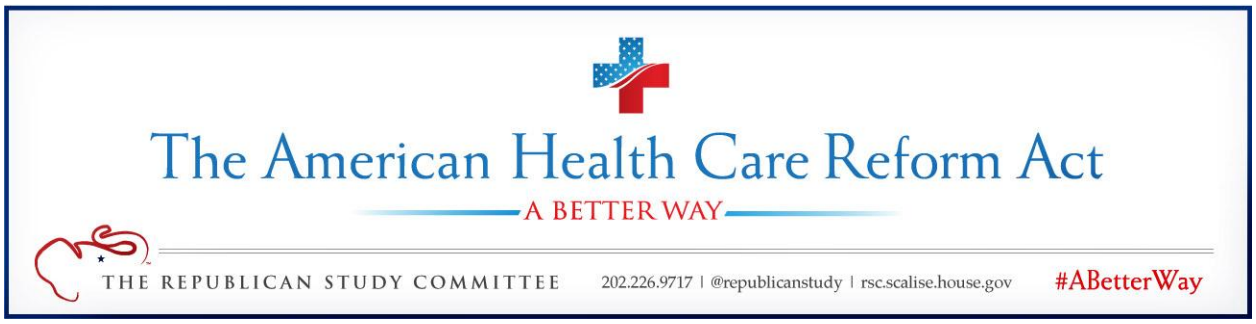


# Section-By-Section Summary

Sec. 1 — Short title; table of contents

## TITLE I — REPEAL OF OBAMACARE

Sec. 101 — Repeal of PPACA and health care-related provisions in the Health Care and Education Reconciliation Act of 2010[1]

- ✚ Full repeal of ObamaCare and related provisions in the reconciliation bill.

## Title II — INCREASING ACCESS TO PORTABLE, AFFORDABLE HEALTH INSURANCE

### *Subtitle A — Standard Deduction for Health Insurance*

Sec. 200 — Amendment of 1986 code

- ✚ Provides that, unless noted otherwise, changes in this title apply to the Internal Revenue Code of 1986.

Secs. 201-204 — Standard deduction for health insurance

- ✚ Creates a standard deduction for health insurance (SDHI)—an above-the-line tax deduction applied to both income and payroll taxes of $7,500 for individuals or $20,000 for a family—available to all Americans with qualifying health insurance. The SDHI can be applied to existing, employer-sponsored insurance or to the purchase of insurance on the individual or small group market. The SDHI will give families flexibility to pick coverage that best fits their needs and ensure that the tax benefit for insurance doesn't go away if you lose or change jobs. The SDHI is intended to be revenue-neutral and is funded through the elimination of the tax exclusion for employer-paid health insurance and the self-employed health deduction. No change is made to employers' ability to deduct payments for employees' health benefits as a business expense. The SDHI will increase annually by CPI-U.

[1] Language adopted from H.R. 45, introduced by Rep. Michele Bachmann.

Sec. 205 — Election to disregard inclusion of contributions by employer to accident or health plan

- ✚ Allows taxpayers to exclude employer contributions to health insurance plans from earned income for purposes of the Earned Income Tax Credit.

*Subtitle B — Enhancement of Health Savings Accounts*[2]

Sec. 221 — Allow both spouses to make catch-up contributions to the same HSA account

- ✚ Currently, if both spouses are HSA-eligible and age 55 or older, they must open separate HSA accounts for their respective "catch-up" contributions. This section would allow both spouses to deposit their catch-up contributions into one account.

Sec. 222 — Provisions relating to Medicare

- ✚ Individuals with HSAs lose their eligibility when they enroll in Medicare, and it is virtually impossible to avoid automatic enrollment in Medicare Part A when an individual begins to receive Social Security benefits at age 65. This section allows Medicare beneficiaries enrolled only in Part A to continue to contribute to their HSA accounts after turning 65 if they are otherwise eligible to contribute to an HSA. In addition, this section allows Medicare beneficiaries enrolled in a Medicare Medical Savings Account (MSA) plan to contribute their own tax-deductible money to their MSAs. Beneficiaries currently enrolled in Medicare MSA plans cannot contribute their own money to their MSAs.

