Affordable Care Act/Indian Health Care Improvement Act Refresher

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The Affordable Care Act (ACA)

Signed into law on March 23, 2010.

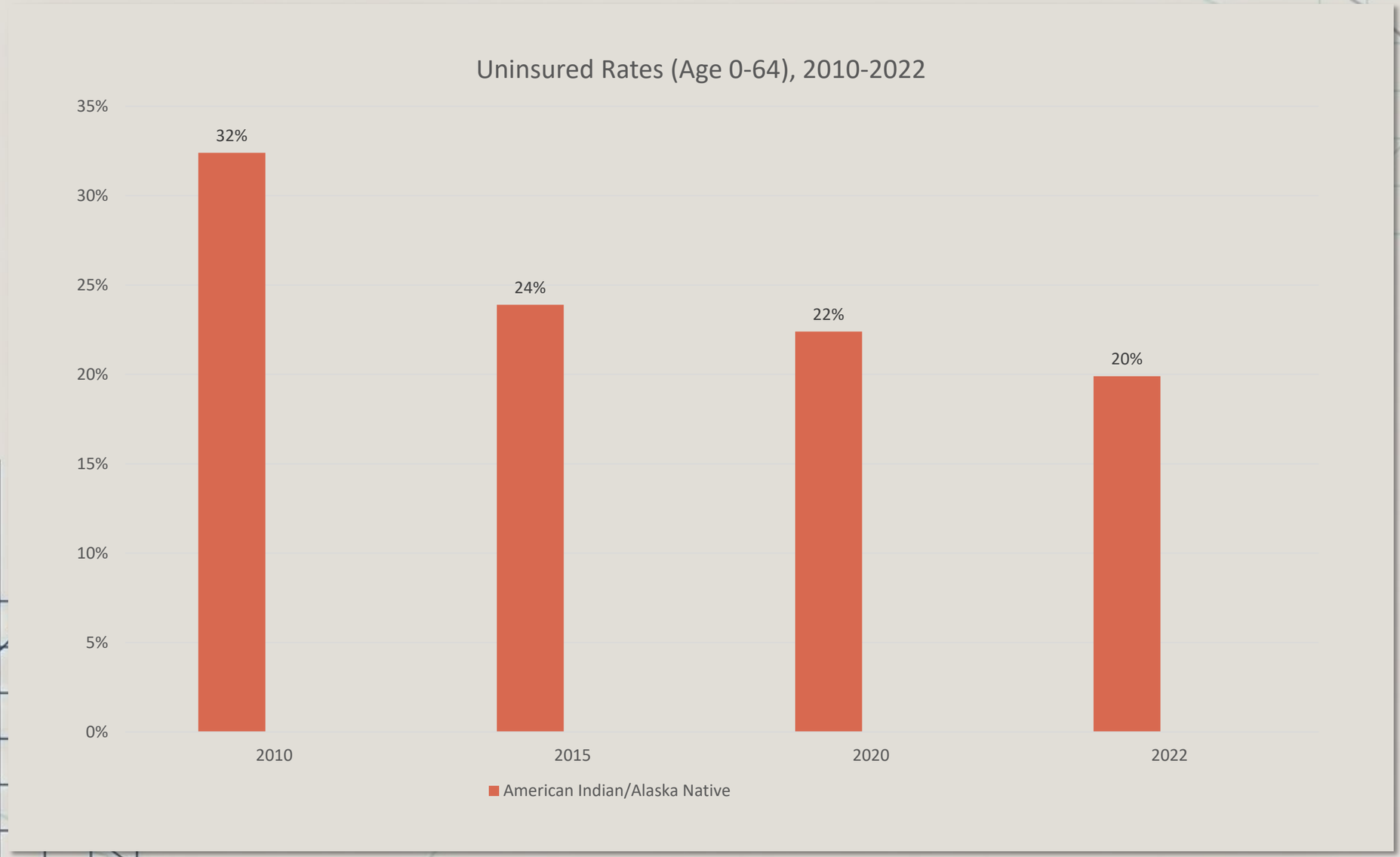
Broadly, the ACA:

- Overhauled the U.S. health system.
- Expanded healthcare coverage for millions of Americans.
- Permanently reauthorized the Indian Health Care Improvement Act (IHCIA).

