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Indian Health Care: Impact of the Affordable Care Act (ACA)

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Summary

On March 23, 2010, President Obama signed into law a comprehensive health care reform bill, the Patient Protection and Affordable Care Act (ACA; P.L. 111-148). The law, among other things, reauthorizes the Indian Health Care Improvement Act (P.L. 94-437, IHCIA), which authorizes many programs and services provided by the Indian Health Service (IHS). In addition, it makes several changes that may affect American Indians and Alaska Natives enrolled in and receiving services from the Medicare, Medicaid, and State Children's Health Insurance Program (CHIP)—also called Social Security Act (SSA) health benefit programs. The ACA also includes changes to private health insurance that may affect American Indians and Alaska Natives and may affect tribes that offer private health insurance.

IHCIA authorizes many IHS programs and services, sets out the national policy for health services administered to Indians, and articulates the federal goal of ensuring the highest possible health status for Indians, including urban Indians. In addition, it authorizes direct collections from Medicare, Medicaid, and other third-party insurers. Prior to the ACA, IHCIA was last reauthorized in FY2000, although programs continued to receive appropriations in later years. The ACA reauthorizes IHCIA and extends authorizations of appropriations for IHCIA programs indefinitely. It amends a number of sections of IHCIA in general, to permit tribal organizations (TOs) and urban Indian organizations (UIOs) to apply for contract and grant programs for which they were not previously eligible; to create new mental health prevention and treatment programs; and to require demonstration projects to construct modular and mobile health facilities in order to expand health services available through IHS, Indian Tribes (ITs), and TOs. It also made several organizational changes to IHS. It requires IHS to establish an Office of Direct Service Tribes to serve tribes that receive their health care and other services directly from IHS as opposed to receiving services through IHS-funded facilities or programs operated by ITs or TOs. In addition, the law requires IHS to develop a plan to establish a new area office to serve tribes in Nevada and requires the Secretary of the Department of Health and Human Services (HHS) to appoint a new IHS Director of HIV/AIDS Prevention and Treatment.

In addition to reauthorizing IHCIA, the ACA includes a number of provisions that may affect American Indians and Alaska Natives who have private insurance coverage or who receive services through SSA health benefit programs. With regard to private insurance coverage, the ACA provides a special enrollment period for American Indians and Alaska Natives who may enroll in private insurance offered through an exchange and exempts certain American Indians and Alaska Natives from the requirement to obtain insurance coverage. Under regulation, additional American Indians and Alaska Natives may also be exempt from the ACA requirement to obtain insurance coverage. With regard to SSA health benefit programs, the new law permits specified Indian entities to determine Medicaid and CHIP eligibility and extends the period during which IHS, IT, and TO services are reimbursed for all Medicare Part B services, indefinitely, beginning January 1, 2010. Prior to the ACA, authority for these facilities to receive Medicare Part B reimbursements for certain specified services had expired on January 1, 2010.

This report, one of a series of CRS products on the ACA, summarizes some of the key changes made in the reauthorization of IHCIA and summarizes other changes included in the ACA that may affect American Indian and Alaska Native health and health care. Another report, CRS Report R41630, *The Indian Health Care Improvement Act Reauthorization and Extension as Enacted by the ACA: Detailed Summary and Timeline*, by Elayne J. Heisler, provides a detailed section-by-section summary of the IHCIA Reauthorization and Extension Act of 2009.

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Introduction

On March 23, 2010, President Obama signed into law a comprehensive health care reform bill, the Patient Protection and Affordable Care Act (ACA),[1] which, among other things, reauthorizes the Indian Health Care Improvement Act (IHCIA[2]).[3] This report, one of a series of CRS products on the ACA, summarizes some of the key changes made in the reauthorization of IHCIA. In addition, the report summarizes other ACA provisions related to American Indians and Alaska Natives enrolled in and receiving services from Medicare, Medicaid, and the State Children's Health Insurance Program (CHIP)—also called SSA health benefit programs.[4] It also discusses ACA changes to private health insurance coverage that may affect American Indians' and Alaska Natives' access to private health insurance coverage. Another report, CRS Report R41630, *The Indian Health Care Improvement Act Reauthorization and Extension as Enacted by the ACA: Detailed Summary and Timeline*, by Elayne J. Heisler, provides a detailed section-by-section summary of the IHCIA Reauthorization and Extension Act of 2009.

The report begins with an overview of the Indian Health Service (IHS) and IHCIA. It then discusses each of the eight titles in IHCIA and how the ACA amends each of these titles. Finally, the report discusses other ACA changes that may affect American Indians and Alaska Natives. For each topic, including each IHCIA title, discussed, the report first gives a brief description for context, and then describes the changes made by the ACA.

This report is primarily for reference purposes. The material in it is intended to provide context to help the reader better understand the intent of ACA's reauthorization of IHCIA at the time of enactment. In general, this report does not track ongoing ACA-related regulatory and other implementation activities.

Overview of Indian Health Care

The Indian Health Service (IHS), an agency within the Department of Health and Human Services (HHS), provides health care for approximately 2.2 million eligible American Indians/Alaska Natives through a system of programs and facilities located on or near Indian

[1] P.L. 111-148, 124 Stat. 119, as amended.

[2] P.L. 94-437, 90 Stat, 1401, as amended.

[3] On June 28, 2011, the Supreme Court ruled, in *National Federation of Independent Business v. Sebelius (NFIB),* on the constitutionality of both the ACA-implemented individual mandate, which requires most U.S. residents (beginning in 2014) to carry health insurance or pay a penalty, and the ACA Medicaid expansion. The Court upheld the individual mandate as a constitutional exercise of Congress's authority to levy taxes. The penalty is to be paid by taxpayers when they file their tax returns and enforced by the Internal Revenue Service. In a separate opinion, the Court found that compelling states to participate in the ACA Medicaid expansion—which the Court determined to be essentially a new program—or risk losing their existing federal Medicaid matching funds was coercive and unconstitutional under the Spending Clause of the Constitution and the Tenth Amendment. The Court's remedy for this constitutional violation was to prohibit HHS from penalizing states that choose not to participate in the expansion by withholding any federal matching funds for their existing Medicaid program. However, if a state accepts the new ACA expansion funds (initially a 100% federal match), it must abide by all the expansion coverage rules. Under NFIB, all other provisions of ACA—including the Indian Health Care Improvement Act—remain fully intact and operative.