Sec. 223 — Individuals eligible for veterans' benefits for a service-connected disability

- ✚ Current law prohibits veterans from contributing to their HSAs if they have utilized VA medical services in the past three months. This section would remove those restrictions and allow veterans with a service-connected disability to contribute to their HSAs regardless of their utilization of VA medical services.

Sec. 224 — Individuals eligible for Indian Health Service assistance

- ✚ Current law prohibits Native Americans from contributing to their HSAs if they have utilized medical services of the Indian Health Service (IHS) or a tribal organization. This section would remove those restrictions and allow Native Americans to contribute to their HSAs regardless of their utilization of IHS or tribal medical services.

[2] Language adapted from H.R. 2194, introduced by Rep. Erik Paulsen. Section 239 adopted from H.R. 1342, introduced by Rep. John Fleming. Section 240 adopted from H.R. 2688 introduced by Rep. Dennis Ross.

Sec. 225 — Individuals eligible for TRICARE coverage

- ✚ Individuals enrolled in TRICARE are not eligible for an HSA because TRICARE doesn't offer any HSA-qualified plan options. This section would remove this restriction for individuals enrolled in TRICARE Extra or TRICARE Standard who are otherwise eligible for an HSA.

Sec. 226 — FSA and HRA interactions with HSAs

- ✚ The HOPE Act of 2006 allowed employers to offer a limited opportunity for their employees to roll over unused funds from Flexible Spending Arrangements (FSAs) and Health Reimbursement Arrangements (HRAs) to an HSA up to January 1, 2012. This section provides employers a greater opportunity to roll-over of funds from employees' FSAs or HRAs to their HSAs in future years.

Sec. 227 — Purchase of health insurance from HSA account

- ✚ Individuals can only use their HSA funds to pay for health insurance premiums when they are receiving federal or state unemployment benefits or are covered by a COBRA continuation policy from a former employer. In addition, HSA funds may not be used to pay for a spouse's Medicare premiums unless the HSA account holder is age 65 or older. This section allows HSAs to be used to pay premiums for long-term care insurance, COBRA coverage, and HSA-qualified policies regardless of circumstances. This section also clarifies that Medicare premiums for a spouse on Medicare are reimbursable from an HSA even though the HSA account holder is not age 65.

Sec. 228 — Special rule for certain medical expenses incurred before establishment of account

- ✚ The IRS does not allow individuals to reimburse medical expenses incurred before the date on which an HSA account is established. This section allows all "qualified medical expenses" (as defined under the tax code) incurred after 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. 229 — Preventive care prescription drug clarification

- ✚ Although IRS guidance allowed certain types of prescription drugs to be considered "preventive care," the guidance generally does not permit plans to include drugs that prevent complications resulting from chronic conditions. Section 229 expands the definition of "preventive care" to include medications that prevent worsening of or complications from chronic conditions.

Sec. 230 — Equivalent bankruptcy protections for health savings accounts as retirement funds

- ✚ Funds in an HSA account are not considered part of the protected estate in a bankruptcy and, as a result, the money is available to creditors. This section clarifies that bankruptcy proceedings cannot result in the loss of HSA funds.

Sec. 231 — Administrative error correction before due date of return

- ✚ HSA contribution errors are infrequent, but they are problematic for employees who are responsible for taxes and penalties if the error is corrected. This section allows for limited corrective distributions, without penalty, in the event of contribution errors.

Sec. 232 — Reauthorization of Medicaid health opportunity accounts

- ✚ This section permits states to once again offer accounts similar to HSAs for Medicaid recipients. A previous law terminated this option for states.

Sec. 233 — Members of health care sharing ministries eligible to establish health savings accounts

- ✚ To promote all forms for consumer directed health care programs, this section allows members of health care sharing ministries to establish Health Savings Accounts.

Sec. 234 — High deductible health plans renamed HSA qualified plans

- ✚ This section changes the name “high deductible health plan” to “HSA-qualified health plan.”

Sec. 235 — Treatment of direct primary care service arrangements

- ✚ This section allows HSA dollars to be used to pay fees associated with primary care service arrangements.

