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Republican Policy Concepts to Replace the Affordable Care Act	**A Better Way White Paper**	**Patient Choice, Affordability, Responsibility, and Empowerment (Patient CARE) Act**	**World's Greatest Healthcare Plan Act of 2016** (H.R. 5284/S. 2985)
	Product of the U.S. House Republican Health Care Reform Task Force; put forward by U.S. House Republican Leadership	*Introduced by U.S. Senators Orrin Hatch (R, UT) and Richard Burr (R, NC), and U.S. Representative Fred Upton (R, MI)*	*Introduced by U.S. Representative Pete Sessions (R, TX) and U.S. Senator Bill Cassidy (R, LA)*
ACA Repeal	Repeals the ACA.	Repeals the ACA with the exception of Medicare provisions.	Repeals individual and employer mandates and certain insurance market reforms, but maintains health insurance marketplaces as well as ACA premium tax credits and cost sharing reductions.
Insurance Market Reforms	• Provides protections against coverage denials for preexisting conditions and ensured guaranteed renewal. • Allows dependents to stay on their parents' plan up to the age of 26. • Extends "continuous coverage" protections to the individual market to ensure individuals with preexisting conditions that remain continuously	• Repeals the individual mandate. Establishes a "continuous coverage" safeguard to protect those with preexisting conditions by requiring state-regulated insurance plans to offer coverage to the continuously insured, and to guarantee its renewal (expanding current HIPAA protections that allow for transition between insurance products).	• Maintains certain ACA consumer protections including: no lifetime or annual limits; dependent coverage up to the age of 26; guaranteed availability; guaranteed renewability; prohibition on pre-existing conditions exclusions; prohibition on discrimination based on health status; and non-discrimination based on professional licensure.

	insured do not face premium increases when switching insurance. • Sets the default age-rating ratio at 5:1, permitting states to narrow or expand. • Offers state innovation grants for states to implement reforms that address affordability and access.	• Generally, leaves benefit regulation to the states but sets a presumption that insurers will allow dependents under age 26 to stay on their parents' coverage; ban lifetime limits; and place an upper limit on age rating of 5:1 (replacing the ACA 3:1 rule).	• Repeals rating restrictions, essential health benefits, coverage for individuals in clinical trials, coverage of preventive services without cost-sharing, appeals rights and other insurance standards included in the ACA. • Generally, gives states broad flexibility to alter the rules applicable to their health insurance markets.
Coverage Provisions	• Lifts ACA restrictions on health savings accounts (HSAs) and seeks to expand the use of HSAs, private exchanges and health reimbursement accounts. • Offers advanceable, refundable tax credits to those who do not have access to job-based coverage, Medicare or Medicaid. The benefit would be adjusted for age and indexed. Details of the credit are not specified. • Allows for cross state purchasing of health insurance coverage and makes it easier for states	• Establishes income-tested age-rated refundable tax credits for persons with incomes up to 300 percent of the federal poverty limit (FPL) who either work for small employers (defined 100 or fewer workers) or who do not have access at all to employer-sponsored insurance. The credit amounts would be indexed to the Consumer Price Index (CPI) plus 1 percentage point each year. • Allows states to establish a default insurance option and place persons eligible for the tax credit into	• Maintains ACA affordability provisions (refundable tax credits and cost-sharing) and establishes a new "universal" (UH) tax credit of up to $2,500 for an individual ($5,000 for an individual plus spouse plus $1,500 for child dependents) to help pay for coverage in and outside of marketplaces. Individuals are NOT eligible for a UH credit if their employer elects to provide pre-tax contributions toward their health coverage or if the individual claims an advance premium tax

	to enter into interstate compacts for pooling arrangements. • Expands the use of pooling by allowing small businesses and voluntary organizations to offer association health plans and individuals to purchase health care coverage through individual health pools. • Lifts legal and regulatory limitations that inhibit employee wellness programs. • Protects self-insurance and stop-loss insurance plans, by preserving the definition of stop-loss insurance and maintaining its distinct difference from "group health insurance." • Provides federal funding for state high-risk pools. • Establishes a one-time open enrollment period for individuals to join the health care market if they are uninsured.	insurance plans at no cost to the enrollee. • Provides federal funding for state high-risk pools. • Lifts ACA restrictions and expands allowable uses of HSAs.	credit. • Allows states to provide for the enrollment of its uninsured residents in "default health insurance coverage" and a newly established "Roth HSA." • Significantly expands incentives to use tax-favored savings accounts.
Tax Treatment of Employer Sponsored Coverage	Caps the exclusion for employer-sponsored insurance at an unspecified level.	Replaces the ACA Cadillac tax with a cap on the amount that may be excluded from a	

