

**SECTION BY SECTION OF RAHALL AMENDMENT
INDIAN HEALTH PROVISIONS TO H.R. 3200,
"AMERICA'S AFFORDABLE HEALTH CHOICES ACT OF 2009"**

INDIAN COUNTRY OVERVIEW

As part of its trust responsibility to Indian tribes, the Federal Government has the obligation to provide health care to Indian people. It is the mission of the Indian Health Service (IHS) to carry out this obligation primarily through the Indian Health Care Improvement Act (IHCA). But since the IHS is funded at little more than 50% of need, the IHS has never been able to supply even the most basic package of benefits to Indian people. H.R. 3200, would make sweeping changes that will profoundly affect health care access and delivery. Tribal leaders seek to assure that the unique Indian health care delivery system – through which some 1.9 million American Indians and Alaska Natives receive their care – is both protected from harm and is strengthened through this legislative process. Thus, tribal leaders have two specific goals:

- ***To increase opportunities for access to health care by Indian beneficiaries.*** This objective is advanced by H.R. 3200's provisions which would expand eligibility for Medicaid, and provide subsidies to help low/moderate income Americans obtain health insurance. All Americans, including Indians, would benefit from these policies.
- ***To preserve the Federal trust responsibility to provide health care to Indians and to protect the unique Indian health system from inadvertent harm*** Both the U.S. trust responsibility to Indian tribes and the Indian health system are unique creations of the Federal government. Specific language is often required in bills of general applicability to prevent unintended adverse consequences. The Rahall amendment to H.R. 3200 would provide vital protections to both the trust responsibility and to the Indian health care system.

**RAHALL EN BLOCK AMENDMENTS TO H.R. 3200
AMENDMENTS MADE TO WAXMAN ANS**

Definitions, Page 1, lines 1 – 11. This provision adds definitions for terms “Indian” and “Indian Health Care Provider” used in the Rahall amendment not currently used in H.R. 3200.

Inclusion of Indian Provider as QHBP, Page 1. Bottom. This provision to page 23, line 21 of the ANS ensures that a qualified health benefit plan (QHBP) guarantees access to Indian health care providers where they exist within the service area (as that term is defined in Sec. 100(c)).

Clarification that Limiting Indian Health Programs to Indians is Not Discrimination, Page, 2, lines 1-3. This amendment would ensure that Indian health care providers, which often may only provide health services to Indians pursuant to the IHCA, are exempt from the regulations. Sec. 152 of H.R. 3200 ANS directs that all services covered by the Act shall be provided "without regard to personal characteristics extraneous to the provision of high quality health care or related services." It is unclear whether this directive would impact the Indian health system whose programs that are equipped/have the capacity to serve only Indian beneficiaries. Being Indian is a *political status*, not a racial characteristic. Thus, this provision should expressly state that IHS or tribal programs which must limit services to Indians are not considered discriminatory.

Indian Health Provider-QHBP-Exchange, Page 2, line 4 – Page 3, line 19. Specific language is needed to Sec. 204 of HR 3200 to assure that components of the Indian health delivery system can participate in provider networks established by a Qualified Health Benefit Plan offering entity, including a public plan, which lists health insurance products on the Exchange. Without specific language, Indian providers face exclusion from plan networks, with the result that they would not receive payment from an insurance plan for services provided Indian enrollees, and the insurance plan, which has received the premium payment, would realize a windfall. Indian health care providers have experienced such exclusion from provider networks established by Medicaid managed care entities, a problem Congress recently enacted legislation to overcome.

The Rahall Amendment is modeled on the recently-enacted provision to assure Indian health providers can participate in Medicaid-managed care programs and receive payments for services. (Sec. 5006(d) of P.L. 111-5, amending Sec. 1932 of the Social Security Act; 42 USC 1396u-2)

IHS and Self Governance Licensing Protection, Page 3 line 20-Page 4, line 16. Sec. 225 of H.R. 3200 bars any health care provider not licensed or certified under State law from participating in the public health insurance option. Federal (IHS) and Tribal facilities are not subject to state licensing laws, so as written, Sec. 225 would bar all of these facilities from participation in a public option. An amendment is needed to exempt IHS and tribal facilities from the licensing requirement, and to exempt their health care professionals from the requirement to be licensed in the state in which they practice, provided that the professionals are licensed or certified by any State. Finally, an individual certified under the IH CIA would also be exempted. Without these exemptions, the referenced entities could not participate in the public health insurance option.

