Impact of ACA Repeal on American Indians and Alaska Natives

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OVERVIEW OF KEY CONSIDERATIONS IN AMERICAN INDIAN HEALTH POLICY

As Congress begins debate on whether and how to repeal or replace the Patient Protection and Affordable Care Act (ACA or "Obamacare"), American Indians and Alaska Natives (AI/ANs) face considerable risk and uncertainty due to many special provisions in the ACA that were intended to address longstanding underfunding and health disparities. AI/ANs have a unique political standing in the United States and are the only population born with a legal right to health services. These rights are based on numerous legal foundations, including treaties, laws, executive orders, and court decisions. However, the Indian Health Service (IHS)—the federal agency charged with providing health services to AI/ANs—has been underfunded for decades, leaving the AI/AN population with among the worst health disparities and poorest access to services in the nation. The IHS is divided into twelve areas with significant regional differences in health outcomes and access to services.

IHS is ***not*** a health insurance program like Medicare or Medicaid; rather IHS is a provider of health services similar to the Veterans Administration. IHS provides services in a variety of ways: directly, through agency-operated programs; through Tribally-contracted/compacted and operated health programs; and indirectly, through services purchased from private providers. IHS also provides limited funding for urban Indian health programs that serve AI/ANs living outside of reservations or other Tribally-operated lands.

When IHS facilities cannot provide health services directly, IHS Purchased and Referred Care (PRC) funds are used to pay for referrals to the private sector. In these circumstances, AI/ANs who do not have health insurance

Indian Health Service—12 Areas

Source: Indian Health Service

Ten States with Highest AI/AN Uninsurance, 2012	
Montana	40%
New Mexico	39%
South Dakota	38%
Alaska	36%
North Dakota	33%
Rhode Island	32%
Mississippi	32%
Wyoming	31%
Arizona	30%
Idaho	30%

North Dakota State University is a student-focused, land-grant, research university of 14,516 students. The university's researchers are leaders in areas spanning health professions, polymers, food safety, and materials science. NDSU is home to the only MPH Program in the nation with an American Indian Public Health specialization, and NDSU is listed in the National Science Foundation's top 100 in several areas, including: agricultural sciences, social sciences, physical sciences, chemistry, psychology, and computer sciences.

Prepared with support from the Montana Healthcare Foundation and the Robert Wood Johnson Foundation's State Health Reform Assistance Network.

and who depend on the IHS for health care, receive health services in the private sector through the PRC program.[1] Unfortunately, due to chronic underfunding, many needed services have been denied over the years, exacerbating health disparities. Many IHS service units are only providing "life or limb" referrals due to funding shortfalls for uninsured patients.[2]

In 2010, the ACA provided new opportunities for AI/ANs to access health services. With high rates of poverty and with the prospect of Medicaid expansion in several states with significant AI populations, many stakeholders and policy experts viewed the ACA as the largest expansion of Indian health in a generation. In addition, special provisions in the Marketplace to promote access to health insurance at little to no cost meant that millions of AI/ANs could have access to previously unavailable health services. The ACA provided significant increases in access to health insurance, less dependence on PRC, and subsequent greater access to health services. In addition, the ACA included permanent reauthorization of the primary legislation governing the Indian health system, the Indian Health Care Improvement Act (IHCIA). This brief explores the provisions for AI/AN health that were included in the ACA, and the implications of a repeal.

KEY COMPONENTS OF THE ACA AND IMPACT ON AMERICAN INDIANS

Permanent Reauthorization of Indian Health Care Improvement Act

First enacted in 1976, the Indian Health Care Improvement Act (PL 94-437) is the legislative embodiment of the federal trust and treaty responsibility to Tribal Nations for health care. The IHCIA was permanently reauthorized in 2010 as part of the ACA (Section 10221). It serves as the backbone legislation for the Indian Health Service/Tribal/and Urban Indian (collectively known as the I/T/U) health system that provides health care services for AI/ANs in fulfillment of the federal government's trust responsibility for health services.

The IHCIA states:

> It is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians—to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.

The law provides the foundational authority for IHS and Tribal health programs to be reimbursed by Medicare, Medicaid, and other third-party insurers, to make grants to Indian Tribes and Tribal organizations, and to run programs designed to address specific, critical concerns for AI/ANs such as substance abuse, diabetes, and suicide.

Significant Impacts of the IHCIA on AI/AN Health Services Include:

Sections 825, 2, and 3 {25 U.S.C. §§ 1601, 1602, and 1680o} permanently reauthorizes the IHCIA and states that a major national goal is to provide the resources, processes, and structure to eradicate health disparities between AI/ANs and the general population.

- This Section is critical in setting forth all federal Indian health policy by declaring that it will be a priority of the federal government to provide health care resources to AI/ANs and legislatively affirms the trust responsibility for health. By permanently enacting IHCIA, I/T/Us can operate their health programs without fear of expiring legislation, thus allowing them to provide a consistent continuum of care for patients, and thereby improving health outcomes.

Section 124 {25 U.S.C. § 1616q} extends the exemption from federal agency licensing fees available to the Public Health Service Commission Corps to employees of Tribal health programs and urban Indian organizations.

- This provision provides parity for Tribal health providers with other federal providers and allows for cost savings that can then be reinvested into health programs to provide additional services to AI/ANs.

Section 202 {25 U.S.C. § 1621a} reduces the Catastrophic Health Emergency Fund (CHEF) threshold to the 2000 level of $19,000, with increases for subsequent years.

- CHEF is part of the PRC program and is designed to cover the medical costs of disasters and catastrophic illnesses for PRC-eligible persons. It is an essential part of the PRC program that is used to fund critical referral services for AI/AN patients. Lowering the threshold to $19,000 ensures that more services can be provided under CHEF. Historically, CHEF has been funded at approximately $51.5 million annually.

