

Indian Sponsorship under Exchange Plans

Background

In October of 2010, the Tribal Technical Advisory Group to CMS provided comments to the Center for Consumer Information and Insurance Oversight (CCIIO) in response to the request for comments on Exchange related provisions in the Patient Protection and Affordable Care Act (ACA).¹ In these comments, NIHB recommended that the Federal government require state-based Exchanges to enable Indian Tribes, tribal organizations, and urban Indian organizations to pay premiums on behalf of American Indians and Alaska Natives (AI/ANs). Since then, through the Centers for Medicare and Medicaid Services (CMS) Tribal Technical Advisory Group (TTAG) and other venues additional discussions have taken place among TTAG members and advisors, NIHB and other tribal representatives, and CMS and CCIIO representatives, the latest of which was a TTAG ACA Policy Subcommittee meeting in mid-March.

To meet its trust responsibility to AI/ANs,² the Federal government has long provided AI/ANs health care services, without charge, through IHS, tribally operated programs, and urban Indian health programs. But, for more than 35 years, IHS has shared that responsibility with other Federal programs, such as Medicare, Medicaid, and Children's Health Insurance and, now with the new insurance opportunities established under the ACA. As with the earlier programs, the impact of the Congressional actions with regard to enactment of the ACA is contingent on effective implementation that makes enrollment in the new comprehensive health insurance programs a realistic possibility.

The ACA gives States considerable flexibility in meeting the core functions required for State Health Insurance Exchanges (Exchanges).³ This letter is intended to follow-up on specific comments and questions that arose during the interactions described above and to try to help inform the mutual work in which we are engaged. We understand CCIIO is developing

¹ Pub. L. 111-143, as amended (March 23, 2010).

² The Federal government's trust responsibility to American Indians was reconfirmed in the reauthorization of the Indian Health Care Improvement Act found in Section 3 of the IHCA, codified at 25 U.S.C. § 1602:

DECLARATION OF NATIONAL INDIAN HEALTH POLICY.

Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians— (1) to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy

³ Pub. L. 111-148, § 1311(d), codified at 42 U.S.C. § 18031(d).

regulations that will provide a mechanism for States to demonstrate how they intend to meet their core functions.

IHS, Tribes and tribal organizations, and urban Indian organizations will almost certainly encourage AI/ANs and other IHS beneficiaries⁴ to participate in an Exchange. However, Tribes, tribal organizations, and urban Indian organizations (T/Us) may also wish to go further by financially sponsoring all or part of the unsubsidized portion of individual plan premiums for certain IHS beneficiaries enrolled through the individual market in an Exchange (referred to in this paper as Indian Sponsors or Indian Sponsorship).⁵ The only cost-effective way for a T/U to accomplish this is to make a periodic collective payment that covers the combined costs of each such beneficiary's premiums.

In developing regulations governing insurance plans offered through an Exchange (Exchange Plans), we are requesting that CCIIO include language that specifically recognizes the benefits of allowing T/Us to financially sponsor IHS beneficiaries through the payment of premiums. We propose specific regulatory language that will accomplish this without adding any costs or burdens to the States.

Request and Justification for Regulatory Language Allowing T/U Financial Sponsorship of Exchange Plan Premiums.

We propose that the following or similar language be included in any regulatory proposal:

The State/Exchange shall describe how it will facilitate requests of Indian Tribes, tribal organizations, and urban Indian organizations, as those terms are defined in 25 U.S.C. § 1603, to sponsor and pay the unsubsidized portion of individual plan premiums for Indian Health Service beneficiaries participating in the individual market in an Exchange through a periodic collective payment.

OR -

The State/Exchange shall establish procedures under which an Exchange will enable Indian Tribes, tribal organizations, and urban

⁴ Other IHS beneficiaries may include children or spouses of AI/ANs who are eligible for services under Section 813 of the Indian Health Care Improvement Act (IHCIA), Pub. L. 94-437, codified as amended at 25 U.S.C. § 1680c.

⁵ In these comments, the term "IHS beneficiary" will include all Indians as that term is defined in 42 C.F.R. § 447.50 and the children and spouses of such Indians if they are eligible for Indian health services under 25 U.S.C. § 1680c.

