

REPORT 4 OF THE COUNCIL ON MEDICAL SERVICE (I-17)

Health Insurance Affordability: Essential Health Benefits and Subsidizing the Coverage of High-Risk Patients

(Reference Committee J)

EXECUTIVE SUMMARY

As the House of Representatives and the Senate have been discussing and crafting legislation related to health reform, the Council spent the past year reviewing the substantial body of American Medical Association (AMA) policy pertaining to the AMA proposal for reform, as well as assessing whether to potentially revisit policy on certain health reform issues. The Council has concluded that the preponderance of AMA policy regarding coverage, choice and access remain relevant. However, in its review, the Council determined that it was necessary to revisit and modify policy on essential health benefits and the relative merits of high-risk pools versus reinsurance.

The Council believes there is an opportunity to include additional safeguards in AMA policy to ensure that patients have meaningful coverage that protects them against catastrophic expenses. While the AMA has long supported patient choice of health plan, AMA policy has also stressed that any health insurance purchased must provide meaningful coverage for hospital, surgical and medical care; protect patients against catastrophic expenses; and promote preventive services. AMA policy also underscores that provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations, and that prohibitions on annual and lifetime limits should remain in place under any reform.

The Council notes that most of the health care claims costs associated with essential health benefits (EHB) are attributable to such services as hospital inpatient and outpatient care, physician services, and prescription drugs. These services are arguably viewed as fundamental components of health insurance coverage. Removing any benefits from the EHB requirements, or allowing waivers of such requirements, can cause insurers to cherry pick patients based on the services their plans cover, as well as hinder patient access to necessary services. If insurers are allowed to offer plans with skimpier coverage, plan designs could potentially discriminate against people with pre-existing conditions. In addition, individuals who use services and benefits no longer included in the EHBs could face substantial increases in out-of-pocket costs. As such, the Council is recommending that our AMA oppose the removal of categories from the EHB package. In addition, the Council believes that our AMA should also oppose waivers of EHB requirements that lead to EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses, being eliminated.

In addition, the Council re-evaluated AMA policy with respect to how to best subsidize the costs of high-cost and high-risk patients, who may have pre-existing conditions. Traditional high-risk pools have historically provided individuals with pre-existing conditions with second-class insurance, with waiting periods to get pre-existing conditions covered, higher premiums, potentially high deductibles, and lifetime limits on benefits. Considering the success of the Affordable Care Act's reinsurance program, as well as state reinsurance programs, and in light of finite resources, the Council believes that resources should be directed to reinsurance programs. Reinsurance provides an equitable, fair and cost-effective mechanism to subsidize the costs of high-risk and high-cost patients, and protects patients with pre-existing conditions.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-I-17

Subject: Health Insurance Affordability: Essential Health Benefits and Subsidizing the Coverage of High-Risk Patients

Presented by: Paul A. Wertsch, MD, Chair

Referred to: Reference Committee J
(Peter C. Amadio, MD, Chair)

1 The American Medical Association (AMA) proposal to cover the uninsured and expand choice,
2 used in AMA advocacy leading up to and following the enactment of the Affordable Care Act
3 (ACA) and highlighted in AMA’s Voice for the Uninsured campaign, is based on numerous
4 policies developed and/or refined by the Council on Medical Service, and adopted by the House of
5 Delegates, during the 1990s and 2000s. The proposal removed the bias toward employment-based
6 insurance and promoted a system of individually selected and owned health insurance coverage,
7 using tax credits, individual responsibility, and other market regulations to maximize coverage
8 gains, make coverage affordable, and ensure patient choice of health plan and physicians.
9

10 As the House of Representatives and the Senate have been discussing and crafting legislation
11 related to health reform, the Council spent the past year reviewing the substantial body of AMA
12 policy pertaining to the AMA proposal for reform, as well as assessing whether to potentially
13 revisit policy on certain health reform issues. The Council has concluded that the preponderance of
14 AMA policy regarding coverage, choice and access remain relevant. However, in its review, the
15 Council determined that it was necessary to revisit and modify policy on essential health benefits
16 and the relative merits of high-risk pools versus reinsurance.
17

18 This report provides background on the issues of essential health benefits, high-risk pools and
19 reinsurance; assesses their impact on health insurance affordability; summarizes relevant AMA
20 policy; and presents policy recommendations.
21

