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Proposals to Replace the Affordable Care Act – Senator Bill Cassidy Proposal

This summary describes Senator Bill Cassidy's Patient Freedom Act of 2017.

	Senator Bill Cassidy Patient Freedom Act of 2017 (S 191)
Date plan announced	January 23, 2017
Overall approach	• **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 The Medicaid expansion is not repealed.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**.

Individual mandate	ACA Electing States • Maintain requirement for individuals to have coverage. Patient-Grant Electing States • Eliminate requirement for individuals to have coverage.
Premium subsidies to individuals	ACA Electing States • Maintain premium tax credits, but reduce to 95% of the otherwise applicable amount. Patient-Grant Electing States • Replace premium tax credits with federal funding of deposits to new Roth HSAs, described below. The amount of funding available for a Patient-Grant Electing state will generally equal 95% of the amount of ACA premium tax credit and cost sharing reduction subsidies that would have been paid on behalf of residents under the ACA. Patient-Grant Electing states that do not elect the Medicaid expansion will also receive an amount equal to the federal payments that would have been provided for the Medicaid expansion population, assuming a 95% federal matching payment. – The total funding amount for a state is divided by the number of deposit qualifying residents in the state and per capita amount is deposited in individual Roth HSAs. – Deposit qualifying residents must have an established Roth HSA and be enrolled in any non-group health insurance or employer-sponsored group health plan. Deposit qualifying residents cannot be eligible for coverage under Medicare, Medicaid or CHIP, TriCare, FEHBP, or VA health benefits. The uninsured are not deposit qualifying residents, but states can auto-enroll uninsured residents in default health plans and auto-establish Roth HSA accounts for uninsured residents if residents have option to decline such coverage and accounts. – Per capita deposit amount for an individual is adjusted for age and geography. Per capita deposit amount is also phased out for high-income individuals. Phase out begins at income of $90,000 ($150,000 for joint filers) on a sliding scale, completely phased out at income of $190,000 ($250,000 for joint filers.) In addition, for individuals with employer sponsored insurance (ESI), deposit amount is reduced by dollar value of the federal tax exclusion for ESI. – The deposit amount is added to the gross income of deposit qualifying resident for federal tax purposes, but an offsetting Roth HSA tax credit also applies. – Patient-Grant Electing states can elect to make Roth HSA deposits available only to those residents who would have been eligible for ACA premium and cost sharing subsidies (in other words, only for those with non-group coverage, not other kinds of creditable coverage); if so the Roth HSA deposit for these individuals will be 95% of subsidy amount they would have received under the ACA. • Allow Roth HSA deposits to be spent tax free on premiums for non-group or employer-sponsored health insurance, also for cost sharing and other qualified medical expenses • Permit states to administer monthly HSA deposits or have the IRS administer monthly deposits via an advanceable, refundable tax credit to deposit qualifying individuals. End-of-year tax reconciliation is required. For any month when a deposit was made for someone when they were not a deposit qualifying resident, a 10 percent tax penalty applies to the monthly deposit amount.
Cost sharing subsidies to individuals	ACA-Electing States • Maintain cost sharing subsidies, reduced to 95% of the otherwise applicable value Patient-Grant Electing States • ACA cost sharing subsidies end. Instead, deposit qualifying residents can spend Roth HSA funds on cost sharing for covered benefits, also for premiums and other qualified medical expenses.

