



## **2015 Legislative and Policy Agenda**

**March 3, 2015**

Founded by the Tribes in 1972, the National Indian Health Board (NIHB) is dedicated to advocating for the improvement in the delivery of health care and public health services and programs to American Indians and Alaska Natives. To advance the organization's mission, the NIHB Board of Directors sets forth the following priorities that the NIHB will pursue at the national level through its legislative work in 2014.

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### **Phase in Full Funding for Indian Health Services and Programs for American Indians and Alaska Natives in the Indian Health Service (IHS) and Beyond**

Each year the National Tribal Budget Formulation Workgroup to the IHS works diligently to synthesize the priorities identified by Tribes in each of the health care delivery Areas of the IHS into a cohesive message outlining Tribal funding priorities nationally. These Tribal priorities are the foundation and roadmap for the work that NIHB does on behalf of Tribes in pursuit of much needed funding for health care services and programs for American Indians and Alaska Natives. In addition to advocating for these national Tribal priorities, NIHB will call on lawmakers to:

- Phase In Full Funding of IHS - Total Tribal Needs Budget of \$29.7 Billion Over 12 Years
- Present a 22% increase in the overall IHS budget from the FY 2016 President's Budget request planning base for a total of \$6.2 billion
- Advocate that Tribes and Tribal programs be permanently exempted from sequestration
- Provide an additional \$300 million to implement the provisions authorized in the Indian Health Care Improvement Act (IHCIA)

### **Enact Mandatory Appropriations for the Indian Health Service**

In the FY 2016 Budget Request to Congress, the Administration has proposed that Contract Support Costs (CSC) be transitioned from the discretionary budget to the mandatory category. If the proposal were enacted, CSC would be made mandatory for three years, (FY 2017-FY 2019) with increases each year to account for the estimated growth in future CSC need. The funding would also be reclassified as "no year" funding and therefore available to be carried over in future years. This legislative change will guarantee legal compliance to fully pay CSC, while ensuring that these payments do not take limited funds from other areas of the Indian Health Service (IHS) services budget. NIHB requests that Congress:

- Enact Mandatory funding of CSC as early as FY 2016
- Ensure that Direct Services budgets at IHS are not impacted by this change

### **Seek Special Diabetes Program for Indians Renewal at \$200 Million Each Year for 5 Years**

NIHB is asking Congress to pass legislation by this year to renew funding for this vital program for 5 years at \$200 million per year. SDPI has not received an increase in funding since 2002, meaning that the program has effectively lost 23 percent over the last 12 years. Few programs are as successful as SDPI in helping reverse chronic illness. SDPI has proven to work, especially in declining incident rates of diabetes-related kidney disease. Between 1999-2006, the incident rate of end-stage renal disease (ESRD) due to diabetes in American Indians and Alaska Natives fell by 28% - a greater decline than for any other racial or ethnic group. Treatment of ESRD costs almost \$90,000 per patient, per year, so this reduction in new cases of ESRD translates into **significant cost savings for Medicare, the Indian Health Service, and third party payers.**

### **Secure Advanced Appropriations for the Indian Health Service**

NIHB is asking Congress to achieve Advanced Appropriation for IHS. If IHS had received advance appropriations, it would not have been subject to the government shutdown or automatic sequestration cuts as

its FY 2014 funding would already have been in place. Adopting advance appropriations for IHS results in the ability for health administrators to continue treating patients without wondering if –or when– they have the necessary funding. Additionally, IHS administrators would not waste valuable resources, time and energy re-allocating their budget each time Congress passed a continuing resolution. Indian health providers would know in advance how many physicians and nurses they could hire without wondering if funding would be available when Congressional decisions funnel down to the local level.

### **Seek a Legislative Fix of the Definition of Indian in Affordable Care Act**

NIHB is asking for a legislative fix of the “Definition of Indian” in the Affordable Care Act (ACA). The “Definitions of Indian” in the ACA are not consistent with the definitions already used by the Indian Health Service (IHS), Medicaid and the Children’s Health Insurance Plan (CHIP) for services provided to American Indians and Alaska Natives (AI/ANs). The ACA definitions, which currently require that a person is a member of a federally recognized Tribe or an Alaska Native Claims Settlement Act (ANCSA) corporation, are narrower than those used by IHS, Medicaid and CHIP, thereby leaving out a sizeable population of AI/ANs that the ACA was intended to benefit and protect.