[4] Other provisions in the ACA may also affect Indian health. For example, Indian tribes may be eligible for new grant or contract programs that augment the health care workforce or improve public health, they may participate in reforms made to the private insurance market, and they may benefit from Medicare and Medicaid reforms. More information about ACA changes can be found at CRS's website under "Issue in Focus-Affordable Care Act and Health Policy" at http://www.crs.gov/Pages/subissue.aspx?cliid=3746&parentid=13.

reservations, and through contractors in certain urban areas.[5] IHS provides services in 35 states, subdivided into 12 geographic "Areas" that consist of one or more states.[6] Each Area is administered by an Area Office; Areas, in turn, are further subdivided into service units that consist of one or more facilities. IHS may provide services directly, or Indian tribes (ITs) or tribal organizations (TOs) may operate IHS facilities and programs themselves through self-determination contracts and self-governance compacts negotiated with IHS.[7] Although most IHS facilities are located on or near reservations, IHS also funds urban Indian health projects (UIHPs), through grants or contracts to urban Indian organizations (UIOs).

The IHS provides an array of medical services, including inpatient, ambulatory, emergency, dental, public health nursing, and preventive health care.[8] The IHS does not have a defined medical benefit package that excludes or includes specific conditions or types of health care. Besides providing general clinical health services, the IHS also focuses on health conditions prevalent among American Indians and Alaska Natives such as infant mortality, diabetes, and hepatitis B. In addition, IHS provides mental health and alcohol and substance abuse services because, compared to the overall U.S. population, American Indians and Alaska Natives are more likely to die from alcoholism-related diseases or to commit suicide.[9]

In addition to health services, the IHS funds projects related to health care facilities and sanitation. Specifically, the IHS funds the construction, equipping, and maintenance of hospitals, health centers, clinics, and other health care delivery facilities, both those operated by the IHS and those operated by tribes. In order to improve the health of, and reduce the incidence of disease among, American Indians and Alaska Natives, the IHS also funds the construction of water supply and sewage facilities and solid waste disposal systems, and provides technical assistance for the operation and maintenance of such facilities. The IHS has attributed decreases in gastrointestinal disease among American Indians and Alaska Natives to improved sanitation facilities.[10]

Indian Health Care Improvement Act

The Indian Health Care Improvement Act, as passed in 1976 and subsequently amended, authorized many specific IHS activities,[11] set out the national policy for health services administered to Indians, and declared that it was a federal goal to improve the health status and conditions of the IHS service population. IHCIA also authorized direct collections from Medicare, Medicaid, and other third-party insurers for American Indians and Alaska Natives

[5] For more information about the Indian Health Service (IHS), see CRS Report R43330, *The Indian Health Service (IHS): An Overview*, by Elayne J. Heisler.

[6] IHS provides services to American Indians and Alaska Natives residing in 35 states. Area offices may serve tribes in one state, such as the Alaska Area office that administers services in Alaska, or may serve tribes in multiple states, such as the Nashville Area office that administers services for tribes on the east coast, in Alabama, Louisiana, and parts of Texas.

[7] Self-determination contracts and self-governance compacts are authorized by P.L. 93-638, the Indian Self-Determination and Education Assistance Act of January 4, 1975, 88 Stat. 2203, as amended; 25 U.S.C. §450 et seq.

[8] See 42 C.F.R. §136.11, "Services available;" and CRS Report R43330, *The Indian Health Service (IHS): An Overview*, by Elayne J. Heisler.

[9] CRS Report R43330, *The Indian Health Service (IHS): An Overview*, by Elayne J. Heisler.

[10] U.S. Department of Health and Human Services, Indian Health Service, "IHS Fact Sheets: Safe Water and Waste Disposal Facilities," January 2013, http://www.ihs.gov/newsroom/factsheets/safewater/.

[11] In addition to IHCIA, the Snyder Act of 1921 (P.L. 67-85, act of November 2, 1921, 42 Stat. 208, as amended; 25 U.S.C. §13) also authorizes Indian health programs.

receiving services at facilities operated by the IHS, an IT, or a TO. IHCIA gave IHS authority to grant funding to UIOs to provide health care services to urban Indians, and established substance abuse treatment programs, Indian health professions recruitment programs, and many other programs. Prior to the ACA, IHCIA was last fully reauthorized by the Indian Health Amendments of 1992,[12] which extended authorizations of its appropriations through FY2000. In 2000, all IHCIA authorizations of appropriations were extended through FY2001.[13] Prior to reauthorizing IHCIA in the ACA, lawmakers introduced multiple reauthorization bills.[14] Despite the lapse in authorization of appropriations during this period, Congress continued to appropriate funds for IHCIA programs.[15]

IHCIA Reauthorization in the ACA

ACA Title X, "Strengthening Quality, Affordable Health Care for All Americans," in Subtitle B, "Provisions Relating to Title II," Part III, amends and enacts the "Indian Health Care Improvement Reauthorization and Extension Act of 2009 (S. 1790)," as reported by the Senate Committee on Indian Affairs on December 16, 2009.[16] Title II, "Role of Public Programs," Subtitle K, "Protections for American Indians and Alaska Natives," contains provisions related to American Indians and Alaska Natives in SSA health benefit programs and in the private health insurance exchange established by the ACA.[17] In addition, other sections of the ACA include changes related to private insurance that may affect American Indians and Alaska Natives. The ACA reauthorizes IHCIA permanently and indefinitely; it appropriates such sums as may be necessary for FY2010 and each fiscal year thereafter, to remain available until expended. The ACA maintains IHCIA's eight titles but amends and adds a number of sections to each of the titles. **Table 1** summarizes the changes that the ACA makes to IHCIA.

[12] P.L. 102-573, act of October 29, 1992, 106 Stat. 4526.

[13] Omnibus Indian Advancement Act, P.L. 106-568, §815, act of December 27, 2000, 114 Stat. 2868, 2918.

