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

Matrix of Key Elements of the House of Representatives Health Plan, Passed on May 4, 2017, With Tracking of a Series of Amendments[1]

May 5, 2017

This brief seeks to provide guidance to Tribes on the latest version of the health plan proposed by the House of Representatives (House bill), which was passed by the House on May 4, 2017. The attached document provides a side-by-side comparison of key elements: (1) under current law (through the Affordable Care Act (ACA)); (2) under the House bill as of March 22, 2017, *after* consideration by the House Ways & Means and Energy & Commerce committees and *before* the withdrawal of the legislation by House leaders prior to a planned floor vote on March 24, 2017; and (3) under the amendments to the legislation made *after* March 24, 2017 through passage of the bill in the House on May 4, 2017.

For the House-passed version of the legislation, a Congressional Budget Office (CBO) analysis has not yet been completed. And (as of May 5, 2017), the complete text of the bill has not been published.

Key elements of the House-passed bill are:

General

- Requirement (for non-AI/ANs) to maintain health insurance coverage repealed.
- Employer "shared responsibility payments" eliminated (as of 2016); reporting requirements continue.

Medicaid Expansion

- On enactment, States not currently "expansion" states blocked from implementing Medicaid expansion.
- No new enrollments under Medicaid expansion as of December 31, 2019; individuals enrolled as of January 1, 2020 can continue until no longer eligible or until disenrolled for one month or more.

Base Medicaid Program

- Repeal of essential health benefit requirements for benchmark plans.
- Recertification of eligibility required at least every 6 months.
- Eliminate three-month retroactive payment option (prior to enrollment date).
- Eliminate presumptive eligibility option.
- Convert Medicaid into per capita allotment (excludes services to AI/ANs at I/Ts)
- Permit states to impose work requirements as a condition of eligibility.
- Permit states to opt for a block grant: State match reduced to CHIP levels; minimum eligibility covering pregnant women up to 50% of federal poverty level.

Marketplace

- As of January 1, 2020, Indian-specific cost-sharing protections eliminated.
- Average value of tax credits cut by 40%; new tax credits based on age, not income or cost of coverage.
- 30% surcharge on premiums for individuals with break in coverage of 63 days or more (not applicable to enrolled Tribal members).
- State option to: (a) eliminate essential health benefit requirements; and (b) permit insurers to raise premiums for persons with pre-existing conditions, if break in coverage of 63 days or more.

[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.

For prior versions of the legislation, the following materials have been prepared:

- The underlying documents, including a House Budget Committee report on the bill, can be accessed at https://rules.house.gov/bill/115/hr-1628.
- The Congressional Budget Office (CBO) analysis of the House bill as of March 9, 2017 (pre-subsequent amendments), can be accessed at https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf.
- A second CBO analysis was released on March 23, 2017, covering the base House bill plus amendments made through March 22, 2017. The document can be accessed at https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628.pdf.
- A Tribal Self-Governance Advisory Committee (TSGAC) analysis of the financial impact of the House bill on American Indian and Alaska Native (AI/AN) families was included in a TSGAC Webinar on March 15, 2017, and can be accessed at http://www.tribalselfgov.org/wp-content/uploads/2017/03/PPT_TSGAC-Webinar-Risk-Assessment-House-Health-Plan-2017-2017-03-14b.pdf.
- A new TSGAC "life cycle" analysis, dated March 22, 2017, identifies the financial impact under the House bill versus the ACA over life cycle stages of AI/AN families (whose members meet the definition of Indian under the ACA), at various household income levels, as well as the financial impact on non-Indian families, and can be accessed at: http://www.TribalSelfGov.org/health-reform.

An amendment, proposed in April 2017 by Rep. Tom MacArthur, that would allow states to apply for waivers of certain health insurance market requirements can be accessed at http://docs.house.gov/billsthisweek/20170424/MacArthur%20Amendment.pdf.