### **Achieve Medicare-Like Rates for the IHS**

NIHB is requesting Congress to extend the Medicare-like rate cap on Purchased and Referred Care (PRC) (formerly Contract Health Services) referrals to all Medicare participating providers and suppliers. Neither the Department of Veterans Affairs nor the Department of Defense pay full billed charges for health care from outside providers. Nor do insurance companies, including those with whom the federal government has negotiated favorable rates through the Federal Employee Health Benefits program.

On December 5, 2014, IHS released a proposed rule that would amend the IHS PRC regulations to apply Medicare payment methodologies to all physician and other health care professional services and non-hospital based services that are either authorized under such regulations or purchased by urban Indian organizations. The National Indian Health Board, along with other Tribes and Tribal organizations submitted comments supporting the Proposed Rule as long as any regulation is flexible enough to allow Tribes to opt out of the regulations requirements if they so choose. While NIHB is generally supportive of the proposed rule, it recognizes that the proposed rule has no enforcement capability. As a result, NIHB is still advocating Congress to pass legislation to extend the Medicare-Like rate cap on PRC.

- Federal PRC programs paid non-contracted physicians two and a half times more than what it estimates Medicare would have paid for the same services.
- The IHS PRC program alone would have saved an estimated \$31.7 million annually if Medicare-Like Rates applied to non-hospital services. These savings would result in IHS being able to provide approximately 253,000 additional physician services annually.
- The expansion of the Medicare-Like Rate Cap from 2010 to the present would have resulted in hundreds of millions of dollars in new federal health care resources being made available to American Indian and Alaska Natives.

### **Seek an Exemption for American Indians/ Alaska Natives from the Employer Mandate Requirement**

The Employer Shared Responsibility Rule, otherwise known as the Employer Mandate, states that all employers with 50 or more employees must offer health insurance to their employees or pay a penalty. Tribal governments are currently counted as large employers for application of this rule even though they are not specifically listed in the language of the statute. Yet, AI/ANs are exempt from the Individual Mandate to purchase health insurance. Requiring Tribal employers to provide AI/ANs with such coverage anyway, and penalizing them if they do not, functionally invalidates the AI/AN exemption from the individual mandate by shifting the penalty from the individual to the Tribe itself. NIHB has reached out to members of Congress to educate them on this important issue and it has garnered some interest and support. However, given the political climate, NIHB believes that a regulatory fix would be more likely to succeed than a congressional one. However, NIHB continues to advance both strategies in 2015

- The Administration should exempt AI/AN employees from the Employer Mandate through a regulatory fix
- Congress should exempt AI/AN employees from the Employer Mandate to purchase health insurance under the ACA

### **Secure Tax Exempt Status for IHS Student Loans**

NIHB supports the proposal in the FY 2016 President's Budget that Congress amend the tax code to provide health care professionals who receive student loan repayments from the Indian Health Service (IHS) the same tax free status enjoyed by those who receive National Health Service Corps (NHSC) loan repayments. Under both the IHS and NHSC programs, dentists, physicians, dental hygienists, and nurses provide health care services to underserved populations.

### **Enact Special Suicide Prevention Program for AI/ANs**

AI/AN communities grapple with complex behavioral health issues at higher rates than any other population. Destructive federal Indian policies and unresponsive or harmful human service systems have left AI/AN communities with unresolved historical and generational trauma. Suicide is the 2nd leading cause of death - 2.5 times the national rate – for AI/AN youth in the 15 to 24 age group (SAMHSA). The Attorney General's Advisory Committee on AI/AN Children Exposed to Violence, comprised of experts in the area of AI/AN children exposed to violence recently released its report. It describes the foundation that must be put in place to treat and heal AI/AN children who have experienced trauma: "We must transform the broken systems that re-traumatize children into systems where [AI/AN] tribes are empowered with authority and resources to prevent exposure to violence and to respond to and promote healing of their children who have been exposed."<sup>1</sup> NIHB recommends that:

- Congress enact a program to target suicide prevention program for Indian Country that would be modeled off of the Special Diabetes Program for Indians

### **Improve Enrollment through the Marketplace**

NIHB is committed to working with CMS to set goals for enrollment and measure progress towards those goals. It has been estimated that about 460,000 AI/AN are eligible for tax credits for premium assistance yet only about 24,000 AI/AN have enrolled. There are a number of ways we can increase in enrollment.

