NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
Colville Tribe
Coos, Suislaw & Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshone Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

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SENT VIA EMAIL: Joel.Thomas@state.or.us

March 28, 2011

The Honorable Laurie Monnes Anderson, Chair
The Honorable Jeff Kruse, Vice-Chair
Senate Health Care, Human Services and Rural Health Policy Committee
900 Court St. NE, Room 453
Salem, OR 97301

Dear Senators Monnes Anderson and Kruse:

We are writing to provide you and members of the committee with our testimony on S.B. 99, Oregon Health Insurance Exchange, a bill to establish an insurance exchange under the Patient Protection and Affordable Care Act (ACA), Pub. Law 110-148.

The Northwest Portland Area Indian Health Board (NPAIHB) is a Public Law 93-638 Tribal organization that represents all nine federally-recognized Tribes in Oregon on health care issues.[1] Our testimony is filed on behalf of our nine member Tribes and the 109,000 American Indian and Alaska Native (AI/AN) people in the State of Oregon. Our comments have been reviewed by our member Tribes and were adopted from our submission to the Office of Consumer Information and Insurance Oversight request for comments on "Planning and Establishment of State-Level Exchanges and Related Provisions in Title I of the Patient Protection and Affordable Care Act."[2]

The purpose of our comments is to make the Committee and the Oregon Health Authority aware of Tribal issues, concerns and opportunities in setting up the insurance exchange and to improve AI/AN participation in programs and services that will be offered through the insurance exchange and when implementing other important aspects of the ACA.

If you should have any questions concerning our testimony, please feel free to contact Jim Roberts, Policy Analyst, at jroberts@npaihb.org or (503) 416-3276. You may also contact me directly at (503) 416-3277.

Respectfully,

Joe Finkbonner, RPH, MHA
Executive Director

[1] A "tribal organization" is recognized under the Indian Self-Determination Education Assistance Act (P.L. 93-638; 25 U.S.C. § 450b(1)) as follows: "[T]he recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities."

[2] Please see File Code OCIIO-9989-NC available at www.regululations.gov.

Testimony of the Northwest Portland Area Indian Health Board

Submitted to the:

Health Care, Human Services and Rural Health Policy
Subcommittee on Health Care Reform

Worksession
March 28, 2011
5:00 P.M.
Room: HR A

I. Background

The Indian health system within the State of Oregon is a unique and complex system comprised of ten ambulatory care clinics and one urban program that is governed by unique laws, regulations and policies. These programs serve some of the poorest and most isolated populations in the state. Due to the severe and chronic underfunding of Indian Health Service (IHS), American Indian and Alaska Native (AI/AN) have extremely poor access to health care services and suffer some of the highest rates of health disparities when compared to other population groups.

Before commenting specifically on S.B. 99 bill provisions, we want to make three essential points:

1. Tribes know the way their communities work and how to access potentially eligible members for exchange programs and services;
2. Tribal consultation must be proactive and ongoing, not after the fact;
3. Resources are required, at the Tribal level, to conduct education, outreach, enrollment, and systems modifications.

Furthermore, the complexity of implementing exchange policies that actually improve access for AI/ANs goes beyond Tribes as health care providers and purchasers. Tribes are governments, small and large employers as well as beneficiary advocates. In all of these roles, Tribes want to be sure that insurance exchange policies acknowledge the essential role they play in effective ACA implementation.

II. FEDERAL TRUST RESPONSIBILITY AND TRIBAL CONSULTATION

The provision of health services to AI/AN people stems from a unique trust relationship between the United States and Indian Tribes. The Federal government's trust responsibility provides the legal justification and moral foundation for Indian specific health policymaking – with the objectives of enhancing their access to health care and overcoming the chronic health status disparities of this segment of the American population. It's important to underscore that when Congress passed, and the President signed, the Affordable Care Act, Indian specific provisions were included to promote health reform goals for AI/AN people.