Menu of Impacts: ACA & IHCIA Policy Blueprint

Affordable Care Act	Indian Health Care Improvement Act
Individual Mandate	National CHAP Expansion
Health Insurance Marketplace	Tribal Sponsorship
Medicaid Expansion	IHS-VA Cooperation and Reimbursement
“Payor of Last Resort”	Data-Sharing with Tribal Epidemiology Centers
Permanent Authority to bill Medicare Part B	Licensing Exemptions
Tax Exemption for Health Benefits for Tribal members	Authority to Provide Long-Term Care
	Right to Recover Directly from Third-Party Payors
	Access to Federal Insurance Benefits

Impacts of the ACA



Source: Office of Health Policy, Assistant Secretary for Planning and Evaluation, Department of Health and Hu

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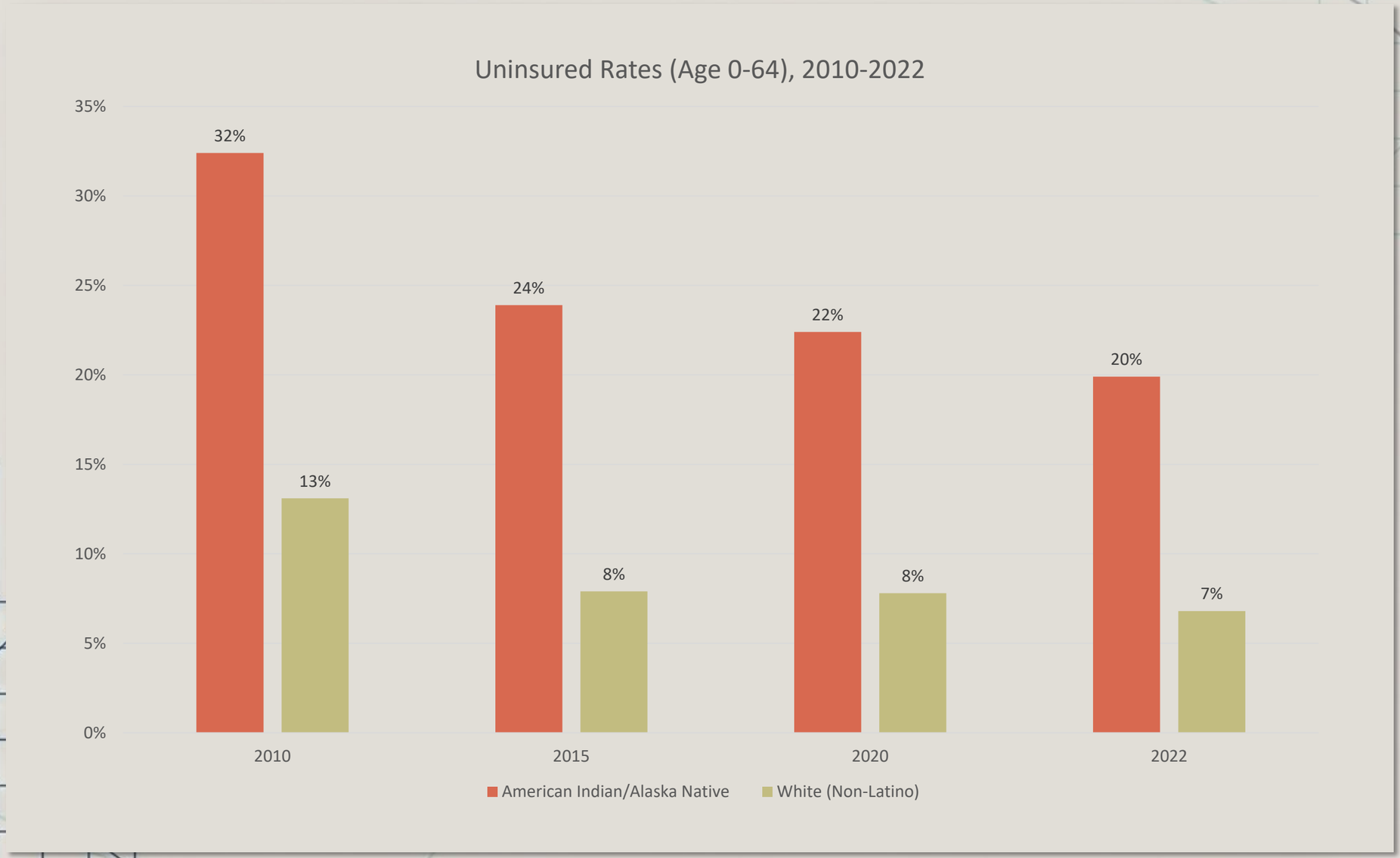

