Self-Governance Communication & Education Tribal Consortium

Background Research on Cost Estimate for the "Equal Access to Medicaid for All American Indians and Alaska Natives Act"[1]

June 1, 2019

Tribal leaders are proposing a set of amendments to the federal Medicaid law that will provide greater access to and responsiveness of the Medicaid program for the Indian health system, while at the same time reducing regulatory burdens and costs on the States. Titled the "Equal Access to Medicaid for All American Indians and Alaska Natives Act" (Act), the legislative proposal aims to eliminate gaps in access to a comprehensive set of health care services under Medicaid across all states for low- and moderate-income American Indians and Alaska Natives (AI/ANs).[2] As designed, the proposal would assist the federal government in meeting its trust responsibility to AI/ANs and Tribal nations. If enacted, the Act would establish in federal Medicaid law the following two provisions:[3]

- **Optional eligibility category**: Establish the authority for states to extend Medicaid eligibility to all AI/ANs with a household income at or less than 138% of the federal poverty level (FPL); and
- **Enhanced FMAP for urban Indian organizations (UIOs)**: Extend full federal funding through the application of a 100% Federal Medical Assistance Percentage (FMAP) rate to Medicaid services furnished by UIOs to Medicaid-eligible AI/ANs, establishing a consistent federal payment policy across all Indian health care providers (IHCPs).[4]

This memo outlines preliminary research relevant to generating a cost estimate—referred to as a "score"—for these two elements of the proposed legislation. It is important to note that the optional Medicaid eligibility category is limited to members of a federally-recognized Tribe, including shareholders in an Alaska Native regional or village corporation, and other individuals eligible for services through the Indian Health Service (IHS). Given the limits on eligibility, data used to estimate costs under the Medicaid expansion option should be drawn from the IHS Active User data sets or from Census data on "individuals with IHS access", not from the broader Census categories for American Indians and Alaska Natives. Ultimately, if advanced by Congress, the Congressional Budget Office (CBO) will be tasked with developing a score for the entire Act.

[1] For questions on this memo, contact Doneg McDonough, Health System Analytics, at DonegMcD@outlook.com.

[2] For the purposes of this memo and the Act, the term "AI/ANs" is limited to members of a federally-recognized Tribe, including shareholders in an Alaska Native regional or village corporation, and other individuals eligible for services through the Indian Health Service (IHS).

[3] See Attachment 2 for Cover Notes for Legislative Text for a summary of all of the key elements of the proposal.

[4] For services furnished by other IHCPs to AI/ANs, the current 100% FMAP would continue to apply. As stipulated by section 1905(b)(4) of the Social Security Act, "the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization."

SUMMARY OF FINDINGS

Based on this preliminary research, upon enactment of these provisions, it is anticipated that the net impact on federal spending would be modest, as a significant portion of the related federal Medicaid program spending is already authorized—and funded—under current federal law. For example, in extending 100% federal funding to services provided by UIOs to AI/ANs, an average of at least 57% of those expenditures are already funded by the federal government.

1. **Optional eligibility category:** In a recent CBO report projecting baseline federal Medicaid spending, the agency stated that the share of Americans gaining eligibility for Medicaid as a result of states continuing to adopt the expansion authorized under the Affordable Care Act (ACA) "would increase annually at a rate based on the historical pace of expansion since 2014."[5] As such, the costs associated with more and more U.S. residents—including AI/ANs—gaining coverage under the existing Medicaid expansion authority is already "funded" under current federal law and captured in current CBO baseline projections. As a result, enactment of the proposal to establish an AI/AN-specific optional Medicaid eligibility category under federal law is expected to result in minimal increases in federal expenditures above the CBO baseline projections.

2. **Extension of 100% FMAP for Services by UIOs**: With regard to establishing a consistent federal payment policy across all IHCPs whereby a 100% FMAP rate is extended to Medicaid services furnished by UIOs to AI/ANs, an earlier estimate (2015) prepared by the Indian Health Service (IHS) projected additional annual federal expenditures of $2.3 million per year.

