Empowering-People Option Act

Empowering-People Tax Benefits are meant to give people the means to directly pay for their medical care before needing to use insurance for major medical bills. People would be empowered to use Direct Primary Care as a qualified medical expense, maintain freedom of choice regarding their medical coverage, and have enforcement of price transparency.

Title I Empowering-People Tax Benefits

The term "Empowering-People Account (E-PA) means a trust created or organized exclusively for the purpose of paying for qualified medical expenses of the account beneficiary or beneficiaries in the case of a family E-PA. The term "qualified medical expenses" means amounts paid on behalf of beneficiaries for medical care as defined in section 213 (d), but only to the extent such amounts are not paid by insurance.

Qualified residents shall be allowed a total tax credit of $4,000 if they are individually in the lower third of federal income tax brackets and $2,000 if they are in the middle third of national income brackets.

Those in the middle third of income brackets may reduce their taxable liabilities by $2,000 and those in the upper third of the income tax brackets by $4,000 that they contribute to either an Empowering-People Account (E-PA) or a health savings account (HSA) if they have one.

Qualified residents will receive an additional $2,000 for each child under 18 or up to 26 if their child is covered under their insurance in the lower third of the federal income tax brackets and $1,000 if they are in the middle tax bracket. Qualified residents in the middle tax bracket can reduce their tax liabilities by $1,000 per child if they are under 18 or under 26 if the child is covered under their insurance to an E-PA or HSA. Qualified residents in the highest third of the tax brackets can reduce their tax liability by $2,000 per child contribution to an E-PA or HSA.

Qualified residents who choose E-PA will receive $1/12^{th}$ of the yearly amounts stated above monthly.

Empowering-People Account and Health Saving Account administrators must report to the IRS the contributions made by qualified residents in a timely manner including the name, address, age, and TIN of the primary insured or account holder (as the case may be) and the name, age, and TIN of each other individual obtaining coverage under such policies.

States may obtain waivers to give Medicaid enrollees the option of having Empowering-People Accounts and/or Health Savings Accounts funded to the maximum allowed by law.

Any amount paid or distributed out of an E-PA to pay for qualified medical expenses of any account beneficiary shall not be included in gross income. Any amount paid or distributed out of an E-PA which is not used exclusively to pay for qualified medical expenses of the account beneficiary shall be included in the gross income of such beneficiary.

The trustee may be a bank, an insurance company, or another approved entity that must create a system of access, like a smart credit card, that can only be used to pay for qualified medical expenses for the beneficiaries. The assets of the trust may not commingle with other property except in a common trust or investment fund. The trustee is responsible for determining if E-PA assets are used for qualified medical expenses. E-PA funds not used for qualified medical expenses will be taxable with an additional

ten percent penalty. Such payments or distributions made after an account beneficiary becomes disabled, becomes Medicare eligible, or dies will not be taxable or have a tax penalty.

The transfer of an individual's interest in an E-PA to an individual spouse or former spouse under a divorce or separation shall not be considered a taxable transfer.

If an individual acquires an account beneficiary's interest in an E-PA or HSA by reason of death of the account beneficiary, such a transfer shall be treated as if the individual were the account beneficiary.

The cost-of-living adjustment to E-PA made after the calendar year of implementation shall be increased by the "CPI medical care component" of the Consumer Price Index published by the Department of Labor.

Title II Treatment of Direct Primary Care Arrangements

"Direct Primary Care Arrangements" means the furnishing (or access to the furnishing) by a physician or group of physicians of physician professional services (and ancillary services) in return for payment of a monthly or other prepaid amount.

Section 530 C (2)(A) of the Internal Revenue Code of 1986, as added by section 201 of this Act, is amended by adding at the end the following: The term qualified medical expenses for purposes of payment from an E-PA or HSA shall include the payment of a monthly or other prepaid amount for the furnishing (or access to the furnishing) by a physician or a group of physicians of physician professional services (and ancillary services).

Direct Primary Care as defined above shall not be treated as health insurance coverage. For purposes of title XXVII of the Public Health Service Act (42 U.S.C. 300gg), subtitle B of title I of the Employee Retirement and Income Security Act of 1974 (29 U.S.C. 1021 et seq.), Public law 111-148, and this Act, the offering of direct primary care arrangements shall not be treated as the offering of health insurance coverage and shall not be subject to regulations as such coverage under such Acts.

Title III State Flexibility in Regulation of Health Insurance Coverage

States are given the flexibility under section 122(b) to revise their regulations of the health insurance marketplace without regard to many of the requirements imposed under Public Law 11-148, to promote freedom of choice of affordable health insurance coverage options outside of an Exchange.

Nothing in the Employee Retirement and Income Security Act of 1974 (29 U.S.C. 1001 et seq.) or of any amendments made by the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) shall be interpreted as preventing an employer from offering, or making an employer contribution towards, individual health insurance coverage for employees and dependent family members.

Nothing in This Act shall be construed as prohibiting the formation of association health plans (as defined under State law).

Nothing in this Act should be construed as prohibiting States from establishing pooling arrangements for high-risk individuals.

Title IV Promoting Price Transparent Hospital Prices for Consumers

The provisions of the rule entitled “Price Transparency Requirements for Hospital to Make Standard Charges Public” published by the Department of Health and Human Services on November 27, 2019 (85 Fed. Re. 65524) shall have the force and effect of law.