



### *Section-by-Section Overview*

#### **Sec. 2. Repeal of PPACA and Health Care-Related HCERA Provisions**

- Provides for a full repeal of the ACA and all health care-related provisions included in the Health Care and Education Reconciliation Act

**Title I – Tax Incentives for Maintaining Health Insurance Coverage**  
**(Makes it financially feasible for all to purchase coverage they want for themselves and their families – not that Washington forces them to buy)**

#### **Subtitle A – Tax Credit for Health Insurance Coverage**

#### **Sec. 101. Refundable Tax Credit for Health Insurance Coverage**

- Provides for refundable, age adjusted tax credits with amounts tied to average insurance on individual market adjusted for inflation.<sup>1</sup>
  - \$1,200 for those between 18 to 35 years of age
  - \$2,100 for those between 35 and 50 years of age
  - \$3,000 for those who are 50 years and older
  - \$900 per child up to age 18
- Tax credits would be available to those who purchase health insurance through the individual market. Upon purchase, individuals would have the option of receiving an advanceable, refundable credit.
- Defines qualified health insurance (in order to qualify for a tax credit) as any insurance that constitutes medical care (i.e., major medical, qualified coverage in the state of purchase) but does not solely include excepted benefits as defined in section 9832(c) of the Internal Revenue Code (IRC), such as wrap around, vision-only or disease specific plans.
- The credit is not available to those receiving federal or other benefits including:
- Medicare, Medicaid, SCHIP, TRICARE, VA benefits, FEHBP, or individuals in employer subsidized group plans
- Prohibits an individual who is not a citizen or lawful permanent resident from receiving a credit.
- Provision to make sure it is only one benefit and there is no extra payout, double benefit rule.

#### **Sec. 102. Election of Tax Credit Instead of Alternative Government or Group Plan Benefits**

- Allows individuals to opt out of Medicare, Medicaid, TRICARE, and VA benefits and receive tax credit to purchase personal health plan instead.

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<sup>1</sup> U.S. Government Accountability Office, *Private Health Insurance: The Range of Base Premiums in the Individual Market by State in January 2013*, <http://www.gao.gov/assets/660/656121.pdf>

- Allows individuals to opt out of Medicare without losing Social Security benefits (as dictated by current law).
- Allows individuals enrolled in either a FEHBP or an employer subsidized group plan to opt out and receive a credit instead.

### **Subtitle B – Health Savings Accounts**

#### **Sec. 111. Refundable Tax Credit for Health Savings Account Contributions**

- Incentivizes the use of HSAs with a one-time \$1000 tax credit

#### **Sec. 112. Allowing HSA Rollover to Child or Parent of Account Holder**

- Allows an account holder's HSA to rollover not only to a surviving spouse, but also to a child, parent, or grandparent

#### **Sec. 113. Maximum Contribution Limit to HSA Coordinated with Retirement Savings Account Limitation**

- Increases the allowable HSA contribution to be equal to the maximum IRA contribution level

#### **Sec. 114. Transfer of Required Minimum Distribution from Retirement Plan to Health Savings Accounts**

- Allows for the transfer of the minimum distribution requirement from a retirement plan to an HSA and prohibits its inclusion in an individual's gross, taxable income

#### **Sec. 115. Equivalent Bankruptcy Protections for Health Savings Accounts as Retirement Funds**

- Protects HSA funds from seizure in bankruptcy proceedings

#### **Sec. 116. Allow Spouses to Make Catch-up Contributions to Same HSA Account**

- Allows spouses who are HSA account holders to double their catch-up contributions to account for their eligible spouses

#### **Sec. 117. Provisions Relating to Medicare**

- Medicare-eligible seniors enrolled only in Medicare Part A may continue to contribute to their HSA
- Medicare enrollees may contribute their own money to their Medicare Medical Savings Accounts (MSAs)

#### **Sec. 118. Individuals Eligible For Veterans' Benefits for a Service-Connected Disability**

- Allows veterans with service-connected disabilities to contribute to their HSAs regardless of utilization of VA medical services