OPTIONAL AI/AN MEDICAID ELIGIBILITY CATEGORY

The ACA provided states with the option, beginning in 2014, of expanding their Medicaid programs to cover all individuals with a household income at or less than 138% FPL.[6] For individuals enrolled in Medicaid under the expansion, the ACA stipulated that the federal government would cover 100% of the cost of their health care services through 2016, with the rate gradually decreasing to a fixed level of 90% in 2020 and subsequent years. As of January 4, 2018, 36 states and the District of Columbia have adopted the ACA Medicaid expansion. Two other states are considering implementing the expansion.

At present, 24 states with federally-recognized Tribes have expanded Medicaid eligibility to all residents with a household income at or less than 138% FPL, leaving 11 states with federally-recognized Tribes not having implemented the ACA expansion.

The "Equal Access to Medicaid for All American Indians and Alaska Natives Act", as noted above, proposes adding an optional eligibility category under which states could extend eligibility under their Medicaid programs to cover all AI/ANs with a household income at or less than 138% FPL. Consistent with existing federal Medicaid law, 100% FMAP would apply to health care services provided to AI/ANs by or through IHCPs, and a 90% FMAP rate would apply to services provided to AI/ANs by non-IHCPs.

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[5] See CBO, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028*, page 5, at https://www.cbo.gov/publication/53826.

[6] Under the ACA's Medicaid expansion provision, the income eligibility threshold is 133% FPL, with a 5% income disregard, making the threshold effectively 138%.

For the approximately 56,000 AI/ANs—and the IHCPs that serve them—residing in one of the 11 remaining states that have at least one federally-recognized Tribe and have not yet expanded Medicaid, the proposed optional AI/AN-specific eligibility category under Medicaid would provide a critical tool for Tribal advocates to work with state governments to meet the health care needs of these AI/ANs, and to do so with minimal-to-no cost to state governments.[7]

BASELINE FEDERAL MEDICAID SPENDING PROJECTIONS AND THE OPTIONAL AI/AN ELIGIBILITY CATEGORY

Current federal law—and the associated baseline CBO spending projections—provides states with the authority to extend Medicaid eligibility to all state residents (including AI/ANs) with household income at or less than 138% FPL, with the federal government funding at least 90% of the covered health care expenditures.

The Budget and Economic Outlook: 2018 to 2028, released in April 2018 by CBO, provides baseline projections for federal Medicaid spending under current law over the 2018-2028 period.[8] In this report, CBO estimated that federal Medicaid spending will grow by an average of 5.5% per year during the period, increasing from about $383 billion in 2018 to about $655 billion in 2028 (see the table below). CBO attributed approximately 5 percentage points of the anticipated average annual increase in federal Medicaid spending to rising per capita costs and about 1 percentage point to increasing enrollment.

CBO Baseline for Federal Spending on Medicaid, 2013-2028 (dollars in billions)																
	Actual					Projected										
	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Federal spending	265	302	350	368	375	383	401	417	437	465	493	524	554	587	620	655
Year-to-year change	--	13.6%	16.0%	5.3%	1.8%	2.1%	4.7%	4.0%	4.8%	6.4%	6.0%	6.3%	5.7%	6.0%	5.6%	5.6%

The CBO baseline projection of federal Medicaid spending assumes increased federal expenditures resulting from adoption of the ACA Medicaid expansion by *additional* states. CBO noted in its report titled *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028*:

> "CBO's estimates of Medicaid enrollment over the next decade reflect the agency's expectation that, **if current federal laws remained in place, additional states would expand eligibility for the program** and that more people would enroll in the program in states that have already done so. **Most of the increase in enrollment during that period would stem from additional states expanding eligibility for the program,** CBO estimates. ... Currently, about 55 percent of people who meet the eligibility criteria established under the ACA live in states that expanded Medicaid. CBO anticipates that share would increase annually at a rate based on the historical pace of expansion since 2014. By 2028, about two-thirds of the people who meet the new eligibility criteria are projected to be in states that have expanded Medicaid coverage."[9]

[7] It is expected that Indian Tribes first would work to have the proposed optional AI/AN-specific eligibility category under Medicaid authorized in states with federally-recognized Tribes, although the option would be available in all states.

[8] See https://www.cbo.gov/publication/53651.

