	Patient CARE Act (Burr-Hatch-Upton)	Transcending Obamacare (Roy /Manhattan Institute)	2017 Project	Empowering Patients First Act (Rep. Price)	Jindal (America Next)	American Health Care Reform Act (Roe/RSC)	Health Care Choice Act (Cruz, Barrasso, Crapo, Rubio, Vitter)	When Obamacare Fails (Miller/AEI)	Comparison
Release Date/Link	2/5/2015	8/1/2014	2/10/2014	5/13/2015	4/2/2014	6/4/2015	3/3/2015	12/1/2012	
Key Quote	“The reforms outlined above are intended to lower healthcare costs, empower patients in their insurance choices and health care decisions, and put our health care system on a sustainable path, all while making sure that we do not add a single dollar to the federal deficit. Taken together, these reforms will better serve the American people.”	“The Universal Exchange Plan would introduce major changes to the broad set of federal health care entitlements: Obamacare, Medicare, and Medicaid. The Plan uses a reformed version of the ACA’s health insurance exchanges as the basis for far-reaching entitlement reform”	"A winning alternative... must meaningfully address Americans’ trio of core goals for real health-care reform: lowering costs, dealing with preexisting conditions, and significantly increasing the number of people who are insured versus the pre-Obamacare status quo."	“The Empowering Patients First Act puts patients, families and doctors in charge by focusing on the principles of affordability, accessibility, quality, innovation, choices and responsiveness. Those principles form the foundation of the solutions in H.R. 2300 – solutions including individual health pools and expanded health savings accounts, tax credits for the purchase of coverage and lawsuit abuse reforms to reduce the costly practice of defensive medicine."	“We focus first and foremost on reducing healthcare costs—because while most Americans want to buy health care and health insurance, many of them struggle to afford it. We also work to preserve and strengthen the safety net for the most vulnerable in our society, including those with preexisting conditions. And we focus on enhancing patient choice, removing obstacles to portability and consumer selection, including many put into place by Obamacare itself”	“A bill to repeal the Patient Protection and Affordable Care Act and related reconciliation provisions, to promote patient-centered health care, and for other purposes”	“The Health Care Choice Act... would remove Obamacare's costly insurance mandates and allow residents in one state the option to purchase a health insurance plan of their choice in any other state.”	"A replacement and renewal program for better health care and health: • Starts with defined-contribution financing of all forms of taxpayer-subsidized health insurance coverage; • Retargets subsidies to strengthen the health care safety net for the most vulnerable Americans; • Stimulates responsible competition among the states in information-based regulation of health insurance and health care delivery; and • Builds better connections between more diverse coverage options and insurance consumers."	
Affordability									

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Premium Assistance	Tax credits: fixed, age- and income-adjusted, growth tied to CPI+1. Example provided for <200% FPL: Age 18-34: $1970 individual/$4290 family Age 35-49: $3190/$8330 Age 50-64: $4690/$11,110	Tax credits: income-based, with aim to keep eligible individual premium contributions near ACA levels	Tax credits: Fixed tax credit of $1200-$3000 per adult based on age, and $900 per child, increased 3% annually. Excess can be put into HSA	Tax Credits: fixed, age-adjusted tax credits: Age 18-35: $1200; Age 36-49: $2100; Age 50+: $3000. Children: $900. Growth tied to CPI	Standard deduction (value defined as producing government revenues at same level as ESI exclusion pre-ACA). Grants to states to assist with coverage for low-income, pre-existing conditions	Standard deduction: $7500 individual/$20,500 families (any remaining value retainable)	No related provisions	Tax Credits: fixed value, risk-adjusted, universal for under-65 population. Possible refinements for income and geography, depending on feasibility. Value "might approximate" current average annual family ESI subsidy: $5000-$6000	Much disagreement. Key areas of dispute: Refundable tax credit or deduction (with Jindal's grants and Cruz's lack of assistance as outliers)? If tax credits: means-tested and income-based, or standard credit? Is tax credit fixed or does it limit individual contributions regardless of premium increases?
Premium Assistance Eligibility Threshold	300% FPL (US citizens only)	317% FPL	N/A	N/A	~150% FPL (grant) N/A (deduction)	N/A	N/A	N/A	3 plans employ some type of means testing, with two establishing a ceiling around 300% FPL (Jindal at 150% is outlier)
Cost-Sharing and/or Deductibles	No limits established	Reduces actuarial value of ACA metal tiers: Bronze: 40%Silver: 55%Gold: 70%Platinum: 85% Benchmark Plan deductibles average $7,000/individual and $14,000/family	No limits established	No limits established	No limits established	No limits established	No limits established	No limits established	Roy's plan is the only one that proposes federal standards for consumer cost-sharing

