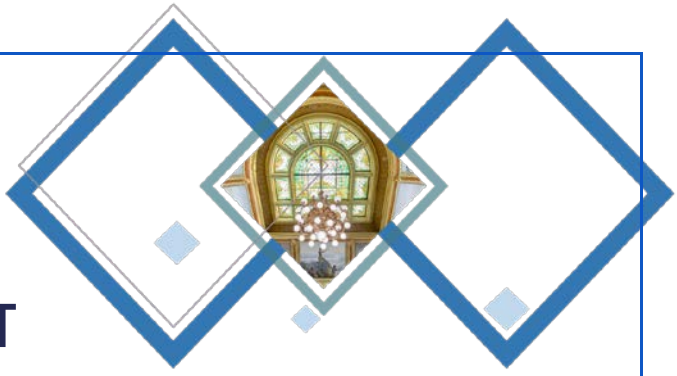
September 18, 2017

State-Tribal Relations Committee
Hope Stockwell



ACA PROVISIONS THAT AFFECT HEALTH CARE FOR AMERICAN INDIANS AND ALASKA NATIVES

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) of 2010 expanded access to health care coverage for American Indians and Alaska Natives and included a permanent reauthorization of the Indian Health Care Improvement Act (IHCIA). Dr. Yvette Roubideaux, director of the Indian Health Service (IHS) at the time, said "the provision of health care services to American Indians and Alaska Natives is a key component of the federal government's trust responsibility, and the updating and permanent authorization of the IHCIA helps to fulfill this responsibility."[1]

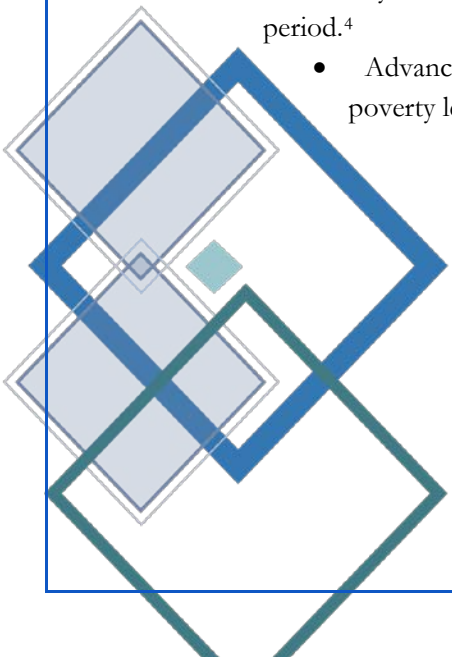
Expansion of Coverage

The ACA expanded health care options and coverage for American Indians and Alaska Natives with the creation of the Health Insurance Marketplace and by allowing states to expand eligibility for Medicaid to all individuals living at or below 138% of the federal poverty level. The additional coverage allows more American Indians and Alaska Natives to access health care services outside of the IHS.

Health Insurance Marketplace

The Health Insurance Marketplace includes several provisions specific to American Indians and Alaska Natives, including:

- No co-pays, deductibles, or co-insurance for a person who buys insurance through the Marketplace and has an income between 100% and 300% of the federal poverty level.[2]
- No co-pays, deductibles, or co-insurance for a person receiving care from an Indian health provider regardless of income.[3]
- The ability to enroll in a Marketplace insurance plan at any time, not just during the yearly open enrollment period.[4]
- Advance premium tax credits for a person whose income is between 100% and 300% of the federal poverty level. [5]



[1] Indian Health Service press release, Indian Health Care Improvement Act Made Permanent, March 27, 2010.
[2] https://www.healthcare.gov/american-indians-alaska-natives/coverage/
[3] Ibid.
[4] Ibid.
[5] Warne, Donald, et al., Impact of ACA Repeal on American Indian sand Alaska Natives, pages 6 and 7.

Medicaid Expansion

The Legislature approved Montana's Medicaid expansion in 2015. The state Department of Public Health and Human Services says 15% (11,228) of Montanans who subsequently became insured are American Indian or Alaska Native.

For individuals with Medicare drug coverage (Part D), prescription expenditures through IHS, a tribe or tribal organization, or an urban Indian organization counts toward the annual out-of-pocket threshold in the so-called "donut hole".[6] By 2020, the donut hole will be closed, and individuals will only pay 25% of the costs of their drugs until they reach the yearly out-of-pocket spending limit.[7]

Updates to the IHCIA

As part of the ACA, Congress permanently reauthorized the IHCIA and updated the law, originally enacted in 1976, in several ways. Updates include:[8] [9] [10]

- Establishing the IHS Director as an official appointee of the president and enhancement the director's authorities, including the responsibility to facilitate advocacy and promote consultation on matters relating to Indian health within the Department of Health and Human Services.

