

OBAMACARE REPEAL AND REPLACE

Policy Brief and Resources

SECTION 1

Topline



Obamacare has failed.

Six years after the enactment of Obamacare, here's what we know: This law has failed the American people.

Insurance markets are collapsing. Premiums and deductibles are soaring. Patients' choices are dwindling. The law has failed to deliver on its core promises.

The law is only getting worse.

While we could simply allow the law to collapse, that would not be fair to the American families struggling under Obamacare. The truth is, left unaddressed, the situation would only get worse – with even fewer coverage options and even higher costs.

Repeal is relief.

That's why, when the House returns after President's Day, we will act to repair the damage done by Obamacare by repealing the law and replacing it with a better system. We will deliver on our promise to the American people.

A stable transition.

Our efforts will ensure protections for the most vulnerable, and there will be a stable transition period to a patient-centered health care system that gives Americans access to quality, affordable care.

We have a better way.

Our replacement plan ensures more choices, lower costs, and greater control over your health care. Specifically it:

- Moves health care decisions away from Washington and to where they belong: with patients, their families, and their doctors,
- Provides coverage protections and peace of mind for all Americans—regardless of age, income, medical conditions, or circumstances,
- Gives patients the right tools, like Health Savings Accounts, to make their health insurance more portable and affordable,
- Allows those who don't receive insurance from an employer or government program to have access to quality coverage,
- Breaks down barriers that restrict choice and prevent Americans from picking the plan that is best for them and their family,
- Modernizes and strengthens Medicaid to protect the most vulnerable.

SECTION 2

Facts



Key Obamacare Facts

25% average increase in premiums this year for the millions of Americans trapped in Obamacare HealthCare.gov exchanges.

(SOURCE: HHS)

Nearly 1/3 of US counties have only 1 insurer offering exchange plans.

(SOURCE: KAISER FAMILY FOUNDATION)

4.7 million Americans kicked off their health care plans by Obamacare.

(SOURCE: ASSOCIATED PRESS)

\$1 trillion in new taxes, mostly falling on families and job creators.

(SOURCE: SENATE BUDGET AND FINANCE COMMITTEES)

18 Failed Obamacare Co-Ops out of 23, which were established as an alternative to the public option, have collapsed, costing taxpayers nearly \$1.9 billion and forcing patients to find new insurance.

(SOURCE: HOUSE ENERGY AND COMMERCE COMMITTEE)

\$53 billion in new regulations requiring more than **176,800,000 hours of paperwork**.

(SOURCE: AMERICAN ACTION FORUM)


Courtesy of:

House Committee on Energy and Commerce
House Committee on Education and the Workforce
House Committee on Ways and Means
Senate Committee on Finance
Senate Committee on Health, Education, Labor, and Pensions

SECTION 3

Key Points

Committee on Energy & Commerce // Committee on Ways & Means



Obamacare is hurting more people than it is helping, forcing Americans to buy insurance they don't like, don't need, and cannot afford.

- Premiums have gone up by an average of 25 percent this year. This year alone, seven states saw premium increases of more than 50 percent.
- Nearly 1/3 of all U.S. counties have only one insurer offering plans on their state's exchange.
- Under Obamacare, we have a new class of uninsured—those paying the penalty because they can't afford the plans, and those who are buying plans that have sky-high premiums and deductibles, prohibiting their access to actually receiving care.
- Families and job creators have faced \$1 trillion in new taxes.

House Republicans are working hand-in-hand with the new administration to provide much-needed relief and deliver a 21st century health care system that:

- Lowers costs, expands access, improves quality, and puts patients and families in charge of their care, while protecting patients with pre-existing conditions and ensuring dependents up to age 26 can stay on their parents' insurance.

There are three different ways we are working to deliver relief to patients across the country.

