

Indian Health Service Appropriations and ACA and Medicaid Primary/Secondary Payer Issues

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BACKGROUND

This paper provides a justification for why funding provided by the Indian Health Service (IHS) to cover eligible beneficiaries who are enrolled in Medicaid and also covered by a Tribal-funded self-insurance plan are secondary payers to the Medicaid program. This analysis applies to Tribally-operated health programs that are funded in part by IHS through a contract or compact under the Indian Self-Determination and Education Assistance Act (P.L. 93-638), and to Tribal-funded self-insurance programs established in part to supplement Contract Health Service (CHS) care.

The Oregon Health Authority (OHA) has recently begun to treat Tribally-funded self-insurance health plans serving IHS-CHS eligible individuals who are also Medicaid covered as primary payers for health care services. It is the position of Oregon Tribes that their Tribal-funded self-insurance health plans are secondary to Medicaid when providing services to CHS eligible individuals. The OHA Division of Medical Assistance Programs (DMAP) has conversely taken a position that the Medicaid program is the secondary payer to private insurance—which they assert includes Tribal-funded self-insurance health plans—and should not be required to pay for services when a CHS eligible individual is also covered by the Tribal plan.

On April 11, 2013, the Oregon Department of Justice provided an opinion letter that explained the OHA is prohibited from paying primary to a Tribe's self-insurance program for Medicaid services. Oregon asserts that the payer of last resort provisions at section 2901(b) of the Affordable Care Act and at 42 C.F.R. 136.61(a) apply only to health care services that are directly provided in an IHS or Tribally-operated facility. The Northwest Portland Area Indian Health Board, a tribal organization that represents Oregon Tribes, does not agree with the Oregon DOJ opinion letter.

Following an appeal by one of the Oregon Tribes, the OHA has begun to conditionally pay some, but not all, Medicaid claims. In the interim, the OHA has appealed to CMS for technical assistance on this matter. If the CMS takes the position that Medicaid is secondary to tribal funded self-insurance, Oregon Tribes may be asked to pay back Medicaid. CMS has explained that the Agency will not take an official position until IHS has issued formal guidance on their interpretation of a "health program" under Section 2901(b). IHS has indicated that the agency is in the process of developing its guidance on what it considers a "health program" and will be issuing it soon.

This paper is intended to inform the IHS and CMS process. Prior to issuing any guidance on this matter that would exclude Tribally-funded self-insurance from treatment as a health program under the foregoing rules, Portland Area Tribes and the NPAIHB respectfully requests IHS and,

if it remains involved, CMS to consult with Tribes in the development of guidance defining a “health program” operated by Indian Tribes under section 2901(b) of the ACA.

TRIBAL CONSULTATION

This issue of IHS defining a “health program” is of significant and critical importance to Tribal governments. The impact of such a policy decision is that it will have serious Tribal implications that affect how Tribes provide health coverage to their members and very significant financial implications. Such issues are covered by the Presidential Executive Orders, HHS, IHS and CMS Tribal Consultation Policies and would all require consultation on this issue. The IHS Tribal Consultation Policy states:

It is the IHS policy that consultation with Indian Tribes will occur to the extent practicable and permitted by law before any action is taken that will significantly affect Indian Tribes. Such actions refer to policies that have Tribal implications and substantial direct effects on one Indian Tribe or more regarding the relationship between the Federal Government and the Indian Tribe(s) or on the distribution of power and between the Federal Government and the Indian Tribe(s).

The IHS policy makes clear that Tribal consultation should “occur to the extent practicable and permitted by law before any action is taken that will significantly affect Indian Tribes.” As we have discussed above, this issue will have serious Tribal implications, direct effects, and compliance costs. The timing of this issue also avail the opportunity to the Agency to conduct Tribal consultation “before any action is taken” that will affect Indian Tribes. We cannot underscore the importance of Tribal consultation on this issue enough; the Agency must consult with Tribes before making any decisions that would exclude Tribally-funded self-insurance from treatment as a health program under the IHCA.

In addition, it is not appropriate for CMS to defer to IHS to issue guidance on their interpretation of the ACA section 2901. IHS has no particular expertise regarding tribal member benefits, including health coverage offered through self-insurance. Moreover, nothing short of regulations adopted by IHS is binding on tribes, and even those are not on Title V tribes. The IHS policy for resolving inter-agency disputes over such policy issues includes factors that differ from the policy involved in resolving disputes between a Tribe and federal agencies. There are often different rules of statutory construction that require resolution of ambiguities in favor of Tribal governments. Given these facts, we do not believe it is appropriate for CMS to defer to IHS in resolving this particular issue. We are hopeful that this issue can be placed on the TTAG agenda for further discussions.

