The Affordable Care Act Remains in Place During Trump’s First Year: How It Happened

EARLY EXPECTATIONS
Throughout President Donald Trump’s first months in office, the top legislative priority for his administration has been the repeal and replacement of the Patient Protection and Affordable Care Act (ACA). While transition officials hinted in 2016 that legislation could be on the new President’s desk a matter of weeks after his inauguration, this quickly proved to be unrealistic.

In January, Congress passed a resolution outlining the process for debating and passing healthcare reform legislation using what is known as “Budget Reconciliation.” Reconciliation allows the Senate to pass legislation directly impacting the federal budget with a majority vote, instead of the usual 60 vote threshold required for most legislation.

INTRODUCTION AND PASSAGE OF HEALTHCARE REFORM LEGISLATION IN THE HOUSE.
On March 6, 2017, the House Energy and Commerce Committee and the House Ways and Means Committee, which both have jurisdiction over healthcare legislation, released draft legislation. The two committees passed the legislation on March 9, combining the two sets of legislation to form the American Health Care Act (AHCA). NIHB staff analyzed the bill, and the NIHB Board of Directors and the National Congress of American Indians sent a letter to Speaker Paul Ryan outlining Tribal concerns with the legislation, including:

However, SDPI is set to expire on September 30, 2017 and if Congress does not reauthorize the program before the deadline, there will be a gap in funding beginning January 2018. What does this mean to SDPI programs? With an uncertain future for the program, many staff will resign; contracts with providers will not be renewed; planned purchases for supplies and equipment will get scrapped; and fitness, nutrition, and education classes and programs will be jeopardized. Amidst all of the uncertainty one thing will be sure – the health of our communities will suffer.

This past June, over 25 SDPI programs participated in the 7th Annual SDPI Poster Session at the opening reception of the 2017 National Tribal Public Health Summit in Anchorage, Alaska, showcasing their unique efforts to combat and prevent diabetes and share stories, successes and ideas with other programs. The National Indian Health Board had the opportunity to speak with several SDPI program staff and discuss not only what a gap in funding might mean for their programs, but how a funding increase might enhance their efforts. With every Congressional reauthorization, even one that is not timely, there is an opportunity for increased

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National Indian Health Board

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FROM THE CHAIRPERSON

DEAR INDIAN COUNTRY FRIENDS AND ADVOCATES,

Welcome to the Fall 2017 edition of the National Indian Health Board’s (NIHB) Health Reporter! As always, we are excited “to advocate for the rights of all federally recognized American Indian and Alaska Native Tribes through the fulfillment of the trust responsibility to deliver health and public health services.” We are excited to see many of you in beautiful Bellevue, Washington this September for our 34th Annual National Tribal Health Conference! We also offer a big THANK YOU to our partners in the Portland Area who have made this event possible.

This summer has been extremely busy for Indian health. Over the summer, Congress considered a repeal and replace of the Affordable Care Act (ACA) in legislation known as the “Better Care Reconciliation Act.” This legislation would have eliminated several key provisions of the ACA and made dramatic cuts to the Medicaid program. This would have severely cut funds going to the Indian health system. Throughout a whirlwind of legislative proposals, NIHB was there every step of the way. This summer, we met with Members of Congress and their staff on a daily basis, sent letters, and coordinated Tribal action to Congress. Fortunately, the effort to repeal and replace “Obamacare” was not successful, but Congress could come back and try to make more reforms this fall.

In the meantime, the Trump Administration will be looking to reform Medicaid through the state waiver process. Tribes must be watchful of these changes at both state and federal levels. NIHB can provide technical assistance to Tribes to help identify challenges and provide information on how to protect American Indians and Alaska Natives during this process.

Other continuing challenges include ensuring the Special Diabetes Program for Indians funding - the most successful disease prevention and health promotion program in Indian Country, continues beyond September. This is the longest the program has gone without reauthorization, and continued advocacy with Congress is necessary to ensure the successful renewal of the program and that patient care is not disrupted.

In this edition of the Health Reporter you will learn about important efforts NIHB and Tribes are undertaking in the fields of public health funding, obesity prevention, Zika virus prevention, and SDPI. Now more than ever, it is critical for our Tribal communities to advocate for increased resources for public health. States and local governments receive federal support and we must as well if we are to see an end to the persistent health disparities in our communities. NIHB is engaged with policymakers in Congress and the Administration to advocate for public health funding to go directly to Tribes.

You can read about all these issues and more in this edition of Health Reporter. We encourage you to provide input on this publication and all issues concerning the health and wellness of our people. NIHB is here to serve you.

Vinton Hawley
Chairperson
MEDICAID AND IHS
The United States has a unique responsibility, agreed to long ago and reaffirmed many times by all three branches of government, to provide health care to Tribes and their citizens. Through the cession of millions of acres of land through treaties and other agreements, Tribes provided the United States with its land base in return for certain promises. Among the most sacred of these promises is the provision of health care.

