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June 26, 2017

The Honorable Mitch McConnell
S-230 The Capitol
Washington, D.C. 20510

Re: Tribal Opposition to the Discussion Draft of the Better Care Reconciliation Act

Dear Majority Leader McConnell,

On behalf of United South and Eastern Tribes Sovereignty Protection Fund (USET SPF) we write to express our opposition to the "Better Care Reconciliation Act of 2017" (BCRA) discussion draft released on Thursday by Senate leadership. The bill would make dramatic and devastating cuts to the Medicaid program, a program that our Tribal health programs rely upon to deliver care to our people. While the legislation mirrors several provisions of the House bill that are of critical importance to Indian Country, we have grave concerns about other aspects of the BCRA that we hope are addressed by the Senate before it passes this legislation. We cannot support the legislation in its current form. We specifically request that the Senate protect Medicaid for Tribal populations and preserve cost-sharing protections and benefits that would be eliminated under the current version of the BCRA.

USET SPF is a non-profit, inter-tribal organization representing 26 federally recognized Tribal Nations from Texas across to Florida and up to Maine[1]. Both individually, as well as collectively through USET SPF, our member Tribal Nations work to improve health care services for American Indians. Our member Tribal Nations operate in the Nashville Area of the Indian Health Service (IHS), which contains 36 IHS and Tribal health care facilities. Our citizens receive health care services both directly at IHS facilities, as well as in Tribally-operated facilities operated under contracts with IHS pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638.

To the extent BRCA does move forward, at a minimum it must be amended so that:

(1) Medicaid continues to be funded based on need, and not artificially capped through a complicated per capita allocation formula or a block grant. The per capita allocation formula and block grant option in BCRA contain funding cuts even higher than the House version of the reconciliation

[1] USET SPF member Tribal Nations include: Alabama-Coushatta Tribe of Texas (TX), Aroostook Band of Micmac Indians (ME), Catawba Indian Nation (SC), Cayuga Nation (NY), Chitimacha Tribe of Louisiana (LA), Coushatta Tribe of Louisiana (LA), Eastern Band of Cherokee Indians (NC), Houlton Band of Maliseet Indians (ME), Jena Band of Choctaw Indians (LA), Mashantucket Pequot Indian Tribe (CT), Mashpee Wampanoag Tribe (MA), Miccosukee Tribe of Indians of Florida (FL), Mississippi Band of Choctaw Indians (MS), Mohegan Tribe of Indians of Connecticut (CT), Narragansett Indian Tribe (RI), Oneida Indian Nation (NY), Passamaquoddy Tribe at Indian Township (ME), Passamaquoddy Tribe at Pleasant Point (ME), Penobscot Indian Nation (ME), Poarch Band of Creek Indians (AL), Saint Regis Mohawk Tribe (NY), Seminole Tribe of Florida (FL), Seneca Nation of Indians (NY), Shinnecock Indian Nation (NY), Tunica-Biloxi Tribe of Louisiana (LA), and the Wampanoag Tribe of Gay Head (Aquinnah) (MA).

legislation. This will hurt our Tribal health programs and lead to fewer services being provided under Medicaid.

(2) Medicaid Expansion remains an option. The BCRA legislation defunds the enhanced federal funding that makes Medicaid expansion possible.

(3) American Indians and Alaska Natives (AI/ANs) are exempt from Medicaid enrollment barriers such as work requirements that are not designed for and will not work in Indian country.

(4) The cost-sharing protections in Section 1402 of the Patient Protection and Affordable Care Act (ACA) are retained. This provision is key to allowing AI/AN access to insurance in the individual marketplace.

We provide the following additional points on the most significant impacts the bill would have on our Tribal healthcare delivery systems.

**1. *Medicaid should not be capped***

Medicaid is a critically important resource for the Indian Health System. The Indian Health Service (IHS) has been chronically underfunded for years, and as a result over 40 years ago, Congress determined that Medicaid resources should be available to Tribal health programs to help fulfill the federal trust responsibility.

The cuts proposed by the BCRA would be devastating to our Tribal health programs. BCRA would make cuts to Medicaid that are even higher than those proposed by the House of Representatives. BCRA's caps are tied to a lower inflation factor beginning in 2025 that would result in even higher cuts to state Medicaid plans. We do not see how the Indian healthcare delivery system can succeed if faced with the cuts proposed in BCRA.

