief under Code Sec. 213(f), which delayed the 10% floor if the taxpayer or the taxpayer’s spouse is 65 before the end of the tax year, to apply to tax years beginning after Dec. 31, 2016. (Repeal and Replace of Health-Related Tax Policy, Sec. 13)

The small employer health insurance credit under Code Sec. 45R, effective for amounts paid or incurred in tax years after Dec. 31, 2019. For tax years beginning after Dec. 31, 2017 and up to the credit’s repeal, the credit would not be available with respect to a qualified health plan that provides coverage relating to elective abortions. (Repeal and Replace of Health-Related Tax Policy, Sec. 4)

The limitation on health Flexible Spending Account (FSA) contributions, for tax years beginning after Dec. 31, 2017. (Repeal and Replace of Health-Related Tax Policy, Sec. 10)

The so-called “Cadillac” tax on high cost employer-sponsored health plans under Code Sec. 4980I, would not apply to any tax period beginning after Dec. 31, 2019 and before Jan. 1, 2025. (Repeal and Replace of Health-Related Tax Policy, Sec. 7)

Observation: The Cadillac tax is currently scheduled to go into effect for tax years beginning after Dec. 31, 2019. The AHCA doesn’t repeal it, but instead further delays its effective date. This controversial tax was originally scheduled to go into effect in 2012 but has been delayed, first to 2017, then to 2020, and now potentially to 2025. One explanation for why it was delayed instead of repealed is for budgetary projection purposes.

The exclusion from “qualified medical expenses” of over-the-counter medications for purposes of Health Savings Accounts (HSAs, Code Sec. 223(d)(2)), Archer Medical Savings Accounts (Archer MSAs, Code Sec. 220(d)(2)(A)), Health Flexible Spending Arrangements (Health FSAs), and Health Reimbursement Arrangements (HRAs, Code Sec. 106(f)), effective for amounts paid, and expenses incurred, with respect to tax years beginning after Dec. 31, 2017. (Repeal and Replace of Health-Related Tax Policy, Sec. 8)

The ACA’s increase to the additional tax on HSAs (Code Sec. 223(f)(4)(A)) and Archer MSAs (Code Sec. 220(f)(4)(A)) for distributions not used for qualified medical expenses, effective for distributions made after Dec. 31, 2017. The percentages would be reduced from 20% to 10% and 15%, respectively. (Repeal and Replace of Health-Related Tax Policy, Sec. 9)

The annual fee imposed on branded prescription drug sales (ACA Sec. 9008), for calendar years beginning after Dec. 31, 2017. (Repeal of Certain Consumer Taxes, Sec. 1)

The medical device excise tax under Code Sec. 4191, for sales after Dec. 31, 2017. (Repeal and Replace of Health-Related Tax Policy, Sec. 4)

The annual fee on health insurance providers (ACA Sec. 9010), for calendar years beginning after Dec. 31, 2017. (Repeal of Certain Consumer Taxes, Sec. 2)

Observation: Under current law, this fee is suspended for the 2017 calendar year.

The elimination of a deduction for expenses allocable to Medicare Part D subsidy under Code Sec. 139A, effective for tax years beginning after Dec. 31, 2017. (Repeal and Replace of Health-Related Tax Policy, Sec. 11)

The 10% tanning tax under Code Sec. 5000B, effective for services performed after Dec. 31, 2017. (Repeal of Tanning Tax, Sec. 1)

The disallowance under Code Sec. 162(m)(6) of any deduction for “applicable individual remuneration” in excess of $500,000 paid to an applicable individual by certain health insurers, for tax years beginning after Dec. 31, 2017. (Remuneration From Certain Insurers, Sec. 1)
✓ Observation: A draft bill that was recently leaked to the press also provided for the repeal of a number of provisions relating to the economic substance rules. That repeal has been omitted from the new version.

Replacement. The main feature of the AHCA’s ACA replacement would be a new refundable tax credit for health insurance, described below. The AHCA would also make a number of significant changes to strengthen HSAs in addition to those described above.