In order to fulfill this responsibility, the federal government in 1955 created the Indian Health Service (IHS), which is unlike any other health care delivery system in the country. This system has grown and changed over the years, and now its hospitals, clinics and health stations are managed by IHS, Tribes and urban Indian health programs (also known as the Indian health system) in 35 states mainly on or near Indian reservations. However, the federal government has not done its part to fulfill its responsibility and provide adequate funding for health services to American Indians and Alaska Natives (AI/ANs). Annual funding provided to the IHS has always fallen short. IHS is currently funded at around 60% of need, and average per capita spending for IHS patients is only $3,688 compared with $9,523 nationally.

Another critical federal program – known as Medicaid –provides critically-needed supplemental revenue for the chronically under-funded IHS. The Medicaid program pays for comprehensive health care primarily for low-income individuals. Eligibility varies by state, but many American Indians and Alaska Natives qualify for coverage in this program, in addition to access to care and eligibility through IHS. As a result, those individuals can use their Medicaid coverage at IHS, Tribal, or urban Indian health programs that can bill Medicaid for the services provided – just like private insurance. It also means that Medicaid recipients can use health providers outside of the Indian health system without depleting scarce referral dollars at IHS.

Since almost 40% of all IHS users are covered by Medicaid, it is an important source of funding for IHS. According to the agency’s Congressional Budget Justification document to Congress, Medicaid funds represent 13% of total IHS funding, and provides coverage for 34% of non-elderly AI/ANs and over half of AI/AN children.

As important as Medicaid is to the Indian health system, Medicaid reimbursements received through the Indian health system only represent a fraction of one percent of total Medicaid funding. IHS Medicaid spending in 2015 represented only 0.15% of total Medicaid spending.

MEDICAID IS AT RISK
As part of the efforts by Republicans in Congress to “repeal and replace” the Affordable Care Act, legislation was debated in the Senate this summer. The bill, known as the Better Care Reconciliation Act, would have dramatically changed the way Medicaid works. Instead of funding the program based mainly on need, as is current practice, the federal government would have cut states’ Medicaid funding. This would have been achieved by either placing limits on spending based on per capita allotments or distributing limited funding in the form of block grants to the states. This type of limited funding would have forced most states to change their Medicaid programs and limit services, which would ultimately mean fewer people who are Medicaid-eligible, including AI/ANs. These cuts would have put crisis-level pressure on the already underfunded Indian health system.

The legislation would have also ended “Medicaid Expansion,” a key part of the Affordable Care Act passed in 2010 which allows any individuals not already covered by Medicaid if they are at or below 138% of the federal poverty line. The uninsured rate for AI/ANs has fallen nationally from 24.2% to 15.7% since the enactment of the Affordable Care Act, due in large part to Medicaid Expansion. This has resulted in increased access to health care services to AI/AN people who might not have otherwise received those services.

One Tribe in Nevada reported that the number of people seen in their health facility that were covered by Medicaid increased from 606 patients in 2011 to 2,302 in 2015 out of a total patient population of 4,500. This resulted in an increase in third party revenue from $3.2 million to $11.8 million during that same time period! Health insurance coverage among Tribal members increased from 54% to 91%. The Tribe was then able to use the resulting increased revenue to hire new medical professionals and add the following services: X-Ray services; Chiropractic care; Mammograms; Cardiology; Endocrinology; Podiatry; and Audiology services. These newly acquired benefits are all at risk if Congress rolls back Medicaid Expansion.

The new legislation would also have included a provision allowing states to receive extra money for Medicaid services provided to AI/ANs outside of IHS and Tribal facilities, but those programs would not receive any additional funding. This would have meant extra cash for states, while jeopardizing crucial health funding for Tribes.

The bill would have also incentivized states to implement work requirements for individuals to remain eligible for Medicaid, which is a problem in many Tribal communities with high unemployment rates: a policy tantamount to punishing the poor for being poor. If fewer AI/ANs are able to enroll in Medicaid, there will be a dramatic decline in health funding for American Indians and Alaska Natives. In turn, the Tribal and IHS health systems will be further

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3 In FY 2016, IHS denied an estimated $371,521,000 in referral care for an estimated 80,000 services needed by eligible AI/ANs.
compromised – as will the health of America’s Indigenous people.

Fortunately, this legislation failed to pass the U.S. Senate in July. However, Congress remains committed to repealing and replacing the Affordable Care Act. It is critical that Indian Country and its friends remain vigilant and tell Congress what Medicaid cuts would mean for Indian health.

We, at the National Indian Health Board are working to ensure that Medicaid continues to thrive so AI/ANs can access the care they need in the Indian health system as well as in the private sector. We have sent letters to Congressional leadership and other key lawmakers outlining these concerns and have had dozens of meetings with policymakers to encourage protection for AI/ANs eligible and enrolled in Medicaid.