#### **Sec. 119. Individuals Eligible for Indian Health Service Assistance**

- Allows Native Americans to contribute to their HSAs regardless of utilization of IHS or tribal medical services

#### **Sec. 120. Individuals Eligible for TRICARE coverage**

- Allows individuals eligible for TRICARE Extra or TRICARE Standard to contribute to their HSA

#### **Sec. 121. FSA and HRA Interactions with HSAs**

- Provides employers with the flexibility to roll-over funds from employees' FSAs or HRAs to their HSAs in a future year in order to ease the transition from FSAs and HRAs to HSAs

**Sec. 122. Special Rule for Certain Medical Expenses Incurred Before Establishment of Account**

- Allows all "qualified medical expenses" (as defined under the tax code) incurred before HSA-qualified coverage begins to be reimbursed from an HSA account as long as the account is established by April 15 of the following year

**Sec. 123. Preventive Care Prescription Drug Clarification**

- Allows coverage of drugs that prevent complications resulting from chronic conditions

**Sec. 124. Administrative Error Correction Before Due Date of Return**

- Allows for limited corrective distributions, without penalty, in the event of contribution errors

**Sec. 125. Members of Health Care Sharing Ministries Eligible to Establish HSAs**

- Allows members of health care sharing ministries to establish Health Savings Accounts

**Sec. 126. HSA Qualified Health Plans**

- Renames "high deductible health plan" as "HSA qualified health plan."

**Sec. 127. Treatment of Direct Primary Care Service Arrangements**

- Allows HSA dollars to be used to cover the fees associated with primary care service arrangements

**Sec. 128. Certain Provider Fees to be Treated as Medical Care**

- Allows for periodic fees paid to medical practitioners for access to medical care

**Sec. 129. Clarification of Treatment of Capitated Primary Care Payments as Amounts Paid for Medical Care**

- HSA can be used for pre-paid physician fees, which could include payments for "concierge" or "direct practice" medicine

**Subtitle C – Other Provisions**

**Sec. 131. Limitation on Employer-Provided Health Care Coverage**

- Allows for the employer exclusion of health care coverage up to \$20,000 for a family and \$8,000 for an individual, with any additional funds used to be taxable dollars<sup>2</sup>

**Sec. 132. Limitation on Abortion Funding**

- Requires that no federal funds authorized under, or credits or deductions allowed under the Internal Revenue Code of 1986 by reason of, this bill may be used to pay for abortion (exceptions if the pregnancy endangers a women's life or was the result of rape or incest) or cover any part of the costs of any health plan that includes coverage of abortion

**Sec. 133. No Government Discrimination Against Certain Health Care Entities**

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<sup>2</sup> Congressional Budget Office, Options for Reducing the Deficit: 2014 to 2023.

<https://www.cbo.gov/sites/default/files/cbofiles/attachments/44715-OptionsForReducingDeficit-3.pdf>

- Prohibits discrimination against any individual or health care entity that does not provide, cover, or pay for abortions, and allows for accommodations of the conscientious objection of a purchaser or health care provider when a procedure is contrary to the religious beliefs or moral convictions of such purchaser or provider.
- Provides for private right of action with actual or threatened violation of this section.

**Sec. 134. Equal Employer Contribution Rule to Promote Choice**

- Allows employer, voluntarily, to grant all employees a pre-tax benefit through a monetary (‘defined’) contribution. The employee could select his or her own plan – stay with the current employer-sponsored plan or choose an option from individual market.
  - If an employer offers more than one plan/policy option, the “defined contribution” is the average amount of the plan options.
  - Applies to all employers and FEHBP.
- Under the “defined contribution” option, if an employee changes jobs, he or she may keep coverage.
- Those moving to the individual market will not experience limitations on pre-existing conditions.

**Sec. 135. Limitations on State Restrictions on Employer Auto-Enrollment**

- Employers may institute auto-enrollment for health insurance for those plans with a federal nexus, provided the employee may opt out of coverage. States may not preclude this.

**Sec. 136. Credit for Small Employers Adopting Auto-Enrollment and Defined Contribution Options**

- Small businesses (50 employees and under) may receive grants, up to \$1,500, to offset the administrative burden to institute auto-enrollment or a defined contribution.
  - This credit is available on a one-time basis.
  - The ability to claim a credit expires two years after date of enactment.

