

March 23, 2017

The Honorable Paul Ryan
Speaker of the House
U.S. House of Representatives
H-232 The Capitol
Washington, DC 20515

Re: Tribal Concerns in the American Health Care Act

Dear Speaker Ryan:

On behalf of the National Indian Health Board (NIHB) and the 567 federally recognized Tribal Nations we serve, I write to express concerns about the American Health Care Act (AHCA) (H.R. 1628) and request that the legislation be amended to take into account concerns of American Indians and Alaska Natives (AI/ANs) and to ensure that the federal government continue to live up to the federal trust responsibility to provide health care for Tribal communities. We recommend that the legislation:

- Preserve Medicaid Expansion for all Americans and especially for individuals receiving Medicaid through an Indian Health Service (IHS) or Tribally operated health facility
- Clarify that AI/ANs should not be subject to state-imposed work requirements under the Medicaid program
- Continue the cost sharing protections for AI/ANs contained in section 1402(d) of the Affordable Care Act

The Indian health care system is unlike any other health care delivery system. It was created by the federal government specifically to carry out a federal responsibility. These health care services were pre-paid by AI/ANs in exchange for vast amounts of lands that were ceded through treaties and other agreements and has been continuously reaffirmed by Congress. We urge you to continue this long-standing precedent by including these Tribal specific provisions in AHCA.

Tribes across the country were very pleased to see that H.R. 1628 preserves the Indian Health Care Improvement Act (IHCIA) and other Tribal specific portions of the Affordable Care Act (ACA) that have major, direct impacts on Tribal health programs. IHCIA serves as the backbone legislation for the Indian Health Service (IHS)/Tribal/ and Urban Indian health system which provides health care services for AI/ANs in fulfillment of the federal government's trust responsibility for health. Since it was enacted as part of the ACA in 2010, the IHCIA has been critical in allowing much-needed reform to come to the Indian health system. Furthermore, Sections 2901, 2902, and 9021 of the ACA are critically important for the financial viability Tribal

health systems and Tribes are glad to see these maintained as part of the AHCA and we appreciate that AHCA maintains all of these provisions.

Medicaid

That said, Tribes have several other concerns regarding the Medicaid program and the elimination of cost-sharing protections in H.R. 1628. Over 40 years ago, Congress permanently authorized the IHS and Tribal facilities to bill Medicaid for services provided to Medicaid-eligible American Indians and Alaska Natives to supplement inadequate IHS funding and as part of the federal trust responsibility to provide health care to AI/ANs. Today, Medicaid represents 67% of 3rd party revenue at the IHS, and 13% of overall IHS spending. However, this amount is just 0.15% of total national Medicaid spending. These proposed changes to the Medicaid program will mean less services for AI/ANs and increased pressure on the severely underfunded IHS.

Medicaid Expansion and Per Capita Funding Mechanism:

We appreciate the need to control costs of the Medicaid program. However, AHCA's proposed cuts to Medicaid expansion represent an unprecedented and irresponsible policy action that will have real-life consequences for tens of millions of Americans, including AI/ANs. Eliminating Medicaid Expansion will enact long-term damage to America's health system by forcing individuals to go without credible health coverage and thereby reduce services leading to negative health impacts nationwide.

Since Medicaid expansion, Medicaid revenues at IHS and Tribal facilities have increased by roughly 20%. This means, that for the first time, IHS patients are able to receive care beyond just "life or limb" services. Reversing the expansion represents a major cut in direct funding for IHS and Tribal health providers and will result in reduced services and loss of life. This is especially troubling when considering tighter discretionary budgets.

The movement toward a per capita and block grant system would be detrimental to Tribal communities. The AHCA correctly does not apply per capita payments to those who receive services through the Indian Health System. However, capping Medicaid through per-capita Medicaid allotment would lead to a significant reduction in federal Medicaid health care investment over the years. This would ultimately force States to choose between allocating additional State funding to maintain coverage; decrease covered services; or reduce eligibility. States do not have a treaty or trust responsibility to provide health care to AI/ANs, and the Medicaid program should not shift costs for AI/AN health to the States.