22 ESSENTIAL HEALTH BENEFITS

23 *Background*

24
25 Under the ACA, all qualified health benefits plans, with the exception of grandfathered individual
26 and employer-sponsored plans, are required to offer at least the essential health benefits (EHB)
27 package, including those offered in health insurance marketplaces and in the individual and small
28 group markets outside of the marketplaces. The ACA specified that the EHB package must cover
29 the following general categories of services:
30

- 31
- 32 • Ambulatory patient services;
- 33 • Emergency services;
- 34 • Hospitalization;
- 35 • Maternity and newborn care;

- 1 • Mental health and substance use disorder services, including behavioral health treatment;
- 2 • Prescription drugs;
- 3 • Rehabilitative and habilitative services and devices;
- 4 • Laboratory services;
- 5 • Preventive and wellness services and chronic disease management; and
- 6 • Pediatric services, including oral and vision care.

7
 8 The Secretary of the US Department of Health and Human Services (HHS) has the responsibility to
 9 determine the scope of the EHB package, which the ACA specified should be equal to the scope of
 10 benefits under a typical employer-sponsored plan. Regulations addressing EHB stated that EHB
 11 shall be defined by state-specific benchmark plans. HHS also stated that “the EHB-benchmark plan
 12 would serve as a reference plan, reflecting both the scope of services and limits offered by a typical
 13 employer plan in that state.” HHS outlined four benchmark plan options for states:

- 14 • The largest plan by enrollment in any of the three largest small group insurance products in
 15 the state’s small group market;
- 16 • Any of the largest three state employee health benefit plans by enrollment;
- 17 • Any of the largest three national Federal Employees Health Benefits Program (FEHBP)
 18 plan options by enrollment; and
- 19 • The largest insured commercial non-Medicaid health maintenance organization operating
 20 in the state.¹

21
 22
 23 *Impact on Health Insurance Affordability*

24
 25 Concerns have been raised that certain categories of essential health benefits drive up premium
 26 costs. The Council notes that most of the health care claims costs associated with essential health
 27 benefits are attributable to such services as hospital inpatient and outpatient care, physician
 28 services, and prescription drugs. These services are arguably viewed as fundamental components of
 29 health insurance coverage. For example, Milliman estimated that removing maternity coverage
 30 from insurance coverage may lower premiums by \$8 to \$14 per month, depending on geographic,
 31 provider and other factors.² In addition, a recent analysis conducted by RAND researchers
 32 projected that, for 2017, maternity care would account for four percent of per capita insurer
 33 spending, and mental health and substance abuse treatment would account for one percent of per
 34 capita insurer spending. Spending on prescription drugs was projected to be more substantial,
 35 accounting for approximately 22 percent of per capita insurer spending.³

36
 37 The ACA also prohibits annual and lifetime limits, but only for care that is considered to be under
 38 the umbrella of EHBs. In addition, the ACA requires health plans to cap out-of-pocket expenses of
 39 enrollees, but only for care that is considered EHBs. As such, several analyses have concluded that
 40 if EHB categories are removed or allowed to be waived, premiums would decrease, but individuals
 41 who use services and benefits no longer included in the EHBs could face substantial increases in
 42 out-of-pocket costs.^{4,5,6,7} If EHB categories are removed or allowed to be waived, health plans
 43 could react in multiple ways, including no longer covering affected categories; providing a level of
 44 coverage for affected categories (but caps on out-of-pocket spending, as well as annual and lifetime
 45 limits may not apply); or offer coverage “riders” for affected categories. Analyses have found that
 46 categories most likely to be removed from the EHB, if states are allowed flexibility to do so,
 47 include maternity care; mental health and substance abuse benefits; rehabilitative and habilitative
 48 services; certain pediatric services, including oral and vision care; and prescription drugs.^{8,9,10,11}

49 The Council notes, for example, that riders for maternity services were available prior to enactment
 50 of the ACA. In addition, if prescription drugs were removed as an EHB category, plans may

1 provide a level of coverage for them, but individuals who rely on expensive prescription drugs
 2 could face an exponential increase in out-of-pocket spending due to the loss of the ACA’s financial
 3 protections afforded to EHB categories.

