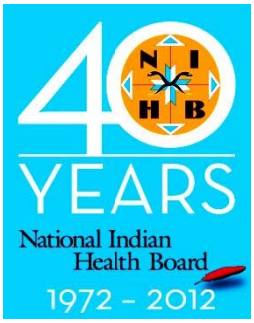


National Indian Health Board

Delivered via electronic transmission

October 22, 2012

Mr. John J. O'Brien
Director, Healthcare and Insurance
U.S. Office of Personnel Management
1900 E Street, NW, Room 5532B
Washington, DC 20415-0001

Re: NIHB Comments on Draft Multi-State Plan Program Application

Dear Mr. O'Brien:

On behalf of the National Indian Health Board[1], I am writing to submit comments on the U.S. Office of Personnel Management (OPM) Draft 2014 Multi-State Plan Program Application. Our comments are provided below as well as in the attached comment template.

The Multi-State Plan Program (Program) will be critically important to ensure that American Indians and Alaska Natives (AI/ANs) are able to access affordable health insurance through the Affordable Insurance Exchanges (Exchanges). As discussed below, AI/ANs have a federal right to health care at no cost to them through the Indian Health Service, Tribes and Tribal programs, and urban Indian organizations (collectively, the I/T/U of the Indian health system). Because of this, they are unlikely to purchase insurance products on the Exchanges unless they can continue to receive care at no cost to them, and do so at the Indian health care provider of their choice. If they do not participate in the Exchanges, AI/ANs will not be able to take advantage of the

[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

premium tax credit assistance and cost-sharing exemptions Congress intended would be made available to improve health care outcomes for AI/AN people.

To overcome this financial barrier to meaningful AI/AN access to the Exchanges, Tribal entities may choose to pay all or part of the premiums on behalf of designated AI/AN individuals. Tribes and Tribal organizations will be hesitant to do so unless the plans on the Exchanges are open to allowing them to make aggregated premium payments on behalf of their members, and the plans offer to include Indian health care providers in their provider networks. In addition, based on the successful experience under the Medicare Part D Program, we have found the use of a standard contract addendum that addresses Indian-specific issues to be critical to successful contracting by health plans with Indian health care providers. Our comments focus on designing the Program application criteria to ensure that the Multi-State Plans (MSPs) selected by OPM will allow Tribal entities to implement this solution for AI/AN people.

Our comments request that the application criteria OPM establishes for the Program encourage MSP applicants to (1) demonstrate how they will offer to include Indian healthcare providers in their provider networks, (2) agree to use a standard contract addendum when contracting with Indian health care providers, and (3) allow Tribes, Tribal organizations and urban Indian organizations to make aggregated group payments of premiums on behalf designated individuals to the MSPs. These requests are consistent with the guidance provided by CMS in its Final Exchange Establishment Rule, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans," 77 Fed. Reg. 18346 (March 27, 2012), and with on-going efforts by the CMS Center for Consumer Information and Insurance Oversight (CCIIO) to draft and issue a standard Indian addendum, thereby facilitating and encouraging Qualified Health Plans (QHPs) to contract with Indian health care providers. For OPM to foster these three measures (*i.e.*, MSP contracting with Indian health care providers, use of a standard Indian addendum, and group payment of premiums on behalf of AI/ANs) is also fully consistent with advancing the Federal trust responsibility.

OPM Has a Continuing Federal Trust Responsibility to Enable Meaningful AI/AN Access to the Federal Health Care Programs It is Charged with Administering

The Federal government's trust responsibility to provide health care services to Tribes originates in treaties and other agreements between Tribes and the United States, and has been consistently reaffirmed in numerous Acts of Congress, Executive Orders, regulations, and the ongoing course of dealings between the Federal government and Indian Tribal governments. The most recent reaffirmation of the unique responsibility was included in the 2010 amendments to the Indian Health Care Improvement Act in which Congress declared:

> "Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians--
>
> (a) to ensure the highest possible health status for Indians

and urban Indians and to provide all resources necessary to effect that policy . . ."[2].