		worker's taxes. Caps the exclusion at $12,000 for individual coverage and $30,000 for family coverage.	
Medicare Reform	Outlines a multi-step process to reform Medicare, ultimately calling for the adoption of a premium support model, and the following structural reforms: • Value-based insurance design for Medicare Advantage • Beginning in fiscal year 2020, restrict Medigap plans from covering cost-sharing • Beginning in fiscal year 2020, combine Medicare Parts A and B with a unified deductible • Allow beneficiaries and health care professionals to voluntarily enter into an arrangement for items and services outside of the Medicare system • Repeal fiscal year 2018 and 2019 Medicare disproportionate share hospital (DSH) cuts and the fiscal year 2018 through 2020 Medicaid DSH cuts; create a	The proposal does not repeal the ACA's Medicare provisions, but legislative sponsors indicate alternative Medicare reforms would be pursued in separate legislation.	Repeals the current physician self-referral policy that governs appropriate physician ownership arrangements.

	combined national pool of uncompensated care funds, and distribute funds based on the S-10 worksheet using data defined as charity care only • Prompt traditional fee-for-service Medicare and Medicare Advantage to compete on quality through a Medicare Compare site • Prohibit weighting on patient experience of care measures rather than outcome and clinical process of care measures for quality reporting and value-based purchasing programs under CMS • Require rulemaking to provide for risk adjustment for socio-economic status Repealing Medicare provisions in the ACA would result in the repeal of the Independent Payment Advisory Board (IPAB), the Center for Medicare & Medicaid Innovation (CMMI) beginning January 1, 2020, current physician self-referral limitations, and nationwide		

	budget neutrality for the rural floor.		
Medicaid Reform	Transitions program financing, starting in 2019, to a per capita allotment. • The federal allotment would be the product of the state's per capita allotment for the four major beneficiary categories — aged, blind and disabled, children, and adults — and the number of enrollees in each of those four categories. The per capita allotment for each beneficiary category would be determined by each state's average medical assistance and non-benefit expenditures per full-year-equivalent enrollee during the base year (2016), adjusted for inflation. • Certain payment categories would be excluded from the allotment and would be reimbursed through a separate funding stream, such as federal payments to states for DSH, Graduate Medical Education, and for other	• Allows individuals who are eligible for Medicaid to choose the federal tax credit instead of purchasing private insurance. • Funds Medicaid through a capped allotment —"health grant." A separate fixed grant would be provided for long-term care services and supports for low-income elderly and disabled persons who enroll in Medicaid. Dually-eligible individuals would continue to be subsidized through the matching rate formula. o For the first year of implementation, funding would be based on federal program costs for the previous year [FMAP allotments, CHIP allotments, administrative costs, long-term care costs and DSH allotments would be included in this calculation]. Funds would be allocated to	• Subjects state Medicaid programs to a per capita cap calculated for four groups of beneficiaries for a base year: people over age 65, people qualifying on the basis of blindness or disability, children, and all other adults. Those amounts would include DSH payments. • Entitles states to receive bonus payments for high performance related to care for people with certain chronic diseases. • Limits eligibility for Medicaid to individuals in families with income below 100% of the federal poverty level except for certain groups of grandfathered individuals. • Provides states an option to allow Medicaid beneficiaries to choose whether to receive coverage under a health plan that qualifies for an UH credit or under the state's Medicaid program.

	appropriate exclusions • States that have expanded Medicaid would be held harmless for 2019 but thereafter the enhanced federal match for the Medicaid expansion population would be phased down to the normal FMAP level. • Medicaid demonstration waivers would be required to be budget-neutral to the federal government. Existing managed care waivers would be grandfathered, and moving forward states would not be required to obtain a waiver to enroll some populations in managed care. Alternatively, states that opt out of the per capita allotment may elect a federal block grant. Funding would be determined using a base year in a manner that would assume states transition individuals currently enrolled in Medicaid expansion into other sources of coverage.	states based on the number of low income individuals at or below 100 percent of FPL. The allotment would grow at CPI+1 and reflect demographic and population changes.	
Liability Reform	• Establishes caps on non-economic damages and	• Establishes caps on non-economic damages and	

	limitations on attorney's fees. • Provides incentives to states to adopt innovative reforms. • Allow safe harbors under federal health care programs and higher standards of evidence for medical professionals following clinical practice guidelines developed by national and state professional medical societies.	limitations on attorney's fees. • Incentivizes states to adopt innovative reforms.	

Transparency		• Requires hospitals participating in Medicare to provide to consumers the average amount paid by uninsured and insured patients for the most common inpatient and outpatient procedures, and publicly post charity care policies along with the amount of charity care provided. • Provides enhanced Medicaid grants to states that establish and maintain requirements on disclosure of hospital charge information and make such information publicly available, and provide individuals with information about estimated out-of-pocket costs of health care services.	Sets parameters for allowable charges for emergency services furnished in an EMTALA-covered hospital and requires health care providers to disclose their "cash prices" through a posting on a publicly accessible website.

Please contact CHA's senior vice president for federal relations, Anne O'Rourke at aorourke@calhospital.org with questions.