PATIENT PROTECTION AND AFFORDABLE CARE ACT (AFFORDABLE CARE ACT)
SUMMARY OF INDIAN HEALTH PROVISIONS

The Patient Protection and Affordable Care Act (ACA) has done much to make vital improvements to the Indian health delivery system. Not only does the ACA permanently reauthorize the Indian Health Care Improvement Act (IHCIA), there are many important provisions outside of IHCIA that are in the ACA that their loss would be a detriment to Indian Country. Below is a summary of some of the most important provisions in the ACA outside of IHCIA, followed by a brief analysis of what the ACA's loss could mean.

TITLE 1 – QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS			
Subtitle D – Part II – Consumer Choices & Insurance Competition Through Health Benefit Exchanges			
Section	**Title**	**Summary**	
1311(c)(6)(d)	Affordable Choices of Health Benefit Plans – Enrollment Periods	Requires the HHS Secretary to require an Exchange to provide for special monthly enrollment periods for Indians.	
Subtitle E – Affordable Coverage Choices for All Americans			
Part I – Premium Tax Credits and Cost-Sharing Reductions **Subpart A – Premium Tax Credits and Cost-Sharing Reductions**			
Section	**Title**	**Summary**	
1402(d)(1)	Reduced Cost-Sharing for Individuals Enrolling in Qualified Health Plans: Special Rules for Indians	Any individual Indian enrolled in any qualified health plan through the Exchange whose household income is less than 300% of the federal poverty line (FPL) shall be treated as an eligible insured. Eliminates all cost-sharing for Indians under 300% of the federal poverty level enrolled in any individual market insurance plan offered through the Exchange.	

1402(d)(2)	Special Rules for Indians, items or services furnished through Indian Health Providers	If an Indian beneficiary enrolled in a qualified health plan is furnished an item or a service directly by IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services, no cost-sharing under the plan shall be imposed under the plan for such item or service, and the issuer of the plan may not reduce the payment to any such entity for services or items.	
1402(d)(3)	Special rules for Indians-(3)Payment	HHS shall pay to a qualified health plan the amount necessary to reflect the increase in actuarial value of the plan as a result of subsection 1402(d).	
Subpart B – Eligibility Determinations			
Section	**Title**	**Summary**	
1411(b)(5)(A)	Procedures for Determining Eligibility for Exchange Participation, Premium Tax Credits and Reduced Cost-Sharing, and Individual Responsibility Exemptions	An individual seeking an exemption from the individual mandate due to their status as an Indian must provide such information as the Secretary prescribes to qualify for the exemption.	
Subtitle F – Shared Responsibility for Health Care **Part I**			
Section	**Title**	**Summary**	
1501 adds Section 5000A(e)(3)	Requirement to Maintain Minimum Essential Coverage	Exempts members of Indian tribes from the shared responsibility payment, or penalty, for failure to comply with the requirement to maintain minimum essential coverage.	

TITLE II – ROLE OF PUBLIC PROGRAMS

Subtitle K – Protections for American Indians and Alaska Natives

Section	Title	Summary	
2901(a)	No-Cost Sharing for Indians With Income At or Below 300% of FPL Enrolled in Coverage Through a State Exchange	Prohibits cost sharing for Indians below 300% of the FPL enrolled in any qualified health plan in the individual market through an Exchange.	
2901(b)	Payer of Last Resort	I/T/U providers are the payers of last resort for services provided to Indians by I/T/U for services provided through such programs.	
2901(c)	Facilitating Enrollment of Indians under the Express Lane Option	Facilities operated by the Indian Health Service (IHS) and Indian, Tribal, and Urban Indian facilities (I/T/Us) would be added to the list of agencies that could serve as an "Express Lane agency" under sec. 1902(e)(13) of the Social Security Act.	
2902	Elimination of Sunset for Reimbursement for all Medicare Part B Services Furnished by Certain Indian Hospitals and Clinics	Makes permanent reimbursement for all Medicare Part B services furnished by Indian Health Service hospitals & clinics.	