Although the Federal trust responsibility to provide health care to AI/ANs has been carried out in recent years by the Indian Health Service (as well as Tribes and Tribal organizations, operating under the Indian Self-Determination and Education Assistance Act (ISDEAA)), this responsibility is not limited to the Indian Health Service. Rather, it applies to the Federal government as a whole, and to each agency charged with administering federal health care programs.

OPM has demonstrated itself as a model agency in administering the Federal trust responsibility in its implementation of the Federal Employees Health Benefits (FEHB) program option for Tribes. OPM's commitment to Tribal consultation and the resources required to getting the program up and running and available to Tribes across the country is to be commended. We hope that OPM will continue to administer the Federal trust responsibility in the Program with the same level of commitment, Tribal consultation and collaboration it has demonstrated with the FEHB program.

The Unique Nature of the Indian Health System Creates Barriers to Accessing Exchange Benefits for American Indians and Alaska Natives

American Indians and Alaska Natives have a right to health care at no cost to them, and AI/ANs who seek services from IHS and Tribal providers do not pay for those services directly. Consistent with the Federal trust responsibility, Congress has enacted laws that ensure that AI/ANs are not charged for participating in other federal health care programs. In Medicaid, CHIP and the Exchanges[3], for example, there are no deductibles or co-pays for AI/ANs. Similarly, the ACA provides that AI/ANs are not subject to the penalties for failing to obtain insurance.

Because AI/ANs can obtain care at no cost to themselves through the I/T/U, AI/ANs will be hesitant to purchase health insurance through the Exchanges. Yet Congress clearly intended Exchange coverage to be an additional vehicle for providing additional resources to the Indian health care system, and Congress encouraged AI/ANs to participate in the Exchange program when it exempted most AI/ANs from cost-sharing in the Exchanges.

The Congressional Budget Office (CBO) estimates that the premium exchange subsidies for qualified individuals will total $1,017 billion over the 2012-2022 period. We estimate as many as 510,000 AI/ANs will qualify for exchange subsidies as their family income falls between 138 and 400 percent of the Federal Poverty Level (FPL). These tax credits are only available through the Exchanges.

[2] 25 U.S.C. § 1602.

[3] All AI/AN who receive their care through an I/T/U or contract health services are not subject to cost-sharing through the Exchanges. AI/AN with incomes below 300 percent of the Federal Poverty Level who receive care from any other provider are similarly exempt from cost-sharing in the Exchanges.

Access to this benefit is critically important to the Indian health system, as it will provide access to the private insurance market that many AI/ANs could not otherwise afford, and create new third party sources of revenues for I/T/U, which are chronically underfunded with federal appropriated funds at only 55 percent of need. Without action by OPM and its sister agencies to remove barriers to access Exchanges by AI/ANs, however, these benefits will likely remain unclaimed by AI/AN people, and provide no relief to the chronic health care disparities between AI/ANs and the general population.

OPM Has an Opportunity to Implement the Program to Reduce Barriers to AI/AN Access to the Exchanges

OPM has a unique opportunity to further reduce impediments to AI/ANs' timely access to comprehensive health care services by lowering barriers to Exchange coverage by AI/ANs and in the process create positive and lasting change in the health care of AI/AN people. As outlined above, there are three critical steps for achieving this goal: (1) encourage MSPs to contract with I/T/U; (2) facilitate the use of a standard Indian addendum when contracting with I/T/U; and (3) require MSPs to accept aggregate payment of premiums on behalf of AI/ANs.

Tribal Sponsorship

Because AI/ANs have little incentive to purchase insurance products on the Exchanges when they otherwise have a right to free care through the I/T/U system, many Tribes and Tribal organizations may choose to pay all or part of the unsubsidized portion of the premium payment on behalf of their members. In the final rule on Exchange establishment, CMS confirmed that an "Exchange may permit Indian Tribes, Tribal organizations and urban Indian organizations to pay aggregated QHP [Qualified Health Plan] premiums on behalf of qualified individuals…" 45 C.F.R. § 155.240(b). Similarly, in the Preamble to the Final Rule, CMS stated that "[w]e encourage Exchanges to include this [Tribal Sponsorship] option as part of its consultation with Tribal governments." 77 Fed. Reg. 18310, 18338 (Mar. 27, 2012).