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Health Savings Accounts	Allows HSAs to be used for COBRA premiums. Removes restrictions on veteran/military benefits and Indian Health Service usage	Funds annual contributions averaging $1,800/year for individuals eligible for premium support ($3,600/year for eligible families)	One-time $1000/person credit to all HSAs. Endorses HSA liberalization rules in Patient CARE Act and RSC proposal.	One-time $1000 credit to incentivize HSA use. Classifies drugs for chronic conditions as preventive care. Allows concierge fees to be paid with HSA funds. Removes restrictions on HSA contributions for Health Sharing Ministry members, TRICARE, IHS, and Medicare Part A-only beneficiaries, and veterans with service-connected injuries. Allows all Medicare enrollees to contribute to Medicare Savings Accounts. Increases maximum HSA contribution to match IRA maximum. Allows tax-free transfer to HSA of minimum distribution requirement from a retirement plan. Protects HSA funds from seizure in bankruptcy	Allows HSAs to be used for premium payment. Allows plan deductibles to vary with size of HSA account.	Classifies drugs for chronic conditions as preventive care. Allows use of HSA funds for HSA-qualified insurance and LTC insurance premiums. Allows use of up to $1,000 in HSA/HRA/FSA funds for fitness programs or nutrition supplements. 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. Allows Medicare Part A-only individuals to continue contributing to HSA. Removes restrictions on veteran/military benefits and Indian Health Service usage. Increases annual contribution to plan's OOP maximum. Allows spouses to make "catch-up" payments into same account.	No changes to current law	No changes to current law	Most would expand the list of permissible uses for HSA money and relax funding and eligibility rules. Roy makes annual contributions to defray cost-sharing for those eligible for premium assistance, while Rep. Price and the 2017 project offer a one-time infusion of $1000.

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				proceedings. Allows HSAs to roll over to surviving children, parents, or grandparents.		Allows FSA/HRA roll-over to HSA. Allows tax-advantaged roll-over of retirement account funds to HSA. Allows parents to establish tax-advantaged deferred-use HSAs on behalf of children.			
Tax Provisions									
ESI Tax Exemption	Capped at $12,000 for individual coverage/$30,000 for family, indexed to CPI+1%.	ACA "Cadillac Tax" preserved, effective date advanced to 2017	Capped at 75th percentile of current ESI (2015 CBO estimate = $8,000 individual/$20,000 family), increased 3% annually.	Capped at $8,000 for individual coverage and $20,000 for family coverage, adjusted to CPI	Standard deduction against income and payroll taxes regardless of coverage source, adjusted to CPI after interim allowance for faster cost growth	Standard deduction ($7500 individual/$20,500 families) against income and payroll taxes regardless of coverage source, adjusted to CPI-U	No changes to current law ("Cadillac Tax" preserved)	Converted to universal tax credit which is fixed-value (though likely risk-adjusted), capped at current average annual family ESI subsidy of $5000-$6000	All except Cruz take steps to limit it (though Cruz maintains the Cadillac Tax by only repealing Title I of ACA)
Non-group Premium Tax Treatment	Post-tax	Post-tax	Post-tax	Post-tax (though employers may offer to receive a pre-tax defined contribution from employees to purchase individual coverage in lieu of a group plan)	Standard deduction--see ESI above	Standard deduction--see ESI above	Post-tax	Standard deduction--see ESI above	3 plans seek to equalize tax treatment through a standard deduction, with a fourth allowing employers to offer pre-tax defined contribution.
Market Reforms									
Age Bands	5:1; state option to reduce or increase	6:1	No federal standard	No federal standard	No federal standard	No federal standard	No federal standard	No federal standard	Only Hatch and Roy establish federal standards