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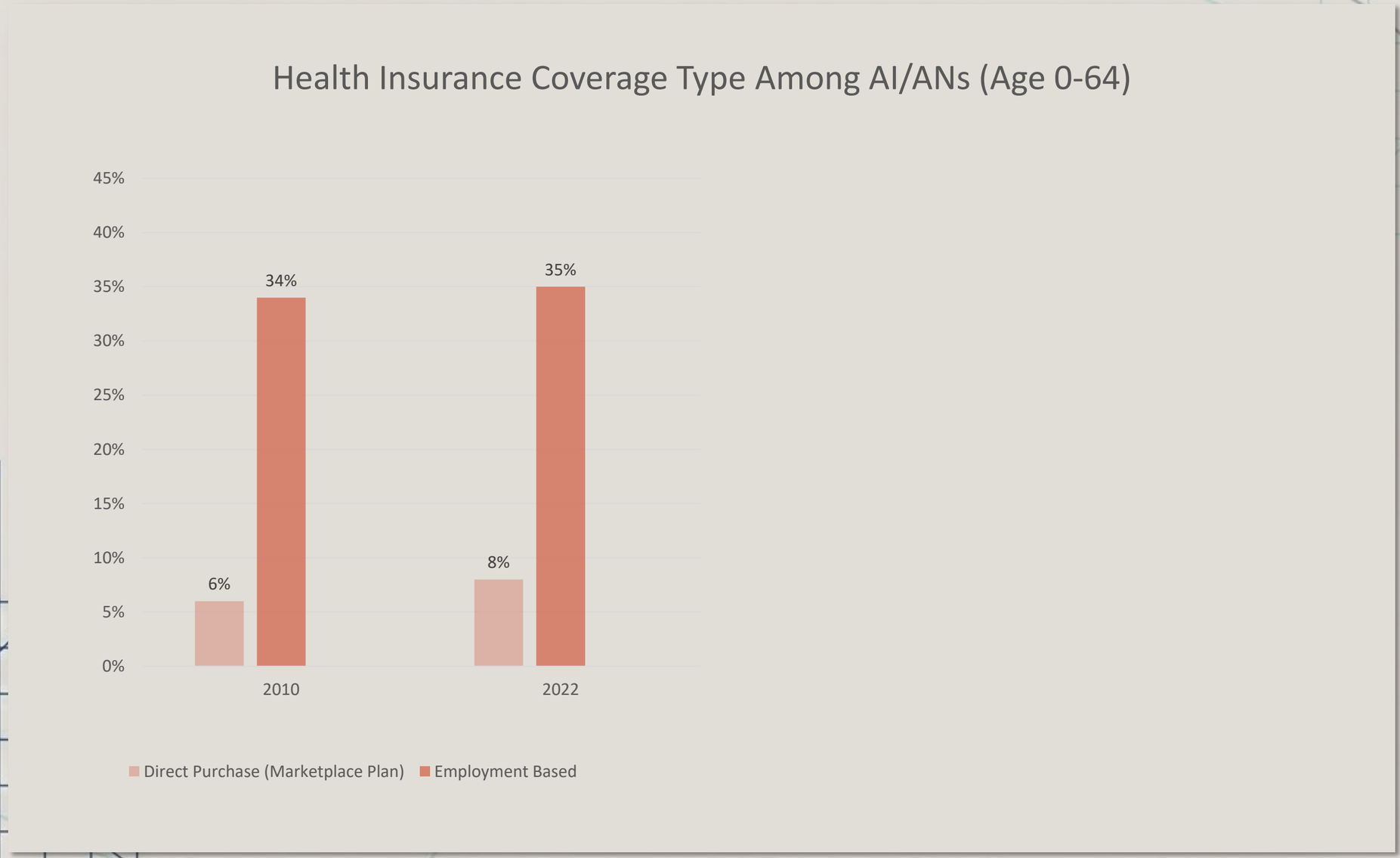