Indian organizations, as those terms are defined in 25 U.S.C. § 1603, to assist Indian Health Service beneficiaries to (1) enroll in any qualified health plan offered through the individual market in an Exchange in the State; and (2) apply for premium tax credits and cost-sharing reductions for plans offered through an Exchange. Such procedures shall include permitting Indian Tribes, tribal organizations, and urban Indian organizations to pay premiums on behalf of Indian Health Service beneficiaries.

The justification for this proposed regulatory language follows.

One of the overarching goals of Exchange Plans is to lower insurance costs by creating more efficient and competitive markets for individuals and small employers. One way to do so is by increasing insurance market participation among hard to reach populations. The ACA and CCIO Guidance specifically require consultation with advocates for enrolling such populations, which include AI/ANs.⁶ In addition, the ACA authorizes agents and brokers to enroll individuals and assist them in applying for premium tax credits and cost-sharing reductions for plans sold through an Exchange.⁷

AI/ANs are entitled by law to receive care without cost from IHS, and therefore have traditionally had little incentive to enter the individual insurance marketplace. To overcome the chronic underfunding of the Indian health system, some tribal health programs have encouraged IHS beneficiaries to participate in other programs, such as Medicare Part D, by subsidizing premiums. The only efficient way for T/Us to accomplish this is to make a periodic collective payment on behalf of the group of beneficiaries for whom it is paying part or all of the premium cost. Absent the sponsorship option, tribal health programs generally cannot afford the high administrative cost of separately reimbursing individual members for individual premiums. Some States, like Washington, have recognized the administrative efficiency of such a sponsorship model. The State concluded in an assessment of their Basic Health insurance program that group sponsorship has resulted in the enrollment of significantly more members of disadvantaged groups, including AI/ANs, in the Basic Health program.

Indian Sponsorship of individual Exchange Plan premiums for IHS beneficiaries will promote efficiency in several ways. It will provide a critical incentive to a traditionally hard to reach population to enroll in an Exchange Plan. It will also benefit Exchange Plans by increasing Exchange Plan membership and providing efficiency and ease of premium payment through a

⁶ ACA §1311(d)(6), codified as amended, at 42 U.S.C. § 18031(d)(6)(e)

⁷ ACA § 1312(e), codified as amended, at 42 U.S.C. § 18032(e).

payment sponsorship. Finally, an Indian sponsorship option will not impose any additional costs or burdens to the States.

An Indian Sponsorship model is consistent with the letter and spirit of the ACA, which, in part, gives States the right to make payments for individuals under a qualified health plan offered through an Exchange.⁸ In addition, Indian Sponsorship is also consistent with the Indian Health Care Improvement Act, which specifically authorizes Tribes, tribal organizations and urban Indian organizations to use IHS funding to purchase health benefits coverage for their members through licensed health plans in a state.⁹

Indian Sponsorship Models

The goal of enabling Indian Sponsorship is to maximize enrollment of AI/AN in comprehensive health insurance coverage. Indian Sponsorship mechanisms have proven to be an effective tool in boosting enrollment of AI/AN in various public health insurance programs, and therefore should be enabled in the context of Exchanges.¹⁰ However, T/U participation in Indian Sponsorship programs would have to be a voluntary option, as some T/U may not have the resources or capacity to participate.

Indian Sponsorship mechanisms may be designed in a variety of ways. In large part, the particular approach taken is dependent upon the structure and processes established for general enrollment in offered plans. Although the design of a particular Indian Sponsorship model may vary, key elements that are common in successful Indian Sponsorship models include:

- The sponsoring Tribe, tribal organization, or urban Indian organization develops policies for its sponsorship, including determining who is eligible for sponsorship and the level of financial sponsorship the Indian Sponsor may provide.
- The Indian Sponsor conducts outreach, explains options and assists in enrollment.
- The Indian Sponsor maintains a list of the individuals it is sponsoring, and the Indian Sponsor is able to verify to the Exchange or Exchange Plan that a particular person is being sponsored and the amount of the financial assistance being provided.
- The Indian Sponsor receives a master bill on a periodic basis for all individuals it agrees to sponsor, and the Sponsor pays the premiums with a single check or electronic

⁸ ACA §1412(e), codified, as amended, at 42 U.S.C. § 18032(e).