[14] IHCIA reauthorization bills were introduced in the 106th (H.R. 3397 and S. 2526), 107th (S. 212 and H.R. 1662), 108th (S. 556 and H.R. 2440), 109th (H.R. 5312, S. 1057, S. 3524, and S. 4122), 110th (H.R. 1328, S. 1200, and S. 2532); and 111th (H.R. 2708 and S. 1790) Congresses.

[15] For a discussion of the relationship between appropriations and authorizations, see CRS Report RS20371, *Overview of the Authorization-Appropriations Process*, by Bill Heniff Jr.

[16] This is S. 1790 in the 111th Congress.

[17] More information about the private health insurance provisions in the ACA can be found in CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*, by Annie L. Mach and Bernadette Fernandez, and CRS Report R42663, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez and Annie L. Mach. In addition, the ACA contains other changes that may affect American Indians and Alaska Natives, but these are not discussed in this report. For Medicare-related changes, see CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*, coordinated by Patricia A. Davis. For information on Medicaid and Children's Health Insurance Program-related provisions, see CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*, by Evelyne P. Baumrucker et al. For public health, workforce, and quality-related changes, see CRS Report R41278, *Public Health, Workforce, Quality, and Related Provisions in ACA: Summary and Timeline*, coordinated by C. Stephen Redhead and Elayne J. Heisler.

Table 1. IHCIA Reauthorization Summary

IHCIA Title Name and Subject	ACA
Title I-Indian Health Manpower Authorizes workforce programs to increase the supply of providers at IHS facilities	Maintains title's major sections; repeals section authorizing appropriations for the title; expands use of community health aide workers at IHS-funded facilities; adds a new section funding a demonstration to address IHS health professional shortages; and exempts employees at IHS-funded facilities from certain licensing, registration requirements and related fees.
Title II-Health Services Authorizes IHS health services, research, payments for service-related transportation, payment for services provided through contracts with outside providers (i.e., Contract Health Services [CHS])[a]	Maintains title's major sections; repeals section authorizing appropriations for the title; amends authorization for two funds (Indian Health Care Improvement Fund and Catastrophic Health Emergency Fund); expands IHS authority for diabetes, cancer screening, and long-term care programs; and amends sections related to the CHS program.
Title III-Health Facilities Authorizes construction and renovation of IHS facilities; sets procedures by which construction and renovation projects are selected	Maintains title's major sections; repeals section authorizing appropriations for the title; amends IHS construction priority system; and adds new sections requiring grants to build modular and mobile facilities.
Title IV-Access to Health Services Authorizes IHS programs to bill Medicare, Medicaid, and private insurance	Maintains title's major sections; repeals section authorizing appropriations for the title; adds the State Children's Health Insurance Program to programs that IHS is authorized to bill; adds new sections permitting ITs, TOs, and UIOs to purchase federal employee health and life insurance benefits for their employees; expands IHS collaboration with the Department of Veterans Affairs and the Department of Defense.
Title V-Health Services for Urban Indians Authorizes grants to UIOs for health projects to serve urban Indians	Maintains title's major sections; repeals section authorizing appropriations for the title; expands grant opportunities available to UIOs.
Title VI-Organization Improvements Establishes IHS's organizational position within HHS; the position of Director of IHS; and requires an automated management information system for IHS record-keeping	Maintains title's major sections; establishes that the IHS Director should report directly to the HHS Secretary; adds new sections requiring (1) an Office of Direct Service Tribes; and (2) a plan to create a new Nevada Area Office.
Title VII-Behavioral Health Programs Authorizes programs related to behavioral health prevention and treatment	Replaces IHCIA Title VII with new language authorizing new comprehensive behavioral health and treatment programs. Includes a new subsection authorizing programs related to youth suicide prevention.
Title VIII-Miscellaneous Requires the IHS Director to submit a number of reports; establishes IHS eligibility for health services; and defines California Indians, amongst other provisions	Maintains title's major sections; repeals section authorizing appropriations for the title; adds new sections that, among other things, establish (1) a prescription drugs monitoring program; (2) an IHS Director of HIV/AIDS Prevention and Treatment; and (3) new requirements for the IHS budget requests to reflect inflation and changes in the IHS service population.

Source: CRS analysis of P.L. 94-437, as amended (IHCIA), and P.L. 111-148 (ACA).

a. Beginning with the FY2014 budget justification, this program is now referred to as the purchased/referred care program. See U.S. Dept. of Health and Human Services, Indian Health Service, Fiscal Year 2014 Indian Health Service Justification of Estimates, http://www.ihs.gov/BudgetFormulation/documents/FY2014BudgetJustification.pdf.

Definitions[18]

The ACA defines a number of new Indian-related terms. Two of the new terms most frequently used are Indian Health Program and Tribal Health Program. "Indian Health Program" (IHP) is defined as (1) any health program administered by the IHS, (2) any Tribal Health Program, or (3) any Indian tribe or tribal organization to which the Secretary provides funding under the Buy Indian Act.[19] "Tribal Health Program" (THP) is defined as any IT or TO operating any health program, service, function, activity, or facility funded, in whole or part, by the IHS through, or provided for in, a contract or compact with the IHS under the Indian Self-Determination and Education Assistance Act (ISDEAA).[20] In addition, the bill maintains a number of IHCIA-defined terms.

Selected Major Changes to IHCIA in the ACA

Purposes and Findings: Adds a new finding that articulates that it is a major national goal of the United States to provide resources, processes, and structure that will enable ITs and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate health disparities between Indians and the general population.

Appropriations: Consolidates authorizations of appropriations into a single provision, authorizes such sums as may be necessary, and extends authorizations of appropriations indefinitely. In addition, the ACA repeals the separate authorizations of appropriations that had been included at the end of each IHCIA title or had been included in specific IHCIA sections.

Expanded Access to UIOs and TOs: Permits TOs and UIOs to apply for grant and contract programs for which these entities were previously not eligible.

Behavioral Health Programs: Expands mental health services to create a comprehensive behavioral health and treatment program. It includes programs related to youth suicide prevention and increases IT and TO access to grants sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA).[21]

Payor of Last Resort: States that IHS is the payor of last resort for all services provided. Prior to the ACA,[22] IHS was the payor of last resort only for contract health services (CHS)—services that IHS, ITs, or TOs may purchase, through contracts, from private providers in instances where the IHP cannot provide the needed care.[23]

Indians in SSA Programs: Extends Medicare payments to hospitals operated by IHS, ITs, or TOs, and permits Indian entities to determine Medicaid and CHIP eligibility in order to facilitate American Indian and Alaska Native enrollment in Medicaid and CHIP.

