



NPAIHB POLICY BRIEF

Tribal Planning for Insurance Exchanges

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Tribal Planning for Health Insurance Exchanges Begins Now

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Health Insurance Exchanges are a centerpiece of the recently enacted health care reform legislation (Public Law 111–148), known as the Patient Protection and Affordable Care Act (ACA). Currently many States are planning and designing their health Insurance exchanges (Exchanges) with grant funding from the federal government, and they should be consulting with Tribes as part of the planning process. If a State decides not to create an Exchange, the federal government will operate one for the residents of that State. The ACA calls for Exchanges to start operations no later than January 1, 2014.

Tribes cannot wait until 2014 to get involved. Decisions that are made in the next two years will affect the future revenues for Tribal health programs. To take advantage of the opportunities presented by Health Insurance Exchanges, Tribes will need to designate funding in 2013 for additional staffing, infrastructure and possibly premium payments.

What is a Health Insurance Exchange?

Under health reform, the Exchanges are the primary hub of activities – and the vehicle for securing federal subsidies for premiums and cost sharing.

Health Insurance Exchanges will provide a website where consumers and small businesses can compare health plans with different levels of benefits, and enroll in a plan of their choice. The website will let consumers know if they are eligible for Medicaid, the State Child Health Insurance Program (CHIP), or government subsidies of premiums, and provide a mechanism for enrollment. The functions of the Exchange also can be accessed via telephone through a call center operated by the Exchange. The government or non-profit organization that runs the Exchange will determine which plans qualify to be listed on the exchange, and will rate the plans using quality measures. Exchanges may also provide grants to organizations for programs to assist consumers enroll.

Exchanges Will Offer a New Source of Income for Indian Health Care

After Exchanges are implemented, all American Indians and Alaska Natives (AI/AN) could have access to health insurance. The Indian Health Service, Tribally-operated programs, and urban Indian clinics (I/T/U) would be able to bill the insurance for services they provide, thus creating new sources of revenue.

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While the law requires most Americans to acquire health insurance or pay a penalty, AI/AN are exempt from these penalties, Premium subsidies will be available to low-income individuals enrolled in Exchange plans, up to 400 percent of the federal poverty level (FPL).² Because there is a high rate of poverty in American Indian communities, this benefit would apply to a high percentage of AI/AN who do not have another source of health insurance.

To access this subsidized health insurance, Tribal health programs may choose to pay the unsubsidized portion of the premium for some of their user population.³ In fact, the Indian Health Care Improvement Act (IHCIA) allows Tribes to make premium payments on behalf of members using federal funds.

For people who are enrolled in Exchange plans, the I/T/U health program would be able to bill the insurance for the services they provide, as well as reduce their Contract Health Services (CHS) expenditures by having the insurance plan pay for the costs of services delivered in the private sector. The law prohibits cost-sharing for AI/AN enrolled in an Exchange plan if the service is provided by an I/T/U. This means the I/T/U would be able to collect 100 percent reimbursement for services from the Exchange plan for those who are enrolled.⁴ Furthermore, AI/AN enrolled in Exchange plans are exempt from cost sharing at all other providers if their income is below 300 percent FPL or if they receive a referral through the ITU.

The increased income for Tribal health programs, as well as the decreased demand on Contract Health Services (CHS) budgets, may more than offset the payments Tribal health programs would make for premiums. Having more patients insured also holds the promise of less reliance on Catastrophic Health Emergency Funds (CHEF), as well as coverage for additional preventive benefits, and some relief from the CHS priority system.

More AI/AN will be Enrolled in Medicaid

The ACA's Medicaid provisions will expand AI/AN eligibility and enrollment in Medicaid. ACA envisions that all individuals with incomes below 133 percent FPL (even childless adults) will qualify for Medicaid. Web portals used by the Exchanges will have a single enrollment form for both Medicaid and Exchange plans. The online site will gather and electronically match information to expedite eligibility determinations for Medicaid. Furthermore, ACA simplifies Medicaid enrollment rules and reduces barriers to enrollment.⁵ The Exchanges may use data supplied by the Internal Revenue Service (IRS) eliminating the need for applicants to produce income documents for eligibility.⁶ The electronic application process will be easier and more convenient than previous Medicaid eligibility determination and enrollment processes. Thus, it is expected that the Health Insurance Exchange will increase the number of AI/AN enrolled in Medicaid.

