[LETTERHEAD]

[INSERT DATE]

The Honorable [INSERT SENATOR]

[INSERT OFFICE ADDRESS]

Washington, D.C. 20515

**RE: Tribal Priorities in Senate Healthcare Reform Legislation**

Dear [INSERT SENATOR]:

On behalf of [INSERT NAME OF TRIBE OR ORGANIZATION] I write to express our deep concerns as the Senate considers the ‘‘Better Care Reconciliation Act of 2017 (BCRA).” [NAME OF TRIBE OR ORGANIZATION]. Our concerns specifically relate to the proposed Medicaid cuts and other reductions in the Senate-draft bill that we hope are addressed by the Senate as it finalizes the legislation in the coming week. We do not support the bill in its current form.

We request that the legislation:

1. Maintain Medicaid funding based on need, rather than capping it according to a complicated per capita allocation formula or through capped block grants
2. Continue Medicaid Expansion, and at the very least, continue Medicaid Expansion for AI/ANs
3. Protect AI/ANs from barriers that are inconsistent with the federal trust responsibility, such as work requirements under Medicaid
4. Retain cost-sharing protections at Section 1402 of the Patient Protection and Affordable Care Act (ACA)
5. Restore cuts to preventative services in the BCRA including the Prevention and Public Health Fund and cuts to women’s health

As you know, the federal government has a trust responsibility, agreed to long ago and reaffirmed many times by all three branches of government, to provide healthcare to Tribes and their members. Both Medicaid and IHS funding are part of the fulfillment of the trust responsibility.

However, the federal government has not done its part to live up to the responsibility to provide adequate health services to AI/ANs. IHS funding is discretionary and is appropriated every year and distributed to IHS and Tribal facilities across the country. If demand for services is higher than the funds available, services are prioritized and rationed. As a result of this chronic underfunding, historical trauma, and a federal-state centric public health system, AI/ANs suffer some of the worst health disparities. AI/ANs live 4.5 years less than other Americans, but in some states life expectancy is 20 years less. This is not surprising given that in 2016, the IHS per capita expenditures for patient health services were just $2,834, compared to $9,990 per person for health care spending nationally. The Senate should pass reform legislation only if it does not reduce access to care for AI/ANs, or further strain the already stretched resources of Indian Health Service, Tribally-operated, and urban Indian health programs (collectively called the “I/T/U”).

**Medicaid**:

Cuts to the Medicaid program outlined in the BCRA are especially troubling. Under a block grant or per-capita system, States will experience a dramatic reduction in federal funding for their Medicaid programs. Most will have to either reduce eligibility for the program or reduce or eliminate benefits that are essential to many AI/ANs. Medicaid is a crucial program for the federal government in honoring its trust responsibility to provide healthcare to AI/ANs. Because health care services are guaranteed for AI/ANs, cuts in Medicaid only shift cost over to the IHS, which is already drastically underfunded. Put simply, without supplemental Medicaid resources, the Indian health system will not survive.

AI/ANs are a uniquely vulnerable population and uniquely situated in the Medicaid program. Unlike other Medicaid enrollees, AI/ANs have access to IHS services to fall back on at no cost to them. As a result, the incentives are completely different for AI/ANs in Medicaid. Medicaid conditions of eligibility designed to encourage healthy behaviors do not work when mandatory in Indian country. Instead, they lead to Medicaid disenrollment.

Over 40 years ago, Congress permanently authorized the IHS and Tribal facilities to bill Medicaid for services provided to Medicaid-eligible AI/ANs to supplement inadequate IHS funding and as part of the federal trust responsibility. At the same time, Congress ensured that States would not have to bear any associated costs by reimbursing them at 100 percent Federal Medical Assistance Percentage (FMAP) for services received through IHS and Tribal facilities. We are pleased to see that BCRA retains this provision.

Several states with large AI/AN populations chose to expand Medicaid as outlined in the ACA, which benefited Tribal members in those states. As the Senate considers changes to healthcare, it should keep in mind the needs of AI/ANs. Transferring Medicaid to a per capita or block grant program would ultimately mean less services for Medicaid recipients. These reforms, if included in Senate legislation, would threaten Tribal sovereignty by placing states in the role of fulfilling the federal trust responsibility; strain the IHS, Tribal, and Urban Indian healthcare systems; and create a burden on Tribal members.