[9] See CBO, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028*, page 5, at https://www.cbo.gov/publication/53826. [Emphasis added.]

By 2028, CBO anticipates that a large majority of states—estimated to total more than 75% of states and represent two-thirds of the potentially-eligible Medicaid population—will have adopted the ACA Medicaid expansion, making all their residents, including AI/ANs, eligible for Medicaid if they have a household income at or less than 138% FPL. And the federal government would cover at least 90% of the cost of their health care services. This means that—for states that have already adopted the Medicaid expansion, as well as those states that are anticipated to adopt the expansion at some point during the 2018-2028 period—the CBO current-law baseline projections already capture the health care costs of AI/ANs.

Tribal advocates view establishment of the optional Medicaid eligibility category as a critical tool for *expediting* the extension of Medicaid coverage to all low- to moderate-income AI/ANs. Even so, the total new costs to the federal government from this provision would be modest given that:

1. **The overall percentage of residents who would become eligible for Medicaid (*i.e.*, individuals who are eligible for services from the Indian Health Service) in states adopting this provision is low**.

    - In the 14 states that have not yet adopted the ACA Medicaid expansion, the total population is 109,792,977, including 615,519 AI/ANs. As such, AI/ANs comprise just 0.56% of the total population of these 14 states; and

    - In the 14 states that have not yet adopted the Medicaid expansion, 11 have federally-recognized Tribes. The total population in these 11 states is 86,534,082, including 591,739 AI/ANs. AI/ANs comprise only 0.68% of the total population of these 11 states.[10]

2. **Only a portion of currently uninsured AI/ANs who reside in these states have a household income at or less than 138% FPL and might become eligible for Medicaid under this provision (see Attachment 1).**

    - In the 14 states that have not yet adopted the ACA Medicaid expansion, about 196,000 AI/ANs lack health insurance. Among these individuals, an estimated 56,000, or only 28.8%, have a household income at or less than 138% FPL; and

    - In the 11 states with federally-recognized Tribes that have not yet adopted the ACA Medicaid expansion, about 190,000 AI/ANs lack health insurance. Among these individuals, an estimated 55,000, or just 28.5%, have a household income at or less than 138% FPL.[11]

3. **A number of the uninsured AI/ANs in the non-expansion states who have a household income at or less than 138% FPL already are eligible for, but not currently enrolled in, Medicaid.**

4. **Even without implementation of an extension of Medicaid eligibility, the underlying Medicaid year-to-year enrollment levels likely will continue to increase in non-expansion states, as**

[10] Figures taken from Census Bureau, 2017 American Community Survey, 1-Year Estimates for "individuals with IHS access."

[11] Based on analysis of Census Bureau, 2017 American Community Survey, 1-Year Estimates. Figures indicate the percentage of uninsured individuals with IHS access with a household income at or less than $28,180 ($35,218 in Alaska), which represents 138% FPL for a 3-person household (the average household size for AI/ANs) in 2017.

Medicaid enrollment of AI/ANs in the 11 non-expansion states with federally-recognized Tribes increased from 130,722 to 156,788, or 19.9%, over the 2010-2017 period.

5. **The expected "take-up rate"—based on experiences in other states—is far less than 100% for those eligible and uninsured, although a small percentage of individuals currently with employer-sponsored insurance typically drop that coverage and enroll in Medicaid coverage, if eligible.**

6. **And, as discussed above, a number of the 14 states that have not yet adopted the ACA Medicaid expansion already are assumed by CBO that they will do so under current law.**

Despite the modest-to-minimal anticipated additional costs to the federal government from enactment of the AI/AN-specific optional Medicaid eligibility category, the provision has the potential to have a dramatically positive impact in those AI/AN communities that currently lack the resources necessary to gain access to quality health care services for their low-to-moderate-income citizens.

ENHANCED FMAP FOR UIOS

The term IHCP, as defined in federal regulations, means a health program operated by (1) IHS, (2) an Indian tribe or tribal organization, or (3) an urban Indian organization pursuant to a grant or contract with IHS under title V of the Indian Health Care Improvement Act. Of these three types of IHCPs, only Medicaid payments to UIOs are not supported by 100% FMAP. At present, there are 41 UIOs located in 22 states.

