

OBAMACARE REPLACEMENT ACT (H.R. 1072)

SEN. RAND PAUL | REP. MARK SANFORD

Repealing the Affordable Care Act (ACA)

Effective as of the enactment date of this bill, the following provisions of the ACA would be repealed:

- Individual and employer mandates, community rating restrictions, rate review, essential health benefits requirement, medical loss ratio, and other insurance mandates.

This bill will work in conjunction with the upcoming House reconciliation bill that will repeal these and other components of Obamacare falling under the Senate Byrd Rule.

Protecting Individuals with Pre-Existing Conditions

Provides a two-year open-enrollment period under which individuals with pre-existing conditions can obtain coverage.

Restores the Health Insurance Portability and Accountability Act's (HIPAA) pre-existing conditions protections that prohibit discriminating against individuals with continuous insurance coverage.

Prior to the ACA, HIPAA guaranteed the availability and renewability of health insurance coverage for certain employees and individuals and limited the use of pre-existing condition restrictions.

Equalize the Tax Treatment of Health Insurance

Equalizes the tax treatment on the purchase of health insurance for individuals and employers by providing a universal deduction on both income and payroll taxes, regardless of how an individual obtains their health insurance.

- Does not interfere with employer-provided coverage for Americans who prefer those plans.

Under existing law dating back to WWII, individuals who receive health insurance through an employer are able to exclude the premium amount from their taxable income. However, this subsidy is unavailable for those that do not receive their insurance through an employer but instead shop for insurance on the individual market.

Expansion of Health Savings Accounts (HSAs)

Tax Credit and No-Maximum Limitation for HSA Contributions

Provides individuals the option of a tax credit of up to \$5,000 per taxpayer for contributions to an HSA.

- Contributions in excess of \$5,000 are fully deductible.

Existing law has no credit and limits tax-free contributions to \$3,400 for individuals.

No Taxpayer-Subsidized Abortions

Elective abortions are specifically excluded as allowable expenses of HSAs.

Eliminates the Requirement that HSAs be Linked to a High-Deductible Healthcare Plan

Removes the HSA plan-type requirement to allow individuals with all types of insurance to establish and use an HSA.

- Enables individuals who are eligible for Medicare, VA benefits, TRICARE, IHS, and members of healthcare sharing ministries to be eligible to establish an HSA.

Currently, in order to be eligible to establish and use an HSA, an individual must be enrolled in a high-deductible health plan.

Allowance of Distributions for Prescription and Over-the-Counter (OTC) Drugs

Allows prescription and OTC drug costs to be treated as allowable expenses of HSAs.

Purchase of Health Insurance from HSA Account

Allows the use of HSA funds for insurance premiums, making health coverage more affordable for American families.

Medical Expenses Incurred Prior to Account Establishment

Allows qualified expenses incurred prior to HSA establishment to be reimbursed from an HSA as long as the account is established prior to tax filing.

Allowing HSA Rollover to Child or Parent of Account Holder

Allows an account holder's HSA to rollover to a child, parent, or grandparent as well as a spouse.

Equivalent Bankruptcy Protections for HSAs as Retirement Funds

Provides bankruptcy protection to funds contained within HSAs.

- Helps protect the health of those finding themselves in dire financial straits.

Under existing law, most tax-exempt retirement accounts are also fully exempt from bankruptcy by federal law. While some states have passed laws that exempt HSA funds from being seized in bankruptcy, there is no federal protection for HSA funds in bankruptcy.

Certain Exercise Equipment and Physical Fitness Programs to be Treated as Medical Care

Expands allowable HSA expenses to include equipment for physical exercise or health coaching, including weight loss programs.

Nutritional and Dietary Supplements to be Treated as Medical Care

Amends the definition of “medical care” to include dietary and nutritional supplements for the purposes of HSA expenditures.

Certain Providers’ Fees to be Treated as Medical Care

Allows HSA funds to be used for periodic fees paid to medical practitioners for access to medical care.

Capitated Primary Care Payments

Allows HSA funds to be used for pre-paid physician fees, which includes payments associated with “concierge” or “direct practice” medicine.