- **Repeal and Replace Legislation:** House Republicans will advance legislation in the weeks ahead to provide relief from Obamacare's taxes and mandates—including eliminating the individual and employer mandate penalties—and move forward with patient-centered reforms.
- **Action from the Trump Administration:** President Trump and HHS Secretary Price have an important role to play in providing relief from Obamacare's burdensome regulations. Most recently, the administration issued a proposed rule to help protect taxpayers and stabilize the collapsing marketplaces.
- **Delivering Solutions through Regular Order:** Both Energy & Commerce and Ways & Means have already begun to hold hearings examining reforms that will:
 - Decrease costs and increase choices by promoting competition and innovation in the insurance market.
 - Increase flexibility for employers to offer affordable, quality health care options to their employees.
 - Allow individuals and families to purchase insurance across state lines.



Through our repeal and replace legislation, House Republicans will:

- **Modernize Medicaid:** Instead of burdening states with more mandates from Washington bureaucrats, our plan empowers states to design plans that will best meet their needs and put Medicaid on sustainable financial footing.
 - The Medicaid program, a critical lifeline for some of our most vulnerable patients, is three times the size as—and costs three times as much as—under President Clinton. This is not sustainable.
 - The reforms will return the focus of the program back to helping those most in need, put Medicaid on a budget, and ensure we don't pull the rug out from anyone who received care under states' Medicaid expansions.
- **Utilize State Innovation Grants:** States know how to best take care of their own patients—not the federal government. Through this process, we can give states the ability to repair their health insurance markets that were damaged by Obamacare.
 - As explained in A Better Way, providing funding for state innovation programs—whether it is high-risk pools, cutting out-of-pocket costs like premiums and deductibles, or promoting access to health care services—states can gain resources to best take care of their unique patient populations.
- **Enhance Health Savings Accounts:** Obamacare's one-size-fits-all policies limited how individuals could spend and save their health care dollars.
 - Our proposal empowers individuals and families to spend their health care dollars the way they want and need—not the way Washington prescribes—by enhancing and expanding Health Savings Accounts, or HSAs.
 - For example, our proposal increases the amount of money an individual or family can put into their HSA, and allows individuals and families to spend money from their HSA on “over-the-counter” health care items. It allows spouses to make additional contributions, and expands the amount of time and individual or family can use an HSA on certain expenses.
- **Provide Portable, Monthly Tax Credits:** Today, many Americans receive support for their health insurance through work, Medicare, Medicaid, or other government programs, while others are forced to subsidize Obamacare's sky-high costs by purchasing mandated health insurance they do not like and cannot afford.
 - Our proposal provides all Americans access to a portable, monthly tax credit that they can use to buy a health insurance plan that's right for them—not one tied to a job or a government-mandated program.
 - Our proposal is based on age, so as individuals' health needs evolve over time, so will their monthly, portable tax credit. It can travel with them from job to job, state to state, home to start a business or raise a family, and even into retirement.

SECTION 4

Policy

Committee on Energy & Commerce // Committee on Ways & Means

Obamacare Is Collapsing, Republicans will Step into the Breach

Obamacare is collapsing. We all know the damage Obamacare has wrought on our health care system, which is why House Republicans began crafting a bill to repeal and replace it last year. Last June, we put forward the Better Way health care plan, a step-by-step approach to give every American access to quality, affordable health care.

This Congress, committees have already begun the hard work of laying the foundation to rebuild America's health care markets as we dismantle Obamacare. Notably, we are on a rescue mission to save the individual market from total collapse – which is where it is headed absent our intervention.

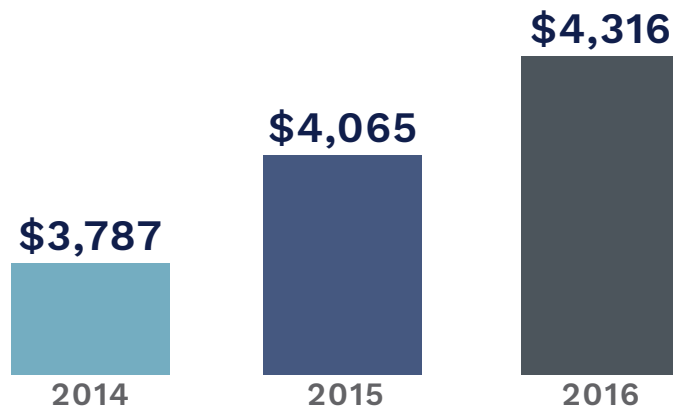
There is no shortage of evidence that patients and families are hurting under the overwhelming weight of Obamacare.