² The FPL is estimated in 2016 to be equal to about \$11,900 for a single person and about \$24,000 for a family of four. So, 300 percent of the FPL in 2016 is estimated to be \$35,700 for an individual and \$72,000 for a family of four.

³ The federal subsidy of premiums for all Americans is 96 percent of the cost of premiums for those below 150 percent of FPL, 83 percent subsidy of premiums at 150-200 percent of FPL, 72 percent subsidy of premiums at 200-250 percent of FPL, and a gradual progression to 35 percent subsidy of premiums at 400 percent of FPL.

⁴ AI/AN enrolled in Exchange plans who are below 300 percent of the FPL will not have cost sharing even if they go to the private sector without a CHS referral.

⁵ ACA requires States to adopt presumptive eligibility for Medicaid, drops asset rules, and uses a new methodology for determining income. Also, renewal of Medicaid eligibility will be easier.

⁶ *Modified adjusted gross income (MAGI)* on federal income tax forms will be used.

Tribes Can Encourage Enrollment

To encourage people to enroll in Exchange plans, Tribes will need to remove barriers, explain the Exchange to Tribal members, and create incentives for enrollment. The two main barriers to enrollment are cost and convenience. Tribes can eliminate these barriers by paying the premiums and having enrollment assistance available at Tribal clinics and places near where people live and work. Explaining the benefits of enrolling in health insurance coverage through an Exchange will require an extensive Tribal communication plan, particularly since many people believe that the IHS is an entitlement and they should not have to enroll in other programs.

Even if Tribes decide to pay the premiums for Exchange plans, Tribal members will need incentives to enroll. The incentives that can be communicated most positively by Tribes are the ability to access a greater range of specialty medical care than what is available under CHS, as well as provide additional resources to improve health care for all Tribal members. In addition, using the Exchange as a portal to enroll in Medicaid can fulfill a requirement to apply for public programs for which Tribal members may be eligible before receiving CHS authorization, thus effectively making CHS the payer of last resort.

Tribal Members Can Benefit when I/T/U are Providers in Exchange Plans

I/T/U should be paid by insurance companies for services they deliver to AI/AN enrolled in their plans, regardless of whether the Indian health programs have provider contracts with Exchange plans. Section 206 of IHCA gives Indian health providers the right to receive reasonable charges, or, if higher, the highest amount an insurance plan would pay for the same care delivered by other providers. Even though we believe Section 206 makes it possible to collect reimbursement without having a provider network contract with an Exchange plan, having such a contract may provide additional benefits to I/T/U providers and their patients – such as better access to specialty providers in a health plan's network

For instance, a health plan may require a plan member to obtain a referral from an in-network primary care provider prior to accessing a specialist. If the I/T/U primary care provider is not in the plan's network, this may mean that an AI/AN would have to go to an in-network primary care provider first to get a referral. So, again, there may be benefits to patients for I/T/U providers to become "in-network" plan providers. Once the Exchange plans are known, Tribes will have to evaluate them for contracting, benefits, network and costs.

Tribal Leadership is Needed to Assure the Best Outcomes for Tribes

Tribal leadership is needed at the Federal, State and Tribal levels to assure that implementation of the Exchanges provides the maximum opportunity with the least administrative burden for Tribes.

The Tribal Technical Advisory Group (TTAG) for the Centers for Medicare and Medicaid Services (CMS), as well as the National Indian Health Board (NIHB), the National Congress of American Indians (NCAI) and Area Indian Health Boards are working at the national level to help shape the regulations for Exchanges. The Center for Consumer Information and Insurance Oversight (CCIIO) within CMS will issue preliminary regulations for Exchanges this year. Tribal representatives are currently focusing on two issues to facilitate contracting:

- Federal regulations should explicitly identify the I/T/U as Essential Community Providers (ECP) that all plans on the Exchange must include in their provider networks.⁷
- Federal regulations should specify that provider contracts used by Exchange plans for the I/T/U acknowledge the unique circumstances of the Indian health system.⁸

At times, these national organizations may need help from all Tribal leaders to respond to alerts by writing letters in support of their recommendations.

