Tribal Self-Governance Advisory Committee (TSGAC) Webinar

Tribal Priorities & Concerns in House Republican Bill

March 15, 2017
1:00 – 2:30 pm EST

Background

- One of the Administration's priorities is to repeal and replace the Affordable Care Act (ACA). The strategy to do this is eliminate the financing mechanisms to purchase insurance and eliminate Medicaid expansion through the Concurrent Budget Resolution on FY 2017, which directs the House Committees on Ways and Means and Energy and Commerce to develop legislation to reduce the deficit.
- The Committees have released bills that would significantly change the number of people who obtain federally subsidized health insurance through the non-group (Exchanges) and employment-based markets and in Medicaid.
- It is estimated that the changes would result in over 14 million people being uninsured under the legislation than under current law. This a direct result of reducing the availability of tax credits, eliminating the personal responsibility requirement, and people foregoing insurance because of higher premiums.
- Following changes in the non-group marketplace and eventual phasing out of Medicaid Expansion, the number of uninsured will rise to 21 million in 2020; and then to 24 million in 2024; and eventually 52 million would become uninsured by 2026.[1]
- The spike in the number of uninsured is in large part due to changes in Medicaid enrollment in those States that will eliminate eligibility of the expansion population.

Major Provisions of the Legislation

Marketplace (Exchange) Changes

- Eliminates individual tax penalties for not having insurance and for large employers to offer employees coverage. There are also a number of other penalties that have been eliminated (e.g. PCORI, Cadillac).
- Effective 2020, repeals current law subsidies for health insurance through non-group market (Exchanges), which include tax credits for premiums; *and subsidies for cost-sharing reductions to health plans*.
- Beginning in 2020, a new refundable tax credit is created to purchase health insurance through the non-group market (may or may not be Exchanges).
- Establishes a new Patient and State Stability Fund is to assist States to stabilize insurance risk pools (similar process defunded by Ryan bill last Congress, this creates a similar mechanism).

[1] Congressional Budget Office Cost Estimate, "American Health Care Act," March 13, 2017, available www.cbo.gov.

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- Relaxes requirements that prevent insurance companies from charging seniors more for insurance unless States set their own limits beginning in 2018.
- Eliminate actuarial requirements of health plans to cover at least 60% of the cost of covered benefits.
- Requires insurers to apply a 30% surcharge on premiums for people that who have been uninsured for more than 63 days.

Medicaid Expansion Changes

- The bill proposes to reduce $880 billion in federal Medicaid outlays and includes significant structural overhaul of the Medicaid program that will shift more costs to the States and create serious coverage issues for elderly, blind, disabled, adults and children.
- Major coverage changes would begin in 2020, when the enhanced federal matching rate would terminate for new enrollees under the ACA's expansion of Medicaid, at which point the expansion beneficiaries would remain enrolled, but would become ineligible if they drop out of the Medicaid program for 30 days.
- The bill proposes a major overhaul of how Medicaid is structured and financed. Instead of the current open-ended federal entitlement, states would get capped payments based on the number of Medicaid enrollees in different categories (Elderly, Blind, Disabled, Children, Expansion Adults, Non-expansion Adults), which would grow over time but not necessarily as fast as the cost of delivering care.
- This would create a per capita-based cap on the federal government's payments to states for medical assistance provided through Medicaid.
- CBO estimates that by 2026 Medicaid spending would be about 25 percent less than under current law.
- The bill allocates $10 billion over 5 years to be used to raise payments to Medicaid providers in non-expansion states.
- The bill does not propose any change to the current FQHC Prospective Payment System (PPS) or the required FQHC services under Medicaid. Indeed, because of some of the parliamentary rules surrounding the bill, very little of the "state flexibility" sought by governors and others is included in the proposal.
- Certain payments are exempt from the Per Capita Allotment process including payments made to, "IHS—An individual who receives any medical assistance under this title for services for which payment is made under the third sentence of section 1905(b)."[2]

[2] 1905(b) is the Social Security Act provision that authorizes the federal government to pay States at 100% Federal Medical Assistance Percentage (FMAP) for services provided to eligible AI/AN served through an Indian health facility.

Tribal Priorities/Concerns

The Indian Health Care Improvement Act (IHCIA) amendments enacted in Section 10221 of the ACA, as well as several other beneficial Tribal provisions enacted as part of the ACA, are separate and distinct from the ACA and must be preserved to ensure that the Indian health delivery system remains viable. A summary of those issues include:

- ✓ Maintain the permanent reauthorization of the Indian Health Care Improvement Act.
- ✓ Maintain monthly enrollment option for AI/AN.
- ➢ *Section 1402(d) special rules for Indians to exempt cost sharing for AI/AN under 300% FPL; or through referral under the contract health service program.* ***Repealed.***
- ✓ Section 2901(b) Payor of Last Resort. This very beneficial provision requires that when an IHS eligible Indian beneficiary is covered by another health program (any Federal, state, local health program, or private insurance) it is required to pay.
- ✓ Section 2901(c) Facilitating Enrollment of Indians under the Express Lane Option. This provision defines Indian health programs as Express Lane Agencies and allows them to conduct simplified eligibility determinations and facilitate enrollment in Medicaid and CHIP.
- ✓ Section 2902 Elimination of Sunset for Reimbursement for all Medicare Part B Services Furnished by Certain Indian Hospitals and Clinics.
- ✓ Title IX, Section 9021 Exclusion of Health Benefits Provided by Indian Tribal Governments as Taxable Income - The provision clarifies that the value of "health services" or "health benefits" received by AI/ANs—whether provided or purchased by the IHS, Tribes, or Tribal organizations—are excluded from gross income because it supplements the programs and services provided by the federal government.
- ✓ Maintain the federal trust responsibility for Indian health care be honored, and maintain 100% FMAP for services received through the Indian health system is preserved.
- ✓ Maintain the ARRA cost sharing and premium exemptions; Indian property and estate recovery protection; managed care protections; and tribal consultation requirements.

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