National Indian Health Board

Submitted via email: consultation@ihs.gov

October 31, 2016

Mary L. Smith
Principal Deputy Director
Indian Health Service
Attention: IHS Tribal Premium Sponsorship Draft Circular
The Reyes Building
801 Thompson Avenue, Suite 400
Rockville, Maryland 20852

RE: Indian Health Service Proposed Circular Governing Purchase of Health Insurance by Tribes and Tribal Organizations

Dear Principal Deputy Director Smith,

On behalf of the National Indian Health Board (NIHB), I write to submit comments in response to Principal Deputy Director Mary Smith Dear Tribal Leader Letter dated July 18, 2016 releasing the draft Indian Health Service (IHS) Circular No. 2016-08. The draft Circular addresses the purchase of health insurance coverage, commonly referred to as Tribal Premium Sponsorship by Tribes and Tribal organizations for IHS beneficiaries under Section 402 of the Indian Health Care Improvement Act (IHCIA), 25 U.S.C. § 1642. NIHB appreciates the opportunity to provide comments and input on the draft Circular.

Established in 1972, the 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 (AI/ANs). The 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 the 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, the NIHB is their advocate.

We appreciate the IHS' commitment to providing support to Tribes, Tribal organizations, and Urban Indian organizations (T/TO/Us) should they choose to implement Tribal Premium Sponsorship and while we appreciate the spirit and intent behind this draft circular and seeking Tribal input, there are a number of concerns that we highlight below. Because of these concerns, we request that IHS work collaboratively with T/TO/Us to develop a different process that informs Tribes on Tribal Premium Sponsorship going forward.

Background

Section 402 of the Indian Health Care Improvement Act (IHCIA) authorizes T/TO/Us to use certain federal funds to pay for health insurance premiums for eligible beneficiaries. The draft Circular seeks to provide detailed guidance on premium sponsorship that uses IHS appropriated funds, including programs that are self-funded in part of whole with Indian Self-Determination and Education Assistance Act (ISDEAA) funds or IHCIA. The draft Circular also addresses residual responsibility and coordination of benefits when a direct service Tribe contracts only a portion of its Purchased/Referred Care (PRC) funds to purchase insurance for its Tribal members.

Recommendations

Based on NIHB's review of the draft Circular and our discussions with representatives from Direct Service and Self-Governance Tribes, we believe that the draft Circular goes beyond the scope of Section 402 authority. While some of the provisions in the draft Circular may be beneficial to Tribes, other provisions could be interpreted to impose restrictions on Tribes and Tribal organizations that are not warranted under the applicable law and limits the IHS and participating Tribes from exercising full authorities available in the ISDEAA and IHCIA. NIHB requests that IHS take the following actions:

1. **Rescind the October 24, 2013 Dear Tribal Leader Letter because of the misstatement of Section 402(b) of the Indian Health Care Improvement Act (as added by Section 152 of the Indian Health Care Reauthorization and Extension Act of 2009).**

2. **Coordinate through a workgroup comprised of I/T/U representatives to make recommendations to IHS to address the issues raised in the draft Circular and other Sponsorship-related issues, including determining the preferred mechanism(s) for providing guidance to the T/TO/Us on Tribal Premium Sponsorship.**

Rescind the October 24, 2013 Dear Tribal Leader Letter

In the October 4, 2013 letter, IHS stated that:

> "…a T/TO/U that wishes to limit the number of beneficiaries covered show be aware that financial need is the only factor permitted by statute upon which to base coverage decisions." (Emphasis added.)

However, the applicable portion of section 402 of IHCIA plainly states that the inclusion of financial need as a criterion for coverage is permitted but not required; it states:

> "The purchase of coverage under subsection (a) by an Indian tribe, Tribal organization, or urban Indian organization may be based on the financial needs of such beneficiaries…" (Emphasis added.)

Rescinding the October 24, 2013 Dear Tribal Leader Letter will remove some of the confusion surrounding Tribal premium sponsorship and be a meaningful step towards providing the clarity, guidance, and assistance on Tribal premium sponsorship that T/TO/Us have been asking for.

A request was made by the Tribal Self-Governance Advisory Committee to rescind this Dear Tribal Leader Letter in a communication dated April 15, 2014. In response, IHS pulled the letter from the website but it was not fully rescinded. We support the TSGAC's request and ask that IHS fully rescind the October 24, 2013 Dear Tribal Leader Letter.

Work collaboratively with Tribes to establish a Tribal Premium Sponsorship working group

Tribal leaders and Tribal representatives have expressed opposition to the draft Circular at several of the recent consultations sessions. Tribes and Tribal organizations have expressed their concern with the suggested scope of the Indian Self-Determination and Education Assistance Act (ISDEAA) language in the draft Circular; the IHS view of using financial need in determining who to cover; the discussion of the eligibility rules as being tied to the funding used for sponsorship; and the lack of clarity in the Circular. In NIHB's discussions with Tribes, both those that operate their health care program through contracts or compacts with IHS or continue to also rely on IHS for delivery of most of their health care, the ask has been universal that IHS work with T/TO/Us to develop a better process for informing and training those Tribes that, to the extent that they choose to implement Tribal Premium Sponsorship. The Circular that has been drafted by IHS is confusing and goes beyond the scope of Section 402 of IHCIA.