The "Equal Access to Medicaid for All American Indians and Alaska Natives Act" would establish a consistent federal policy across all IHCPs by extending 100% FMAP to services provided to AI/ANs by or through UIOs. Enactment of this provision also would reduce costs to state governments, as well as make UIOs eligible for the "OMB/IHS encounter rate," which more accurately reflects the costs of outpatient services provided by IHCPs, including UIOs.

PRIOR ESTIMATES OF EXTENDING 100% FMAP TO SERVICES PROVIDED BY UIOS TO IHS-ELIGIBLE INDIVIDUALS

In 2015, the IHS prepared an estimate of the additional costs to the federal government from applying a 100% FMAP rate to services provided by or through UIOs to IHS-eligible individuals. In that estimate, the IHS projected total additional annual federal expenditures of $2.3 million. This figure was generated by calculating the additional average per service cost funded by the federal government under the provision and multiplying this figure by the total number of billable services provided by UIOs to IHS-eligible Medicaid enrollees.

Given that the IHS estimate was prepared in 2015, it would be beneficial to update the projection using more recent payment rate and service volume data.

CONCLUSION

Based on this preliminary research, it is anticipated that the net impact on federal spending from enactment of these two provisions of the "Equal Access to Medicaid for All American Indians and Alaska Natives Act" would be fairly modest, as a significant portion of the related federal Medicaid spending is already authorized—and funded—under current federal law.

Attachment 1

Medicaid Enrollment of Individuals with IHS Access, by State (Non-ACA Expansion States); 2010-2017												
State	Federally Recognized Tribe	Medicaid Expansion Status[1]	Medicaid Enrollment of Individuals with IHS Access, by Year[2]								Change (2010-2017)	Percent Change (2010-2017)	Remaining Uninsured[3] (0-138% FPL)
			2010	2011	2012	2013	2014	2015	2016	2017			
Newly Authorized (Not Implemented)													
Idaho	Yes	Authorized	2,636	4,648	3,150	2,667	3,518	4,446	4,412	4,473	1,837	69.69%	1,041
Nebraska	Yes	Authorized	3,038	2,692	2,789	3,532	2,510	3,007	3,571	4,734	1,696	55.8%	354
Utah	Yes	Authorized	4,168	2,639	2,451	4,209	2,313	4,828	3,955	3,231	-937	-22.5%	1,140
Not Authorized													
Alabama	Yes	No	1,094	1,071	1,370	832	1,858	519	976	761	-333	-30.44%	0
Florida	Yes	No	4,070	3,547	3,632	4,267	4,347	4,505	5,168	5,936	1,866	45.8%	1,120
Georgia	No	No	2,242	3,224	2,318	1,127	1,131	1,662	2,597	2,922	680	30.3%	38
Kansas	Yes	No	2,644	3,121	2,594	1,782	3,266	2,191	2,250	4,851	2,207	83.5%	232
Mississippi	Yes	No	2,690	3,524	2,681	4,146	2,342	3,289	3,731	3,794	1,104	41.0%	1,182
Missouri	No	No	1,502	474	1,485	3,171	3,002	1,512	1,092	2,891	1,389	92.5%	1,043
North Carolina	Yes	No	3,925	3,876	3,955	3,986	5,543	5,203	3,557	4,209	284	7.2%	522
Oklahoma	Yes	No	70,818	70,000	77,084	82,333	71,713	74,865	84,544	79,125	8,307	11.7%	34,474
South Carolina	Yes	No	1,399	997	3,194	2,058	621	2,338	1,102	1,200	-199	-14.2%	617
South Dakota	Yes	No	23,824	31,067	29,797	28,875	25,617	26,575	30,798	32,275	8,451	35.5%	9,285
Tennessee	No	No	694	857	1,141	505	843	1,291	1,537	930	236	34.0%	105
Texas	Yes	No	7,726	8,051	5,967	8,060	4,200	6,058	9,803	8,272	546	7.1%	2,605
Wisconsin	Yes	No	9,231	9,463	7,849	9,390	10,556	8,975	10,676	12,902	3,671	39.8%	3,712
Wyoming	Yes	No	3,301	4,471	3,064	2,876	2,487	1,495	4,410	3,463	162	4.9%	1,028
TOTAL (Newly Authorized States)			**9,842**	**9,979**	**8,390**	**10,408**	**8,341**	**12,281**	**11,938**	**12,438**	**2,596**	**26.4%**	**2,535**
TOTAL (Non-Expansion States)			**135,160**	**143,743**	**146,131**	**153,408**	**137,526**	**140,478**	**162,241**	**163,531**	**28,371**	**21.0%**	**55,963**
Non-Expansion States with Tribe			130,722	139,188	141,187	148,605	132,550	136,013	157,015	156,788	26,066	19.9%	54,777
Non-Expansion States with no Tribe			4,438	4,555	4,944	4,803	4,976	4,465	5,226	6,743	2,305	51.9%	1,186
GRAND TOTAL			**145,002**	**153,722**	**154,521**	**163,816**	**145,867**	**152,759**	**174,179**	**175,969**	**30,967**	**21.4%**	**58,498**