Tribal Action Needed at the State Level

States are currently designing Exchanges and are required to consult with a variety of stakeholders in the planning, establishment and on-going operation of Exchanges. States should also be consulting with Tribes; however, Tribes may have to be proactive to ensure on-going consultation. The CMS Center for Consumer Information and Insurance Oversight has alerted States that they have a responsibility to establish a consultation with Tribes concerning Exchange design and operation.⁹ Some States are providing grants to Tribal organizations to assist in the planning process. The funding announcement to assist in setting up Exchanges instructs States that subcontracting with Tribes is an allowable activity. States will assess the qualifications of plans offered in the Exchange, decide enrollment eligibility, design computer systems to provide information to consumers and link them to related programs and services, and provide outreach, education and navigation assistance.

Right now, in the earliest stages of the State planning process for Exchanges, Tribal leaders need to be making recommendations to State agencies. Representatives of the I/T/U should be meeting with the State on a regular basis with agendas that include the following topics:

A. Application and Enrollment Process, with Identification of AI/AN

- Define American Indian for purposes of the Exchanges.
- Develop data match systems to identify AI/AN who are I/T/U users.
- Use documents acceptable to Medicaid for AI/AN as proof of citizenship in the Exchanges.
- Develop procedures to contest decisions related to identity or income.
- Design system to allow monthly open enrollment for AI/AN.

B. Specific AI/AN Benefits and Protections

⁷ The National Indian Health Board has provided the legal justification for the I/T being ECPs in the paper, “Assuring the Inclusion of Indian Health Providers in Provider Networks of Exchange Plans,” as well as the paper, “Determination of Patient Volume in Tribal and Urban Indian Health Programs for Meaningful Use Incentives.” They also have produced a one-page handout, “I/T/U Are Essential Community Providers.”

⁸ The National Indian Health Board has identified these contract provisions in the paper, “Assuring the Inclusion of Indian Health Providers in Provider Networks of Exchange Plans.”

⁹ See Funding Announcement Number: IE-HBE-11-004, CFDA: 93.525, January 20, 2011. The announcement at p. 45 contains explicit instructions for States to comply with Tribal consultation requirements of Executive Order 13175.

- Require web portals to identify AI/AN and provide information about AI/AN specific provisions so informed choices can be made online.
- Because Medicaid, ACA and the IHCA contain different provisions intended to protect AI/AN, make sure these important access provisions are preserved.
- Design data systems so that providers will know that AI/AN qualify for exemptions from cost sharing, and I/T/U providers will be notified when AI/AN enroll in Exchange plans.

C. Group Purchasing and Sponsorship of Tribal Members

- Design systems and computer programs that allow Tribes to sponsor AI/AN by paying the premiums.
- Develop rules and processes to prorate premiums in households where some people are sponsored by Tribes and others are not.

D. I/T/U as Providers in Exchange Plans

- Designate I/T/U health programs as Essential Community Providers (ECP) and require Exchange plans to include I/T/U providers in their networks.
- Require Exchange plans to use contract addendum for I/T/U.
- Require Exchange plans to pay Indian health programs at the rates specified by law (reasonable charges billed, or, if higher, the highest rate paid to providers in the plan).
- Prepare materials about the Indian health system, in cooperation with the I/T/U, so that plans will know how to include I/T/U in their networks

E. Enrollment Assistance, Outreach, Accessibility, Problem Solving

- Identify funding sources and mechanisms for Tribes to assist in the enrollment process for Exchanges.
- Review web sites and portals to assure they are culturally appropriate.
- Train call center employees of the Exchange on Indian health.
- Develop culturally appropriate outreach and education materials about the Exchange and use effective channels of communication.
- Designate an Indian health expert at the Exchange who is empowered to resolve problems, answer questions, keep a list of FAQs, and work with I/T/U, Exchange Plans, call center and others.

