American Health Care Act (AHCA) Facts: Employer-Sponsored Insurance

Under the ACA, insurance plans have to cover certain basic health services known as the 10 Essential Health Benefits (EHBs):

1. Ambulatory patient services (outpatient care you get without being admitted to a hospital)
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services (including behavioral health treatment)
6. Prescription drugs
7. Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental or physical skills)
8. Laboratory services
9. Pediatric services (including dental and vision care)
10. Preventive wellness services and chronic disease management (including screenings and vaccinations).

941 O STREET, SUITE 920
LINCOLN, NE 68508

P 402.438.8853
F 402.438.0263

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The American Health Care Act (AHCA) would dramatically change health insurance in the U.S. It would have significant negative impacts for people who buy private health insurance, people who are covered by Medicaid, and people who get health insurance through their jobs.

Currently, under the Affordable Care Act (ACA), people with insurance through their employers are protected against catastrophic costs. The AHCA would weaken those protections.

One of the main reasons why people have health insurance is to protect them against catastrophic costs. The ACA helped make sure people were more financially protected in two main ways: banning annual and lifetime limits on coverage and limiting annual out-of-pocket costs.

- Before the ACA, insurance plans often had a set dollar limit each year or over the course of a lifetime over which an insurer would stop paying costs, leaving the customer to pay costs above that amount out of their own pocket. There are many awful stories of people being diagnosed with cancer and quickly hitting an annual limit or of children with expensive health needs hitting their lifetime limits before reaching adulthood. The ACA protects people from these limits.
- Insurance companies are now longer allowed to have annual or lifetime limits apply to the EHBs. So, insurance companies can't limit their coverage of this list of services to an annual or lifetime amount. Insurance plans can have annual or lifetime limits for services outside of the EHBs, but, since the EHBs cover such a wide variety of services, consumers are largely protected from hitting those limits.
- The ACA also limits the amount of out-of-pocket spending a person must pay in a year on EHBs, which makes sure that people with serious health needs are able to protect themselves financially. For example, if a person is sick and needs expensive medication, they would be protected from costs over a certain limit and be less likely to have to drain their savings or go bankrupt just to get the care they need.

The AHCA would weaken these important protections.

- The AHCA would allow states to get rid of the EHBs as they currently exist and set their own benefits packages. This means states could decide what services they consider essential. Looking at regulations states had in place before the ACA, it's very likely that many states will set much weaker benefits packages, taking out services like maternity care or mental health treatment. People who need these common forms of health care could go back to paying high amounts for them.
- Because the ACA's ban on annual and lifetime limits and limit on out-of-pocket spending only applies to spending on EHBs, if states weaken their benefits package, it will weaken these protections too. For example, if a state removes prescription drugs from its EHBs, a person who needs costly medications could be subject to annual or lifetime limits on coverage for medications and also not have any limit to what they could be forced to pay out of pocket.

All in all, the AHCA's changes would be a huge step backwards for consumers.