

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
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Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
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Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinalt Tribe
Samish Indian Nation
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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

2121 SW Broadway Drive
Suite 300
Portland, OR 97201
(503) 228-4185
(503) 228-8182 FAX
www.NPAIHB.org

SENT VIA TELEFAX: (202)401-3702

September 8, 2010

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Sebelius:

The Northwest Portland Area Indian Health Board (NPAIHB) is a P.L. 93-638 Tribal organization that represents health care issues of forty-three federally recognized Tribes in Idaho, Oregon, and Washington. On behalf of our Tribes, I am writing to express concerns over implementation of the Affordable Care Act (ACA) and the Indian Health Care Improvement Act (IHCIA). Northwest Tribes worked to develop many of the Indian specific provisions in the ACA, supported its passage, and were pleased that the Indian specific provisions acknowledged the importance of ensuring that American Indians and Alaska Natives could benefit from the health reform law. We were also hopeful that the Administration would recognize the vital role Tribes must play throughout the implementation process.

Many of the implementation issues are complex and involve the interaction of numerous federal agencies. For example, Section 154 requires the Department of Defense (DOD) and Department of Veterans Affairs (VA) to reimburse Indian Health Service a Tribe or Tribal organization for services provided to DOD or VA beneficiaries. Implementing this provision successfully will require a coordinated effort among all of the federal agencies as well as the Centers for Medicare and Medicaid services (CMS). This is just one example of the complex legal and policy negotiations that must take place to implement the law.

Our immediate concern is that IHS should not have unilateral authority to interpret specific provisions in the law or to drive key policy discussions and decisions that will have a direct impact on Tribal governments, their health programs, and the members they serve.

While IHS plays a vital role within the federal agencies' internal discussions, their role is limited to the very specific authorities they are granted and further bound by the constraints of their current system and personnel. We are and always will be strong partners with IHS within the context of their mission; however, both ACA and IHCIA go far beyond the current policy and regulatory capacity of IHS expertise. In those areas, IHS should not be tasked, alone, with representing Tribal interests. In fact, there have been times when IHS has been unable to appreciate the importance of Tribal innovations to provide more appropriate and effective health services to their American Indian and Alaska Native beneficiaries. In order for ACA and IHCIA to have a positive impact in Tribal communities, the Administration must involve Tribes in implementation discussions immediately.

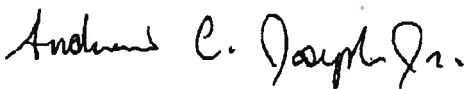
For example, IHCA Section 409 allows a Tribe or Tribal organization to purchase health and life insurance for their employees through programs established for federal employees. IHS has no organizational interest in this provision except to the extent that this new option would provide savings to Tribes which could then be reprogrammed back into health care services. The provision does not have an impact on the federal or IHS budget. IHS does not understand how many Tribes currently are structured beyond health services nor how they provide employee benefits. Furthermore the provision took effect in March, 2010 and the delayed progress has resulted in denying Tribes this important benefit for an indefinite period of time. Little specific information has even been shared with Tribes on process or progress. Tribes are becoming increasingly concerned about the possibility that IHS may attempt to limit this benefit in ways the law was not intended.

Another example is how the Exchanges will work for Indian people and the Indian health programs that serve them. IHS does not pay premiums on behalf of beneficiaries, but many Tribes do. This gives Tribes experience and perspectives that IHS does not share. Laws and policies must be interpreted in a way that will be inclusive of all Tribes and the populations they serve, and not constrained to impacts on the existing services provided directly by IHS.

For these reasons, we urge you to include area Indian health board and Tribal policy experts, Tribal attorneys, and other Indian health advocates in moving implementation forward more quickly and effectively. Both legal and policy interpretations need to include the Tribal perspective.

We respectfully request that you appoint appropriate Tribal policy experts to any advisory committees or groups that are working on the implementation of critical IHCA and/or ACA provisions.

Sincerely,

A handwritten signature in black ink, reading "Andrew C. Joseph, Jr." with a stylized, cursive script.

Andrew C. Joseph, Jr.
NPAIHB Chairperson,
Council Member, Confederated Tribes of the Colville Tribal Council