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[18] The ACA defines the term "Indian" in three different ways. The three definitions are discussed below in "ACA Private Health Insurance Changes."

[19] 25 U.S.C. §47.

[20] P.L. 93-638 and 25 U.S.C. §§450 et seq.

[21] More information about the Substance Abuse and Mental Health Services Administration (SAMHSA) can be found in CRS Report R43304, *Public Health Service Agencies: Overview and Funding*, coordinated by Amalia K. Corby-Edwards and C. Stephen Redhead.

[22] Prior to the ACA, IHS was the payor of last resort only for contract health services (CHS) (See 42 C.F.R. §136.61). In general, Medicaid is considered the payor of last resort.

[23] Beginning with the FY2014 budget justification, CHS is now referred to as the purchased/referred care program. See U.S. Dept. of Health and Human Services, Indian Health Service, *Fiscal Year 2014 Indian Health Service Justification of Estimates*, http://www.ihs.gov/BudgetFormulation/documents/FY2014BudgetJustification.pdf.

Office of Direct Service Tribes: Requires that IHS establish an Office of Direct Service Tribes to serve tribes that receive their health care and other services directly from IHS rather than through facilities or programs operated by ITs or TOs.

Nevada Area Office: Requires a plan to establish a new area office to serve tribes in Nevada.

Demonstration Projects: Includes two facilities demonstration projects that will award funds for IHS, ITs, or TOs to construct modular and mobile health facilities.

IHCIA Title I: Indian Health, Human Resources, and Development

IHCIA Title I included provisions related to increasing the number of American Indians and Alaska Natives entering the health professions in order to increase the supply of health professionals available to facilities and programs operated by IHS, ITs, and TOs. At the time of the ACA's enactment, the IHS had high vacancy rates in many of its health professions—over 20% for physicians, and over 15% for dentists and nurses, for instance, as of January 2010.[24] IHCIA authorized a number of workforce programs, including, for example, scholarship and loan repayment programs, to encourage health professionals to work at facilities operated by the IHS or ITs; funding for continuing education for IHS employees; funding for advanced training and for recruitment and retention for individuals working at facilities operated by the IHS, an IT, a TO, or a UIO; training for nursing; and programs to encourage American Indians and Alaska Natives to enter medicine. In addition, Title I authorized two innovative health professions programs: the community health representative (CHR) program, which permits the training of American Indians and Alaska Natives to serve as paraprofessionals who provide health care, health promotion, and disease prevention services at IHS facilities; and the community health aide program (CHAP), which provides training for Alaska Natives to serve as health aides or community health practitioners.

The ACA maintains and reauthorizes a number of these health professions programs. It expands the CHAP program to areas outside of Alaska, but excludes CHAP's dental health aide therapist program in Alaska from states outside of Alaska unless an IT or a TO, in a state authorizing such a program, elects to include it. The ACA also includes additional requirements for the Secretary to facilitate the implementation of the CHAP dental health aide program by ITs and TOs and prohibits the Secretary from filling IHS program vacancies for certified dentists with dental health aide therapists.

IHCIA Title II: Health Services

IHCIA Title II authorized a number of specific health programs and activities, including mental health programs, prevention activities, diabetes and tuberculosis programs, Indian women's health, Indian school health education programs, epidemiological centers, and a fund for the elimination of backlogs and deficiencies among Indian health programs (called the Indian Health Care Improvement Fund (IHCIF)), and other programs. The title also included provisions relating

[24] U.S. Department of Health and Human Services, Indian Health Service, "IHS Fact Sheets: Workforce," January 2010, http://www.ihs.gov/PublicAffairs/IHSBrochure/Workforce.asp. For more recent information about IHS workforce vacancies, see CRS Report R43330, *The Indian Health Service (IHS): An Overview*, by Elayne J. Heisler.

to CHS delivery areas in several states.[25] CHS services are limited to American Indians and Alaska Natives living in defined geographic areas called CHS delivery areas.

The ACA reauthorizes the IHCIF as well as the Catastrophic Health Emergency Fund (which provides extra funding to facilities with extraordinary medical costs because of disasters and catastrophic illnesses). It expands the range of health promotion and disease prevention activities required to be provided, and includes new authorizations for hospice care, assisted living, long-term care, and home- and community-based services for disabled elderly persons. Title II also includes sections related to the Indians into Psychology Program, the Indian youth grant program, epidemiology centers, prevention and control of communicable and infectious diseases, requirements for prompt IHS payments to CHS providers, and timely notification to providers that CHS patients are exempt from payment for CHS services.

The ACA also requires the Secretary to maintain any existing or future model diabetes projects, and requires recurring funding for THPs' model diabetes projects.

IHCIA Title III: Facilities

IHCIA Title III includes provisions related to health care and sanitation facilities. IHS funds the construction, equipping, and maintenance of hospitals, health centers, clinics, and other health care delivery facilities for facilities operated by IHS and tribes. IHS also funds the construction of sanitation facilities, including water-supply and sewage facilities and solid waste disposal systems, and provides technical assistance for the operation and maintenance of such facilities. IHCIA required the Secretary to ensure that pay rates on such facility construction or renovation projects, if funded under IHCIA Title III, must not fall below the prevailing local wage rates, as determined in accordance with the Davis-Bacon Act.[26]

The ACA maintains current pay rate requirements; it requires the development of a priority system for construction of Indian health care facilities, with a methodology to be reported to Congress, and with priority lists for the 10 highest-priority facilities in five categories of facilities (inpatient, outpatient, specialized facilities, staff quarters, and facility-related hostels). The priority system also permits new facilities to be nominated at least every three years, but protects the priority of facilities at the top of the current lists for construction. The law also requires consultation with ITs and TOs to develop innovative approaches to solving unmet healthcare facility needs, and includes an "area distribution fund" as an option for such innovation. Under the concept of an area distribution fund, each IHS area would receive at least some health facilities construction funding, which was not the case prior to IHCIA's reauthorization.

