

June 7, 2017

The Honorable Mitch McConnell
S-230 The Capitol
Washington, D.C. 20510

RE: Tribal Priorities in Senate Healthcare Reform Legislation

Dear Senator McConnell:

On behalf of the National Indian Health Board (NIHB), the National Congress of American Indians (NCAI) and on behalf of the Tribal Nations of the United States, we write to express the needs of American Indians and Alaska Natives (AI/ANs) as the Senate formulates healthcare reform legislation. While the American Health Care Act (AHCA; H.R. 1628), passed by the House of Representatives in May 2017, preserves several critical aspects for Indian Country, NIHB has concerns that we hope are addressed by the Senate as it crafts its own bill in the coming weeks. We specifically request that the Senate continue to protect Medicaid for Tribal populations as well as cost-sharing protections and benefits that were eliminated in the AHCA.

Tribes across the country were very pleased to see that the AHCA preserves the Indian Health Care Improvement Act (IHCA) and other Indian specific provisions of the Affordable Care Act (ACA) that have a direct impact on Indian health programs. Some of the provisions include IHS as a payor of last resort, permanent authority to bill Medicare Part B, and a tax exemption on health benefits provided by Tribal governments. This is a short list of provisions that have a direct benefit to Indian health programs and also help extend IHS appropriations to provide more health care services.

The federal government has a duty, agreed to long ago and reaffirmed many times by all three branches of government, to provide healthcare to Tribes and their members throughout the country. The Senate should pass reform legislation that would not reduce access to care for AI/ANs; and that would not strain the Indian Health Service, Tribally-operated, and urban Indian health programs' (collectively called the "I/T/U") resources further. The IHCA provides the programmatic structure and serves as the backbone of the Indian health system.

Medicaid

Cuts to the Medicaid program outlined in the H.R. 1628 are especially troubling. Medicaid is a crucial program for the federal government to fulfill the trust responsibility. 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. At that time and in recognition of this Congress stated:

“...the Committee took the view that it would be unfair and inequitable to burden a State Medicaid program with costs which normally would have been borne by the Indian Health Service.”¹

The Senate Finance Committee, which has primary legislative responsibility for the Medicare and Medicaid programs, adopted a similar reimbursement provision as a part of H.R. 3153, the Social Security Amendments of 1973. In the report, the Finance Committee justified the 100 percent FMAP by noting:

“...that with respect to matters relating to Indians, the Federal Government has traditionally assumed major responsibility. The Committee wishes to assure that a State's election to participate in the Medicaid program will not result in a lessening of Federal support of health care services for this population group, or that the effect of Medicaid coverage be to shift to States a financial burden previously borne by the Federal Government.”

In light of this legislative history, Tribes are pleased to see the 100 percent FMAP preserved in the AHCA. In recognition of this Congressional intent the Senate must ensure that this remains in place and extend 100 percent FMAP to urban Indian health programs (UIHPs) because the States do not share the trust responsibility to Tribes and the trust responsibility also follows AI/ANs off of reservations. Therefore we respectfully request that the Senate:

1) Ensure Medicaid Reform Upholds Federal Responsibility for Medicaid through the Indian health system

As Congress approaches Medicaid reform, it should ensure that any reform efforts maintain the federal responsibility for Indian health care, rather than passing this obligation on to the states. In 1976, Congress amended Section 1905(b) of the Social Security Act to provide for a 100 percent FMAP. This ensures that the federal government retains responsibility for Medicaid costs for AI/ANs rather than shifting the financial burden to the States. The Senate should ensure that 100 percent FMAP for services received through an IHS or Tribal healthcare facility is preserved.

