National Indian Health Board

September 28, 2010

Via electronic transmission to: <http/www.regulations.gov>

Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS – OCIIO – IFC
P.O. Box 8010
Baltimore, MD 21244-8010

RE: Comments of the National Indian Health Board regarding
Pre-Existing Condition Insurance Plan Program;
Interim Final Rule; File Code OCIIO – 9995 – IFC

These comments are filed on behalf of the National Indian Health Board (NIHB) in response to the Interim Final Rule (45 CFR part 152) published in the July 30, 2010 FEDERAL REGISTER regarding establishment of the Pre-Existing Condition Insurance Plan (PCIP) program authorized by Sec. 1101 of the Patient Protection and Affordable Care Act (PPACA).

Established nearly 40 years ago, the NIHB is an inter-tribal organization which advocates on behalf of Tribal governments, American Indians and Alaska Natives (AI/ANs) for the provision of quality health care to all AI/ANs. The NIHB is governed by a Board of Directors consisting of 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 the NIHB. Whether Tribes operate their own health care programs through contracts or compacts, or receive health care directly from the IHS, NIHB is their advocate. NIHB serves as a conduit for advancement of Indian health care through partnerships with other national and international organizations, foundations, corporations and others in its quest to build support for and advance the interests of Indian health care.

COMMENTS ON REGULATIONS

Summary of objection to regulations.

NIHB objects to these regulations because they may be interpreted to categorically exclude from eligibility for the Pre-Existing Condition Insurance Plan (PCIP) program Indian people eligible for medical services from the IHS and medical care programs operated by Indian

tribes without regard to whether they actually have coverage. As a consequence, these regulations and Sec. 1101 may have a racially discriminatory impact on AI/ANs with pre-existing health conditions by denying such individuals any opportunity to access the Federally-supported coverage of a PCIP program. Even if the regulations are applied narrowly to only exclude those AI/ANs who actually have access to an Indian health program, they fail to take into account whether that program is adequate to address the health care needs of the individual, and fail to effectuate the ultimate objective of the PPACA and the Indian Health Care Improvement Act (IHCIA), as amended, which is to increase access to health services by AI/ANs in order to improve their health status.

Cause of the potentially discriminatory impact.

To be eligible to enroll in a PCIP program, an individual must meet four criteria: (i) be a citizen of the United States or lawfully present in the United States; (ii) have not been covered under "creditable coverage" during the six month period prior to date of application; (iii) have a pre-existing condition as described in §152.14; and (iv) be a resident of a state that is within the service area of the PCIP to which he/she applies. It is criterion (ii) – no "creditable coverage" for the prior 6 months – that may be misinterpreted.

The PCIP regulations adopt the definition of "creditable coverage" found in Sec. 2701 of the Public Health Service Act (42 USC §300gg) and the regulations at 45 CFR 146.113(a)(1) which implement the insurance portability requirements of the Health Insurance Portability and Accountability Act (HIPAA). The purpose of defining "creditable coverage" in HIPAA is to identify the types/sources of health coverage which must be taken into account to *reduce* the length of any waiting period imposed by health insurance issuers which would delay the effective date of coverage based on an individual's pre-existing condition. One source of such "creditable coverage" is "coverage of an individual under… a medical care program of the Indian Health Service or of a tribal organization." 45 CFR 146.113(a)(1)(vi).

We are concerned that this will be read as excluding from coverage every AI/AN who might be eligible for health services of the IHS or a tribal organization without regard to whether the individual has actual access or whether the Indian health program can provide services. For instance, an AI/AN who lives in Washington D.C. has no access to an Indian health program because there is no such program within hundreds of miles. Alternatively, an AI/AN who lives within the Service Unit of an Indian health program may still have no access to adequate care to treat the qualifying condition. The vast majority of the Indian health system is made up exclusively of outpatient programs, many of which are limited to primary care services wholly inadequate to address the types of conditions for which this the PCIP program was designed.

These same programs rely on contract health services to acquire more complex or specialized care, but that program is wholly underfunded and even AI/ANs with conditions in which the person’s life is endangered due to their health condition may not be able to obtain care because of the limits of funding. When speaking on the floor of the Senate in support of the amendments to the Indian Health Care Improvement Act, the Chair of the Senate Committee on Indian Affairs cited example after example of individuals who had died or suffered irreparable harm due to the lack of resources in the Indian health program on which they relied. He described the contract health service program, all too accurately, as the “don’t get sick after

June" program since in most locations the total Federal fiscal year funding for purchasing such services has been exhausted by June.