4
 5 In addition, analyses have found that removing EHB categories or allowing EHB waivers could
 6 cause market segmentation.^{12,13,14} If categories are removed from EHB, individuals who do not
 7 foresee a need for removed services will be attracted to more affordable, less comprehensive plans.
 8 However, individuals in need of affected services, which could range from mental health to
 9 maternity services to pediatric services, would either not have any plan options or face much higher
 10 premiums for plans that offer at least some level of coverage for removed services. As such, health
 11 plans would be able to structure their offerings as to attract lower-risk and healthier enrollees, as
 12 sicker, higher-risk individuals would tend to gravitate toward richer, more generous coverage.

13
 14 Finally, concerns have been raised that removing EHB categories or allowing waivers of EHBs
 15 could allow for mini-meds and other “sham” health insurance to have greater standing in the
 16 marketplace. As ACA’s protections against catastrophic costs are tied to EHBs, if EHBs are
 17 eliminated, individuals could increasingly enroll in health insurance coverage that does not protect
 18 them against catastrophic expenses. Notably, the health reform debates in the House of
 19 Representatives and the Senate have been impacted by the Congressional Budget Office’s
 20 definition of private health insurance coverage, which has been outlined as “consisting of a
 21 comprehensive major medical policy that, at a minimum, covers high-cost medical events and
 22 various services, including those provided by physicians and hospitals... The definition excludes
 23 policies with limited insurance benefits (known as mini-med plans); ‘dread disease’ policies that
 24 cover only specific diseases; supplemental plans that pay for medical expenses that another policy
 25 does not cover; fixed-dollar indemnity plans that pay a certain amount per day for illness or
 26 hospitalization; and single-service plans, such as dental-only or vision-only policies. In this
 27 estimate, people who have only such policies are described as uninsured because they do not have
 28 financial protection from major medical risks.”¹⁵

29
 30 *AMA Policy Relevant to Essential Health Benefits*

31
 32 Policy H-165.846 states that existing federal guidelines regarding types of health insurance
 33 coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program
 34 [FEHBP] regulations) should be used as a reference when considering if a given plan would
 35 provide meaningful coverage. The policy also advocates that the Early and Periodic Screening,
 36 Diagnostic, and Treatment (EPSDT) program be used as the model for any EHB package for
 37 children. Policy H-165.865 states that in order to qualify for a tax credit for the purchase of
 38 individual health insurance, the health insurance purchased must provide coverage for hospital
 39 care, surgical and medical care, and catastrophic coverage of medical expenses as defined by Title
 40 26 Section 9832 of the US Code. Policy H-165.848 states that under an individual mandate,
 41 individuals should be required to obtain, at a minimum, coverage for catastrophic health care and
 42 evidence-based preventive health care. Policy D-180.986 states that our AMA will encourage local,
 43 state, and federal regulatory authorities to aggressively pursue action against “sham” health
 44 insurers. Policy H-165.856 cautions that benefit mandates should be minimized to allow markets to
 45 determine benefit packages and permit a wide choice of coverage options. Policy H-185.964
 46 opposes new health benefit mandates unrelated to patient protections, which jeopardize coverage to
 47 currently insured populations.

1 HIGH-RISK POOLS AND REINSURANCE

2 3 *Background*

4
5 The ACA established risk adjustment, reinsurance, and risk corridor programs to not only stabilize
6 premiums during the early years of ACA implementation, but to blunt the impact of adverse risk
7 selection. ACA's risk adjustment program, which is permanent in nature, redistributes funds from
8 plans with lower-risk enrollees to plans with higher-risk enrollees, thereby removing insurer
9 incentives to "cherry pick" healthier enrollees. The ACA's temporary reinsurance program played
10 a role in stabilizing premiums in the individual marketplace during the early years of ACA
11 implementation. The program provided payments to plans that enrolled higher-cost individuals
12 whose costs exceeded a certain threshold, also known as an attachment point, up to the reinsurance
13 cap. The ACA's temporary risk corridor program aimed to promote accurate premiums while there
14 was uncertainty among insurers in the early years of the marketplaces about who would enroll and
15 the cost of their care. The risk corridor program limited health plan losses and gains beyond an
16 allowable range.¹⁶