Secs. 236-238 — Expanded definition of “qualified medical expenses”

- ✚ These sections modify the definition of “qualified medical expenses” under Section 213(d) of the Internal Revenue Code to include the cost of: 1) exercise and physical fitness programs, up to $1,000 per year (Sec. 236); nutritional and dietary supplements, including meal replacement products, up to $1,000 per year (Sec. 237); and periodic fees paid for direct practice primary care practitioners (Sec. 238). These modifications affect all health care programs using the definition, including HSAs, HRAs, FSAs, and the medical expense deduction when taxpayers itemize.

Sec. 239 — Increase the maximum contribution limit to an HSA to match deductible and out-of-pocket expense limitation

- ✚ Current law limits annual HSA contributions. The limits are updated annually for inflation. For 2013, self-only coverage contributions are limited to $3,250 for singles and $6,450 for individuals with family coverage. This section would allow HSA-eligible individuals to contribute an amount equal to the annual limit on out-of-pocket expenses under their HSA-qualified insurance plan. For 2013, these out-of-pocket limitations cannot exceed $6,250 for singles and $12,500 for families.

Sec. 240 — Child health savings account

- ✚ Creates a tax incentive for parents who establish a deferred-use Health Savings Account (HSA) on behalf of their child/children prior to the fifth birthday. The Child HSA is treated for tax purposes as "owned" by the parent until the child: (1) reaches the age of 18, and (2) obtains health insurance coverage independent of their parents. Any amount paid or distributed out of the Child HSA prior to satisfying these criteria will be treated as normal yearly income for the parents. In the case that a child becomes disabled, dies, or is medically incapacitated, the parents may roll the HSA funds into: (1) an Individual Retirement Account, (2) their own HSA, or (3) another child's HSA.

Sec. 241 — Distributions for abortion expenses from health savings accounts included in gross income

- ✚ Prohibits HSA funds from being used to pay for abortions, except in the case of rape, incest, or when the life of the mother is threatened.

*Subtitle C — Enhanced Wellness Incentives*

Sec. 251 — Providing financial incentives for treatment compliance[3]

- ✚ 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 III — IMPROVING ACCESS TO INSURANCE FOR VULNERABLE AMERICANS**

*Subtitle A — Eliminating Barriers to Insurance Coverage*

Sec. 301 — Elimination of certain requirements for guaranteed availability in individual market[4]

[3] Language adopted from H.Amdt. 510, offered by Rep. John Boehner in the 111th Congress.
[4] Ibid.

- ✚ The bill extends existing HIPAA guaranteed availability protections, which will improve insurance portability and protections for Americans with pre-existing conditions. Under current law, individuals purchasing insurance in the individual market are protected from pre-existing condition exclusions if there is not a substantial break in coverage, their previous coverage was through an employer, and they fully exhaust COBRA coverage. This provision would allow individuals to receive those same protections regardless of the source of their prior coverage and without requiring them to exhaust COBRA coverage, which is often very expensive for both employees and employers.

*Subtitle B – Ensuring Coverage for Individuals With Preexisting Conditions and Multiple Health Care Needs Through High Risk Pools*

Sec. 311 — Improvement of high risk pools

- ✚ Reauthorizes pre-ACA state high risk pools and provides $25 billion of federal funding over 10 years for operational expenses. Insurance offered through these programs will ensure everyone has access to affordable health care, regardless of their health status. States will have to eliminate high risk pool waiting lines and premiums for enrollees in high risk pools would be limited to 200% of the average premium charged in a State. Specifies that only citizens or nationals can participate in high risk pools.

**TITLE IV — ENCOURAGING A MORE COMPETITIVE HEALTH CARE MARKET**

*Subtitle A — Expanding Patient Choice*

Sec. 401 — Cooperative Governing of Individual Health Insurance Coverage[5]

- ✚ Differences in state regulation of health insurance have resulted in significant variance in health insurance costs from state to state. Americans residing in a state with expensive insurance plans are locked into those plans and do not currently have an opportunity to choose a lower cost option. This provision will allow Americans to purchase licensed health insurance in any state. Insurance sold in a secondary state will be still be subject to the consumer protections and fraud and abuse laws of the policy holder's state of residence. This provision will provide access to more affordable health insurance options.

