

State Health Reform Assistance Network

Charting the Road to Coverage

POLICY BRIEF

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Implications of Health Reform for American Indian and Alaska Native Populations

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IN BRIEF

The Affordable Care Act (ACA) has important implications for American Indians and Alaska Natives (AI/AN), including the expansion of Medicaid coverage to nearly 400,000 currently uninsured AI/AN individuals. This brief outlines ACA provisions that uniquely affect AI/AN populations and provides strategies to help states and other key stakeholders fully realize the potential of the ACA to improve the health and health care of AI/ANs. Areas addressed include:

1. Coverage expansion;
2. State outreach to and engagement with federally recognized tribal groups; and
3. Opportunities to fill gaps in the organization and financing of care.

INTRODUCTION

The ACA authorizes the Secretary of Health and Human Services (HHS) to develop a national strategy to “improve the delivery of health care services, patient health outcomes, and population health.”¹ Toward this end, the ACA directs the Secretary of HHS to ensure that the national strategy addresses racial and ethnic disparities in health and health care. Specific provisions are aimed at addressing chronic disparities in health care quality and access facing AI/AN populations.

Health disparities profoundly impact AI/ANs, who experience shorter life expectancies, higher disease burdens, and poorer overall health status than the general population. AI/ANs die at much higher rates than the general population of numerous causes, including alcoholism (514 percent higher), tuberculosis (500 percent higher), diabetes (177 percent higher), unintentional injury (140 percent higher), homicide (92 percent higher), and suicide (82 percent higher).² AI/ANs also have a high prevalence of mental illness, obesity, substance abuse, sudden infant death syndrome (SIDS), teenage pregnancy, liver disease, and hepatitis.³ Poor health in these populations has been exacerbated by high poverty rates and limited access to high-quality health care.

ABOUT THE PROGRAM

State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit www.rwjf.org/coverage.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES (CHCS)

CHCS is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high cost health care needs.

ABOUT THE NATIONAL ACADEMY FOR STATE HEALTH POLICY

The National Academy for State Health Policy is an independent academy of state health policy makers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice.

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Federal involvement in AI/AN health began with the Snyder Act of 1921. In addition to extending full U.S. citizenship to American Indians, the Snyder Act authorized the use of federal funds for “the relief of distress and conservation of health... [and] for the employment of...physicians” for Indian tribes throughout the United States.⁴ The Indian Health Service (IHS) was established under the 1955 Transfer Act, which transferred responsibility for Indian health to the Department of Health, Education, and Welfare.

Today, IHS functions as one of the nation’s main health care providers for AI/AN individuals, serving approximately 1.5 million people. However, IHS providers are located predominantly on or near tribal reservations in rural areas of the U.S., making them geographically inaccessible to the more than 60 percent of the AI/AN population who live in urban areas.⁵ Outside IHS, eligible AI/AN individuals may receive health care services through tribal 638 provider facilities or urban Indian organizations—entities that are led by Indian boards of directors and sometimes receive IHS contracts/grants as part of their funding.⁶ IHS, tribal 638 providers, and urban Indian organizations that provide health care for AI/AN populations are collectively referred to as I/T/U.

AI/AN HEALTH INSURANCE COVERAGE AND ACCESS TO CARE

IHS is a direct service provider, but it does not function as a health plan. In addition to the services received through IHS, AI/AN people may obtain health care coverage through any public, private, or state-operated health initiatives for which they qualify, including Medicaid, Medicare, and CHIP. Only about 41 percent of AI/AN people obtain private coverage through employer-sponsored insurance or other sources, compared to 76 percent of whites.⁷

Because these rates of private coverage are so low, and because a disproportionate number of AI/AN people have incomes below the federal poverty level (FPL), Medicaid assists in filling the coverage gap. About 28 percent of nonelderly AI/ANs reported coverage through Medicaid and other public programs, higher than the rate of publicly-funded coverage for other populations.⁸ Although Medicaid plays an increasingly large role, 16 percent of nonelderly AI/ANs rely solely on IHS and another 16 percent remain uninsured.⁹

