NPAIHB POLICY BRIEF

Health Reform and Indian Country

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Health Care Reform and the Indian Health System

Jim Roberts, NPAIHB Policy Analyst

Portland, OR— Five Congressional committees are involved in developing health reform options to address rising health care costs, quality of care issues, and the growing number of uninsured and under-insured in this country. They include the Senate Committees on Finance and Health, Education, Labor, and Pensions (HELP); and the House Committees on Energy and Commerce, Ways and Means, and Education and Labor. Achieving comprehensive health reform is a high priority for President Obama and the Congress. In response to the movement to reform the country's health care system, the Board in partnership with Affiliated Tribes of Northwest Indians convened the "Northwest Roundtable on Health Care Reform Policy Options for the Indian Health System" on June 2-3, 2009 in Portland, Oregon.

The roundtable served as a forum for Northwest Tribes to develop policy recommendations on a series of papers released by the Finance Committee, which provided a broad framework of options for health reform. At the time, the Finance Committee papers were the only details available from any of the Congressional committees outlining health reform options. The Board's recommendations have since served as the basis for developing recommendations provided to Congress by the National Indian Health Board (NIHB), the National Congress of American Indians (NCAI), and the National Council on Urban Indian Health. As Tribal health reform issues have come up, Northwest Tribes have been at the center of the health reform debate.

Since the Northwest roundtable, health reform packages have been released by the Finance and HELP committees. The House has issued a discussion draft bill and is currently working on finalizing the comprehensive bill (called the "House Tri-Committee Health Reform" bill) that was scheduled to be released Friday, July 10th, however was postponed due to concerns from conservative Democrats and Republican members who are threatening to withhold their support due to the high costs of the bill and until other concerns are addressed. Some of the concerns include the need for more cost containment measures, protections for small businesses and a focus on rural health care.

Health Reform Proposals

The underlying premise for all health reform policy options is a "shared responsibility" for individuals, employers, and the federal government to provide for varying aspects of health insurance coverage. The overall approach by the various committees to expand access and health care coverage to the country's uninsured and under-insured are very similar with different requirements. The Finance Committee legislation is not available yet, although details of the proposal indicate that it would provide a range of options to achieve health reform goals. The Finance package would require all individuals to have health insurance. It would create a health Insurance Exchange for individuals and businesses to purchase health insurance coverage. Insurance subsidies would be available to individuals and families with incomes between 100 – 400% of the federal poverty level. The Finance options would expand Medicaid and CHIP and offer a

temporary Medicare buy-in for the pre-Medicare population. Finally, new regulations would reform the non-group and small group insurance markets.

The HELP Committee legislation is available and the title of the bill is the Affordable Health Choices Act. Like the Finance Committee, the HELP bill would require all individuals to have health insurance. It would establish state operated health insurance exchanges (called "gateways") through which individuals and small businesses could purchase health coverage. The gateways would set certain minimum requirements regarding the availability, pricing, and actuarial value of insurance policies and provide federal subsidies to substantially reduce the cost of coverage for eligible enrollees. The subsidies would be available to individuals and families with incomes up to 400% of the federal poverty level. Like the Finance Committee, the HELP bill also includes new regulations on the individual and small group insurance markets and expands Medicaid to all individuals with incomes up to 150% of the poverty level. The HELP proposal also includes provisions to establish a reinsurance program for early retirees and improve access to and availability of community assisted living (long-term care and home and community based services).

The House Tri-Committee health reform discussion bill would also all require individuals to have health insurance. The House bill creates a Health Insurance Exchange similar to the Senate proposals that allow individuals and employers to purchase health insurance coverage. The House proposal also creates a public health insurance option as a qualified health benefit plan to be offered through the insurance exchange. Many involved in the health reform debate feel that the public plan is a necessary component of health reform. The public plan will include a basic, enhanced, and premium level of services for enrollees that have a defined set of benefits. Many feel that this will provide incentive for the private insurance markets to lower administrative costs, allow health purchasers to negotiate lower prices for health care and drugs, and lower overall costs and premiums for insurance. The Tri-Committee bill will offer premium and cost-sharing credits available to individuals and families with incomes up to 400% of the federal poverty level. The bill will require employers to provide coverage to employees or pay into a Health Insurance Exchange Trust Fund, with exceptions for certain small employers, and provide certain small employers a credit to offset the costs of providing coverage and impose new regulations on plans participating in the exchange and in the small group insurance market. The House plan would also expand Medicaid to 133% of the poverty level.

