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Proposals to Replace the Affordable Care Act – Speaker Paul Ryan Proposal

This summary describes "A Better Way," a policy paper offered by Speaker Paul Ryan as a framework for repealing and replacing the Affordable Care Act (ACA). It is not a legislative proposal and, as such, lacks some of the details and specificity of legislative text.

	House Speaker Paul Ryan A Better Way: Our Vision For a Confident America
Date plan announced	June 22, 2016
Overall approach to expanding access to coverage	• **Repeal ACA,** including mandates, private market rules, standards for minimum benefits and maximum cost sharing, and premium and cost sharing subsidies. • **Retain some private market rules**, including requirement to extend dependent coverage to age 26 and prohibition on pre-existing condition exclusion periods. • **Provide refundable tax credits** based on age (unspecified), to individuals to purchase insurance in the individual market. • **Provide for one-time Open Enrollment (OE)**. Individuals can obtain coverage at other times, but failure to sign up during OE forfeits continuous coverage protections and leads to higher premiums for a period in the future. • **Require insurers to offer portability protections** for people who maintain continuous coverage • **Implement state high-risk pools** with $25 billion in federal grant support. • **Establish Association Health Plans** and Individual Health Pools 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.** • **Permit enrollees to opt out** of coverage under public programs and employer-sponsored group health plans in favor of private non-group insurance with tax credit subsidy. • **Convert federal Medicaid funding to a per capita allotment**, or to a block grant at state option. • **Convert Medicare to a premium support system** that would include traditional Medicare as an option. • **Redesign Medicare's benefits and cost-sharing**, and restrict Medigap plans from providing first-dollar coverage. • **Raise the age of Medicare eligibility to 67**. • **Combine all Medicare Savings Programs** into one program with a unified asset test. • **Create a personalized care demonstration** allowing physicians to enter into private contracts with Medicare beneficiaries.
Individual mandate	• No requirement for individuals to have coverage
Premium subsidies to individuals	• Provide a refundable, flat, age-adjusted tax credit for the purchase of health insurance in the individual market; tax credit amount not specified, but described as sufficient to purchase the typical pre-ACA health insurance plan. Citizens and legal permanent residents of the US who do not have access to job-based

	coverage, Medicare, or Medicaid 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. • Tax credits would be administered through multiple portals, including private exchanges. Robust verification methods would be put in place.
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	• Require insurers to offer one-time open enrollment period (OE) for uninsured individuals to enroll regardless of health status. • Prohibit denials of coverage based on health status. • ACA single risk pool rating standard not mentioned. Permit rate variation up to 5:1 based on age, with state flexibility to adopt different age bands. Rate variation based on health status not allowed for individuals who are continuously covered. Rate variation at other times or based on other factors not addressed. • Prohibit pre-existing condition exclusions.
Benefit design	• Repeal ACA essential health benefit standards and preventive health benefit standards. • Retain ACA prohibition on lifetime limits; prohibition on annual limits not addressed. • Repeal ACA standards for out-of-pocket cost sharing; encourage use of high deductible health plans (HDHP) and health savings accounts (HSAs) by consumers. • Permit state flexibility to mandate benefits; state benefit laws preempted for policies sold through associations, or by insurers selling across state lines • Prohibit taxpayer dollars from paying for abortion or abortion coverage by codifying Hyde Amendment. • Prohibit 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	• Encourage states to establish high-risk pools for individuals who are priced out of coverage. High-risk pool premiums would be capped (level not specified) and wait lists would be prohibited. • Provide at least $25 billion in federal funding for high risk pools; details on allocation of funding and time period not specified.
Selling insurance across state lines	• Permit consumers to purchase health insurance from insurer licensed in a different state, other detail not specified.
Exchanges/ Insurance through associations	• Allow individuals to purchase coverage through individual health pools (IHPs). IHPs would be “unbound by state benefit mandates” and provide protections for sick and high-risk patients, detail not specified. • Permit small employers to buy coverage through association health plans (AHPs). Association health plans would negotiate premiums, and would be prohibited from charging higher rates for sicker people except to the extent allowed under the relevant state rating law. State mandated benefit laws would be preempted for coverage sold through AHPs.
Dependent coverage to age 26	• Retain ACA requirement