In general, AI/ANs report more difficulties in accessing health care and have lower rates of utilization than white Americans. Almost half of low-income, uninsured AI/AN individuals report not having access to IHS.¹⁰ Even when AI/ANs are able to access care through IHS, the agency is underfunded and gaps in services are likely to exist, especially in the areas of preventive health and specialty care.¹¹

THE ACA’S IMPACT FOR AI/AN POPULATIONS

Provisions in the ACA aimed specifically at AI/ANs are designed to expand coverage and access and address the disparities experienced by this population. These provisions offer new approaches for ensuring that AI/AN populations can realize the benefits of coverage expansions. These opportunities fall into five categories:

1. AI/AN participation in Health Insurance Exchanges (Exchanges);
2. Medicaid eligibility;
3. IHS and I/T/U responsibilities and reimbursement;
4. Reauthorization of the Indian Health Care Improvement Act (IHCIA); and
5. Grant opportunities for I/T/U.

Health Insurance Exchanges: Federal or state-operated Exchanges will serve as marketplaces for insurance products. Under the ACA, individuals with incomes between 138 and 400 percent of FPL will be eligible to purchase coverage through Exchange qualified health plans (QHPs). Qualified individuals will receive subsidies, based on premium tax credit calculations, to help defray the cost of coverage. QHPs within the Exchange may require the payment of deductibles or co-pays.

A number of ACA provisions outline special rules for AI/AN enrollment in Exchanges. While most individuals who qualify for coverage in the Exchange will only be able to change health plans once a year, AI/AN individuals will have the ability to change their health plan on a monthly basis, if they desire. To increase access to care, AI/ANs with incomes below 300 percent FPL, and all who obtain services from or receive a referral from I/T/U providers, will be exempt from cost-sharing

requirements. An additional protection exempts AI/ANs from a mandate requiring all individuals to purchase minimum health care coverage.

In an effort to encourage more engagement of AI/ANs in the establishment of the Exchanges, the Center for Consumer Information & Insurance Oversight (CCIIO) at the Centers for Medicare & Medicaid Services (CMS) has asked states with one or more federally recognized tribes to provide documentation, when applying for Exchange establishment grants, that the state has “(1) established a process of consultation with such Tribe(s) regarding the start up and ongoing operation of the Exchanges; (2) implemented that process; and (3) assurance that it will continue to conduct and document such Tribal consultations for Exchange matters.”¹²

Special provisions are also outlined within the ACA for AI/AN Exchange eligibility, such as the exclusion of certain income sources from eligibility determination for Medicaid and Exchange coverage.¹³ To determine eligibility for cost-sharing protections, the ACA allows the Exchange to verify AI/AN status using documentation of citizenship and electronic data sources approved by the Secretary of HHS or documents currently accepted by Medicaid showing tribal membership.

AI/AN Tribes as Exchange Navigators: Exchanges are required to award grant funds to public and private entities to serve as navigators for individuals who enroll in a QHP through the Exchange. To serve as navigators, eligible entities must demonstrate existing relationships or the ability to establish relationships with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals.¹⁴ According to proposed Exchange regulations, Indian tribes, tribal organizations, and urban Indian organizations can be navigators, along with state or local human service agencies.¹⁵

AI/AN tribes that serve as navigators can use this role to provide culturally and linguistically appropriate information and outreach focused on improving health care access for tribal members. Tribal navigators would be ideally suited to understand the health needs of their peers and well-versed on the breadth of resources, services, programs, and coverage available to AI/ANs. With appropriate training, they would be well-equipped to help tribal members determine their best coverage options, including QHPs through the Exchange or other available programs. From an accountability perspective, the Exchange will monitor navigator performance and ensure that duties are met.