- Patients in 21 states have seen average premium increases of 25 percent or more this year.
- Individuals in seven states will experience premium increases of 50 percent or more.
- In 2016, 255 counties had one insurer. This year, one-third of counties in the entire country – 1,022 counties – have just one insurer.
- Five entire states just have one insurer offering coverage on the exchange.
- Only five of the original 23 health insurance CO-OPs remain in business.

The law has also caused problems for Americans with employer health care coverage. Average annual family premiums in the employer-sponsored market have soared by roughly \$4,300 and now total more than \$18,000 annually.¹ Even individual premiums are up 27 percent in the employer-sponsored market, double the rise in workers' wages (13 percent) and almost triple the cumulative inflation rate since 2010 (10 percent).² Deductibles are also increasing under Obamacare. Deductibles for individual plans in the employer-sponsored market are up an average of 60 percent since 2010 – from \$917 to \$1,478 in 2016.³

OBAMACARE COSTS FAMILIES MORE

AVERAGE ANNUAL OUT-OF-POCKET COSTS FOR FAMILY OF 4 WITH EMPLOYER-BASED COVERAGE



SOURCE: COUNCIL FOR AFFORDABLE HEALTH COVERAGE

There is no saving Obamacare. It cannot be fixed. It cannot be saved. We have the responsibility to prevent a real train wreck for millions of Americans. And not only can we solve this problem, we **must** solve this problem.

We Have A Better Way

Our replacement plan, built on key elements of the Better Way proposal, ensures more choices, lower costs, and greater control over your health care:

Health Care Tax Credits

For decades, the inability of American families and individuals to receive a tax benefit for the purchase of health insurance outside of job-based coverage stifled the growth of the private, individual health insurance market. In response, reformers— Republican and Democrat alike—have considered what could be refined or created to bring more fairness to the tax code. This includes work on deductions and refundable, nonrefundable, and/or advanceable tax credits. The evolution of the tax credit in the context of health reform in recent years has led to a focus on advanceable refundable tax credits being available for those in the individual market, tied to qualified coverage, and adjusted by family size.

Conservative think tanks and thought leaders have long promoted the concept of a tax credit. The Heritage Foundation and the American Enterprise Institute have both written about individual market tax credits as a way to expand coverage and reduce perverse incentives for the past twenty-five years. Congress has been exploring legislative options for just as long.

For instance, the Omnibus Budget Reconciliation Act of 1990 allowed for a non-advanceable supplement to the Earned Income Tax Credit to help recipients pay health insurance premiums on policies covering their children.⁴ That add-on was repealed by the Omnibus Budget Reconciliation Act of 1993.⁵ GAO found the supplement suffered from low participation rates, in part because of its small size and a lack of public awareness.⁶

President George W. Bush’s administration oversaw two major milestones in the movement for more equity in the tax code. The first was the Health Coverage Tax Credit (HCTC), an advanceable, refundable tax credit for the purchase of health insurance. Included as a part of the Trade Act of


2002, the HCTC covered 65 percent of the cost of qualified health insurance for eligible taxpayers and their family.⁷ Qualified health insurance included individual market coverage, a group health plan available through a spouse’s employer, and state-based plans, like one offered through a state high-risk pool. Among other requirements, plans that qualified through the latter group were required to be guaranteed issue and could not deny on pre-existing conditions. Over time, the HCTC expanded to the current level of 72.5 percent of costs. It is due to sunset January 1, 2020.⁸

Advanceability is a key feature of the HCTC because many Americans need

help paying their monthly premiums. They cannot afford to wait until they file their taxes the following year to get assistance. As a result, a system that allows for the delivery of financial help in “advance” of tax filing is critical.