The ACA creates a facilities needs assessment workgroup and a facilities appropriations advisory board in IHS. It maintains authorization for construction of sanitation and water-supply facilities, requires reports to Congress on the priority system for such facilities, authorizes the Secretary to accept major renovations or modernizations of Indian health facilities carried out by ITs, and requires grants to ITs and TOs for construction or upgrading of small ambulatory care facilities.

The ACA also includes a new provision that authorizes the Secretary to accept funding from any other source for facilities construction. It explicitly authorizes other federal agencies to transfer

[25] These states are Arizona, California, North Dakota, and South Dakota.

[26] Act of March 3, 1931, chap. 411, 71st Cong., 46 Stat. 1494, as amended; 40 U.S.C., Chap. 31, Subchap. IV. The Davis-Bacon Act requires that employers pay prevailing wage rates, as determined by the Secretary of Labor, on federal construction projects. For more information, see CRS Report R41469, *Davis-Bacon Prevailing Wages and State Revolving Loan Programs Under the Clean Water Act and the Safe Drinking Water Act*, by Gerald Mayer and Jon O. Shimabukuro.

funds, equipment, or supplies to the Secretary for facilities construction and related activities, makes sanitation as well as health care facilities eligible, requires the Secretary to establish health and sanitation facility construction standards by regulation, and specifies that the Secretary's receipt of funds from other sources would not affect priorities established under Section 301 of IHCIA Title III. In addition, the ACA authorizes a new demonstration grant program for modular component health care facilities in Indian communities, and a new demonstration program for mobile health stations for providing specialty health care services.

IHCIA Title IV: Access to Health Services

IHCIA Title IV contained sections related to billing, and enrollment in, the Medicare and Medicaid programs operated by the Centers for Medicare & Medicaid Services (CMS);[27] a section authorizing appropriations; and a section that authorized emergency CHS services. The title's authorization for IHS health care facilities to receive reimbursements from the Medicare and Medicaid program was a major component of the original IHCIA passed in 1976. Prior to the ACA, IHCIA did not mention funds received under the State Children's Health Insurance (CHIP) program because the program was enacted after IHCIA was last reauthorized.[28]

Title IV contained provisions related to billing and receiving reimbursements from the Medicare and Medicaid programs. Specifically, IHCIA (1) authorized a demonstration project that permits ITs or TOs operating under ISDEAA contracts or compacts to directly bill CMS for Medicare and Medicaid payments; (2) required direct billing reimbursements be placed into a "special fund" that must be used first to achieve compliance with Medicare and Medicaid requirements and then, if excess funds exist, to improve health services available to the population the facility serves; (3) specified the auditing and other requirements related to direct billing; and (4) required that the federal government pay 100% of the cost of all Medicaid services billed.[29] In addition, IHCIA required that reimbursements from Medicare or Medicaid may not be considered when determining annual Indian health appropriations, required the Secretary to submit a report accounting for Medicare and Medicaid funds reimbursed to IHS, and required the Secretary to make grants to ITs or TOs to facilitate enrollment in Medicare and Medicaid.

The ACA maintains SSA health benefit reimbursement requirements, but adds reimbursements received from the CHIP program to these requirements. For example, reimbursements received from CHIP are included in the requirement that reimbursements from SSA health benefit programs not be taken into account when determining IHS appropriations. The ACA also expands and makes permanent the prior demonstration project that permitted ITs or TOs operating under ISDEAA contracts or compacts to directly bill CMS for Medicare and Medicaid payments and excludes such direct billing reimbursements from the special fund. The ACA also includes grants for outreach and enrollment into SSA health benefit programs and maintains and expands current authorization to recover reimbursements from third-party entities and to credit such reimbursements to the facility that provided the services. In addition, the ACA authorizes ITs, TOs, and UIOs to use SSA health benefit funds and ISDEAA funds to purchase health care coverage and permits ITs, TOs, and UIOs to purchase Federal Employee Health Benefits and Federal Employee Group Life Insurance coverage for their employees. The ACA requires that

[27] CMS programs are also referred to herein as SSA health benefits programs.

[28] See CRS Report R40444, *State Children's Health Insurance Program (CHIP): A Brief Overview*, by Elicia J. Herz and Evelyne P. Baumrucker.

[29] In general, Medicaid is a shared federal and state program in which the state government pays a share of Medicaid expenses based on a formula where the federal share is inversely proportional to the state's per capita income (i.e., states with lower per capita income receive a greater percentage of Medicaid payments from the federal government).

federal health care programs accept an entity operated by the IHS, an IT, a TO, or a UIO as a provider eligible to receive payments, on the same basis as other qualified providers, if it meets the applicable licensure requirements for its provider type, regardless of whether the facility obtains the applicable license. The ACA also applies this licensing requirement to providers working at Indian entities, and prohibits providers and entities that are excluded from receiving reimbursements from other federal programs from receiving reimbursements from Indian entities.

The ACA expands IHS's relationship with the Department of Veterans Affairs (VA) and the Department of Defense (DOD) by authorizing increased coordination to treat Indian veterans.[30] In addition, the ACA requires the Secretary to conduct a study to determine the feasibility of treating the Navajo Nation as a state for Medicaid purposes, for Indians living within the Navajo Nation's boundaries.[31]

IHCIA Title V: Health Services for Urban Indians

IHCIA Title V directed the HHS Secretary to make contracts with or grants to UIOs for health projects to serve urban Indians, and set requirements for the contracts and grants. Such grants or contracts are under the authority of the Snyder Act,[32] not the ISDEAA. The purpose of Title V programs is to make health services more accessible and available to urban Indians. Urban Indian Health Projects (UIHPs) may serve a wider range of eligible persons than the general IHS health care programs, including not only members of federally recognized tribes but also members of terminated[33] or state-recognized tribes, as well as their children and grandchildren.