Tribal Recommendations

All of the congressional proposals will have an impact on the Indian health care system. The requirements and penalties concerning reform proposals like the individual mandate, employer requirements, expansion of public programs, premium subsidies for individuals, families, and employers, and the tax changes related to health insurance will have a profound impact on Indian people and the system for which they rely on health care.

The HELP Committee's Affordable Choices Act exempts Indians from financial penalties if they do not prove they have health insurance but does not do much else to protect individuals and the IHS system from reform changes. The House Tri-Caucus bill has very few Indian provisions other than a requirement for the Health Choices Commissioner, who will oversee the health insurance exchange, to consult with Indian Tribes and tribal organizations; allowing costs paid by the IHS to count toward the annual out-of-pocket threshold in the Medicare Part D program; and allowing IHS and Tribal programs to be eligible for funding to conduct home health visits. The details of the Finance Committee package are not available, but discussions with committee staff indicate that some protections for the Indian health system will be included, such as exemptions from the individual mandate, tax penalties for Tribes providing care to Indian people, and Indians being eligible for subsidies who do not receive care from the Indian health system. These details are still preliminary and the final bill language could change these requirements.

The recommendations developed at the joint ATNI-NPAIHB health reform roundtable are summarized below. These recommendations have been provided to all five congressional committees and staff working on health reform legislation. The format of the original recommendations has been changed for the purposes of this article, and the full roundtable recommendations report can be accessed at www.npaihb.org:

1. Include Tribes on key commissions and boards created by health reform legislation and direct HHS Secretary to consult with Tribes on a government-to- government basis on any health reform policies and regulations so they are developed in a way that will create positive changes in the diverse Indian communities.

2. Confer with representatives of urban Indian organizations to determine the impact of reform proposals on the Indian people served by those programs.

3. Indian tribes perform several roles in a health care context: They are governments, employers, health care providers, patient advocates, and beneficiaries of the U.S. trust responsibility for health. All of these roles must be respected, together with the recognition that Indian people are a unique and distinct political group, not merely a minority classification.

4. Exempt AI/AN from mandates and penalties. AI/ANs have already paid for their health care coverage. Failure to acknowledge that Indian people are different from other groups needing health care coverage will result in an abrogation of the federal trust responsibility or denial of their right to fully participate in health reform. It is not appropriate to subject AI/ANs to the individual mandate, especially the penalty for failing to acquire or purchase health insurance.

5. Tribal government exemption from employer penalties. The employer mandate provisions must also exempt Indian tribes, as employers, from penalties. Indian tribes are sovereign nations and should not be subject to federal penalties in their roles as employers.

6. AI/ANs should be eligible for insurance subsidies. Permit AI/AN to participate in subsidized insurance and explicitly permit tribes to pay premiums and cost sharing on their behalf.

7. Portability of health care is essential. In order to guarantee portability between health insurance and the Indian health system, include explicit language which allows AI/ANs to enroll in an insurance plan at any time without assessment of late enrollment penalties or other negative consequences. Without this protection Indian people may be denied options to which they are entitled as United States citizens. Indians should not be forced to choose between the Indian health system and other options; both should be available to them.

8. Indian tribes must retain the authority to decide whether or not to serve non-Indians at their health facilities and extend the Federal Tort Claims Act coverage now provided to ISDEAA contractors to include coverage for services to non-Indians.

9. Health care reform should require Tribal collaboration across all HHS agencies and other federal health programs to coordinate health care resources in order to ensure health related funding is more effectively available to tribes.

