



June 27, 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), National Council on Urban Indian Health (NCUIH), Self-Governance Communication and Education (SGCE), and the Tribal Nations of the United States we serve, we write to convey and explain our strong and united opposition to the Senate's Better Care Reconciliation Act of 2017 (BCRA) in its current form.

While the legislation mirrors several provisions of the House bill that are of critical importance to Indian Country, we have grave concerns about other aspects of the BCRA that make it impossible for us to support the legislation in its current form. Specifically, we cannot support legislation that would gut the Medicaid program or eliminate cost-sharing protections for American Indians and Alaska Natives (AI/ANs). Most importantly, 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 to care 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); and
- 5) Maintain funding for preventative services, including the Prevention and Public Health Fund and women's health services.

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. But IHS appropriations have been about 50% of need for decades, and Medicaid revenue is essential to help fill the gap. When demand for services is higher than the funds available, services must be prioritized and rationed. As a result of this chronic underfunding, historical trauma, and a federal-state centric public health system, AI/ANs suffer from a wide array of health conditions at levels shockingly higher than other Americans. Nationally, 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 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, because of the federal trust responsibility, AI/ANs have access to limited IHS services to fall back on at no cost to them. As a result, Medicaid enrollment and utilization incentives are completely different for AI/ANs in Medicaid. Medicaid conditions of eligibility designed to ensure that beneficiaries have “personal investment” do not work when mandatory in Indian country. Instead of participating in these programs, many AI/ANs will simply choose not to enroll in Medicaid and fall back on the underfunded IHS instead. This will deprive Tribal and urban programs of vital Medicaid revenue and strain limited IHS resources to the breaking point.

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, because Congress recognized 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 it ensured that States would not have to bear any such costs, by providing that States would be reimbursed at 100 percent Federal Medical Assistance Percentage (FMAP) for services received through IHS and Tribal facilities.

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

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 its report on the legislation, 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 BCRA. As the Senate considers this proposed legislation, please ensure that this remains in place. In addition, because the federal trust responsibility also follows AI/ANs off of reservations, 100 percent FMAP should also be extended to services provided through urban Indian health programs (UIHPs).

With regard to Medicaid, we respectfully request that the Senate:

1) Continue to Fund Medicaid Based on Need without Caps

Medicaid is an important tool through which the federal government uses to fulfill its trust responsibility to provide for Indian health care.

The cuts proposed by Sections 133 and 134 of the BCRA would be devastating to Tribal and urban health programs. BCRA would make cuts to Medicaid that are even higher than those proposed by the House of Representatives. BCRA's caps are tied to a lower inflation factor beginning in 2025 that would result in even higher cuts to State Medicaid plans.

We were encouraged to see that BCRA contains provisions that would prevent the cost of care provided to AI/ANs from counting against either a per capita cap or a block grant. However, we request that urban Indian health programs be included in the exemption as well. Faced with the cuts proposed in Sections 133 and 134 of the bill, most States will be forced to make cuts to eligibility and/or services in future years. This will affect all providers and recipients, including Tribal/urban providers and AI/AN patients. This will lead to significant cuts in Medicaid revenues for I/T/Us, and will threaten our ability to provide healthcare services to our people. The Indian healthcare delivery system will not succeed if faced with the cuts proposed in BCRA.

To the extent that the Senate bill maintains such dramatic caps, it should work with Tribes to develop a mechanism to exempt reimbursements for services received through IHS/ Tribal/Urban facilities from any State-imposed limitations on eligibility or services that may result from these caps. Such reimbursements would be covered by 100 percent FMAP and therefore will not affect State budgets.

We also request language be added to the bill that requires States with one or more Indian Tribes or Tribal health providers to engage in Tribal consultation on a regular and ongoing basis, and *prior* to the submission of *any* Medicaid or CHIP State Plan Amendment, waiver applications, demonstration projects or extensions that may impact them as Medicaid providers or their Tribal members as Medicaid recipients.

2) Preserve Medicaid Expansion

Medicaid Expansion has increased access to care and provided critical third-party revenues to the Indian health system. The uninsured rate for Native Americans 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 health care services to AI/AN people who might not have normally received care. It has also resulted in saved revenues to the Medicaid program through preventing more complex and chronic health conditions and saved the Medicaid program money. Medicaid Expansion has increased Medicaid revenues at IHS/Tribal/Urban health programs that are being reinvested back into both the Indian and the larger national health care system.

The BCRA would roll back federal funding Medicaid Expansion by 2024. The Senate should preserve Medicaid Expansion as an option for States on a permanent basis. While BCRA contains important provisions designed to equalize funding between Expansion and non-Expansion States, we are concerned that the funding made available to non-Expansion States is insufficient to match that which has been provided to Expansion States. At the very least, Expansion should be retained for the AI/AN population under a special Medicaid optional eligibility category for State Plans in recognition of the federal trust responsibility.

3) Exempt AI/ANs from Work Requirements

The BCRA 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.