Attachment (7 pages)

Proposal		Affordable Care Act (ACA)	American Health Care Act (AHCA) (REVISED analysis of bill as of 3/20/2017)	Subsequent Amendments to ACHA
Bill Number (if applicable)		(Current; enacted in 2010; Public Law 111–148)	H.R. 1628	Rules Committee Amendments to H.R. 1628
Date Introduced			3/20/2017 draft, as reported by Budget Committee	Late March-May 2017, as proposed to Rules Committee
Main Sponsor(s)			Speaker Paul Ryan, House E&C/W&M Committees	Rules Committee
Latest Action			**5/4/2017, passed by full House (final version not published as of 5/5)**	
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).	
	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.	
	Other Provisions	--AI/AN exemption from individual shared responsibility payments (individual mandate). --Expansion and permanent reauthorization of the Indian Health Care Improvement Act (IHCIA).	-- No individual mandate (retroactive to January 1, 2016) **-- IHCIA: No changes.**	

Proposal		Affordable Care Act (ACA)	American Health Care Act (AHCA) (REVISED analysis of bill as of 3/20/2017)	Subsequent Amendments to ACHA
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).	MANAGER'S AMENDMENT (3/20) "About $85 billion would be set aside for tax credits to help Americans between 50 and 64, who would see their premiums increase under the House plan. The amendment would not set up the tax credits but would instruct the Senate to do so. It would be paid for by allowing consumers to write off less medical debt" (*Politico* , 3/20).
	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	
	Repayment of Over-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)	
	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.	

Proposal		Affordable Care Act (ACA)	American Health Care Act (AHCA) (REVISED analysis of bill as of 3/20/2017)	Subsequent Amendments to ACHA
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," which includes a default federal reinsurance program ("Market Stabilization") for issuers. $100 billion in funding over 2018 - 2026. -- As part of Patient and State Stability Fund, allows funding for a range of purposes.	MANAGER'S AMENDMENT (2nd DEGREE) (3/23) --Allows states to use the Patient and State Stability Fund (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 PALMER/SCHWEIKERT AMENDMENT (4/6) --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
	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		UPTON AMENDMENT (5/3) --For states that have obtained a waiver under the MacAurthur Amendment (see 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"
	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.	
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)	

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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 percentage[1]	--Delay of the ACA Cadillac tax until 2025.	MANAGER'S AMENDMENT (3/20) Delay of 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.	
	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 2017.	MANAGER'S AMENDMENT (3/20) Repeal of tax effective for years after 2016.
	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 2017.	MANAGER'S AMENDMENT (2nd DEGREE) (3/23) Repeal of tax effective for years after 2022.
	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 2017.	MANAGER'S AMENDMENT (3/20) Repeal of tax effective for years after 2016.
	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 2017.	MANAGER'S AMENDMENT (3/20) Repeal of tax effective for years after 2016.
	PCORI Fee	Fee on issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans to fund the Patient-Centered Outcomes Research Institute.	Repeal of fee effective for years after 2017.	MANAGER'S AMENDMENT (3/20) Repeal of tax effective for years after 2016.
	Excise Tax on Tanning Services	10% tax on indoor UV tanning services.	Repeal of tax effective for years after 2017.	MANAGER'S AMENDMENT (3/20) Repeal of tax effective for years after 2016.

Proposal		Affordable Care Act (ACA)	American Health Care Act (AHCA) (REVISED analysis of bill as of 3/20/2017)	Subsequent Amendments to ACHA
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.	MACARTHUR AMENDMENT (4/26) --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
	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.	
	Interstate Insurance Market	Permits states to enter into cross-state compacts.	-- No changes made (due to "reconciliation" restrictions).	

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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.	-- Repeal of ACA Medicaid expansion for years after 2019. -- Starting in 2020, 90% federal medical assistance percentage (FMAP) applies only to persons enrolled as of January 1, 2020, with no break in coverage greater than 30 days. -- States can continue existing eligibility expansion but at regular FMAP rates.	MANAGER'S AMENDMENT (3/20) -- 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).
	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.	MANAGER'S AMENDMENT (3/20) 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 the base House bill with regard to how AI/ANs are counted for purposes of determining per capita cap allotments and block grant amounts.** -- 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. OTHER MEDICAID 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].
	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.	-- 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.	

Proposal	Affordable Care Act (ACA)	American Health Care Act (AHCA) (REVISED analysis of bill as of 3/20/2017)	Subsequent Amendments to ACHA
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.]	
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-AAnV0qh?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/