Thirty-four UIHPs operate at 41 locations; they offer different programs with some offering different services, such as ambulatory health care, health promotion and education, immunizations, case management, child abuse prevention and treatment, and behavioral health services.[34] Besides IHS grants and contracts, UIHPs receive funding from state and private sources, patient fees,[35] Medicaid, Medicare, and other non-IHS federal programs.[36]

The ACA enables UIOs to expand their urban Indian health programs by permitting UIOs to establish a UIHP in urban centers other than where the UIO is located; prior to the ACA UIOs could only establish UIHPs in the urban area where the UIO was based. In addition, the ACA provides UIOs access to goods and services purchased through federal prime vendors, by deeming UIOs with Title V contracts or grants to be federal executive agencies under the section

[30] A memorandum of understanding between IHS and the VA was signed on October 1, 2010; see http://www.ihs.gov/announcements/documents/3-OD-11-0006.pdf. See also, U.S. Department of Veterans Affairs, "VA and Indian Health Service Announce National Reimbursement Agreement," press release, December 6, 2012.

[31] The Navajo reservation is located in parts of Arizona, Utah, and New Mexico.

[32] The Snyder Act of 1921 (P.L. 67-85, act of November 2, 1921, 42 Stat. 208, as amended; 25 U.S.C. §13) provides general authorization for Indian health programs. The Snyder Act is a permanent, indefinite authorization for federal Indian programs, including for "conservation of health."

[33] "Terminated" tribes are tribes whose federal recognition was withdrawn by statute.

[34] U.S. Department of Health and Human Services, Indian Health Service, *Indian Health Service: Fiscal Year 2012 Justification of Estimates for Appropriations Committees* (Rockville, MD: HHS, 2012), http://www.ihs.gov/NonMedicalPrograms/BudgetFormulation/documents/FY%202012%20Budget%20Justification.pdf

[35] IHS is forbidden to bill or charge Indians (see 25 U.S.C. §1681 and 25 U.S.C. §458aaa-14), but IHCIA, Title V does not prohibit UIHPs from charging their patients.

[36] IHS, Office of Urban Indian Health Programs, *Urban Indian Health Program Statistics, FY2005* (Rockville, MD: October 16, 2007), p. 4.

of the Federal Property and Administrative Services Act of 1974[37] concerning federal sources of supply. It also authorizes the Secretary to donate excess or surplus property to such UIOs and to permit the UIOs to use HHS facilities. The ACA also expands to UIOs the authorization for a number of programs currently only at IHS, IT, or TO facilities. For example, the ACA authorizes UIOs to employ Community Health Representatives (CHRs) trained under the CHR program authorized under current IHCIA Title I, and authorizes the Secretary to establish programs for UIOs that are identical to IHS programs for prevention of communicable diseases, for behavioral health prevention and treatment, and for youth multi-drug abuse prevention and treatment. The ACA also authorizes grants to UIOs for the development and implementation of health information technology, telemedicine, and related infrastructure.

IHCIA Title VI: Organizational Improvements

IHCIA Title VI established IHS as part of the Public Health Service (PHS)[38] within HHS, and is administered by a Director who reports to the HHS Assistant Secretary for Health. IHCIA Title VI also required the Secretary to establish an automated management information system for IHS and IHPs, with a patient privacy component, and requires that patients have access to their own IHS records.

The ACA maintains the placement of IHS in PHS, but directs the head of IHS to report directly to the HHS Secretary. It also maintains requirements regarding the automated management information system. The ACA also adds two new requirements: the Secretary must establish an IHS Office of Direct Service Tribes (for tribes served directly by IHS instead of under ISDEAA), and the Secretary must submit to Congress a plan to create a new Nevada Area Office (Nevada is currently within the Phoenix Area Office).

IHCIA Title VII: Behavioral Health Programs

IHCIA Title VII authorized alcohol and substance abuse programs, including grant and contract programs to provide comprehensive alcohol and substance abuse prevention and treatment services. It required coordination with the Department of the Interior to assess the need for such services and to provide community education in alcohol and substance abuse; requires services to specified groups including women and youth; and authorizes training and community education programs, demonstration projects to establish substance abuse counseling education curricula at tribally operated community colleges, and grants for preventing, treating, and diagnosing fetal alcohol syndrome (FAS) and fetal alcohol effects. In addition, Title VII included authorization for substance abuse treatment projects in specified locations in New Mexico, Arizona, and Alaska.

The ACA replaces current IHCIA Title VII with new language that authorizes programs to create a "comprehensive behavioral health prevention and treatment program" providing a "continuum of behavioral health care." For example, the ACA includes programs related to behavioral health prevention and treatment; provisions related to training and licensure requirements for the behavioral health workforce serving at facilities operated by IHS, ITs, or TOs; specific programs to treat Indian women and youth; and programs to treat and prevent child sexual abuse and fetal alcohol disorder. Many of these programs are similar to those that were authorized in IHCIA Title VII. The ACA also includes a new program to award grants to ITs and TOs to carry out

[37] Section 201(a), P.L. 81-152, act of June 30, 1949, 63 Stat. 377, 383, as amended; 40 U.S.C. §501.

[38] For more information on the Public Health Service, see CRS Report R43304, *Public Health Service Agencies: Overview and Funding*, coordinated by Amalia K. Corby-Edwards and C. Stephen Redhead.

demonstration projects using telehealth technology to provide youth suicide prevention and treatment services and authorizes appropriations of $1.5 million for each of FY2010-FY2013 for the new program. In addition, the ACA includes authorization for programs to prevent and treat domestic and sexual violence, and includes a number of requirements for the Secretary to facilitate ITs' and TOs' applying for, and inclusion in, grants from SAMHSA. It also requires the Secretary to carry out activities to increase the use of pre-doctoral psychology and psychiatry interns in order to increase access to mental health services, and authorizes the Secretary to establish a demonstration program through SAMSHA to test a culturally appropriate life skills curriculum to prevent suicide in American Indian and Alaska Native adolescents. The ACA also authorizes an appropriation of $1 million for each of FY2010-FY2014 for the Secretary to establish a grant program to award grants to ITs, TOs, or other entities to establish life skills curriculums to prevent suicide in schools located in high suicide areas that serve Indian children.

IHCIA Title VIII: Miscellaneous

IHCIA Title VIII included a number of separate provisions covering reports, regulations, an IHCIA implementation plan, abortion, eligibility for IHS services, service unit funding reductions, and a variety of other topics.