Medicaid Eligibility: The rules for Medicaid eligibility mirror those for Exchanges in terms of income levels and documentation of citizenship. The proposed Exchange regulations envision a system that will include state outreach to vulnerable populations generally, including AI/AN groups.¹⁶ The ACA places a new emphasis on Medicaid enrollment assistance and will require that all applicants be able to apply by mail, in person, online, and by phone. The ACA also requires Medicaid programs to ensure that the eligibility process is accessible, including for people with limited English proficiency; states should consider this requirement in designing outreach and enrollment materials for AI/AN populations.

This new level of assistance and accessibility in the eligibility process should improve access to coverage for people living in rural areas—including reservations—who may have historically experienced challenges with enrollment due to their geographic distance from eligibility sites or to cultural and linguistic barriers. Indeed, the expansion of Medicaid under the ACA will make 185,000 to 380,000 uninsured AI/ANs who receive care from IHS providers eligible for Medicaid coverage.¹⁷ States are required to work with tribes to ensure that existing Medicaid protections for AI/ANs are maintained and that I/T/U providers are included in health plan provider networks under Medicaid (and Exchange-offered) plans.¹⁸

The CHIP Reauthorization Act (CHIPRA) permits states to designate Express Lane Agencies that can determine whether a child meets one or more of the eligibility criteria for Medicaid or CHIP. Under the ACA, I/T/U are eligible to be designated as Express Lane Agencies. The ACA also provides grants to I/T/U to be used for outreach and enrollment in publicly financed health care.

IHS and I/T/U Responsibilities and Reimbursement: The ACA designates I/T/U as payers of last resort. Other public, private, and state health care initiatives for which an individual qualifies will cover the majority of health care expenses.

In addition, the ACA eliminates a sunset provision that limits the federal government’s ability to reimburse I/T/U providers for Medicare Part B services. Without this amendment, these facilities would only have been eligible for reimbursement of

select Part B services, which would have placed additional financial and resource constraints on I/T/U facilities.

Finally, the ACA allows prescription drug costs paid by I/T/Us to be counted as part of an individual's True Out-of-Pocket (TrOOP) expenses. TrOOP is used to determine whether an individual has reached the threshold, or "donut hole," of Medicare Part D coverage, in which prescription drugs within the expense range are not covered until costs reach the catastrophic coverage threshold (95 percent coverage level). Including prescription drugs as a part of TrOOP will allow AI/ANs to benefit from ACA provisions that provide a 50 percent discount on brand name drugs and a discount on generics to individuals in the Part D donut hole. Prior to the ACA, CMS refused to count the value of prescription drugs from an I/T/U pharmacy toward an enrollee's TrOOP. Thus, AI/ANs served by I/T/U pharmacies could not get out of the donut hole and reach the 95 percent coverage level, and I/T/U pharmacies could not collect at the 95 percent level. The ACA's fix will provide relief to I/T/U pharmacies by allowing them to collect reimbursements for high prescription drug users enrolled in Part D who reach the highest coverage level.

IHCIA Reauthorization: The Indian Health Care Improvement Act, originally passed in 1976, outlines the commitment of the United States to provide for quality health care to eliminate disparities between AI/ANs and the general population. Though the Act expired on September 30, 2000, the ACA permanently authorizes all IHCIA provisions. The IHCIA contains the following directives:

1. Requires IHS to establish behavioral health prevention and treatment programs for AI/ANs.
2. Authorizes I/T/U providers to provide hospice, assisted living, and home- and community-based services.
3. Gives I/T/U providers more power to recover costs from liable third parties, including managed care organizations, employee benefit plans, and any others.
4. Permits tribes or tribal organizations operating under the Indian Self Determination and Education Assistance Act and urban Indian organizations operating IHCIA Title V programs to purchase coverage for employees through the Federal Employees Health Benefits program.
5. Allows IHS to share medical services and facilities with the Department of Veterans' Affairs and the Department of Defense.
6. Permits I/T/U providers to purchase coverage for IHS beneficiaries.
7. Authorizes I/T/U organizations to establish programs to train and employ AI/ANs to provide health care services.