Please visit www.nihb.org to view sample letters and talking points about this important legislation.
The Complicated Tribal-State Medicaid Relationship

The Indian health system relies heavily on third-party revenue, especially Medicaid. As the largest insurance program in the United States, Medicaid currently covers approximately 72.3 million people, including eligible low-income adults, children, pregnant women, elderly adults and disabled individuals. This summer, Congress proposed new changes to Medicaid, but those efforts ultimately failed – for now. In the meantime, the Trump Administration will be using their Administrative tools to rework how Medicaid works in the various states. This could have serious implications for Medicaid in Indian Country, and ultimately funding for the Indian health system overall.

In 1976, Congress authorized Medicaid reimbursement to be at a 100 percent Federal Medical Assistance Percentage (FMAP) for Medicaid services provided to American Indians and Alaska Natives that are received through an Indian Health Service (IHS) or Tribal health program. This means that American Indians and Alaska Natives can receive Medicaid covered services (unique to each state) and the state will fully pay for those services. The money is paid to the IHS or Tribal health program and then can be used to provide additional services to other AI/ANs and conserve precious Purchased/Referred Care (PRC) dollars. This is all possible because the state is reimbursed at 100% from the federal government.

For the most part, states have the authority to design their Medicaid programs according to broad requirements established by federal law. Meaning, states have control over who is eligible for the program, what types of services are covered, and the rates at which providers are paid for services.

Here are some of the ways states can do that:

**STATE PLAN AMENDMENTS (SPAS)**
States can submit State Plan Amendments (SPAs) that modifies the agreement between a state and the federal government on how a state administers its Medicaid and Children’s Health Insurance Programs (CHIP). The state plan sets out groups of individuals covered, services provided, and methodologies for providers to be reimbursed, as well as the associated administrative activities.

**WAIVERS**
States may also use demonstration or program waivers to provide an avenue to test and implement coverage approaches that do not meet federal program rules but “waive” them.

**1115 Waiver**
Section 1115 of the Social Security Act gives the U.S. Department of Health and Human Services (HHS) Secretary the authority to waive provisions of major health and welfare programs authorized under the Act, including certain Medicaid requirements, and to allow a state to use federal Medicaid funds in ways that are not otherwise allowed under federal rules. They are approved at the discretion of the Secretary through negotiations between a state and the Centers for Medicaid and Medicare Services (CMS). Recently, many states have used this authority to expand Medicaid under the Affordable Care Act which allows anyone within 138% of the Federal Poverty Level to be eligible for the program.

**1332 Waivers**
Section 1332 of the Patient Protection and Affordable Care Act (ACA) permits states to apply for a State Innovation Waiver to pursue innovative strategies for providing their resident with access to high quality, affordable health insurance while retaining the basic protections of the ACA.

**1915 (b) Waiver**
Some states may apply for waivers that require all Medicaid beneficiaries to enroll in the managed care program, including American Indians and Alaska Natives. However, states may be granted a waiver to this requirement since Tribal members are eligible for exemption from mandatory enrollment. Upon consideration of the waiver, CMS includes any input the state received through the Tribal-state consultation process. It is intended that through this process, Tribes and states can reach mutual consensus regarding this type of waiver.

**TRIBAL CONSULTATION**
In a March 2017 letter to State Governors, HHS Secretary Price and CMS Administrator Verma expressed their priorities for the Medicaid program. In the letter, HHS makes it known that they want to give states more flexibility and fast-track the waiver approval process. As a result, it is important that Tribes remain vigilant about what their states are doing with their Medicaid program and request Tribal consultation before any changes to their state’s Medicaid program are made.

For example, several states are exploring adding work requirements as a condition of Medicaid eligibility. This is problematic for Indian Country. Not only are joblessness rates very high on many reservations, but AI/ANs already have access to healthcare services through the Indian Health Service (IHS), so work requirements create a barrier to Medicaid, and put more pressure on the IHS budget.

NIHB, through its Medicare, Medicaid, and Health Reform Policy Committee (MMPC) works closely with the CMS Tribal Technical Advisory Group (TTAG) to remain engaged on state waiver and SPA applications, as well as provide technical assistance and advocacy for affected Tribes.

Please continue to check [www.nihb.orgtribal-healthreform/mmpc/](http://www.nihb.orgtribal-healthreform/mmpc/) for the latest information and news.
insurance coverage is a complicated morass of paperwork and deadlines. Often, confusing terms like “premiums” and “cost-sharing” were explained and demystified. Between 2013 and 2014, the percentage of AI/AN aged 18-64 years old who were uninsured decreased from 45 to 40 percent! Not only has outreach and education resulted in more AI/AN getting coverage, but also a more robust Indian health system as a result of the increased third party revenue. As we face yet another period of change in health care reform, we must work to incorporate lessons learned in order to better facilitate outreach, education, and consumer assistance for health care coverage. As a result of the progress made over the last four years, Indian Country has become more knowledgeable about the role of health insurance coverage in Tribal communities and how it impacts the Indian health system at large. We must work to expand the scope of O&E beyond Marketplace and ACA and into other concepts of health coverage, including: Medicaid expansion, Children’s Health Insurance Program, and veterans’ benefits. We must use lessons learned and best practices to move forward.