Subtitle L – Maternal and Child Health Services

Section	Title	Summary	
2951	Maternal, Infant, and Childhood Home Visiting Programs	Provides funding to States, tribes, and territories to develop and implement one or more evidence-based Maternal, Infant, and Early Childhood Visitation model(s). Sets asides 3% of funding for I/T/Us, tribal entities preferred.	
2953	Personal Responsibility Education	Creates grant programs to educate adolescents on abstinence and contraception. Includes a 5% set aside (out of $65 million per year) for grants to Indian Tribes and Tribal Organizations.	

TITLE III – IMPROVING THE QUALITY AND EFFECIENCY OF HEALTH CARE

Subtitle A – Transforming the Health Care Delivery System

Part II – National Strategy To Improve Health Care Quality
Data Collection, Public Reporting

Section	Title	Summary
3015	Collection and Analysis of Data For Quality and Resource Use Measures	Authorizes the Secretary to award grants or contracts to eligible entities to support efforts to collect and aggregate quality and resource measures. IHS and tribal health programs are eligible entities.

Subtitle D – Medicare Part D Improvements for Prescription Drug Plans and MA-PD Plans

Section	Title	Summary
3314	Including Costs Incurred by AIDS Drug Assistance Programs and IHS in Providing Prescription Drugs Towards the Annual Out-of-Pocket Threshold under Part D.	Amends the Social Security Act to allow IHS, Indian tribe or tribal organization, and urban Indian program spending to count toward the Medicare Part D out of pocket threshold, or coverage gap.

Subtitle F – Health Care Quality Improvements

Section	Title	Summary
3501	Quality Improvement and Technical Assistance and Implementation	Grants funded under the program authorized in this section will identify, develop, evaluate, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services. Eligible entities include Federal Indian Health Service programs, health programs operated by tribes, and tribal organizations, Provision includes specific language around cultural competence.

3502	Establishing Community Health Teams to Support Patient-Centered Medical Home	Indian tribes and tribal organizations (per IHCIA Sec. 4) are eligible entities for a grant program to establish community-based interdisciplinary, inter-professional teams to support primary care practices, including OB-GYN, within hospital service areas.	
3504	Design & Implementation of Regionalized Systems for Emergency Care	Authorizes Secretary to award competitive grants for pilot projects for innovative models of regionalized & comprehensive emergency care and trauma systems. Indian tribes (per IHCIA Sec. 4) or multi-tribal govt. partnerships are eligible entities.	
3505	Trauma Care Centers and Services Availability	Authorizes three program awards to qualified IHS, tribal, and urban Indian trauma centers to assist in defraying substantial uncompensated care costs and to further the core missions of such trauma centers.	

TITLE IV – PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH

Subtitle A – Modernizing Disease Prevention and Public Health Systems

Section	Title	Summary	
4001	National Prevention, Health Promotion and Public Health Council	Assistant Secretary for Indian Affairs will be part of the council and the council will establish a process for continual public input from Indian tribes & tribal organizations.	
4003	Clinical & Community Preventive Services - Community Preventative Services Task Force	Directs the Community Preventive Services Task Force to review scientific evidence on effectiveness, appropriateness, & cost-effectiveness of clinical prev. services, and develop recommendations for delivery of population-based prevention intervention services by wide range of programs including government public health agencies (IHS), Indian tribes, tribal organizations & urban Indian organizations.	
4004	Education and Outreach Campaign Regarding Preventative Benefits	Includes Indian health programs as providers to which health promotion and disease prevention information consistent with national priorities should be distributed for dissemination for a prevention and health promotion outreach and education campaign.	

Subtitle B – Increasing Access to Clinical Preventive Services

Section	Title	Summary	
4102	Oral Healthcare Prevention activities	Four parts. Part 1) requires the Secretary to ensure that AI/ANs are targeted in activities for oral health care prevention education campaign. Part 2) makes I/T/Us eligible for grants for dental programs. Part 3) requires grants be award to I/T/U providers—but does not set the number of grantees. Part 4) Indian tribes and tribal organizations (per IHCIA sec. 4) along with states are eligible entities for the new CDC Oral Health Care Infrastructure Cooperative Agreements.	

