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Proposals to Replace the Affordable Care Act – Rep. Tom Price Proposal

	Representative Tom Price Empowering Patients First Act (H.R. 2300)
Date plan announced	May 13, 2015
Overall approach to expanding access to coverage	Repeal ACA entirely, including individual and employer mandates, private insurance rules, standards for minimum benefits and maximum cost sharing, and premium and cost sharing subsidies. Provide refundable tax credits of $900 to $3,000 based on age to individuals to purchase insurance in the individual market. Require insurers to offer portability protections for people who maintain continuous coverage. Pre-existing condition exclusions and rate surcharges based on health status can otherwise apply. Implement state high-risk pools with federal grant support for 3 years. Establish Association Health Plans and Individual Membership Associations through which employers and individuals can purchase coverage. Permit sale of insurance across state lines. Encourage use of Health Savings Accounts. Cap the tax exclusion for employer-provided health benefits and permit employers to contribute toward workers' premiums for non-group health policies. Permit enrollees of public programs, and employer-sponsored group health plans to opt out of coverage in favor of private non-group insurance with tax credit subsidy. Repeal Medicaid expansion. Repeal Medicare benefit enhancements, savings provisions, premiums for higher-income beneficiaries, taxes on high earnings, and quality, payment and delivery system provisions. Eliminate certain constraints on private contracts between physicians and Medicare beneficiaries and the amount that can be charged for services.
Individual mandate	• No requirement for individuals to have coverage
Premium subsidies to individuals	• Provide a refundable, flat, tax credit for the purchase of health insurance in the individual market ($900 per child, $1,200 age 18-34, $2,100 age 35-49, $3,000 age 50 and over; indexed by CPI.) Citizens, legal permanent residents of the US are eligible for the tax credit, regardless of income • Tax credit can be applied to any individual health insurance policy sold by a licensed insurer, including short term policies, but not excepted benefits (e.g., insurance only for specific disease); excess credit can be contributed to HSA • Permit individuals eligible for other health benefit programs, including Medicare, Medicaid, CHIP, TRICARE, Veterans' Affairs, the Federal Employee Health Benefits Program, and subsidized group coverage to receive a tax credit instead of coverage through the program
Cost sharing subsidies to individuals	• Repeal ACA cost sharing subsidies • Encourage use of Health Savings Accounts (HSAs) with one-time refundable tax credit of $1,000. Also raise annual tax-free contribution limit to $5,500; minimum distributions from retirement accounts, unused premium tax credit amounts, unclaimed flexible spending account balances, and other contributions permitted beyond the limit. Allow tax-free transfer of HSA balances at death to any beneficiary. Expand definition of qualified medical expenses (for which tax free withdrawals permitted), including for periodic fees paid to boutique physician practices. Expand eligibility for HSAs to enrollees of Medicare (Part A only), VA, TRICARE, others

Individual health insurance market rules	• Insurers must offer 30-day open enrollment period (OE) every two years for all individuals. Insurers also must offer 60-day special enrollment periods (SEP) for individuals after qualifying events • Guaranteed issue all products required during biennial OE and SEP; denials based on health status permitted at other times • Repeal ACA single risk pool rating standard, 3:1 age limits, gender rating prohibition, rate review requirements. For people with at least 18 months of continuous prior coverage, premiums cannot vary based on health status, but can vary based on other factors (e.g. age, gender, occupation). For individuals with less than 18 months of continuous prior coverage, permit 50% surcharge of applicable standard rates based on health status for up to 24-36 months; surcharge period reduced by prior continuous coverage. • Repeal ACA prohibition on pre-existing condition exclusions. For people with at least 18 months of continuous prior coverage, no pre-existing condition exclusion period can be applied. For people with less than 18 months of continuous prior coverage, exclusion periods up to 18 months are permitted, but must be reduced by prior continuous coverage.
Benefit design	• Repeal ACA essential health benefit standards, preventive health benefit standards, mental health parity requirements for individual market and small group market policies • Repeal ACA prohibition on lifetime and annual limits • Repeal ACA limits on annual out-of-pocket cost sharing • State flexibility to mandate benefits; state benefit laws preempted for policies sold through associations, or by insurers selling across state lines • Prohibit use of federal funds, tax credits and deductions for coverage of abortions, except to save the life of the woman or in cases of rape or incest • Prohibits discrimination against individuals, health care entities that do not pay for, cover, provide abortion services; require accommodations for religious, conscientious objections of payers, backed by private right of action
High-risk pools	• States encouraged to establish high-risk pools for individuals charged premiums at least 150% of standard rates. Alternatively, states can establish reinsurance pool or other risk adjustment mechanism used for purpose of subsidizing private health insurance • Federal grant support of $1 billion per year for 3 years. Federal grant formula allocates more money to state high-risk pools that hold premiums below 200% of standard rates, offer low income premium subsidies, and meet other standards
Selling insurance across state lines	• Non-group insurers can designate primary state in which to be licensed, policies sold in secondary states are subject to regulation by primary state with respect to the offer, sale, rating (including medical underwriting), renewal, and issuance of coverage, standards for covered benefits, claims administration
Insurance through associations	• Individual health pools (IHPs) are associations that may form and offer fully insured non-group policies. Federal private market standards apply; state laws, including stronger guaranteed issue and rating laws and benefit standards, are preempted for policies sold through IHPs • Small employers can buy coverage through association health plans (AHPs). For fully insured small group AHPs, state rating laws and mandated benefits are preempted. Self-insured AHPs permitted; for federally certified self-funded associations with membership of at least 1,000, state regulation is preempted
Dependent coverage to age 26	• Repeal ACA requirement
Other private insurance standards	• Repeal ACA minimum loss ratio standards, rebate requirements for insurers with claims expenses less than 80% of premium revenue (85% for large group policies) • Repeal ACA right to independent external appeal of denied claims • Repeal ACA transparency standards, including requirement to offer standardized, simple summary of benefits and coverage, and requirement to report periodic data on denied claims and other insurance practices