Refundable vs. Non-Refundable Credits

A tax credit can be refundable or non-refundable. A refundable credit means a taxpayer can receive a payment— or “refund”— from the federal government if the amount of the credit exceeds an individual’s tax liability. In contrast, a non-refundable credit means the credit is limited to the amount of tax liability. When deciding between the two options, intent is critical: if the credit is to be valuable to the low-income— those who are most in need of assistance to purchase health insurance— then refundability is an important feature.



The second important effort made by the Bush administration was to put forward a plan calling for the replacement of the preferential tax treatment of job-based insurance with a standard deduction of \$7,500 for single filers and \$15,000 for families.⁹ One concern with a deduction, however, is that it reduces taxable income.¹⁰ This makes it most valuable to higher-income tax filers. Without taxable income, a deduction loses its value.¹¹ Those who most struggle to buy health insurance are likely lower income, making a deduction an incomplete benefit.

During his Presidential run, Senator John McCain built upon the Bush proposal by again calling for the repeal of the preferential tax treatment of job-based insurance. McCain, however, replaced this benefit with a universal tax credit of \$2,500 for individuals and \$5,000 for families, indexed annually for inflation.¹² While Obamacare was being debated, Republican alternatives, like the Empowering Patients First Act and the Patients Choice Act, included a similar advanceable refundable credit system. Today, the consensus document, *A Better Way*, and plans advanced by Senators Orrin Hatch and Richard Burr and Representative Fred Upton¹³ as well Former Representative Tom Price call for universal credits.¹⁴

Replacing Obamacare with Universal Health Care Tax Credit

Republicans want to repeal Obamacare's expensive and rigid system of subsidies and replace them with a simple and flexible, advanceable and refundable tax credit to help Americans who do not receive insurance through their employer or a government program.

The Obamacare subsidy system did not work because the law required the subsidies only be used to purchase expensive, one-size fits all coverage. Further, the subsidies could only be used on the government exchanges. The lack of competition on the exchanges — where one-third of U.S. counties have only one insurer on the exchange— has made the complicated Obamacare subsidy unworkable or not useful for millions of Americans.


Republicans want to change all of that. To lower the cost of healthcare, Republicans would provide relief from all the Obamacare tax increases, including:

- The tax on health insurance premiums
- The medicine cabinet tax
- The tax on prescription drugs
- The tax on medical devices
- The increased expense threshold for deducting medical expenses

To provide relief during the transition period, the penalty taxes for the individual mandate and the employer mandate are zeroed-out immediately. Additionally, Americans eligible for the Obamacare subsidy will be able to use their credit for expanded options, including currently prohibited catastrophic plans. To promote market stability and premium stabilization during the transition period, the Obamacare subsidies are adjusted slightly to provide additional assistance for younger Americans and reduce the over-subsidization older Americans are receiving. Hyde restrictions on federal funding for abortions are included for the transition period.

Our proposal will then create a new, advanceable, refundable tax credit to assist with the purchase of health insurance on the individual insurance market. The legislation creates a new code section – 36C— to do this. The credit is:

- Universal for all citizens or qualified aliens not offered other qualifying insurance
- Age-rated
- Available for dependent children up to age 26
- Portable
- Grows Over Time



The credit is not based on income. This will help simplify the verification process and expand access for Americans who have been left behind by Obamacare. Additionally, a universal credit does not create the same labor market distortions and perverse incentives as President Obama’s law did: according to CBO, the Obamacare income-based subsidy system resulted in so many lost labor hours it would be as if 2 million full-time equivalent workers left the labor force in 2025. A universal credit fixes this unnecessary disincentive to work and makes sure our tax code is built for growth.

Older Americans will receive a higher credit amount than younger Americans, reflecting the higher cost of insurance for older Americans. Taxpayers can receive credits for their dependents – including children up to the age of 26. The credit, however, is limited only to citizens or qualified aliens. Incarcerated individuals are not eligible for the credit.

The credit is not available to individuals who are eligible for coverage through other sources, specifically through an employer or government program.