These unique Federally-related circumstances require insertion of specific language to allow these providers to participate in a public health insurance option and to receive payments for such services.

No Tax Penalty For Indians, Page 4, lines 17-20. A tax is imposed on individuals who do not have acceptable health coverage insurance. Exemptions are provided in HR 3200 for others, including for religious reasons and residence in the territories. In order to fulfill treaty obligations and the Federal trust responsibility for Indian health, this provision exempts Indians from the tax. The Tribal perspective is that the US has failed to supply Indian people with access to an appropriate level of health care as is the trust responsibility; it would then be unconscionable for the United States to impose a penalty on Indian people for failing to acquire their own health insurance. [Sec. 401 of HR 3200 creating new3 IRC Sec 59B]

Health Care as Taxable Income, Page 5, line 1-Page 7, 24. The IRS Regional Office in California has recommended to the Washington IRS office that the health care and benefits provided through tribal paid insurance, as well as other general welfare benefits (meals on wheels, etc.) provided by tribes to their members be considered taxable income. The Rahall amendment would clarify that the care, benefits and other general welfare benefits are exempt from gross income.

Medicare Amendments, Page 8, lines 1-17, Currently, Section 1880(e) of the SSA authorizes ambulatory care clinics operated by the IHS, Indian tribes, and tribal organizations to collect payment for all Part B services. This authority expires on Dec 31, 2009. This provision would permanently extend this authority. It would also require 100% Medicare reimbursement to such facilities for Part A and B services.

INDIAN HEALTH CARE IMPROVEMENT ACT AMENDMENTS

Reauthorization of IHCIA Page 9, lines 3 – 6. Except as written below, the Rahall Amendment would reauthorize the IHCIA through 2025.

Self Governance Licensing Fees Equity, Page 9, lines 9 – 15. This provision would amend the IHCIA to exempt Tribal Health Program employees and Urban Indian Organization employees from paying licensing, registration, and other fees imposed by a Federal agency to the same extent that Commissioned Corps Officers and Indian Health Service employees are exempt. The Drug Enforcement Administration began charging a \$500 fee to pharmacists working in tribally operated health facilities. The fee is not charged to IHS pharmacists.

Third Party Collections Page 9, lines 18 – Page 15, line 8. This provision strengthens existing law which grants the United States, Indian tribes and Tribal Organizations a right of recovery against certain third parties for the cost of health services. Third parties include HMO's, employee benefit plans, and tortfeasors.

Epidemiology Centers Page 15, line 11 – Page 20, line 2. The Rahall Amendment would update the current law by identifying epidemiology centers as public health authorities to better enable these entities to carry out their mission of collecting and analyzing health and disease information in Indian communities, creating data sets, and developing recommendations for improvement of health delivery systems and services to target specific needs in those communities.

Hospice, Assisted Living, Long-Term and Homecare Services Page 20, line 5 – Page 22, line 14. This provision would expressly permit the Indian Health Service and tribally-operated health programs to offer modern and more efficient methods of health care delivery – hospice; long-term care; assisted living; and home- and community-based care – using definitions of those terms found elsewhere in Federal law.

Self Governance Licensing Requirements Page 22, lines 15 – 22. This provision would exempt Tribal Health Program employees from State licensing requirements within the State which the Tribal Health Program is operating, if the employee is licensed in at least one State.

Non Taxation of Scholarships and Loans, Page 23, lines 1 – 6. This provision would deem scholarships and loans provided pursuant to the IHCIA as “qualified scholarships” for purposes of Section 117 of the Internal Revenue Code and, therefore, non- taxable.

Elevation of Director of IHS to Assistant Secretary Page 23, lines 9 – Page 27, line 20. This provision would elevate the Director of the IHS to an Assistant Secretary within DHHS.