Other private insurance standards	• Other private insurance standards, including ACA minimum loss ratio standards, right to independent external appeal of denied claims, requirement to offer standardized, simple summary of benefits and coverage, and requirement to report periodic data on denied claims and other insurance practices are not addressed. • Require GAO study of advantages and disadvantages of repealing McCarran-Ferguson anti-trust exemption for health insurance.
Employer requirements and provisions	• No requirement for large employers to provide health benefits that meet minimum value and affordability standards; prohibition of excessive waiting periods not addressed. Emphasize right of employers to self-insure, clarify that stop loss insurance purchased by self-insuring employer plans is not "group health insurance." • Cap annual tax exclusion for employer-sponsored benefits at an unspecified level that would "assure job based coverage continues unchanged for the vast majority of health insurance plans." Exempt employee pre-tax contributions to HSA from counting toward the annual cap. • Encourage expanded use of direct, or defined contribution, payment arrangements, such as health reimbursement accounts (HRAs), that allow employees to purchase coverage in the individual market. • Permit employers to offer wellness programs that are tied to financial reward or surcharge up to the limits under current law. Clarify that offer of financial incentives do not violate the Americans with Disabilities Act (ADA) or the Genetic Information Nondiscrimination Act (GINA)
Medicaid	*Financing* • Beginning in 2019, cap federal Medicaid funding available to each state to a total federal Medicaid allotment. Total allotment will be based on per capita allotments for four major beneficiary groups—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 using average medical assistance and non-benefit expenditures per full-year-equivalent enrollee in 2016, adjusted for inflation. Certain payment categories, including disproportionate share hospital (DSH) payments, Graduate Medical Education payments, and others are excluded from the allotment. States would draw down the federal allotment based on current federal medical assistance percentage (FMAP) levels. • Phase down the enhanced FMAP for the expansion population until it reaches the regular FMAP level for states that had expanded Medicaid, beginning in 2019. States that had not expanded Medicaid as of January 1, 2016 would be prohibited from doing so. • Permit states to receive federal Medicaid funding in the form of a block grant instead of a per capita cap. Block grant funding would be determined using a base year (unspecified) and would assume that states transition individuals currently enrolled in the Medicaid expansion into other coverage. States would have flexibility in how Medicaid funds are spent, except that they would be required to provide required services to mandatory populations, including dual eligibles. • Repeal FY 2018-2020 Medicaid DSH cuts and FY 2018-2019 Medicare DSH cuts, and create a national pool of uncompensated care (UCC) funds for DSH hospitals beginning in FY 2021. Require distribution of UCC funds to be based on federally-collected data defined as charity care only. *Children's Health Insurance Program (CHIP)* • Continue CHIP at its original enhanced match rate and adopt changes to the program to prevent crowd-out of private coverage and target resources on children in working families. *Other changes to Medicaid* • Allow states to require able-bodied adults on Medicaid to be employed, looking for a job, or participating in an education, training, or community program. • Allow states to charge premiums to most non-disabled adults and allow states to require non-disabled adults to use premium assistance when available.

	• Permit states to offer limited benefit packages, impose waiting lists and enrollment caps for optional populations, and allow states that expanded Medicaid to reduce income eligibility levels below 138% FPL or phase out expansion by closing enrollment to new enrollees. • Eliminate the need for a Medicaid waiver to enroll certain populations into managed care; grandfather managed care waivers that had been renewed twice; prohibit the use of "costs not otherwise matchable" in determining budget neutrality for waivers unless a state focuses on serving Medicaid or uninsured populations below a specific income threshold. • Permit states to exclude from participation in their Medicaid program providers who perform or participate in the performance of elective abortions.
Medicare	*Structural Changes to Medicare* • Convert Medicare into a premium support system whereby new beneficiaries receive a defined contribution payment to use to purchase a private plan or traditional fee-for-service Medicare, beginning in 2024. The premium support payment would be adjusted for health status and income; no plan would be permitted to deny coverage to a beneficiary. • Combine Parts A & B with a single deductible, 20% cost-sharing on all covered services, and annual limit on out-of-pocket expenses, beginning in FY2020. • Increase the age of Medicare eligibility (65) to correspond with that of Social Security (67), beginning in FY 2020. • Restrict Medigap plans from providing first-dollar coverage, beginning in FY 2020. • Combine all Medicare Savings Programs into one program and require states to use one (unspecified) asset test for beneficiary qualification, beginning in FY 2020. *Changes to Provider Payments* • Create a "personalized care demonstration" that would allow physicians to enter into private contracts with beneficiaries and provide items/services outside of Medicare. *Changes to Medicare-related provisions in the ACA* • Repeal the benchmark cap that prevents some Medicare Advantage plans from receiving full bonus amounts, and freeze the HHS Secretary's authority to adjust Medicare Advantage plans' payments for "coding intensity." • Repeal the Center for Medicare and Medicaid Innovation (CMMI), beginning in 2020. • Repeal the Independent Payment Advisory Board (IPAB). • Repeal the moratorium on physician-owned hospitals. • Repeal the FY2018 and FY2019 cuts in Medicare DSH and create a national pool of UCC funds for DSH hospitals. • Repeal changes to the hospital wage index system. *Other changes to Medicare* • Require HHS Secretary to report on Medicare Compare the performance of Medicare Advantage and traditional Medicare for each MSA on a core set of quality measures, beginning in 2020. • Require MedPAC to develop a prototype competitive bidding system by June 2021 that would adjust beneficiaries' support payments for plans' historical bids and performance on quality measures.
State role	• Provide states flexibility to adopt stronger private insurance standards, market rules, subject to preemption rules applicable to IHPs, AHPs, insurance sold across state lines. • Encourage states to implement a high-risk pool. • Provide $25 billion in federal "State Innovation Grants." Grants reward states for developing effective reforms to make health care more affordable and accessible. Grants awarded on sliding scale based on state achieving a target (unspecified) reduction of individual and small group premiums and number of uninsured residents.

Financing	• 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://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf