Health Care Reform in Indian Country
Self-Governance Communication & Education
Self-Governance Tribes Striving Towards Excellence in Health Care

Side-by-Side Comparison of Health Plans: House Health Bill and Senate Health Bill in Comparison to Current Law / Affordable Care Act[1]

June 28, 2017

This brief examines key elements of the health plan under consideration by the U.S. Senate (Senate Plan; released June 22, 2017 and amended June 26, 2017), as well as the health bill passed by the House of Representatives (House Plan; passed May 4, 2017), to current law, inclusive of the Patient Protection and Affordable Care Act (Affordable Care Act, or ACA).

Analysis of Select Provisions of Senate Bill, House Bill, and ACA

In the attached matrix, a side-by-side comparison of the Senate Plan, the House Plan, and current law / the Affordable Care Act is provided on a number of key elements.

Congressional Budget Office Analysis

A detailed analysis of the financial and coverage impact on the Senate bill is found at:

https://www.cbo.gov/publication/52849.

Attachment

- Side-by-side matrix comparing Senate Plan, House Plan, and current law / ACA

[1] This brief is for informational purposes only and is not intended as legal advice. For questions on this brief, please contact Doneg McDonough, TSGAC Technical Advisor, at DonegMcD@Outlook.com.

Proposal		Affordable Care Act (ACA)	American Health Care Act (AHCA) (REVISED analysis of bill as of 5/4/2017)	Better Care Reconciliation Act (BCRA)
Bill Number (if applicable)		(Current; enacted in 2010; Public Law 111–148)	H.R. 1628	Substitute for H.R. 1628
Date Introduced			5/4/2017 final version	6/22/2017 discussion draft, with 6/25/2017 revision
Main Sponsor(s)			Speaker Paul Ryan, House E&C/W&M/Rules Committees	Majority Leader Mitch McConnell
Latest Action			Passed by full House on 5/4/2017	Released on 6/22/2017
Indian-Specific Provisions in Marketplace	**Cost-Sharing Protections**	--For members of an Indian tribe or shareholders in an Alaska Native regional or village corporation, eligibility for either a zero or limited cost-sharing Marketplace plan, depending on income level (under both plan variations, AI/AN enrollees have no cost-sharing when receiving health care services). -- Ability for AI/ANs to enroll in bronze plan and still receive cost-sharing protections. -- Ban on Marketplace plans reducing payments to Indian health care providers by the amount of any cost-sharing that AI/AN enrollees would have otherwise owed for health care services.	**-- Eliminates Indian-specific cost-sharing protections (as of January 1, 2020).** -- Eliminates cost-sharing protections for general population (as of January 1, 2020).	--For 2018 and 2019, funds current (ACA) cost-sharing protections. --Beginning in 2020, eliminates Indian-specific cost-sharing protections --Beginning in 2020, eliminates general cost-sharing protections
	M-SEPs	-- Monthly special enrollment periods (M-SEPs) for AI/ANs and their dependents.	-- M-SEPs for AI/ANs are not repealed and continue to be effective for coverage secured through a Marketplace.	--Retains M-SEPs for AI/ANs; Senate bill was revised to add, beginning in 2019, a 6-month delay in enrollment for individuals lacking creditable coverage for 63 days or more. The provision does not delay effective date of M-SEP for IHS-eligible persons as a "medical care program of the Indian Health Service or of a tribal organization" is considered creditable coverage.
	Other Provisions	--AI/AN exemption from individual shared responsibility payments (individual mandate). --Expansion and permanent reauthorization of the Indian Health Care Improvement Act (IHCIA).	--Repeals individual mandate (retroactive to January 1, 2016) **--Makes no changes to the IHCIA**	--Repeals individual mandate retroactive to January 1, 2016 --Repeals employer coverage mandate retroactive to January 1, 2016. (Retains requirement for 2015; employer reporting requirements retained.) **--Makes no changes to the IHCIA**

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Insurance Market Provisions (Afford-ability)	**Premium Tax Credits (PTCs)**	-- Household income-based, advanceable, refundable PTCs for individuals and families with incomes of 100-400% FPL, with amounts adjusted for geographic differences in cost of health insurance premiums. -- Not eligible for PTCs if eligible for other public insurance programs, or employer-sponsored coverage that meets affordability, coverage, and AV standards. IHS eligibility not considered "coverage." (See attachment for comparison of impact of ACA and AHCA PTCs for households at various income levels.)	-- In 2019 transition period, ACA's PTCs adjusted to modify caps on the household income percentage contribution: 4.3% < 30 yrs; 5.9% < 40 yrs; 8.35% < 50 yrs; 10.5% < 59 yrs; 11.5% >59 yrs. (Higher net premiums for 50+; lower net premiums for some enrollees <50.) -- Not eligible for PTCs if eligible for other public insurance programs, or employer-sponsored coverage (no affordability or coverage standards for employer coverage). -- Repeal ACA's PTCs at end of 2019. -- Starting in 2020, new, advanceable, refundable, age-adjusted tax credits, with amounts initially set at following levels (2020): $2,000 for 0-29 year-olds; $2,500 for 30-39; $3,000 for 40-49; $3,500 for 50-59; $4,000 for 60+; $14,000 per family max tax credits. Overall value of tax credits drops by 40% (ACA to ACHA). -- Except for phase-out period (2019), PTCs not based on household income; PTCs not based on regional differences in the cost insurance premiums. -- PTCs begin phase out for single filers at $75,000 (to $95,000/$105,000 range) and joint filers at $150,000 (to $170,000/190,000 range). -- Can use PTCs on coverage purchased inside or outside Marketplace, including catastrophic plans (possibly beginning 2018). -- Instructs Senate to allocate about $85 billion for tax credits to help individuals ages 50-64 pay premiums, funded by allowing consumers to write off less medical debt (Politico, 3/20).	--In 2018 and 2019, retains current PTC structure and amount. --Beginning in 2020, provides household income-based, advanceable, refundable PTCs for individuals and families with incomes of 0%-350% FPL [compared with 100%-400% under the ACA], with amounts adjusted for geographic differences in cost of health insurance premiums [structure similar to the ACA tax credits]; percentage contribution amounts modified from ACA levels. --Excludes Medicaid-eligible individuals from PTC eligibility. --Excludes individuals with offer of employer-sponsored insurance (ESI) from eligibility for PTCs with NO consideration of affordability/minimum value of ESI (as under ACA). --Limits the amount of PTCs based on the "applicable median cost benchmark plan," defined as the QHP that has the median premium among all plans offered in an applicable rating area with an AV of 58% [the ACA bases the PTC amount on the second-lowest-cost silver plan, which has an AV of 70%] (The change in reference plan has the effect of shifting 17% of the premium costs from being funded by the PTCs to being added to enrollee out-of-pocket costs.) --Revises the cap on the required household income percentage contribution, with the cap adjusted based on income [similar to the ACA] and the age of the oldest member of the household enrolled in a QHP (with a higher percentage contribution required for older individuals) [the ACA does not adjust the cap based on age]
	Cost-Sharing Protections	- 100% cost-sharing protections for members of an Indian tribe or shareholders in an Alaska Native regional or village corporation. -- Reduced out-of-pocket costs for individuals / families under 250% FPL in Marketplace coverage.	--Retains out-of-pocket maximums per individual and family -- Repeals Indian-specific and general cost-sharing protections completely, beginning in 2020	--For 2018 and 2019, appropriates funding needed to pay for ACA cost-sharing protections **--Beginning in 2020, repeals Indian-specific and general cost-sharing protections**
	Repayment of Excess Payments	-- Limits repayment of excess premium tax credits advanced, based on income of tax filer	-- Requires 100% repayment of any excess premium tax credits advanced (effective for 2018 and 2019)	--Beginning in 2018, requires 100% repayment of any excess PTCs advanced (and eliminates the income-related caps on repayment under ACA)
	Health Savings Accounts (HSAs)	-- Permitted (HSA contribution of approx. $3,350 (self-only coverage) and $6,750 (family coverage).	-- Allowable HSA tax-deductible contribution increased to amount of deductible/out-of-pocket maximum (approx. $6,750 (single coverage); $13,500 (family coverage). -- Allows deposit of excess PTCs (in excess of premium costs) into HSA. -- Other provisions to promote the use of HSAs.	--Beginning in 2018, increases allowable HSA tax-deductible contribution to amount of deductible/out-of-pocket maximum --Includes other provisions to promote the use of HSAs

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Market Stability Mechanisms	**3 R's**	-- Three risk adjustment mechanisms: Risk corridors; Reinsurance; Risk adjustment [Subsequently, Republican Congress eliminated majority of funding for 2 of 3]	-- Establishes a "Patient and State Stability Fund" (Fund), which includes a default federal reinsurance program ("Market Stabilization") for issuers, with $100 billion in funding over 2018-2026 -- As part of the Fund, allows funding for a range of purposes --Allows states to use the Fund for reducing the cost of health insurance in the individual and small group markets for individuals with high costs due to the low population density of their state --Allows states to use the Fund for maternity and newborn care and for prevention, treatment, or recovery support services for individuals with mental illness or substance abuse disorders --Appropriates $15 billion for the Fund in 2020 for maternity, mental health, and substance abuse disorder purposes --As part of the Fund, establishes a Federal Invisible Risk Sharing Program (FIRSP), administered by HHS, to provide payments to health insurance issuers with respect to claims for eligible high-cost individuals for the purpose of lowering individual market premiums --Makes available $15 billion in funding for FIRSP over 2018-2026 --Beginning in 2020, allows states to take over operation of FIRSP	--Establishes a state stability and innovation program (funded through CHIP), with short-term and long-term components Short-Term Program --For 2018-2020, appropriates $50 billion for CMS to allocate to fund health care arrangements "to address coverage and access disruption and respond to urgent health care needs within States," with payments made directly to health insurance issuers Long-Term Program --For 2019-2026, appropriates $62 billion for states to provide financial assistance to help high-risk individuals obtain individual market coverage, stabilize insurance markets, pay health care providers for services, or provide assistance to reduce out-of-pocket costs in the individual market (requires use of at least $5 billion for insurance market stabilization over the 2019-2021 period) --Requires states to apply for funding once, with applications deemed approved for future years --Allows CMS to determine the formula for allocating the funding --Requires states to spend any funding received within 3 years --Beginning in 2022, requires states to provide matching contributions to obtain funding, ranging from 7% in 2022 to 35% in 2026
	State-Run High-Risk Pools	--Established a temporary high-risk pool program, which operated until 2014, for individuals who have pre-existing medical conditions and cannot obtain health insurance in the individual market --Required HHS to administer the program directly or through contracts with states or non-profit private entities that operate qualified high-risk pools --Appropriated $5 billion in funding for the program	--For states that have obtained a waiver (see "Waivers" section below), makes available $8 billion in funding over 2018-2023 (described as funding for state-run high-risk pools) --Directs states to use the funding to provide "assistance to reduce premiums or other out-of-pocket costs of individuals who are subject to an increase in the monthly premium rate for health insurance coverage as a result of such waiver"	Not addressed
	Coverage Rules	-- Requires individuals to secure health insurance coverage or make a payment to federal government (exemption from requirement for AI/ANs).	--Individual coverage requirement technically retained (because of "reconciliation" restrictions) but penalties for not securing coverage repealed, retroactive to January 1, 2016. -- Health plan required "to increase monthly premium rate" by 30% for persons with a break in coverage of more than 63 days. IHS eligibility considered "creditable coverage" for purposes of not being subject to non-continuous coverage (30%) penalty.	--Individual coverage requirement technically retained (because of "reconciliation" restrictions) but penalties for not securing coverage repealed retroactive to January 1, 2016.
State Insurance Market Operations		-- Health plan offerings standardized with actuarial values (AVs) set by metal level to facilitate plan comparisons. -- Maximum out-pocket amounts established. -- Requirement for each state to establish a Marketplace that allows individuals to: Learn about their health insurance options; compare health plans based on costs, standardized benefits (EHBs), and other important features; obtain information on insurance affordability programs designed to help individuals with low-to-moderate incomes pay for coverage; select a health plan and enroll in coverage. -- Permits 3:1 premium ratings, by age. -- Permits catastrophic plans (AV = 55%) for < 30 year olds (no PTCs).	-- Requirement for plans to be offered by specified actuarial value (metal level) repealed as of December 31, 2019. -- Maximum out-of-pocket limits retained. -- Requirement for a state-by-state Marketplace not repealed. -- EHB standards retained. -- Permits 5:1 premium rating, by age -- Permits catastrophic plans for all enrollees (with PTCs)	--Retains most ACA requirements, but under revised Section 1332 waivers [see below] can waive many ACA requirements --Increases allowable age rating of premiums to 5:1 [from 3:1 under the ACA] --Ends ACA medical loss ratio (MLR) requirements (provides states with authority to impose requirements)

