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SENATE

{ REPORT
{ 114-376

A BILL TO AMEND THE INDIAN HEALTH CARE IMPROVEMENT ACT TO ALLOW THE INDIAN HEALTH SERVICE TO COVER THE COST OF A CO-PAYMENT OF AN INDIAN OR ALASKA NATIVE VETERAN RECEIVING MEDICAL CARE OR SERVICES FROM THE DEPARTMENT OF VETERANS AFFAIRS, AND FOR OTHER PURPOSES

NOVEMBER 16, 2016.—Ordered to be printed

Mr. BARRASSO, from the Committee on Indian Affairs,
submitted the following

R E P O R T

[To accompany S. 2417]

The Committee on Indian Affairs, to which was referred the bill (S. 2417) to amend the Indian Health Care Improvement Act to allow the Indian Health Service to cover the cost of a copayment of an Indian or Alaska Native veteran receiving medical care or services from the Department of Veterans Affairs, and for other purposes, having considered the same, reports favorably thereon without amendment and recommends that the bill do pass.

PURPOSE

The purpose of this bill is to amend section 222(a) of the Indian Health Care Improvement Act (IHCA). It would authorize the Indian Health Service (IHS) to cover the cost of copayments for American Indian or Alaska Native (collectively referred to as “Indian”) veterans receiving medical care or services from the Department of Veterans Affairs (VA) upon an authorized referral from the IHS. The bill would require an MOU between the IHS and VA that allows the IHS to use Purchase Referred Care Program funds (PRC) to cover the cost of VA copayments assessed upon Indian veterans who are treated, through a IHS referral, at a VA facility. Under the PRC program, the IHS may reimburse private non-IHS healthcare providers for treating Indian patients using PRC funds (PRC funds).

NEED FOR LEGISLATION

This bill is needed to amend current federal law to clarify that the IHS is authorized to use PRC funding to cover the copayment

cost of an Indian veteran being treated at a VA healthcare facility with an approved referral from an IHS provider.

BACKGROUND

Originally enacted in 1976,¹ the IHCA was permanently authorized as part of the Patient Protection and Affordable Care Act.² The IHCA governs many programs for the provision of health care services and programs for Indians.

The IHS is the primary agency responsible for providing federal health care services to Indians either directly or through contracts or compacts negotiated with Indian tribes. When specific healthcare services are not available through IHS or tribal providers, the IHS may, through the PRC program, provide referrals to Indian patients so that they can be treated by non-IHS healthcare providers.

The IHCA allows for the IHS and VA to enter into agreements for the reimbursement of healthcare services.³ Under federal law, IHS can be reimbursed by the VA for providing services for eligible beneficiaries.⁴ However, according to IHS, under federal law⁵ there is no authority for a provider, including the VA, to impose financial liability on an IHS patient pursuant to an authorized PRC referral.⁶ The prohibition against liability of payment for health services to Indian patients would include a VA copay assessed for Indian veterans that receive care at VA facilities pursuant to an IHS referral. As a result, VA is not able to be reimbursed from PRC funds for the copay assessed upon an Indian veteran who, pursuant to the PRC referral, has received services at a VA facility.

LEGISLATIVE HISTORY

On December 15, 2015, Senator Thune introduced S. 2417 with Senator Rounds as a cosponsor. On May 11, 2016, the Committee held a legislative hearing on the bill in which Roger Trudell, Chairman of the Santee Sioux Tribe and Indian veteran, testified in favor of the bill. The administration did not provide testimony on the bill at the hearing. On June 6, 2016 the Committee met in a duly called business meeting to consider the bill. The Committee then ordered the bill to be reported favorably without amendment to the Senate.

SECTION-BY-SECTION ANALYSIS OF BILL AS ORDERED REPORTED

Section 1—Short title

Section 1 states that the Act may be cited as the “Tribal Veterans Health Care Enhancement Act”.