The ACA maintains a number of IHCIA requirements including those requiring reports, regulations, an IHCIA implementation plan, and those defining individuals eligible for IHS services. The ACA extends the prior IHCIA limitation on the use of federal funds for abortions to IHS, and applies restrictions contained in other federal laws to IHS appropriations. The ACA also makes IHP and UIO medical quality assurance records confidential, and adds several new required reports. The ACA requires a new report on disease and injury prevention, and two new Government Accountability Office reports: (1) on the coordination of Indian health care services provided through IHS, Medicare, Medicaid, or CHIP, or with tribal, state, or local funds;[39] and (2) on the CHS program, including CHS payments to providers (since CHS providers still experience late payments).[40]

The ACA also requires that IHS budget requests reflect inflation and changes in the IHS service population, and requires the establishment of a prescription drug monitoring program at IHP and UIO facilities. The ACA also permits a tribe operating an IHS health program through an ISDEAA self-governance compact to charge Indians for services; adds language stating that the United States has no liability for injury or death resulting from traditional health care practices; and establishes an IHS Director of HIV/AIDS Prevention and Treatment.

[39] U. S. Government Accountability Office, Indian Health Service: Most American Indians and Alaska Natives Potentially Eligible for Expanded Health Coverage, but Action Needed to Increase Enrollment, 13-533, September 5, 2013, http://www.gao.gov/products/GAO-13-553.

[40] GAO has released four reports on aspects of the CHS program: (1) GAO-11-767, "Indian Health Service: Increased Oversight Needed to Ensure Accuracy of Data Used for Estimating Contract Health Service Need." http://www.gao.gov/new.items/d11767.pdf, September 23, 2011; (2) GAO-12-446, "Indian Health Service: Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Service Program," http://www.gao.gov/assets/600/591631.pdf, June 15, 2012; (3) GAO 13-272, *Indian Health Service: Capping Payments for Nonhospital Services Could Save Millions of Dollars for Contract Health Services*, http://www.gao.gov/products/GAO-13-272, April 11, 2013; and (4) GAO 14-57, "*Indian Health Service: Opportunities May Exist to Improve the Contract Health Service Program,"* http://www.gao.gov/products/GAO-14-57, December 11, 2013.

Native Hawaiian Health Care Reauthorization

The ACA also includes the reauthorization of the Native Hawaiian Health Care Act of 1988,[41] which authorizes health education, health promotion, disease prevention services, and health professions scholarship programs for Native Hawaiians.[42] It extends the act's authorizations of appropriations through FY2019, permits a specified school in Hawaii to offer educational programs to Native Hawaiians first, and amends a definition in the act.[43]

ACA Private Health Insurance Changes

The ACA makes significant changes to private health insurance coverage that may affect certain American Indians and Alaska Natives. The ACA includes a requirement for individuals, with certain exceptions, to obtain health insurance or be subject to a financial penalty (i.e., the individual mandate). It also establishes health insurance exchanges to provide individuals and small employers access to purchase private health insurance plans.[44] With respect to benefits and penalties, these provisions use several different statutory definitions of "Indian"; however, these definitions define the same groups as "Indian" (see text box for definitions and their uses). The following definitions of "Indian" and "Indian Tribe" are used for these ACA sections:

- Section 1311(c)(6)(d) requires a special enrollment period for American Indians and Alaska Natives, as defined in IHCIA, who are seeking to enroll in private health insurance plans offered through the health insurance exchanges. This special enrollment period permits members of federally recognized Indian Tribes to enroll in a qualified health plan monthly and to change their plan monthly.[45] In general, individuals who enroll in a qualified health plan through an exchange may only do so during a defined period and may only change plans annually.[46]
- Section 1501 exempts members of Indian tribes (as defined in the Internal Revenue Code [IRC]) from any penalty associated with a failure to comply with the individual mandate.[47]
- Section 1411(b)(5)(A) requires an "Indian" (not defined) who is seeking an exemption from the individual mandate to provide the Secretary of HHS with certain documentation that demonstrates his or her eligibility for this exemption.
- Section 1402(d) exempts American Indians and Alaska Natives who meet the definition of "Indian" in ISDEAA and whose income is not more than 300% of the

[41] P.L. 100-579, act of October 31, 1988, 102 Stat. 2916, as amended; 42 U.S.C. Chap 122 (§11701 et seq.).

[42] This program receives appropriations through the federal health center program. For more information, see http://bphc.hrsa.gov/about/specialpopulations.htm or CRS Report R42433, *Federal Health Centers*, by Elayne J. Heisler.

[43] For details, see *The Indian Health Care Improvement Act Reauthorization and Extension Act of 2009 as Enacted by PPACA: Detailed Summary and Timeline by Elayne J. Heisler.* CRS Report R43233, *Private Health Plans Under the ACA: In Brief*, by Bernadette Fernandez and Annie L. Mach

[44] CRS Report R43233, *Private Health Plans Under the ACA: In Brief*, by Bernadette Fernandez and Annie L. Mach.

[45] Section 14029(d) in P.L. 111-148; 45 C.F.R. §155.420(d)(8) see CRS Report R41152, *Indian Health Care: Impact of the Affordable Care Act (ACA)*, by Elayne J. Heisler.

[46] Individuals may change plans outside of the general enrollment period if they experience certain qualifying life events (e.g., the birth or adoption of a child or a change in marital status). For more information, 45 C.F.R. §155.420.

[47] CRS Report R41331, *Individual Mandate and Related Information Requirements Under ACA*, by Annie L. Mach.

federal poverty level from cost-sharing requirements if they are enrolled in a private health insurance plan offered through the exchange.

- Section 9021 uses the IRC definition of Indian to exclude the value of Indian tribe health benefits from calculations of gross income for tax purposes.[48]

The Three Definitions of Indian and Indian Tribe in the ACA

Indian Health Care Improvement Act (IHCIA) definition: IHCIA defines "Indian(s)" as "any person who is a member of an Indian tribe. IHCIA defines the term "Indian tribe" to mean "…any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians." **ACA Usage:** All of the IHCIA reauthorization (Title X) and Section 1311, which established a special enrollment period for Indians to enroll in private health insurance plans offered through the exchange.