Despite a changing landscape, we came together, shared experiences, and learned from each other to increase health coverage for American Indians and Alaska Natives.

The Patient Protection and Affordable Care Act (ACA), also referred to as ‘Obamacare’, promised great change to the nature of health care delivery in this country and that all Americans would have access to quality, affordable, health care. To achieve its mission, the law created Health Insurance Marketplace Exchanges and mobilized a wide variety of consumer assistance resources. As a result of this mobilization, American Indians and Alaska Natives (AI/ANs) throughout Indian Country are now more aware of how they can get referrals, save Purchased/Referred Care (PRC) dollars for their hospitals and clinics, and the ability of third party health insurance to bring resources into the Indian health system.

When these efforts were first launched, it became clear to the National Indian Health Board (NIHB) and other assister organizations that the strategies employed would differ from the outreach and education (O&E) work of non-Tribal entities. We knew that the outreach materials had to be culturally competent and culturally appropriate so we created several toolkits targeted at elders and youth. Tribal leaders from around the country were excited to participate and lent their appearance and voice to our elders toolkits because they knew the incredible value that third party revenue provides to the Indian health system. These respected leaders galvanized others into enrolling as a result. In addition, targeted videos on enrollment shown in IHS and Tribal hospitals and clinics provided further guidance and understanding of health insurance and the benefits for enrolling. In addition, NIHB created a number of tool kits and conducted presentations to train patient benefit coordinators and others in local Tribal communities on the importance of enrollment in the exchanges. By training the ‘trainers,’ patients had someone from their local communities they could turn to for enrollment assistance and support. To assist these enrollment trainers, NIHB developed comprehensive health literacy toolkits that explained what insurance is all about, relieving folks of the notion that health

1 American Community Survey, U.S. Census Bureau, 2014
Increasing Public Health Funding - A Smart Upstream Approach in Indian Country

We often think of Indian health funding as being just funding provided to the “Indian Health Service” through Congressional appropriations. But it is much more than that. In Indian Country, we need to be prepared to advocate for comprehensive funding from the federal government so that our people can experience health systems on par with other Americans.

Chairperson Cathy Abramson (Sault Ste. Marie Tribe of Chippewa Indians), "Instead of waiting until people become ill, and then investing in expensive, sometimes unsuccessful treatments, a public health approach targets actions we can take now to keep healthy."

In Tribal communities, public health efforts are often managed by the Tribe with a variety of sources of funding. Some Tribal communities possess large public health departments, but the reality is that many are just not able to support robust public health services with available resources.

Tribal communities are forced to cobble together public health funding from a variety of federal, state, local, and private funding sources. State governments receive base operational and programmatic funding through large flagship or federal “block” grants; Tribes are either not eligible to compete for the funding or are woefully underrepresented in the grantee pool. This leads to unpredictability and inconsistency in the funding of Tribal public health initiatives.

Funding received by Tribal communities often leads to impressive results. For example, a Tribe in Wisconsin received a grant to increase seatbelt and child safety seat use. Through simple interventions including car-seat clinics, media campaigns, and seatbelt checks, the average use of these safety devices greatly improved over the four year project period, with seatbelt use increasing from 50% to 69% and child safety seat use increasing from 26% to 76%. Public health efforts like this promote health with research, education and raising awareness, with the goal of reducing health disparities.

Medical facilities and providers often are trained to address the immediate health needs of individuals, but American Indian and Alaska Native (AI/AN) communities have long approached health and wellness from a public health perspective. Public health efforts are by definition broader than a medical or health approach because they aim to address the health of entire communities or populations. This includes activities such as growing traditional foods, encouraging physical activity and wellness, education about the dangers of substance abuse, and implementing various practices that help to prevent injuries and diseases. When Tribes lead public health efforts in their communities, AI/ANs are healthier and communicate are stronger. This also means that there is a growing need for public health funding, resources, and infrastructure to help Tribal communities.

“Public health really works; it’s a smart upstream approach,” says former NIHB

Public health practitioners and advocates gather for the fitness event during the 2017 Tribal Public Health Summit - the largest Tribal public health gathering to date, with over 700 people gathered in Anchorage, AK to talk about best practices in policies and programs for Tribal public health. #ThisIsTribalPublicHealth at work!
PUBLIC HEALTH FUNDING IN 2018 AND BEYOND

While the outlook for federal funding in fiscal year (FY) 2018 is still unclear at the time of this writing, there are certainly many cuts being proposed to public health resources by both Congress and the Administration – including funding streams that will directly impact Indian Country. The President’s FY 2018 Budget Request proposed to cut the federal government’s leading public health agency, the Centers for Disease Control and Prevention (CDC), by 17%. The budget currently moving through Congress does not include the cuts proposed by the Administration. But many crucial public health funding streams will still likely see decreases in the coming year.

