



American Bridge

Trump Policy Brief: The Meadows-MacArthur Amendment to the AHCA

4.26.17

THE MEADOWS-MACARTHUR AMENDMENT

In yet another effort to win over enough GOP House members to pass a bill to repeal and replace the Affordable Care Act, Republican House leadership introduced an amendment targeting essential health benefits coverage, protections for patients with pre-existing conditions, and rules limiting how much more insurers can charge older enrollees in relation to younger enrollees.

The bill would allow states to forgo the ACA's "community rating" requirement and allow premiums to once again be calculated based upon an individual's personal likelihood of needing healthcare. This would result in higher premiums for people with pre-existing conditions.

Under the plan, states that choose to opt out of the community rating requirement would be required to take part in a program funding high-risk pools. High-risk pools are meant to separate healthy customers from those with pre-existing conditions to make insurance available to all and cheaper for most. Thirty-five states ran high-risk pool programs before the ACA required coverage for pre-existing conditions, which largely failed to keep costs down or increase coverage.

The bill would also make it less likely that states will require insurers to cover "essential health benefits," ten categories of services the ACA required all healthcare plans to cover. Under the new plan, states would be able to opt out of the essential health benefits requirement if they could prove doing so would lower premiums overall. This is an easy standard to meet, since covering fewer services will lead to lower premiums. The essential health benefits at risk include emergency room trips, maternity care, prescription drug coverage, and others.

In a startling admission of the bill's harmful implications, the Republican authors of the bill exempted themselves and their staffs from being subject to its waivers.

A large majority of the American public objects to Republican efforts to undermine protections for people with pre-existing conditions and essential health benefits requirements. Seventy percent of adults favor protections for pre-existing conditions and 62 percent support essential health benefits requirements, according to a Washington Post-ABC poll.

House GOP Leaders Targeted Essential Health Benefits, Coverage For Patients With Pre-Existing Conditions, And Older Americans' Premiums In The Latest Version Of The American Health Care Act

THE AMENDED BILL WOULD ALLOW STATES TO WAIVE THE ACA'S ESSENTIAL HEALTH BENEFITS REQUIREMENTS

The Amendment To The AHCA Proposed By Rep. MacArthur Would Allow States To Waive The ACA's Essential Health Benefits. According to Vox, "House Republicans are floating a new amendment to their health care bill, one that would likely cause even more Americans to lose coverage than the last version. The American Health Care Act that House Speaker Paul Ryan introduced into the House last February dismantled parts of Obamacare. It also left popular provisions, like a ban on preexisting conditions and the requirement that insurers cover things like maternity care, intact. This new amendment, offered by Rep. Tom MacArthur (R-NJ), would allow states to waive out of those key Obamacare regulations too. In particular, this amendment would allow some states to charge higher premiums to Americans with preexisting conditions. States would also have the choice to opt out of the Affordable Care Act's essential health benefits

requirement, as well as the possibility of charging older Americans significantly higher premiums.” [Vox, [4/25/17](#)]

THE AMENDED BILL WOULD ALLOW INSURERS TO CHARGE MORE TO CUSTOMERS WITH PRE-EXISTING CONDITIONS

The Amendment Would Remove Protections Against Higher Premiums For Consumers With Pre-Existing Conditions. According to Vox, “House Republicans are floating a new amendment to their health care bill, one that would likely cause even more Americans to lose coverage than the last version. The American Health Care Act that House Speaker Paul Ryan introduced into the House last February dismantled parts of Obamacare. It also left popular provisions, like a ban on preexisting conditions and the requirement that insurers cover things like maternity care, intact. This new amendment, offered by Rep. Tom MacArthur (R-NJ), would allow states to waive out of those key Obamacare regulations too. In particular, this amendment would allow some states to charge higher premiums to Americans with preexisting conditions. States would also have the choice to opt out of the Affordable Care Act’s essential health benefits requirement, as well as the possibility of charging older Americans significantly higher premiums.” [Vox, [4/25/17](#)]

THE AMENDED BILL WOULD ALLOW INSURERS TO WIDEN THE DIFFERENCE BETWEEN WHAT THEY CHARGE OLDER AND YOUNGER CUSTOMERS

The Amendment To The AHCA Would Allow States To Increase The 5-1 Ratio The Original Bill Allowed Insurers To Charge Younger Enrollees Compared To Younger Enrollees. According to the Associated Press, “For coverage starting as early as next year, states could seek waivers of federal restrictions on premiums charged to older adults. The ACA limits insurers from charging older adults more than 3 times what young adults pay. The underlying GOP bill has a 5-to-1 limit. The amendment would allow states to seek a higher ratio. That would make more low-premium plans available for people in their 20s and 30s but raise rates for those in their 50s and early 60s.” [Associated Press, [4/26/17](#)]

The Bill Would Allow States To Forgo The ACA’s “Community Rating” Requirement That Makes Insurance Affordable For Patients With Pre-Existing Conditions

THE BILL WOULD ALLOW INSURERS TO CALCULATE PREMIUMS ON AN INDIVIDUAL – RATHER THAN “COMMUNITY” – BASIS, WHICH WOULD RESULT IN HIGHER COSTS FOR PEOPLE WITH PRE-EXISTING CONDITIONS

The Amendment Would Allow A Return To Individually Rating Insurance Customers Based On Their Likelihood Of Needing Healthcare, Rather Than Applying A “Community Rating” To All Customers Regardless Of Their Health Status. According to Vox, “The amendment takes aim at two Obamacare policies that have long been on the Freedom Caucus’s hit list: community rating and essential health benefits. Before the Affordable Care Act, insurance companies would ‘individually rate’ each patient who wanted to buy coverage on the individual market. They would send out detailed questionnaires about a potential customer’s age, medical history, and current behaviors (whether she currently smokes, for example, or is pregnant) and then set a specific premium for that person. It was meant to reflect the insurers’ best guess of how expensive that individual’s health care would be. Obamacare banned this so-called individual

rating. It required all insurers, instead, to use ‘community rating’: setting one premium for the entire community of people buying coverage. This had the practical effect of driving down premiums for sick people, who no longer had to bear the full burden of covering their more expensive health needs. It also drove up the costs for healthy people, who were suddenly asked to pay more to help cover those expensive bills from the sicker people. The Obama administration made this change because it felt like this was a good trade-off. It prioritized getting sicker people access to health insurance. This new GOP amendment to let states waive community rating would once again allow insurers to charge people based on their expected health care costs, so long as the state participates in the Patient and State Stability Fund. This is a pool of money in AHCA that states can use to set up high risk pools or shore up insurers that get stuck with really expensive patients.” [Vox, [4/25/17](#)]