Including IHS and tribally-operated medical programs in the HIPAA "creditable coverage" definition produces a fair and appropriation result for Indians in that law. It enables IHS/tribal health program eligibility to be taken into account to reduce waiting periods (under other insurance coverage) which might otherwise be imposed on Indians with pre-existing conditions. Since care from the IHS or tribal programs may be the only source of health care for many Indian people, it is appropriate to recognize such coverage for purposes of reducing a waiting period.

But importing that definition of "creditable coverage" with the IHS/tribal organization component into the PCIP program without any clarification that there must be actual coverage for the pre-existing condition produces an adverse and discriminatory impact on Indian people and runs counter to the goals established by Congress regarding Indian health.

> "[A] major national goal of the United States is to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States."[1]

Any application of the PCIP eligibility criteria for AI/ANs that does not take into account, at the very least, their actual access to meaningful coverage will exacerbate the disparities, rather than assist in eradicating them.

Moreover, denying access to this insurance, even where some services may actually exist in an Indian health program to which the AI/AN has actual access, still defeats the objectives of the PPACA and the IHCIA. The PPACA enacted special rules for AI/ANs. Among these is the payor of last resort rule.

> "Health programs operated by Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations (as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603) shall be the payer of last resort for services provided by such Service, tribes, or organizations to individuals eligible for services through such programs, notwithstanding any Federal, State, or local law to the contrary."[2]

Any denial of access to the PCIP program for those AI/ANs who otherwise meet the qualifications for this program and who are willing to purchase the coverage has the effect of shifting the cost of care back to the already underfunded Indian health program and, almost certainly, also has the effect of denying the individual AI/AN access to critically needed health care.

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[1] Section 2(2) of the Indian Health Care Improvement Act, as amended, 25 USC §1601.
[2] Section 2901(b) of the PPACA.

Indians are protected from discrimination by Federal law.

Indians and Indian tribes have a unique status in our Federal system. Being "Indian" is both a political classification as well as a racial distinction. In their political context, Indian tribes are recognized as governments, subject only to the United States as superior sovereign; the United States interacts with tribes on a government-to-government basis. In addition, the Federal government owes a unique trust responsibility to Indian tribes and their members, one long recognized in statutes, regulations, case law, Presidential executive orders, agency policies and the general course of dealings between tribes and the Federal government.[3] This trust responsibility extends to the duty to provide health care to Indian people. The U.S.'s obligation for Indian health has long been articulated in Sec. 3 of the Indian Health Care Improvement Act; the most recent reaffirmation of the obligation is found in the revised Sec. 3 of the IHCIA, as enacted by Sec. 10221 of the PPACA which states (in part):

> "Sec. 3. DECLARATION OF NATIONAL INDIAN HEALTH POLICY.
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> "Congress declares that it is the policy of this nation, in fulfillment of its special trust responsibilities and legal obligations to Indians –
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> (1) to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy;"

Indians and Alaska Natives are, of course, also considered to be an ethnic, racial or minority group in our nation's social fabric. As such, Indian/Alaska Native people are entitled to protection from discrimination in Federally-supported programs – such as the PCIP program – by Title VI of the Civil Rights Act, 42 USC 2000d, *et seq.* and the Department's Title VI implementing regulations at 45 CFR part 80.

The interim regulations at Part 152 require PCIP program operators – states or non-profit private entities that contract with HHS – to deny eligibility to Indian individuals, as they are covered under "a medical care program of the Indian Health Service or of a tribal organization". This puts the PCIP operator in the untenable position of either complying with Part 152 or with the HHS Title VI regulations. A PCIP cannot do both.

The PCIP exclusion is inconsistent with Indian-specific PPACA policies.

The exclusion of Indians from PCIP eligibility cannot be reconciled with Congress's efforts elsewhere in the PPACA to facilitate AI/AN access to health care reform programs. For example:

- Indians at/below 300% of the Federal Poverty Level are expressly eligible for enrollment in an Exchange plan and are exempt from cost-sharing.
- All Indians enrolled in an Exchange plan are exempt from cost-sharing for services provided by IHS and tribally-operated health programs.

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[3] *See Morton v. Mancari*, 417 U.S. 535 (1974), for a discussion of the political status of Indians.