Section 206 {25 U.S.C. § 1621e} allows Tribes and Tribal organizations who operate their own programs the right to recover costs from third parties (such as insurance companies, HMOs, and employee health plans).

- This Section permits Indian health care providers the ability to bring in supplemental revenue from third parties by giving them the authority to be reimbursed from third parties for the services provided. This allows facilities to generate significant funds that can be used to support

the local services expansion and PRC. There have been cases in which insurers would not reimburse I/T/U facilities for the services provided, but later complied upon notification about the content of Section 206. Removal of this authorization would be devastating to I/T/U providers. Third-party revenue for the I/T/U system totaled approximately $1.2 billion in fiscal year (FY) 2017.

Section 207 {25 U.S.C. § 1621f} clarifies that IHS may not offset or limit any amount obligated to any service unit, Tribe, Tribal organization, or urban Indian organization because of receipt of third-party reimbursements.

- This provision is critically important to ensure that the federal government lives up to its trust responsibility to provide appropriations for health care to AI/ANs. Since FY 2011, the IHS discretionary budget has increased 18 percent, despite increased revenues due to Medicaid expansion and access to the Health Insurance Marketplace. By not allowing appropriated funding to be offset by reimbursements, local service units are incentivized to increase third-party revenue and thus bring more funding into the severely underfunded Indian health system.

Section 213 {25 U.S.C. § 1621l} continues the authority for funds to be used for travel costs of patients receiving health care services provided either directly by IHS, under PRC, or through a contract or compact entered under the Indian Self-Determination Act and amendments.

- Because Indian reservations are often located in remote and rural areas, having funds available for travel is a critical need to ensure that patients are receiving access to the best treatment. This provides life-saving resources for patients who need emergent, acute, or high-level chronic care services.

Section 221 {25 U.S.C. § 1621t} exempts a licensed health care professional who is employed by a Tribally-operated health program from state licensing requirements if the professional is licensed in any state, as is the case with IHS health care professionals.

- As rural, not-for-profit health care providers, Tribal providers often struggle to find qualified medical personnel to work at their health care facilities. When Tribal providers assume the role of the federal government in providing health care to AI/ANs in their local areas, it is critical that those providers be given the same opportunities to recruit and retain professional staff as federal sites. This provision allowing for licensing reciprocity across states has made recruitment for Tribal health care providers national in scope, and it has allowed for much more expedient hiring of licensed professionals.

Section 222 {25 U.S.C. § 1621u} says that a patient who receives authorized PRC services will not be held liable for any charges or costs associated with those authorized services. Following receipt of proper notice or an accepted claim, the PRC provider shall have no further recourse against the patient who received the health care.

- Many Tribes have experienced difficulty and resistance with PRC health providers who are requesting payment from Tribal patients. Under this Section, a patient is not personally liable for services that have been authorized by PRC and carried out by a private sector provider. Private sector providers are prohibited from collecting payments for these services from a patient. This authority is essential for protection of the federal trust responsibility and AI/AN patient rights.

Section 309 {25 U.S.C. § 1638a} allows Tribes and Tribal organizations that operate a health facility and federally-owned quarters associated with a facility under the Indian Self-Determination and Education Assistance Act to set rental rates and collect rents from occupants of the quarters.

- Several Tribes have utilized this authority to manage living quarters for federal staff working in their communities. Management of the facilities by the Tribe allows for additional revenue generation that can be reinvested in local services and facilities. Under this provision, Tribes can make housing more attractive to providers and staff, reinvest rental income into property enhancement, expand properties available for leasing, and provide technical jobs in the community.

Section 311 {25 U.S.C. § 1638e} allows for the transfer of funds, equipment, or other supplies from any source, including federal or state agencies, to the U.S. Department of Health and Human Services (HHS) for use in construction or operation of Indian health care facilities.

- This Section provides authority for other agencies to transfer funds to IHS for health and sanitation facility construction and operation. Due to the remoteness of Tribal communities and lack of infrastructure, the need for improvements and maintenance of water supply, sewer systems, and solid waste facilities remains substantial.

Section 401 {25 U.S.C. § 1641} updates current laws regarding collection of reimbursements from Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) by Indian health facilities, and revises procedures which allow a Tribally-operated program to purchase health benefits coverage for IHS beneficiaries.

- This provision intended to help fulfill the federal trust responsibility and bring additional revenue into the Indian

health system. The House of Representatives report on IHCIA Reauthorization stated: "These Medicaid payments are viewed as a much needed supplement to a health care program which has for too long been insufficient to provide quality health care to the American Indian."[3] Medicaid funding is a crucial component in filling the disparity gap created by inadequate IHS appropriations. Without it, many IHS and Tribal facilities would have to discontinue vital programs and lay off critical staff. In FY 2016, IHS and Tribally-operated facilities earned $808 million in Medicaid funding for services provided to the Medicaid-eligible individuals they serve. This represents 13 percent of the total funds received by IHS facilities in 2016. Medicaid today covers 34 percent of non-elderly AI/ANs, and more than half of AI/AN children.

Section 402 {25 U.S.C. § 1642} authorizes Tribes and Tribal organizations to purchase health benefits coverage for IHS beneficiaries.

- Many beneficial impacts are created by "Sponsorship," when a Tribe pays health insurance premiums on behalf of IHS beneficiaries. When Tribal members enroll in health insurance plans, they improve their access to care with increased options through an expanded provider pool. In turn, revenue collected by Tribal and IHS providers goes back into local services and can improve access to services for the broader community. In addition, with more community members accessing alternate resources, PRC funds go farther as more patients have coverage.

Section 404 {25 U.S.C. § 1644} authorizes IHS to issue grants or contracts to Tribes, Tribal organizations, and urban Indian organizations to conduct outreach and education to enroll eligible AI/ANs in Social Security Act health benefits programs including electronic methods or telecommunication networks.