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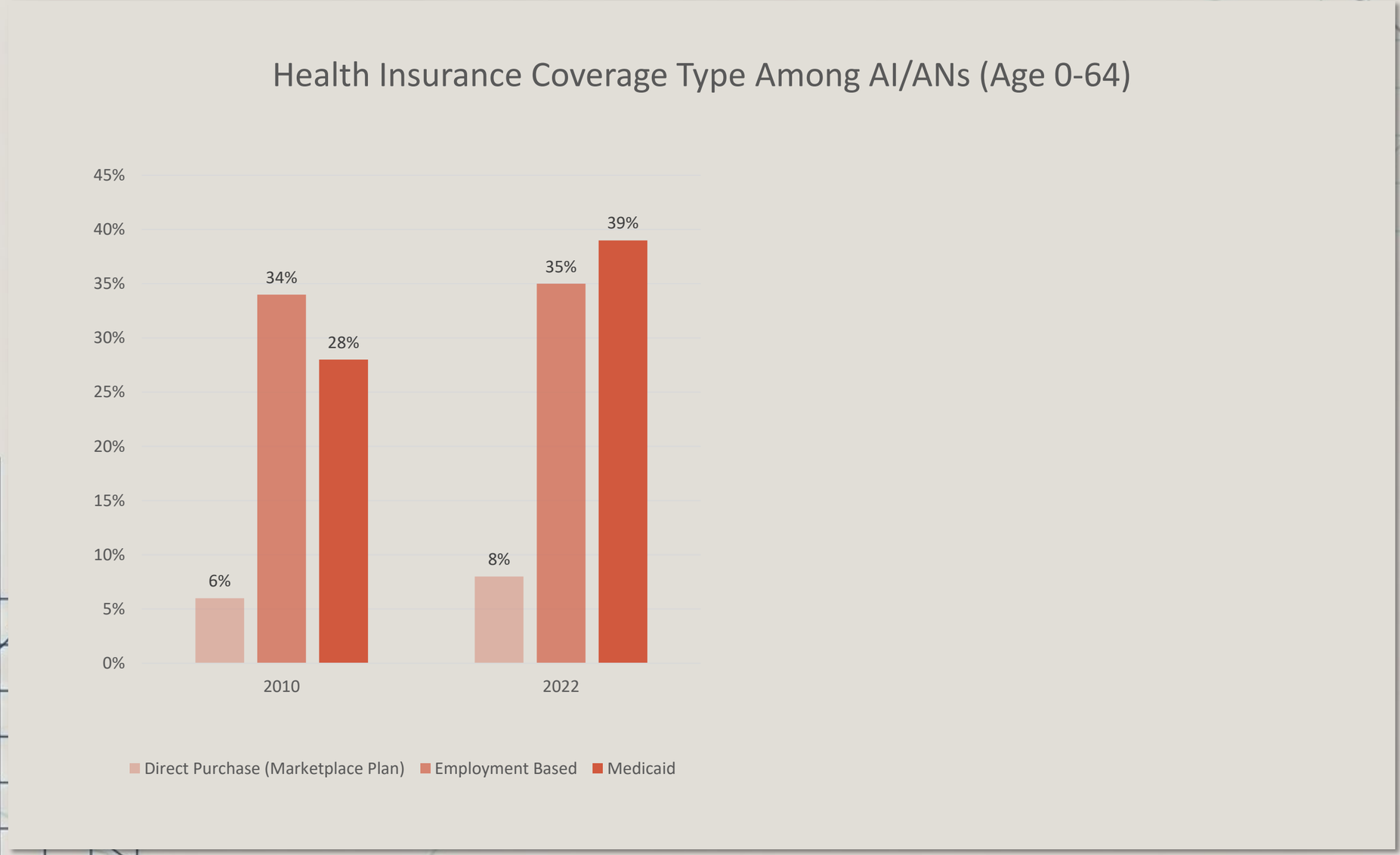

