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Fact Checking Claims About the MacArthur Amendment

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The MacArthur Amendment to the House Republicans' Affordable Care Act (ACA) repeal bill would eliminate key ACA protections for people with pre-existing health conditions by allowing states to waive both the ACA's standards for what health benefits insurance plans must offer and its prohibition on charging people more based on their medical history. Just like before the ACA, insurers could discriminate based on medical history, eliminate coverage for key health services, and impose annual and lifetime limits on benefits, except in states that chose to prohibit these practices — which few chose to do before the ACA. This brief report corrects a number of false claims made by supporters of the amendment.

Claim: Pre-existing conditions protections would remain for most people, since they'd only go away if states sought waivers to drop them.

REALITY: The amendment would end nationwide protections for people with pre-existing conditions and restore the pre-ACA status quo.

Before the ACA, states always had the option to protect people with pre-existing conditions, but very few did: 43 states plus Washington, D.C. let insurers charge people more based on their medical history. Even in the other seven states, benefit standards were generally much weaker than they are today. Plans could exclude coverage for maternity care, mental health treatment, or other key services.

That's because robust protections for people with pre-existing conditions weren't sustainable for states without the rest of the ACA package: an individual mandate and subsidies that keep individual-market premiums affordable. Without a mandate and subsidies, states that tried to implement pre-existing conditions protections found that premiums rose and markets were unstable due to adverse selection, with healthy people largely leaving the risk pool. And the House ACA repeal bill would largely dismantle those other ACA elements, by repealing the mandate and deeply cutting subsidies, leading to rising premiums and sharp increases in consumers' out-of-pocket costs. That, in turn, would pressure states to seek waivers to eliminate the ACA's pre-existing conditions protections and benefit requirements. Insurers would also probably press states to seek waivers — and could threaten to stop offering individual market plans if they didn't. While waivers would lower premiums for healthy people at the expense of the sick, they would likely strike many states as the only option to stabilize their individual markets if the rest of the House bill became law.

For more:
http://www.cbpp.org/blog/macarthur-amendment-would-mean-return-to-pre-aca-law-for-people-with-pre-existing-conditions

Claim: The amendment protects people with pre-existing conditions because states can't waive the requirement that insurers at least offer them coverage.

REALITY: Exorbitant premiums and coverage exclusions are no different in practice from coverage denials.

It's true that, even in states with waivers, insurers would have to offer coverage to people with pre-existing conditions. But they could meet that requirement by offering plans with unaffordable premiums of thousands or tens of thousands of dollars per month, or plans that exclude coverage for hospitalizations, prescription drugs, mental health, or other services that people with pre-existing conditions need. For consumers, an offer like that is no different than a coverage denial.

For example, the Center for American Progress estimates that, if insurers charged people the full cost of their pre-existing conditions, that would mean annual surcharges of $140,510 for people with metastatic cancer, $17,060 for people who are pregnant, $8,370 for people with depression, and $20,140 for people with substance use disorders. Costs that high would put coverage out of reach for many or most moderate-income people with serious health needs.

For more:
https://www.americanprogress.org/issues/healthcare/news/2017/04/20/430858/latest-aca-repeal-plan-explode-premiums-people-pre-existing-conditions/

Claim: States that wanted waivers would have to prove that they'd help people with pre-existing conditions stay covered.

REALITY: Waiver approval would be virtually automatic.

States would receive automatic approvals for waivers within 60 days as long as they *stated* that the waiver would lower premiums, increase coverage, stabilize their markets, stabilize premiums for people with pre-existing conditions, or increase the choice of plans. There would be no federal review to determine whether the waiver would actually *achieve* any of these goals.

States could only waive the ACA's "community rating" requirement, which prohibits insurers from charging people based on their medical history, if they had a program in place for people with pre-existing conditions. But states could meet that requirement just by participating in the House bill's modestly funded Federal Invisible Risk Sharing Program or by using *any* of the funding in the bill's Patient and State Stability Fund for *any* program that they argue would assist high-risk individuals or stabilize premiums — irrespective of the program's funding levels, benefits, or overall impact.