- Medicaid and Medicare (M&M) are essential components to fulfil the federal government's obligation to provide health care to AI/ANs. M&M supplement the underfunded Indian health system by bringing in nearly $1 billion in third-party revenue annually. More outreach and education is needed regarding the benefits of M&M to increase the number of eligible AI/ANs enrolled and to increase revenue into the system.

Section 405 {25 U.S.C. § 1645} authorizes IHS to enter into arrangements with the U.S. Department of Veterans Affairs (VA) and U.S. Department of Defense to share medical facilities and services. These arrangements could include IHS, Tribal, and Tribal organization hospitals and clinics.

- The VA and IHS signed a Memorandum of Understanding (MOU) on October 1, 2010 with the intent to establish coordination, collaboration, and resource-sharing between the VA and IHS. By the end of 2015, the VA had disbursed a total of $33 million to IHS and Tribal health programs to help support health care for eligible veterans. This supplemental revenue is crucial to the Indian health system to ensure that services are provided to AI/AN veterans, since AI/ANs serve in the U.S. military at a proportionately higher rate than any other population in the United States.

Section 407 {25 U.S.C. § 1647} establishes procedures to facilitate the provision of health services to eligible Indian veterans by the IHS and the VA.

- This provision establishes procedures to facilitate the provision of health services to eligible AI/AN veterans and to prevent delayed access to health services, especially to AI/AN veterans living in remote and rural areas. It promotes access to culturally competent, high-quality health care in rural and medically-underserved areas with a disproportionately high number of AI/AN veterans. It also prevents redundancies in federal health care services across IHS and the VA.

Section 409 {25 U.S.C. § 1647b} grants Tribes and Tribal organizations the ability to purchase coverage for their employees by providing access to the Federal Employees Health Benefits Program.

- This provision may reduce health insurance costs for Tribal employers, providing savings that they can reinvest back into their health care systems. The Office of Personnel Management recently reported that 19,540 Tribal employees from over 90 Tribes are participating in the program.

Section 514 {25 U.S.C. § 1660d} requires IHS to confer with urban Indian organizations in carrying out certain provisions of the ACA.

- The federal government has a duty, as trustee, to consult with Tribes on matters that concern them. However, over 60 percent of AI/ANs live in urban areas,[4] with 25 percent residing in counties served by urban Indian health programs. This provision reaffirms that urban organizations must be conferred with when health policies are considered that might affect their constituents.

Section 601 {25 U.S.C. § 1661} amends current law to enhance the duties, responsibilities, and authorities of the IHS Director, including the responsibility to facilitate advocacy and promote consultation on matters relating to Indian health within HHS.

- This establishes the IHS Director as an official appointee of the president, subject to the advice and consent of

the Senate for a four-year term. This provision states that the IHS Director reports directly to the Secretary of the U.S. Department of Health and Human Services on all policy and budget matters related to Indian health, interacts with assistant secretaries and agency heads on Indian health, and coordinates department activities on Indian health. This Section also maintains Indian preference for IHS employment, a practice that helps to promote culturally-competent services. These changes elevated Indian health issues to a top priority within the administration, leading to better understanding of Indian health challenges across all HHS agencies.

Section 809 {25 U.S.C. § 1679} updates laws governing provision of health care services to California Indians.

- This Section clarifies confusion that existed previously, and was due to the unique history of California Indian Tribes. This provision clarifies that California Indians are still eligible for IHS services, despite the loss of jurisdiction over their lands when the United States passed Public Law 280 in 1958. This clarification was essential to allow provision of PRC services in California due to the absence of IHS hospitals and clinics. According to the most recent census, there are approximately 590,445 Indians in California, including members of California Tribes and many descendants of members of other Tribes relocated to urban centers as part of the federal relocation policy of the 1950s.

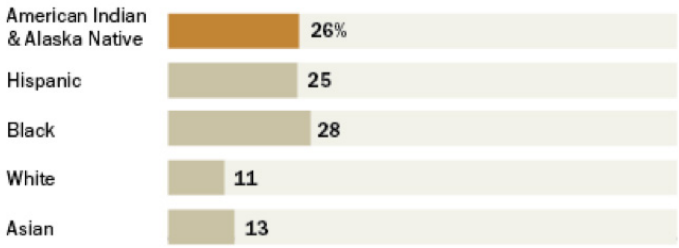
Section 812 {25 U.S.C. § 1680b} facilitates access to National Health Service Corps (NHSC) personnel by Indian health programs.

- Out of a total of more than 10,000 primary care clinicians currently providing health care in the ranks of the NHSC, there are 471 NHSC clinicians working at Tribal sites across the country. Of those, 144 provided mental and behavioral health services in Tribal sites as Licensed Professional Counselors, Health Service Psychologists, Marriage and Family Therapists, Licensed Clinical Social Workers, Allopathic Psychiatrists, Osteopathic Psychiatrists, and Nurse Practitioners. Sixty of the 471 self-identify as AI/AN, and there are 36 active NHSC-approved sites and 23 NHSC clinicians in the Great Plains states alone.

Medicaid Expansion

Congress amended the Social Security Act over 40 years ago in 1976 to authorize Medicare and Medicaid reimbursement for services provided in IHS and tribally operated health care facilities.[5] The House report explained that "these Medicaid payments are viewed as a much-needed supplement to a health care program which has for too long been insufficient to provide quality health care to the American Indian…" In 2010, the ACA allowed states to expand eligibility for Medicaid to all individuals living at or below 138 percent of the federal poverty level (FPL). The AI/AN population is among the most impoverished in the nation, resulting in predictable problems in accessing health services. According to the American Community Survey in 2012, approximately 2.5 times as many AI/ANs as whites live at or below the FPL.[6] In addition, many AI/ANs live at or below 138 percent of FPL, the threshold for eligibility for Medicaid expansion.