In recognition of this special relationship with tribal governments, the Administration has recognized the importance of Tribal consultation by reaffirming Executive Order 13175 to ensure regular and meaningful consultation and collaboration with tribal officials in Federal policy decisions that have tribal implications.[3] In 1975, Oregon established the Legislative Commission on Indian Services (CIS) to improve services to Indian people by improving communication and coordination with Tribes. Following establishment of the Commission, the legislature overwhelmingly supported passage of SB 770, a bill that acknowledges and promotes government-to-government relations with Oregon Tribes. This establishes a foundation that the State and the legislature should consult with Oregon Tribes in developing policies and implementing programs that will affect their interests.

The Centers for Consumer Information and Insurance Oversight (CCIIO) have announced grants to establish State-operated health insurance exchanges. Throughout the solicitation for the planning grants "stakeholder" and "Tribal" consultation requirements are recommended. Specifically, states are required to comply with Presidential Executive Order 13175 and required to establish a process for consultation with Tribes regarding the start-up and ongoing operation of the exchanges. The solicitation also requires implementing a process to assurance that States will continue to conduct and document such Tribal consultations for exchange planning. The grant solicitation instructs that States have the option to budget and subcontract with Tribes or Tribal organizations for these activities.

RECOMMENDATIONS:

NPAIHB recommends that legislature and state recognize the importance of Tribal consultation when developing the insurance exchange and that a process is established to take into consideration the needs and concerns of Tribes in setting up the exchange. Only through this direct dialogue and relationship building can we move forward, especially with complex problems.

III. DEFINITION OF "INDIAN"

The Affordable Care Act (ACA) contains a number of Indian-specific provisions around cost-sharing protections and mandatory enrollment exemptions that apply specifically to AI/ANs. The Act generally extends eligibility for these provisions to "Indians" without any other definition or qualification in most instances. This can create the potential for confusion and inefficiency in the implementation of the ACA and possibility that AI/ANs will not receive intended benefits and special protections included for them in the law.

On July 1, 2010, the Centers for Medicare & Medicaid Services (CMS) published a final rule that adopts a definition of "Indian" in its implementation of the cost sharing protections made available under Sec. 5006 of the American Recovery and Reinvestment Act (ARRA).[4] The CMS regulation defines "Indian" consistent with the Indian Health Service (IHS) regulations on eligibility for services. This definition should be adopted uniformly in implementation of the ACA for both exchange plans and the Medicaid

[3] "Memorandum for the Heads of Executive Departments and Agencies, and Independent Regulatory Agencies", Whitehouse Memorandum, M-10-33, July 30, 2010.

[4] Codified at 42 U.S.C. § 1396o(j).

expansion. Adopting this interpretation will align eligibility policies of various federal health programs with Medicaid and avoid bureaucratic confusion that will only cost money to address when implementing the new law.

RECOMMENDATION: To the extent that States will have the opportunity to establish definition criteria for AI/AN people, we recommend that the State adopt the definition of "Indian" adopted by CMS to implement ARRA Section 5006(a)(2). Federal Register, Vol. 75, No. 103, May 26, 2010.

IV. STATE EXCHANGE OPERATIONS

Insurance exchanges are the centerpiece of health reform brought by the Affordable Care Act. If operated as planned, exchanges will create a single marketplace through which individuals and businesses can purchase health insurance from competing health plans, which can improve the quality of health care and reduce costs. In order for these outcomes to be realized by AI/AN people, the State and legislature must ensure that the special Indian provisions and protections are implemented in an effective manner and addressed by the State in establishing insurance exchanges.

Sec. 1402(d) Special Rules for Indians

Congress passed these provisions to provide incentives for un-insured Indians to obtain insurance through the Exchange, and for Indian health programs to encourage their patients to enroll. Indian health programs serving such patients will be able to bill the Exchange plan and thereby generate additional revenue. To the extent any tribe, tribal organization or urban Indian organization wishes to purchase coverage for an Indian beneficiary (perhaps at a subsidized premium), Sec. 402 of the IHCIA now allows funds provided under any law to be used to purchase health benefits coverage. These provisions include:

- Indians at or below 300% of FPL are expressly eligible to purchase coverage from an Exchange and are protected from any cost-sharing under such plan.
- No cost-sharing may be assessed for any service provided to an Indian enrolled in an Exchange plan by an IHS, tribal or urban Indian program, or through referral to a contract health services provider.
- Indians would be allowed to enroll in an Exchange plan on a monthly basis.