The House Appropriations Committee’s FY 2018 funding legislation included level funding for the Good Health and Wellness in Indian Country program at $16 million per year, and supports the inclusion of Tribes in the state-level programming for public health projects. It also includes a $2 million set-aside for the Zero Suicide prevention Initiative and $15 million in Tribal Behavioral Health Grants both administered by the Substance Abuse and Mental Health Services Administration. This is a far cry from the current need so we all must do more to advocate for increased public health funding. At the time of this writing the Senate Appropriations Committee has not released its FY 2018 spending for these programs.

Throughout the FY 2018 Appropriations process, the National Indian Health Board, along with the 567 federally recognized Tribes we serve, will continue to advocate to Members of Congress for the creation of an AI/AN focused public health block grant so that Tribes will not have to rely on funds passed through state governments or to compete for funding with state governments.

ADDITIONAL PUBLIC HEALTH POLICY RECOMMENDATIONS

- **Extend Tribal Self-Governance authority to agencies at the US Department of Health and Human Services beyond the Indian Health Service (IHS).** This would allow Tribes to manage their own public health programs. Self-Governance represents efficiency, accountability and best practices in managing and operating Tribal programs and administering federal funds at the local level.

- **Provide targeted funding for disease surveillance and prevention in Indian Country.** Reliable data is the foundation for effective program planning and funding allocation. Both the Tribes and the CDC have a vested interest in establishing more effective public health surveillance systems for Indian Country.

- **Support traditional and cultural healing practices when it comes to public health.** Often, federal grants require the use of “evidence-based practices” which have been tested or proven successful in non-Tribal communities. Yet, many Tribes find that traditional healing practices, especially when addressing issues like behavioral health and obesity, are effective in their communities. It is critical that both Congress and federal funders recognize the importance of traditional healing and support public health policy and programs that honor indigenous knowledge as the base for which to build programs.

Team Yaqui from the Pascua Yaqui Tribe of Arizona’s diabetes prevention program participates annually in the El Tour de Tucson, one of the biggest road cycling events in the country, to help employees and program participants stay healthy and prevent Type 2 diabetes. #ThisIsTribalPublicHealth at work!
An Overview of Public Health and its Importance in Tribal Communities

In Tribal communities, medical practitioners in Indian Health Service (IHS) hospitals and Tribal clinics treat disease and illness one patient at a time. Public health, on the other hand, aims to protect and improve the health of communities through prevention, education, and promotion of healthy lifestyles. For example, while health care providers prescribe medications to manage diabetes and treat other chronic diseases, public health professionals look at the causes of these diseases—including lifestyle choices and structural factors—in order to identify ways of preventing illness and protecting overall population health. These populations can be as small as a local neighborhood, or as big as a country or Tribe.

Public health does not diminish the importance of medical care and the overall health care system. Instead, public health functions as “the natural and historic bridge between the health care system and the community.” It does this by linking the health care system to organizations and services within the community to address the social determinants of health, which include individual lifestyle factors (e.g., income level, employment status, and social support network) and other indicators such as education, healthy food access, transportation, housing, and environment.

The core functions of public health have been summarized as: assessment, policy development, and assurance. Within these functions are ten essential services of public health, as shown in Figure 1. Importantly, public health aims to:

- Prevent epidemics and spread of disease
- Protect against environmental hazards
- Prevent injuries
- Promote and encourage healthy behaviors
- Respond to disasters and assist communities in recovery
- Assure the quality and accessibility of services
- Respond to disasters and assist communities in recovery
- Promote and encourage healthy behaviors
- Assure the quality and accessibility of services

It is commonly said that an ounce of prevention is worth a pound of cure. Despite this understanding, there is a lack of public health investment in the U.S. This is because public health receives, at best, only about 3 percent of the approximate $3 trillion spent on health. While there is not a clear estimate for how much funding Tribal public health receives, we do know that, like the IHS, Tribal public health is severely underfunded.

Public health is vital to Tribal communities because this means the community gets sick less frequently and spends less money on health care. The result is better economic productivity and an improved quality of life for all of Indian Country. In addition to these overarching reasons to invest in public health, the health disparities experienced in Indian Country are often the areas of health that benefit the most from a public health approach. For example, chronic diseases like diabetes, heart disease, and chronic lower respiratory disease are some of the leading causes of death for American Indian and Alaska Native (AI/AN) people. These chronic conditions can be prevented with a well-designed and comprehensive public health approach.

Where does NIHB work in the space of public health? In addition to advocating on behalf of all Tribal Governments and AI/ANs for increased public health resources, NIHB is committed to: promoting healthy practices; preventing diseases and injuries; building capacity and the public health infrastructure of Tribes; and providing Tribal leaders with public health policy research and analysis. To support this commitment, NIHB is currently working on a variety of projects, initiatives, programs that support Tribes through primary research, investigation, and technical assistance. These include:

- Climate Ready Tribes
- Health Systems Improvements to Cancer Screening in Tribal Communities
- Tribal Leaders Diabetes Committee (TLDC)
- Public Health in Indian Country Capacity Scan
- Tribal Zika Response and Planning
- Methamphetamine and Suicide Prevention Initiative (MSPI) Technical Assistance
- Tribal Accreditation Support Initiative (ASI)

To learn more about NIHB’s public health work in Tribal communities, visit https://www.nihb.org/public_health/public_health.php.
Obesity prevention and intervention in Indian Country takes many forms, but one common thread seen in many successful initiatives is a return to culture and traditional ways. These programs have revitalized traditional foods, implemented community-wide projects, brought together elders and youth, reintroduced culturally significant sports and physical activity, and celebrated rich stories of holistic health, vitality and overall wellness.