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Guaranteed Issue (without consideration of pre-existing conditions)	Only with 18 months of continuous coverage after initial open enrollment period	Yes	Only with 12 months of continuous coverage, or if purchased during one-year buy-in periods that occur after 18th birthday (or loss of dependent coverage before age 25) or before 1st birthday. Must select a plan with same level of coverage if switching between individual market plans with preexisting condition.	No. (Pre-ACA HIPAA standards for continuous coverage.) Modifies HIPAA creditable coverage standard to include prior individual and small group coverage	No. (Pre-ACA HIPAA standards for continuous coverage. Eliminates COBRA exhaustion requirement.)	Only with continuous coverage. Eliminates COBRA exhaustion requirement and modifies HIPAA standard to include prior individual coverage	No. (Pre-ACA HIPAA standards for continuous coverage.)	Only with continuous coverage. Eliminates COBRA exhaustion requirement and modifies HIPAA standard to include prior individual coverage	Only Roy preserves guaranteed issue without continuous coverage limitations. Several plans revert to HIPAA standards.
Adjusted Community Rating	Only with continuous coverage	Yes	Only with continuous coverage	No	No	No	No	Only with continuous coverage	4 plans would allow medical underwriting without exception. Only Roy's prohibits without exception, while Hatch, Miller, and 2017 eliminate it for those meeting continuous coverage requirements
Dependent Coverage	Up to age 26 (state option to opt out)	No federal standards	No federal standards	No federal standards	No federal standards	No federal standards	No federal standards	No federal standards	Other than Hatch, most plans revert to pre-ACA lack of federal standard

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Lifetime Limits	Prohibited	Prohibited	Allowed	Allowed	Allowed	Allowed	Allowed	Allowed	Only Hatch and Roy explicitly prohibit Lifetime Limits, while others allow by repealing Title I without new protections
Allows sale of insurance "across state lines"?	Allow states to merge markets; remove "federal barriers" to state lines, leaving option open to states	No	Yes	Yes	Yes	Yes	Yes	Yes, possibly at individual state discretion.	All except Hatch and Roy expressly allow. Hatch language suggests it would be up to states to decide
Gender Rating	No	No	Allowed	Allowed	Allowed	Allowed	Allowed	Allowed	Hatch and Roy prohibit. Others allow due to repeal of ACA provision
Wellness incentive expansions?	No	No	Allows unlimited premium/cost sharing variation for wellness program participation	Allows premium/cost sharing variations of up to 50% of value of coverage for wellness program participation	Allows premium variations of up to 50% of value of coverage for wellness program participation ; allows employers to offer financial incentives for healthy behavior on a tax-free basis via Wellness Accounts	Allows premium/cost sharing variations of up to 50% of value of coverage for wellness program participation	No	Efforts encouraged, no changes to federal law	4 expand size of allowed variation; 3 of those to 50% and one without limit.
Federally Mandated Benefits (EHB)	No	"Minimizes prescriptiveness" of ACA essential health benefits	No	No	No	No	No	No	Only Roy maintains, but he would limit scope