Provisions Relating to Medicare

Allows Medicare enrollees to contribute their own money to the Medicare Medical Savings Accounts (MSAs).

Charity Care and Bad Debt Deduction for Physicians

Amends the Internal Revenue Code to provide physicians with a tax deduction equal to the amount that physician would otherwise charge for charity medical care or uncompensated care due to bad debt. This deduction is limited to 10% of a physician’s gross income for the taxable year.

Pool Reform for the Individual Market

Establishes Independent Health Pools (IHPs) in order to allow individuals to pool together for purposes of purchasing insurance.

Plans offered through an IHP cannot impose any exclusion of a specific disease from such coverage.

IHPs can include nonprofit organizations (including churches, alumni associations, trade associations, other civic groups, or entities formed strictly for establishing an IHP) so long as the organization does not condition membership on any health status-related factor.

Requires that the IHP will provide insurance through contracts with health insurance issuers in fully insured plans and not assume insurance risk with respect to such coverage.

Allows the IHP to provide administrative services to members, including accounting, billings, and enrollment information.

Interstate Market for Health Insurance

Increases access to individual health coverage by allowing insurers licensed to sell policies in one state to offer them to residents of any other state.

Exempts issuers from secondary state laws that would prohibit or regulate their operation in the secondary state.

- Secondary states may still impose requirements such as consumer protections and applicable taxes, among others.

Prohibits an issuer from offering, selling, or issuing individual health insurance coverage in a secondary state:

- If the state insurance commissioner does not use a risk-based capital formula for the determination of capital and surplus requirements for all issuers;
- Unless both the secondary and primary states have legislation or regulations in place establishing an independent review process for individuals who have individual health insurance coverage; or
- The issuer provides an acceptable mechanism under which the review is conducted by an independent medical reviewer or panel.

Gives sole jurisdiction to the primary state to enforce the primary state's covered laws in the primary state and any secondary state.

Allows the secondary state to notify the primary state if the coverage offered in the secondary state fails to comply with the covered laws in the primary state.

Association Health Plans (AHPs)

Amends the Employment Retirement Income Security Act (ERISA) to define AHPs and allow for their treatment as if they were large-group, single employer health plans.

- This definition would allow a dues-collecting organization maintained in good faith for a purpose other than providing health insurance to benefit from the same status afforded to large-group health plans under ERISA.
- Large-group health plans under ERISA prohibit establishing health-based eligibility requirements.

Requires solvency standards to protect patients' rights and ensure benefits are paid.

Requires AHPs to have an indemnified back-up plan in order to prevent unpaid claims in the event of plan termination.

AHPs must undergo independent actuarial certification for financial viability on a regular basis.

Requires AHPs to maintain surplus reserves of at least \$500,000 in addition to normal claims reserves, stop loss insurance, or indemnification insurance.

Association Health Plans (AHPs) allow small businesses to pool together across state lines through their membership in a trade or professional association to purchase health coverage for their employees and their families. AHPs increase the bargaining power, leverage discounts, and provide administrative efficiencies to small businesses while freeing them from state benefit mandates.

While AHPs currently exist, strict Department of Labor standards exist regarding the types of organizations that may qualify as a single large-group health plan under ERISA. The standard is considered a difficult standard for most associations to meet and thus precludes many associations from accessing the benefits of AHPs.

Anti-Trust Reform

Amends the McCarran-Ferguson Act of 1945 to ensure that health insurance companies are subject to anti-trust laws to create greater competition among them to drive down prices for consumers.

Increasing State Flexibility to Conduct Medicaid Waivers

Provides new flexibilities to states in their Medicaid plan design, through existing waiver authority in current law.

Under existing law, including under Obamacare, states have the option to request a waiver from the Department of Health and Human Services to allow them to test new coverage rules under Medicaid and other programs.

Self-Insurance Protections

Amends the definition of “health insurance coverage” under the Public Health Service Act (PHSA) and parallel sections of ERISA and the Tax Code to clarify that stop-loss insurance is not health insurance.

- This provision is designed to prevent the federal government from using rule-making to restrict the availability of stop-loss insurance used by self-insured plans.