2) Exempt Medicaid Payments to IHS/Tribal Facilities from State per capita allocations

Medicaid is an important tool through which the federal government works to fulfill its trust responsibility to provide for Indian health care. Exempting services received through an IHS or Tribal facility from statewide caps or block grants is critically important, but not enough to protect IHS and Tribal programs from state limitations on eligibility or services that may result from capping Medicaid funds. The United States funds Medicaid

¹ Senate Report 94-133, Indian Health Care Improvement Act

reimbursements to States at 100 percent FMAP, and capping Medicaid services for AI/ANs regardless of need is fundamentally inconsistent with fulfillment of the trust responsibility and Congress' intent in authorizing the Indian health system to access Medicaid resources.

H.R. 1628 exempts reimbursements to States for services received through IHS and Tribal healthcare facilities from per-capita allotment caps through Section 1903A, and exempts services received through the IHS and Tribal healthcare facilities from optional block-granting, as added in new section (i) on pp. 10-17 of the manager's amendment. If the Senate considers similar caps it must include a similar exemption as included in H.R. 1628.

Additionally, if the Senate considers similar caps, it should develop a mechanism to exempt reimbursements for services received through IHS and Tribal facilities from any State limitations on eligibility or services that may result from Medicaid caps. Such reimbursements would be covered by 100 percent FMAP and therefore will not affect State budgets.

3) Preserve Medicaid Expansion

Medicaid expansion has increased access to care and provided critical third-party revenues to the Indian health system. This has resulted in health care services to AI/AN people that might not have normally received care. This has resulted in preventing more complex and chronic health conditions and saved the Medicaid program money. Medicaid expansion has increased Medicaid revenues at IHS and Tribal health programs that is reinvested back into the health care system.

The AHCA would roll back Medicaid expansion starting in 2020 by ending the enhanced FMAP rates for new enrollees or enrollees that experienced a gap in coverage of over a month. Only States that expanded Medicaid coverage as of March 1, 2017 would be able to continue enhanced FMAP for grandfathered enrollees. The Senate should preserve Medicaid expansion as an option for States over a longer duration or on a permanent basis. At the very least, expansion should be retained for the AI/AN population under a special Medicaid optional eligibility category in recognition of the federal trust responsibility.

4) Exempt AI/AN from Any Mandatory Work Requirements

H.R. 1628 would allow the States to impose mandatory work requirements as a condition of Medicaid eligibility, and incentivize States that impose such requirements with a 5 percent increase in FMAP to reimburse them for the administrative costs of implementing such a requirement.

Mandatory work requirements will not work in Indian country because the incentive structures are completely different. Unlike other Medicaid beneficiaries, Indians members have access to IHS services, and will simply elect not to enroll in Medicaid and fall back on the underfunded IHS if work requirements are imposed as a condition of Medicaid

eligibility. As a result, rather than encouraging job seeking or saving program costs, mandatory work requirements will discourage AI/ANs from enrolling in Medicaid.

Tribes fully support work programs and employment, but we believe such programs should be voluntary so as not to provide a barrier to access to Medicaid for our members. Again, this is consistent with over 40 years of Medicaid policy for Indian Country. To the extent it considers imposing work requirements, the Senate should exempt AI/ANs from any work requirements to the same extent as other exempt groups, such as the aged and disabled.

5) Support State Flexibility While Preserving Tribal Rights

State flexibility is an important part of the Medicaid program. We support State flexibility, but important existing Tribal protections in the Medicaid program must be preserved. These include:

- An AI/AN who is eligible to receive or has received an item or service from an Indian health care provider or through referral under Contract Health Services (CHS)² is exempt from Medicaid premiums or cost sharing (such as deductibles and copayments) if the items or services are furnished by an I/T/U or through referral under CHS. SSA § 1916(j)(1)(A); 42 U.S.C. § 1396o(j)(1)(A).
- Payment to I/T/U providers cannot be reduced by the absence of copays or premiums from an AI/AN patient. SSA § 1916(j)(1)(B); 42 U.S.C. § 1396o(j)(1)(B).
- A state is prohibited from classifying trust land and items of cultural, religious or traditional significance as “resources” for purposes of determining Medicaid eligibility for AI/ANs. SSA 1902(ff)(1)-(4); 42 U.S.C. § 1396a(ff)(1)-(4).
- Certain income and resources (including interests in or income from trust land or other resources) are also exempt from Medicaid estate recovery. SSA § 1917(b)(3)(B); 42 U.S.C. § 1396p(b)(3)(B).
- If an AI/AN elects to enroll in an MCO, they are allowed to designate an Indian health care provider as their primary care provider if in-network. SSA § 1932(h)(1); 42 U.S.C. § 1396u-2(h)(1).
- An Indian health care provider must be promptly paid at a rate negotiated between the MCO and provider, or at a rate not less than the amount an MCO would pay to a non-Indian health care provider. SSA § 1932(h)(2)(A)-(C); 42 U.S.C. § 1396u-2(h)(2)(A)-(C).