The importance of culture in these programs is paramount. In 2014, the Centers for Disease Control and Prevention (CDC) National Health Interview Survey collected data conveying that 31.2% of AI/AN above the age of 18 are diagnosed as overweight, while 42.3% are classified as obese. Multiple factors known collectively as the social determinants of health have contributed to these health disparities – including poverty, lack of infrastructure, and a high prevalence of food deserts. However, another important social determinant that is often overlooked is the loss of culture.

Many Tribal communities were forced to abandon their traditional languages, customs, lands, and hunting and gathering practices, and subsequently, had to rely on commoditized food programs that lacked proper nutrition. Fortunately, in recent times more and more Tribes have exercised their sovereignty and reintegrated their traditional foods and practices. This has led to a renaissance of traditional seed saving programs, community gardens, youth-based programming, and even Tribal government policies such as eliminating the usage of Tribal funds for the purchase of sugary sweetened beverages.

One example of a culturally-based obesity prevention program is the Traditional Foods of Puget Sound Project. The Traditional Foods of Puget Sound Project is a collaborative venture that has engaged several local Washington State Tribes from the Muckleshoot to the Lummi. Initially launched in 2008, the program was birthed at the Northwest Indian College Cooperative Extension Department. After conducting a community-based participatory research project (CBPP) centered on increasing knowledge and access to traditional foods, the college engaged local Tribal leaders, cooks, healthcare personnel, and even archaeologists in a discussion around the following question: How do we utilize research about traditional foods of Puget Sound Indians to create a healthier diet and lifestyle for Indian people today? To answer it, the college worked closely with local archeologists investigating traditional plants, animals, recipes, and diets of the Puget Sound region in order to gain a more comprehensive understanding of Native foods.

These ideas led to a “Tribal Cooks Camp” where traditional foods were organized and explained in detail, and traditional recipes were developed. The camp transformed into a celebration of culture, wherein Tribal members freely shared ideas, concerns and suggestions while Tribal elders conversed on the Traditional Foods Principles:
• Food is at the Center of Culture
• Honor the Food Web / Chain
• Eat with the Seasons
• Eat a Variety of Foods
• Traditional Foods are Whole Foods
• Eat Local Foods

These principles, including the recipes developed in the camp, were compiled with illustrations and traditional stories into a curriculum entitled Feeding the People, Feeding the Spirit: Revitalizing Northwest Native Food Culture.

The Traditional Foods of Puget Sound Project is just one example of the incredible work being done across Indian Country to bring together Tribal communities and collectively advance strategies to reduce chronic disease rates. By embracing culture, celebrating tradition, and focusing on holistic health, each initiative pushes forward the concept of Culture as Prevention.
funding and program expansion. SDPI has not seen a funding increase since 2004.

In Alaska, the Yukon-Kuskokwim Health Corporation (YKHC) SDPI program supports the most basic of patient care by connecting providers to patients. In remote, roadless villages, coordinating patient care can be challenging and costly. The YKHC SDPI program meets the challenge by implementing the innovative Group Medical Appointments model, begun only one year ago, where providers are flown in to the villages and see several patients as one appointment, thus saving travel time of patients and providers, associates costs and building social support among patients. If SDPI do not get reauthorized soon, all of their diabetes classes would go away as well as specialty clinics. “Specialty clinics” might sound like a luxury but considering the higher risk of lower extremity amputations and blindness in diabetic patients, specialty clinics such as podiatry and optometry provide basic services for that population.

The award winning Native American Rehabilitation Association (NARA) SDPI program attributes their success to continuity of funding and continuity of staff through which strong relationships with the community are built and sustained. With a gap or loss in funding, all of their diabetes classes would go away as well as specialty clinics. For the Bad River Band of Lake Superior Tribes of Chippewa Indians, SDPI supports youth programming, such as a community garden. Pam Feustel has worked on the diabetes team for 8 years and states that during that time she has seen weight loss, increased healthy lifestyles and kids trying new healthy foods for themselves. She has seen the effect on families as parents become involved in the garden not so much for themselves, but because of their children. If SDPI were to lose funding, the Bad River Health Lifestyle Program would be discontinued. Any momentum and cohesion that has been built will be lost and they would have to start all over again.

All of these stories emphasize the need for additional outreach to Members of Congress on early renewal for SDPI. At the time of this writing, Congress has not renewed this critical program. We encourage all Tribal members to contact their Senators and Representatives letting them know the value of this critical program!

For more resources on how to contact your member of Congress visit www.nihb.org/sdpi.