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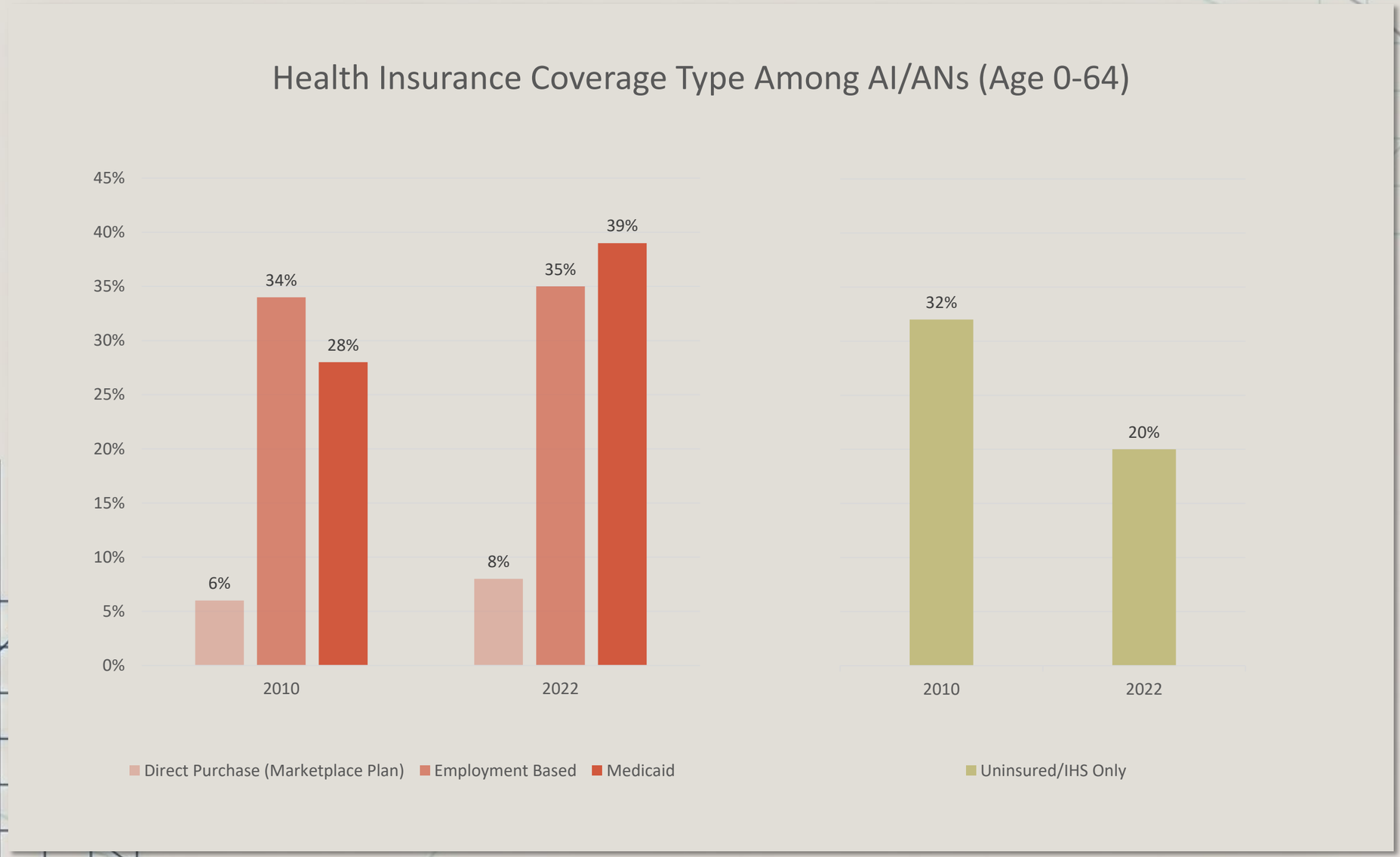