Tribes do want technical assistance, guidance, and training but IHS needs to be strategic and thoughtful about developing a process that addresses the needs of T/TO/Us. For example, some Tribes may require there to be official guidance before they will move forward with implementation of Premium Sponsorship, yet IHS cannot limit the authority and ability of Tribes to maximize resources by distributing a Circular that exceeds the authority of Section 402. Therefore it is imperative that a workgroup comprised of I/T/U representatives develop a process to inform T/TO/Us about Tribal Premium Sponsorship should they choose to implement it.

Below are a number of specific concerns that Tribes have identified that need to be addressed when the workgroup develops recommendations to IHS.

Use of Third-Party Revenues

Third-party revenue derived through Tribal Premium Sponsorship should be budgeted back into PRC to allow Tribes to continue sustainability of their Sponsorship Programs. Section 402 of IHCIA gives T/TO/Us the authority to use funds funding to purchase coverage through a self-insured plan and those funds may be used for the expenses of operating the self-insurance plan, "including administration and insurance to limit the financial risks to the entity offering the plan."

In Section 2 (F)(2) of the draft Circular, IHS proposes that the contract or compact specify that Medicare and Medicaid collections must be used first to "maintain or achieve compliance with the respective program" as provided in Section 401 of the Indian Health Care Improvement Act (IHCIA). However, under Section 401(d), Tribes and Tribal organizations which have opted to directly bill for and receive payment from Medicare, Medicaid, and CHIP have greater flexibility in how they use such funds for health care related purposes. The term "health status and resource deficiency" provides wide flexibility beyond meeting the Medicare and Medicaid requirements and conditions. More information, training, guidance needs to be provided to facilitate T/TO/Us in establishing a Title 1 contract.

NIHB recommends that IHS provide regular third party collection reports to T/TO/Us to facilitate and provide data for those that choose to implement a Sponsorship Program. It is critical that IHS be transparent with regard to (a) the amount of third party collections in prior years, (b) the amount of those third-party revenues that have been expanded, and (c) any projections IHS has for spending the third-party revenues to comply with Section 401 of IHCIA. Providing these reports that included these data elements would be a benefit to establishing further processes to inform T/TO/Us on Tribal Premium Sponsorship.

Payer of Last Resort and Alternative Resources

In Section 4 of the draft Circular, IHS places limits on Tribal self-insurance by treating such insurance as a payer before IHS, also excluding individuals from being considered eligible for Purchased and Referred Care (PRC) if they have insurance that was purchased by a Tribe or Tribal organization under Section 402 of the Indian Health Care Improvement Act (IHCIA). NIHB believes Tribal self-insurance should be the payer of last resort without the limitations being included in the proposed Circular. Tribal self-insurance should not be treated as primary to PRC, especially for claims that are excluded by the self-insurance plan or where Tribal self-insurance is part of a Tribe's PRC program. Unlike the language included in Section 4(C) of the Circular, there is no exception in law for IHS to bill and collect from a Tribal plan, even if the plan was purchased by ISDEAA funds.

NIHB is strongly opposed to the inclusion of "Tribal" as part of the list of primary payers in the "alternate resource" definition that is indirectly referred to in Section 4 of the draft Circular. According to 42 CFR Section 136.61, "alternate resource" is used to identify programs that must be exhausted before PRC program funds are paid. In this context the payer of last resort defines "alternate resource" to include Federal programs with specific mention of Medicare and Medicaid, and State, or local health care programs, and private insurance." There is no reference or intent to include Tribal governments and programs.

NIHB requests that IHS conduct specific Tribal consultation on its interpretation of "alternate resource", alluded to in this draft Circular.

IHS to Bill Certain Tribal Self-Insurance Plans

In Section 4(C) of the draft Circular, IHS states that if a Tribal plan is indemnified or reinsured, IHS can bill and collect from that Tribal plan – regardless of whether or not the plan was purchased with ISDEAA funds under Section 402. Section 5 of the draft Circular states that if a Tribe or Tribal organization: (A) has a self-insurance plan; (B) the plan is funded entirely or partially with ISDEAA funding; (C) there is no reinsurance or indemnity; and (D) the plan "is designed to follow PRC eligibility," then IHS will consider the plan to be eligible for Catastrophic Health Emergency Fund (CHEF) reimbursements on the same basis as any other PRC program is eligible for CHEF.

Eligibility Criteria

We recommend that IHS provide examples for eligibility criteria but do not require or recommend what they should be. We want to prevent "recommendations" from becoming "requirements." This is critical and we request that IHS make it absolutely clear that eligibility criteria can be established that is consistent with relevant laws but a sponsorship program can be structured with eligibility criteria that is different from the original source of re-programmed funds. There are other instances where funds are re-programmed from one program function to another, therefore eligibility criteria of the source program are not always carried over to the second program function that receives those funds.

Conclusion

Thank you for this opportunity to provide Tribal comments and recommendations on the IHS Tribal Premium Sponsorship draft Circular, we look forward to further engagement with IHS. NIHB hopes that IHS, in the spirit of its partnership and shared interest in improving American Indian and Alaska Native (AI/AN) access to quality health care, will work with Tribes to advance access to quality health care. Please contact NIHB's Director of Federal Relations at ddelrow@nihb.org or (202) 507-4072 if there are any additional questions or comments on the issues addressed in these comments.

Sincerely,

Lester Secatero
Chairman, National Indian Health Board