OVERVIEW OF TRIBAL HEALTH PROGRAM

Indian health programs operated under the ISDEAA have established health programs that allow them to maximize and effectively manage limited Contract Health Services (CHS) resources and meet the health care needs of their Tribal members. For most Tribes, this consists of providing direct services and CHS services. In addition to direct and CHS services, many Tribes operate tribal funded self-insurance programs that provide benefits for CHS eligible members. In managing these programs, Tribes have provided supplemental funding from their general assets to better meet the health care needs of their Tribal community. They also may use CHS funds to assist to purchase premiums for those Tribal members that may not elect to enroll in the self-funded insurance program. These Indian health programs are specifically designed to comply with the federal policy objectives of the Indian Health Care Improvement Act (IHCIA) and the Affordable Care Act (ACA).

The IHCIA (25 U.S.C. § 1601) makes a declaration of national Indian health policy that it is "a national goal of the United States to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services." [Emphasis added]. The Act affirms Congressional intent "to ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities ..." (25 U.S.C. § 1602). Section 1602 further provides that it is Congress' intent "that the United States and Indian tribes work in a government-to-government relationship and consult with Tribes in carrying out the Act in order to ensure quality health care for all tribal members." [Emphasis added]

Tribally-funded self-insurance programs that incorporate CHS funding to cover eligible beneficiaries are intended to achieve the objectives of the IHCIA declaration of national Indian policy. These programs maximize IHS appropriations in order to raise the health status of their Tribal members to the highest possible level. These programs have been developed with the participation of Tribal governments to meet the unique needs and desires of their Indian communities. The programs provide health care benefits to eligible IHS-CHS beneficiaries whether the service is provided or purchased, directly or indirectly, by the Tribal health program. They provide supplemental funding for CHS through the self-insurance component when providing benefits for CHS eligible individuals. It is the position of Oregon Tribes that these programs are a "health program" as described at 25 U.S.C. § 1623(b) and 25 U.S.C. § 1603. As such the payer of last resort requirements contained in the ACA (U.S.C. § 1623(b)) and in regulation at 42 CFR § 136.61(a) protect Tribally-funded self-insurance programs when providing services to eligible CHS beneficiaries.

These health programs provide a number of benefits to Tribal CHS programs. Tribally-funded self-insurance programs serve as a key component of a Tribe's overall CHS program by providing access to negotiated network rates, provider billing edits, utilization review and case management services that are not typically available to tribal CHS programs acting alone. Moreover, by linking the authorization, approval and payment processes between the two

delivery systems as part of a coordinated health care program, a Tribe can ensure that all care is delivered in the most efficient and effective manner.

CHS & TRIBAL FUNDED SELF INSURANCE

At first glance, tribal funded self-insurance programs that incorporate CHS eligibility may appear to be similar to elements of traditional insurance. However they are not. The most confusing aspect of these programs is that, in some cases, they integrate the operation of the self-insurance coverage provided to eligible tribal members with that of the self-insurance offered to employees of the Tribe. As discussed above this allows the Tribe to achieve efficiencies and buying power that are generally not available to stand alone CHS programs. The tribal member benefit self-insurance plans are sponsored and financed by the Tribes. Health claims are not paid through individual or group insurance. All covered claims are paid from the general assets of Tribes, including CHS funds, and are generally processed through a third party administrator.

Congress clearly intended that the kind of member coverage of health services described in this paper be treated as a tribal governmental benefit. Pursuant to 26 U.S.C. § 139D the value of such benefits is not included in the gross income of the Indian taxpayer.

We understand the confusion that may exist among state Medicaid personnel. When one focuses in on “insurance” elements of the way these Indian health benefit programs are operated, one can easily mistake them for traditional insurance and not understand that Tribes have the authority to also integrate coverage of those Tribal members who are CHS eligible, including some tribal members who are also employees and some who also qualify to be enrolled in the Medicaid program. When these individuals receive care, whether provided by an Indian health provider or another Medicaid provider, the Indian health program and self-insurance are secondary payers to Medicaid in accordance with the CHS payer of last resort regulations (42 CFR § 136.61) and the ACA payer of last resort statute (25 U.S.C. § 1623(b)).