Individual health insurance market rules	All States • ACA Section 1557 nondiscrimination rules continue to apply; all plans are prohibited from discriminating based on race, color, national origin, sex, age, or disability. ACA Electing States • ACA private market rules and health plan standards continue. Patient-Grant Electing States • Require insurers to offer annual open enrollment periods (OE) and ACA-like special enrollment periods (SEP) following qualifying life events. During the first OE (which must not be less than 45 days), all residents can buy coverage regardless of health status (that is, canned be denied, charged more, or have coverage limitation for pre-existing condition). • After initial OE, allow only residents with continuous coverage (not interrupted by a break of 63 or more consecutive days) to enroll in or change plans regardless of health status during OE or SEP. Insurers must be allowed to turn other residents down, except when applying for the default health plan. This underwriting action is permitted for a period of time equal to number of months during the prior 18-month period in which the individual did not have continuous creditable coverage. • Eliminate single risk pool requirement and limits on age and gender rating. After initial OE, only residents with continuous coverage cannot be charged more based on health status. Insurers must be allowed to charge other residents more, except when applying for default health plan. This underwriting action is permitted for a period of time equal to number of months during the prior 18-month period in which the individual did not have continuous creditable coverage. • Charge residents who have not maintained continuous coverage a late enrollment penalty equal to the lesser of 10% of premium or 1% of the monthly premium for the default health plan times number of months uninsured during 2-year period preceding enrollment. Insurers must remit late enrollment penalty to the US Treasury. Penalty applied for two years. • Prohibit pre-existing condition exclusions only for residents with continuous coverage. Insurers must be allowed to exclude pre-existing conditions for other residents, except when applying for default health plan. This underwriting action is permitted for a period of time equal to number of months during the prior 18-month period in which the individual did not have continuous creditable coverage.
Benefit design	All States • Maintain ACA prohibition on lifetime and annual limits. Also maintain requirement to cover preventive services except for those individuals whose employers make contributions to the individual's Roth HSA. Also maintain parity of coverage for treatment of serious mental health conditions and substance use disorders. ACA Electing States • Maintain ACA health benefit standards and preventive health benefit standards. Patient-Grant Electing States • Eliminate ACA health benefit, preventive health benefit, and cost sharing standards, other than those required to continue in all states. • Design "default health plans," which all insurers must offer. Default health plans must have high-deductibles, cover generic drugs for a limited number of chronic conditions, and cover childhood immunizations with no cost sharing. States can require default health plans to cover other benefits. • Permit state flexibility to mandate benefits. • Coverage for abortion not mentioned.
Women's health	*All States* • Maintain requirement to cover preventive services, including contraception and cancer screenings, except for those individuals whose employers make contributions to the individual's Roth HSA. *ACA electing states* • Maintain ACA health benefit standards and preventive health benefit standards including maternity care, contraception, and cancer screenings. • Retain ban on preexisting conditions exclusions and gender rating.

