

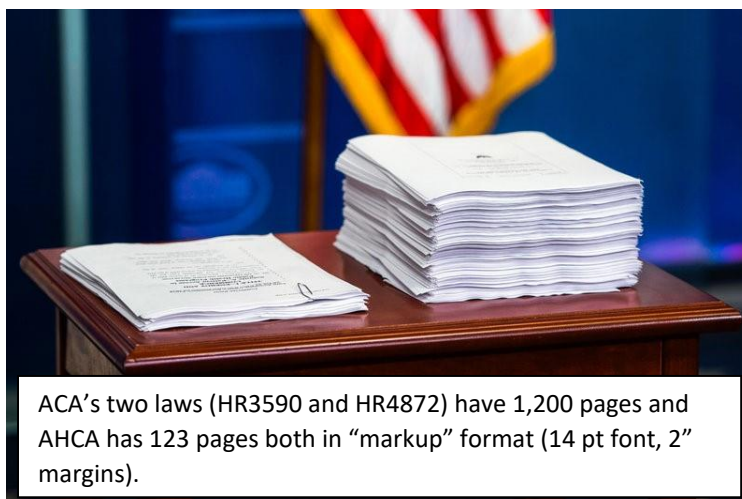
2015-2017 Proposals to Replace the Affordable Care Act

Prior to GOP Proposed Health Plan: American Health Care Act released on March 6, 2017

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For definitions and descriptions of key words (examples: exchanges, market place, individual mandate, use the glossary at HealthCare.gov (<https://www.healthcare.gov/glossary>)).



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Affordable Care Act (ACA) / Obamacare: Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act – March 24 2010

- Requires most U.S. citizens and legal residents to have health insurance.
- Created state-based health insurance exchanges through which individuals and small businesses can compare plans, apply for financial assistance, purchase coverage.
- Provides refundable premium tax credits, based on income and cost of coverage, for individuals/families with income between 100-400% of the federal poverty level.
- Imposed new insurance market regulations, including requiring guaranteed issue of all non-group health plans during annual open enrollment and special enrollment periods; limiting rating variation to 4 factors: age (3 to 1 ratio), geographic rating area, family composition, and tobacco use (1.5 to 1 ratio); prohibiting pre-existing condition exclusion periods; prohibiting lifetime and annual limits on coverage; and extending dependent coverage to age 26.
- Requires ten essential health benefits be covered by all individual and small group health insurance
- Requires plans to provide no-cost preventive benefits and limit annual cost-sharing.
- Expands Medicaid to 138% of the federal poverty level at state option and require a single, streamlined application for tax credits, Medicaid, and CHIP.
- Extends CHIP funding to 2015 and increase the match rate by 23 percentage points up to 100%.
- Closed the Medicare Part D doughnut hole and enhance coverage of preventive benefits in Medicare.
- Reduced Medicare spending by reducing payments for Medicare Advantage plans, hospitals, and other providers.
- Established the Independent Payment Advisory Board and the Center for Medicare and Medicaid Innovation (CMMI).

<http://kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/>

<https://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>

<https://www.gpo.gov/fdsys/pkg/PLAW-111publ152/pdf/PLAW-111publ152.pdf>

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Empowering Patients First Act – May 13, 2015 by Rep. Tom Price

- 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 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.
- 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.

<https://www.congress.gov/bill/114th-congress/house-bill/2300/text>

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A Better Way: Our Vision for a Confident America – June 22, 2016 by House Speaker Paul Ryan

- 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.
- 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.

<https://abetterway.speaker.gov/assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf>

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Patient Freedom Act – January 13, 2017 by Rep Paul Cassidy

- State option to continue or discontinue implementation of Title I of ACA, including mandates, most private market rules, standards for minimum benefits and maximum cost sharing, and premium and cost sharing subsidies. The Medicaid expansion is not repealed. States electing to continue ACA are described below as “ACA Electing States;” ACA subsidies for their residents are reduced to 95% of what they would otherwise have been, individual and employer mandate and ACA private market rules continue to apply. States opting to discontinue the ACA, described below as “Patient-Grant Electing States,” can elect alternative subsidies for their residents and alternative market rules, individual and employer mandates will not apply. States can also elect to discontinue ACA Title I, do nothing else, and receive no federal subsidies. States can change their election at any time.
- Retain some private market rules in all states, including requirement to cover dependents to age 26, prohibition on lifetime and annual limits, and prohibition on discrimination based on race, color, national origin, sex, age, or disability.
- In Patient-Grant Electing states, provide federal monthly deposits to new health savings accounts (called Roth HSAs) for eligible individuals (called deposit qualifying residents.) Federal government will make available to Grant Electing states an amount of money that is generally equal to 95% of ACA premium and cost sharing subsidy dollars that would have been paid on behalf of residents under ACA. This total amount will be distributed on a per capita basis to deposit qualifying residents (those privately insured, not uninsured or eligible for public coverage) and paid as deposits into Roth HSAs. Individuals can use Roth HSA funds to pay insurance premiums, cost sharing, and other qualified medical expenses.
- In Patient-Grant Electing states, provide for annual Open Enrollment (OE). All individuals can obtain non-group coverage during first OE with no medical underwriting. Thereafter, only individuals who have been continuously covered can enroll or change policies during OE with no medical underwriting. States can auto-enroll uninsured residents in default health plans and Roth HSAs, with option for such residents to opt out.
- In Patient-Grant Electing states, require insurers to offer portability protections for people who maintain continuous coverage. Those with coverage lapse of 63 consecutive days can be subject to medical underwriting (denied, rates surcharged, pre-existing condition excluded) for up to 18 months and required to pay a late enrollment penalty for 2 years. People enrolled or auto-enrolled in a default health plan will not be medically underwritten.
- In Patient-Grant Electing states, offset grant deposits to Roth HSAs by value of the tax exclusion for employer-provided health benefits.
- Retain option for all states to expand Medicaid. In addition, Patient-Grant Electing states may elect to have the expansion population enroll in private health plans and be eligible for grant deposits to Roth HSAs.
- No changes to Medicare.