IN ORDER TO WAIVE THE COMMUNITY RATINGS REQUIREMENT, STATES WOULD HAVE TO TAKE PART IN A PROGRAM FUNDING HIGH-RISK POOLS

The Waiver From The Community Rating Requirement Would Be Contingent Upon States Participating In The Patient And State Stability Fund, A Pool Of Money That Could Be Used To Create High-Risk Pools Or Given To Insurers With High-Cost Patients. According to Vox, “This new GOP amendment to let states waive community rating would once again allow insurers to charge people based on their expected health care costs, so long as the state participates in the Patient and State Stability Fund. This is a pool of money in AHCA that states can use to set up high risk pools or shore up insurers that get stuck with really expensive patients. Insurers could only charge these fees to people who had a break in health insurance coverage, showing up on the individual market wanting to purchase a plan. The language does not appear to allow an insurer to ask questions about the health status of someone who is transitioning directly from an insurance plan at work, for example, into the individual market. Republicans’ operating theory here is that it’s okay for states to charge sick people higher premiums so long as they have some kind of fallback option for coverage, like a high-risk pool. But health law expert Tim Jost points out that states don’t have to use their stability funds to create high-risk pools, which means these people could find themselves out of luck. ‘The idea was people who fall through the cracks would have a high-risk pool,’ he says. ‘What happens though if a state uses their money for reinsurance instead?’” [Vox, [4/25/17](#)]

High-Risk Pools Are Meant To Separate Healthy Customers From Those With Pre-Existing Conditions To Make Insurance Available To All And Cheaper For Most

Under A High-Risk Pool System, Patients With Pre-Existing Conditions Are Placed In Their Own Government-Subsidized Pool, Which Allows Lower Premiums For Healthy People Who Are No Longer In The Same Pool As Sick People. According to NPR, “The argument in favor of high-risk pools goes like this: Separate the healthy people, who don't cost very much to insure, from people who have pre-existing medical conditions, such as a past serious illness or a chronic condition. Under GOP proposals, this second group, which insurers fear might be expected to use more medical care, would be encouraged to buy health insurance through high-risk insurance pools that are subsidized by states and the federal government.” [NPR, [2/18/17](#)]

HIGH-RISK POOLS HAVE BEEN TRIED BEFORE WITH LITTLE SUCCESS

35 States Had High-Risk Pools Before The ACA Required Insurers To Cover People With Pre-Existing Conditions, And The Programs Were Largely Unsuccessful

State-Based High-Risk Pools Have A History Of High Premiums, Insufficient Revenue, High Deductibles, And Low Coverage Limits

State-Based High-Risk Pools Have A History Of High Premiums, Insufficient Revenue, High Deductibles, And Low Coverage Limits. According to Jean P. Hall of the Commonwealth Fund, “Recent proposals to replace ACA reforms with high-risk pools focus on using state-based programs, but historical experience with 35 state-based high-risk pools and more recent experience with the national Pre-Existing Condition Insurance Plan (PCIP) illustrate the problems with this approach. Even though state-based high-risk pools charged premiums of up to 250 percent of those charged to healthy beneficiaries in the individual insurance market, premium revenues paid just 53 percent, on average, of program costs. In addition to these high premiums, enrollees in state-based high-risk pools faced annual deductibles as high as \$25,000 and annual coverage limits as low as \$75,000.¹ Past research indicated that high costs and limited benefits associated with high-risk pool coverage resulted in delayed or forgone care and adverse outcomes for enrollees. Many also accrued medical debt despite having insurance.” [Jean P. Hall – Commonwealth Fund, [2/13/15](#)]

University Of Kansas Researcher Jean Hall: “What We Found In Kansas Was That Premiums Were Very High And The Coverage Was Very Limited.” According to KMUW, “Among other challenges, Marshall and others trying to sell the Republican plan have a rhetorical problem. They have to reassure people that scary-sounding ‘high-risk pools’ are better than ‘guaranteed issue’ provision in Obamacare. It prohibits insurance companies from denying coverage to people with pre-existing health conditions. ‘They do not work very well, unfortunately,’ says Jean Hall, a University of Kansas researcher who has written extensively about high risk pools for several national health policy organizations. Before Obamacare, 35 states – including Kansas and Missouri – operated such pools. But, Hall says, a combination of high-premiums, thin coverage and enrollment limits often made them ineffective. ‘What we found in Kansas was that premiums were very high and the coverage was very limited,’ Hall says. ‘So, you have people with chronic conditions who don’t have access to very comprehensive care.’ Studies found that only a fraction of the people who needed high-risk pool coverage were able to afford it.” [KMUW, [3/8/17](#)]

High-Risk Pools Are Expensive For States To Administer, Necessitating Strict Eligibility Requirements And Waiting Lists

Commonwealth Fund: High-Risk Pools “Are Prohibitively Expensive To Administer.” According to Jean P. Hall of the Commonwealth Fund, “In fact, the risk pools are suggested as a viable alternative to the ACA’s ban on preexisting condition exclusions in the individual market and the marketplaces. My recent analysis of high-risk pools, however, explains why these entities simply are not a realistic alternative to coverage requirements under the ACA. In a nutshell, high-risk pools: 1. are prohibitively expensive to administer, 2. are prohibitively expensive for consumers to purchase, and 3. offer much less than optimal coverage, often with annual and lifetime limits, coverage gaps, and very high premiums and deductibles.” [Jean P. Hall – Commonwealth Fund, [2/13/15](#)]