Indian Self Determination and Education Assistance Act (ISDEAA) definition: ISDEAA defines an "Indian" "as a person who is a member of an Indian tribe." ISDEAA defines "Indian tribes" as "…any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 U.S.C. § §1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians." **ACA Usage:** Exempts Indians from cost sharing if they are enrolled in a plan offered through the private health insurance exchange.

Internal Revenue Code (IRC) definition: The term "Indian tribe" means any Indian tribe, band, nation, pueblo, or other organized group or community, including any Alaska Native village, or regional or village corporation, as defined in, or established pursuant to, the Alaska Native Claims Settlement Act (43 U.S.C. §§1601 et seq.) which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians. **ACA Usage:** Exempts Indians from penalties associated with the failure to comply with the requirement to have health insurance coverage (i.e., the individual mandate) and permits individuals who receive private health insurance through a plan offered by a tribe to exclude the value of private health insurance benefits received from their calculation of gross income for tax purposes.

Source: CRS analysis of P.L. 94-437 as amended; P.L. 93-638 as amended, I.R.C. §45(A)(c)(6), and P.L. 111-148 as amended.

These three definitions include individuals who are eligible for IHS services, but some individuals may be eligible for IHS services but not meet any of the ACA statutory definitions of an "Indian" or a member of an "Indian Tribe." IHS eligibility is indicated by tribal membership (i.e., meeting the IHS definition of Indian), but certain other individuals are also eligible for IHS services because they

- reside within an IHS health service delivery area, defined as a county where purchased/referred care services are available;
- reside on tax-exempt land or have ownership of property on land for which the federal government has a trust responsibility;
- are recognized as an Indian by the community in which they live;

[48] Section 9021 excludes the following health benefits from calculations of gross income: (1) health services or benefits provided or purchased by IHS, an IT, or a TO or through programs of third parties funded by the IHS; (2) medical care services, including those provided, purchased, or reimbursed by an IT or TO or to a member of an IT and the member's spouse or dependents; (3) accident or health plan coverage (or an arrangement having the same effect) provided by an IT or TO for medical care to a member of an IT and the member's spouse or dependents; and (4) any other medical care provided by an IT that supplements, replaces, or substitutes for the programs and services provided by the federal government to IT or tribal members.

- actively participate in tribal affairs; or
- meet other relevant factors in keeping with general Bureau of Indian Affairs (BIA) practices in the jurisdiction for determining eligibility.[49]

A non-Indian woman pregnant with an eligible Indian's child would be eligible for care at an IHS-funded facility during the pregnancy and six weeks following birth, as long as paternity is acknowledged.

Most IHS services are intended for members of federally recognized tribes, but UIOs may also provide services to members of terminated tribes—tribes whose federal recognition was withdrawn by statute—or to tribes that states recognize, but are not recognized by the federal government.[50] Members of terminated or state-recognized tribes are not eligible for services at facilities operated by the IHS, an IT, or a TO.

In a July 1, 2013 rule, HHS addressed the concern that some, but not all, IHS-eligible individuals will be exempt from the requirement to maintain health insurance. The rule provided a hardship exemption for individuals who are eligible for IHS services, but are not members of federally recognized tribes, thereby clarifying that these individuals would not be subject to the individual mandate and associated penalties.[51] American Indians and Alaska Natives who are eligible for an exemption because they meet the ACA definition of "Indian" can claim this exemption through the tax filing process or may apply for an exemption through a health insurance exchange. American Indians seeking a hardship exemption must apply through a health insurance exchange.[52]

SSA Health Benefit Improvements for Indians

The ACA amends the SSA to define a number of Indian terms as they are defined in IHCIA Section 4. These terms include IHS, IT, TOs, UIOs, IHPs, and THPs. These definitions apply for Medicare, Medicaid, and CHIP and general provisions included in SSA Title XI.

The ACA includes amendments to the SSA, although these amendments are not included in the "Indian Health Care Improvement" part of the law. Rather, amendments to the SSA are included in Title II, Subtitle K, "Protections for American Indians and Alaska Natives." This subtitle does the following: (1) it designates facilities operated by IHS, an IT, a TO, or a UIO as the payor of last resort notwithstanding federal or state law to the contrary;[53] (2) it includes IHS, ITs, and TOs as entities that are permitted to determine Medicaid and CHIP eligibility; (3) it prohibits cost sharing for Indians whose incomes are at or below 300% of the federal poverty level and who are enrolled in a qualified health benefit plan in the individual market through the exchange (as

[49] 42 C.F.R. §136.12(a). The Bureau of Indian Affairs (BIA) is an agency within the U.S. Department of the Interior.

[50] 25 U.S.C. §§1 603(f), 1651-1660d.

[51] Center for Medicare & Medicaid Services, "Patient Protection and Affordable Care Act; Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions; Final Rule," 78 *Federal Register* 39494-39529, July 1, 2013.

[52] U.S. Department of Health and Human Services, Indian Health Service, "The Affordable Care Act and the Indian Health Service," http://www.ihs.gov/ACA/. Individuals eligible for a hardship exemption may also be eligible for catastrophic health insurance plans. For more information, see CRS Report R42663, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez and Annie L. Mach.

[53] Prior to the ACA, IHS was the payor of last resort only for contract health services (CHS) (See 42 C.F.R. §136.61). In general, Medicaid is considered the payor of last resort.

established by the ACA),[54] and (4) it extends the period for which IHS, IT, and TO services are reimbursed by Medicare Part B for all services, indefinitely, beginning January 1, 2010. Prior to the ACA, authority for these facilities to receive Medicare Part B reimbursements for certain specified services had expired on January 1, 2010. In addition, the ACA, in Title III, amended the Medicare Part D program to permit costs paid by IHS for prescription drugs for Medicare Part D beneficiaries to count toward the beneficiaries' out-of-pocket threshold for catastrophic protection. In order for a Part D beneficiary to receive catastrophic protection, a certain level of out-of-pocket costs must be incurred; prior to the ACA, expenses incurred by IHS, on behalf of a Part D beneficiary, did not count toward this threshold.[55]

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[54] This applies to private insurance coverage and is also discussed above; see "ACA Private Health Insurance Changes."

[55] See Section 3114 in CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*, coordinated by Patricia A. Davis.