If SDPI were expanded, the LSDP would be able to hire more staff and expand upon the innovative policy, systems and environmental change work of the Lower Sioux Health and Human Services Advisory Committee to encourage more healthy and indigenous foods in the community.
NIHB is committed to taking action to help Tribal communities prepare for Zika virus. Weekly Zika newsletters are sent on Fridays and will continue through peak mosquito season. These newsletters are designed to deliver relevant information about Zika and include information on preventing infection, funding opportunities, related trainings and events, and Zika myths. The online Zika hub is frequently updated with new information and NIHB recently added a question box for people to submit questions and see their questions answered on the frequently asked questions page of the website. Further, NIHB offers technical assistance for Tribes looking for other resources or help related to Zika planning and response. Assistance is available by request.

UPCOMING EVENTS AND ACTIVITIES
NIHB is hosting a series of webinars related to the Zika virus and prevention efforts and is also planning to award up to 10 Tribes with mini-awards of $5,000 in Zika funding to help with preparedness activities. One or more of these Tribal sites may be highlighted as a promising approach in an upcoming webinar.

With guidance from CDC, NIHB is also finalizing a Zika Action Plan training curriculum – a resource for Tribes wishing to create a Zika Action Plan.

ZIKA THIS SUMMER
From 2015-2016, the world saw images of mothers with babies who were born with microcephaly and other birth defects because of Zika virus. CDC reports 215 symptomatic Zika cases in the United States during the 2017 year from January through mid-August. Zika remains a threat and may also become more common again in the future. Zika may have been less common this summer for several reasons.

After a person is infected with Zika virus, he or she will have immunity. Therefore, in areas where many people have previously been infected with Zika virus, Zika cannot spread as easily. This includes many parts of Latin America that were affected by the original epidemic. Most people in the United States are still vulnerable to Zika infection. Although frequent and widespread local transmission is not expected to occur in the States as in some countries or territories, local transmission is a concern and few Americans are expected to have immunity.

When more individuals and communities take action to prevent Zika, Zika virus cases may decrease; this means that additional action to prevent Zika is working, not that the action should stop because Zika is no longer a concern. Prevention can include actions such as wearing insect repellents and emptying standing water to prevent mosquitoes from breeding.

The consequences of Zika have not changed and viral infection during pregnancy still has devastating consequences. Even if you may be less likely to get Zika this year, it is still “worth it” to take personal protective measures. Not taking preventive action is a risk that can lead to catching or spreading Zika infection – which may lead to birth defects, feeling sick, and other health complications, such as Guillain-Barré syndrome.

Finally, taking action against Zika can also help protect against other mosquito-borne diseases, such as West Nile Virus, chikungunya, dengue, and others.

HELPFUL WEBSITES
• AHCA’s elimination of cost-sharing revenue, including specific subsidies for AI/AN enrollees.
• The end of Medicaid Expansion, which has increased access and helped keep resources in the Indian healthcare system.
• Proposed Medicaid changes, which would have allowed states to impose additional barriers, such as work requirements, between the AI/AN Medicaid population and the healthcare that is legally promised to them.

Fortunately, the legislation did not alter the Indian Health Care Improvement Act, which was permanently reauthorized in the ACA. It also did not repeal any other Indian-specific provisions of the ACA.

The Congressional Budget Office (CBO) estimated that AHCA would reduce the federal deficit by a net $337 billion over a decade and result in 24 million people becoming uninsured. While most Republicans in Congress were supportive of the legislation, unanimous opposition from the House Democrats and increasing public opposition made the bill’s passage far from certain. Indeed, on March 24, Speaker Ryan pulled the bill after members of both the conservative and moderate wings of the caucus announced their opposition. Speaker Ryan announced at a press conference, “Obamacare is the law of the land.”

However, House Republicans were eager to fulfill their largest campaign promise, and a few weeks later Rep. Tom MacArthur (R-NJ) wrote an amendment to the bill, which gave states more leeway in regulating health insurance. The amended AHCA also included $8 billion to subsidize premiums for people with pre-existing conditions. On May 4, 2017, the House of Representatives passed AHCA by a vote of 217-213.

INTRODUCTION OF SENATE LEGISLATION

Senate Republican leadership said early on that it would draft its own version of an Affordable Care Act repeal independent of the House legislation. Majority Leader Mitch McConnell (R-KY) appointed a group of 13 Republican Senators to craft the Senate bill. They then released the Better Care Reconciliation Act (BCRA) as a discussion draft on June 22, 2017.

On June 27, NIHB, again with the National Congress of American Indians, sent a letter to Senate leadership outlining Tribal priorities in federal healthcare reform, including:
• Keeping the Medicaid program, including Expansion, as is
• Retaining cost-sharing revenue for AI/AN enrollees, found in ACA Section 1402(d)
• Maintaining funding for the Prevention and Public Health Fund
• Repealing the Employer mandate, or at least exempting Tribal governments and enterprises

Like with AHCA, all Democrats and several Republicans criticized the bill. BCRA proposed a more gradual phase out of Medicaid Expansion, but overall more drastic cuts to Medicaid than did AHCA and loosened health insurance requirements for both insurers and enrollees.