Kaiser Family Foundation: “Because Most States Do Not Have Sufficient Funding To Cover Everyone Who Needs Coverage, States Are Forced To Implement Enrollment Caps And Strict Eligibility Requirements. According to the Kaiser Family Foundation, “High-risk pools are also extremely expensive for states to operate. Because most states do not have sufficient funding to cover everyone who needs coverage, states are forced to implement enrollment caps and strict eligibility requirements, purposely limiting enrollment. Although the California high-risk pool does not currently have a wait list, it had a wait list for most of its existence because state funding comes from tobacco taxes. Enrollment is currently capped at 7,100 enrollees. Illinois also had a wait list in 2004 and 2005 and Florida’s high-risk pool has been closed to new enrollment since 2001. Nationally, the Government Accountability Office estimates that 3.97 million people may be eligible for state high-risk pools based on their uninsured status and pre-existing health conditions.” [Kaiser Family Foundation, January [2010](#)]

Richard Figueroa, Who Worked For California’s High-Risk Program, Said Its Lack Of Funding Meant “People Would Literally Pass Away While They Were On The Waiting List.” According to Kaiser Health News, “Now President-elect Donald Trump and Republican Congressional leaders say they want to revive high-risk insurance pools for the sick or uninsurable. But some California health officials and policy experts say that would be a big step backward — to a state program that offered long waits for coverage, high prices, limited benefits and few health plan choices. ‘People would literally pass away while they were on the waiting list,’ said Richard Figueroa, who was one of the original staff members of California’s program, the Major Risk Medical Insurance Program (MRMIP), when it started in the early 1990s. Later, he served on the governing agency’s board before it was dissolved under the Affordable Care Act. The program never had enough money to cover the need among the uninsured, Figueroa said. It had a \$30 to \$40 million budget in a given year, mostly from tobacco tax revenue. Figueroa said the limit on how many people could enroll declined over the years in part because costs kept rising. In 2011, fewer than 7,000 people were enrolled. In the 1990s, thousands of people languished on waiting lists, Figueroa said. When their turn came for coverage, some people found they couldn’t afford the monthly premium.” [Kaiser Health News, [11/23/16](#)]

High-Risk Pools Make Insurance Too Expensive For Many To Purchase

Commonwealth Fund: High-Risk Pools “Are Prohibitively Expensive For Consumers To Purchase.”

According to Jean P. Hall of the Commonwealth Fund, “In fact, the risk pools are suggested as a viable alternative to the ACA’s ban on preexisting condition exclusions in the individual market and the marketplaces. My recent analysis of high-risk pools, however, explains why these entities simply are not a realistic alternative to coverage requirements under the ACA. In a nutshell, high-risk pools: 1. are prohibitively expensive to administer, 2. are prohibitively expensive for consumers to purchase, and 3. offer much less than optimal coverage, often with annual and lifetime limits, coverage gaps, and very high premiums and deductibles.” [Jean P. Hall – Commonwealth Fund, [2/13/15](#)]

Craig Britton Of Minnesota Had Insurance Through His State’s High-Risk Pool, Which Cost Him \$18,000 Per Year In Premiums. According to NPR, “Craig Britton of Plymouth, Minn., once had a plan through the state’s high-risk pool. It cost him \$18,000 a year in premiums. Britton was forced to buy the expensive MCHA coverage because of a pancreatitis diagnosis. He calls the idea that high-risk pools are good for consumers ‘a lot of baloney.’ ‘That is catastrophic cost,’ Britton says. ‘You have to have a good living just to pay for insurance.’ And that’s the problem with high-risk pools, says Stefan Gildemeister, an economist with Minnesota’s health department. ‘It’s not cheap coverage to the individual, and it’s not cheap coverage to the system,’ Gildemeister says.” [NPR, [2/18/17](#)]

Eighty Percent Of Uninsured People With Pre-Existing Conditions Before The ACA Made Below 400 Percent Of The Federal Poverty Level, Which Made Affording Coverage In High-Risk Pools Difficult. According to Jean P. Hall of the Commonwealth Fund, “For these reasons, use of high-risk pools in lieu of marketplace and Medicaid expansion coverage would result in greater state and federal costs, fewer people with preexisting conditions able to obtain coverage, and coverage that fails to meet the often greater needs of people with chronic conditions. Affording coverage would be particularly difficult for people with incomes below 400 percent of the federal poverty level, who accounted for 80 percent of the uninsured population with preexisting conditions prior to implementation of the ACA.” [Jean P. Hall – Commonwealth Fund, [2/13/15](#)]

The ACA Created A Temporary High-Risk Pool On The Federal Level, Which Also Failed To Keep Costs Down

Commonwealth Fund: “The ACA Also Created A Temporary High-Risk Pool To Cover People Unable To Obtain Coverage Because Of Their Preexisting Conditions,” Which Was “Designed To

Serve As Bridge Coverage Until The 2014 Insurance Reforms And Expansions Were In Place.”

According to The Commonwealth Fund, “The ACA also created a temporary high-risk pool to cover people unable to obtain coverage because of their preexisting conditions. This national pool, which came to be known as the Pre-Existing Condition Insurance Plan (PCIP), was designed to serve as bridge coverage until the 2014 insurance reforms and expansions were in place. The legislation allocated \$5 billion to cover the costs of PCIP coverage from its inception in mid-2010 through December 31, 2013. The legislation also mandated that assistance be provided to PCIP enrollees to help them find coverage in the DECEMBER 2014 2 The Commonwealth Fund marketplaces, via Medicaid expansion, or elsewhere in the last quarter of 2013. States were given the option of administering their own PCIP programs or allowing the federal government to do so. By late 2010, 27 states had elected to run their own programs and 23 states and the District of Columbia had elected to have the federal government administer PCIP for their residents.” [Commonwealth Fund, December [2014](#)]

The ACA’s High-Risk Pool Program Was Subject To Fewer Cost-Sharing Rules Than Plans On The ACA Marketplace To Make Up For The High Cost Of Covering High-Risk Patients.