- Authorization for hospice, assisted living, dialysis, and long-term, home-, and community-based care.

- The ability for tribally-operated facilities to recover costs from third parties such as insurance companies, HMOs, and employee health plans.

- Collection of reimbursements from Medicare, Medicaid, and CHIP (Children's Health Insurance Program) by Indian health facilities.

- Clarifying that IHS funding appropriated to tribal health programs may not be offset by reimbursements.

- Authorization for tribes and tribal organizations to purchase health benefits coverage for IHS beneficiaries.

- Allowing tribes and tribal organizations operating a program under the Indian Self-Determination and Education Assistance Act and allowing an urban Indian organization operating a program under Title V of IHCIA to purchase coverage for their employees from the Federal Employees Health Benefits Program.

- Authorization for the IHS to enter into arrangements with the Departments of Veterans Affairs and Defense to share medical facilities and services.

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[6] American Indian Health & Family Services of Southeastern Missouri Inc, Health Reform for American Indians and Alaska Natives, page 2.
[7] Tribalhealthcare.org, The Affordable Care Act Benefits American Indians and Alaska Natives, page 1.
[8] Indian Health Service press release, Indian Health Care Improvement Act Made Permanent, March 27, 2010.
[9] Warne, Donald, et al., Impact of ACA Repeal on American Indian sand Alaska Natives, pages 2 through 5.
[10] Tribalhealthcare.org, The Affordable Care Act Benefits American Indians and Alaska Natives, page 2.

- Establishment of a Community Health Representative program for urban Indian organizations to train and employ Indians to provide health care services.

- Directing the IHS to establish comprehensive behavioral health, prevention, and treatment programs for Indians.

- Continuing to allow IHS funds to be used for patient travel costs.

- Exempting patients receiving authorized private sector services from liability for charges or costs associated with those services.

- Exempting employees of tribal health programs and urban Indian organizations from federal agency licensing fees and exempting licensed health care professionals at tribal health programs from state licensing requirements if the professional is licensed in any state.

- Allowing for the transfer of funds, equipment, and other supplies from any source to the IHS for health and sanitation facility construction and operation.

- Requiring the IHS to confer with urban Indian organizations in carrying out certain provisions of the ACA.

ACA-Authorized Grants and Programs

In addition to increased coverage and reauthorization of the IHCIA, the ACA also authorized several grants and programs that benefit American Indians and Alaska Natives including:[11]

- Funding for maternal, infant, and early childhood home visiting programs with a specific focus on pregnant women, expectant fathers, and caregivers of children under 5 years of age.

- Expanded access to preventive services, including immunizations, for eligible adults enrolled in Medicaid.

- Authorization for states to purchase vaccines for adults at the federal contract price.

- Establishing the Office of Women's Health within the Department of Health and Human Services and in the director's office of each of the following agencies: the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, the Food and Drug Administration, the Health Resources and Services Administration, and the Substance Abuse and Mental Health Services Administration.

- Creation of the Prevention and Public Health Fund to provide for expanded and sustained national investments in prevention and public health, to improve health outcomes, and to enhance health care quality.

- Coverage of comprehensive tobacco cessation services for pregnant women in Medicaid, including counseling and drug therapy.

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[11] Warne, Donald, et al., Impact of ACA Repeal on American Indian sand Alaska Natives, pages 8 through 10.

- Development of a national strategy to improve the delivery of health services, patient outcomes, and population health.

- Establishment of the Interagency Working Group on Health Care Quality.

- Creation of the Center for Medicare and Medicaid Innovation to test payment and service delivery models to reduce costs and improve quality of care.

- Creation of the National Prevention, Health Promotion, and Public Health Council to provide coordination and leadership among federal departments and agencies.

- Establishment of an independent panel of public health and prevention experts to generate evidence-based findings and recommendations about community preventive services, programs, and policies to improve health.

- Collection and reporting of data by new federal health programs, activities, and surveys on race, ethnicity, sex, primary language, and disability status to monitor public health trends and disparities.

- A loan repayment program for providers of medical, mental, and behavioral health services who are or will be working in a Health Professional Shortage Area, Medically Underserved Area, or with a Medically Underserved Population.