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Open Enrollment Period	One-time with no underwriting. Annual enrollment periods without rating protections.	One 6-week period every 2 years	One-time, year-long buy-in for newborn babies and adults at age 18 or at time they lose dependent coverage	No OEP for those without continuous coverage. Required at least once every 2 years for those with continuous coverage	No	No	No	One-time buy-in to establish continuous coverage protections	Roy offers a true open enrollment period every 2 years. Hatch offers a limited opportunity after passage of the legislation, while 2017 offers for newborn babies and at adulthood. Others have elliminated the ACA marketplaces so the open enrollment period is irrelevant
High Risk Pools	Targeted federal funding for state-administered plans; states work with insurers to establish disincentives for excessive referrals	N/A	Allocates $7.5 billion/year (+3% annually) on a defined contribution basis to states to administer high-risk pools. Proposes cap on enrollee premiums of 150-250% of market rates (state discretion on actual number)	Extends currently available PHSA funding and provides $1 billion/year for new and ongoing state-run high-risk pools, reinsurance pools, or other risk-adjustment mechanism for subsidizing individual insurance Sunsets 10/1/16	Requires states to establish a high-risk pool, reinsurance fund, or other risk-transfer mechanism to cover individuals with pre-existing conditions. States may use part of grant funding described in Affordability section to cover high-risk population	Provides $25 billion in funding for state-run high-risk pools. Premiums limited to 200% of state average premium. Only U.S. citizens or nationals allowed to enroll. Waiting lines prohibited.	No new funding or changes to current law.	Capped appropriations to states to fund high risk pools, with potential future transfer of financial responsibility to states. States should establish limits on premiums relative to individual market and provide additional premium subsidies to low-income. Utilize neutral third-party underwriter for subsidy eligibility to discourage dumping.	6 plans establish new high risk pools, and each provides some funding to establish and/or to operate. Miller would send decision and financing to states. Roy does not feature. Others makes no attempt to cover.

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Medical Malpractice Reform	Caps non-economic damages, limits attorney's fees, incentivizes states to reform (adopt expert panels or a special medical tribunal to settle malpractice disputes quicker).	Caps damages for patients receiving any federal health care subsidy (including Medicare, Medicaid or Exchange coverage); leaves state reform to states' discretion.	States choose to implement reforms, but encouraged to consider capping noneconomic damages at $250,000 and consider creating medical malpractice tribunals consisting of medical experts	Changes burden of proof to be based on compliance with "best practice guidelines" for any federally subsidized care. Leaves state reform to state's discretion.Suggests formation of expert panels and a tribunal prior to appealing to a trial by jury. Provides grants to states for development and implementation of tribunals.	Suggests caps on non-economic damages, restrictions on attorney contingency fees, and the discouragement of "frivolous lawsuits" for federally financed programs.	Caps noneconomic damages at $250,000, implements "fair share" rule for physician liability, limits attorney contingency fees, allows state laws to supercede the federal law if they impose greater protections	No changes to current law.	Suggests consideration of caps on damages, health courts, early-offer incentives, and a no-fault schedule of damage claim amounts. Suggests maintenance of state role outside of federal programs.	3 plans establish or propose global federal caps; two more cap damages in federal programs and another urges states to adopt caps. State role in policy and adjudication. 3 plans propose adopting tribunals, and two propose state incentives for formation of expert panels.
Public Programs									

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Medicare	No changes	Phase-out: all seniors eventually enrolled in Exchanges through progressive increase of qualifying age. A number of incremental reforms are proposed for the short term.	No changes	Opt-out: Individuals allowed to opt out of government coverage (Medicare, Medicaid, TRICARE, VA) to receive tax credit. Allows beneficiaries to enter into contracts to receive care from non-Medicare providers.	Converts Medicare to a premium support voucher system. Caps catastrophic expenses. Limits allowable Medigap benefits. Allows seniors and doctors to make arrangements for care outside of Medicare payment system.	Allows individuals to contribute tax-deductible funds to a Medicare Medical Savings Account (MSA). Allows Medicare Part A-only enrollees to continue to contribute to HSAs.	No changes to current law.	Convert Medicare to premium support ("voucher") system. Define benefit package broadly and use less rigorous actuarial equivalence standards. Benchmark federal contributions based on a percentage (<100%) of average bid within market, with risk adjustment and subsidies for low-income individuals (current "dual eligibles"). Relax constraints on CMS adjusting premiums, cost-sharing, benefits and selective provider contracting in traditional Medicare.	Roy, Jindal, and Miller propose sweeping changes--Roy would bring seniors onto Exchanges, while Jindal and Miller embrace House GOP voucher plan. Others avoid Medicare or make small changes. Price allows beneficiaries to opt out of Medicare and receive the standard deduction to buy a private plan.