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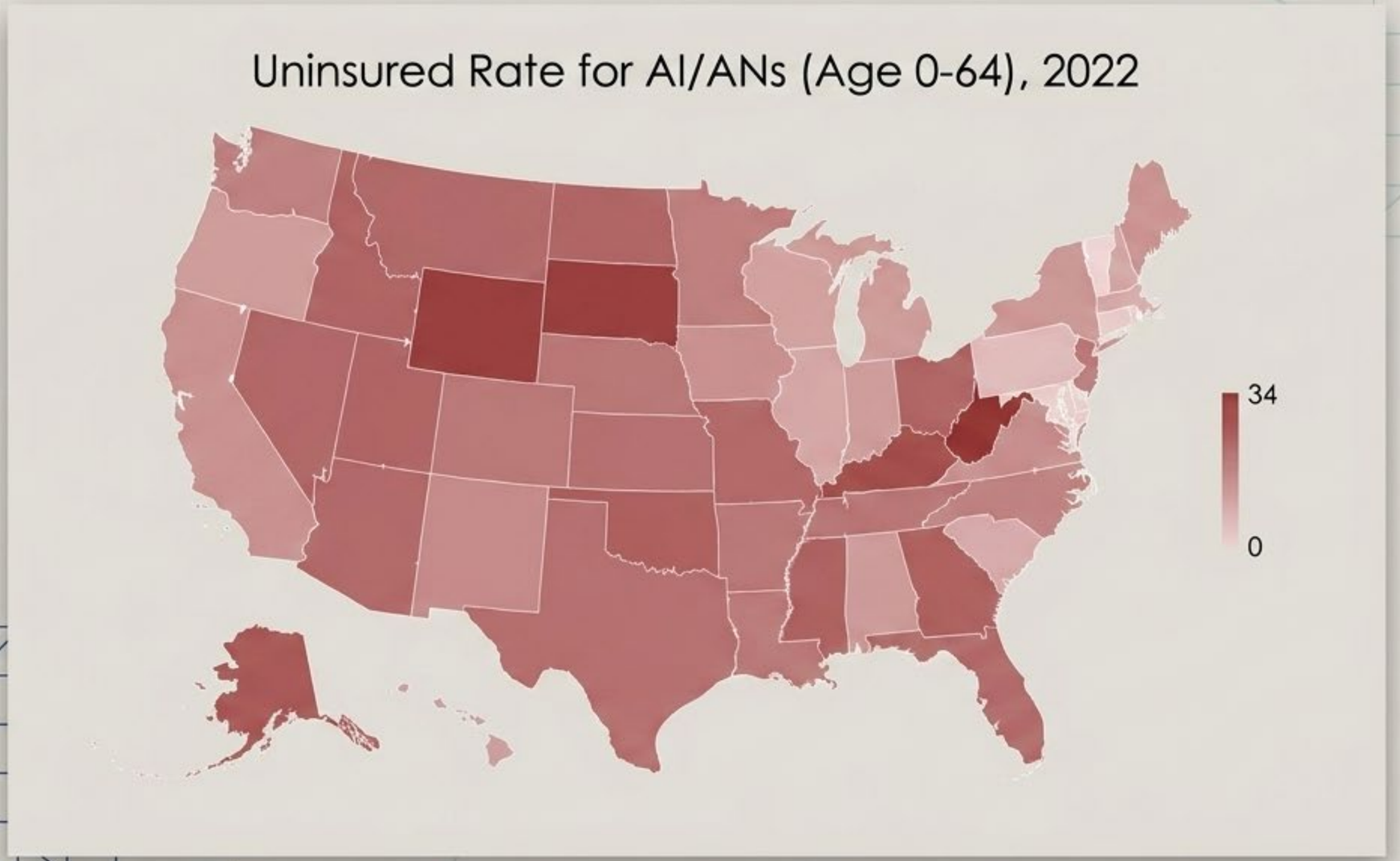

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Impacts of the ACA

Wyoming

- Uninsured Rate: 30.9%
- One of the highest in the country
- No Medicaid expansion

South Dakota

- Uninsured Rate: 31.1%
- South Dakota began implementing Medicaid expansion in 2023

New Mexico

- Uninsured rate: 15.9%
- One of the biggest drops since 2010 (30%)
- Implemented Medicaid expansion in Jan. 2014

Montana

- Uninsured rate: 21.6%
- Dropped from 45% in 2010 to 25% in 2020
- Implemented Medicaid expansion in 2016

Source: Office of Health Policy, Assistant Secretary for Planning and Evaluation, Department of Health and Human Services

Affordable Care Act

Key Terms and Acronyms

Authorize v. appropriate

Just because a program has been authorized does not mean it can be established. Funding must also be appropriated to the program.

I/T/U

IHS, Tribal, and Urban Indian Programs.

FPL

Federal Poverty Level

Health Insurance Marketplace

Description

Creates a marketplace of Qualified Health Plans.

Includes subsidies on a sliding scale for individuals between 100% and 400% of FPL.

Impact

Tribal members are eligible for limited to no cost-sharing plans depending on income level.

Sliding Scale

0-100% of FPL: no cost-sharing from any I/T/U provider or with a referral from an I/T/U provider