As noted above, mandatory work requirements will not work in Indian country because the incentive structures are completely different. Unlike other Medicaid beneficiaries, AI/ANs have access to IHS services. If work requirements are imposed as a condition of eligibility, many AI/ANs will elect not to enroll in Medicaid. As a result, rather than encouraging job seeking or saving program costs, mandatory work requirements will discourage AI/ANs from enrolling in Medicaid and place pressure on the already underfunded IHS. Further, cash jobs are scarce or non-existent in much of Indian country, making work requirements impossible to meet and job training programs an exercise in futility.

Tribes fully support work programs and employment, but we believe such programs should be voluntary so as not to provide a barrier to access 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.

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 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 deeply concerned by the proposed reduction of prevention services in the legislation. The elimination of the Prevention and Public Health Fund will cripple Tribes' efforts 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 crisis. However, states do not often pass these funds to Tribes. Drug-related deaths among AI/ANs is almost twice that of the general population. To address this problem, Tribes should either receive direct federal funding to address the opioid crisis, or states should be required to engage in state-Tribal consultation on the use of funds appropriated for the states.

In conclusion, the undersigned organizations must oppose the BCRA in its current form. We could support the legislation only if needs-based funding for Medicaid is preserved, Medicaid Expansion is continued, and the other changes outlined above are made to the bill before passage. In fulfillment of the trust responsibility, current exemptions for AI/ANs from health insurance

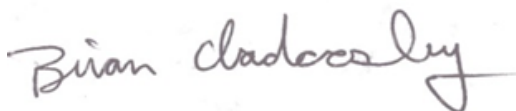
premiums, co-pays, and cost sharing must be preserved, and Medicaid-eligible AI/ANs must be allowed access to the program without further requirements attached to ensure additional burden is not placed on very limited IHS appropriations. Tribes across the country are eager to come to the table to discuss how shortcomings in the current healthcare system can be addressed, without wreaking immeasurable harm on our health programs and the people we serve.

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.

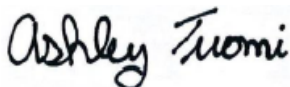
Sincerely,



Vinton Hawley
Chairperson
National Indian Health Board



Brian Cladoosby
President
National Congress of American Indians



Ashley Tuomi
President
National Council on Urban Indian Health



W. Ron Allen
Board Chairman
Self-Governance Communication &
Education Tribal Consortium

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

Better Care Reconciliation Act of 2017
Issue for American Indian and Alaska Natives
Section 208. Repeal of Cost-Sharing Subsidy

SECTION AT ISSUE: Section 208 of the Better Care Reconciliation Act (BCRA) would repeal the cost-sharing subsidy program, which is at Section 1402 in the Patient Protection and Affordable Care Act (ACA). This is of great concern for American Indian and Alaska Natives (AI/ANs), as Section 1402(d) includes critical cost sharing protections for AI/ANs that have incomes at or below 300% of the federal poverty level. These cost-sharing protections make health insurance affordable for AI/AN people. Eliminating them would also have a destabilizing effect on the tribal health system that is responsible for providing health care to most AI/AN people. For the reasons explained in this paper, Congress should continue the cost-sharing protections for AI/ANs by amending Section 208 of the BCRA to continue the cost-sharing protections for AI/ANs contained in section 1402(d) of the ACA. These protections were included for AI/ANs in fulfillment of Congress and the United States federal trust responsibility to provide health care to Indians.

JUSTIFICATION FOR CHANGE:

- The objectives of the Indian cost-sharing protections are to: (1) to promote access to affordable insurance for eligible Indians and to overcome the comparatively low health coverage that Indians have in comparison to the general population; and (2) to carry out the unique federal responsibility to provide health care to Indians long recognized in federal law.
- Indian families have disproportionately lower incomes than the general population and spend a higher proportion of their household earnings on necessities such as housing, transportation, utilities, and food, leaving little money for health care costs.
- Eliminating cost-sharing for Indians at or below 300% of federal poverty level aligns with federal statutes that prohibit Indians from being charged cost-sharing for premiums or co-payments in the Medicaid program.
- Because the Indian Health Service (IHS) provides care without cost to Indians, there is already a strong disincentive for eligible Indian patients to purchase insurance. The disincentive is exacerbated when cost-sharing is imposed on a low-income Indian patient for using insurance.
- Because of inadequate funding (IHS is funded at roughly 50-60% of need), the federally-created Indian health system is unable to provide the full scope of medical care needed by the AI/ANs it serves. Thus, IHS operates a Purchased and Referred Care (PRC) program through which needed care is purchased from public and private providers. But due to inadequate PRC funding, access to outside care is very limited and many patient care needs are delayed or unfilled. Eliminating barriers like cost sharing for Indians to purchase insurance saves federal funding in the PRC program.
- The Indian health care system is unlike any other mainstream health care delivery system. It was created by the federal government specifically to carry out its trust responsibility to provide health care to AI/AN people. In order to fulfill this trust responsibility Congress must enact Indian-specific provisions where necessary to ensure that Indians served by the IHS system can fully utilize their rights under federal health care laws such as the BCRA.

