

National Indian Health Board



Submitted via FFEcomments@cms.hhs.gov

June 18, 2012

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

RE: Comments on the General Guidance on Federally-facilitated Exchanges

Dear Secretary Sebelius:

The National Indian Health Board¹ (NIHB) is submitting these comments in response to comment on the *General Guidance on Federally-facilitated Exchanges* issued by the Center for Consumer Information and Insurance Oversight (CCIIO) at Centers for Medicare & Medicaid Services (CMS) on May 16, 2012.

Throughout the past year, the Department of Health and Human Services (HHS) and the Department of Treasury have issued a series of seven (7) notices of proposed rule-making (NPRMs) for Exchanges. In each case, the National Indian Health Board and the CMS Tribal Technical Advisory Group (TTAG) have reviewed the NPRMs in consultation with Tribes and submitted extensive comments regarding ways to make Exchange plans accessible to American Indians and Alaska Natives (AI/AN) and thereby reduce the terrible health disparities experienced by this segment of the population.

In nearly every case, HHS and Treasury have issued final regulations that do not adopt the recommendations from Tribes, but instead defer to States Exchanges to make decisions about those important issues. On September 14, 2011, you sent a letter to State Governors stating that “Tribes should be considered full partners by States during the design and implementation of programs that are administered by States with HHS funding” and requiring States to consult with Tribes in the development of Exchanges. You used words like “proactive” and “partner” and we applauded this approach. In many cases, the States are not meeting this goal. However, some States have been

¹ Established 40 years ago, NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives. NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (“IHS”) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (“ISDEAA”), or continue to also rely on IHS for delivery of some, or even most, of their health care, NIHB is their advocate.

doing an exemplary job of consulting with Tribes, including Oregon, Washington and Minnesota. Some Exchanges have provided funding to Tribal Organizations to create policy documents, serve on planning committees and provide useful input as the details of such things as computer software are being designed. Where Tribal representatives, employees or technical advisors are serving on committees, there have been substantive and beneficial outcomes in the Exchange planning process.

Tribes expect no less from the Federal government in States that will have Federally-facilitated Exchanges. This means more than holding regional “listening sessions” – it means workgroups and policy engagement with Tribes and the organizations that represent them. We understand that the law sets January 1, 2013, as the date that HHS will decide whether there will be a State-operated Exchange, a Federally-facilitated Exchange, or a partnership. However, it is clear right now that some States with large AI/AN populations, including Alaska and Oklahoma, will not be prepared to have a State-operated Exchange. It is not too early for the Federal government to begin working with Tribes and Tribal organizations in those States to resolve important policy issues.

Our comments on the Exchange rules were designed to remove significant barriers that will prevent AI/AN from accessing the Exchanges. As you know, AI/AN have a right to free care through the Indian health system, and as a result have little or no incentive to purchase insurance on the private market, particularly if doing so would mean they could no longer as a practical matter receive convenient and culturally appropriate care through their choice of Indian health provider. AI/AN are unlikely to purchase private insurance on their own if they have right to free care, and Tribes need the ability to group pay premiums on their behalf if AI/ANs are going to be able to take advantage of the premium tax credits offered only through the Exchanges. Similarly, if Indian health providers are not allowed to participate in the Qualified Health Plans offered through the Exchanges, either because the Plans do not offer to contract with them or because when they do they impose conditions for participation that are contrary to federal law (such as imposing state licensing requirements which Indian health providers are exempted from under the Indian Health Care Improvement Act), then AI/AN are unlikely to participate in the Exchanges. That is why our comments urged HHS to allow Tribes to group pay Exchange premiums for their members and require Qualified Health Plans (QHPs) to offer to contract with Indian health system providers using an Indian addendum to those contracts that sets out existing federal laws applicable to the Indian health system.

The premium tax credits offered through the Exchanges represent a significant federal resource designed to assist the most vulnerable populations purchase insurance coverage and improve their health care outcomes. Congress intended that AI/ANs be able to take advantage of this resource, and added additional cost-sharing protections for AI/ANs who participate in the Exchanges in Section 1402(d) of the Affordable Care Act. If barriers to access to the Exchanges are not removed, however, these resources will likely be left on the table, and the AI/AN population, which suffers some of the greatest health disparities in the nation, will effectively be excluded from meaningful participation in this critically important program.

In some cases, the final rules for health insurance exchanges defer to States and also encourage them to implement recommendations from Tribes. We would sincerely hope that the Federal government would demonstrate leadership by implementing those Tribal recommendations in Federally-facilitated Exchanges. For example, the final rules encourage but do not require State Exchanges to use an Indian Addendum for QHP contracts with I/T/U providers, and we believe the appropriate

approach for the Federal government is to require use of an Indian Addendum in the Federally-facilitated Exchanges. When the Federal government is responsible for Exchanges, we see no reason to defer, delay or deny the approaches suggested by Tribes to make the systems workable.