⁹ See, IHCA Section 402, 25 U.S.C. § 1642. We note that this provision does not limit the ability of a T/U to use other funds for this purpose as well, either under its funding agreement with IHS or under other tribal authority.

transfer to (i) the Exchange (if the State elects to have all premiums flow through the Exchange); or (ii) to each Exchange Plan in which one or more sponsored individuals are enrolled.

- Sponsored individuals can choose to list the address of the Indian Sponsor as their mailing address for issues regarding enrollment and premiums so that the Sponsor is aware of payment, access or other issues that could arise and can assist the individual to resolve them.

In discussions with CCIIO staff, a question was raised as to how an Indian Sponsorship mechanism would work if plan premiums were either 1) paid through the Exchange or 2) paid directly to Exchange Plans. In addition, a question has been raised as to the degree to which Indian Sponsorship mechanisms may be automated. Below, we offer two attachments that respond to these issues.

Attachment 1 provides a summary of the Indian sponsorship mechanisms in place under Medicare Part D and the Washington State Basic Health insurance program. These programs provide examples of currently operating Indian sponsorship mechanisms. Attachment 2 contains one example of an Indian sponsorship model that incorporates the elements outlined above. This model is provided to illustrate how an Indian sponsorship mechanism may be structured, but any model implemented by a T/U and an Exchange (and/or Exchange Plans) would need to meet the particular circumstances of the Indian Sponsor, Exchange, and Exchange Plans involved. The example in Attachment 2 is functional under both a structure where plan premiums are paid through an Exchange or directly to Exchange Plans. The degree to which the model would be automated is dependent, in part, on the interest in and capacity of the sponsoring T/U and the Exchange and/or Exchange Plans to establish and maintain the capability for such a system.

Attachment 1: Case Studies

Medicare Part D

Medicare Part D legislation and regulations did not specifically address Indian sponsorship for Part D premiums. Using sponsorship models developed for Medicare Part B and other state subsidized insurance programs like Basic Health, several Tribes organized programs to pay Part D premiums on behalf of tribal members. Eligible AI/ANs were offered the opportunity to enroll in Part D and were provided information on the tribal program and Part D plans. If an eligible AI/AN agrees to participate, tribal staff assist him or her with the online enrollment process.

To expedite the process and minimize costs, tribal staff develop relationships with staff at Part D plans – generally these individuals are called account managers. Tribes also provide names of individuals they are sponsoring to the plan. Where agreed upon, plans send consolidated bills to the Tribe.

Although CMS regulations on Part D did not specifically address Indian sponsorship, we believe that it is important for CCIIO to do so with regard to the Exchanges. Unlike with Part D, in which T/Us dealt directly with insurance carriers, Exchange operators function as a new variable in the process. With the issuance of regulatory language, Exchanges (and Exchange Plans) will receive an indication of Federal support for establishing such a mechanism. Conversely, without the regulatory language, Exchanges might be hesitant to establish this mechanism out of concern of exceeding ACA program rules, and T/Us themselves might be hesitant to undertake the administrative responsibility of sponsorship out of concern that individual Exchanges might decide to categorically reject an Indian sponsorship payment model. Affirmative regulatory authority would further encourage responsiveness from T/Us that are already interested in acting as a Sponsor and can provide notice to those T/Us that may not already be aware of such an option. Finally, the inclusion of regulatory language that facilitates Indian Sponsorship will inform concerned individual Exchange enrollees that participating in Indian sponsorship is a viable option. Essentially, we believe that affirmative regulations are critical to establishing this efficient enrollment mechanism for which the Exchanges were designed.

Washington Basic Health

Recognizing that premium payment was a significant barrier to Basic Health (BH) enrollment for some populations, the state of Washington developed a program that permitted certain entities to sponsor premiums for select individuals.