¹Pub. L. No. 94–437, Sept. 30, 1976, 90 Stat. 1400 (codified at 25 U.S.C. §§ 1601–1683).

²Pub. L. No. 111–148, Mar. 23, 2010, 124 Stat. 119 (codified at 42 U.S.C. § 18001 et seq.).

³25 U.S.C. § 1645(a)(1)

⁴25 U.S.C. § 1645(c)

⁵See 25 U.S.C. § 1623(b) and 25 U.S.C. § 1647(c) as cited in official congressional correspondence with IHS.

⁶25 U.S.C. 1621u

Section 2—Copayments for Indian veterans receiving certain medical services

Section 2(a) amends Section 222(a) of the Indian Health Care Improvement Act (25 U.S.C. 1621u(a)) by authorizing the IHS to pay for copayments assessed to eligible Indian veterans by the Department of Veterans Affairs.

Section 2(b) provides a definition of eligible Indian veterans as a veteran that (1) receives an authorized referral from IHS and (2) has their healthcare services administered at a VA facility.

Section 2(b) amends section 2901(b) of the Patient Protection and Affordable Care Act (25 U.S.C. 1623(b)) to provide authorization for the VA to accept copayments from the IHS.

Section 2(c) requires the IHS and VA to enter into a Memorandum of Understanding (MOU) to provide for the payment of copayments.

Section 2(c) provides that the required MOU can be waived if the IHS and VA certify to Congress that doing so would decrease the quality of care or impede access to medical care for the patients that they serve.

Section 2(c) requires the Director of the IHS and Secretary of the VA to submit, within 45 days of enactment, a report to the Committee on Indian Affairs of the Senate, Committee on Veterans Affairs of the Senate, the Committee on Veterans Affairs of the House of Representatives, and Committee on Natural Resources of the House of Representatives a report that includes:

- the number, by state, of eligible Indian veterans utilizing VA medical facilities;
- the number of referrals, by state, received annually from the Indian Health Service from 2010 to 2015; and
- an update on efforts at the VA and IHS to streamline care for eligible Indian veterans who receive care at both the VA and the IHS including changes required under the Indian Health Care Improvement Act and any barriers to achieve efficiencies.

COST AND BUDGETARY CONSIDERATIONS

The following cost estimate for S. 2417, as provided by the Congressional Budget Office, dated September 12, 2016.

SEPTEMBER 12, 2016.

Hon. JOHN BARRASSO,
Chairman, Committee on Indian Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 2417, the Tribal Veterans Health Care Enhancement Act.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Robert Stewart.

Sincerely,

KEITH HALL.

Enclosure.

S. 2417—Tribal Veterans Health Care Enhancement Act

S. 2417 would allow the Indian Health Service (IHS) to cover the cost of any copayment assessed by the Department of Veterans Affairs (VA) to an eligible Indian veteran who is referred to the VA for treatment. Based on an analysis of information from an IHS report regarding Indian veterans, CBO estimates that there would be, on average, about 5,000 Indian veterans treated annually at IHS facilities over the 2017 to 2021 period. Some of these Indian veterans would be referred to VA health facilities for more complex care that could not be provided at IHS facilities. A small percentage of those referred veterans would make copayments to the VA based on their VA priority group. Using information provided by the VA regarding the collection of copayments from veterans, CBO estimates that S. 2417 would cost less than \$500,000 over the 2017 to 2021 period; such spending would be subject to the availability of appropriated funds. Enacting S. 2417 would not affect direct spending or revenues; therefore, pay-as-you-go procedures do not apply.

CBO estimates that enacting S. 2417 would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2027.

S. 2417 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act and would not affect the budgets of state, local, or tribal governments. American Indian and Alaska Native military veterans would benefit from provisions in the bill that authorize copayments for medical treatment received from the VA.

The CBO staff contact for this estimate is Robert Stewart. The estimate was approved by Holly Harvey, Deputy Assistant Director for Budget Analysis.

EXECUTIVE COMMUNICATIONS

The Committee has received no communications from the Executive Branch regarding S. 2417.