Health insurance coverage credit. The AHCA would create a new Code Sec. 36C refundable tax credit for health insurance coverage — generally, state-approved major medical health insurance and unsubsidized COBRA coverage. (Repeal and Replace of Health-Related Tax Policy, Sec. 15(a)) The credit would generally equal the lesser of: (i) the sum of the applicable monthly credit amounts (below) or (ii) the amount paid by the taxpayer for “eligible health insurance” for the taxpayer and qualifying family members. (Code Sec. 36C(b))

■ Monthly credit amount. The monthly credit amount with respect to any individual for any “eligible coverage month” (in general, a month when the individual is covered by eligible health insurance and is not eligible for “other specified coverage,” such as coverage under a group health plan or under certain governmental programs, like Medicare and Medicaid) during any tax year would be 1/12 of:

(A) $2,000 for an individual who has not attained age 30 as of the beginning of the tax year;
(B) $2,500 for an individual age 30 - 39;  
(C) $3,000 for an individual age 40 - 49;
(D) $3,500 for an individual age 50 - 59; and
(E) $4,000 for an individual age 60 and older. (Code Sec. 36C(c)(1))

■ Income-based phaseout. The Code Sec. 36C credit would phase out at higher levels of income. Specifically, it would be reduced by 10% of the excess of the taxpayer’s modified adjusted gross income (MAGI, as specifically defined) for a tax year over $75,000 (double that for a joint return). (Code Sec. 36C(c)(2)) The $75,000 amount, as well as the dollar amounts in (A) through (E), above, would be adjusted for inflation.

✓ Observation: The earlier draft version of the bill didn’t provide any income limitations for the credit.

■ Other limitations on the credit. The Code Sec. 36C credit would be subject to a $14,000 aggregate annual dollar limitation with respect to the taxpayer and the taxpayer’s qualifying family members (generally meaning the taxpayer’s spouse, dependent, and any child of the taxpayer who hasn’t attained age 27). (Code Sec. 36C(c)(3)(A)) In addition, monthly credit amounts would be taken into account only with respect to the five oldest qualifying individuals of the family. (Code Sec. 36C(c)(3)(B)) Married couples would have to file jointly in order to receive a Code Sec. 36C credit (Code Sec. 36C(i)(1)), and no credit would be allowed with respect to any individual who is a dependent of another taxpayer for a tax year beginning in the calendar year in which such individual’s tax year begins. (Code Sec. 36C(i)(2))

■ Coordination between the credit and other rules. The AHCA would also provide special rules for, among other things, coordinating the Code Sec. 36C credit with the medical expense deduction under Code Sec. 213, and calculating the credit where the taxpayer (or any qualifying family member) has a “qualified small employer health reimbursement arrangement” under Code Sec. 9831(d)(2).

■ Advance credit payments. The AHCA would also create a new Code Sec. 7529, which would direct a number of Agency heads to consult and establish a program for making payments to providers of eligible health insurance for taxpayers eligible for the new Code Sec. 36C credit, no later than Jan. 1, 2020. (Repeal and Replace of Health-Related Tax Policy, Sec. 15(b))

■ Excess amounts. The AHCA would also create an “excess health insurance coverage credit” under Code Sec. 7530 which would provide a mechanism under which “excess” credit amounts (generally, the amount, if any, by which the Code Sec. 36C credit amount exceeds the amount paid for coverage) can, at the taxpayer’s request, be contributed to a designated HSA of the taxpayer.
AN OVERVIEW OF THE TAX TREATMENT OF ROTH IRAS

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Information reporting and penalties relating to the credit. Reporting requirements relating to the Code Sec. 36C health insurance coverage credit would be provided by new Code Sec. 6050X, and penalties for failure to meet the requirements would be added to Code Sec. 6724(d). (Repeal and Replace of Health-Related Tax Policy, Sec. 15(c)) Code Sec. 6676(a) would also be amended to provide for an increased 25% penalty in the case of erroneous claims for refund or credit relating to Code Sec. 36C.