17
18 The ACA established a temporary state-based high-risk pool program, known as the Pre-Existing
19 Condition Insurance Plan (PCIP) program, in 2010, to be phased out when the key coverage
20 provisions of the ACA became operational in 2014. HHS ran the PCIPs in 23 states and the District
21 of Columbia, while 27 states administered their own programs. Individuals had to be uninsured for
22 at least six months before enrolling, but otherwise, the program had no pre-existing condition
23 exclusions. Unlike traditional state high-risk pools that existed before the ACA, PCIP premiums
24 were able to vary by age but were otherwise equal to premiums paid by individuals without pre-
25 existing conditions. In addition, there were no annual or lifetime dollar limits on covered benefits
26 under PCIP, there were caps on out-of-pocket spending, and there was a minimum actuarial value
27 of plans, which impacted deductibles. The ACA appropriated \$5 billion to fund net losses of PCIP
28 programs.¹⁷

29
30 While the CBO estimated in June 2010 that an average of 200,000 individuals would be enrolled in
31 PCIP for the 2011-2013 period,¹⁸ PCIP enrollment peaked at about 115,000 in March 2013. Also in
32 March 2013, new PCIP enrollment had to be suspended in order to ensure that there were sufficient
33 resources to pay the claims of individuals already enrolled. Between September 2012 and
34 September 2013, the final 12-month period for which PCIP expense data were reported, PCIP had
35 net losses of more than \$2 billion, with \$4 billion in total net losses reported as of September
36 2013.¹⁹

37 38 *Impact on Health Insurance Affordability*

39
40 Mechanisms to subsidize the costs of high-risk and high-cost enrollees have had various rates
41 of success. Concerning high-risk pools, prior to implementation of the ACA, 35 states offered
42 high-risk pools as a mechanism to cover high-risk and high-cost residents, including those with
43 pre-existing conditions. At their peak, state high-risk pools that existed prior to passage of the ACA
44 covered more than 200,000 people nationally, with combined net losses for the state high-risk
45 pools totaling more than \$1.2 billion for 2011, or \$5,510 per enrollee, on average. Overall, state
46 high-risk pools featured premiums above standard non-group market rates, with most states
47 capping them at 150 to 200 percent of standard rates. Many also featured high deductibles,
48 including deductibles in the \$5,000 range. Nineteen states had some degree of premium subsidy for
49 low-income individuals. In addition, despite the fact that many individuals had to seek coverage in
50 high-risk pools because of a pre-existing condition, most states excluded coverage for these

1 conditions for medically eligible individuals ranging from six to 12 months. Almost all
 2 high-risk pools imposed lifetime limits on covered services, with some also imposing annual limits
 3 on covered benefits. A few states capped or closed enrollment.²⁰

4
 5 The Council notes that a January 2017 report from the American Academy of Actuaries also raised
 6 concerns regarding high-risk pools, noting that “enrollment has generally been low, coverage has
 7 been limited and expensive, they require external funding, and they have typically operated at a
 8 loss... Removing high-risk individuals from the insured risk pools reduces costs in the private
 9 market only temporarily. Over time, even lower-cost individuals in the individual market can incur
 10 high health care costs, which would put upward pressure on premiums.”

11
 12 The actuaries also noted that funding could be directed toward a reinsurance program that
 13 reimburses plans the costs of high-risk enrollees. For example, to fund the ACA’s transitional
 14 reinsurance program, insurers and third party administrators paid \$63 per enrollee per year in 2014,
 15 \$44 in 2015 and \$27 in 2016. These investments in reinsurance yielded premium reductions. For
 16 example, in 2014, the \$10 billion reinsurance fund, the result of the \$63 per enrollee per year
 17 contributions, was estimated to reduce premiums by 10 to 14 percent. The actuaries stated that a
 18 permanent program to reimburse plans for the costs of their high-risk enrollees would reduce
 19 premiums.²¹ Reinsurance enables high-risk enrollees to remain in the same individual market risk
 20 pool and enjoy the same protections and choices as healthy plan enrollees.