State laws will be enacted to designate the governmental or non-profit organization that will operate the Exchange. So, in addition to being involved in the planning process, Tribes and Tribal organizations will need to advocate for provisions in legislation and regulation at the State level that are beneficial to the I/T/U and the people they serve. At minimum, State law should specify that there will be a Tribal representative on the governing body of the statewide Exchange.

Tribal Planning to Prepare for Exchanges Should Begin Now

Tribes should designate immediately an individual or a team to become informed about the ACA and the Exchange, to engage in advocacy on behalf of the Tribe in the development of regulations at the Federal and State levels, and to participate in Exchange planning activities.

Tribal health programs will need to decide whether they are going to pay the non-subsidized portion of premiums for Tribal members to enroll in insurance plans offered by the Exchange. There will be an initial cost outlay for the premiums in the first year that a person is enrolled, so the source of funding to pay the premiums will need to be identified. Revenues and CHS savings that Tribes receive from billing the insurance companies may be sufficient to pay premiums after the first year, but this may require accounting practices to identify and reserve revenues for that purpose. To budget for paying premiums in 2014, Tribes will need to develop models to estimate the cost of premiums in the first year based on the number of people who will be covered, their estimated income levels, their level of utilization of health services and the cost of the plan premium. Tribal governments may have to consider the criteria that they will use to pay premiums.

Opportunities in the Exchange should be considered in the Tribal planning and budgeting process in 2012, so that there is adequate funding and staffing in 2013 for the following types of activities:

- Provide training for Tribal employees so they are knowledgeable about Health Insurance Exchanges.
- Hire or designate a person to track contracts that are received from Exchange plans, review contracts to assure that Tribal-specific provisions are included and to target unacceptable provisions for elimination, fill out forms to enroll Tribal providers/clinics as providers under plans, sign contracts in a timely way, and provide contract compliance review.
- Consider whether there is a need for changes in the CHS authorization process for people with health insurance under the Exchange.
- After plans have qualified to be included in the Exchange, analyze the plans to figure out which provide the greatest benefit to the Tribe and the individuals they serve. There will be different plans with different levels of benefits, different costs and varying participation by ITU providers.. Tribes will need to decide whether they want to pay premiums for one or more plans. They will need to work out the mechanisms to pay those premiums. Tribal budgets will need to be prepared for 2014 to accommodate the cost of premiums.
- Assist in enrolling Tribal members in Medicaid and plans in the Exchange. They will want to explore funding sources and mechanisms by which they can help facilitate enrollment of AI/AN. They may need to hire and train additional staff to perform this function.

- Develop a communications plan to inform Tribal members about the Exchange, explain the benefits of health insurance coverage to the Tribe, and assist in the enrollment process. Some Tribes have already begun this process by explaining ACA and the Exchange to their Tribal members in Tribal newspapers, newsletters, websites and radio programs.
- Make changes in their registration and billing systems to assure that plans are billed for services provided by the Tribe.

Tribes that are already paying premiums for the Medicare Part D prescription drug benefit have been engaged in planning, outreach, enrollment and implementation activities similar to what will be required for the Exchange. These Tribal programs can be used as models for Exchange plan premium payments. IHCIA and ACA made changes to Medicare Part D rules that make it even more advantageous for Tribal members to be enrolled. Medicare Part D premium payment programs will give Tribes valuable knowledge and experience to help them understand the opportunities created by ACA and the Exchange. Pharmacy revenues and CHS savings from Medicare Part D may also create a source of funding to pay for premiums for Tribal members to enroll in plans under the Exchange.

Summary

Health care reform has provided new opportunities for expanded access to health care services and to increase revenues to provide needed services. Tribal consultation in the development of Health Insurance Exchanges should result in specific outcomes to make the Exchanges workable for Tribes and Tribal members. Tribal action is needed now as States begin planning for Exchanges. Tribal health providers also need to begin internal planning for their participation in the Exchanges.

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