**Title II-- Health Care Access and Availability**

**Subtitle A—Health Insurance Pooling Mechanisms for Individuals**

**Sec. 201. Federal Grants for State Insurance Expenditures**

- Each State may receive grants for providing health benefits coverage through a high-risk pool, a reinsurance pool, or other risk-adjustment mechanism used for the purpose of subsidizing the purchase of personal health insurance.
- Extends funding currently available under the PHSAs to implement and run high-risk or reinsurance pools for those rejected by individual market insurers or whose premium offers are above a certain level.
  - Those receiving a quote above the premium charged by the high-risk pool would, usually, make one eligible.
  - States may use current funding to transition from a high-risk to reinsurance pool.
- Provides \$1 billion annually for new and on-going qualified pools to be divided among the states.
- New annual funding may only go toward:
  - Current qualified high-risk and reinsurance pools that only cover “high-risk” populations. Individuals under the Health Care Tax Credit may be exempted.
  - Pools created after date of enactment that offer:
    - High-Risk Pools
      - Cover only high-risk individuals (with same exemption)

- Offer at least one option of a high deductible HSA plan
- Offer multiple competing plan options
- Reinsurance Pools
  - Cover only high-risk populations (with the aforementioned exemption)
  - Structures pool on prospective basis (to encourage cost containment measures) under which a health insurance issuer cedes covered lives to pool in exchange for payment of reinsurance premium
- Bonus grants are awarded to states that provide:
  - Guaranteed issue to individuals with prior group coverage
  - A reduction in actual or premium trends, or other cost-sharing requirements
  - An expansion/broadening of pool of high-risk individuals eligible for coverage
  - Adoption of the NAIC Model Health Plan for Uninsurable Individuals Act
  - Grants are conditioned upon the premium level, which cannot be unreasonably burdensome on individuals
- This Section shall sunset on October 1, 2018.

**Sec. 202. Pool Reform for Individual Membership Expansion**

- Establishes Independent Health Pools (IHPs) in order to reform and expand enrollment in health insurance coverage in the individual and small group markets.
- Amends the Public Health Service Act to allow individuals to pool together to provide for health insurance coverage through IHPs.
- An individual may enroll for health insurance coverage (including coverage for dependents of such individual) or an employer may enroll employees for health insurance coverage (including coverage for dependents of such employees) offered by a health insurance issuer through the IHP.
- IHPs are formed as legal nonprofit entities that:
  - Have been formed and maintained in good faith for a purpose that includes the formation a risk pool in order to offer health insurance coverage to its members.
  - Do not condition membership in the IHP on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee).
  - Do not make health insurance coverage offered through the IHP available other than in connection with a member of the IHP.
  - Are not health insurance issuers, and do not receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any individuals, or employees of employers, in any health insurance coverage (except for consideration received in direct conjunction with services offered through the IHP).

**Subtitle B— Small Business Health Fairness**

**Sec. 211-216. Small Business Health Fairness Act**

- Association Health Plans (AHPs) allow small business owners to band together across state lines through their membership in a bona fide trade or professional association to purchase health coverage for their families and employees at a lower cost. Increases small businesses’ bargaining power, volume discounts and administrative efficiencies while giving them freedom from state-mandated benefit packages.
- Requires solvency standards to protect patients’ rights and ensure benefits are paid.
  - Requires AHPs to have an indemnified back-up plan to prevent unpaid claims in event of plan termination.

- Requires AHPs to undergo independent actuarial certification for financial soundness on a quarterly basis.
- Requires AHPs to maintain surplus reserves of \$2 million above normal claims reserves.

