

National Indian Health Board



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October 31, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201
Attention: CMS-9980-NC

RE: NIHB Comments in Response to CMS-9980-NC; Request for Information Regarding State Flexibility to Establish a Basic Health Program under the Affordable Care Act of 2010¹

The National Indian Health Board² (NIHB) appreciates the opportunity to provide input on the topic of the Basic Health Program option in response to the request for information from the Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services (HHS), published September 14, 2011 in the *Federal Register* titled "Request for Information Regarding State Flexibility To Establish a Basic Health Program Under the Affordable Care Act" (CMS-9980-NC; Request for Information).

Analysis and Recommendations

The health insurance program in Washington State that served as the model for the Basic Health Program (BHP) provided affordable options to low and moderate income individuals and families. The BHP may hold similar promise, depending upon the structure and requirements ultimately established for the program.

¹ Refers collectively to the Patient Protection and Affordable Care Act (Pub.L. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), and referred to herein as the Affordable Care Act or ACA. Section 36B, contained in section 1401 of the ACA, was subsequently amended by the Medicare and Medicaid Extenders Act of 2010 (Pub. L. 111-309), the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011 (Pub. L. 112-9), and the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (Pub. L. 112-10).

² Established nearly 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.



Applicability of Affordability and Access Provisions and Protections from Exchange

To achieve the result of providing timely and affordable access to necessary health care services, it is critical that the affordability and access provisions and protections afforded to American Indians and Alaska Natives (AI/ANs) enrolled in a health plan in the individual market through an Affordable Health Insurance Exchange (Exchange) carry over to the BHP. Without this guarantee, AI/ANs will not be assured that they will be able to, for instance, secure health insurance coverage without cost-sharing requirements.

To the greatest extent possible, NIHB is requesting that BHPs be required to offer the same protections to AI/ANs as AI/ANs would receive in an Exchange. Although some of these protections will flow to AI/ANs by force of law, some of the protections anticipated in the Exchanges have been the outcome of careful analysis, protracted negotiation, and thoughtful deliberation. In both cases, NIHB believes that CMS has the authority to ensure an adequate BHP design through the inclusion of these provisions.

Where provisions are mandated by Federal Indian law, CMS can and should provide direction to States, and clear and specific language for BHP policy. Where “best practices” would demand the adoption of certain measures, CMS, using its rulemaking authority, can and should require state BHPs to include those measures. If CMS fails to take this leading role, Tribes will have to educate, advocate and negotiate state-by-state, simultaneously. Tribes cannot conduct this process, state-by-state, without draining tremendous resources in time, effort, and money. Tribes would not be the only ones to suffer from this inefficiency. States too, would be forced to replicate efforts and waste resources.

The AI/AN-specific provisions and protections accessible to AI/AN enrolled in a health plan in the individual market through an Exchange include –

- AI/AN-specific cost-sharing protections;
- Ability to enroll in bronze plan and retain premium assistance and full cost-sharing protections;
- Facilitating the application of IHCIA section 408 mandating that plans offer to contract with Indian Health Care Providers as in-network providers;³
- Facilitating the use of an Indian Addendum for Indian Health Care Providers; and

³ The term "Indian Health Care Provider" means the Indian Health Service (IHS), an Indian Tribe, tribal organization or urban Indian organization, and is sometimes referred to collectively as "I/T/U". The term "Indian Health Service" means the agency of that name within the U.S. Department of Health and Human Services established by Sec. 601 of the Indian Health Care Improvement Act (IHCIA), 25 USC §1661. The term "Indian tribe" has the meaning given that term in Sec. 4 of the IHCIA, 25 USC §1603. The term "tribal organization" has the meaning given that term in Sec. 4 of the IHCIA, 25 USC §1603. The term "urban Indian organization" has the meaning given that term in Sec. 4 of the "IHCIA", 25 USC §1603.

- Facilitating Indian sponsorship of enrollees for payment of premium contributions, if any, through the use of group payment mechanisms.

Tribal Consultation

NIHB requests that, prior to the issuance of proposed rules on the BHP, CMS engage in tribal consultation on the requirements to be established under the BHP.

To ensure that the Federal government fulfills its trust responsibility to Tribes and AI/AN people, NIHB believes that CMS must consult with Tribes regarding the BHP option before a proposed rule is issued. While consultation is required, it also is advisable as a practical matter. In many places, Tribes and States must work together for the program to reach intended beneficiaries. Because Tribes are important and necessary partners in the effort to execute the program, they are critical to the planning process as well.

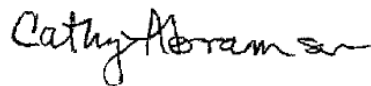
Although asking for “information” regarding the BHP option is a start, CMS must go further to fulfill its consultation requirement to Tribes. A “consultation” meeting needs to give Tribes the chance to ask questions about the program, as well as the opportunity to provide advice and recommendations. CMS’ solicitation of information on this occasion does not discharge its consultation duties.

Conclusion

We thank you in advance for consideration of these comments and look forward to further discussions on this topic prior to the release of proposed rules.

As always, we appreciate your efforts as we jointly work to advance the health status of American Indian and Alaska Native individuals and communities across the United States.

Sincerely,



Cathy Abramson
Chairman, National Indian Health Board

C: Dr. Donald Berwick, Administrator, CMS
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