While the Federal government has outlined some of the policies it will use in Federally-facilitated Exchanges, it has not addressed AI/AN protections and supports in the law. Our recommendation is that the Federal government takes the following approach:

1. Create a document that acknowledges each of the recommendations from Tribes and Tribal organizations submitted as a response to NPRMs.
2. Indicate which of the recommendations from Tribes and Tribal organizations the Federal government is willing to implement in Federally-facilitated Exchanges.
3. Use the remaining recommendations as the agenda for engaging Tribes and Tribal organizations on a State level to discuss the best ways to assure access to care for AI/AN through Exchanges. Involve Tribes and Tribal Organizations in each State in setting agendas that may include additional items that arise in the planning process.
4. If this requires an extensive engagement process with Tribes and Tribal organizations, HHS should provide funding (using funds that would have otherwise been used for Establishment grants for States that have chosen not to apply for, not to accept or to turn back their funding for Establishment grants, or other funds that may be available) to Tribal organizations in each State to prepare policy documents, participate in planning activities, and organize Tribal consultation agendas and meetings in the State.
5. HHS and Treasury should designate a person with policy authority in each State where there will be a Federally-facilitated Exchange as a key point of contact for Tribes and Tribal organizations. That policy person should have a list of Tribes, elected Tribal Leaders, and their designated technical advisors to contact with information and schedules for the development of policies, project deadlines related to the development of Exchanges, and meeting schedules.
6. At minimum, in each State where there will be a Federally-facilitated Exchange, Tribes and Tribal Organizations should be engaged with the Federal government to resolve issues related to the following topics:
 - a. Network Adequacy – requiring all QHPs to offer contracts to all I/T/U providers with an Indian Addendum.
 - b. Essential Health Benefits –reviewing the scope and duration of services and providers covered, and offering pediatric oral and vision services in the QHP versus a separate plan.
 - c. Eligibility – identification of individuals who are eligible for special protections and provisions as AI/AN in the eligibility process and at the provider level to assure that deductibles and co-pays are waived. Utilization of existing databases or development of new databases to expedite eligibility determinations. Identifying how additional documentation

will be requested and reviewed and eligibility determinations will be made when individuals are not included in approved data systems.

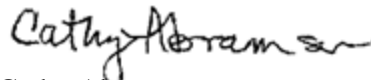
- d. Enrollment – enrollment processes must accommodate not only special provision for AI/AN in Exchanges (monthly enrollment, waiver of cost sharing, exclusion of certain sources of income), but also in Medicaid, Medicaid Expansion, Child Health Insurance Programs, and Basic Health Plans, if there are any in the State.
- e. Enrollment Assistance – carve outs for navigator contracts for the I/T/Us and other enrollment assistance funding, such as Medicaid Administrative Match (MAM).
- f. Tribal Sponsorship – allow aggregate payment of premiums and other policies to encourage Tribal sponsorship of individuals to enroll in Exchange plans.
- g. Outreach and Education – provide outreach and education that is culturally appropriate and assures that AI/AN know which QHPs have I/T/U providers in their networks and informs them of the special protections and provisions for AI/AN.
- h. Call Centers – decide whether it is most appropriate to have an Indian desk to handle questions and resolve problems regarding AI/AN and I/T/Us, or whether everyone who works at a call center should receive training about Tribes in the State, the Indian health care delivery system and special provisions in the law, regulations and systems for AI/AN.
- i. Website – ensure that the design of the website includes information specific to AI/AN and the I/T/U and is easy to access by consumers, as well as those assisting with enrollment.
- j. Waiver of Penalties for AI/AN without Insurance -- develop the system to assure that individuals are not penalized and to communicate who is covered by this provision in the law.
- k. Enforcement of Section 206 of the Indian Health Care Improvement Act (IHCA) -- assure that the I/T/U is paid in a sufficient and timely way for services delivered to individuals who are enrolled in QHPs if the I/T/U is not a network provider.
- l. Reimbursements for Waived Cost Sharing – process to assure that the I/T/U receives payment for the co-pays and deductibles that are waived for AI/AN.
- m. Referrals through Contract Health Services (CHS) -- rules and processes to assure that AI/AN who are enrolled in a QHP and referred through an I/T/U CHS program are not charged a co-pay or deductible for services they receive outside the I/T/U.

We believe that many of the issues listed above can be resolved on a nationwide basis by adopting policies for Federally-facilitated Exchanges. However, some issues will need solutions that are specific to the State in which the Federally-facilitated Exchange will operate. For example, a State with only one or two Tribes may require a very different scale of problem solving related to such things as enrollment assistance compared to a State with 30 or more Tribes.

National Indian Health Board has observed that this Administration has too often made decisions behind closed doors with only Federal agency representatives participating in the discussion and debate. We do not believe that the Indian Health Service or any other Federal agency speaks for Tribes. Tribal leaders and the individuals they designate need to be at the table to assure that that our Tribal citizens receive the benefits and protections which are specified in Federal law and that systems are developed that enhance the ability of our health care facilities and programs to meet the needs of our people.

Please consider this a request for enhanced Tribal Consultation on a federal and State-by-State basis for any issue that was included in Tribal comments on the NPRMs for Exchanges that the Federal government has not yet agreed to implement. We appreciate the opportunity to provide input on this important government-to-government process. If you have any questions, you can email Jennifer Cooper at jcooper@nihb.org. Thank you.

Sincerely yours,



Cathy Abramson
Chairman, National Indian Health Board

cc: Dr. Yvette Roubideaux, Director, Indian Health Service (IHS)
P. Benjamin Smith, Acting Director, Office of Tribal Self-Governance, IHS
Stacy Bohlen, Executive Director, NIHB
Kitty Marx, Tribal Affairs Group (TAG) Director, CMS
Pete Nakahata, Center for Consumer Information and Insurance Oversight (CCIIO), CMS
Lisa Wilson, CCIIO/ CMS