### **Subtitle C—Health Insurance Reforms**

#### **Sec. 221. Requirements for Individual Health Insurance**

- Provides comparable coverage protections for those in the individual market already established for the group market
  - Expands the definition of creditable coverage to insurance purchased through the individual or small group market

### **Title III--Interstate Market for Health Insurance**

#### **Sec. 301. Cooperative Governing of Individual Health Insurance Coverage**

- 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.
- Allows consumers to shop for health insurance across state lines, just like other insurance products – online, by mail, by phone, or in consultation with an insurance agent.
- Exempts issuers from any secondary state laws that would prohibit or regulate the operation of the issuer in such state, except that any such state may require such an issuer to regulate items such as consumer protections, applicable taxes, etc.
- Requires an issuer to comply with the guaranteed availability requirements under the Public Health Service Act if:
  - The issuer is offering coverage in a primary state that does not accommodate, or provide a working mechanism for, residents of a secondary state; and
  - The secondary state has not adopted a qualified high risk pool as its acceptable alternative mechanism.
- 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.
- Sets forth criteria for qualification as an independent medical reviewer.
- 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 of the primary state.

### **Title IV—Lawsuit Abuse Reforms**

#### **Sec. 401. Change in Burden of Proof Based on Compliance with Clinical Guidelines**

- The Secretary of Health and Human Services shall enter into a contract with a qualified physician consensus-building organization, such as the Physician Consortium for Performance Improvement (PCPI), in concert and agreement with medical specialty societies, to develop clinical guidelines for the evaluation and/or treatment of medical conditions.
  - The PCPI (convened by the AMA and comprised of over 100 medical specialty societies, state medical societies, AHRQ, CMS, and others) works on quality of care and patient safety through the development, testing, and maintenance of evidence-based clinical performance measures and resources for physicians.
- Secretarial review and approval: The Secretary shall issue, by regulation, after notice and opportunity for public comment, clinical guidelines endorsed by medical specialty societies.
  - Limitation: The Secretary may not make a rule that includes guidelines other than those approved and submitted by physician specialty organizations.
- Clinical guidelines shall be publicly available.
- Clinical guidelines shall be updated regularly, at least every two years.
- Clinical guidelines provide for a safe harbor if a defendant adhered to the appropriate clinical guidelines, a defendant will not be held liable unless clear and convincing evidence establishes liability otherwise.
- Clinical guidelines may be used by a defendant as an affirmative defense in a lawsuit relating to medical treatment.
- Clinical guidelines may, by a preponderance of the evidence, demonstrate that the treatment provided was consistent with those guidelines. This safe harbor will apply in federal courts and in any state action, if such claim concerns items or services with respect to which payment is made under Medicare, Medicaid, SCHIP, or for which the claimant receives a federal tax benefit.

**Sec. 402. State Grants to Create Administrative Health Care Tribunals**

- Secretary may award grants to States for the development and implementation of administrative health care tribunals.
- Each case must first be reviewed by a panel of experts made up of 3-5 members (at least half physicians or health care professionals), selected by a state agency responsible for health.
- The panel will make a recommendation about liability and compensation. The parties may then choose to settle or proceed to the tribunal. The panel cannot recommend a finding of negligence from the mere fact that a treatment or procedure was unsuccessful or failed to bring the best result. Each tribunal must be presided over by a special judge with health care expertise, selected by the state. The opinion of the expert panel may be admitted before the tribunal. This judge will have the authority, granted by the state, to make binding rulings on standards of care, causation, compensation, and related issues.
- The legal standard for the tribunal will be gross negligence. No preliminary finding by the panel that the defendant breached the standard of care as set forth under the practice guidelines shall constitute negligence per se or conclusive evidence of liability.
- In any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court may restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity.
- Prevents a physician's apology from being used as evidence against a physician showing liability.
- Provides for proportional damages. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility.

- If either party is dissatisfied with the tribunal’s decision, that party may appeal the decision to a state court, to preserve a trial by jury. Any determinations made by the panel and the tribunal will be admissible in state court.
  - At that point, any party filing an action in state court must forfeit any compensation awarded by the health care tribunal.
  - No state may preclude any party from obtaining legal representation during any review by the expert panel, administrative tribunal, or a state court.

**Sec. 403. Authorization of Payment of Future Damages to Claimants in Health Care Lawsuits**

- Provides for periodic payments of future damage awards over \$50,000.
- Rather than reduce the amount a plaintiff will receive, past and current expenses will continue to be paid at the time of judgment or settlement, while future damages may be funded over time to ensure payment without risking bankruptcy of the defendant.