Grant Opportunities: In addition to the Exchange establishment grants referenced earlier, and to further address health disparities, the ACA offers grants for the initiation or expansion of programs targeted to AI/ANs. Grants are offered for I/T/U providers to operate programs providing in-home medical services to pregnant mothers and newborns.¹⁹ The Act also expands the Community Health Aid Program, which utilizes community members to provide home health care, and allocates additional funds to trauma centers to cover uncompensated care and emergency relief for AI/ANs.²⁰ Finally, to expand the number of health workers trained in Indian health, the ACA provides grants to demonstration projects that offer low-income AI/ANs health care education and training.²¹

WHAT CAN STATES DO? ENHANCING ENGAGEMENT OF TRIBES IN ACA IMPLEMENTATION

As of January 2011, states with one or more federally recognized tribes are required to establish a process of tribal consultation regarding development and implementation of the Exchanges.²² In doing so, states have the opportunity to engage in meaningful tribal consultation in a way that builds trust, shares responsibility, and respects tribal sovereignty. To make the most of their tribal consultations, state-designated teams or liaisons should solicit guidance from tribes on evaluating the impact of the ACA on AI/AN communities and I/T/U systems. Initial guidance should be supplemented by periodic regional consultation meetings and "All Tribes" conference calls to seek ongoing input. Particular attention should be paid to the following implementation issues:

- **Designing data systems and interfaces between IHS, Medicaid, CHIP, and the Exchanges.** Access to health care coverage for AI/ANs will be best facilitated by a smooth and well-defined relationship between IHS, Medicaid, CHIP, and the Exchanges. For example, tribes can assist state officials with data system design that alerts providers in Exchange health plans that AI/AN beneficiaries are exempt from cost-sharing. This system could alert I/T/U when AI/ANs enroll in an Exchange plan. If desired by the I/T/U, the data system could also be designed to allow premium payments for qualified AI/ANs by I/T/U providers. Coordination among programs can be facilitated by preparing IHS

informational materials so that health plans in the Exchange will know how to include IHS providers in their provider networks.

- **Structuring an outreach and enrollment strategy.** To expand insurance coverage among AI/ANs, tribes can identify funding sources and mechanisms that will allow them to assist in the Exchange enrollment process. Tribes can also help state officials to design an outreach and enrollment strategy that effectively promotes the benefits of ACA programs and enrollment. Such a strategy can help remove enrollment barriers by:
 - **Ensuring an accessible and understandable enrollment process**, for both AI/AN populations and the I/T/U providers that serve them, including the use of culturally and linguistically competent eligibility workers and call center staff;
 - **Providing remote access** to online applications through off-site eligibility stations or field workers;
 - **Creating marketing materials** and campaigns to educate qualified AI/AN individuals about available benefits;
 - **Providing extensive training** to eligibility and enrollment employees within Medicaid and the Exchange;
 - **Creating enrollment incentives** by emphasizing the scope and quality of care available through public programs beyond Contract Health Services;
 - **Including tribes and I/T/U providers** directly in planning efforts and ensuring I/T/U relationships and/or representation among navigators; and, finally,
 - **Supporting program continuity and seamlessness** for AI/AN populations, by ensuring that eligibility and enrollment rules and policies are to the greatest extent possible comparable for Medicaid, Exchange and other insurance affordability programs.