	Patient-Grant electing states • Eliminate ACA health benefit, preventive health benefit, and cost sharing standards, other than those required to continue in all states. This eliminates no-cost contraception and cancer screenings as well as maternity care. • Repeal ban on gender rating • Repeal ban on preexisting coverage exclusions unless 18 months of continuous coverage is maintained.
Health Savings Accounts (HSAs)	<u>All States</u> • Phase out current law HSAs and authorize new "Roth HSAs." In Roth HSAs, contributions to the account are not tax deductible, but interest and investment income to the account can accumulate tax free. Distributions from the account used for qualified medical expenses are tax free. Distributions for non-qualified expenses are subject to income tax and, before age 65, a tax penalty. • Permit any individual enrolled in creditable coverage (including non-group plans, employer-sponsored plans, Medicare, Medicaid, and other public plan coverage) to establish new Roth HSAs and make contributions with their own funds, and/or accept employer contributions, subject to annual limits. • Limit annual Roth HSA contributions to $5,000 per individual per year, increased by $1,000 for individuals age 55 and older, indexed annually to medical component of CPI. No contribution limits apply for individuals in the month when they become eligible for Medicare. Government deposits to Roth HSAs on behalf of deposit-eligible individuals residing in Patient-Grant Electing States do not count against the limit. • Tax personal contributions to Roth HSAs. In addition, contributions made by residents during months when they are uninsured are subject to 10% tax penalty. Investment income from Roth HSA balances grows tax free. • Define qualified medical expenses to include premiums for health insurance, cost sharing for covered benefits, out-of-pocket costs for non-covered medical benefits, and payments to concierge physician practices. • Allow tax-free transfer of Roth HSAs at death to any beneficiary.
High-risk pools	• No provision
Selling insurance across state lines	• No provision
Exchanges/ Insurance through associations	<u>ACA Electing States</u> • Continue exchanges as under current law. <u>Patient-Grant Electing States</u> • Permit states to continue exchanges and, if states elect, the federal government will operate the state exchange. States have flexibility to waive any activity or standard for exchanges, including certification of health plans, network adequacy standards, requirement to provide consumer assistance through navigators, and others. States also have flexibility to repurpose exchanges, including to provide for auto-enrollment in default health plans.
Dependent coverage to age 26	• Retain ACA requirement for all states.
Other private insurance standards	<u>All States</u> • Apply new limits on provider charges for emergency care. For doctors and other professionals, the limiting charge is 85% of usual, customary and reasonable (UCR) charges (states will publish UCR fee schedules). For hospital and most other services, the limit is 110% of the Medicare payment rate. Providers charging more than the limit are subject to civil money penalty of up to $25,000 per violation. <u>ACA Electing States</u> • Continue all 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. Patient-Grant Electing States • Eliminate ACA standards described in paragraph above.
Employer requirements and provisions	ACA Electing States • Require large employers to offer affordable health benefits that meet minimum value standards or pay tax penalty. All other ACA employer health plan standards, e.g. relating to maximum OOP cost sharing, excessive waiting periods, also continue to apply. • Maintain the tax exclusion for employer-sponsored benefits unchanged. Patient-Grant Electing States • Eliminate the large employer mandate and other employer health plan standards (other than those expressly preserved). • Reduce federal deposits to Roth HSAs by an amount equal to the dollar value of the tax exclusion for ESI, for individuals enrolled in job-based health plans.
Medicaid	*Financing* All States • Continue option to expand Medicaid to 138% FPL with enhanced federal matching payments. Patient-Grant Electing States • Permit states to continue or adopt the expansion or to elect to make the expansion population eligible for federal Roth HSA deposits. • For states electing to make the expansion population eligible for Roth HSA deposits, provide an amount equal to the federal matching funds they would have received for the expansion population, assuming a 95% federal matching payment, in addition to amounts otherwise available for Roth HSA deposits. *Children's Health Insurance Program (CHIP)* • No changes *Other changes to Medicaid* • In all states, permit Medicaid enrollees to open Roth HSAs and make after-tax contributions with their own funds. In applying asset tests for Medicaid eligibility determinations other than for long term care, States shall disregard funds in Roth HSAs.
Medicare	*Structural Changes to Medicare* • No changes *Changes to Provider Payments* • No changes *Changes to Medicare-related provisions in the ACA* • No changes *Other changes to Medicare* • No changes
State role	All States • Provide flexibility to adopt stronger private insurance standards. • Require states to develop a fee schedule of UCR charges for emergency services provided by physicians and other providers. Patient-Grant Electing States cannot receive funds for Roth HSA deposits unless they comply. Patient-Grant Electing States • Permit states to create a "modified health status insurance mechanism" as an incentive to insurers to develop plans with benefits adequate to serve chronically ill individuals. Under this mechanism, when an individual changes plans during open enrollment, the prior plan will pay 75% of claims incurred during the first 3 months the individual is enrolled in the successor plan, and the successor plan will pay the prior plan 75% of the premium paid by the individual during the first 3 months enrolled.

	• Permit states to auto-enroll uninsured residents into default health insurance coverage and establish a Roth HSA for them unless the resident affirmatively opts out of enrollment. • Permit states to establish risk mitigation programs, such as risk adjustment, reinsurance, risk-corridor programs, to help stabilize markets. No federal funding is available for such programs. • Provide an additional federal payment equal to 2% of the amount its deposit-qualifying residents will receive in Roth HSA deposits in a year. This additional amount can only be used for population health initiatives, to be defined by the Secretary. Population Health Initiative Funding is an entitlement to states, not subject to annual appropriation by Congress.
Financing	• Retain all ACA tax changes, including 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. • In ACA Electing States, retain the individual and employer mandate and tax penalties. • In Patient-Grant Electing States, eliminate the individual and employer mandate and tax penalties.
Sources of information	https://www.cassidy.senate.gov/imo/media/doc/PFA%20Bill%20Text.pdf