REGULATORY AND PAPERWORK IMPACT STATEMENT

Paragraph 11(b) of rule XXVI of the Standing Rules of the Senate requires each report accompanying a bill to evaluate the regulatory and paperwork impact that would be incurred in carrying out the bill. The Committee believes that S. 2417 will have a minimal impact on regulatory or paperwork requirements.

CHANGES IN EXISTING LAW (CORDON RULE)

In accordance with subsection 12 of rule XXVI of the Standing Rules of the Senate, changes in existing law made by S. 2417, as ordered reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic):

25 U.S.C. § 1621 (Indian Healthcare Improvement Act)**SEC. 222. LIABILITY FOR PAYMENT.**

(a) NO PATIENT LIABILITY.—

[A patient] (1) *IN GENERAL.*—Subject to paragraph (2), a patient who receives contract health care services that are authorized by the Service shall not be liable for the payment of any charges or costs associated with the provision of such services.

(2) *VETERANS AFFAIRS COPAYMENTS.*—The Service may pay, in accordance with section 405(d), the cost of a copayment assessed by the Department of Veterans Affairs to an eligible Indian veteran (as defined in section 405(d)(1)).

25 U.S.C. § 1645 (Indian Healthcare Improvement Act)

SEC. 405. SHARING ARRANGEMENTS WITH FEDERAL AGENCIES.

(a) AUTHORITY.—

(1) *IN GENERAL.*—The Secretary may enter into (or expand) arrangements for the sharing of medical facilities and services between the Service, Indian tribes, and tribal organizations and the Department of Veterans Affairs and the Department of Defense.

(2) *CONSULTATION BY SECRETARY REQUIRED.*—The Secretary may not finalize any arrangement between the Service and a Department described in paragraph (1) without first consulting with the Indian tribes which will be significantly affected by the arrangement.

(b) *LIMITATIONS.*—The Secretary shall not take any action under this section or under subchapter IV of chapter 81 of title 38 which would impair—

(1) the priority access of any Indian to health care services provided through the Service and the eligibility of any Indian to receive health services through the Service;

(2) the quality of health care services provided to any Indian through the Service;

(3) the priority access of any veteran to health care services provided by the Department of Veterans Affairs;

(4) the quality of health care services provided by the Department of Veterans Affairs or the Department of Defense; or

(5) the eligibility of any Indian who is a veteran to receive health services through the Department of Veterans Affairs.

(c) *REIMBURSEMENT.*—The Service, Indian tribe, or tribal organization shall be reimbursed by the Department of Veterans Affairs or the Department of Defense (as the case may be) where services are provided through the Service, an Indian tribe, or a tribal organization to beneficiaries eligible for services from either such Department, notwithstanding any other provision of law.

(d) *PAYMENTS FOR ELIGIBLE INDIAN VETERANS RECEIVING MEDICAL SERVICES AT VA FACILITIES.*—

(1) *DEFINITION OF ELIGIBLE INDIAN VETERAN.*—In this subsection, the term “eligible Indian veteran” means an Indian or Alaska Native veteran who receives any medical care or service that is—

(A) authorized on referral by the Service; and

(B) administered at a facility of the Department of Veterans Affairs.

(2) *PAYMENT BY SERVICE.*—Notwithstanding any other provision of law, the Service may cover the cost of any copayment assessed by the Department of Veterans Affairs to an eligible In-

dian veteran receiving services authorized under the Purchased/Referred Care program.

(3) AUTHORIZATION TO ACCEPT FUNDS.—Notwithstanding section 407(c) of this Act, section 2901(b) of the Patient Protection and Affordable Care Act (25 U.S.C. 1623(b)), or any other provision of law, the Secretary of Veterans Affairs may accept a payment from the Service under paragraph (2).

[(d)](e) CONSTRUCTION.—Nothing in this section may be construed as creating any right of a non-Indian veteran to obtain health services from the Service.