We were encouraged to see that BCRA contains provisions that would prevent the cost of care provided to AI/ANs from counting against either a per capita cap or a block grant. However, that protection alone is insufficient. Faced with the cuts proposed in Sections 133 and 134 of the bill, states will likely be forced to make cuts to eligibility and/or services in future years which will affect all providers in a given state, including Tribal health programs. This will lead to significant cuts in Medicaid revenues for the Indian Health System, and will threaten our ability to provide healthcare services to our people.

- ***Medicaid Expansion must be Maintained***

In states that have chosen to expand, Medicaid Expansion has increased access to care and provided critical third-party revenues to the Indian Health System. The uninsured rate for AI/AN has fallen nationally from 24.2% to 15.7% since the enactment of the Affordable Care Act, due in large part to Medicaid Expansion. This has resulted in health care services to AI/AN people who might not have normally received care due to the chronic underfunding of the IHS. It has also resulted in savings to the Medicaid program through the prevention of more complex and chronic health conditions. Medicaid expansion has increased Medicaid revenues at IHS/ Tribal/Urban health programs, which are being reinvested back into both the Indian and the larger national health care system.

We recognize that the decision to pursue expansion is a state choice, and can come at a cost to the state. However, the option to expand in future years, and the federal funding necessary to do so, should not be

foreclosed. We recognize that the bill contains important provisions designed to equalize funding between expansion and non-expansion States, but are concerned that the amounts provided to non-expansion States do not equal the funding that could be obtained through expansion. We believe it is important to keep the door open to expansion for the future. At the very least, expansion should be retained for the AI/AN population under a special Medicaid optional eligibility category for State Plans in recognition of the federal trust responsibility.

### *3. AI/ANs must be exempt from work requirements*

AI/ANs are uniquely situated in the Medicaid program. Unlike other Medicaid enrollees, because of the federal trust responsibility, AI/ANs have access to the limited services provided by IHS at no cost to them. As a result, Medicaid enrollment incentives are completely different for AI/AN enrollees. Mandatory Medicaid conditions of eligibility designed to encourage work do not work in Indian country. Rather than seek work, many individuals will choose not to enroll in Medicaid at all and rely on the underfunded IHS instead. Section 131 of the Senate bill would provide enhanced Federal Medical Assistance Percentage (FMAP) payments to states to encourage them to impose work requirements as a condition of Medicaid eligibility. It contains exemptions for certain categories of individuals, but AI/ANs are not included. This will have serious, negative implications for our Tribal health program if enacted and adopted by our State. Instead of encouraging work, many of our people can and will simply elect not to enroll in Medicaid and rely on IHS coverage alone.

In addition, work requirements and other barriers to Medicaid access are a violation of the federal trust responsibility. Congress has previously provided that AI/AN are exempt from Medicaid premiums, co-pays or cost sharing of any kind.[2] This is consistent with the federal government's trust obligations, which are the result of the millions of acres of land and extensive resources ceded to the U.S., in exchange for which it is legally and morally obligated to provide benefits and services in perpetuity, including health care. Work requirements and other barriers run counter to this sacred promise.

Finally, work requirements assume easy access to jobs, treatment centers and other services. Unemployment continues to be an issue in our community, and is one that Tribal Nations are working to address. Tribal Nations, like other units of government, are in the best position to determine how to encourage full employment of our citizens, and should not have access to a federal health care program conditioned on meeting work requirements and other conditions of participation a state deems best for its citizens.

- ***ACA Cost Sharing Protections Must be Maintained***

The cost-sharing subsidies in the ACA made private health insurance accessible for many AI/ANs for the first time. By making it easier for more of our people to obtain private insurance, the law has encouraged AI/AN enrollment in private health coverage, which has led to increased resources for many of our Tribal health systems. Section 1402(d) of the ACA enacted special cost-sharing protections for AI/ANs that are critical to opening the door for AI/ANs to obtain individual marketplace coverage. BCRA would eliminate all cost sharing protections in Section 1402, including the special cost sharing protections for AI/ANs. We respectfully request that Congress continue the cost-sharing protections for AI/ANs contained in section 1402(d) of the Affordable Care Act.

[2] 42 U.S.C. §1396o(j).

**Conclusion**

As written, the "Better Care" Act will not provide better care for our people. With this in mind, USET SPF opposes it in its current form and urges you to make these critical amendments to BRCA before allowing it to proceed. Should you have any questions, please do not hesitate to contact Ms. Liz Malerba, USET SPF Director of Policy and Legislative Affairs at LMalerba@usetinc.org or 202-624-3550.

Sincerely,

Kirk Francis
President

Kitcki A. Carroll
Executive Director

CC: Senator Lamar Alexander
Senate Committee on Indian Affairs