The credit can be used to purchase any eligible plan approved by a State and sold in their individual insurance market, including catastrophic coverage. Additionally, if an employer does not subsidize COBRA coverage, the individual can use the credit to help pay unsubsidized COBRA premiums while he or she is between jobs. If the individual does not use the full value of the credit, he or she can deposit the excess amount into a health savings account. The portability of this credit makes it significantly more user-friendly and will promote competition in the individual insurance market to create the types of plans Americans actually want to purchase.

The credit is not available to be used for plans that cover abortion.


Health Savings Accounts

Conservatives have long championed health reform efforts that empower Americans and unleash the forces of choice and competition to lower costs and increase quality. One such policy with a long conservative record is the health savings account (HSA).

According to the National Center for Policy Analysis, work in this area first began in 1984 to advance “medical IRAs,” owned by a Medicare-eligible individual.¹⁵ In 1985, Virginia Republican D. French Slaughter, Jr. introduced the Health Care Savings Account Act.¹⁶ The bill would allow individuals and employers to contribute to a tax-preferred account up to the amount of Medicare payroll tax the employee and employer paid during that year. Early distributions would be penalized, spending from the account could not also be taken as a medical expense deduction and catastrophic health protection for certain Medicare-eligible individuals would be established. An examination by Michelle Ye Hee Lee of the *Washington Post* found this bill was the earliest legislation that included some of the basic elements that would later become today’s HSAs.¹⁷

By the 1990s, conservative think tanks were joining forces to advance newly renamed “medical savings accounts” (MSAs).¹⁸ And a flood of— often bipartisan— legislation soon followed: former Senators Breaux and Daschle joined with ten other Senators to introduce a bill¹⁹; then-Representative Santorum authored a bill with former Senator Phil Gramm²⁰; and Representative Sam Johnson sponsored a measure to provide Medical Savings Accounts to those who did not have access to an employer-provided group health plan, but who are covered by a qualified catastrophic coverage health plan and no other coverage.²¹

Building upon these efforts, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 included what became known as Archer MSAs, named for then-Ways and Means Committee Republican Chairman Bill Archer.²² These accounts eventually begat HSAs as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, championed by then-President Bush.²³ The rules surrounding these accounts have stayed generally consistent ever since: an



individual can contribute to an HSA on a tax-preferred basis if she has coverage under a high deductible health plan and no other health coverage.²⁴ Required deductibles and contributions levels are set in statute²⁵ and the account itself belongs to the individual.

Today, 20 million Americans are enrolled in HSA-eligible plans.²⁶ And Republicans have continued to advance legislation to expand access and accessibility of these plans, especially in the context of repeal and replace:


- The 2009 House Republican alternative to Obamacare included four improvements to HSAs²⁷
- In 2009, Senators Tom Coburn and Richard Burr and Representatives Paul Ryan and Devin Nunes championed a bill expanding the use of HSAs²⁸
- H.R. 2300, the health reform bill authored by Former Representative Price, includes 19 HSA provisions²⁹
- The Republican Study Committee's proposal includes nearly two dozen HSA refinements³⁰
- The Patient CARE Act, written by Senators Richard Burr and Orrin Hatch and Representative Fred Upton, contains several common sense reforms to expand access to HSAs³¹
- The consensus document, *A Better Way*, improves how HSAs operate and allowed for greater flexibility for individuals and families³²
- The Ways and Means Committee advanced HSA changes in 2012³³ and 2015, including increases to the contribution levels to match the sum of the maximum out-of-pocket and deductible limit³⁴

Making Health Savings Accounts More Flexible and Accessible

HSAs are tax-advantaged savings accounts, tied to a high-deductible health plan (HDHP), which can be used to pay for certain medical expenses. HSAs tied to HDHPs are popular and effective options that lower costs and empower individuals and families. It allows individuals and families to control their utilization of health care by providing incentives to shop around. This ultimately makes health care more affordable and increases quality.