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Medicaid	Block grants for pregnant, child, parent, and LTC eligibility categories, based on number of individuals below 100% FPL and demographic and health status adjustments. Amount increases at CPI+1%. No changes to federal funding for aged, blind, and disabled category. Eligible individuals allowed to opt out and use tax credit to purchase private coverage. Reauthorizes "Health Opportunity Accounts" to be paired with HDHPs as a state alternative.	Enrollees transferred to Exchanges; long-term care costs transferred entirely to states	Medicaid eligibles would have choice to leave program and utilize tax credit to purchase coverage.	Individuals allowed to opt out of government coverage (Medicare, Medicaid, TRICARE, VA) to receive tax credit. Prohibits CHIP/pregnancy category expansion to >200% FPL without >90% take-up <200% FPL. Requires ESI premium assistance and alternative private coverage option.	Converts Medicaid to block grant and provides unspecified state flexibility in program management.	Establishes HSA-like Medicaid Opportunity Accounts	No changes to current law.	For non-disabled population, convert to defined contribution state block grant holding taxpayer costs below current trajectory and more constant eligibility rules. Allow nature, level, and quality of benefits to vary. Use Medicaid to supplement tax credits and lower cost-sharing for very low-income individuals. Allow states that spend under the block grant cap to apply funds to other areas of need, such as TANF.	Jindal would block grant entire program; Hatch and Miller would block grant non-ABD portion. Roy would transfer all enrollees to the Exchanges. 2017 and Price would allow individuals to opt out. Others avoid addressing Medicaid or make small changes.

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Other Major Provisions	State option for auto-enrollment of tax credit-eligible individuals into a default policy (with individual ability to opt out); requires states to allow small businesses to purchase stop-loss; allows small businesses to pool together to buy insurance; enhanced Medicaid funding to establish and maintain hospital charge information.	All federally subsidized health insurance plans exempt from state and local sales and premium taxes.; Restructuring of and increases in federal graduate medical educational funding and visa expansion for healthcare workers; Measures to increase competition and discourage monopolies among providers; Integration of VA with broader health system; migrate some or all federal employees to exchanges		Claims information response requirements; prohibits use of comparative effectiveness or outcomes research in federal programs; exempts health care professionals from federal antitrust laws in negotiating with health plans; federal solvency standards for association health coverage. Allows formation of non-profit "Independent Health Pool" entities to pool risk in the individual and small group markets.	Establishes federal protections for association plans; restores DSH payments cut by ACA.	Amends McCarron-Ferguson to restore application of antitrust law; allows for recognition of Association Health Plans; repeals Federal Coordinating Council for Comparative Effectiveness Research; establishes an eight year, $15 billion Medical Breakthrough Fund at NIH to fund research in heart disease, cancer, stroke, Alzheimer's, and diabetes.		Encouragement of state regulators to be more active in monitoring insurance product and provider performance and to provide greater data transparency	A variety of idiosyncratic proposals. Elements featured in multiple plans include antitrust application, workforce measures, and framework for association plans.

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Impact on ACA/HCERA	Repealed except for changes to Medicare	In addition to the changes described above, the proposal would alter the ACA by: Repealing individual and employer mandates; Repealing all tax hikes except for the “Cadillac” tax; Eliminating annual review of proposed premium increases; Eliminating federal regulation of medical loss ratios; Prohibiting creation of “public option” insurers; Restoring the pre-ACA tax subsidy for employer sponsored retiree coverage; Repealing sections that "discourage or bar new hospital construction"	Repealed	Repealed	Repealed	Repealed	Title I repealed	Repealed	4 of 7 plans include “full repeal,” while Hatch repeals everything except Medicare changes and Cruz only repeals Title I. Roy seeks to accommodate the existence of the ACA in a way that others do not.