BCRA headed directly for the Senate floor, bypassing processes such as committee hearings and a score by the CBO. Several Senators from Medicaid Expansion states stressed their desire to see Medicaid funding maintained in the 2017 bill, including Rob Portman (R-OH), Shelly Moore Capito (R-WV), and Lisa Murkowski (R-AK). Other Senators complained that the rush to a vote prevented them from adequate analysis of the legislation. McConnell announced that the BCRA vote would take place after the July 4 recess, but that proved not to be enough. On July 19, the initial version of BCRA was pulled from the Senate calendar after enough Senators announced their opposition to kill the bill.

Several Senators proposed their own legislation, but these bills lacked the support of Senate leadership and were not actively pursued. Instead, leadership introduced an amended BCRA, again announcing that the legislation would proceed directly to the floor without a committee hearing or CBO score.

NEW TRIBAL PROVISION

Included in the Senate legislation was a Tribal provision from Senator John Thune (R-SD), a member of the Republican leadership. Section 138 of BCRA would have changed federal reimbursement for AI/AN Medicaid patients. Medicaid is run by the individual states but funded by the states and federal government jointly. The share of expenses per patient paid by the federal government is called the Federal Medical Assistance Percentage, or “FMAP”. Currently, as part of the federal trust responsibility, the federal government funds FMAP at 100% for Medicaid-eligible AI/ANs for care "received through” an Indian health facility (excluding Urban Indian Health Organizations).

The legislative language would have expanded 100% FMAP to any provider seeing AI/ANs. This would have changed a 40-year policy of the federal government which ensures that valuable third party revenue from Medicaid is reinvested back into the chronically underfunded Indian health system. This provision was added without any Tribal consultation or input. NIHB and other Tribal organizations sent a letter to Senate leadership urging them to remove Section 138 and
instead include Urban Indian facilities in the 100% FMAP policy.

**SENATE VOTES**
The first thing the Senate must do to consider legislation is pass a Motion to Proceed, which begins official debate on the matter at hand. Bills that do not pass this threshold are not considered. The Senate voted 50-50 on the Motion to Proceed, Vice President Pence broke the tie, and the Senate took up a vote on the new BCRA. As debate wore on, it became clear that many Republican priorities would not be included in the final bill, including Medicaid reforms and opioid funding. This was in part due to the Senate Parliamentarian’s ruling that many of these priorities did not directly impact the budget. Two votes on repeal and replace amendments failed, driven by opposition from Senators from Medicaid Expansion states.

As a fallback option, Senator McConnell floated the idea of a “Skinny repeal,” a bill that would eliminate the ACA’s mandates and a few taxes, as a way to advance healthcare reform to a conference committee between the House and Senate. The night of July 27, 2017, McConnell released the text of the skinny repeal and scheduled a vote for two hours later. The bill failed when Senators McCain (R-AZ), Murkowski (R-AK), and Collins (R-ME) joined 48 Democrats in opposition. A frustrated Mitch McConnell spoke on the Senate floor immediately after the vote, saying “It’s time to move on.”

**WHAT’S NEXT FOR HEALTH CARE?**
With the final defeat of the Senate’s healthcare bill, the ACA is more likely than not going to remain in place for the time being. Republicans may try to repeal the law again if conditions become more favorable or they are able to reach agreement from within their ranks.

In the meantime, the Trump Administration will likely employ administrative tools that would have the effect of disrupting Medicaid coverage for American Indians and Alaska Natives.

His first week in office, President Trump eliminated funding for enrollment advertising in the federal marketplace. This advertising is geared toward younger, healthier citizens to encourage them to sign up for health insurance. There is also specific funding geared toward American Indian and Alaska Native outreach and education. The Trump Administration has indicated that they do not intend to continue to fund outreach and education for the law.

So far, the Trump Administration has made the decision to fund the marketplace’s cost sharing revenue on a monthly basis. President Trump has referred to these payments as bailouts to the insurance industry, and their continued payment in light of the repeal bill’s failure is far from certain. Short term decisions have generated uncertainty, and caused some insurers to increase premiums. The bipartisan “Problem Solvers Caucus” in the House of Representatives has suggested making the cost sharing revenue payments permanent as a way to provide certainty to marketplace insurers and lower the frequency of premium increases.

However, there are opportunities for coverage to expand. As states debated whether to expand Medicaid throughout 2016 and 2017, lawmakers in Wyoming, Idaho, South Dakota, and Oklahoma, states with large Tribal populations, cited the imminent repeal of the ACA and its Medicaid Expansion funding as a reason not to expand the program. With federal funding for MedicaidExpansion continuing, these lawmakers may find themselves revisiting the Expansion debate in their states. Medicaid Expansion has increased healthcare access for AI/ANs and saved the Indian healthcare system crucial resources, so more states implementing Expansion would be a positive development for Indian Country.

To read letters, NIHB sent to Congress, fact sheets, and talking points regarding the health reform legislation please visit [www.nihb.org](http://www.nihb.org).
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