- Indians have a special monthly enrollment period for Exchange plans.
- Indians are exempt from any penalty for failure to maintain minimum essential insurance coverage.
- When an Indian tribe purchases health care coverage for its members, the value of the coverage is exempt from the individual member's gross income.
- IHS, tribes, urban Indian organizations and tribal public health agencies are expressly eligible for a variety of grant programs intended to expand the health workforce and improve the quality and effectiveness of health care delivery.

Census Bureau definition of health insurance coverage removed IHS programs.

The Census Bureau collects data about different types of health insurance coverage and broadly classifies the types into either Private (non-government) coverage and Government-sponsored coverage. At one time, the "major categories of government health insurance" included programs operated by the IHS. The Census Bureau definition was subsequently revised, and for over a decade the definition of health insurance coverage used by the Census Bureau has not included programs operated by the IHS.

> A footnote to the "CPS Health Insurance Definitions" reads:
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> "After consulting with health insurance experts, the Census Bureau modified the definition of the population without health insurance in the Supplement to the March 1998 Current Population Survey, which collected data about coverage in 1997. Previously, people with no coverage other than access to the Indian Health Service were counted as part of the insured population. Subsequently, the Census Bureau has counted these people as uninsured. The effect of this change on the overall estimates of health insurance coverage was negligible."[4]

Due to the limitations on annual appropriations, the IHS does not provide guaranteed access to a defined set of covered services for the eligible population. As indicated above, the IHS is funded for only a fraction of the level required to provide guaranteed access to a standard set of covered services. As is the case with other health care programs operated by governments at the Federal, State or local level, health care programs that do not provide guaranteed access to a defined and comprehensive set of services—such as is the case with the IHS programs—should not be included in the definition of "creditable coverage" for purposes of implementing the PCIP.

And although the Census Bureau identified the change in their definition as having a "negligible" effect on the overall estimates of health insurance coverage, and a similar definitional change may have a negligible effect on the operation of the PCIP[5], inclusion of

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[4] http://www.census.gov/hhes/www/hlthins/methodology/definitions/cps.html

[5] The Pre-Existing Condition Insurance Plan is subject to a capped appropriation and, as such, elimination of the proposed ban on AI/AN would not increase overall program expenditures.

AI/AN with pre-existing conditions would have a tremendously positive impact on this population.

Similarly, the Congressional Budget Office does not consider individuals served only by the Indian Health Service to be "insured":

> "Because of staff shortages, limited facilities, and a capped budget, the IHS rarely provides benefits comparable with complete insurance coverage for the eligible population; as a result, estimates of the uninsured population in the United States do not treat the IHS as a source of insurance."[6]

Indian people have a high rate of pre-existing conditions.

Indian people are in particular need of the coverage the PCIP program offers. According to data compiled by Families USA, AI/ANs are the racial/ethnic group most likely to be subject to denial of coverage due to pre-existing conditions, with more than one-quarter (25.9 percent) having such conditions.[7] This is not surprising, as numerous studies have demonstrated that AI/ANs suffer disproportionately high rates of chronic conditions such as diabetes, mental health disorders and cardiovascular disease, as well as pneumonia, injuries and alcohol-related disorders.[8] Indian people with such conditions, however, are not receiving the treatment they need from the Indian health system.

Although the IHS exists to carry out the United States' trust obligation to provide health care to Indian people, that agency's programs are chronically underfunded and are incapable of providing all of the health care needed by this population. Resource deficiencies have prevented the Indian Health Service from establishing a full complement of necessary health services for all Indian beneficiaries. As a result, the range of services available varies from location to location within the IHS system. And the IHS's Contract Health Services program – through which needed care that the IHS cannot provide is purchased from public and private providers – is so underfunded that CHS care is severely rationed, with only the most serious medical priorities qualifying for care. IHS estimates the extent of CHS denials at more than $130 million in 2008.[9]

Despite being born with a legal right to health care, AI/ANs eligible for services from IHS find themselves in the position of receiving the lowest per-capita level of Federal support – lower than Medicare beneficiaries, veterans, Medicaid beneficiaries, Federal prisoners, and

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[6] Congressional Budget Office, *"Key Issues in Analyzing Major Health Insurance Proposals," at 127 (Dec. 2008).*

[7] Families USA, *Health Reform: Help for Americans with Pre-Existing Conditions*, at 5 (May, 2010).

[8] *See, e.g.*, James, C., Schwartz, K. and Berndt, J., *Race, ethnicity Health Care Issue Brief – A profile of American Indians and Alaska Natives and Their Health Coverage*, Kaiser Family Foundation (Sept. 2009); U.S. Commission on Civil Rights, *Broken Promises: Evaluating the Native American Health Care System*, (Sept. 2004).