Republicans believe that replacing Obamacare means expanding the number of individuals with HSAs as well as expanding how individuals and families can use their HSA. The policies include:

- **Increase maximum HSA contribution limit:** Under current law, in 2017, the maximum amount that can be contributed (both employer and individual contributions) to an HSA is \$3,400 for self and \$6,750 for a family. H.R. 1270 (114th Congress) and *A Better Way* significantly increase the contribution limits by allowing contributions to an HSA to equal the maximum out of pocket amounts allowed by law. For 2017, those amounts are \$6,550 for self-only coverage and \$13,100 for family coverage.
- **Allow Both Spouses to Make Catch-Up Contributions to the Same HSA:** HR. 1270 and *A Better Way* provide that if both spouses of a married couple are eligible for catch-up contributions and either has family coverage, the annual contribution limit that can be divided between them includes both catch-up contribution amounts. Thus, for example, they can agree that their combined catch-up contribution amount is allocated to one spouse to be contributed to that spouse's HSA. In other cases, as under present law, a spouse's catch-up contribution amount is not eligible for division between the spouses; the catch-up contribution must be made to the HSA of that spouse.
- **Administrative fix for expenses incurred prior to establishment of HSA:** H.R. 1270 and *A Better Way* provide that, if an HSA is established during the 60-day period beginning on the date that an individual's coverage under a high deductible health plan begins, then the HSA is treated as having been established on the date that such coverage begins for



purposes of determining if an expense incurred is a qualified medical expense. Thus, if a taxpayer establishes an HSA within 60 days of the date that the taxpayer's coverage under a high deductible health plan begins, any distribution from an HSA used as a payment for a medical expense incurred during that 60-day period after the high deductible health plan coverage began is excludible from gross income as a payment used for a qualified medical expense even though the expense was incurred before the date that the HSA was established.

Modernizing and Strengthening Medicaid to Protect the Most Vulnerable

The Medicaid program today is a critical lifeline for some of our nation's most vulnerable patients, as the program provides health care for children, pregnant mothers, the elderly, the blind, and the disabled. Medicaid currently covers nearly 72 million Americans—more than Medicare — and up to 98 million may be covered at any one point in a given year.

But today, the Medicaid safety net is under strain and not serving patients as well as it should. Many state Medicaid programs suffer from significant waste, fraud, and abuse, due to failures in state and federal oversight. Medicaid's incentives often lead States to offer more benefits, but cut payments to health care providers, which means low-income patients have less and less access to quality care. The result is nationally, only a portion of primary health care providers accept Medicaid beneficiaries— often with even fewer specialists accepting such patients.


On its current path, the Medicaid program is on unsustainable financial footing. This is not merely a fiscal issue, but an issue that jeopardizes the ability of federal and state government to take care of the most vulnerable who actually rely on the program. Today the program spends more general revenue than Medicare and is projected to cost more than defense spending next year.

Obamacare upset this historic balance and worsened Medicaid's spending problem. Obamacare provided enhanced federal funding for able-bodied adults. In 2017, the federal government is paying 95 cents of each expansion dollar, and that phases down to 90 cents in 2020 and beyond for the Medicaid expansion. This is unfair because the federal government is paying a greater portion of the cost of coverage for able-bodied adults, than for the disabled, elderly, and most vulnerable patients. This disparity also creates a perverse incentive for States when they have budget shortfalls and need to trim their Medicaid program. That's because it creates an incentive for States to reduce services or provider payments related to the most vulnerable patients, rather than able-bodied adults.

Repealing Obamacare's Unsustainable and Unfair Medicaid Expansion and Putting States In Charge

For too long, states have been treated like junior partners in the oversight and management of the Medicaid program – forced to go through long and cumbersome waiver processes just to make modest changes to their program. But governors and state legislatures are closer to patients in their states and know better than Washington bureaucrats where there are unmet needs and opportunities to cut down on waste, fraud, and abuse. House Republicans agree control should be returned back to states and Washington bureaucrats role in Medicaid reduced. Instead of simply expanding a broken program, Republicans instead want to put states in charge of their Medicaid programs and give them the tools, resources, and flexibility to address their unique needs