As the Legislature moves forward to develop its insurance exchange bill, it must take into consideration the special circumstances of AI/ANs served by the Indian health system. This recognition must acknowledge the special duty under the federal trust relationship, the significant health disparities that affect AI/ANs, and recognized the chronic and severe underfunding of the Indian health system.

Exchanges and the role of Navigators

The health reform bill requires state exchanges to award grants to Navigators that educate the public about qualified health plans, distribute information on enrollment and tax credits, facilitate enrollment, and provide referrals on grievances, complaints, or questions. The concept of Navigators is promising; however we are concerned about how Tribes, Tribal enterprises, Indian health programs and individual AI/AN people will have access to the programs and information they need. The size and sophistication of Indian health programs is diverse. While large Tribes may have the volume to provide all of the duties of a Navigator, others do not.

We have found that the best way to guarantee this access is to be sure Tribes themselves are able to directly provide the services they have the capacity to deliver. Tribes know their members, where to locate them and how to convey information in a culturally competent way. Tribal governments are trusted by their members while individuals from outside agencies often are not. Explaining the benefits of enrolling in exchange programs to AI/AN people will require communication channels and skills that may be unique to each Tribe. Assistance with the actual enrollment itself is a skill that many Tribes have developed on site, often through health programs.

RECOMMENDATION: We ask that the Legislature and State explicitly include directives to Navigator programs and their contractors to provide resources directly to Tribes so they can conduct Navigator tasks within their own communities.

Medicaid and the Exchange

As Oregon moves forward and innovations proliferate, we ask that the State remain explicit about the special Indian protections under Medicaid. There is speculation, and now some real examples, that insurance exchange can make coverage options look more seamless to consumers. While this is a laudable goal, we believe that it is essential for States to continue to respect these important provisions which have been enacted in order to promote access to Medicaid coverage for AI/ANs and adequate reimbursement to Indian health programs. Examples of these Medicaid protections include exemption from cost sharing and mandatory Managed Care enrollment, payments to Indian health programs, income and estate recovery protections.

Key issues for IHS and Tribal health programs include: how can IHS and Tribal governments integrate and interface with exchange systems to ensure that AI/AN beneficiaries are enrolled in the appropriate programs; how will IT funding and/or technical assistance be made available to assist Medicaid/CHIP agencies; and how to align the special rules and cost-sharing and income exemptions so that AI/AN get enrolled into programs without any adverse effects. States will continue to have significant leeway in how they operate their Medicaid and CHIP programs. It is critical to ensure that States maintain the special Medicaid protections and consultation requirements when integrating Medicaid into exchange programs and operations.

RECOMMENDATION: We request that the Legislature and State be explicit with Tribes when coordinating Medicaid funding, eligibility and delivery systems with exchange plans to assure that

adequate and effective Tribal consultation can occur and that any Indian specific protections for either Medicaid or Exchanges are well understood.

Tribes Paying Premiums on behalf of Tribal Members

Special exchange rules for AI/ANs will make participation in health insurance coverage much more accessible. The exemption from cost sharing and special monthly enrollment periods will help AI/AN both on and off-reservations achieve portability of coverage. However, the most significant obstacle to accessing this benefit is the premium. While all AI/ANs are exempt from penalties for failing to acquire health coverage, and many AI/ANs whose household income is below 300 percent of poverty will be entitled to premium free coverage under a health exchange plan, others above 300 percent of poverty may still benefit from the coverage opportunities available through the exchanges**.** [5]

Many benefits accrue to Tribes and Indian health programs when tribal members are covered by some form of third-party coverage. These benefits are significant enough in some cases to cause Tribes and Indian health programs to consider paying premiums on behalf of beneficiaries either with Tribal funds or under the authority of Sec. 402 of the IHCIA, as amended.[6] These benefits include increased Tribal health program revenues from third party payers, decreased Contract Health Service expenditures as Tribal members have alternative resources, reduced reliance on the contract health emergency fund, to reimburse for extraordinary costs, and the opportunity to provide to their members more access to health care than the funds appropriated to IHS can support.