PROPOSED AMENDMENT: We propose amending Section 208 of the BCRA, 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 208, with *italic/underlined* text the amending language we propose:

Sec. 208. REPEAL OF COST-SHARING SUBSIDY PROGRAM.

- (a) In General. – *Subject to subsection (c)* Section 1402 of the Patient Protection and Affordable Care Act is repealed.

Better Care Reconciliation Act: Issue for American Indians and Alaska Natives
Section 208. Repeal of Cost-Sharing Subsidy Program

- (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.

Better Care Reconciliation Act of 2017:
Issue for American Indians and Alaska Natives
Sec. 131. Optional Work Requirement for Nondisabled,
Nonelderly, Nonpregnant Individuals.

SECTION AT ISSUE: Section 131(a) of the Better Care Reconciliation Act of 2017 (BCRA) would amend the Social Security Act at Section 1902 by adding a new section at 1902(o) to permit states, effective October 1, 2017, to require non-disabled, non-elderly, non-pregnant individuals to satisfy a work requirement as a condition for receipt of Medicaid medical assistance. The provision would define work requirements as an individual's participation in work activities for a specified period of time as administered by the state. The provision would incorporate, by reference, the definition of work activities as they appear in SSA Section 407(d) under Part A of Title IV (Block Grants to States for TANF).

Incentivizing access to Medicaid will not work for American Indian and Alaska Native people (AI/AN) since they have access to health care from the Indian Health Service (IHS). Work requirements would actually have the opposite effect to hinder access (or block access entirely) to Medicaid. Instead of participating in these programs, many AI/ANs will simply choose not to enroll in Medicaid and rely on the underfunded IHS instead. Tribal governments support full employment for their citizens, but making work requirements a condition of Medicaid eligibility will not encourage them to find work. Many tribal citizens are located in remote rural areas with limited employment opportunities. While some work requirement proposals would create exceptions for individuals who can demonstrate they are looking for work, those proposals require accessing state employment programs. Tribal citizens generally look to their Tribal governments for employment assistance programs, not state programs, and as a result will not be able to demonstrate they are seeking employment through state programs.

Section 131(a) as drafted would result in cost-shifting from the Medicaid program back to the IHS appropriation that has historically been chronically underfunded. The following language exempts AI/ANs that are eligible to receive their Medicaid services through the Indian health system from work requirements. This protection is in fulfillment of Congress and the United States federal trust responsibility to provide health care to Indians.

**SEC. 131. OPTIONAL WORK REQUIREMENT FOR NON-DISABLED, NONELDERLY,
NONPREGNANT INDIVIDUALS.**

(a) **IN GENERAL.**—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as previously amended, is further amended by adding at the end the following new subsection:

(o) **OPTIONAL WORK REQUIREMENT FOR NON-DISABLED, NONELDERLY,
NONPREGNANT INDIVIDUALS.**—

(1) **IN GENERAL.**—Beginning October 1, 2017, subject to paragraph (3), a State may elect to condition medical assistance to a nondisabled, nonelderly, nonpregnant individual under this title upon such an individual's satisfaction of a work requirement (as defined in paragraph (2)).

(2) **WORK REQUIREMENT DEFINED.**—In this section, the term 'work requirement' means, with respect to an individual, the individual's participation in work activities (as defined in section

Better Care Reconciliation Act of 2017:
Issue for American Indians and Alaska Natives
Sec. 131. Optional Work Requirement for Nondisabled,
Nonelderly, Nonpregnant Individuals.

407(d)) for such period of time as determined by the State, and as directed and administered by the State.

(3) REQUIRED EXCEPTIONS.—States administering a work requirement under this subsection may not apply such requirement to—

(A) a woman during pregnancy through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends;

(B) an individual who is under 19 years of age;

(C) an individual who is the only parent or caretaker relative in the family of a child who has not attained 6 years of age or who is the only parent or caretaker of a child with disabilities; or

(D) an individual who is married or a head of household and has not attained 20 years of age and who—

(i) maintains satisfactory attendance at secondary school or the equivalent; ~~or~~

(ii) participates in education directly related to employment; ~~or~~

(E) an individual eligible to receive health services from the Indian Health Service, an Indian Tribe, a Tribal Organization, or an Urban Indian Organization.

(b) INCREASE IN MATCHING RATE FOR IMPLEMENTATION.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end the following:

(aa) The Federal matching percentage otherwise applicable under subsection (a) with respect to State administrative expenditures during a calendar quarter for which the State receives payment under such subsection shall, in addition to any other increase to such Federal matching percentage, be increased for such calendar quarter by 5 percentage points with respect to State expenditures attributable to activities carried out by the State (and approved by the Secretary) to implement subsection (oo) of 14 section 1902.

###