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Funding Provisions	**ESI Excise Tax/Tax Exclusion Cap**	-- Beginning in 2020, 40% tax (Cadillac tax) imposed on cost of employer-sponsored insurance (ESI) exceeding the following amounts, with amounts adjusted annually for CPI: --For individuals, $10,200 times health cost adjustment percentage;1 --For families, $27,500 times health cost adjustment percentage1	--Delays the ACA Cadillac tax until 2026.	--Delays the ACA Cadillac tax until 2026
	Employer Mandate	Employers required to offer insurance to full-time (FT) employees and pay a portion of premium if employee enrolls, or make an annual per FT employee payment (approx. $2,000) to federal government.	-- Repeal of employer mandate penalties retroactive to January 1, 2016. (Coverage requirements technically staying in effect.) -- Employer reporting requirements remain in effect.	--Repeals employer mandate penalties retroactive to January 1, 2016 --Retains employer reporting requirements
	Net Investment Income Tax	3.8% tax on individuals, estates, and trusts that have certain investment income exceeding certain thresholds.	Repeal of tax effective for years after 2016.	--Repeals tax beginning in 2017
	Additional Medicare Tax	0.9% tax on wages and self-employment income that exceeds the following thresholds: --$250,000 for married taxpayers filing jointly; --$125,000 for married taxpayers filing separately; --$200,000 for all other taxpayers.	Repeal of tax effective for years after 2022.	--Repeals tax beginning in 2023
	Health Insurance Provider Fee	Fee on each covered entity engaged in the business of providing health insurance for U.S. health risks (moratorium instituted for 2017).	Repeal of fee effective for years after 2016.	--Repeals tax beginning in 2018
	Medical Device Excise Tax	2.3% tax on manufacturers and importers for sales of certain medical devices (moratorium instituted for 2016 and 2017).	Repeal of tax effective for years after 2016.	--Repeals tax beginning in 2018
	Excise Tax on Tanning Services	10% tax on indoor UV tanning services.	Repeal of tax effective for years after 2016.	--Repeals tax beginning in 2018