According to The Commonwealth Fund, “Due to the high costs associated with having a pool of enrollees with serious health conditions, PCIP programs were allowed to contain costs through a variety of measures that are not allowed to be used by plans operating in the marketplaces. These include imposing cost-sharing on preventive services, charging higher premiums for women, and implementing annual or lifetime coverage caps and dollar or number caps on some kinds of visits.⁵ PCIP plans also were not required to have parity for mental health services, as marketplace plans are required to do.⁶ Finally, age rating was capped at a 4:1 ratio for older versus younger enrollees, which is greater than the 3:1 ratio allowed for marketplace plans. Thus, older enrollees in PCIP—and PCIP enrollment skewed toward older enrollees due to their higher incidence of chronic conditions—paid relatively more for coverage than older consumers in the marketplaces.” [Commonwealth Fund, December [2014](#)]

- **Commonwealth Fund: “Despite These Cost-Saving Measures, PCIP Coverage Was Still Very Expensive For Both Enrollees And Administrators.”** According to The Commonwealth Fund, “Despite these cost-saving measures, PCIP coverage was still very expensive for both enrollees and administrators.” [Commonwealth Fund, December [2014](#)]
- **“Annual Premiums Could Be As High As \$12,264 For A 50-Year-Old Person— More Than Half Of The Annual Income Of Someone Making Twice The Federal Poverty Level In 2014.”** According to The Commonwealth Fund, “One study detailed potential out-of-pocket costs for individuals with varying levels of health care utilization in the federally administered PCIP program and selected state-administered PCIP programs.⁷ Annual premiums could be as high as \$12,264 for a 50-year-old person— more than half of the annual income of someone making twice the federal poverty level in 2014.” [Commonwealth Fund, December [2014](#)]
- **“The Average Expenditure In 2012 Per PCIP Enrollee Was \$32,108, Indicating That The Program Cost Far More Than It Generated In Premiums.”** According to The Commonwealth Fund, “At the same time, the average expenditure in 2012 per PCIP enrollee was \$32,108, indicating that the program cost far more than it generated in premiums. One state had a per enrollee cost of \$171,909.⁸ State high-risk pools have historically had similar challenges. Even though premiums in state high-risk pools range from 100 percent to 250 percent of standard risk rates (average rates charged to others in Why a National High-Risk Insurance Pool Is Not a Workable Alternative 3 the state’s individual insurance market), premiums on average paid just 53 percent of program costs in 2011.” [Commonwealth Fund, December [2014](#)]

Commonwealth Fund: A National High-Risk Pool Would Make Coverage “Unaffordable For People With Incomes Below 400 Percent Of The Federal Poverty Level” And Would “Likely Be More

Limited In Scope Than That Required For Marketplace Plans.” According to The Commonwealth Fund, “As the exhibit shows, national high-risk pool coverage would be unaffordable for people with incomes below 400 percent of the federal poverty level. Moreover, based on the PCIP and state high-risk pool experiences, the coverage individuals could obtain through such a high-risk pool would likely be more limited in scope than that required for marketplace plans.” [Commonwealth Fund, December [2014](#)]

Commonwealth Fund: The ACA High-Risk Pool Program “Provides A Useful Example Of The Types Of Enrollees And Costs Associated With A National High-Risk Pool.” According to The Commonwealth Fund, “The PCIP experience provides a useful example of the types of enrollees and costs associated with a national high-risk pool. Unquestionably, PCIP fulfilled its intended purpose of providing critically needed coverage to people with serious and often life-threatening conditions on a short-term basis.¹⁵ Even with premiums set at standard rates for the individual market, however, PCIP coverage was too expensive for many uninsured individuals with preexisting conditions, and subsidies were not available for low-income enrollees.¹⁶ This situation likely contributed to adverse selection in the program because people with high needs were more likely to pay the relatively high premiums. Enrollees also tended to be older, even though younger individuals are much more likely to be uninsured. Sixtytwo percent were ages 45 and older, reflecting the fact that people are more likely to develop serious health conditions as they age.¹⁷ Owing at least in part to this adverse selection, PCIP program costs were much higher than anticipated.¹⁸ Indeed, in February of 2013, PCIP programs were directed to cease new enrollment to ensure that sufficient funds would be available for the remaining life of the program.” [Commonwealth Fund, December [2014](#)]

The Bill Made It Less Likely That States Would Require Insurers To Cover Essential Health Benefits

THE AMENDED BILL WOULD ALLOW STATES TO OPT OUT OF COVERING ESSENTIAL HEALTH BENEFITS IF THEY COULD PROVE DOING SO WOULD LOWER PREMIUMS

The Amendment Would Allow States To Opt Out Of The ACA’s Essential Health Benefits Requirement And Limits On What Older Enrollees Could Be Charged. According to Vox, “States could also opt out of Obamacare’s essential health benefits requirement. This is the core set of medical services that the Affordable Care Act requires all insurers to cover, including things like doctor trips, hospital stays, maternity care, and mental health services. These two Obamacare requirements have been at the top of the Freedom Caucus’s hit list for some time. They also tack a third regulation they want to dismantle onto the list in this new amendment, the one that limits what premiums insurers can charge older enrollees.” [Vox, [4/25/17](#)]

States Would Be Able To Opt Out Of The Requirements If They Could Show Doing So Would Lower Premium. According to Vox, “States could also opt out of Obamacare’s essential health benefits requirement. This is the core set of medical services that the Affordable Care Act requires all insurers to cover, including things like doctor trips, hospital stays, maternity care, and mental health services. [...] The GOP amendment would allow states to opt out of these provisions if they show that the change would lead to ‘reducing average premiums for health insurance coverage in the State.’” [Vox, [4/25/17](#)]