We understand that the MSPs selected by OPM will operate in accordance with the rules of the Exchange in which they participate. For example, some Exchanges may permit premium payments from plan enrollees to be made through the Exchange, while others (such as those operated as Federally-facilitated Exchanges) will require payments to be made directly to the QHPs themselves. But, as provided for the Affordable Care Act, all Exchange enrollees have the right to make direct payments to QHPs. Likewise, OPM should ensure that any MSP selected be willing to permit Tribal entities to make aggregate payments for sponsored AI/ANs in each Exchange they operate.

Inclusion of I/T/U in MSP Provider Networks

Tribal entities are unlikely to make such premium payments on behalf of their members unless their Tribal health facilities can fully participate as in-network providers in the MSP provider networks. Although Section 206 of the Indian Health Care Improvement Act (IHCIA) allows I/T/U providers to bill health plans for services provided to the plan's enrollees whether or not the I/T/U provider is in the plan's network, it is preferable that the I/T/U be part of a plan's network. Section 408 of the IHCIA provides that Federal health care programs like the Multi-

State Plan Program must accept I/T/Us as in-network providers on the same basis as any other provider. Including I/T/U in MSP networks will facilitate coordination of care, minimize duplication of services, and provide greater certainty to the I/T/U providers in the timeliness and amount of payments. It will also significantly reduce the transaction costs that would be involved for each I/T/U to enforce its right to payment under Section 206 of the IHCIA.

Accordingly, we request that OPM encourage plans that seek qualification as an MSP to offer to contract with I/T/U providers in their service areas. Inclusion of I/T/U providers should be central to demonstrating network adequacy for AI/AN people who are likely to have long-standing relationships with these providers who provide culturally competent care.

The Draft 2014 Multi-State Plan Program Application (Application) requires MSPs to

> "Describe provisions for adequate choice for enrollees who are American Indians and for ensuring covered services from the Indian Health Service, as applicable"

in demonstrating the adequacy of their provider networks. The Application also requires MSPs to

> "Describe your approach to ensuring compliance with 45 CFR 156.235, regarding Essential Community Providers in your network."

We are encouraged that OPM has proposed to ask potential MSPs to demonstrate their networks will provide adequate choice for AI/AN enrollees and to ensure continued coverage of services from the IHS. However, we believe this section of the application must be strengthened and made more precise if it is to have the desired effect. First, we note that it should cover American Indians and Alaska Natives, not just American Indians. Second, we note that health care services to AI/ANs are not only provided by the IHS, but also by Tribes, Tribal organizations and urban Indian organizations. Third, the only adequate choice for most AI/AN people is their local I/T/U provider. In many cases in Indian country, the only alternative health care option for AI/AN people is located hundreds of miles from Tribal population centers, leaving the I/T/U as the only practical option available. Even in more densely populated areas of the country, the I/T/U offers the only health care facility providing culturally competent care. Accordingly, because "adequate choice" for AI/AN people means the I/T/U of their choice, this requirement should be revised to explicitly require MSP applicants to describe provisions to offer to include I/T/U providers in their provider networks.

To address these concerns, we recommend that the first of the two provisions above from the Application be amended, as follows:

> Describe provisions for adequate choice for enrollees who are American Indians <u>or Alaska Natives</u> and for ensuring <u>these enrollees have access to</u> covered services from the Indian Health Service<u>, Tribal health programs, and urban Indian health programs, as applicable</u>.

We also note with approval that the draft application would require a plan to demonstrate compliance with 45 CFR 156.235 regarding essential community providers. I/T/Us are essential

community providers for purposes of the final Exchange rule, and a "sufficient number and geographic distribution of essential community providers" must be included in any provider network for that reason as well.