[9] Indian Health Service, Fiscal Year 2011 Budget Justification, at CJ-95.

Federal employees. Per capita spending for IHS medical care in 2003 was only slightly more than 50% of the per capital amount spent for Federal prisoners.[10]

Thus, AI/ANs with pre-existing conditions are particularly in need of access to PCIP assistance. But they are the one group of Americans which is denied eligibility for this vital PPACA program. This exclusion contravenes the fundamental objective of the PCIP program and potentially constitutes racial discrimination in application of a Federally-funded program.

Recommended modification to Interim Final Rule to eliminate potentially discriminatory impact.

As demonstrated above, the medical care offered by the IHS and tribal programs is severely limited due to resource deficiencies. Experts in the field agree that Indian people who receive their care from IHS and tribal programs are not considered to have health insurance coverage. The PPACA's individual responsibility and Exchange features reflect that view: IHS-funded medical care is not included in the PPACA definition of "minimum essential coverage". *See* new Internal Revenue Code sec. 5000A(f), as added by PPACA sec. 1501(b).

To be consistent with this PPACA policy, and to avoid the potentially discriminatory impact of the Interim Final Rule described in these comments, we recommend that one or both of the following options be implemented. Option A is the preferred option of the NIHB.

Option A: Modify the definition of "creditable coverage" in §152.2 of the Interim Final Rule to provide that an individual who is eligible for medical care from IHS or a tribal organization is considered to have creditable coverage only if the medical care program provided by IHS or a tribal organization satisfies the definition of health insurance coverage under section 2791 of the PHSA [42 USC 300gg(b)(1)]. Suggested language follows:

> §152.2 Definitions.
>
> For purposes of this part the following definitions apply:
>
> *Creditable coverage* means coverage of an individual as defined in section 2701(c)(1) of the Public Health Service Act as of March 23, 2010 and 45 CFR 146.113(a)(1), provided that subparagraph (F) of section 2701(c)(1) shall apply only to the extent that the medical care program is provided pursuant to Section 2791(b)(1) of the Public Health Service Act.

Option B: At a minimum, the Rule should establish the authority for a case-by-case determination of whether an AI/AN applicant for the PCIP program actually has access to an IHS or tribal medical program, and, if so, whether such program is capable of supplying the health care needed by the applicant. An individual who does not have access to the needed care should be eligible for the PCIP program.

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[10] U.S. Commission on Civil Rights, *Broken Promises: Evaluating the Native American Health Care System*, at 98 (Sept. 2004).

Conclusion.

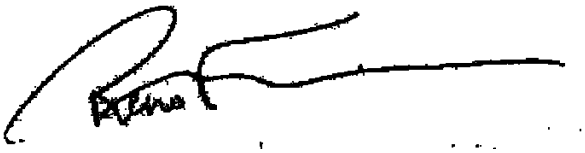
The exclusion of Indians from PCIP eligibility cannot be ignored; it must be corrected at the outset of the program. Any delay in correction will exacerbate the adverse impact of the exclusion. Since the PCIP program is funded with a capped appropriation, only a fraction of those individuals likely to qualify for the coverage will be able to enroll. The regulations authorize PCIP operators to stop admitting new enrollees and to employ other strategies when needed to comply with Federal funding limitations. Thus, unless AI/ANs are eligible when the program starts, they could find themselves totally closed out, if – as is likely – all available funding is quickly committed to individuals who enroll first.

The threat that Indians will be totally closed out is real. Families USA estimates that 880,000 AI/ANs under age 65 have a pre-existing condition that could result in denial of coverage.[11] When this figure is compared with the Department's estimate that only between 200,000 and 400,000 individuals are likely to be able to enroll in a PCIP[12], one can immediately see that unless Indians who meet the eligibility criteria have the chance to apply for coverage at the same time as others who qualify, their chances of ever receiving coverage during the four-year life of this program will be small or non-existent.

The Department cannot promulgate a regulation with such disparate impact on American Indians/Alaska Natives and still be in compliance with Title VI of the Civil Rights Act and the Department's own Title VI regulations. NIHB urges the Department to take corrective action immediately.

Thank you for your consideration of these comments.

Sincerely yours,



Reno Keoni Franklin
Chairman

[11] Families USA, *Health Reform: Help for Americans with Pre-Existing Conditions*, at 6 (May, 2010).

[12] 75 FED. REG. at 45026 (July 30, 2010).