Subtitle C – Creating Healthier Communities

Section	Title	Summary	
4201	Community Transformation Grants	Authorizes CDC competitive grant awards for implementation, evaluation & dissemination of evidence-based community preventive health activities to reduce chronic disease rates, address health disparities, and develop a stronger evidence-base of effective prevention programming. Indian tribes are eligible entities.	
4202	Aging Healthy; Living Well; Evaluation of Community-based Prevention and Wellness Programs for Medicare Beneficiaries	Authorizes CDC grant awards to carry out 5-year pilot programs to provide public health community interventions, screenings, & where necessary clinical referrals for individuals who are between 55 and 64 years of age. Indian tribes are eligible entities with states.	

Subtitle D – Support for Prevention and Public Health Innovation

Section	Title	Summary	
4302 adds section 3101	Understanding Health Disparities: Data Collection, Analysis, and Quality	Makes data analyses of federally conducted or supported health care or publicly health program or activity available to IHS and epidemiology centers funded under the IHCIA.	
4304	Epidemiology-Laboratory Capacity Grants	Authorizes the establishment of a CDC grant program to assist public health agencies in improving surveillance for, and response to, infectious diseases and other conditions of public health importance by epidemiology capacity, enhancing lab practices, improving IT systems, and implementing control strategies. Tribal health departments are eligible entities.	

TITLE V – HEALTH CARE WORKFORCE

Subtitle A – Purpose and Definitions

Section	Title	Summary	
Sec.5002	Health Work Force – Definitions	Defines 'allied health professional' and includes employees of tribal public health agency as eligible to meet the definition.	

Subtitle C – Increasing the Supply of Health Care Workforce

Section	Title	Summary	
5204	Public Health Workforce Loan Repayment Program	Authorizes new loan repayment program to assure adequate supply of PH professionals to eliminate critical public health workforce shortages in Federal, state, local, tribal and other public health agencies. Tribes are eligible as well as UIOs in HPSA areas.	
5205	Allied Health Workforce Recruitment and Retention Programs	Amends authorization for a loan repayment program to allied health professionals employed at public health agencies or in settings providing health care to patients, including acute care facilities, ambulatory care facilities, residences, and other settings located in Health Professional Shortage Areas, Medically Underserved Areas, or serving Medically Underserved Populations. Tribes are eligible as well as UIOs in HPSA areas.	
5206	Grants for States and local programs	Amends authorization for scholarship programs for mid-career public and allied health professionals employed in public and allied health positions at the Federal, State, tribal, or local level to receive additional training in public or allied health fields. Tribes are eligible as well as UIOs in HPSA areas.	

Subtitle D – Enhancing Health Care Workforce Education and Training

Section	Title	Summary	
5304 adds Sec 340G	Alternative Dental Health Care Providers Demonstration Project	Authorizes grant program for 15 eligible entities to establish demo programs to establish training program to train and employ alternative dental health care providers. Eligible entities include IHS facility or health facility operated by a Tribe,	

		Tribal organization, or urban Indian organization.	
Subtitle E – Supporting the Existing Health Care Workforce			
Section	**Title**	**Summary**	
5405 adds Section 399W	Primary Care Extension Program	Authorizes program to provide assistance to primary care providers to educate providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services (including substance abuse prevention and treatment services), and evidence-based and evidence-informed techniques, to enable providers to incorporate such matters into their practice and to improve community health by working with community-based health connectors. The Secretary is required to consult with federal agencies including IHS.	
Subtitle F – Strengthening Primary Care and Other Workforce Improvements			
Section	**Title**	**Summary**	
5507	Demonstration Projects to Address Health Professions Workforce Needs	HHS Secretary, in consultation with Secretary of Labor, is to award demonstration project grants designed to give eligible individuals the opportunity to obtain training and education in high demand health care fields. The Secretary must award at least 3 grants to eligible entity that is an Indian tribe, tribal organization or tribal college or university.	
5508	Increased Teaching Capacity—Teaching Health Centers Development Grants	Authorizes grant program for teaching health centers for the purpose of establishing new accredited or expanded primary care residency programs. Entities eligible include health centers operated by an I/T/U provider.	
Subtitle G – Improving Access to Health Care Services			
Section	**Title**	**Summary**	
5601	Spending for FQHCs	Authorizes appropriations for grants to Federally Qualified Health Centers.	