Essential Benefits Are 10 Services The Affordable Care Act Required All Insurance Plans To Cover

The Affordable Care Act Required Health Insurance Plans To Cover “A Set Of 10 Categories Of Services,” Known As “Essential Health Benefits.” According to Healthcare.gov, “Essential Health Benefits” are “A set of 10 categories of services health insurance plans must cover under the Affordable Care

Act. These include doctors' services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, mental health services, and more. Some plans cover more services. Plans must offer dental coverage for children. Dental benefits for adults are optional." [HealthCare.gov, accessed [3/24/17](#)]

THE LOWER PREMIUM STANDARD WOULD BE EASY TO MEET, SINCE PLANS WOULD BE ALLOWED TO COVER FEWER SERVICES

States Would Be Able To Opt Out Of The Requirements If They Could Show Doing So Would Lower Premium Costs – An Easy Standard To Meet, Since Plans Would Be Allowed To Cover Fewer Services. According to Vox, "The GOP amendment would allow states to opt out of these provisions if they show that the change would lead to 'reducing average premiums for health insurance coverage in the State.' If the federal government took no action when these applications came in, the waivers would be automatically approved after 60 days. This does not set an especially high bar for this waiver option. It means that states could, for example, end the essential health benefits requirement because they believe it will lower premium costs. And of course it would! Tell insurers they no longer have to cover expensive mental health services or maternity care, and average prices would almost certainly drop. The same would happen if insurers had the option to charge sick patients prices they couldn't afford. Those people would drop out of the market, and premiums would decline." [Vox, [4/25/17](#)]

THE ACA'S ESSENTIAL BENEFITS INCLUDE COVERAGE FOR EMERGENCY ROOM TRIPS, MATERNITY CARE, SUBSTANCE ABUSE TREATMENT, AND OTHER BASIC SERVICES

Essential Health Benefits Include Coverage For:

- **Outpatient Care.** According to NBC News, "Outpatient Care — This covers most scheduled doctor visits, such as to check a rash, or a non-emergency stomach ache. Insurance companies negotiate deals for these and often designate 'networks' of doctors and clinics with approved charges. Individuals who walk in without coverage pay much, much more." [NBC News, [3/24/17](#)]
- **Emergency Room Trips.** According to NBC News, "Emergency room trips — Insurance policies cover both the ER visit and ambulance trips. Otherwise people can get socked with bills totaling tens of thousands of dollars, perhaps incurred while they were unconscious." [NBC News, [3/24/17](#)]
- **In-Hospital Care.** According to NBC News, "In-hospital care — All care people get as hospital patients, such as surgery. Some conservatives argue that people should be able to choose to opt out of this type of coverage and pay lower premiums. Most health policy experts say this is a gamble. 'One answer is because someday you may be sick and that's the way that insurance works,' says David Cutler, a Harvard University economics professor who helped design the Affordable Care Act." [NBC News, [3/24/17](#)]
- **Pregnancy, Maternity, And Newborn Care.** According to NBC News, "Pregnancy, maternity and newborn care — This one's controversial to some, who ask why men should pay for a service they'll never use. 'It is true that women get pregnant but men kind of help them get pregnant,' Cutler said. Pre-ACA, 62 percent of people with non-group policies had no maternity benefit." [NBC News, [3/24/17](#)]
- **Mental Health And Substance Abuse Treatment.** According to NBC News, "Mental health and substance abuse disorder services — This particular benefit has gotten some attention with the

ongoing opioid epidemic. Before the ACA, 18 percent of non-group policies left off mental health benefits.” [NBC News, [3/24/17](#)]

- **Prescriptions.** According to NBC News, “Prescription drugs — Insurance companies usually negotiate discounts. Out of pocket costs for many drugs can be much higher than what an insurer pays for them.” [NBC News, [3/24/17](#)]
- **Rehabilitation Services.** According to NBC News, “Rehabilitative services and habilitative services. These include help recovering from an injury or illness, but also treatment for kids with autism or cerebral palsy.” [NBC News, [3/24/17](#)]
- **Lab Tests.** According to NBC News, “Lab tests.” [NBC News, [3/24/17](#)]
- **Mammograms, Colonoscopies, Birth Control, And Other Preventive Services.** According to NBC News, “Preventive services — This includes vaccines, cancer screenings such as mammograms and colonoscopies and, controversially, coverage of birth control.” [NBC News, [3/24/17](#)]
- **Pediatric Services.** According to NBC News, “Pediatric services — Including dental and vision care for children.” [NBC News, [3/24/17](#)]

REQUIRING INSURERS TO COVER ESSENTIAL BENEFITS MEANS AMERICANS NO LONGER END UP PAYING FOR PLANS THAT OFFER LITTLE ACTUAL COVERAGE

Vox: EHBs Ensured “Insurance Policies On The Individual And Small Group Markets Finally Covered The Core Set Of Benefits That Come Through Standard Employer Plans Or Through Medicare Or Medicaid,” And “Meant An End To All The Shoddy Insurance Plans That Lacked The Basics.” According to Julia Belluz in Vox, “So where did the idea for the EHBs come from? They mostly came about to address problems in the insurance risk pool that other parts of the health law created. [...] This also made health insurance more equitable. The average cost of plans went up, but more people could access more care. Insurance policies on the individual and small group markets finally covered the core set of benefits that come through standard employer plans or through Medicare or Medicaid. It also meant an end to all the shoddy insurance plans that lacked the basics.” [Julia Belluz – Vox, [3/24/17](#)]

Vox: “So The EHB Requirement Put An End To The Very Skimpy Plans That Allowed People To End Up In A Hospital And Leave With Massive Bills Because Their Hospital Stays Weren’t Covered.” According to Julia Belluz in Vox, “So the EHB requirement put an end to the very skimpy plans that allowed people to end up in a hospital and leave with massive bills because their hospital stays weren’t covered. And it meant new moms who were buying insurance on the individual marketplace didn’t have to worry about where their health care would come from.” [Julia Belluz – Vox, [3/24/17](#)]