Living at or Below the Federal Poverty Level by Race/Ethnicity, 2012



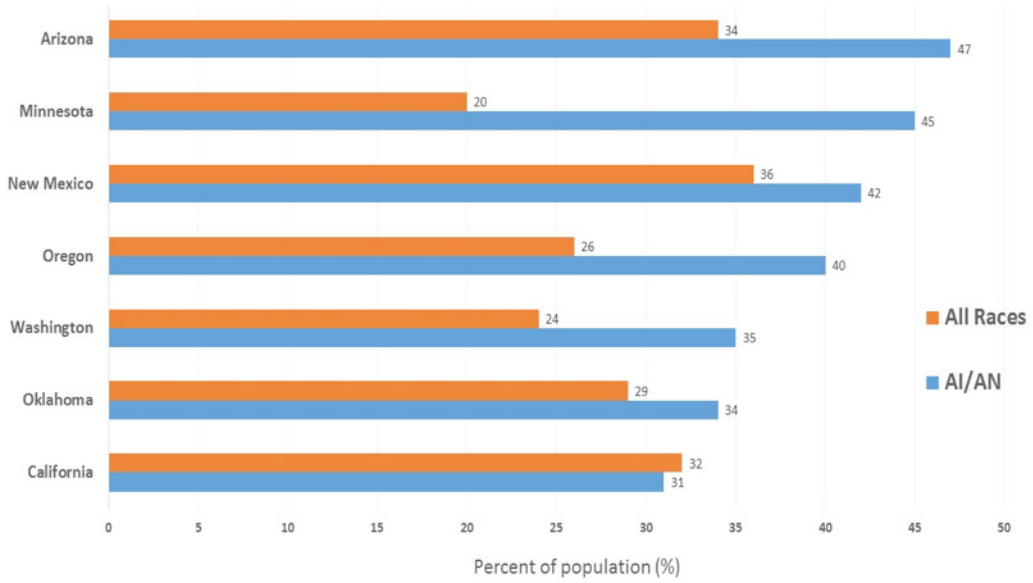
Source: 2012 American Community Survey

In a separate study that included 33 states with significant AI/AN populations as well as IHS access, 41 percent of AI/ANs in those states (approximately 1.5 million people) have an income at or below 138 percent FPL.[7] Providing insurance to this population in the form of Medicaid and Medicaid expansion significantly decreases the burden of providing health services through referrals under the limited PRC budget.

The ACA included Medicaid expansion that benefits numerous AI/ANs individually as well as the IHS as a system. Starting in 2014, Medicaid eligibility expanded in states that chose to participate, such that everyone with incomes at or below 138 percent of the FPL became eligible for Medicaid, including previously ineligible categories of individuals, such as childless adults. Many AI/ANs were newly able to access health insurance because they were newly eligible for Medicaid. Moreover, increased Medicaid funding for services provided within the Indian health system resulted in more funding to serve AI/AN patients overall.

With Medicaid expansion, more AI/ANs are able to gain access to a full spectrum of specialty care that is not typically available through IHS direct care. Although many states that have a significant AI/AN population have expanded Medicaid, such as California, Alaska, Montana, Arizona, New Mexico, and North Dakota, other states that have a large percentage of AI/ANs have not, including

Percent of Population Under 138% Federal Poverty Level by State



Source: Centers for Medicare & Medicaid Services

Oklahoma and South Dakota. If every state expanded Medicaid, more than half (51%) of AI/ANs would be eligible for Medicaid—totaling over 550,000 people.[8] The benefits to the AI/AN health care system resulting from Medicaid expansion would be reversed if the Medicaid expansion were revoked as part of a successful ACA repeal effort.

Special rules relating to American Indians and Alaska Natives (ACA §2901)

Facilities operated by the IHS were added to the list of agencies qualifying as "Express Lane" agencies that make eligibility determinations for enrollment in CHIP and Medicaid. This is especially beneficial for underserved populations, such as AI/ANs. In 2015, 32 percent of AI/AN women of child-bearing age were covered by Medicaid, and numerous studies have documented high risk for poor birth outcomes in this population, making seamless access to health insurance a vital consideration for maternal and child health.

Marketplace

The ACA's Indian-specific provisions make vital improvements to the Indian health care delivery system and have improved insurance coverage rates for AI/ANs. Between 2013 and 2014, the percentage of AI/ANs under age 65 who were uninsured (meaning they reported no health coverage other than access to IHS services) decreased from 22.6 percent to 17.8 percent.[9] This increase in coverage can be attributed to AI/AN participation in Medicaid expansion and Marketplace exchanges created by the ACA. The Health Insurance Marketplace gives individuals, families, and small businesses the ability to compare, shop, and choose quality affordable insurance options. In addition to these services, the Marketplace also offers several provisions that specifically benefit AI/ANs, Tribes, and Indian health facilities:

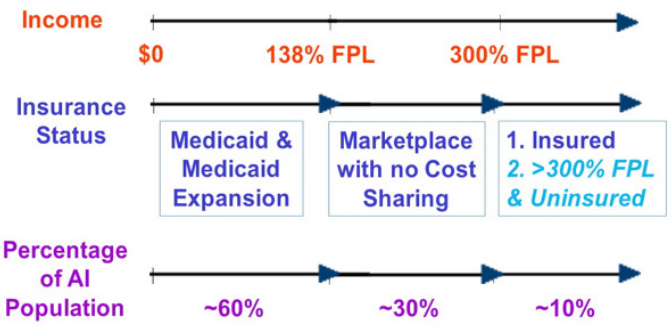
- **Zero Cost-Sharing:** AI/ANs with incomes *between 100 percent and 300 percent of the FPL* who purchase health insurance through an exchange do not have to pay co-pays, deductibles, or co-insurance when receiving care from an Indian health provider or when receiving essential health benefits (EHB) through a qualified health plan (QHP). There is no need for a referral when receiving EHB through a QHP.
- **Limited Cost-Sharing:** AI/ANs with income *below 100 percent and above 300 percent of the FPL* will not have to pay co-pays, deductibles, or co-insurance when receiving care from an Indian health care provider or when receiving EHB through a QHP. A referral is needed from an Indian Health Service, Tribal, or urban Indian clinic (I/T/U) to avoid cost-sharing when receiving EHB through a QHP.
- **Essential Health Benefits:** Health plans offered on the Health Insurance Marketplace must be certified to participate in the Marketplace. Additionally, they must provide the 10 EHB as defined in the ACA to participate.
- **Premium Tax Credits:** AI/ANs who fall *between 100 percent and 300 percent of the FP*L may qualify for an advance premium tax credit through the Health Insurance Marketplace, which makes health insurance more affordable.