**Sec. 404. Definitions**

**Sec. 405. Effect on Other Laws**

- Exempts civil actions brought for vaccine-related injuries from this act to the extent that the Public Health Service Act (PHSA) covers them.

**Sec. 406. Applicability, Effective Date**

- Provisions in the bill will be effective for any claim initiated on or after the date of enactment of the Act except that the applicable statute of limitations provisions in effect at the time the injury occurred will govern any lawsuit arising from an injury occurring prior to enactment.

**Title V--Wellness and Prevention**

**Sec. 501. Providing Financial Incentives for Treatment Compliance**

- Amend HIPAA wellness regulations to increase permissible variation for programs of health promotion and disease prevention from 20% allowance to 50% of the cost of coverage, effective one year after date of enactment.

**Title VI--Transparency and Insurance Reform Measures**

**Sec. 601. Receipt and Response to Requests for Claim Information**

- Sets forth requirements for the reporting of claim information under certain group health plans; providing administrative penalties.
  - 30 days after the date a health insurance issuer receives a request for a report of claim information from a plan, plan sponsor, or plan administrator, the health insurance issuer shall provide the requesting party the report.
- Limitations:
  - The health insurance issuer is not required to provide a report to an employer or group health plan more than twice in any 12-month period.
  - The employer must have 50 or more employees.
- The report must be a written report transmitted through an electronic file or available online to the requesting plan, plan sponsor, or plan administrator.



- A report of claim information provided must contain protected health information under time limits set by this provision. A report provided must include:
  - Aggregate paid claims experience by month, including claims experience for medical, dental, and pharmacy benefits, as applicable
  - Total premium paid by month
  - Total number of covered employees on a monthly basis by coverage tier, including whether coverage was for an employee only or an employee with dependents
  - Total dollar amount of claims pending as of the date of the report
  - A separate description and individual claims report for any individual whose total paid claims exceed \$15,000 during the 12-month period preceding the date of the report, including the following information related to the claims for that individual:
    - A unique identifying number, characteristic, or code for the individual
    - Amounts paid
    - Dates of service
    - Applicable procedure codes and diagnosis codes
  - For claims that are not part of the report described above, a statement describing precertification requests for hospital stays of five days or longer that were made during the 30-day period preceding the date of the report.
- In order to receive data on the following items, a plan sponsor must make to the health insurance issuer a certification that the plan documents comply with HIPAA requirements, and it will safeguard and limit the use and disclosure of protected health information that the plan sponsor may receive from the group health plan to perform the plan administration functions.
  - Request for additional Information:
    - After receiving the initial report the requesting entity may within 10 days make a written request to the health insurance issuer for additional information in accordance with this section for specified individuals.
- Privacy Protections: A health insurance issuer may not disclose protected health information if the health insurance issuer is prohibited from disclosing that information under another state or federal law that imposes more stringent privacy restrictions than those imposed under federal law.
  - To withhold information in accordance with this subsection, the health insurance issuer must:
    - Notify the entity requesting the report that information is being withheld.
    - Provide a list of categories of claim information that the health insurance issuer has determined are subject to the more stringent privacy restrictions under another state or federal law.
- Clarifies that a health insurance issuer that releases information as set out in this provision has not violated a standard of care and is not liable for civil damages resulting from, and is not subject to criminal prosecution for, releasing that information.
- Limitation on pre-emption: Nothing in this title is meant to limit states from enacting additional laws in addition to this, but not in lieu of.

## Title VII—Quality

### **Sec. 701. Prohibition on Certain Uses of Data Obtained from Comparative Effectiveness or Patient-Centered Outcomes Research; Accounting for Personalized Medicine and Differences in Patient Treatment Response**

- The Secretary of HHS is prohibited from using comparative effectiveness or patient-centered outcomes research to deny coverage of an item or service under a Federal health care program.