*[Use this space to write about your Tribe’s experience with the ACA and Medicaid (especially Medicaid expansion, if applicable). Is your Tribe in a State that expanded? If so, what gains did it lead to? Did additional revenue impact the PRC budget? If you have data on the number of people newly enrolled in the Marketplace or on Medicaid since ACA, put it here.]*

Additionally, the Senate must ensure that States not create any barriers to access Medicaid for AI/ANs, such as work requirements, time limits, health assessments, co-pays or usage caps. For example, Section 131 of the BCRA allows states to impose work requirements as a condition of Medicaid eligibility, but does not exempt AI/ANs. This again, will have serious, negative implications for the Indian health system. As a result of these requirements, many of our people can and will simply elect not to enroll in Medicaid and rely on IHS coverage instead.

While we understand the rationale for imposing these requirements in order to encourage individuals to take an active role in improving their wellbeing, this will not have the intended effect in Indian Country as AI/ANs already have access to health care services through the IHS. Furthermore, work requirements assume easy access to jobs and treatment centers. Indian Country has chronic infrastructure needs and to punish individual AI/ANs for not having access to these services is in contradiction to the purpose of Medicaid and what Congress intended for AI/ANs. These barriers will lead to more uncompensated care being provided to otherwise Medicaid eligible individuals by the IHS, Tribes and non-Indian healthcare providers. Tribal communities are often located in the most remote areas of the country, with jobless rates reaching 80% in some areas.

**Marketplace**

We also ask that the Senate amend the BCRA to maintain cost sharing protections for AI/ANs. These protections were included for AI/ANs in fulfillment of Congress and the United States federal trust responsibility to provide health care to Indians. Section 208 of the BCRA would repeal the cost-sharing subsidy program established by Section 1402 of the Patient Protection and Affordable Care Act (ACA). However Section 1402(d) of the ACA also includes important and critical cost sharing protections for AI/ANs who have incomes at or below 300 percent of the federal poverty level, or who are referred for care through the IHS Purchased/ Referred Care (PRC) program. These cost-sharing protections incentivize AI/ANs to sign up for health insurance and also make it affordable. Eliminating them would create a disincentive for AI/AN to sign up for insurance, since they already have access to IHS services. This would result in less third party reimbursements for the Indian health system and have a destabilizing effect on the system’s ability to provide health care to AI/AN people. Dollar-for-dollar, leveraging cost sharing protections for AI/ANs and thereby encouraging insurance coverage is a very efficient means of moving the needle forward in meeting the federal trust responsibility for health care resources.

**Prevention Services**

We are also concerned about the reduction of prevention services in the legislation. The elimination of the Prevention and Public Health Fund will have major consequences on the ability for Tribes to support public health initiatives. Many Tribal health programs rely on PPHF directed funding to keep their public health systems operational. Unlike states, Tribes must piece together a patchwork of funds, some of which are derived from the PPHF, to administer basic prevention services. Additionally, the reduction in funding for women’s health services around the country will have major impacts on Tribal members, especially those who do not have direct access to services on or near their reservation. The Senate should restore cuts to the preventative services in the legislation.

Tribes support the inclusion of state funding to address the opioid crises, however, states do not often pass these funds to Tribes. Drug-related deaths among AI/ANs is almost twice that of the general population. In addition, the chronic underfunding of the Indian health system and staffing shortages often raises concern about the amount of prescription drugs that are being distributed to AI/AN patients. Tribes request funding to address the opioid crises as well or at the very least require state-Tribal consultation on the use of the appropriate use of these funds.

In conclusion, [NAME OF TRIBE OR ORGANIZATION] requests that the Senate not enact the BRCA in its current form, largely due to cuts in Medicaid and cost-sharing provisions. In fulfillment of the trust responsibility, current exemptions for AI/ANs from health insurance premiums, co-pays, and cost sharing must be preserved. Finally, Medicaid-eligible AI/ANs must be allowed access to the program without further strings attached to prevent additional burden on the already very limited IHS appropriations.

If you have any questions please do not hesitate to contact [INSTERT NAME] at [INSERT CONTACT INFORMATION].

Sincerely,

[INSERT NAME, SIGNATURE, AND TITLE]