Larry Levitt Of The Kaiser Family Foundation: “The EHBs In The ACA Were In Part A Reaction To The Fact That Some Insurance Plans Previously Had Holes In Them And People Didn’t Know Or Even Understand The Gaps They Were Buying Into.” According to Julia Belluz in Vox, “‘The EHBs in the ACA were in part a reaction to the fact that some insurance plans previously had holes in them,’ said Larry Levitt, senior vice president for special initiatives at the Kaiser Family Foundation. ‘And people didn’t know or even understand the gaps they were buying into.’” [Julia Belluz – Vox, [3/24/17](#)]

WITHOUT AN ESSENTIAL BENEFITS REQUIREMENT, INSURERS WOULD BE INCENTIVIZED TO RAISE PRICES ON PLANS WORTH HAVING

Former Chief Economist Of The Council Of Economic Advisors Matthew Fiedler: “Without These Requirements, You Are Looking At An Individual Market Where The Only Policies Available Are Extremely Skimpy Or Expensive.” According to Julia Belluz in Vox, “‘Without these requirements, you are looking at an individual market where the only policies available are extremely skimpy or expensive,’ said Matthew Fiedler, a fellow at Brookings who served as chief economist of the Council of Economic Advisors, where he oversaw work on the Affordable Care Act. In the past, insurers had strong incentives to design plans in ways that were unattractive to people with predictable health needs or sick people. And getting rid of the essential health benefits, Fiedler said, ‘would give them a powerful tool to avoid people that expect to need care.’” [Julia Belluz – Vox, [3/24/17](#)]

Without An Essential Health Benefits Requirement, Only Patients Who Need Coverage For Specific Services Will Buy Packages That Include Those Services, Driving Up The Prices For Coverage Of Those Services. According to The Atlantic, “The problem is that if coverage of needs such as maternity care or mental health is not included in all policies, the only people likely to buy it a la carte are those who expect to use it. And that will rapidly raise the cost of such coverage—if insurers offer it at all. ‘The losers would generally be people who want to buy a comprehensive insurance policy,’ said Sabrina Corlette, a research professor at the Center on Health Insurance Reforms at Georgetown University. ‘Because once you give carriers flexibility to design the benefit package, they will do so to attract healthy people. No chump insurance company is going to be out there offering a comprehensive package, because then they’ll be stuck with higher-risk enrollees.’” [The Atlantic, [3/23/17](#)]

Example: Before Maternity Care Coverage Was Required, Insurers Charged High Prices For It Because They Knew Only Women Expecting To Need It Would Buy It

The Atlantic: Before Maternity Care Coverage Was Required, Insurers Charged High Prices For It Because They Knew Only Women Expecting To Need It Would Buy It. According to The Atlantic, “Maternity care captures the dilemma. Before the ACA, experts note, it was rarely available at all and prohibitively expensive when it was, because insurers expected that anyone who purchased it was intending to have a child and thus planned to access the benefits. Such a concentration of users undermines the essence of insurance, which is to pool those at higher- and lower-risk of employing the coverage.” [The Atlantic, [3/23/17](#)]

Older Americans, Who Are Likely To Need Robust Coverage, Would Be Hit Harder By Rising Prices Than Younger Americans, Who Are More Likely To Get By On A Bare-Bones Plan

Older Americans, Who Are More Likely To Need Comprehensive Coverage, Would Be Hit Harder By Rising Prices Than Younger Americans, Who Are More Likely To Get By On A Bare-Bones Plan. According to The Atlantic, “In its analysis of the original bill, the Congressional Budget Office concluded it would lower premiums for younger and healthier consumers, but substantially raise them for people with greater health needs—particularly older, working-age adults. [...] Repealing the essential health benefits would intensify this cost shifting, which already threatens to impose the greatest harm on those older, working-age adults who are a predominantly white, Republican-leaning constituency. Whites over 45 provided a majority of Trump’s votes last November and about 60 percent of House Republicans represent districts older than the national average. The benefits repeal would allow insurers to court younger and healthier people with plans that are less expensive but much skimpier—which would probably satisfy many of those consumers unless and until they have a major health need. ‘Winners will be those who are healthy and

looking for low-premium plans,' Corlette said. 'Of course, those folks will need to have savings on hand in case anything serious does happen to them.'" [The Atlantic, [3/23/17](#)]

- **The Atlantic: As Prices Rise On Comprehensive Plans And Drive Away Healthy People, Further Increasing Prices, The Market Will Enter A "Death Spiral."** According to The Atlantic, "But as those healthier consumers withdraw from the larger risk pool to switch to more threadbare plans, enrollment in the remaining comprehensive plans would tilt further toward those with greater health needs. That creates the classic conditions for what insurance experts call a 'death spiral': As the risk pool for a plan includes more and more expensive customers, insurance companies must raise the price, which further drives away those who are least likely to use the service, undermining the economics even more." [The Atlantic, [3/23/17](#)]

ESSENTIAL HEALTH BENEFITS MAKE IT POSSIBLE TO COVER PATIENTS WITH PRE-EXISTING CONDITIONS

Requiring Insurers To Cover Americans With Pre-Existing Conditions Necessitated Everyone In The Risk Pool Purchasing A Minimum Package Of Benefits. According to Julia Belluz in Vox, "So where did the idea for the EHBs come from? They mostly came about to address problems in the insurance risk pool that other parts of the health law created. The ACA said insurers could no longer discriminate against people on the basis of their health — so they could no longer deny someone coverage because they were sick with a 'preexisting condition.' The law's individual mandate also required everybody to buy insurance. So all Americans were suddenly eligible for insurance, including sick people, and everybody had to buy coverage. But no insurance company would want to attract all the sick or expensive people looking for the kind of comprehensive coverage they would need. To even out the playing field and standardize what types of insurance people had to buy, the ACA included this pretty high level list of benefits. Plans on the individual and small-group marketplace had to cover these basics, and do so at standardized levels of generosity, known as the metallic tiers including bronze, silver, gold, and platinum. (As Brookings explained, each tier has a higher value and covers more of the expected spending: from 60 percent in the bronze plans to 90 percent for platinum plans.) This made the individual marketplace more viable. Requiring everyone to pay a little more for the EHBs evened out the risk among insurers who suddenly had to take on sick people." [Julia Belluz – Vox, [3/24/17](#)]

