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December 7, 2017

The Honorable Gene L. Dodaro
Comptroller General
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Dodaro:

We write to request the Government Accountability Office (GAO) undertake a review of the effect of the Affordable Care Act (ACA), including Medicaid expansion, on health coverage for American Indians and Alaska Natives (Indians) and funding for Indian Health Service (IHS) or Tribal facilities. We are requesting this review to better understand how the ACA has improved access to health care services for Indians.

Indians have a unique legal relationship with the federal government that provides them guaranteed access to health care. Health care is provided to Indians through a distinctive system with special rules, and in most cases, multiple sources of coverage. The IHS is the primary health care provider to nearly 2.2 million non-elderly individuals who self-identify as Indian.[1] In addition to being eligible for IHS-funded health care, Indians may also have other sources of health coverage – such as Medicaid, VA Health Benefits, and Federal Employee Health Benefits, and private health insurance coverage through the marketplace – which in 2015 covered 42 percent and 44 percent of American Indians and Alaskan Natives, respectively.[2]

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[1] Department of Health and Human Services, "Putting America's Health First: FY 2018 President's Budget for HHS." May 23, 2017, https://www.hhs.gov/sites/default/files/Consolidated%20BIB_ONLINE_remediated.pdf.

[2] Census Bureau, "Selected Population Profile in the United States," 2015 American Community Survey, 1-Year Estimates, https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_15_1YR_S0201&prodType=table.

IHS-funded health care is provided to Indians through a network of hospitals, clinics, and health stations which mostly provide primary care services. However, ancillary and specialty care is quite limited. If facilities are unable to provide specialty care, they contract with private providers through the Purchased/Referred Care (PRC) program to provide services. Funding for the PRC is limited — $914 million in fiscal year 2016 — resulting in PRC funding being reserved for the most critical cases.[3]

Indians have historically had higher rates of uninsurance than the general population. With the enactment of the ACA, Indians have more coverage options available to them through the expansion of Medicaid and subsidized marketplace coverage. These additional coverage pathways have helped reduce the Indian uninsured rate by more than a quarter, from 29 percent in 2010 to 21 percent in 2015.[4] Additional coverage has proven essential to supplementing the chronic underfunding of the IHS. Medicaid in particular is a critical source of coverage for Indians. It is also a key source of financing for IHS as it can bill Medicaid, at an enhanced match, for covered services that it provides to Medicaid-enrolled Indians. Medicaid covers 100 percent of these costs as long as the services are "received through" an IHS or Tribal facility. This special financing rule allows the IHS to collect additional revenue, enhancing its capacity to provide services, retain and hire staff, and stretch its limited PRC dollars further. In fiscal year 2016, the IHS collected $1.2 billion in revenue from other forms of insurance (e.g., Medicaid, Medicare, and Veteran Affairs, etc.), with the largest share — $880 million — coming from Medicaid.[5]

Specifically, we ask the GAO to examine:

1) any changes in health coverage, including the enrollment of Indians in Medicaid, CHIP, or private health insurance available through the marketplaces, since the implementation of the ACA;

2) any changes in third party reimbursements to the IHS by IHS Area and/or facility during that period, including the amount and source of the reimbursement. Tribal facilities, as is their right under the Indian Health Care Improvement Act, should be exempt from reporting these numbers should they choose to; and

3) whether IHS Area Offices have been able to expand PRC services to include those that have been designated as level III (primary and secondary care) services or IV (chronic tertiary care) services since the implementation of the ACA.

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[3] Department of Health and Human Services, "Putting America's Health First: FY 2018 President's Budget for HHS."

[4] *Ibid.* and Census Bureau, "Selected Population Profile in the United States," 2015 American Community Survey, 1-Year Estimates.

[5] Department of Health and Human Services, "Indian Health Service: Fiscal Year 2018 Justification of Estimates for Appropriations Committees."

As part of your report, we encourage you to work closely with Tribes and both regional and national Tribal organizations to fully ascertain the impacts that these benefits have had in Indian Country.

Thank you for your consideration.

Sincerely,

Frank Pallone, Jr.
Ranking Member

Raul Ruiz, M.D.
Member of Congress