TITLE VI – TRANSPARENCY AND PROGRAM INTEGRITY

Subtitle E – Medicare, Medicaid, and CHIP Program Integrity Provisions

Section	Title	Summary
6402	Enhanced Medicare and Medicaid Program Integrity Provisions	Requires that the Integrated Data Repository of the CMS shall include, at minimum, claims and payments data from certain programs including IHS and the Contract Health Services Program. Also requires the Secretary to enter into agreements with individuals of certain agencies, including the IHS Director, to share and match data in the record system of the respective agencies with data in the HHS system for the purposes of identifying potential fraud, waste, and abuse.

TITLE IX – REVENUE PROVISIONS

Subtitle B – Other Provisions

Section	Title	Summary
9021	Exclusion of Health Benefits Provided by Indian Tribal Governments	Excludes the values of health benefits provided or purchased by the Indian Health Service, tribes, or tribal organizations from gross income.

TITLE X – STRENGTHENING QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS			
Section	**Title**	**Summary**	
10221	Indian Health Care Improvement Act	Adds the Senate bill to amend the Indian Health Care Improvement Act to revise and extend that Act, and for other reported purposes, as reported by the Senate Committee on Indian Affairs in December 2009.	

Loss of the Patient Protection and Affordable Care Act in parts or whole:

The ACA's Indian-specific provisions make vital improvements to the Indian health care delivery system and has improved health coverage for American Indians and Alaska Natives (AI/AN). A complete repeal of the ACA would increase the number of individuals uninsured by as much as 19 million. Coverage losses would disproportionately affect low-income individuals in poor health, including Indians. Between 2013 and 2014, the percentage of AI/AN of all ages who were uninsured (that is they reported no health coverage other than access to IHS services) decreased from 35% to 32%.[1] Among AI/AN adults aged 18-64 years the percentage who were uninsured decreased from 45% to 40%, a much larger difference. American Indians and Alaska Natives (AI/AN) are also significantly more likely than Whites to be uninsured. In 2015, approximately 22% of AI/AN nonelderly adults reported being uninsured, compared to 9% White nonelderly adults.[2] Even worse are the uninsured rates for AI/AN children: 19% compared to 4% for White children. However, because of the ACA, in Medicaid Expansion states, the percentage of uninsured youth has decreased significantly, a change that is associated with increases in Medicaid and private coverage. For example, Medicaid reimbursements at the I/T/U have gone up 21% since the enactment of Medicaid Expansion.

Title II of the ACA provides incentives for un-insured Indians to obtain insurance through the Health Insurance Marketplace (previously referred to as Exchange), and for Indian health programs to encourage their patients to enroll. As of 2016, it is estimated that .05 million AI/AN are eligible for coverage under the ACA.[3] The potential loss of the ACA and resulting loss of the Health Insurance Marketplace would mean AI/AN's could no longer have a streamline resource to review and compare qualified health plans for themselves and families. The Marketplace offers a vetting process through which Qualified Health Plans are reviewed before being accepted into the Federally Facilitated Marketplace. Additionally, the guarantee of providers offering ten essential health benefits is only one that applies to plans secured through the Marketplace. If the Health Insurance Marketplace were to disappear the standard of a "Qualified Health Plan" and the requirement to provide ten Essential Health Benefits

[1] American Community Survey, U.S. Census Bureau, 2014.
[2] Kaiser Family Foundation, *Health and Health Care for American Indians and Alaska Natives (AI/ANs).* (Washington, DC: Kaiser Family Foundation, November 2016), http://kff.org/infographic/health-and-health-care-for-american-indians-and-alaska-natives-aians.
[3] *Id.*

would also.

Several aspects of the ACA and Health Insurance Marketplace facilitate affordability of health insurance for AI/AN's; the ability to qualify for Zero-Cost and Limited-Cost sharing plans through the Marketplace. The Applied Premium Tax Credit Is another benefit that can help consumers afford quality health insurance. If changes were made to the Marketplace and or these affordability provisions specifically, the ability for AI/ANs to purchase quality health insurance plans through the Marketplace would be greatly diminished. The loss of affordable insurance on the marketplace would mean that AI/ANs, unless enrolled via other private insurance, would have to rely on the resources of the chronically underfunded IHS for services. In addition, the loss of the federally facilitated marketplace would mean higher premiums and taxes. The loss of financial protections and limitations on charging higher premiums to older adults would make coverage more expensive. It is estimated that the total out-of-pocket spending for individual enrollees, including enrollee premium contributions and cost-sharing at the point of service, averages about $3,200 per year. Repealing the ACA would cause total out-of-pocket expenses to increase to $4,700.[4] Insurers would likely respond by offering skimpy-low-cost plans appealing to healthy young adults.