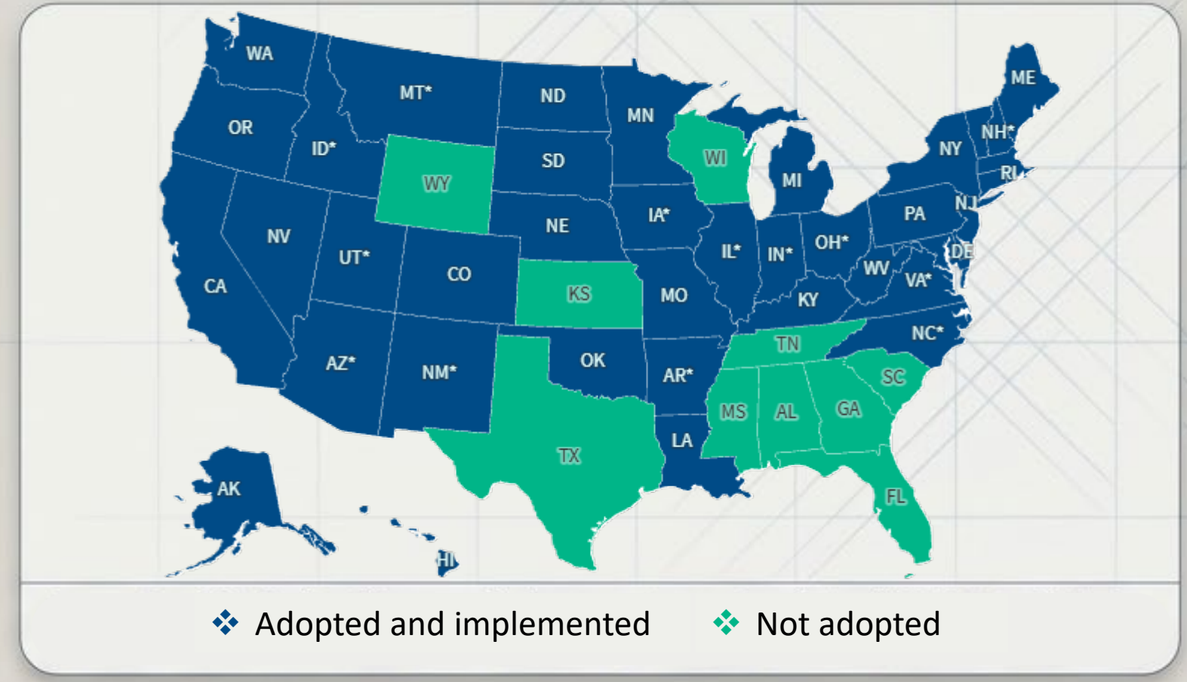
100-300% of FPL: eligible for no cost-sharing from any provider

400%+ of FPL: no cost-sharing from any I/T/U provider or with a referral from an I/T/U provider.

Structural Footer tag:
Source: Sec. 1402. Reduced cost-sharing for individuals enrolling in qualified health plans. [42 U.S.C. § 18071]

Medicaid Expansion

- Expands Medicaid to cover individuals up to 133% of the federal poverty level.
- National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012), made Medicaid expansion optional for states.



2014

Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Rhode Island, Vermont, Washington, and West Virginia.

2015

Alaska, Indiana, New Hampshire, and Pennsylvania.

2016

Louisiana and Montana.

2019

Maine and Virginia.

2020

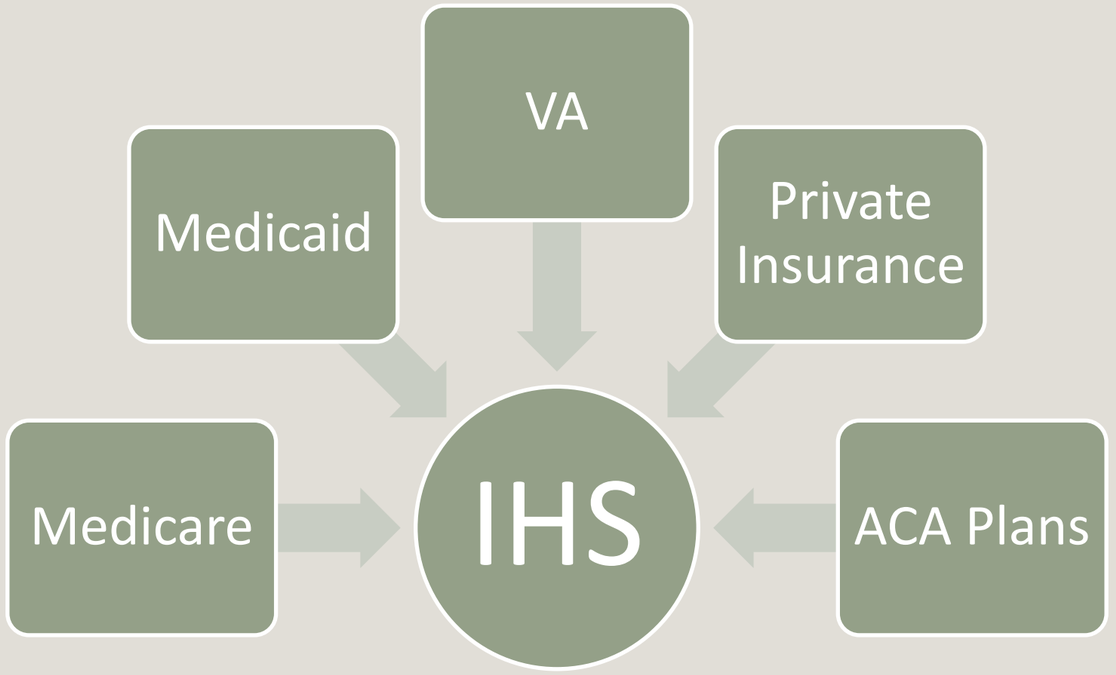
Idaho, Nebraska, and Utah.