- **Exemption from Shared Responsibility Payment:** All AI/ANs who are eligible to receive services from an Indian health care provider may claim an exemption from the shared responsibility payment if they do not maintain minimum essential coverage under the ACA.

Repeal of the ACA would have a significant negative impact on the hundreds of thousands of AI/ANs who have an income between 100 percent and 300 percent FPL and who are eligible for Marketplace insurance. The essential health benefits provided by Marketplace insurance expand patients' access beyond what is typically available with PRC only, with more health benefits and a decreased financial burden. Pre-Marketplace insurance plans might claim to cover these services, but the actual coverage provided was uneven and patients faced unexpected dollar limits on services.[10] Plans offered on the Marketplace do not do that.

With high rates of poverty and lower average incomes, the increase in access to health insurance provided by the ACA is unprecedented in terms of the percentages of AI/ANs eligible. In states that expanded Medicaid, up to 90 percent of the AI/AN population is eligible for health insurance at little to no cost to the individual.[11]

Increased Access to Health Insurance in a Northern Plains Medicaid Expansion State

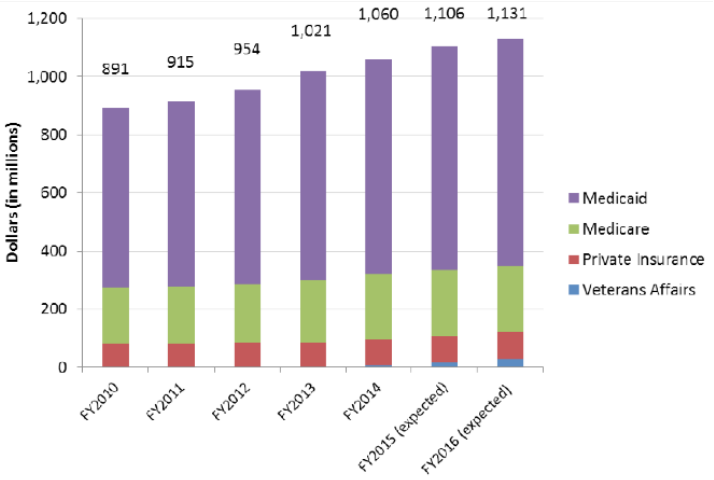


Source: U.S. Census Data, American Community Survey

Expanded access to health insurance is clearly a benefit to individual AI/ANs. In addition, the I/T/U system benefits from increases in third-party revenue. With increased facility revenue, the financial burden on PRC budgets is reduced, ensuring improved overall access to much-needed health services for all AI/ANs.

Since the overall system is underfunded, I/T/U programs all rely on third-party revenue to provide services. Historically, Medicaid has been the largest source of third-party funding. Repealing the ACA would be devastating to individual AI/ANs in terms of access to services, and it would be devastating to the Indian health system in terms of significantly reduced revenue with subsequent cuts in services as budgets dwindle.

IHS Reimbursements by Source



Source: Congressional Research Service

IMPACT ON PURCHASED AND REFERRED CARE

The PRC program and its predecessors have long been a glaring indicator of the lack of access to necessary health services among AI/AN patients. Annual appropriations from Congress fund the PRC program, and the IHS has established several guidelines for the PRC program that must be met for a service to be eligible for PRC payment. These rules include eligibility of the individual AI/AN as being a member or descendant of a federally-recognized Tribe, living within the home region ("Contract Health Services Delivery Area"), and having no access to alternate resources/ health insurance to pay for PRC services, among others.

Ten of the 12 IHS Area Offices supervise at least some IHS-operated facilities, and these facilities oversee local PRC programs in 33 states. An Area Director leads each IHS Area, but IHS Headquarters determines PRC program policies. The Area Offices allocate funds to and monitor the local PRC programs within their purview, and they establish policies and procedures to provide direction and technical assistance to the programs. Due to chronically insufficient funding from Congress to support PRC and in the IHS system in general, many local facilities cannot afford to pay for referrals beyond Medical Priority Level I.

IHS Medical Priority Levels for Purchased and Referred Care

Medical priority level	Services included in priority level
Level I	Emergent/acutely urgent care services, such as trauma care, acute/chronic renal replacement therapy, obstetrical delivery and neonatal care.
Level II	Preventative care services, such as preventative ambulatory care, routine prenatal care, and screening mammograms.
Level III	Primary and secondary care services, such as scheduled ambulatory services for nonemergent conditions, elective surgeries, and specialty consultations.
Level IV	Chronic tertiary and extended care services, such as rehabilitation care, skilled nursing facility care, and organ transplants.
Level V	Excluded services, such as cosmetic plastic surgery and experimental procedures that programs may not pay for with CHS program funds.