Medicaid is another crucial source of insurance coverage for AI/AN. In 1976, Congress enacted Title IV of the IHCIA which amended the Social Security Act (SSA) to require Medicare and Medicaid reimbursement for services provided in IHS and Tribally operated health care facilities. The enactment of Title IV of IHCIA (which was permanently authorized by the ACA) is intended to help fulfill the federal trust responsibility and bring additional revenue into the Indian health system. Unlike IHS, Medicaid is not subject to annual appropriation limits, making it available on an ongoing basis and not subject to depletion. In addition, Medicaid claims are processed throughout the year, ensuring facilities receive ongoing Medicaid payments, making it possible for facilities to cover needed operational costs, including provider payments and infrastructure development, supporting their ability to meet the high demand for care.

The ACA provided federal funding for states to expand their Medicaid programs to cover more low-income people – those with incomes at or below 138% of the federal poverty level (FPL) ($16,394 for an individual in 2016). A 2012 Supreme Court ruling made expansion optional for states. All but 19 states chose to expand the program. States in Indian Country with Medicaid Expansion are: Alaska, Arizona, California, Colorado, Connecticut, Iowa, Louisiana, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Mexico, North Dakota, Oregon, and Washington.

Nationwide, over four in ten (41%) or over 440,000 American Indians and Alaska Natives who were uninsured as of 2015 are eligible for Medicaid. This includes newly eligible adults in states that have expanded Medicaid as well as adults and children who were previously eligible but not enrolled in both expansion and non-expansion states. If all states were to expand Medicaid, this gap would be eliminated and more than one in two (51%) or over 550,000 uninsured American Indians and Alaska Natives would be eligible for Medicaid.

The Medicaid expansion also provides an opportunity for increased Medicaid revenues for IHS-and Tribally-operated facilities. Medicaid serves as a key source of revenue for I/T/U providers. According to the IHS Congressional Budget Justification, from FY 2011 to FY 2016 Medicaid

[4] The Commonwealth Fund, *Donald Trump's Health Care Reform Proposals: Anticipated Effects on Insurance Coverage, Out-of-Pocket Costs, and the Federal Deficit*, http://www.commonwealthfund.org/publications/issue-briefs/2016/sep/trump-presidential-health-care-proposal

reimbursements at IHS went up by 21.15% or $171 million. It is important to note that this figure does not necessarily include Tribal health programs that are not required to report 3rd party collection data. The loss of this revenue would be devastating for IHS, and would be a gaping hole in the budgets of many facilities.

President-elect Trump has not said specifically that he wants to repeal the expansion of Medicaid eligibility, and a number of Republican governors broadened the program. But Trump committed on the campaign trail to exploring a more drastic change than repealing expansion through so-called block grants for Medicaid, which would limit federal funding for the state-run programs. Trump's transition website lays out his intent to "maximize flexibility for States" so they can "experiment with innovative methods to deliver healthcare to our low-income citizens."

Currently, the federal government pays a fixed percentage of a state's Medicaid costs. If a state has an unexpectedly high number of enrollees or begins paying for an expensive new treatment, federal funding increases to help cover the higher costs. Under a block grant plan, the federal government would pay each state a fixed dollar amount. A related idea, called per-capita caps, would limit Medicaid spending based on costs per enrollee. Both of these plans could have major cost impacts on the I/T/U system. Under current law, the United States reimburses States for 100 percent of the cost of providing Medicaid services to AI/ANs. This reflects Congress's view that the federal government has a trust responsibility to provide health care services to AI/AN, and an obligation to implement federal health care programs in a manner that does not shift this burden onto the States. Any plan to change the manner in which State Medicaid costs are reimbursed by the United States must include a carve out for services provided to AI/ANs so that the United States' obligation is not shifted to the States.