² Now called Purchased/Referred Care

- If the MCO pays the Indian health care provider less than what the Indian health care provider would be paid under the State plan (the encounter rate), then the State must make up the difference in a wraparound payment to the Indian health care provider. SSA § 1932(h)(2)(C)(ii); 42 U.S.C. § 1396u-2(h)(2)(C)(ii).

The American Healthcare Act of 2017 does not impact these protections, and the Senate should ensure they are preserved.

Cost-Sharing Provisions

6) Preserve Cost-Sharing Protections for AI/ANs

Section 131 of the AHCA repeals the cost-sharing subsidy program, which is at Section 1402 in the Patient Protection and Affordable Care Act (ACA). However Section 1402(d) of the ACA includes important and critical cost sharing protections for AI/ANs that have incomes at or below 300 percent of the federal poverty level or through referral by 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 ability to provide health care to AI/AN people.

To the extent that the Congress considers changes to existing cost-sharing protections, it should 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. Please see the attached legislative proposal to amend section 131 of the AHCA.

Other provisions

7) Preserve the Indian Health Care Improvement Act

The Indian Health Care Improvement Act (IHCIA), 25 U.S.C. Chapter 18, is the foundational legislation governing the Indian health care system. In 2000, IHCIA's authorization expired, and in 2010 IHCIA was permanently enacted by cross-reference in Section 10221 of the ACA. Although the ACA was the legislative vehicle through which the IHCIA was passed, the IHCIA predates and is independent from the ACA. As Congress addresses the ACA, it is critical that it leaves intact the IHCIA, exempting it from any repeal. H.R. 1628 does not repeal the IHCIA and the Senate should ensure that the IHCIA is preserved as well.

8) Safeguard Indian-specific Provisions of the Affordable Care Act

In addition to enacting the IHCA, the ACA contained several crucial Indian-specific provisions unrelated to the rest of the ACA, and these provisions must be safeguarded as reform moves forward. These provisions include Section 2901, which makes Indian health programs the payer of last resort; Section 2902, which allows the Indian Health Service (IHS) permanent authority to bill Medicare Part B; and Section 9021, which excludes Indian health benefits from taxation. H.R. 1628 does not repeal these very important provisions and the Senate should ensure that they are preserved as well.

In conclusion, NIHB requests that the Senate take care in its deliberations to maintain and expand access to healthcare for AI/ANs and to reduce burdens on the I/T/U system. 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 ensure additional burden is not placed on very limited IHS appropriations. Tribes across the country are eager to come to the table and address shortcomings in the current healthcare system.

If you have any questions please do not hesitate to contact NIHB's Executive Director Stacy A. Bohlen at sbohlen@nihb.org or (202) 507-4070.

Sincerely,



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Chairman
National Indian Health Board



Jacqueline Pata
Executive Director
National Congress of American Indians

Cc:

Senator, John Cornyn, Majority Whip
Senator John Thune, Republican Conference Chairman
Senator Orrin Hatch, Chairman, Senate Finance Committee
Senator Mike Enzi, Chairman, Senate Budget Committee
Senator Lamar Alexander, Chairman, Senate Health, Education, Labor and Pensions Committee
Senator John Hoeven, Chairman Senate Committee on Indian Affairs