- **Linda Blumberg, Senior Fellow At The Urban Institute's Health Policy Center: "This Is A Risk Pooling Issue. It Makes Sure Everybody Has Affordable Access To This Array Of Benefits."** According to Julia Belluz in Vox, "'This is a risk pooling issue,' said Linda Blumberg, a senior fellow in the Health Policy Center at the Urban Institute. 'It makes sure everybody has affordable access to this array of benefits, and that way the cost of providing those services is shared across this larger pool of people.'" [Julia Belluz – Vox, [3/24/17](#)]

Without Essential Health Benefits Requirements, There Would Be No Guarantee That Insurers Would Offer Patients With Pre-Existing Conditions Plans That Covered The Services They Needed, Even If Insurers Were Not Allowed To Deny Those Patients Coverage Outright. According to The Atlantic, "By allowing insurance companies to limit what they cover, many experts note, the House bill would undermine its promise to maintain the ACA requirement that the firms provide coverage to all consumers regardless of preexisting conditions. Even with a statutory ban on discriminating based on preexisting health problems, insurers could effectively segment out those with major needs by offering policies that do not cover the treatments they require. 'Preexisting-condition protections are empty promises without EHB,' wrote Blumberg, referring to the ACA's essential health benefits. 'I can't get rejected for having cancer, but you don't have to cover my chemotherapy drugs, my radiation therapy, etc. ... It throws more and more of the costs of health care back on people when they need to use services.'" [The Atlantic, [3/23/17](#)]

REMOVING THE ESSENTIAL BENEFITS REQUIREMENT COULD COST THE FEDERAL GOVERNMENT MONEY IN THE LONG RUN

Michael Hiltzik In The LA Times: Removing The Essential Health Benefits Requirement Would Lower Average Premiums, But Raise Premiums Dramatically For People Who Need Essential Services And “Transfer Much Of The Cost To Other Public Programs.” According to Michael Hiltzik in the Los Angeles Times, “David Anderson of Duke points us to a recent paper by Milliman, the preeminent cost-analysis firm in healthcare, about how much these essential benefits actually add to the cost of health insurance and the consequences of removing the mandates. The paper finds that eliminating the most vulnerable mandates, such as maternity care, will reduce average premiums somewhat but drive costs for people who need those services sky-high and transfer much of the cost to other public programs. The net gain for society is almost invisible. To put it another way, the savings are an illusion. In fact, eliminating the mandates might even cost the federal government more money.” [Michael Hiltzik – Los Angeles Times, [3/22/17](#)]

Hiltzik: Repealing Essential Health Benefits Requirements Would Result In Customers Using Their Tax Credits To Buy Inadequate Insurance. According to Michael Hiltzik in the Los Angeles Times, “But what if regulators don’t step in, and consumers become less discriminating or more desperate? That could lead to a market chockablock with meager health plans—and to higher costs for the government. How? With no government standard established for what needs to be included for a health plan to qualify for the subsidy, insurers would offer plans that are skimpy, but priced just low enough to be covered by the tax subsidies that are part of the GOP repeal bill. Perversely, more Americans would use their subsidies — to buy lousier insurance. This would be the worst of all possible worlds: more federal spending, on crappy coverage that doesn’t really protect its buyers from risk.” [Michael Hiltzik – Los Angeles Times, [3/22/17](#)]

Kellogg Schools Of Business Health Economist Craig Garthwaite: “If You Allow The Essential Health Benefits To Go Away, You Will Have Lower Premiums Because It’s A Skinnier Product.” According to Vox, “‘If it could be shown that states could lower premiums on an identical policy, that would be one thing, but that is not the metric being used here,’ [Northwest University Kellogg School of Business health economist Craig] Garthwaite said. ‘If you allow the essential benefits to go away, you will have lower premiums because it’s a skinnier product. The people working on this don’t seem to understand the market ramifications of what they are doing.’” [Vox, [4/25/17](#)]

The Republican Authors Of The Bill Exempted Themselves And Their Staffs From Being Subject To The Waivers

THE REPUBLICAN AUTHORS OF THE BILL EXEMPTED THEMSELVES AND THEIR STAFFS FROM BEING SUBJECT TO THE WAIVERS

The Hill: “A New Amendment To The House Republicans’ ObamaCare Replacement Bill Exempts Members Of Congress And Their Staffs From Its Effects.” According to The Hill, “A new amendment to the House Republicans’ ObamaCare replacement bill exempts members of Congress and their staff from its effects. The new changes to the bill would allow states to apply for waivers for certain ObamaCare provisions, such as a ban on insurers charging premiums based on a customer’s health and the requirement that insurers’ basic health plans cover certain services, like prescription drugs and mental health. The GOP amendment exempts members of Congress and their staffs to ensure that they will still be protected by those ObamaCare provisions. The exemption was flagged by health law professor Tim Jost. Democrats quickly

jumped on the development, arguing that Republicans are willing to take away protections for the general public, but not themselves.” [The Hill, [4/26/17](#)]

Vox: “Republican Legislators Liked” The Provision Allowing Waivers For Pre-Existing Coverage Requirements “Well Enough To Offer It In A New Amendment,” But Not “Enough To Have It Apply To Themselves And Their Staff.” According to Vox, “House Republicans appear to have included a provision that exempts members of Congress and their staff from their latest health care plan. The new Republican amendment, introduced Tuesday night, would allow states to waive out of Obamacare’s ban on preexisting conditions. This means that insurers could once again, under certain circumstances, charge sick people higher premiums than healthy people. Republican legislators liked this policy well enough to offer it in a new amendment. They do not, however, seem to like it enough to have it apply to themselves and their staff. A spokesperson for Rep. Tom MacArthur (R-NJ), who authored this amendment, confirmed this was the case: Members of Congress and their staff would get the guarantee of keeping these Obamacare regulations. Health law expert Tim Jost flagged this particular issue to me.” [Vox, [4/25/17](#)]