Effective date. The above amendments relating to the Code Sec. 36C health coverage credit would apply to months beginning after Dec. 31, 2019, in tax years ending after that date. (Repeal and Replace of Health-Related Tax Policy, Sec. 15(g))

HSA reforms. The AHCA would make a number of changes intended to strengthen and enhance HSAs, including:

Increased contribution limits. The AHCA would increase the maximum HSA contribution limits to equal the sum of the amount of the HSA deductible and out-of-pocket limitation, effective for tax years beginning after Dec. 31, 2017. (Repeal and Replace of Health-Related Tax Policy, Sec. 16) These limits are currently $2,250 as adjusted for inflation ($3,400 for 2017) for self-only coverage and $4,500 as adjusted for inflation ($6,750 for 2017) for family coverage. (Code Sec. 223(b)(2)) Under the AHCA, they would be at least $6,650 for self-only and $13,100 for family coverage beginning in 2018 (“at least” because these amounts will likely increase due to inflation adjustments by 2018).

“Catch-up contributions” by both spouses. The AHCA would also amend Code Sec. 223(b)(5) to allow both spouses to make “catch-up contributions” to the same HSA, effective for tax years beginning after Dec. 31, 2017. (Repeal and Replace of Health-Related Tax Policy, Sec. 17)

Pre-HSA medical expenses. Finally, the AHCA would amend Code Sec. 223(d)(2) to provide a special rule under which, if an HSA is established within 60 days of the date that certain medical expenses are incurred, it would be treated as having been in place for purposes of determining if the expense is a “qualifying medical expense.” This provision would be effective for coverage beginning after Dec. 31, 2017. (Repeal and Replace of Health-Related Tax Policy, Sec. 18)

Observation: The prior draft version of the bill also included a new subsection, Code Sec. 106(h), which would have required inclusion in income of “excess coverage” under employer-provided health coverage. Essentially, a taxpayer would have been required to include in gross income the amount for any month by which his or her “specified employer-provided health coverage” for that month exceeds 1/12 of the “annual limitation,” which is an amount determined by IRS to be equal to the 90th percentile of annual premiums for self-only, or other-than-self-only, coverage in 2019 (and adjusted for inflation thereafter). This provision immediately drew comparisons to the unpopular “Cadillac” tax on high-cost plans and was removed from the current version of the AHCA.

Medicaid Expansion. Although an in-depth review of the Medicaid provisions is beyond the scope of this article, the AHCA would generally retain the Medicaid expansion through Dec. 31, 2019. At that point, people who had enrolled pursuant to the ACA expansion provisions would remain in the program (with continued Federal subsidies) if they remain eligible, but the eligibility standards would otherwise generally revert to the way they were before the ACA. (Title I, Subtitle B—Medicaid Program Enhancement, Sec. 112) “Safety net funding” would also be provided, from 2018 to 2021, to States that didn’t participate in the Medicaid expansion. (Sec. 115) The AHCA would also shift Medicaid funding so as to cap the amount that each state receives from the Federal government on a per-capita basis. (Title I, Subtitle C—Per Capita Allotment for Medical Assistance) The Act would also provide a number of provisions designed to reduce Medicaid costs, such as disenrolling “high dollar lottery winners” (Sec. 114) and “providing incentives for increased frequency of eligibility redeterminations.” (Sec. 119)

CBO’s Report. CBO, along with the Joint Committee on Taxation (JCT) (referred to collectively throughout this article as CBO), issued its report on Mar. 13, 2017. The report was issued pursuant to the Concurrent Resolution on the Budget for Fiscal Year 2017, which directed the House Committee on Ways and Means and the Committee on Energy and Commerce to develop legislation to reduce the deficit. The resolution
included reconciliation instructions, which effectively paved the way for the repeal of the ACA by a fast track process that requires only a simple majority vote in both chambers of Congress. As explained below, CBO’s report does project that the AHCA would reduce the deficit and thus comports with the resolution.

✓ Observation: Bills that increase the federal deficit in the long term are generally ineligible for reconciliation (i.e., the fast track/majority vote process described above).

For scoring purposes, CBO assumed a May 2017 enactment of the AHCA and measured against its March 2016 baseline with adjustments for subsequently enacted legislation — essentially, against CBO’s projections under current law (including the ACA). CBO cautioned that there is uncertainty surrounding its estimates in light of the difficulty in predicting the ways that agencies, states, individuals, hospitals and other affected parties would respond to the legislation.

Effect on Federal budget. CBO estimated that enacting the AHCA would reduce federal deficits by $337 billion over the 2017-2026 period. Government spending would be reduced by $1.2 trillion over the period, which would be partially offset by an $883 billion reduction in revenues.