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Insurance Market Regulations	**Individual Market Rules/ Protections**	--Ban on annual and lifetime coverage limits; --Ban on rescissions (withdrawal of coverage); --Required coverage of preventive services; --Dependent coverage through age 26; --Required Summary of Benefits and Coverage; --Required internal claims/appeals/external review; --Ban on pre-existing condition exclusions; --Ban on discriminatory premium rates; --Guaranteed availability/renewability of coverage; --Ban on discrimination based on health status; --Nondiscrimination in health care; --Ban on excessive waiting periods; --Required coverage of mental health services/parity	-- Retains ACA's: ban on pre-existing condition exclusions; health status underwriting; life-time and annual coverage limits; coverage for adult children to age 26; essential health benefit (EHB) requirements (although likely to be modified by regulation); and other ACA consumer protections. --Penalty equal to 30% of the premium required for 12 months for enrollees who do not maintain continuous coverage (individuals eligible for IHS services exempt from penalty). -- Repeals plan actuarial value and metal level requirements. --Essential health benefits (EHBs) determined / regulated by states. --Increases allowable age rating of premiums to 5:1 (from 3:1). --Verification requirement for enrollment during SEPs. --Option to continue offering ACA Marketplace plans outside of Marketplace.	--Retains the ACA ban on pre-existing condition exclusions, health status underwriting, life-time and annual coverage limits, coverage for adult children to age 26, EHB requirements, and other ACA consumer protections (but under revised Section 1332 waivers can waiver many ACA requirements) --Includes no penalty for failing to maintain continuous coverage [the House bill does include a penalty] --Increases allowable age rating of premiums to 5:1 [from 3:1 under the ACA] --Beginning in 2019, ends ACA medical loss ratio (MLR) requirements and allows states to determine MLR and any rebates that health insurance issuers would have to pay to consumers for failing to meet those requirements --Senate bill revised to add, beginning 2019, a 6-month delay in enrollment for individuals lacking creditable coverage for 63 days or more. The provision does not delay effective date of M-SEP for IHS-eligible persons as a "medical care program of the Indian Health Service or of a tribal organization" is considered creditable coverage.
	Waivers (Section 1332)	--Beginning in 2017, allows states to submit a (section 1332) waiver application to HHS or the Department of Treasury to exempt them from certain health insurance market requirements, specifically those: 1) Relating to the establishment of QHPs; 2) Relating to consumer choices and insurance competition through the Marketplace; 3) Relating to cost-sharing reductions; and 4) Relating to premium tax credits and individual/employer mandates --Requires states seeking a waiver to a) provide access to health care as comprehensive and affordable as absent the waiver; 2) provide health insurance to a comparable number of residents as absent the waiver; and 3) not increase the federal budget deficit --Prior to submitting a waiver application, requires states to a) provide a public comment period, including consultation with Tribes; and b) conduct public hearings and accept written comments during the comment period --After states submit a wavier application, requires HHS to a) make a preliminary determination of whether the application is complete within 45 days; b) if complete, make the application public for a federal comment period; c) make a final decision on the application within 180 days of the determination of a complete application	--Allows states to submit a waiver application to HHS to: 1) Increase the age rating ratio above the 5:1 ratio in the House bill, as introduced (and the 3:1 ratio under the ACA), after 2017 [effectively eliminates age rating restrictions]; 2) Specify their own EHBs after 2019; 3) After 2018, replace the 30% penalty for not maintaining continuous coverage with the ability to charge individual premiums based on health status (for the duration of the enforcement period, generally up to 12 months), with the stipulation that the state has made some effort to assist high-risk individuals or subsidize insurers for high-risk individuals [by either a) providing financial assistance to help high-risk individuals obtain coverage in the individual market; b) providing incentives to appropriate entities to enter into arrangements with the state to help stabilize premiums in the individual market (operating a reinsurance program); or c) participating in a FIRSP] --Grants automatic approval of waiver applications unless HHS notifies states of the reasons for denial within 60 days --Allows waivers to last up to 10 years (voided if states end their risk program) --Provides exemption for members of Congress	--Amends the ACA section 1332 state innovation waiver program immediately and retroactive to previously requested waivers --Requires states seeking a waiver to describe plans to "provide for alternative means of, and requirements for, increasing access to comprehensive coverage, reducing average premiums, and increasing enrollment" [a lower standard than the ACA, which requires states to ensure no reduction in: EHBs; premium and out-of-pocket costs affordability; number covered, as absent the waiver] --Provides $2 billion in additional funding in 2017 (available through 2019) for grants to states for seeking and implementing waivers --States permitted to receive PTCs and cost-sharing subsidies as "pass-through payments" (i.e., lump sum payments) --Allows states to use long-term state innovation and stability program allocations for funding waiver programs --Requires HHS to establish an expedited process for considering waivers in urgent or emergency situations involving access to health insurance --Provides that HHS "shall," rather than "may," approve waiver applications --Increases the duration of waivers to 8 years [from 5 years under the ACA], with an option for states to renew waivers for an additional 8 years --Does not specifically allow states to waive the ACA prohibition of health insurance underwriting based on health status [as the House bill allows] --Does allow states to waive ACA requirements related to essential health benefits, out-of-pocket maximums, PTCs, QHP requirements, Exchange provisions, and actuarial value
	Coverage of Reproductive Services	--Ban on use of federal funding to pay for abortions (with certain exceptions). --Marketplace plans not required to cover abortions. --Marketplace plans covering abortions (if allowed by state law) must take steps to ensure no use of federal funding to pay for abortions.	-- Ban on use of federal funding to pay for abortions (with certain exceptions) -- Prohibits using premium tax credits on health plan that covers abortion services. -- Bars Medicaid funding for Planned Parenthood.	--Beginning in 2018, revises the definition of "QHP" to exclude any plan that includes coverage for abortions (with certain exceptions) --Beginning in 2020, prohibits the use of PTC to pay for QHPs that include coverage for abortions (with certain exceptions) --Prohibits Medicaid funding for Planned Parenthood (for 1 year)
	Interstate Insurance Market	Permits states to enter into cross-state compacts.	-- No changes made (due to "reconciliation" restrictions).	--Allows small businesses to form "small business health plans," fully insured plans offered by health insurance issuers to small businesses through association sponsors (association health plans) --Extends ERISA preemption of state insurance regulations to small business health plans --Pre-empts any state laws that would preclude health insurance issuers from offering coverage related to small business health plans