Source: GAO Analysis of IHS Documents

In 2013, the Government Accountability Office assessed that over half of the AI/AN population was eligible either for Medicaid/Medicaid expansion or cost-sharing exemptions and premium tax credits for Marketplace insurance.[12] The majority of AI/ANs represented in this potential new health insurance enrollment pool live within IHS service areas. Clearly, having access to alternate resources through Medicaid, Medicaid expansion, the Marketplace, and other sources significantly decreases the burden on the limited PRC budget. This can also significantly improve access to health services, improve outcomes, and save the lives of numerous AI/ANs.

Emerging evidence supports the conclusion that positive impacts are being realized, including Level IV referrals from IHS facilities in Medicaid expansion states. In the Billings Area IHS for example, due to the increase in the number of patients with insurance from Medicaid expansion and the Marketplace, three Service Units recognized an increase in the number of referrals for PRC coverage. In addition, all locations improved medical priority level approvals from Level I only in 2015 to Levels II, III, and IV in 2016. This represents a significant and measurable impact of ACA programs on increasing access to health services for AI/ANs. Additional research comparing Medicaid expansion states with those that did not expand Medicaid is warranted to further elucidate the impact of ACA on access to health services for AI/ANs.

ACA-authorized Grants and Programs

The access and coverage expansion provisions of the ACA and the associated Health Care Reconciliation Act (HCRA, P.L. 111-152) were not the only provisions of the ACA to positively impact health care for AI/ANs. The following list, while not comprehensive, discusses grants and other ACA-authorized programs that are independent of the access and coverage expansion provisions. These special opportunities authorized by the ACA represent funding authorities for programs that can significantly improve health outcomes for underserved populations, including AI/ANs.

Maternal, infant, and early childhood home visiting programs (ACA §2951)
The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program provides funding to eligible entities (states, Tribes, and territories) to develop and implement evidence-based maternal, infant, and early childhood visitation models. The Health Resources and Services Administration (HRSA) administers MIECHV in collaboration with the Administration for Children and Families. MIECHV programs are vitally important to Tribes because AI/ANs in several regions have higher infant mortality rates than other populations. These home visiting programs are specifically designed to reach pregnant women, expectant fathers, and caregivers of children under five years of age. Home visiting is a proven method with significant return on investment to improve birth and childhood outcomes on numerous measures.[13]

Improving access to preventive services for eligible adults in Medicaid (ACA §4106)
This Section of the ACA expands the current Medicaid state option to provide other diagnostic, screening, preventive, and rehabilitation services to include: (1) any clinical preventive service recommended with a grade of A or B by the U.S. Preventive Services Task Force and (2) adult immunizations recommended by the Advisory Committee on Immunization Practices. If preventive services are not available as a direct IHS service, they are designated as a Level II priority for PRC, and access to these preventive services might not otherwise occur. Thus, this authorization makes the valuable and cost-containing benefits of prevention efforts much more realizable to the AI/AN health care system and individual patients than they have been before.

Immunizations (ACA §4204)
This Section authorizes states to purchase vaccines for adults at the federal contract price, and it creates a Centers for Disease Control and Prevention (CDC) program to award grants to improve immunization coverage for children, adolescents, and adults through the use of evidence-based interventions. Both of these provisions increase access to vaccines, a proven cost-effective preventive intervention and cornerstone of public health nationwide, including for AI/ANs.

Improving women's health (ACA §3509)
This Section of the ACA codifies the establishment of the Office of Women's Health within HHS and in the Director's Office of each of the following agencies: the Agency for Healthcare Research and Quality (AHRQ), 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 (SAMHSA). Each agency Women's Health Office is responsible for ensuring that its agency is aware of the latest developments in women's health related to prevention, research, education and training, service delivery, and policy developments. Women's health disparities are a significant concern to AI/ANs, because of the dire need for better care reflected in statistical analysis of AI/AN women's health indicators.[14]

Prevention and Public Health Fund (ACA §4002)
The Prevention and Public Health Fund (PPHF) was established by this Section in the Office of the Secretary. The PPHF was created to provide for expanded and sustained national investments in prevention and public health, to improve health outcomes, and to enhance health care quality. The PPHF is needed to implement effective public health programs, reverse the loss of key public health programs, and to invest in the health of all Americans, including AI/ANs. This program has used community-based prevention methods, including tobacco prevention, breastfeeding promotion, obesity reduction, and childhood immunizations—all important components of a comprehensive approach to reducing AI/AN health disparities.

Coverage of comprehensive tobacco cessation services for pregnant women in Medicaid (ACA §4107)
This provision requires Medicaid programs to cover counseling and drug therapy for the purpose of smoking cessation for pregnant women. Cost-sharing is prohibited from being passed on to the patient. This provision of the ACA is vitally important to AI/ANs, particularly in the Northern Plains and Alaska, because use of commercial tobacco is linked to numerous chronic health conditions, and smoking during pregnancy has been linked to low birth weight, pre-term birth, and a host of other adverse birth outcomes.

National strategy to improve health care quality (ACA §3011)
This Section directs the Secretary of HHS to develop a national strategy to improve the delivery of health services, patient outcomes, and population health. The resulting National Quality Strategy serves as a catalyst and compass for a nationwide focus on quality improvement efforts and approach to measuring quality. Given the recent challenges related to IHS quality of care, efforts to improve the quality services through the use of evidence-based quality improvement measures, tools, and programs are a key component to improving AI/AN health systems. Improving quality of care is a priority for IHS, and they released a Quality Framework in November 2016 that highlights goals that include strengthening organizational capacity, improving quality of care, and improving the patient experience, among other components.[15] An ACA repeal threatens the renewed national focus on improving the quality of care.

Interagency Working Group on Health Care Quality (ACA §3012)
This Section of the ACA established an Interagency Working Group on Health Care Quality, comprised of federal agencies, to develop health care goals and initiatives that are consistent with national priorities and assess the alignment of quality efforts. The IHS should be included in future interagency efforts to improve quality of care. Repeal of this provision would only represent a step backwards in that goal.