The largest savings would come from reductions in outlays for Medicaid and from the elimination of the ACA’s subsidies for nongroup health insurance — namely, cost-sharing subsidies and premium tax credits. The largest costs would come from repealing many of the ACA-related tax increases and from the establishment of a new tax credit for health insurance.

Specifically, the budgetary effects relating to health insurance coverage would stem primarily from the AHCA’s:

■ Elimination of the individual mandate and the employer mandate; and other affected parties would respond to the legislation.
■ Elimination, beginning in 2020, of the ACA’s Medicaid expansion;
■ Changing the government’s Medicaid funding obligations to be a per capita-cap (i.e., a limit on the amount of reimbursement provided to states based on an average per-enrollee cost);
■ Creation of a new health insurance coverage credit for insurance purchased through the nongroup market beginning in 2020;
■ Appropriation of funding for grants to states through the Patient and State Stability Fund (i.e., beginning in 2018 and ending after 2026, allotments to states from the federal government that the states could use for a variety of purposes such as reducing premiums);
■ Repeal of existing subsidies for coverage obtained through the nongroup market (i.e., the ACA’s cost-sharing subsidies and premium tax credits);
■ Changes to several of the ACA’s market reforms, including allowing insurers to charge older people five times more for premiums than younger people beginning in 2018, and removing the requirement that certain insurers offer plans that cover at least 60% of the cost of covered benefits beginning in 2020; and
■ Enactment of a “continuous coverage” provision under which insurers would be required to apply a 30% surcharge on premiums for people with coverage gaps exceeding 63 days within the past year.

The budgetary effects that don’t relate to insurance coverage would stem primarily from the AHCA:

■ Repealing the 3.8% net investment income tax;
■ Repealing the 0.9% Medicare surtax;
■ Repealing the annual health insurance provider fee; and
■ Delaying the effective date of the “Cadillac” tax on certain high-cost plans.

The report noted that many of the changes described above would affect coverage and costs in complex ways. For instance, while repealing the individual and employer mandate would reduce federal revenues, in that individuals and employers wouldn’t have to pay penalties, it would also substantially reduce the number of people with health insurance coverage, which in turn would reduce government costs in subsidizing their coverage. CBO projects that the estimated savings from lower enrollment would exceed the estimated loss of revenues.
With respect to Medicaid changes, CBO estimated that direct Medicaid spending would decrease by $880 billion over the 2017-2026 period, stemming primarily from lower enrollment and from converting the federal government’s funding obligations for Medicaid to a per capita-based cap.

**Effects on health insurance coverage.** CBO estimated that, by 2018, 14 million more people would be uninsured under the AHCA than under current law. Most of that increase would stem from repealing the penalties associated with the individual mandate under Code Sec. 5000A. That repeal would cause some people to choose not to have insurance because they chose to be covered under current law only to avoid paying the penalties, and some people would forgo insurance in response to higher premiums (see below). Additionally, as the AHCA would change employers’ incentives to offer health insurance, CBO projects that over time, fewer employers would do so.

CBO further predicted that, following additional changes (i.e., going into effect after 2018) to subsidies for insurance purchased in the nongroup market and to the Medicaid program, the increase in the number of uninsured people relative to the number under current law would rise to 21 million in 2020 and then to 24 million in 2026. The reductions in insurance coverage between 2018 and 2026 would stem in large part from changes in Medicaid enrollment — because some states would discontinue their expansion of eligibility, some states that would have expanded eligibility in the future would choose not to do so, and per-enrollee spending in the program would be capped. In 2026, an estimated 52 million people would be uninsured, compared with 28 million who would lack insurance that year under current law.

One provision that would affect coverage levels is the continuous coverage provision (see above). In general, CBO projected that a 30% increase to the future price of insurance would induce roughly 1 million people to purchase insurance in 2018, but that in 2019 and later years, it would result in 2 million fewer people purchasing insurance. The people deterred from purchasing coverage would, CBO estimated, tend to be healthier than those who choose to purchase it.