2021

Missouri and Oklahoma.

2023

North Carolina and South Dakota.



Payor of Last Resort

Makes the IHS, Tribal, and urban programs the payor of last resort for persons eligible for services through those programs

Impact

The payor of last resort rule means that the IHS pays only after Medicare, Medicaid, VA, CHIP and private insurance pay.

Medicare Part B

Description

Permanent authority for I/T to collect Medicare Part B.

Impact

Impact

Increases third party revenue

Source: Sec. 2902. Elimination of sunset for reimbursement for all Medicare part B services furnished by certain Indian hospitals and clinics [42 U.S.C. $ 1395qq]; Sec. 9021. Exclusion of health benefits provided by Indian Tribal governments. [26 U.S.C. § 139D]

Tax Exemption for Health Benefits

Description

Excludes from gross income the value of health benefits provided by an IHS and Tribal program to its members.

Impact

Impact

Protects Tribal members from being taxed for health benefits owed by trust and treaty responsibility

Indian Health Care Improvement Act

Community Health Aide Program (CHAP)

Authorizes a national CHAP program.

Prohibits lower-48 states from including DHAT services except when permitted by state law.

Impact

Congress has not provided proper funding.

An additional $5 million was appropriated in FY 2024.

IHS is still working on implementing the program.

Sec. 119. Community Health Aide Program [25 U.S.C. § 1616l]; Sec. 205. Other Authority for Provision of Services [25 U.S.C. § 1621d]

Long Term Care

Authorizes hospice care, long-term care, and home- and community-based care.

Impact

Congress has not yet provided funding for these programs.

Description	Impact
Veterans Allows IHS to cover a Department of Veterans Affairs co-pay	Reduces financial burden on I/T/U
Tribal Sponsorship Allows T/U to use federal funds to purchase health benefits for beneficiaries.	Gives Tribal members portable coverage Increases third-party revenue
Right to Recovery from Third Party Payors I/T have the right to recover from third-party payers for "the reasonable charges billed ... or, if higher, the highest amount the third party would pay for care and services furnished by providers other than governmental entities"	Increases third party revenue

Sec. 402. Purchasing Health Care Coverage [25 U.S.C. § 1642]; Sec. 407. Eligible Indian Veteran Services [25 U.S.C. § 1647]; Sec. 206. Reimbursement from Certain Third Parties of Costs of Health Services [25 U.S.C. § 1621e]; Sec. 207. Crediting of Reimbursements 25 [U.S.C. § 1621f]

Description	Impact
Direct Collection All reimbursements must be credited directly to the I/T/U program that provided the service	Makes third-party billing more efficient and effective
Licensing Exemptions I/T/U is eligible to participate in Federal healthcare programs without a state license so long as they meet the requirements for licensure	• A Tribal provider is not required to be licensed by the state in which the Tribal program is located as long as they are licensed in any state. • Reduces administrative overhead. • Provides more flexibility to I/T/U. • Better honors Tribal sovereignty.
Federal Health Insurance Tribal programs operating any ISDEAA program may purchase insurance coverage for all employees (not just of the ISDEAA program) through the Federal employee health benefits program	Allows Tribal programs to offer better benefits to their employees

Sec. 221. Licensing [25 U.S.C. § 1621t]; Sec. 408. Nondiscrimination under Federal Health Care Programs in Qualifications for Reimbursement for Services [25 U.S.C. § 1647a]; Sec. 409. Access to Federal Insurance [25 U.S.C. § 1647b]

Questions?

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For more information on the TSGAC Affordable Care Act/IHCIA Project, please visit the Health Reform website at:

Health Reform - Tribal Self-Governance (tribalselfgov.org)