- Funding for Enrollment Assistance for the I/T/U. Navigator grants have been limited to only a few regions in the country; and the rules associated with Navigator grants make them unattractive to some Tribes and Tribal organizations, which are in the best position to do outreach, education, and enrollment assistance. NIHB needs to work with CMS to consider alternatives for funding for enrollment assistance that is specifically designated to reach the I/T/U
- Change the Rule for AI/AN in Family Plans. A regulatory decision was made in the first year that everyone on a family plan would get the least generous cost sharing reduction that anyone qualified to receive. NIHB will recommend that a family plan includes one person who is eligible for Indian-specific cost sharing reductions, then others who are in the tax-filing unit who are eligible for the Indian Health Service will get the same cost-sharing reduction as the person with Indian Status.
- Access to Analytics to Manage Enrollment for AI/AN. To manage the problem of increasing enrollment requires a system of reporting and analyzing enrollment data in a regular and consistent way that allows us to better understand the impediments and the approaches that are successful. NIHB and TTAG have made recommendations about the most useful types of information and how they can be retrieved from existing data files and we intend to follow up with CMS until we receive access to the data that we need.

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<sup>1</sup> U.S. Department of Justice. (2014) "Attorney General's Advisory Committee on American Indian and Alaska Native Children Exposed to Violence: Ending Violence so Children can Thrive," p. 7.

### **Indian-Specific Call Centers**

We have reported to CMS numerous times that AI/ANs continue to experience poor assistance when contacting the marketplace call center for help. Issues range from technicians having no knowledge of the Indian-specific protections like exemptions and tax credits, to technicians being rude and having no patience to walk elderly consumers through the troubleshooting process.

Because AI/AN consumers continue to receive such poor customer service we have suggested before and continue to suggest that the Center for Consumer Information and Insurance Oversight (CCIIO), in CMS, establish an Indian-specific call center to respond to questions and provide technical assistance to AI/ANs, as well as enrollment assisters such as Navigators and Certified Application Counselors. We also believe that an Indian-specific help desk would be better equipped and more sensitive to the needs of AI/AN consumers.

### **Support Increase Oversight of QHPs**

CMS put into regulations the provisions in the 2015 Issuer Letter requiring Qualified Health Plan (QHP) Issuers to offer contracts to all Indian Health Care Providers that operate in the QHP's service area and to do so by including the QHP Indian Addendum with "good faith" payment provisions. However, not all QHP Issuers are complying with the requirement. Depending upon the region of the country, some QHP issuers are offering contracts, but in other regions, QHP issuers do not appear to be offering contracts to Indian Health Care Providers. NIHB is advocating and working with CCIIO to provide better oversight in Federally Facilitated Marketplaces (FFM) States and that the contract requirement be extended to State-based Marketplaces to ensure Indian Health Care Providers are included in plan networks in those states.

For a variety of reasons, an I/T/U may be unable to join the network of plan providers or chose not to do so. In any case, if the I/T/U is an out-of-network provider, AI/AN will continue to seek the I/T/U for many of their health services. NIHB will advocate to CMS for assurances that Marketplace plans make accurate and timely payments to the I/T/U for services to people enrolled in the Marketplace plans, and that the cost sharing reductions for AI/AN are handled properly at the time of service.

### **Meaningful Use of Electronic Health Records**

Meaningful Use (MU) of electronic health records (EHR) requires both changes in technology and changes in business practices. For a variety of reasons, this has been difficult to accomplish in many places within the I/T/U. Now Indian health providers are threatened with reduced revenues for lack of progress on MU. In addition, many I/T/U facilities are small and located in extremely rural areas where it is difficult or impossible to attract and retain the kind of personnel who can understand, implement and manage the new requirements for reporting that result in Medicare payments being reduced. NIHB will advocate for exemption to these requirements.