Notes:

[1] As of January 4, 2019. Montana and Louisiana implemented the Medicaid expansion in January 2016 and July 2016, respectively. Maine approved the Medicaid expansion through a ballot initiative in November 2017 but the then-governor did not set a date for implementation; the newly elected governor on January 3, 2019, signed an executive order directing the state Department of Health and Human Services to begin implementation of the expansion and provide coverage to eligible residents retroactive to July 2018. Virginia approved the Medicaid expansion as part of its FY 2019-2020 budget in June 2018, with implementation planned for January 1, 2019. In November 2018, Idaho, Nebraska, and Utah authorized the Medicaid expansion through ballot initiatives. In addition, lawmakers in Kansas and Wisconsin have indicated a likelihood of authorizing Medicaid expansion. See Kaiser Family Foundation, "Status of State Action on the Medicaid Expansion Decision."

[2] Figures taken from Census Bureau, 2010-2017 American Community Survey, 1-Year Estimates.

[3] Based on analysis of Census Bureau, 2017 American Community Survey, 1-Year Estimates. Figures indicate the number of uninsured individuals with IHS access with a household income at or less than $28,180 ($35,218 in Alaska), which represents 138% FPL for a 3-person household (the average household size for AI/ANs) in 2017.

National Indian Health Board

AN ACT TO ACHIEVE --

"EQUAL ACCESS TO MEDICAID FOR ALL AMERICAN INDIANS/ALASKA NATIVES"

Cover Notes for Legislative Text

As of June 1, 2019

Tribal leaders are proposing a set of amendments to the federal Medicaid law that will provide greater access to and responsiveness of the Medicaid program for the Indian health system, while at the same time reducing regulatory burdens and costs on the States. The amendments are designed to provide equal access to Medicaid resources for Indian health programs and American Indians and Alaska Natives (AI/ANs)[1] across all States.

Titled the "Equal Access to Medicaid for all American Indians/Alaska Natives Act" (Act), upon enactment, these initiatives would improve access to quality health care services for low- and moderate-income AI/ANs across all states.

The main provisions of the Act are:

1. Create an optional eligibility category under federal Medicaid law providing authority for states to extend Medicaid eligibility to all AI/ANs with household income up to 138% of the federal poverty level (FPL).
2. Authorize IHCPs in all states to receive Medicaid reimbursement for all services authorized under Medicaid and specified services authorized under the Indian Health Care Improvement Act—referred to as Qualified Indian Provider Services—when delivered to Medicaid-eligible AI/ANs.
3. Extend full federal funding through a 100% FMAP (Federal Medical Assistance Percentage) rate for Medicaid services furnished by Urban Indian Organizations to AI/ANs, in addition to services furnished by IHS/Tribal providers to AI/ANs.

In addition, the following items are included in the Act:

4. Clarify in federal law and regulations that state Medicaid programs are prohibited from over-riding (through waivers) Indian-specific provisions in federal Medicaid law.
5. Address the "four walls" limitations on IHCP "clinic" services by removing the restriction that prohibits billing for services provided outside a clinic facility.

[1] AI/ANs are defined here as individuals eligible to receive services from the Indian Health Service (IHS) pursuant to 42 CFR 447.51.