21
 22 States have also submitted waivers under Section 1332 of the ACA, as outlined in Council on
 23 Medical Service Report 1 being considered at this meeting, to fund state reinsurance programs.
 24 Alaska’s waiver, which has been approved, allows the state to implement the Alaska Reinsurance
 25 Program (ARP) for 2018 and subsequent years. The ARP will cover claims in the individual
 26 market for individuals with one or more of 33 identified high-cost conditions to help stabilize
 27 premiums. As a result, insurers will relinquish both premiums received for such individuals as well
 28 as claims they would have paid absent the waiver. As a result of the ARP, it is expected that
 29 premiums will be 20 percent lower in 2018 than absent the waiver, and 1,460 additional individuals
 30 will have health insurance coverage.²² The waiver application of Minnesota, which has also been
 31 approved, would create the Minnesota Premium Security Plan, which was estimated to yield a 20
 32 percent reduction in average premiums in 2018.²³ While Minnesota’s waiver was approved, the full
 33 amount the state requested in its waiver for federal pass-through funding to financially support its
 34 reinsurance program was not approved. Only federal pass-through funding reflecting savings from
 35 less spending on premium tax credits and cost-sharing reductions was approved, not the amount
 36 also requested by the state that reflects federal savings due to lower premiums for plans under the
 37 state’s Basic Health Program.²⁴ The waiver application of Oregon, which was still under review
 38 when this report was prepared, anticipates that its waiver to establish the Oregon Reinsurance
 39 Program will reduce premiums, including those for the second-lowest cost silver plan, by 7.5
 40 percent in 2018 (net of the premium assessment), with an increase in enrollment in the individual
 41 market by approximately 1.7 percent in the same year.²⁵

42
 43 Maine also had an “invisible high-risk pool” that it implemented in 2011, which in functionality
 44 was more similar to a reinsurance program than a high-risk pool. The main difference between
 45 invisible high-risk pools and the more traditional approach to reinsurance as included in the ACA is
 46 that the pools identify potential high-cost individuals prospectively, versus being reimbursed
 47 retrospectively for patients who actually incur high-cost claims. As a result, some plan enrollees
 48 who end up having unpredictably costly claims may not be included in invisible high-risk pools,
 49 and as such insurers would not be reimbursed for a portion of their claims. For example, under

1 Maine’s program, all health insurance applicants were required to complete a health statement with
 2 their application for insurance, and insurers used the statement to ascertain which individuals to
 3 place in the invisible high-risk pool, based on what health conditions they had. Selected individuals
 4 were enrolled in the same plan they applied for at the same premium levels, but on the back-end,
 5 their health insurers were reimbursed for 90 percent of their claims between \$7,500 and \$32,500
 6 per year and 100 percent of claims more than \$32,500. Premium reductions were achieved as a
 7 result, which varied based on applicant age.²⁶

8
 9 *AMA Policy Relevant to Risk Subsidization*

10
 11 Policy H-165.842 supports the principle that health insurance coverage of high-risk patients be
 12 subsidized through direct risk-based subsidies such as high-risk pools, risk adjustment, and
 13 reinsurance, rather than through indirect methods that rely heavily on market regulation; and
 14 supports state-based demonstration projects to subsidize coverage of high-risk patients through
 15 mechanisms such as high-risk pools, risk adjustment, reinsurance, and other risk-based subsidies.

16
 17 Policy H-165.995 supports: (1) the establishment in each state of a risk pooling program, in which
 18 all health care underwriting entities in the state participate, to provide adequate health insurance
 19 coverage at a premium slightly higher than the standard group rate to (a) those who are unable to
 20 obtain such coverage because of medical considerations, and (b) those with medically standard
 21 risks who could afford, but presently lack, access to such group coverage; (2) the amendment of the
 22 federal tax code to require employers to purchase group health insurance coverage from an entity
 23 participating in the state risk pool or, if self-insured, to participate in the risk pool if such a pool is
 24 available, in order to deduct the cost of their coverage as a business expense; and (3) using state tax
 25 revenues as an alternative source for defraying excess pool costs.

26
 27 **DISCUSSION**

28
 29 As millions of Americans have gained coverage resulting from the ACA, the Council affirms that
 30 progress has been made on a long-time policy priority of the AMA – expanding access to
 31 affordable, quality health insurance coverage. However, in light of the health reform discussions
 32 and debates that have occurred this year, the Council believes there is an opportunity to include
 33 additional safeguards in AMA policy to ensure that patients have meaningful coverage that protects
 34 them against catastrophic expenses. While the AMA has long supported patient choice of health
 35 plan, AMA policy has also stressed that any health insurance purchased must provide meaningful
 36 coverage for hospital, surgical and medical care; protect patients against catastrophic expenses; as
 37 well as promote preventive services. AMA policy also underscores that provisions must be made to
 38 assist individuals with low-incomes or unusually high medical costs in obtaining health insurance
 39 coverage and meeting cost-sharing obligations, and that prohibitions on annual and lifetime limits
 40 should remain in place under any reform.