- **Ensuring meaningful access.** States can allow AI/AN populations to more easily access care and increase coordination of care by permitting those enrolled in Exchange plans to use insurance coverage at I/T/U. One way to do this is by designating I/T/U as essential community providers and encouraging plans to accept referrals from I/T/U as primary care providers. States can also facilitate discussions around modifying Exchange provider contracts to ensure that they accommodate for the unique features of the I/T/U system. Additionally, states can consider allowing I/T/U providers to purchase coverage for Exchange beneficiaries who do not qualify for the full tax subsidy. Finally, states will want to continually collect and monitor information on the number and demographics of Exchange-enrolled AI/ANs to ensure that their health care needs are met and access to care is ensured.

- **Identifying and developing a plan of action to address health disparities.** States and tribes can look to a multitude of provisions in the ACA as they develop a plan to address racial and ethnic disparities. The ACA requires all federally supported programs—including Medicaid/CHIP, Medicare, population surveys, etc.—to collect and report data on race, ethnicity, primary language, gender, and disability.²³ This can serve as an impetus for states to strengthen state-level data collection across programs and mimic federally endorsed race, ethnicity, and language data standards.

States may also want to improve the diversity of their workforce through ACA provisions that support professionals and para-professionals who have cultural and language expertise, are serving in medically underserved areas, and are

CURRENT STATE EFFORTS: NEW MEXICO'S EXPERIENCE

New Mexico's AI/AN population makes up almost 10 percent of its total state population. This includes people living on tribal land, pueblos, off-reservation, and in urban areas. Tribal consultation efforts have been underway for several years in New Mexico through the authority of the State-Tribal Collaboration Act (SB 196). SB 196 creates a framework in state statute for effective communication and collaboration between state and tribal governments.

The New Mexico Office of Health Care Reform (OHCR) engages AI/ANs through: stakeholder committee meetings; tribal and off-reservation contracts; formal state-tribal consultation; and informal communication. Tribal liaisons, tribal advisory bodies, and workgroups all have a role in providing recommendations on policy development or program changes that have implications for tribes.

Through the formal tribal consultation process, New Mexico identified the need for targeted assistance and support in designing and implementing its Exchange. In its CMS-funded Level One Grant, New Mexico proposed to establish a Native American Service Center. The Center will facilitate meaningful, ongoing tribal consultation; will work to ensure that the Exchange is accessible and complies with the required components of the ACA and the Indian Health Care Improvement Act (ICHIA); and will share best practices with other states. It is envisioned that the Center assist with technical support, outreach, and education.

practicing in primary care, oral health, and behavioral health domains—clinical areas typically under-accessed by racial and ethnic minority populations. States should also note “culturally and linguistically appropriate” obligations placed by the ACA²⁴ on several types of communication materials, including: forms and websites used by states and health plans in the Exchanges; prescription drug and nutrition labeling; clinical shared decision-making and personalized prevention tools; and the state Medicaid campaign educating consumers about preventive care benefits.²⁵

Finally, states that are implementing the ACA’s quality provisions, such as the delivery redesign models (e.g., health homes, community health teams) and public health innovations (e.g., community transformation grants, maternal home visiting programs, obesity demonstration grants), will have to consider the extent to which these mechanisms support patient-centeredness and address social determinants of health—such as income, neighborhood, culture, and language—that are inextricably tied to the quality of health and health care experienced by racially and ethnically diverse populations.

CONCLUSION

The AI/AN community continues to experience higher rates of health disparities and lower rates of access to care than the general population. Particularly vulnerable are low-income AI/ANs, half of whom lack insurance coverage and are unable to access services provided through IHS. ACA provisions attempt to rectify these disparities by lowering cost and increasing access to care for AI/AN populations. To maximize opportunity, minimize administrative burden, and encourage cultural relevance, states should work closely with tribes to implement the applicable provisions of the ACA.

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Notes

¹ ACA § 3011 (s).

² <http://www.ihs.gov/PublicAffairs/IHSBrochure/Disparities.asp>.

³ <http://minorityhealth.hhs.gov/templates/browse.aspx?vl=2&vlID=52>.

⁴ The Snyder Act, Public Law 67-85, November 2, 1921.