Under our proposal, Obamacare's Medicaid expansion for able-bodied adults enrollees would be repealed in its current form. There would be a period of stability to ensure we are not pulling the rug out from underneath States or patients. States that chose to expand their Medicaid programs under Obamacare could continue to receive enhanced federal payments for currently enrolled beneficiaries for a limited period of time. However, after a date certain, if states choose to keep their Medicaid programs open to new enrollees in the expansion population, states would be reimbursed at their *traditional* match rates for these beneficiaries. This ensures continuity of care



and coverage for low-income adults, but does not reward States that expanded Medicaid under Obamacare and allows individuals to cycle off the program into other coverage sources naturally. To provide equity, non-expansion States could be eligible to receive additional temporary resources for safety net providers during this time frame.

Putting Medicaid On a Budget By Reforming Medicaid Financing With a Per Capita Allotment

Back in 1995, then-President Bill Clinton called for reforming Medicaid with a per capita allotment. But today's Medicaid program is three times larger by enrollment and annual spending than it was when President Clinton first proposed per capita allotments. Caring for the most vulnerable patients must include not only ensuring they receive the care they need, but it must include ensuring programs like Medicaid that provide such care are sustainable. CBO has noted that Medicaid spending will continue to grow at a rate faster than the economy, so it would be irresponsible for Congress not to make targeted improvements to a program that is mathematically unsustainable.

Based on *A Better Way*, House Republicans are looking at transitioning Medicaid's financing to a per capita allotment.

This policy idea has been supported by Republicans in Congress and Republican presidential candidates. For example, House Committee on Energy and Commerce Former Chairman Fred Upton and Senate Finance Committee Chairman Orrin Hatch – both leaders of the congressional committees charged with overseeing the Medicaid program – have proposed per capita allotment reforms. A form of a per capita allotment policy was also supported by several Republican presidential candidates in 2015—including Senator Marco Rubio, Governor Scott Walker, former Governor Jeb Bush, and Governor Chris Christie.

Beginning at a year in the future, a total federal Medicaid allotment will be available for each state to draw down based on its federal medical assistance percentage (FMAP). The amount of the federal allotment will be the product of the state's per capita allotment for major beneficiary categories—aged, blind and disabled, children, and adults—multiplied by the number of enrollees in each group. The per capita allotments for each beneficiary group will be determined by each state's average Medicaid spending in a base year, grown by an inflationary index. Some federal payments, including disproportionate share hospital (DSH) payments, administrative costs, and others, are excluded from the total allotment.

Giving States the Choice to Receive a Medicaid Block Grant

Under this approach, States would also have the choice to receive federal Medicaid funding in the form of a block grant or global waiver. Block grant funding would be determined using a base year and would assume that states transition individuals currently enrolled in the Medicaid expansion out of the expansion population into other coverage. States would have flexibility in how Medicaid funds are spent, but would be required to provide required services to the most vulnerable elderly and disabled individuals who are mandatory populations under current law.

Repealing Obamacare's Medicaid DSH Cuts

Federal law requires states to make Medicaid DSH payments to hospitals treating large numbers of Medicaid and uninsured patients. The federal government provides each state an annual maximum DSH allotment. Obamacare reduced these DSH allotments.

House Republicans will repeal the Medicaid DSH cuts.

State Innovation Grants: The Next Generation of High Risk Pools

Before Obamacare, 34 states had high risk pools. Some were successful at providing relief for patients facing high costs and complex conditions. Building on the purpose of high risk pools, A Better Way envisions new and innovative State Innovation Grants. But instead of being tied to a separate pooling mechanism, these resources would give states sole flexibility to help lower the cost of care for some of their most vulnerable patients.

Here is how it works. These funds will help repair state markets damaged by Obamacare. States can use the pool to cut out-of-pocket costs, like premiums and deductibles. States may also use these resources to promote access to preventive services, like getting an annual checkup, as well as dental and vision care. And if they choose, states could funnel the money through a now-dormant high risk pool to achieve the same goals of the dated program.