Therefore, we request a mechanism through which American Indians and Alaska Natives would not be affected by reduced eligibility requirements implemented by States or other similar expenditure controls within the purview of states. This is consistent with the trust responsibility and Congress's original intent when they amended the Social Security Act in 1976 to provide full Medicaid reimbursement for eligible AI/AN as a means to supplement the underfunded Indian health care system.

Work Requirements:

Recent changes to the AHCA allow states the option of instituting a work requirement in Medicaid for nondisabled, nonelderly, non-pregnant adults as a condition of receiving coverage under Medicaid. Tribal communities are often located in the most remote areas of the country, with jobless rates reaching 80% or 90% in some areas and are often disconnected from state unemployment services. Work requirements and co-pays pose barriers to access to Medicaid that are unique to American Indians and Alaska Natives because they can and will simply elect not to enroll in Medicaid and rely on IHS coverage instead. This means little cost savings, and just more demand put on IHS facilities. Again, this will lead to increased uncompensated care being provided to otherwise Medicaid eligible individuals by the IHS, Tribes and non-Indian healthcare providers. Therefore, we request that the following language be added to H.R. 1628 that would clarify the intent of Congress to ensure AI/ANs full access to Medicaid:

Notwithstanding any other provision of this title, no work requirements may be imposed as a condition of eligibility under this title or as a condition of receiving medical assistance under this title for Indians who are furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under purchased referred care.

Cost-Sharing Protections:

Section 131 of the AHCA repeals the cost-sharing subsidy program, which is at Section 1402 in the ACA. However, Section 1402(d) includes important and critical cost sharing protections for AI/ANs that have incomes at or below 300% of the federal poverty level or through referral by the IHS Purchased and Referred Care (PRC) program. These protections were included for AI/ANs in fulfillment of Congress and the United States federal trust responsibility to provide health care to Indians. They make health insurance affordable for AI/AN people. Like Medicaid cuts, ending these cost-sharing protections would destabilize the Indian health system by decreasing available 3rd party revenue and limiting services for patients. Congress should continue the cost-sharing protections for AI/ANs by amending Section 131 of the AHCA to continue the cost sharing protections for AI/ANs contained in section 1402(d).

We propose amending Section 131, to exempt the cost-sharing protections for Indians contained in subsection 1402(d) of the ACA from repeal. This would still accomplish Congress' intent to repeal the overall cost-sharing subsidies, but leave the Indian cost-sharing protections in place. The language below is Section 131, with *italic/underlined* text the amending language we propose:

Sec. 131. REPEAL OF COST-SHARING SUBSIDY.

- (a) In General. – *Subject to subsection (c)* Section 1402 of the Patient Protection and Affordable Care Act is repealed.
- (b) Effective Date. – The repeal made by subsection (a) shall apply to cost-sharing reductions (and payments to issuers for such reductions) for plan years beginning after December 31, 2019.

(c) Exemption. – Notwithstanding any other provision of law, subsection (d) of Section 1402 of the Patient Protection and Affordable Care Act shall continue to be implemented and payments required under that subsection shall continue to be made.

Conclusion:

In conclusion, we thank you again for your commitment to ensuring AI/AN-specific provisions of the ACA are preserved as part of the AHCA, but we urge you to amend the current legislation to ensure that services are not disrupted for AI/ANs. In short, the proposed changes in the AHCA addressed above would not save money, but would place unnecessary pressure on IHS discretionary appropriations. It would result in less services for AI/ANs, greater long-term health costs, and ultimately loss of life. The suggested changes detailed above will maintain the intent and spirit of AHCA, but still safeguard federal trust responsibility. If you have any questions, please do not hesitate to contact NIHB Executive Director Stacy A. Bohlen at (202) 507-4070 or sbohlen@nihb.org.

Sincerely,



Vinton Hawley
Chairman



Jacqueline Pata
Executive Director
National Congress of American Indians

Cc:

Chairman Greg Walden, House Energy and Commerce Committee
Chairman Kevin Brady, House Ways and Means Committee
Chairman Rob Bishop, House Natural Resources Committee
NIHB Board of Directors