10. The IHS budget must be protected from offsets and must be enhanced to assure that Indian programs can attract and retain health care personnel needed to fulfill the Federal government's trust obligation to "permit the health status of Indians to be raised to the highest possible level".

11. Health reform should provide opportunities and incentives to facilitate opportunities for IHS and tribes to develop cost-effective cooperative arrangements for sharing of facilities and staff with local non-Indian communities.

12. Health care reform in Indian Country it will create a short term financial burden on the already seriously under-funded Indian health system and financing must be provided to assist in policy analysis and rule making and at the tribal level staff to build the local systems that are needed to effectively educate, enroll and coordinate patient participation in a reformed system.

13. If the IHS is provided additional resources consistent with what would be provided in a publicly-funded health plan or other programs under health reform, the IHS shall distribute funds equitably to tribal and urban health programs under the terms and conditions of Indian Self-Determination and Education Assistance Act (ISDEAA) and the Indian Health Care Improvement Act (IHICA) on the same allocation basis IHS makes funds available to directly operated service units.

Tribes Must Weigh-in Fast

NIHB and NCAI, in collaboration with Area Health Boards, have been working diligently to track health reform legislation. The Board's recommendations have been instrumental to assist Indian Country to prepare responses to the hill. Because congressional proposals do not adequately address health reform objectives for Indian County, NIHB and NCAI (along with other health advocates) have sent to the hill technical and substantive amendments, as well as recommendations from the Indian Health Care Improvement Act that should be included in the health reform legislation.

The House is scheduled to adjourn for a summer recess by July 31 and the Senate by Aug. 7, though there have been suggestions the Senate deadline could slip to allow floor time for the health care overhaul. The aggressive time line to complete the health reform bills leaves Tribes little time to weigh in with Congressional members and it is imperative that they do so in order to protect AI/AN participation in health reform options and protect the vital role that the Indian health system plays in providing care. Tribes need to send forward their support for the NIHB and NCAI amendments (described below), which were provided to Congress on July 2nd. It is expected that the HELP committee will resume its mark-up sometime next week, while the House leadership and staff will hash out their concerns next week in order to begin mark-up very soon.

The substantive amendments include adding a definitions section to the bills to include Indian health programs as providers; requiring that health plans offered through the insurance exchange guarantee access to Indian health providers and prohibit discrimination in accessing health care for Indian beneficiaries; assure that components of the Indian health delivery system can participate in provider networks established by an entity which offers health benefits through a insurance exchange; exempt IHS and Tribal health facilities from state licensing requirements when participating in the public plan option; exempt Indian tribes as employers as well as sovereign governments from penalties, taxes, or contribution requirements imposed by its trustee and the Federal Government when a tribe acts in its role as an employer; exempt Indians from the tax assessed against an individual who does not meet the acceptable coverage requirement; waiver of the Medicare Part B late enrollment penalty, and; provisions that improve communication and promote access to health reform programs.

Substantive amendments for Medicare and Medicaid include making permanent the billing authority for all Medicare Part B services (set to expire on December 31, 2009); and a provision that clarifies that the value of "health services," "health benefits" or "health coverage" received by Indians, whether provided or purchased

by the IHS or an Indian tribe or tribal organization is excluded from gross income when determining eligibility for subsidies or other benefits. This last provision is very important to protect Indian people from tax penalties and preserve their ability to qualify for subsidies that might be offered under health reform.

The Board will continue to weigh in with Congress on health reform proposals and continue to update Northwest Tribes. The full details of the Tribal amendments described above as well as additional details on health reform are available at: www.npaihb.org.

With the problem of the uninsured continuing to grow, states have taken the lead in developing proposals to reform their health care systems with the goal of significantly increasing the number of people with health care coverage. Three states, Maine, Massachusetts and Vermont, have enacted and are implementing reform plans that seek to achieve near universal coverage of state residents. Many other governors and legislators have announced comprehensive reform proposals or have established commissions charged with developing recommendations on how to expand coverage. As of July 2009, 3 states had enacted and 14 states were moving toward comprehensive reform.

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