For more:
http://healthaffairs.org/blog/2017/04/25/the-macarthur-amendment-language-race-in-the-federal-exchange-and-risk-adjustment-coefficients/

Claim: States couldn't waive key ACA protections like prohibitions on annual and lifetime limits or on charging women more than men.

REALITY: Letting states waive essential health benefit standards would *also* let them waive prohibitions on annual and lifetime limits, and it means women would pay more than men.

The ACA prohibits plans from imposing annual or lifetime limits on coverage, but only on coverage of services classified as essential health benefits. Plans can still impose coverage limits on other services (for example, adult dental coverage). So, in states that eliminated or greatly weakened essential health benefits standards, plans could go back to imposing coverage limits on anything from emergency services to inpatient care to prescription drugs — including for people covered through their employer. Before the ACA, 105 million people nationwide had lifetime limits on coverage, 28 million of them children and the vast majority of them with employer coverage. Waiving essential health benefits would also eviscerate the ACA's requirement that plans cap out-of-pocket costs, as that requirement, too, only applies to covered benefits.

Likewise, eliminating essential health benefits standards means that plans could charge more for maternity coverage. In practice, that means women would once again pay more for health insurance than men.

For more:
http://www.cbpp.org/research/health/amendment-to-house-aca-repeal-bill-guts-protections-for-people-with-pre-existing

Claim: High-risk pools would keep coverage affordable for people with pre-existing conditions.

REALITY: High-risk pools have consistently failed to deliver affordable coverage.

High-risk pools combine sick people with even sicker people, rather than pooling sick and healthy people together, as regular insurance does. Before the ACA, many states had high-risk pools, and they came with enrollment caps, long waiting lists, unaffordable premiums, exclusions for pre-existing conditions, high deductibles, benefit caps, and annual and lifetime limits on coverage. They covered only several hundred thousand people nationwide, and even so, generally weren't sustainable for states over time: costs kept rising as the composition of the pools became sicker and sicker. Nothing in the amendment would make high-risk pools work any better than before the ACA.

What's more, high-risk pools aren't even intended to help people with many of the most common pre-existing conditions, just those with the most serious and expensive health issues. The amended House bill would force millions of Americans with pre-existing conditions like asthma, hypertension, or depression to cope with an individual market where insurers could once again charge them unaffordable premiums or offer policies that excluded key health services — without even the inadequate help that high-risk pools could offer.

For more:
http://www.cbpp.org/blog/trump-house-gop-high-risk-pool-proposals-a-failed-approach

Claim: People with pre-existing conditions could only be charged higher premiums if they hadn't maintained continuous coverage.

REALITY: People with pre-existing conditions would pay more, even if they maintained continuous coverage.

Even if that limitation were binding, many people with pre-existing conditions would go unprotected: nearly one-third of people with pre-existing conditions experience a gap in coverage over a two-year period due to job changes, other life transitions, or periods of financial difficulty.

And, in practice, the limitation almost certainly *wouldn't* be binding: people with pre-existing conditions who maintained coverage would still end up being charged more due to the waiver. That's because, in states with waivers, healthy people with continuous coverage could avoid being pooled with sicker, higher-cost individuals. That's because the amendment says that insurers in states with waivers could base premiums on medical history only for people who *fail to show* they have maintained continuous coverage. So if healthy people simply chose not to submit proof of their continuous coverage, insurers would then base their premiums on their medical history, which would qualify them for lower premiums. Sick people with continuous coverage would find themselves pooled mostly with other sick people — and insurers would raise premiums for this group accordingly, to very high levels.

For more:
https://www.brookings.edu/blog/up-front/2017/04/27/new-amendment-to-gop-health-bill-effectively-allows-full-elimination-of-community-rating-exposing-sick-to-higher-premiums/