41
 42 Under current law, the requirement that all qualified health plans, with the exception of
 43 grandfathered individual and employer-sponsored plans, offer at least the EHBs in the EHB
 44 package, has helped ensure that individuals have had access to meaningful coverage. Importantly,
 45 the prohibition on annual and lifetime limits, as well as the cap on out-of-pocket expenses, is only
 46 required for care that is considered to be under the umbrella of essential health benefits. Consistent
 47 with previously established AMA policy, the Council believes that using the current benchmark
 48 approach to EHBs, while requiring ten categories of essential health benefits, strikes a balance
 49 between offering meaningful coverage and maintaining patient choice in health plans and their
 50 respective benefits packages. The Council believes that the benchmark approach to EHBs

1 recognizes that there is not a “one size fits all” approach to health insurance benefits, and that some
2 variability is needed.

3
4 The Council notes that most of the health care claims’ costs associated with EHBs are attributable
5 to such services as hospital inpatient and outpatient care, physician services, and prescription
6 drugs. These services are arguably viewed as fundamental components of health insurance
7 coverage. Removing any benefits from the EHB requirements, or allowing waivers of such
8 requirements, can cause insurers to cherry pick patients based on the services their plans cover, as
9 well as hinder patient access to necessary services. If insurers are allowed to offer plans with
10 skimpier coverage, plan designs could potentially discriminate against people with pre-existing
11 conditions. In addition, individuals who use services and benefits no longer included in the EHBs
12 could face substantial increases in out-of-pocket costs. As such, the Council is recommending that
13 our AMA oppose the removal of categories from the EHB package. In addition, the Council
14 believes that our AMA should also oppose waivers of EHB requirements that lead to EHB
15 categories and their associated protections against annual and lifetime limits, and out-of-pocket
16 expenses, being eliminated.

17
18 In addition, after the expiration of the ACA’s reinsurance program, and with policymakers and
19 stakeholders evaluating various options to improve the stability of health insurance premiums and
20 the overall health insurance marketplace, the Council reevaluated AMA policy with respect to how
21 to best subsidize the costs of high-cost and high-risk patients, who may have pre-existing
22 conditions. Critics of high-risk pools as a viable option for covering high-risk individuals have
23 emphasized that the funding allocated to them, in the past and in legislation that was considered
24 this year, has not been sufficient. More importantly, however, is that traditional high-risk pools
25 have provided individuals with pre-existing conditions with second-class insurance, with waiting
26 periods to get pre-existing conditions covered, higher premiums, potentially high deductibles, and
27 lifetime limits on benefits. As such, the Council is recommending that Policy H-165.995 be
28 rescinded, resulting from the evidence that shows the consequences of high-risk pools, and their
29 subjection of individuals with pre-existing conditions to a different level of health insurance. At
30 this juncture, considering the success of the ACA’s reinsurance program, as well as state
31 reinsurance programs, the Council believes that, considering finite resources, that resources should
32 be directed to reinsurance programs. Reinsurance provides an equitable, fair and cost-effective
33 mechanism to subsidize the costs of high-risk and high-cost patients, and protects patients with
34 pre-existing conditions. The Council concludes that data suggest that a permanent reinsurance
35 program may be a desirable policy option, whether administered at the federal or state level.

36 37 RECOMMENDATIONS

38
39 The Council on Medical Service recommends that the following be adopted and the remainder of
40 the report be filed:

- 41
42 1. That our American Medical Association (AMA) oppose the removal of categories from the
43 essential health benefits (EHB) package and their associated protections against annual and
44 lifetime limits, and out-of-pocket expenses. (New HOD Policy)
45
- 46 2. That our AMA oppose waivers of EHB requirements that lead to the elimination of EHB
47 categories and their associated protections against annual and lifetime limits, and out-of-pocket
48 expenses. (New HOD Policy)

- 1 3. That our AMA prefer reinsurance as a cost-effective and equitable mechanism to subsidize the
- 2 costs of high-cost and high-risk patients. (New HOD Policy)
- 3
- 4 4. That AMA Policy H-165.995 be rescinded. (Rescind HOD Policy)

Fiscal Note: Less than \$500.