Among other purposes, states could use these creative State Innovation Grants to:

- Reduce patients' out-of-pocket costs, like copayments, coinsurance, premiums, and deductibles
- Lower the cost of providing care to high utilization patients
- Stabilize the individual and small group markets
- Access preventative services, like an annual checkup
- Promote participation in private health care plans

Some may suggest State Innovation Grants would lead to enrollment caps or waiting lists – like certain high risk pools functioned prior to Obamacare. This is false. These new and innovative State Innovation Grants are designed to help vulnerable patients. Why would anyone allow them to potentially harm the very patients they are intended to help?

We all want a market that works. We all want patients to have access to high-quality, affordably-priced health coverage. To achieve this shared goal, states need well-functioning and stable marketplaces that encourage and incentivize patients to get covered and stay covered.

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1. Kaiser Family Foundation, *2016 Employer Health Benefits Survey*, September 14, 2016: <http://kff.org/report-section/ehbs-2016-summary-of-findings/>.
 2. Kaiser Family Foundation, *2016 Employer Health Benefits Survey*, 14 September 2016.
 3. Kaiser Family Foundation, *2016 Employer Health Benefits Survey*, 14 September 2016, Exhibit 7.7.
 4. <https://www.congress.gov/bill/101st-congress/house-bill/5835>
 5. <https://www.congress.gov/bill/103rd-congress/house-bill/2264>
 6. <https://www.gpo.gov/fdsys/pkg/GAOREPORTS-GGD-94-99/html/GAOREPORTS-GGD-94-99.htm>
 7. <https://www.congress.gov/bill/107th-congress/house-bill/3009>
 8. http://www.crs.gov/Reports/R44392?source=search&guid=6971074d281e42dab011cb0bf8e265c7&index=0#_Toc443985170
 9. <https://georgewbush-whitehouse.archives.gov/news/releases/2007/01/20070122-3.html>
 10. http://www.crs.gov/Reports/R42872?source=search&guid=03bd76a31c3c4a22aa5acc1516de8371&index=2#_Toc440442501
 11. <http://www.taxpolicycenter.org/briefing-book/whats-difference-between-tax-deductions-and-tax-credits>
 12. http://www.heritage.org/health-care-reform/report/the-mccain-health-care-plan-more-power-families#_ftn1
 13. <https://energycommerce.house.gov/news-center/press-releases/burr-hatch-upton-unveil-obamacare-replacement->



plan

14. <https://www.congress.gov/bill/114th-congress/house-bill/2300>
15. <http://www.ncpa.org/pub/a-brief-history-of-health-savings-accounts>
16. <https://www.congress.gov/bill/99th-congress/house-bill/3505>
17. https://www.washingtonpost.com/news/fact-checker/wp/2015/03/25/did-santorum-invent-health-savings-accounts/?utm_term=.2fd6f396b036
18. <http://www.ncpa.org/pub/a-brief-history-of-health-savings-accounts>
19. <https://www.congress.gov/bill/102nd-congress/senate-bill/2873>
20. <https://www.congress.gov/bill/102nd-congress/house-bill/4130>
21. <https://www.congress.gov/bill/102nd-congress/house-bill/5970>
22. <https://www.congress.gov/bill/104th-congress/house-bill/3103>
23. <https://www.congress.gov/bill/108th-congress/house-bill/1>
24. <https://www.jct.gov/publications.html?func=startdown&id=4922>
25. <https://www.irs.gov/pub/irs-drop/rp-16-28.pdf>
26. <https://www.ahip.org/2015-census-of-health-savings-account-high-deductible-health-plans/>
27. http://housedocs.house.gov/rules/health/111_hr3962_boehner_sub.pdf
28. <https://www.congress.gov/bill/111th-congress/house-bill/2520>
29. <https://www.congress.gov/bill/114th-congress/house-bill/2300>
30. <https://www.congress.gov/bill/115th-congress/house-bill/277>
31. <https://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/114/20150205-PCARE-Act-Plan.pdf>
32. http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf
33. <https://www.congress.gov/bill/112th-congress/house-bill/5858>
34. <https://www.congress.gov/bill/114th-congress/house-bill/1270>