Use of a Standard Indian Addendum

One impediment for I/T/U providers may be the standard contract language an MSP requires. Often, the standard contract language offered by health plans contains provisions that are inconsistent with federal Tribal rights. For example, many such contracts will impose a requirement that the provider demonstrate it has obtained sufficient insurance. I/T/Us are generally covered by the Federal Tort Claims Act, however, and should not be required to spend significant and unnecessary dollars purchasing private insurance that is duplicative of FTCA coverage simply to enter into a provider contract. Likewise, when health plans are informed of the applicability of various Indian-specific federal laws, their concerns are often addressed.

The attached Addendum for Indian Health Care Providers has been developed to preemptively address these issues. It sets out federal laws that apply to provider contracts between I/T/Us and QHPs. We believe that use of this Indian Addendum will benefit both the plans and the Indian Health Care Providers by lowering perceived barriers to contracting, assuring compliance by the MSPs with key federal laws protecting I/T/Us, and minimizing potential disputes.

HHS has recognized the merits of the use of such an Indian Addendum. In the preamble to the Final Rule on Exchange Establishment, HHS stated that:

> We recognize that furnishing QHP issuers with a standard Indian Addendum to a provider contract may make it easier for QHP issuers to contract with Indian providers. We note that QHP issuers may not be aware of the various Federal authorities that govern contracting with Indian health providers, and such an Addendum may lower the perceived barrier of contracting with Indian providers. We plan to develop a template for contracting between QHP issuers and Tribal health care providers. While we do not uniformly mandate that QHP issuers use the template, we believe that QHP issuers will find it in their interest to adopt such a template when contracting with Indian providers. We also note that Exchanges may elect to direct QHP issuers to use the Indian Addendum when contracting with Indian providers. 77 Fed. Reg. at 18423.

CCIIO, the agency tasked with developing guidance and regulations on the Exchanges, is currently developing a standard Indian Addendum template. We further understand that CCIIO is preparing additional guidance that would encourage health plans to offer to contract with I/T/U using the Indian Addendum. We understand that this guidance may be released soon. We encourage OPM to ensure that the evaluation criteria OPM sets for the MSPs require or at the very least encourage plans in the strongest possible terms to offer to contract with I/T/U using the Indian Addendum. For your reference, we have attached a copy of a guide to the Indian Addendum we previously provided to CCIIO. Again, we strongly encourage OPM to make the attached Indian Addendum a part of OPM's 2014 Multi-State Plan Program Application along with the explanatory guide.

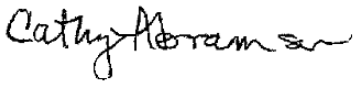
The MSPs will be of particular importance to AI/ANs and I/T/Us across the country. Ultimately, the MSPs will be available in every state, regardless of how a state implements their Exchange and regardless of whether an Exchange is operated by a state or HHS. Consistent with that Federal trust responsibility, we urge OPM to ensure that any plan that seeks MSP designation be required to demonstrate how it will offer to contract with the I/T/U using the Addendum as a condition for participation as an MSP.

Conclusion

The Multi-State Plan Program provides an important opportunity to ensure that AI/AN people will be able to meaningfully participate in Exchange coverage options and take advantage of the federal health care funding offered only through the Exchanges. As discussed above and in the specific recommendations we have made in the attached comments template, we urge OPM to administer this federal health care program in a way that incentivizes AI/AN participation in the Exchanges while still allowing them to receiving culturally competent care at the I/T/U provider of their choice. OPM can accomplish this by requiring the MSPs to offer to enter into network provider contracts with I/T/Us using the attached Indian addendum, and to allow aggregate payment of premiums by Tribal entities on behalf of qualified AI/AN individuals.

We appreciate the opportunity to provide comments on OPM's Draft 2014 Multi-State Plan Program Application. We would like to have further consultation with OPM on the issues raised in our comments and are available to provide additional information as may be necessary. You may contact Jennifer Cooper, NIHB Legislative Director at jcooper@nihb.org for further questions.

Sincerely Yours,



Cathy Abramson

Chairperson, National Indian Health Board

cc: Yvette Roubideaux, IHS
Stacy A. Bohlen, NIHB
Susan McNally, OPM
John Cutler, OPM
Gary Cohen, CMS
Peter Nakahata CCIIO