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Medicaid Program Changes	**ACA's Medicaid Expansion (to 138% FPL)**	--Optional Medicaid expansion under which states can extend eligibility to all non-elderly residents with incomes up to 138% FPL. --Availability of federal financial assistance covering 100% of Medicaid spending on health care services for the expansion population through 2016, with the rate gradually decreasing to a fixed level of 90% in 2020.	-- No ACA Medicaid expansion option for current non-expansion states after 2017. -- No enhanced FMAP available for states adopting the Medicaid expansion after March 1, 2017. -- In current Medicaid expansion states, enhanced FMAP (90% in 2020) retained for individuals enrolled under the expansion prior to 2020, for as long as they retain coverage -- For states expanding Medicaid outside of ACA's "Medicaid expansion" authority, 80% FMAP in 2017 and each subsequent year (versus standard FMAP rate).	--Technically retains the ACA Medicaid expansion option but eliminates the enhanced FMAP (90% +) for the expansion population --For states that expanded Medicaid by March 1, 2017, begins to phase out the enhanced FMAP for the expansion population in 2020, decreasing the rate annually over the 2021-2023 period and providing the standard rate in subsequent years [rate remains at 90% in 2020 and subsequent years under the ACA] --For states that expanded Medicaid outside of the ACA "Medicaid expansion" authority, provides 80% FMAP for the expansion population over the 2017-2023 period and the standard rate in subsequent years
	Base Medicaid Program	-- Eligibility requirements. -- Health care benefit package requirements. -- Consumer protections, including under managed care plans. -- Numerous other provisions. -- Retroactive program eligibility of up to 3 months from date of application.	--Per capita cap / allotment on federal financial assistance for Medicaid spending on health care services. --Spending for AI/ANs at I/Ts not subject to per capita cap. --AI/AN enrollees (and spending at non-I/T providers) included in applicable section 1903A category. --Repeal of Essential Health Benefits (EHBs) requirement for benchmark plans. --For non-expansion states, repeal of Medicaid DSH allotment reductions and provides increased federal assistance for safety net providers. --Repeal of 3-month retroactive eligibility (limit to month of enrollment) and other provisions to reduce Medicaid costs (such as update allowable home equity limits). -- Require states to conduct income eligibility redeterminations at least every six months. -- Remove an ACA option enabling states to enroll uninsured adults in Medicaid immediately if they need acute medical care. BLOCK GRANT -- Option for states to receive a 10-year block grant, beginning in FY 2020. -- Requirement for states to file 10-year plan with HHS [deemed approved unless HHS finds the plan either "incomplete" or "actuarially unsound" within 30 days]. -- Initial block grant amount determined using the same base year calculation as for the per capita allotment, with amount adjusted annually by CPI-U [similar potential concern as with regard to how AI/ANs are counted for purposes of determining per capita cap and block grant allotments]. -- Requirement for states to audit block grant spending to ensure use on health care [and "make available" results to HHS]. -- Any unspent block grant funding retained by states. -- Federal/state spending ratio under block grant based on CHIP levels, meaning a state could reduce state-funding below FMAP proportions and rely on federal block grant funding as a greater share of total program funding. Eligibility -- Option 1: Must cover children (up to 100% FPL), newborns (for one year), and pregnant women (up to 50% FPL). -- Option 2: Must cover pregnant women (up to 50% FPL). -- Inclusion of others as eligible populations at state discretion. -- Block grant excludes disabled, elderly, and adults covered under Medicaid expansion. Benefit Package -- Elimination of current health services coverage requirements, with the exception of providing certain broad benefit categories: hospital care; surgical care and treatment; medical care and treatment; obstetrical and prenatal care and treatment; prescribed drugs, medicines, and prosthetic devices; other medical supplies and services; and health care for children under 18 [no EPSDT requirement]. -- Elimination of current cost-sharing protections / requirements [appears to eliminate existing Indian-specific cost-sharing protections]. -- Elimination of current service delivery protections / requirements.	--Imposes a per capita cap/allotment on federal financial assistance for Medicaid spending on health care services, with the option for states to receive a block grant for certain populations, beginning in FY 2020 Per Capita Cap --Does not subject spending on AI/ANs (i.e., persons receiving services from the IHS/Tribes/Tribal organizations) to per capita cap --Uses less generous growth rate than the House bill version Block Grant --Differs from the House bill version in structure and the populations that states can include (excludes children) [More details on per capita cap/block grant TBA] Other Provisions --Repeals the ACA essential health benefits (EHBs) requirement for benchmark plans --For non-Medicaid expansion states, repeals Medicaid DSH allotment reductions and provides increased FMAP for safety net providers --Beginning in FY 2018, repeals 3-month retroactive Medicaid eligibility (limits to month of enrollment) --Requires states to conduct income eligibility redeterminations at least every six months --Allows states to impose work requirements on certain Medicaid beneficiaries --Imposes new restrictions on the ability of states to finance Medicaid through provider taxes