The IHCA also includes authority for tribes, tribal organizations, and urban Indian organizations to purchase health benefits coverage for their beneficiaries. This important new authority is very beneficial for the IHS system and it will become more important as IHS programs to implement opportunities under the ACA. Section 402 of the IHCA allows Tribes operating an ISDEAA contract or compact to use CHS funds to purchase health benefits coverage (including coverage for a service, or service within a contract health service delivery area, or any portion of a contract health service delivery area that would otherwise be provided as a contract health service) for such beneficiaries in any manner, including through a tribally owned and operated health care plan and a self-insured plan (25 U.S.C. 1642). That tribal direct operations and operation of self-insurance as an integral part of CHS is reinforced by the express provision of this section authorizing the use of IHS funds “for expenses of operating the [self-insurance] plan, including administration and insurance to limit the financial risks to the entity offering the plan” (42 U.S.C. 1642(c)).

Tribally-funded self-insurance programs are protected even from billing by IHS (25 U.S.C. Section 1621e(f)). The IHS Contract Health Service Manual also prohibits IHS from seeking

recovery when the health services provided to an eligible patient are covered by a self-insured health plan funded by a Tribe or Tribal organization under Section 206(f) of the IHCA, P.L. 94-437, 25 U.S.C. §1621e(f). Consistent with congressional intent not to burden Tribal resources, the Agency has made a determination that tribally-funded self-insured health plans are not to be considered alternate resources either for purposes of obtaining third-party recovery or the related protections that make the I/T/U the Payor of Last Resort.

Congressional Intent: Payer of Last Resort

Congress took into consideration the special circumstances of AI/ANs when enacting the Affordable Care Act and the amendments to permanently reauthorize the IHCA. Congress recognized 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. In response, Congress has declared –

*“...that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligation to Indians–
(1) to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy;”¹*

Because of this Congress included a number of Indian specific protections in the Affordable Care Act (as it had earlier in Section 5006 of ARRA for Medicaid) to enhance Indian participation in Medicaid and Exchange programs. These provisions include:

- Payer of last resort rule that requires other federal, state, local health programs or private insurance to pay for the cost of health care prior to an IHS program.
- 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.

Congress passed these packages of Indian protections recognizing the chronic underfunding of the Indian health system. It also acknowledged the severe health disparities that Indian people face. Thus, the intent of Congress was to enhance Indian participation in Medicaid and make other federal and state payers of health care primary payers to the appropriations of the Indian Health Service.

The Oregon Attorney General’s office has opined that tribal self-insurance is a “health program” within the context of the IHCA statute and that the term “clearly encompasses a plan for paying for health care services provided to tribal members or others in privity with them.”² The legal

¹Section 3 of the IHCA, as amended by Sec. 103 of S. 1790, and incorporated into the ACA pursuant to Sec. 10221.

² See State of Oregon letter by Kailana Piimauna, Assistant Attorney General, Health and Human Services Section, Department of Justice, April 11, 2013.

opinion from the State concludes that while the statute does not define the term health program it meets the requirements.

There can be no question that the clear intent of the IHCA changes was to enhance efficiencies and opportunities for tribes to improve health care for their members. Senate Report 110-197, in commenting on the Bill's introduction, opened with an express purpose statement "to maintain and improve the Indian health care delivery system ... to raise the health status of AI/ANs to the highest possible level..." Moreover, the Report is particularly instructive in its description of the particular statutory change at issue. The Senate Report confirms a broad rather than narrow view of the payer of last resort rule.

CONCLUSION

Tribal self-insurance and CHS programs are entitled to benefit of payer of last resort status in the Medicaid program for care provided to CHS Medicaid eligible patients. Even if the language were ambiguous, however, the statute must be read in favor of the Tribe based on Indian law canons of statutory construction. Any other result would turn the special protections under the IHCA, as amended by the ACA, on their head by shifting financial burdens for health care to any tribe willing to use its own resources to provide coverage and would be inconsistent with the federal obligation to provide health care services to AI/ANs. If Medicaid is able to treat tribal self-insurance as an alternative resource then it ceases to fulfill the objective established in 1976, and strengthened since, of being a fully federally funded supplementary source of funding to Indian health programs.

The direction on this issue should be easy, but if there is any doubt in the minds of either CMS (or IHS to the extent it has any role), full tribal consultation must occur prior to any opinions or guidance being issued.

<p>This brief prepared by Northwest Portland Area Indian Health Board with contributions by attorneys representing Tribal health programs. For questions contact Jim Roberts, NPAIHB Policy Analyst, at jroberts@npaihb.org or (503) 228-4185.</p>