Quality measure development (ACA §3013 and 10303)
The Agency for Healthcare Quality and Research works with the Secretary of HHS to develop quality measures in areas where gaps exist, and to renew this effort every three years. Once again, the IHS should be involved in the development of evidence-based quality improvement measures, tools, and programs, and elimination of the authority in these sections would only make that goal harder to reach. Quality of care is a major concern to the IHS, as indicated in the 2016-2017 IHS Quality Framework.[16]

Establishment of Center for Medicare and Medicaid Innovation within CMS (ACA §3021 and 10306)
This Section of the ACA created the Center for Medicare and Medicaid Innovation (CMMI) within the Centers for Medicare & Medicaid Services (CMS) to test payment and service delivery models in order to reduce costs and improve quality of care. With shortfalls in funding, these efforts are needed to explore innovative ways to improve the delivery of and payment for health care for AI/ANs.

National Prevention, Health Promotion, and Public Health Council (ACA §4001)
The National Prevention, Health Promotion, and Public Health Council was established at HHS to provide coordination and leadership among federal departments and agencies on prevention, wellness and health promotion practices, and public health. The Council comprises 20 federal departments, agencies, and offices and is chaired by the Surgeon General. The National Prevention Council developed the National Prevention Strategy with input from the Prevention Advisory Group, stakeholders, and the public. The Council's priorities include health issues that are important to promoting AI/AN health. Although IHS is an agency within the United States Public Health Service, relatively few resources are focused on public health and health promotion.

Clinical and community preventive services (ACA §4003)
This Section established the independent Community Preventive Services Task Force in the CDC. The Task Force is an independent panel of public health and prevention experts that generates evidence-based findings and recommendations about community preventive services, programs, and policies to improve health. Preventive services are vitally important to improve AI/AN health outcomes.

Understanding health disparities: data collection and analysis (ACA §4302)
This Section of the ACA requires any new federal health program, activity, or survey to collect and report on data on race, ethnicity, sex, primary language, and disability status (and geographic location when possible) in order to monitor public health trends and disparities. Having access to comprehensive, accurate data and statistics is essential to improving AI/AN health outcomes.

Patient-Centered Outcomes Research (ACA §6301)
This provision of the ACA established the Patient-Centered Outcomes Research Trust Fund to build the capacity and infrastructure needed to establish the Patient-Centered Outcomes Research Institute (PCORI), and to enable PCORI findings to be integrated into clinical practice. This type of research can provide critical insights that allow patients and providers to make better-informed decisions, including AI/ANs.

Health care workforce loan repayment programs (ACA §5203)
The ACA establishes 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. Essentially all IHS sites are medically underserved, and this component of the ACA could significantly improve access to providers and services.

Impacts to special authorizations if ACA is repealed
For each of these opportunities listed, the potential and real benefits created by their authorization in the ACA are directly threatened by their rescission, either individually or as part of an overall ACA repeal. Each represents culmination of a "best practices" effort by experts within their respective relevant disciplines, and each is designed to promote long-term beneficial health impacts. If outright ACA repeal were to happen, the benefits of the individual programs described here should be reauthorized individually or as part of subsequent comprehensive health system legislation.

CONSIDERATIONS FOR "ACA REPLACEMENT"

Several components of an ACA replacement plan have been discussed, including health savings accounts (HSAs), selling insurance across state lines, and making Medicaid a block grant program for the states to administer. Although not an exhaustive list, these considerations are addressed in terms of their potential impact on AI/ANs.

1. Health Savings Accounts in the Face of Federal Trust Responsibility and Poverty

Some proposals for replacement of the ACA rely heavily on expanded use of HSAs that will allow people tax breaks on money saved and used for health care expenses. A criticism of this approach is that savings plans do not benefit those who are unable to save at an adequate rate to cover future health care costs. In an attempt to address such concerns, some proposals consider granting HSA funds to people with lower incomes or in poverty in order to make this approach more effective for people with very low incomes. The risk with this approach is that the HSAs would not fully match coverage offered under the ACA, leaving low-income people with inadequate coverage.

HSAs benefit young, healthy people with financial means. However, impoverished, sick, and elderly populations may see less benefit. In Indian Country, an impoverished 45 year old with diabetes for example, would have relatively high health care costs and might not be able to afford to contribute to an HSA. In this circumstance, the pre-existing and expensive-to-treat illness, distance from competent health care delivery systems, and pervasive poverty combined with negligible economic opportunity in the community significantly limits the potential benefits of an HSA. In addition to issues related to individual poverty, lack

of access to financial institutions to hold savings accounts are commonplace in reservation communities, with all of these factors working against an individual's ability to save for anticipated health care expenses.

Another consideration with regard to using HSAs for AI/ANs is the federal government's trust responsibility to provide health services to this population. To require AI/ANs to save money for their own health care could be seen as a unilateral abrogation of a legal obligation established over many decades.

2. Sale of Health Insurance Across State Lines

Allowing the sale of health insurance "across state lines" has been proposed as an element of an ACA replacement. The theory is that persons living in a state where the cost of health insurance is relatively high, due to their own state's regulatory requirements and/or a lack of competitive options in their state, would benefit from being able to purchase less costly health insurance based in other states. The simple logic might make sense at first, but a deeper understanding of how the health insurance industry works reveals the flaw in this approach.

Privately-owned insurance companies are charged with making a profit for their owners, which are usually shareholders. Health insurance is both a product and a service. One of the most certain ways to make higher profits is to deny payments as often as possible. The way society traditionally puts a limitation on this incentive to deny coverage is to regulate the insurance companies. Such regulation is generally left to each state—within state boundaries, a state insurance commission is charged with protection of consumers from undue denials of insurance coverage (along with other potential abuses). Thus, the reason we have insurance commissioners and insurance regulation at the state level is to protect the citizens of each state from abuses by insurance companies. If a company wants to do business within a state, it must submit to the regulatory authority of that state.