Criteria for the financial sponsor program were developed over time and included:

- Sponsors sign up with the State.
- Sponsor is expected to assist enrollees in their interaction with BH and distribute communications to them.
- Sponsor must establish eligibility for participation with that particular financial sponsor; and sponsored enrollees must meet all BH eligibility requirements as outlined in regulations.

The goals for the sponsorship program included:

- Providing hard to serve populations with health care.
- Involving populations with little experience with health insurance and managed care concepts.
- Addressing ethnic and racial health care disparities.
- Developing integrated health care for low income, underserved populations.

After negotiating and signing an agreement with the State, interested Tribes developed internal policies to find, educate and enroll eligible individuals. BH had dedicated staff to interact with Indian sponsors. Tribes provided updated lists of sponsored individuals monthly. BH confirmed enrollment and notified the Tribe if renewal information was needed. Payments were made to and reconciled with BH. BH staff provided updates, engaged in problem solving, and met regularly with Indian sponsors.

An evaluation of the BH sponsorship program concluded that “the sponsor program has been instrumental in significantly boosting ethnic enrollment by effectively reaching ethnic and racial minorities.”

Attachment 2: Example of an Indian Sponsorship Model

Indian Sponsorship: Process for American Indians/Alaska Natives to Enroll in a Health Plan through an Exchange and Receive Premium Assistance from Indian Sponsor.^{11, 12}

Steps shown in bold below are unique to Indian Sponsorship process.

1. Applicant accesses application process through Exchange Internet website.
2. Applicant enters standard demographic information requested (e.g., age, family size), including indicating whether Applicant is an “American Indian/Alaska Native” as that term is ultimately implemented. This may include providing information that will allow verification of the assertion either from the Applicant or an external source.¹³
3. If “AI/AN” box is checked, Applicant will be asked their tribal affiliation and will be given information about special Indian provisions that may affect them.
 - **Exchange/plan would query database maintained by Indian Sponsor (either by receiving a copy of list, or by making a telephone call or initiating some other agreed upon communication) to report AI/AN enrollment and confirm if Applicant is eligible for premium assistance from Indian Sponsor and the amount or type of premium assistance to be provided.**¹⁴
4. Applicant researches health plans.
5. Applicant selects health plan.
 - Website would indicate that calculation of Applicant’s premium is subject to verification of the information provided, **including any premium assistance from Indian Sponsor.**

¹¹ This model is provided to illustrate how an Indian sponsorship mechanism may be structured, but any model implemented by a T/U and an Exchange (and/or Exchange Plans) would need to meet the particular circumstances of the Sponsor, Exchange, and Exchange Plans involved.

¹² “Indian Sponsor” refers to a Tribe or tribal organization or urban Indian organization.

¹³ Even without the Indian sponsorship option, Exchange websites will need the capability to identify AI/ANs in order to administer cost-sharing protections established in § 1402(d) of the ACA.

¹⁴ Alternatively, if the capability has been established by the Indian Sponsor and access granted to the Exchange or Plan, the query could be run using an automated process similar to those used to verify other data.

6. Applicant submits premium payment, if any, to Exchange/Plan via mail or Exchange/Plan website. Alternatively, the Indian Sponsor could collect the individual enrollees' share of any premium and pay the Exchange or Plan the full amount of the premium.
- 7. Exchange provides invoice to Indian Sponsor on a periodic basis indicating which sponsored Applicants are enrolled in plans and the amount due from Indian Sponsor for sponsored Applicants.¹⁵**
- 8. Indian Sponsor confirms data in invoice from Exchange/Plan and makes payment to Exchange/Plan for sponsored Applicants enrolled in Exchange Plans.**
9. If the amount of the premium due from Applicant needs to be subsequently adjusted (due to income being different than originally reported, Indian Sponsor indicating Applicant is not eligible for premium assistance from Indian Sponsor, or other reason), the Exchange/plan would notify Applicant/Indian Sponsor and explain reason(s) for adjustment in the premium due.
10. Indian-sponsored enrollees, like all enrollees in Exchange Plans, will have to be periodically reviewed/updated to identify any change in eligibility to purchase insurance in the individual market. T/Us can help facilitate this review process for the individuals they sponsor.