

National Indian Health Board



December 3, 2020

The Honorable Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-1850

Re: CMS-2438-PN, “Basic Health Program; Federal Funding Methodology for Program Year 2022”

Dear Administrator Verma:

On behalf of the National Indian Health Board (NIHB), I write to provide a response to the Centers for Medicare and Medicaid Services (CMS) item, “Basic Health Program; Federal Funding Methodology for Program Year 2022,” listed as CMS-2438-PN. As with previous comments on this matter that the CMS Tribal Technical Advisory Group (TTAG) sent, NIHB believes that the payment policies should be adjusted in order to fully accommodate the unique protections that American Indians/Alaska Natives (AI/ANs) are afforded through the Affordable Care Act (ACA). While we acknowledge that there are statutory limitations that constrict CMS’s ability to accommodate many of these protections, we believe that there are steps that CMS could take to supplement the amount that states have in order to provide assistance to those who wish to enroll in a Basic Health Plan (BHP). We hope that you will consider our suggestions.

Trust Responsibility

The United States owes a special duty of care to Tribal Nations, which animates and shapes every aspect of the federal government’s trust responsibility to Tribes. Rooted in treaties and authorized by the United States Constitution, the federal government’s unique responsibilities to Tribal Nations has been repeatedly re-affirmed by the Supreme Court, legislation, executive orders and regulations.¹ In 1977, the Senate report of the American Indian Policy Review Commission stated that, “[t]he purpose behind the trust doctrine is and always has been to ensure the survival and welfare of Indian tribes and people.” This trust responsibility is highlighted recently in the Department of Health and Human Services (HHS) Strategic Plan FY 2018–2022:

Importantly, the Federal Government has a unique legal and political government to-government relationship with Tribal governments and a special obligation to provide

¹ The Court has consistently held that the federal government has a trust responsibility to Tribes, which has formed the foundation for federal/Tribal relations. See Seminole Nation v. United States, 316 U.S. 286 (1942), United States v. Mitchell, 463 U.S. 206, 225 (1983), and United States v. Navajo Nation, 537 U.S. 488 (2003).

services for American Indians and Alaska Natives based on these individuals' relationship to Tribal governments.²

The trust responsibility establishes a clear relationship between the Tribes and the federal government.³ The existence of this truly unique obligation supplies the legal justification and foundation for distinct health policy and regulatory making when dealing with American Indians and Alaska Natives (AI/ANs) and the Indian health system that provides their care. The federal government is responsible for ensuring the health of the Indian health system and its ability to provide health care to AI/ANs. We believe that ensuring that AI/AN beneficiaries are able to take advantage of all available programs is necessary in order for the trust responsibility to be fulfilled. While we acknowledge the protections provided for both patients and providers under 42 CFR § 600.160, we believe that the agency could do more to ensure that enrolling in a BHP is a feasible financial decision for AI/AN beneficiaries.

Tribal Implications

Perhaps the most fundamental issue with the BHP methodology is the use of the second-lowest cost Silver plan available through the Exchange as the ceiling for premiums that a BHP could charge. While many Americans would opt to enroll in a Silver plan in order to access the cost-sharing protections available to those who enroll, many AI/ANs have the ability to access cost-sharing protections by enrolling in a Bronze plan. In the past, the Tribal advocates have asked that BHP premiums not be allowed to exceed the cost of the Bronze-level. **We believe that AI/AN premiums in a BHP should not exceed the cost of the second least expensive Bronze plan.** We acknowledge that statutory limitations in the ACA make this an impossibility. However, we reiterate our concern to you that an AI/AN who opts for a BHP may face increases in premiums over the Bronze plan that they may have otherwise selected. We feel that this makes a BHP an impractical choice for AI/AN beneficiaries and makes it unlikely that they would avail themselves of the program.

AI/AN Preferred Metal Tier

We also believe that CMS should give states additional funding in order to subsidize the premiums of AI/ANs who may leave a Bronze plan in order to enroll in a BHP. We believe that this could be achieved by providing the full amount of the expenditures that would have been provided for the premium tax credits and the Indian specific cost shares. **The uniqueness of the Indian cost-sharing protections renders this absolutely necessary.** As it currently stands, there is little financial incentive for AI/ANs to accept what would be essentially be a premium increase. Given the aforementioned statutory limitations in the ACA, the agency should exercise its ability to subsidize costs, thereby ensuring that states have the necessary support to prevent any automatic premium increase associated with BHP enrollment.

When doing any funding calculations in regard to enrollment in a Qualified Health Plan (QHP), we ask that the agency include in their calculations the assumption that AI/ANs will enroll in the

² Introduction, "Cross-Agency Collaborations", <https://www.hhs.gov/about/strategic-plan/introduction/index.html>

³ In *Worcester v. Georgia*, 31 U.S. 515 (1832), the Supreme Court explicitly outlined that the relationship between the federal government and the Tribes is a relationship between sovereign nations and that the states are essentially third party actors.

second lowest cost Bronze plan. We believe that this will most accurately reflect the choice that AI/AN beneficiaries are likely to make. We also made this request in our May 2, 2019 comment on the Federal Funding Methodology for Program Years 2019 and 2020 and we believe that it remains the most accurate way to estimate AI/AN enrollment in private insurance. We believe that this assumption will result in a more accurate funding of the BHP and will ensure that states have the necessary resources to make this affordable to AI/ANs.

Conclusion

While we believe that the BHP is a valuable program for helping to expand access to health insurance, we also believe that it currently fails to take in account the special protections that AI/ANs enjoy and the impact that it may have on their choice of health insurance providers. While we acknowledge that the agency is constricted in its ability to make an exception for AI/ANs in regard to the maximum that a state could charge for premiums in a BHP, we believe that they could subsidize the premiums for AI/ANs in order to keep them from incurring a premium increase. We believe that this would be fair, equitable, and most importantly, an acknowledgement of the unique protections that AI/ANs have been given through the ACA. Thank you in advance for your consideration of our comments.

Sincerely,

A handwritten signature in black ink, appearing to read "Stacy A. Bohlen". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Stacy A. Bohlen, CEO

National Indian Health Board