Some Tribes already pay health insurance premiums on behalf of members. These premium payment programs include Medicare Part B and Part D. Typically, such premium support either requires retroactively reimbursing the member for the premiums or arranging to send and account for numerous small checks. Neither is a satisfactory method creating additional, unnecessary costs that are better invested in health care. Explicitly permitting Tribes to "group pay" exchange plans on behalf of eligible members is an essential policy to improve AI/ANs enrollment in health insurance.

Unfortunately, there is no clear mechanism specified under the ACA that will enable a Tribe to directly pay a high risk pool or exchange plan premium on behalf of an eligible member or to supplement premium tax credits to which the individual AI/AN may be eligible. We strongly recommend that specific mechanisms be established.

RECOMMENDATIONS: NPAIHB recommends that the Legislature and State establish an option for direct payment of premiums by Tribes and Indian health programs. Because premium payment is such a significant barrier to Indian enrollment in exchange plans or high risk pools, the State could establish an administratively simple mechanism which allows Tribes and Indian health programs to group-pay

[5] ACA Sec. 1501(b) and 111(b(5)(A) and Sec. 1402(d)(1)(A).

[6] *See*, Sec. 152 of S. 1790. We should note that we are not ignoring the possibility that some AI/ANs will opt to pay premiums personally if there is no other source of funding. However, many, if not most, AI/ANs believe, correctly, in fact, that the United States has a duty to provide health care to them at no cost. As Senator Inouye commented in 1999, American Indians and Alaska Natives have the first pre-paid health plan in this country – paid for with the cession of millions of acres of land and abundant resources.

premiums on behalf of individual beneficiaries. Such group payment mechanisms are now used for enrolling individual beneficiaries in Medicare Part D plans.

Inclusions of Indian Health Plans in the Exchange

Drawing from years of experience, we would be interested in discussing the many, many barriers Indian health programs have faced in contracting with Medicaid Managed Care plans. As a result, numerous legislative provisions, regulations and policies have been developed to ensure that AI/AN people are able to access Indian health care providers and that these providers are reimbursed for the care they deliver.

Similarly, increasing the availability of exchange health insurance plans on Indian reservations will provide the opportunity for high quality services that will improve access to health care and promote quality of care in Tribal communities. This will be the case for the American population at large and should also be the case for AI/ANs living on Indian reservations. This goal can be promoted if Indian-sponsored health plans are encouraged and if regulations are tailored to permit them to be offered in the insurance exchange.

We believe that the inclusion of Indian sponsored plans holds great promise for several reasons. First, the plan could tailor benefits in a way that would have the greatest impact on the health disparities facing Indian communities. Second, an AI/AN plan could develop provider networks that are most culturally and linguistically responsive to a Tribal population. Finally, an Indian-sponsored plan could develop administrative structures that would streamline enrollment, provider payment, and implementation of Indian specific policies.

RECOMMENDATION: NPAIHB recommends that the Legislature and State permit Indian-sponsored plans to be offered through the exchange. We are unaware of any health plans currently offering coverage, although numerous Tribes self-insure employees and members. These plans may require specific regulations that address the unique status of Tribes as governments, distinctive benefit structures for AI/ANs and compatibility with Indian health care programs. It would be uncertain whether such a plan would be developed prior to 2014, however without permissive regulations, Indian plans could be squeezed out by State imposed commercial requirements.

V. Conclusion and Recommendations

In closing, it is important to understand that the Indian health systems comprised of the federal IHS, Tribal, and Urban Indian health programs is very complex. It is governed by unique laws and regulations intended to serve AI/AN people that are some of the poorest and most isolated populations, and suffer the worst health disparities in the United States.

Finally, Congress and the Administration has acknowledged these facts and the federal duty to provide health care to AI/AN people by passing special legislation and provisions that protect and enhance Indian participation in federal health care programs. These actions provide the legal justification and moral foundation for health policy making specific to American Indians and Alaska Native people.