REFERENCES

¹ US Department of Health and Human Services. Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule. February 25, 2013. Available at: <https://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf>.

² Bayram R and Dewey B. Are Essential Health Benefits Here to Stay? Milliman. March 2017. Available at: <http://us.milliman.com/uploadedFiles/insight/2017/essential-health-benefits.pdf>.

³ Eibner C and Whaley C. Loss of Maternity Care and Mental Health Coverage Would Burden Those in Greatest Need. The Commonwealth Fund. June 19, 2017. Available at: <http://www.commonwealthfund.org/publications/blog/2017/may/maternity-care-and-mental-health-coverage-requirements>.

⁴ *Id.*

⁵ Fiedler M. New Changes to Essential Benefits in GOP Health Bill Could Jeopardize Protections Against Catastrophic Costs, Even For People With Job-Based Coverage. Brookings Institution. March 24, 2017. Available at: <https://www.brookings.edu/blog/up-front/2017/03/24/new-changes-to-essential-benefits-in-gop-health-bill-could-jeopardize-protections-against-catastrophic-costs-even-for-people-with-job-based-coverage/>.

⁶ Jost T. Essential Health Benefits: What Could Their Elimination Mean? Health Affairs Blog. March 23, 2017. Available at: <http://healthaffairs.org/blog/2017/03/23/essential-health-benefits-what-could-their-elimination-mean/>.

⁷ Congressional Budget Office. Cost Estimate: H.R. 1628, American Health Care Act of 2017, as passed by the House of Representatives on May 4, 2017. May 24, 2017. Available at: <https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf>.

⁸ Bayram and Dewey, *supra* note 2.

⁹ Eibner and Whaley, *supra* note 3.

¹⁰ Jost, *supra* note 6.

¹¹ CBO, *supra* note 7.

¹² Bayram and Dewey, *supra* note 2.

¹³ Fiedler, *supra* note 5.

¹⁴ Jost, *supra* note 6.

¹⁵ CBO, *supra* note 7.

¹⁶ Cox C, Semanskee A, Claxton G, and Levitt L. Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors. Kaiser Family Foundation. August 17, 2016. Available at: <http://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/>.

¹⁷ Pollitz K. High-Risk Pools For Uninsurable Individuals. Kaiser Family Foundation. February 22, 2017. Available at: <http://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/>.

¹⁸ Congressional Budget Office. Letter to the Honorable Michael B. Enzi, Ranking Member, Senate Committee on Health, Education, Labor, and Pensions. June 21, 2010. Available at: http://cbo.gov/sites/default/files/cbofiles/ftpdocs/115xx/doc11572/06-21-high-risk_insurance_pools.pdf.

¹⁹ Pollitz, *supra* note 17.

²⁰ Pollitz, *supra* note 17.

²¹ American Academy of Actuaries Individual and Small Group Markets Committee. An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes. January 2017. Available at: http://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf.

²² Centers for Medicare & Medicaid Services. Alaska: State Innovation Waiver under section 1332 of the PPACA. July 11, 2017. Available at: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Fact-Sheet.pdf>.

²³ Tolbert J and Pollitz K. Kaiser Family Foundation. Section 1332 State Innovation Waivers: Current Status and Potential Changes. July 6, 2017. Available at: <http://www.kff.org/health-reform/issue-brief/section-1332-state-innovation-waivers-current-status-and-potential-changes/>.

²⁴ Letter to the Honorable Mark Dayton. State of Minnesota — Patient Protection and Affordable Care Act Section 1332 Waiver Approval. September 22, 2017. Available at: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Approval-Letter-MN.pdf>.

²⁵ Oregon Department of Consumer and Business Services. Oregon 1332 Draft Waiver Application. August 31, 2017. Available at: <http://healthcare.oregon.gov/Documents/1332-application.pdf>.

²⁶ Allumbaugh J, Bragdon T, and Archambault J. Invisible High-Risk Pools: How Congress Can Lower Premiums And Deal With Pre-Existing Conditions. Health Affairs Blog. March 2, 2017.