If, under an ACA replacement plan, a person can purchase cheap insurance in another state, it is doubtful that consumers would be protected by the distant state's insurance regulations. Even if some protections were provided, that consumer might be forced to figure out how to reach the remote regulatory agency, and hope that agency would truly represent their interests. If a dispute needed resolution by a court, the distant state might be the required forum, and so resolution of disputes might require consumers, who were seeking out-of-state insurance because of cost factors already, to somehow obtain justice in the distant courts of another state.

Essentially, the existing consumer protection mechanisms of state regulation of insurance companies that choose to pursue business within a given state will be inadequate to protect all consumers. Therefore, a new federal insurance regulatory agency would eventually be required, resulting in increased expenses and federal involvement in the health care insurance industry. The purported benefits of the ACA replacement, even if some really were to be realized, would be effectively eroded. To the extent that costs were shifted back to the insurance companies by preventing them from unjust denials of coverage, those costs would be passed back to consumers. This would be the required outcome unless it is deemed acceptable for insurance companies to sell cheap insurance across state lines with little to no accountability to their actions under those new trans-boundary policies. Given these factors and high rates of poverty, simply selling health insurance across state lines provides little to no direct benefit to AI/ANs.

3. Capping Federal Medicaid Spending

Transforming the Medicaid financing structure through a cap in federal funding to the states, either through a block grant or per capita cap, has also been raised in the ACA policy debate. These proposals, aimed at reducing federal spending on Medicaid, are based on a model that has been tried in other areas of federal funding in recent decades, and the outcomes commonly result in less access to resources for AI/ANs. The theory is that states can administer funds more efficiently and effectively. Under a block grant or per capita cap, responsibility for passing Medicaid funding to Tribes would fall to the state, rather than the federal government. First however, provision for Tribes must be made in the block grants, otherwise states would have no authority—and possibly, little motivation—to pass funds through to Tribes.

In a capped funding approach, even if funds belonging to Tribes are adequately identified Tribes may still have difficulty accessing the funds. For example, in some states (South Dakota is one example) there is a history of poor coordination of getting block grant funds actually passed through to intended Tribal recipients. Capping federal programs to states sets up a paradigm wherein AI/ANs are dependent on states being "friendly" to the Tribes in order to get the funding to them. Title IV funding under block grants provides one example of this structure being so unworkable in practice that eventually Congress scrapped the expectation that the states would administer the funds judiciously, and rather enacted legislation to provide direct funding to Tribes with a tiered implementation.

The tendency of the federal government to attempt to absolve its obligations towards Tribes has arisen

intermittently throughout the history of federal-Tribal relations. Recently, the efforts in this area have occurred in the form of attempted discharge of the federal responsibilities by putting states in charge of administering social programs. However, since the very formative years of the United States, it has been recognized that the federal government must exert supremacy against the states in regard to Indian affairs. The Constitution itself, in the Commerce Clause (Article 1, Section 8) states that Congress (as opposed to states) shall regulate commerce with the Tribes. Moreover, the Supreme Court has had to step in at various times over the decades to turn back state aggression and disregard toward Tribal interests, even as early as the first cases in the Supreme Court directly addressing federal-state-Tribal relations.[17]

By now it is a well-settled tenet of U.S. federal Indian law that the federal government has primacy in Indian affairs. Many times over the years this tenet has been reaffirmed, with the recognition that the states do not provide adequate consideration and protection of Tribal interests. Although Medicaid is jointly funded by federal and state dollars, services provided to AI/ANs in IHS or Tribal facilities are paid with 100 percent federal funds (100% federal medical assistance percentage, or FMAP). Imposing a "per capita allotment" so states can better serve patients does not adequately account for the 100 percent FMAP that is reimbursed to states to ensure federal coverage for AI/ANs. Additionally, in *Assiniboine & Sioux Tribes v. Board of Oil and Gas*,[18] it was reinforced that "the Federal Government cannot delegate its trust responsibilities." This foundational concept is pertinent to federal trust responsibilities for the provision of Medicaid-funded health care services to AI/ANs. Putting states in charge of Medicaid in a manner that will have direct impact on Indian health through block grants ignores this long-standing principle, and it does so in the face of recent proof that many states are not able to adequately administer such responsibilities regarding Tribal needs.

Finally, many Tribes have treaty-based rights to health care services—natural resources provided to fuel the growth and development of the nation were sacrificed by them and in return the United States promised in various treaties that the members of the Tribes would be provided health care (frequently housing and education as well). The federal government cannot discharge this responsibility by block granting Medicaid funds to states and hoping that funds contained in those grants will be passed through as appropriate to meet pre-existing federal trust and treaty obligations.

SUMMARY

Repealing the ACA presents risks beyond access to health services. Analysis recently released by the Commonwealth Fund shows that dire impacts to states will result from repeal, including losses in 2019 of $140 billion in federal funding to state budgets, a loss of 2.6 million jobs across all states, with only a third of those jobs being in health care and the rest in other industries as ripple effects.[19] In Indian Country, it is common that federal programs providing federal services to AI/ANs, of which health care is a major component, are one of the primary sources of employment for Tribal people. Federal jobs, in many cases, stimulate and grow the local economy by providing a rare source of income from the outside. As a result, the impacts on local Tribal economies would likely be even more severe—and come at a time when recent improvements from health care reform were starting to take root.

Repeal of the ACA will lead to AI/ANs having less access to health services, less options for care, worsening health disparities, increased unnecessary suffering, and an increase in preventable deaths. The issue of repealing the ACA, therefore, should be examined through the lens of treaty responsibilities, social justice, and civil rights. Any attempt to repeal and replace the ACA should leave in its place programs and options that will increase access to direly needed health services, not further limit care for Indigenous Americans.

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