<https://www.cassidy.senate.gov/imo/media/doc/PFA%20Bill%20Text.pdf>

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Obamacare Replacement Act – January 24, 2017 by Sen. Paul Rand

- Repeal most private market rules, including requirement to guarantee issue and renewal of policies, prohibitions on pre-existing condition exclusion periods, lifetime and annual limits, and rescissions, essential health benefit and cost sharing standards, minimum medical loss ratio (MLR) requirements, coverage standards for out-of-network emergency care, and the right to independent external review of denied claims. Retain dependent coverage to age 26 and authority for state consumer assistance programs.
- Restore pre-ACA portability protections under HIPAA, which required non-group insurers to offer policies on guaranteed issue basis with no pre-existing condition exclusion periods, and with no limits on rating, to eligible individuals who are leaving group health plans and have maintained continuous coverage for at least 18 months.
- Retain ACA premium and cost sharing subsidies for non-group plans sold through the Marketplace. In addition, make health insurance premiums tax deductible for individuals and families.
- Encourage use of Health Savings Accounts (HSAs) including by eliminating the annual tax-free contribution limit to HSAs and the requirement to be enrolled in a qualified high-deductible health plan.
- Authorize association health plans and individual membership associations through which employers and individuals can purchase coverage.
- Permit sale of insurance across state lines
- Retain Medicaid expansion and increase state flexibility to obtain waivers
- No changes to Medicare. Retain Medicare benefit enhancements, savings provisions, premiums for higher-income beneficiaries, taxes on high earnings, and quality, payment and delivery system provisions.

<https://www.congress.gov/115/bills/s222/BILLS-115s222is.pdf>

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House Discussion Draft – February 10, 2017

- Repeal ACA mandates (2016), standards for minimum benefits (2020), and, premium and cost sharing subsidies (2020).
- Modify ACA premium tax credits for 2018-2019 to increase amount for younger adults and reduce for older adults, also to apply to coverage sold outside of exchanges. In 2020, replace ACA income-based tax credits with flat tax credits adjusted for age.
- Retain private market rules, including requirement to guarantee issue coverage, prohibition on discriminatory premiums and pre-existing condition exclusions, requirement to extend dependent coverage to age 26. Modify age rating limit to permit variation of 5:1, unless states adopt different ratios. In addition, permit pre-ACA transition plans (for which none of these rules apply) to continue indefinitely and to be sold to new enrollees outside of the marketplace. Transition plans are also eligible for premium tax credits (though not advance-payable) starting in 2018.
- Retain health insurance marketplaces, annual Open Enrollment periods (OE), and special enrollment periods (SEPs). Plans first sold on or after January 1, 2014 can only be sold during OE and SEP, but transition plans can be sold at any time.
- Impose late enrollment penalty for people who don't stay continuously covered.
- Establish State Innovation Grants and Stability Program with federal funding of \$100 billion over 9 years. States may use funds to provide financial help to high-risk individuals, promote access to preventive services, provide cost sharing subsidies, and for other purposes
- Rescind unobligated funds in Prevention and Public Health Fund at the end of Fiscal Year 2018. In addition, provide supplemental funding for community health centers of \$285 million for FY 2018 and specify that Hyde amendment applies to community health centers
- Encourage use of Health Savings Accounts by increasing annual tax free contribution limit and through other changes
- Eliminate enhanced FMAP for Medicaid expansion as of January 1, 2020 except for those enrolled as of December 31, 2019
- Convert federal Medicaid funding to a per capita allotment and limit growth beginning in 2020 using 2016 as a base year
- Cap tax exclusion for employer-provided group health benefits
- No change to Medicare benefit enhancements or provider/Medicare Advantage plan payment savings
- Repeal Medicare High Income (HI) tax increase and other ACA revenue provisions
- Prohibit federal Medicaid funding for Planned Parenthood clinics

<http://www.politico.com/f/?id=0000015a-70de-d2c6-a7db-78ff707e0000>

Adapted from Kaiser Family Foundation (2017). Comparing proposals to replace the affordable care act. <http://kff.org/interactive/proposals-to-replace-the-affordable-care-act/>.