⁵ L.R. Hendricks. "Health and Health Care of American Indian and Alaska Native Elders." Ethnogeriatric Curriculum Module, Stanford University. Available at <http://www.stanford.edu/group/ethnoger/americanindian.html>.

⁶ "638 Tribal Facility" refers to a facility that is operated by a tribe or tribal organization and funded by Title I or Title III of the Indian Self Determination and Education Assistance Act (Public Law 93-638), including all facilities under contract, compact, or receiving grants from the IHS. The tribal facility is operated by a Federally recognized tribe under a funding agreement with IHS. Tribal facilities may elect to be paid at the IHS rates or at fee-for-service rates. For more information, see <http://www.doi.gov/ost/information/tribal/contracting.html>

⁷ C. James, K. Schwartz, and J. Berndt. "A Profile of American Indians and Alaska Natives and Their Health Coverage." Kaiser Family Foundation, September 2009. Available at <http://www.kff.org/minorityhealth/upload/7977.pdf>.

⁸ Ibid.

⁹ Ibid.

¹⁰ S. Zuckerman, J. Haley, Y. Roubideaux, and M. Lillie-Blanton. "Health Service Access, Use, and Insurance Coverage Among American Indians/Alaska Natives and Whites: What Role Does the Indian Health Service Play?" *American Journal of Public Health*, 2004.

¹¹ C. James et al., op cit.

¹² U.S. Department of Health and Human Services Office of Consumer Information and Insurance Oversight.

"Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges." January 20, 2011. Available at

http://ccio.cms.gov/resources/fundingopportunities/foa_Exchange_establishment.pdf.

¹³ These sources include:

1. Financial assistance to students through the Bureau of Indian Affairs education program;
2. Income from Alaska Native corporations and settlement trusts;
3. Earnings from property under the Secretary of Interior's supervision, on or near reservations or sites formerly housing reservations; and
4. Payments from ownership interests and usage rights that support a traditional or subsistence lifestyle.

¹⁴ 45 CFR Parts 155 and 156, Proposed Regulations Establishment of Exchanges and Qualified Health Plans, § 155.210 (2011).

¹⁵ Ibid.

¹⁶ 45 CFR Parts 155 and 156, Proposed Regulations Establishment of Exchanges and Qualified Health Plans, § 155.130 (2011).

¹⁷ "Medicaid Expansion Under ACA for American Indians and Alaska Natives." National Indian Health Board Issue Paper, April 14, 2011. Available at <http://www.nihb.org/docs/05212011/NIHB%20Issue%20Paper%20-%20Medicaid%20Expansion%20under%20ACA%20for%20AI-AN%20FINAL%202011-04-14.pdf>

¹⁸ Sec. 5006(e) of the Recovery Act codified in statute, at section 2107(e)(1)(C) of the Social Security Act, the requirement that states seek advice from tribes on a regular and ongoing basis in states where one or more Indian health program or urban Indian organization furnishes health care services.

¹⁹ National Indian Health Board. op cit.

²⁰ Indian Health Service. "The Indian Health Care Improvement Reauthorization and Extension Act." Available at

http://www.ihs.gov/PublicAffairs/DirCorner/docs/IHCIA_Reauthorization_Summary_Table_IHS.pdf

²¹ National Indian Health Board. "Patient Protection and Affordable Care Act Summary of Indian Health Provisions." Available at

http://www.nihb.org/docs/05142010/Affordable_Care_Act_Provisions_Summary.pdf.

²² CCIIO Planning and Establishment Grants Pre-Application Conference Call Transcript. March 3, 2011. Available at

http://ccio.cms.gov/resources/files/Exchange_establishment_grants_03032011.pdf

²³ ACA § 4302.

²⁴ ACA §§ 1311 and 2715.

²⁵ 45 CFR Parts 155 and 156, Proposed Regulations Establishment of Exchanges and Qualified Health Plans, § 155.205 (2011).