A Large Majority Of The American Public Objects To Republican Efforts To Undermine Protections For Pre-Existing Conditions And Essential Health Benefits Coverage

A WASHINGTON POST-ABC NEWS POLL FOUND 70% OF ADULTS IN FAVOR OF PRE-EXISTING CONDITIONS PROTECTIONS AND 62% IN FAVOR OF ESSENTIAL HEALTH BENEFITS REQUIREMENTS

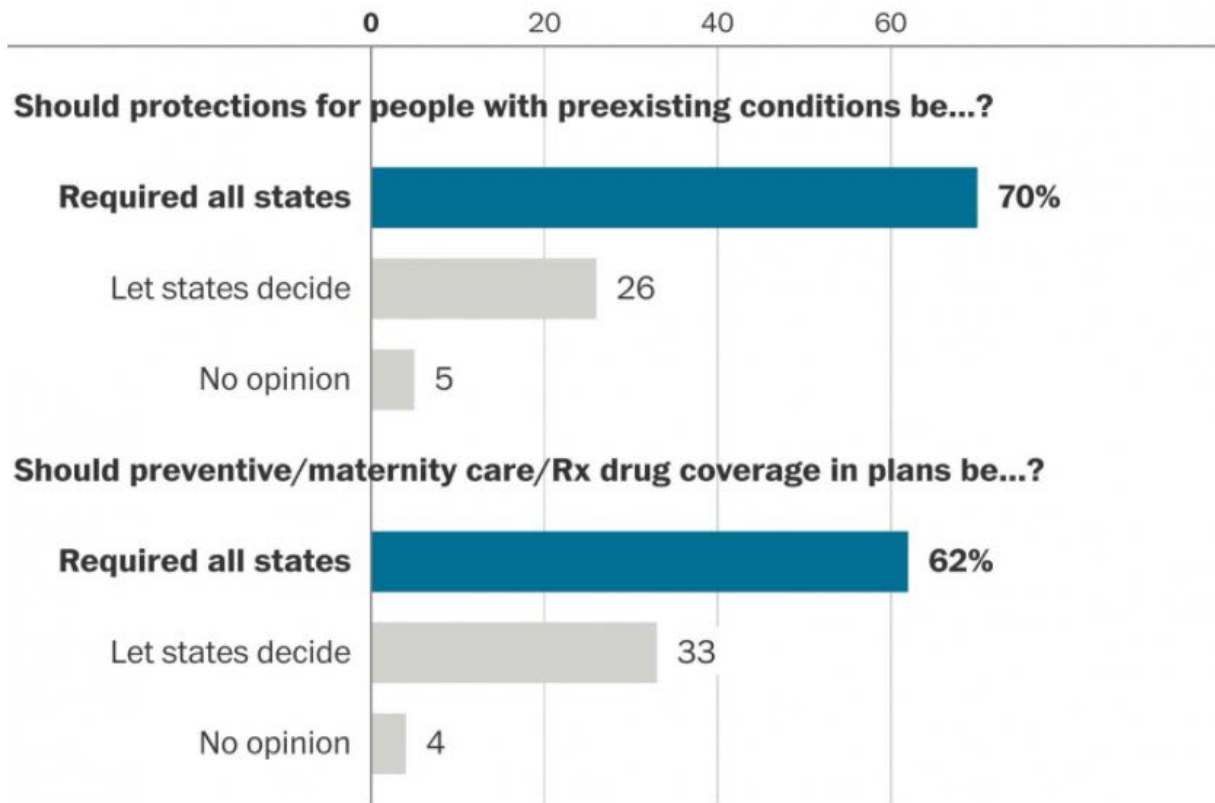
Washington Post: “About 8 In 10 Democrats, 7 In 10 Independents And Even A Slight Majority Of Republicans Say” Protections For Pre-Existing Conditions “Should Continue To Be A National Mandate, Rather Than An Option For States To Retain Or Drop.” According to The Washington Post, “In strategy and substance, the American public disagrees with the course that President Trump and congressional Republicans are pursuing to replace the Affordable Care Act with conservative policies, according to a new Washington Post-ABC News poll. Large majorities oppose the ideas at the heart of the most recent GOP negotiations to forge a plan that could pass in the House. These would allow states to choose whether to keep the ACA’s insurance protection for people with preexisting medical problems and its guarantee of specific health benefits. Public sentiment is particularly lopsided in favor of an aspect of the current health-care law that blocks insurers from charging more or denying coverage to customers with medical conditions. About 8 in 10 Democrats, 7 in 10 independents and even a slight majority of Republicans say that should continue to be a national mandate, rather than an option for states to retain or drop.” [Washington Post, [4/25/17](#)]

Washington Post: 62 Percent Of American Support Essential Health Benefits Requirements.

According to The Washington Post, “The survey finds 62 percent of Americans also support keeping federal requirements that many plans cover preventive services, maternity and pediatric care, hospitalization and prescription drugs, while 33 percent say states should decide what, if any, minimum coverage should be provided. Just under half of Republicans (46 percent) favor federal requirements, with support at 67 percent among independents and 80 percent among Democrats.” [Washington Post, [4/25/17](#)]

Most support nationwide mandates on preexisting conditions, minimum benefits in health insurance coverage

Results among U.S. adults.



Note: Percentages may not add to 100 due to rounding. See full question wording at wapo.st/pollarchive

Source: Washington Post-ABC News poll conducted April 17-20. Questions above asked of 490-511 respondents; the margin of sampling error is plus or minus five points.

[Washington Post, [4/25/17](http://www.washingtonpost.com/2017/04/25/)]