Employer requirements and provisions	• No requirement for large employers to provide health benefits that meet minimum value and affordability standards; repeal prohibition of excessive waiting periods • Cap annual tax exclusion for employer-sponsored benefits at $8,000 for self-only/$20,000 for family coverage, indexed annually to CPI • Require employers that sponsor group health plans to offer employees an equivalent defined contribution for the purchase of health insurance in the individual market. • Permit employers to automatically enroll individuals in the lowest cost group health plan as long as they can opt out of coverage • Wellness incentives up to 50% of cost of group health plan permitted
Medicaid	• Repeal ACA Medicaid expansion
Medicare	• Repeal all Medicare provisions in the ACA, including: o benefit expansions (preventive benefits, close Part D donut hole) o savings provisions that reduce updates in payments to providers and modify payments to Medicare Advantage plans o quality, payment and delivery system provisions, including the Center for Medicare and Medicaid Innovations o Independent Payment Advisory Board o Medicare premiums increases for higher income Medicare beneficiaries (Parts B and D) • Eliminate certain constraints on physicians' ability to enter into private contracts with Medicare beneficiaries for the amount they can charge Medicare beneficiaries for services, and allow patients with private contracts to seek some reimbursement from Medicare • Preempt state laws limiting the amount providers can charge for Medicare-covered services • Allow enrollees of Medicare Advantage MSAs to contribute their own funds to the MSA
State role	• State flexibility to adopt stronger private insurance standards, market rules, subject to preemption rules applicable to insurance sold across state lines, IHPs and AHPs. • Encourage states to implement a high-risk pool, reinsurance pool, or other risk adjustment mechanism.
Cost containment and transparency	• Adopt medical malpractice reforms that limit lawsuit rewards and create state health care tribunals to review cases and render decisions. Parties will still have access to state courts if not satisfied with decisions • Insurers of large group plans must comply with employer requests for periodic, aggregated claims data. Upon request insurers must also provide separate reports on individuals with high cost claims in a year, including amounts paid, dates of service, diagnosis and procedure codes. Unique ID codes for such individuals required. Employer must certify it will use only for administrative purposes and safeguard against other uses and disclosures
Health system performance	• Prohibit comparative effectiveness research from being used to deny coverage of a health care service under a Federal health care program and require the Federal Coordinating Council for Comparative Effectiveness Research to present research findings to relevant specialty organizations before publicly releasing them • Create a process to develop performance-based quality measures that could be applied to physician services under Medicare • Health care professionals engaged in negotiations with private insurers and health plans over contract terms are exempt from federal antitrust laws • Create a health plan and provider portal website to provide standardized information on health insurance plans and provider price and quality data. Provide states with funding to implement the standardized health plan and provider portal website
Tax revenues	• Repeal ACA tax changes, including the individual and large employer mandate tax penalties, Medicare Health Insurance (HI) tax increases on high earnings, Cadillac

	tax on high-cost employer-sponsored group health plans, and taxes on health insurers, pharmaceutical manufacturers, and medical devices • Revenue increases from new cap on tax exclusion for employer-sponsored group health benefits
Sources of information	https://www.congress.gov/bill/114th-congress/house-bill/2300/text