*Subtitle B — McCarran-Ferguson Reform*

Sec. 411 — Restoring the application of antitrust laws to health sector insurers[6]

[5] Language adapted from H.R. 762, introduced by Rep. Marsha Blackburn.
[6] Language adapted from H.R. 911, introduced by Rep. Paul Gosar.

- ✚ Amends the McCarran-Ferguson Act so that nothing contained in the bill would modify, impair, or supersede the operation of any of the antitrust laws with respect to the business of health insurance (including the business of dental insurance). This section further clarifies that "traditional health insurance" not the business of life insurance (including annuities) or property and casualty insurance is being addressed.

*Subtitle C — Medicare Price Transparency*

Sec. 421 — Public availability of Medicare claims data[7]

- ✚ This section requires HHS to make Medicare claims and payment data publicly available, at no cost, through a searchable database. Payment amounts to providers and suppliers, as well as their respective locations will be available. The database will be organized according to provider or supplier specialty, and will be searchable based on the types of services and items furnished. Personnel and medical files that would constitute an unwarranted invasion of personal privacy will not be made available to the public.

*Subtitle D — State Transparency Portals*

Sec. 431 — Providing information on health coverage options and health care providers[8]

- ✚ Authorizes $50 million in grants to be made available to states to help establish optional state transparency plan portals. These portals would serve as a resource for providing standardized information on certified health insurance plans available in that state as well as price and quality information on health care providers. These portals would be prohibited from directly assisting in plan enrollment.

*Subtitle E — Protecting the Doctor-Patient Relationship*[9]

Sec. 441 — Rule of construction

- ✚ States that nothing in this act shall be construed to interfere with the doctor-patient relationship or the practice of medicine.

Sec. 442 — Repeal of Federal Coordinating Council for Comparative Effectiveness Research

- ✚ This provision repeals the Federal Coordinating Council on Comparative Effectiveness Research. Patient and physician groups are concerned about the federal government

[7] Language adopted from H.R. 2843, introduced by Rep. Jim Sensenbrenner
[8] Language adapted from H.R. 2300, introduced by Rep. Tom Price.
[9] Language adopted from H.Amdt. 510, offered by Rep. John Boehner in the 111th Congress.

rationing care, as is done in other countries. This removes the potential authority of the federal government to ration care based on cost of treatment.

*Subtitle F — Establishing Association Health Plans*

Secs. 451-455 — Association Health Plans[10]

- ✚ These provisions will allow small businesses to pool together through Association Health Plans (AHPs) to leverage lower cost health insurance on behalf of their employees. By creating larger insurance pools for small businesses, these provisions will make health insurance more affordable and more accessible.

**Title V — REFORMING MEDICAL LIABILITY LAW**

Secs. 501-509 — Medical Liability Reform[11]

- ✚ It's widely accepted that defensive medicine is driving up health care costs. These provisions address this problem by: placing a statute of limitations on bringing a case; capping non-economic damages to $250,000 with assignation of proportional responsibility; allowing courts to restrict lucrative attorney contingency fees; clarifying and limiting punitive damages; and protecting states with existing functional medical liability laws. These provisions set no caps on economic damages, which are often the largest component of liability awards, thus patients will continue to have their rights to economic damages protected.

**Title VI — RESPECTING HUMAN LIFE**

Sec. 601 — Special rules regarding abortion

- ✚ Provides that nothing in this act requires health plans to provide coverage of abortion services, or permits any government official to require coverage of abortion. Prohibits federal funds authorized or appropriated by this act from covering abortion, except in the case of rape, incest, or when the life of the mother is jeopardized. Ensures that nothing in the bill will preempt state pro-life or conscience protection laws.

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[10] Language adopted from H.R. 1050, introduced by Rep. Sam Johnson in the 112th Congress.
[11] Language adopted from H.R. 5, introduced by Rep. Phil Gingrey in the 112th Congress.