- The Secretary must ensure that comparative effectiveness or patient-centered outcomes research conducted or supported by the Federal Government accounts for factors contributing to differences in the treatment response and treatment preferences of patients, including patient reported outcomes, genomics and personalized medicine, the unique needs of health disparity populations, and indirect patient benefits.
- Prohibits findings from the Federal Coordinating Council for Comparative Effectiveness Research (FCCER) from being released in final form until after consultation with and approval by relevant physician specialty organizations.
- This does not affect the authority of the Commissioner of Food and Drugs under the Federal Food, Drug, and Cosmetic Act or the Public Health Service Act.

**Sec. 702. Establishment of Performance-Based Quality Measures**

- Requires the Secretary to submit to Congress a proposal for a formalized process for the development of performance-based quality measures that could be applied to physicians’ services under the Medicare program.
- Such proposal shall be in concert and agreement with the Physician Consortium for Performance Improvement (PCPI) and shall only utilize measures agreed upon by each physician specialty organization.

**Title VIII – State Transparency Plan Portal**

**Sec. 801 – State Transparency Plan Portal**

- State-based portal: A state (or states) may contract with a private entity to establish a Health Plan and Provider Portal Website for the purposes of providing standardized information on certified plans available in that state as well as price and quality information on health care providers (including hospitals and other health care institutions).
- Eases individual access to various health plans.
- Requirements for Plan Portals:
  - Plans:
    - Health plans meet state law requirements and are certified in that state.
    - Provide all relevant information regarding co-payments, covered benefits, etc in a uniform manner.
  - Providers:
    - Provide all relevant information regarding price and quality information on health care providers (including physicians, hospitals, and other health care institutions).
- Limitation: Plan portal may not assist in direct enrollment.

**Title VI – Patient Freedom of Choice**

**Sec. 901. Guaranteeing Freedom of Choice and Contracting for Patients under Medicare (H.R. 1650)**

- Allows Medicare beneficiaries to voluntarily enter into contracts with participating and non-participating Medicare eligible professionals without penalty.
- Beneficiaries can submit a claim for Medicare payment or allow the eligible professional to file claims on their behalf.
- Requires the eligible professional and the beneficiary to enter into a written contract that establishes all the terms of the contract.

- Provides that a contract may not be entered into when the Medicare beneficiary is facing an emergency medical condition or urgent health care situation. Dual eligible beneficiaries also may not be parties to such contracts.
- Provides that Medicare limiting charges do not apply to Medicare charges by the eligible professional.

**Sec. 902. Preemption of State Laws Limiting Charges for Physician and Practitioner Services**

- Provides that a state may not impose a limiting charge for services provided by eligible professionals for which Medicare payment is made.

**Sec. 903. Health Care Provider Licensure Cannot be Conditioned on Participation in a Health Plan**

- Prohibits the Secretary or any state from conditioning a health care provider’s licensure on participation in any health plan.

**Sec. 904. Bad Debt Deduction for Doctors to Partially Offset the Cost of Providing Uncompensated Care Required Under Amendments Made By the Emergency Medical Treatment and Labor Act**

- Allows for physicians assisting emergency room patients to be fairly compensated for that care.
- This bill amends the Internal Revenue Code to allow certain physicians a bad debt tax deduction for their costs in providing uncompensated care as required under the Social Security Act to emergency room patients and pregnant women in labor.

**Sec. 905. Right of Contract with Health Care Providers**

- Prohibits the Secretary from precluding any enrollee, participant, or beneficiary in a health benefits plan from entering into any contract or arrangement for health care with any health care provider. A health benefits plan does not include Medicaid and Tricare.

**Title X – Quality Health Care Coalition**

**Sec. 1001. Quality Health Care Coalition**

- Exempts health care professionals engaged in negotiations with a health plan regarding the terms of any contract under which the professionals provide health care items or services from the Federal antitrust laws.
- Allows non-economically aligned physicians to negotiate together for higher quality care for their patients.
- Specifies that this section applies only to health care professionals excluded from the National Labor Relations Act. It also would not apply to negotiations relating to care provided under Medicare, Medicaid, SCHIP, the FEHBP, or the Indian Health Care Act as well as medical and dental care provided to members of the uniformed services and veterans.