Graham-Cassidy-Heller-Johnson Claim vs Fact

Claim: Ends Federal protections for pre-existing conditions and essential health benefits.

Fact: Does **NOT** repeal protections for pre-existing conditions in the Public Health Service Act, including discrimination based on pre-existing conditions, guaranteed issue, and guaranteed renewability. Under GCHJ, an insurer must offer every individual a plan, and every state must ensure individuals with pre-existing conditions have access to affordable and adequate coverage. GCHJ also does not end the prohibition on annual or lifetime caps.

Claim: Estimated 32 million will lose coverage within 10 years.

Fact: This number has nothing to do with GCHJ, but rather a previously scored 'repeal only' bill. Further, while CBO forecasts around 15 million people would 'lose' coverage simply by repealing the individual mandate, the architect of Obamacare, Jonathan Gruber, co-authored a paper for the National Bureau of Economic Research and published in the New England Journal of Medicine, finding "The individual mandate's exemptions and penalties had little impact on coverage rates." Because of this we do not expect the actual losses that are often predicted by models. When states are free of structural regulation, the American people will see innovative ideas that lead to increased patient choice and overall enrollment.

Claim: Ends Medicaid expansion, all subsidies for the exchange, and ends all cost sharing payments.

Fact: States may choose to use their block grant to continue coverage similar to Medicaid expansion, or pursue alternatives. GCHJ takes the dollars used on Medicaid expansion under Obamacare, along with the cost-sharing reductions, Basic Health Plan, and advanced premium tax-

credit dollars, and gives those dollars to the state to cover that population with the policy that works best for them. Instead of Washington prescribing a one-size-fits-all system for every state, we encourage states to be laboratories of democracy, and provide adequate funding for them to do so.

Claim: The block grant does not have to be spent on the same population as Obamacare.

Fact: The block grant must be spent on health care and will be focused on lower income and working families. While the states are allotted funding based on their 50-138% FPL demographic, they are not limited to only spending their funds on this group. This is an essential provision to avoid "cliffs" where someone would ultimately be penalized for getting a job and migrating up out of the bracket, resulting in a loss of coverage. States will decide, taking into account their specific health care environment and coverage needs, how to divide the money among those requiring support.

Claim: Cuts coverage for low income seniors, children, and people with disabilities with a "per capita cap."

Fact: Funding for Medicaid per capita caps will continue at sustainable levels, and the states have the ability to spend up to 20% of their block grant money on additional optional Medicaid provisions. Medicaid is on an unsustainable path, and Obamacare only exacerbated the problem. GCHJ strengthens and sustains Medicaid by aligning the financing to match how states pay managed care providers. Much of healthcare funding is moving toward a capitated model as the optimal arrangement to produce value. In fact, Ranking Member of the HELP Committee Senator Murray, along with 46 members of the Democratic caucus, supported a per capita cap proposal under the Clinton

Administration. This is a responsible solution to sustain our commitment to our most vulnerable.

Claim: Ends all funding for coverage by 2026

Fact: As with the CHIP program, the idea a future Congress will not reauthorize these programs is absurd. Congress routinely authorizes programs through the budget window, and reauthorizes those programs before expiration. This allows Congress to evaluate the strengths and faults of a program, and restructure them to ensure efficiency, instead of creating entitlements that have no end date and little opportunity for restructuring. Saving federal taxpayer dollars by encouraging states to control health costs and giving patients the power of their health care dollar represents a step in the right direction to save our entitlement programs for future generations.

Claim: Provides no funding for recessions, natural disasters, public health emergencies, or price spikes.

Fact: GCHJ provides funding in all of these instances. The specific purpose of a per capita cap, as GCHJ establishes for Medicaid, is to be flexible during recessions. Medicaid is a countercyclical program, meaning, as the economy does worse, Medicaid enrollment spikes, and vice versa. Per capita caps are based on enrollment and thus, as enrollment grows, so does the money allotted to a state.

GCHJ explicitly allows the Secretary to exclude any expenditures made under a public health emergency (See 'Excluded Expenditures' under the 'Adjusted Total Medical Assistance Expenditures' section.)

Claim: This bill will increase premiums

Fact: This bill will lower premiums by stabilizing the individual market and allowing states to innovate and engage in population health, so that they can actually reduce health care costs and improve outcomes.

Claim: Targets women's health/family planning.

Fact: GCHJ maintains the prohibition on health insurers charging premiums based on gender and provides additional dollars for community health centers.

Claim: Uses the same "50 votes" only partisan technique to pass; upends all bipartisan progress of the last 2 weeks.

Fact: Obamacare is collapsing, and Democrats have proved unwilling to take the steps necessary to save the individual insurance market and ensure Medicaid is sustainable for the most vulnerable among us. GCHJ is the only proposal standing between the United States and a single-payer health system destined to fail.