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	AI/AN provisions	-- Cost-sharing prohibited for AI/AN. -- Mandatory managed care enrollment prohibited for AI/AN. -- 100% FMAP for services to AI/ANs by / through IHS and Tribal providers. -- Tribal consultation requirements.	Other Provisions -- Under per capita allotment, increase in inflation factor for elderly enrollees from CPI-U Medical to CPI-U Medical plus 1 percentage point. -- New York State provision: Per capita allotment reduced by the amount raised from cities/counties, except funds raised in New York City. -- Beginning October 1, 2017, option for states to institute a work requirement for non-disabled, non-elderly, non-pregnant adults as a condition of receiving coverage [does not include an exception from the work requirement for students, except in limited circumstances].	
Medicare Program Changes		--Phase-out of the Part D coverage gap. --Increased financial assistance for individuals in the Part D coverage gap. --Elimination of copays for certain preventive services. --Changes in payment rates. --Provisions designed to improve efficiency/quality/program integrity.	-- Retain phase-out of the Part D coverage gap. -- Repeal ACA taxes dedicated to funding Part A Trust Fund. [-- Other TBD.]	--Retains phase-out of the Part D coverage gap --Repeals ACA taxes dedicated to funding Part A Trust Fund
Notes and Recommended Articles:		1 Health cost adjustment percentage equals 100% plus the excess (if any) of the percentage over 55% by which the per employee cost for providing coverage under the BC BS standard benefit option under FEHBP for plan year 2018 (determined by using the benefit package for such coverage in 2010) exceeds such cost for plan year 2010	--Tim Jost blog: http://healthaffairs.org/blog/2017/03/07/examining-the-house-republican-aca-repeal-and-replace-legislation/ --CBPP article: http://www.cbpp.org/research/health/little-noticed-medicaid-changes-in-house-plan-would-worsen-coverage-for-children -- https://www.nytimes.com/interactive/2017/03/06/us/politics/republican-obamacare-replacement.html?WT.nav=top-news&action=click&clickSource=story-heading&emc=edit_nn_20170307&hp=&module=a-lede-package-region&nl=morning-briefing&nlid=69595147&pgtype=Homepage&region=top-news&te=1 -- http://www.msn.com/en-us/news/politics/house-republicans-unveil-plan-to-replace-health-law/ar-AAnVOqh?li=BBnb7Kz&ocid=wispr -- http://www.modernhealthcare.com/article/20170306/NEWS/170309925?utm_source=modernhealthcare&utm_medium=email&utm_content=20170306-NEWS-170309925&utm_campaign=mh-alert -- http://www.politico.com/story/2017/02/house-republicans-obamacare-repeal-package-235343 -- http://www.politico.com/story/2017/03/house-obamacare-repeal-bill-what-does-it-say-235648 -- Sara Rosenbaum blog (Medicaid block grant): http://healthaffairs.org/blog/2017/03/21/the-house-managers-medicaid-amendments-the-state-block-grant-option/ -- Tim Jost blog (elimination of EHBs): http://healthaffairs.org/blog/2017/03/23/essential-health-benefits-what-could-their-elimination-mean/ -- New York Times article: https://www.nytimes.com/interactive/2017/03/20/us/changes-to-republican-health-plan.html -- Politico article: http://www.politico.com/story/2017/03/obamacare-repeal-bill-changes-236278 -- Tim Jost blog (MacArthur Amendment): http://healthaffairs.org/blog/2017/04/25/the-macarthur-amendment-language-race-in-the-federal-exchange-and-risk-adjustment-coefficients/ --Tim Jost blog (Upton Amendment): http://healthaffairs.org/blog/2017/05/03/new-8-billion-for-those-with-preexisting-conditions-appears-to-boost-ahca-critics-say-amount-is-too-low/	Tim Jost blog: http://healthaffairs.org/blog/2017/06/22/unpacking-the-senates-take-on-aca-repeal-and-replace/