CBO also examined the potential effect of the AHCA health coverage tax credit on consumer behavior and its application to people at different income levels compared to the ACA subsidies. The main distinction is that the current subsidies are based on income, whereas the AHCA credit would be based primarily on age (but would phase out at $75,000 of adjusted gross income for a single taxpayer and $150,000 for joint filers). Overall, CBO projected that many lower-income people would receive smaller credits under the AHCA as compared to under current law, and higher-income individuals — particularly, with income above 400% of the Federal poverty line but below the phase-out levels — would receive larger credits. Additionally, while credits under the AHCA would be larger for older taxpayers (up to twice the amount of the credit for younger taxpayers), the provision allowing insurers to charge older enrollees up to five times more would likely result in reduced enrollment in the nongroup market. CBO also noted that subsidies under current law tend to grow with insurance premiums, whereas subsidies under the AHCA would grow with inflation, the effect of which CBO projected would be a 50% reduction in the average subsidy by 2026.

**Stability of the health insurance market.** Decisions about offering and purchasing health insurance depend on the stability of the health insurance market. In CBO’s assessment, the nongroup market would probably be stable in most areas under either current law or the AHCA. Specifically, under the ACA, the subsidies to purchase coverage combined with the penalties paid by uninsured people stemming from the individual mandate generally create sufficient demand for insurance by people with low health care expenditures for the market to be stable.

On the other hand, under the AHCA, CBO noted that key factors bringing about market stability would include subsidies to purchase insurance, which would maintain sufficient demand for insurance by people with low health care expenditures, and grants to states from the Patient and State Stability Fund, which would reduce the costs to insurers of people with high health care expenditures. CBO projected that, even though the AHCA’s health coverage tax credit would be generally less generous for those receiving subsidies as compared to the ACA, the other changes would lower average premiums enough to attract a sufficient number of relatively healthy people to stabilize the market. CBO did project, however, that the first three years following the AHCA’s enactment would see lower nongroup enrollment and worse overall health status of enrollees.

**Effect on premiums.** CBO projected that the AHCA would tend to increase average premiums in the nongroup market prior to 2020 and lower average premiums thereafter. In 2018 and 2019, according
to CBO’s estimates, average premiums for single policy holders in the nongroup market would be 15% to 20% higher than under current law. This is because the individual mandate penalties would be eliminated so fewer healthy people would sign up. However, starting in 2020, the increase in average premiums from repealing the individual mandate penalties would be more than offset by the combination of several factors that would decrease those premiums, and by 2026, CBO projected that average premiums for single policyholders in the nongroup market would be roughly 10% lower under the AHCA as opposed to under current law. However, the premium changes would also differ significantly for people of different ages because the AHCA would allow insurers to charge five times more for older enrollees than younger ones, so this reduction would mostly fall to younger people.

Political response. According to Reuters, CBO’s report is considered to make the AHCA “a harder sell for lawmakers.” Some health policy experts and Wall Street analysts said the report was “more draconian than expected.”

House Minority Speaker Nancy Pelosi (D-CA) cited CBO’s figures on 24 million more uninsured Americans by 2026 as “a remarkable figure that underscores the need for GOP leaders to scrap their bill.” Senate Minority Leader Chuck Schumer (D-NY) said that the CBO estimates show that the AHCA means “higher costs for less coverage,” and that Republicans need to “heed this warning and turn back on their plan that would be a disaster for the country.” Senator Susan Collins (R-MA) said the CBO report was “cause for alarm” and “should prompt the House to slow down and reconsider certain provisions of the bill.”

However, House Speaker Paul Ryan (R-WI) issued a statement that the report confirms that the AHCA “will lower premiums and improve access to quality, affordable care. CBO also finds that this legislation will provide massive tax relief, dramatically reduce the deficit, and make the most fundamental entitlement reform in more than a generation.” Referring to the lower coverage levels, he said that “[i]f we stop forcing people to buy something they don’t want to buy, they’re not going to buy it.”

Other AHCA advocates downplayed the importance of CBO’s predictions, even before the report was issued. Said Sean Spicer, White House spokesman, “If you’re looking at the CBO for accuracy, you’re looking in the wrong place.” After the report was released, Health and Human Services Secretary Tom Price said it was “just not believable.”

Spicer also indicated that the bill was a work in progress and that the White House intended to submit a “manager’s amendment” to it. He stated that the White House was “obviously in talks with House leadership about [the bill’s] contents.” This sentiment was echoed by Speaker Ryan, who said the he was open to changes and acknowledged that “of course” certain modifications may have to be made to the legislation.