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Health Reform for Indian Country

Presentation at
Some Assembly Required: Making Health Reform Work for Utah

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Today's Presentation

- Brief Overview of Health Care for American Indians and Alaska Natives
- What Health Care Reform Means for American Indians and Alaska Natives
  - How we got here
  - Projected outcomes from health reform
  - Major Indian Specific Provisions
- Federal government actions and NIHB activities

Indian Health Care in the United States

- **Foundation for health care**: Based on Treaties → the Federal Trust responsibility and Govt to Govt relationship
- **Health Care**: Indian Health Service provides health care to American Indians/Alaska Natives (AI/AN)
  - Indian Health Service is not insurance – public health delivery system

Forms of Delivery of Care

- **IHS**:
  - 29 hospitals, 59 health centers, 4 school health centers, and 28 health stations
- **Tribes/Tribal Organizations** via contract or compact w/IHS
  - 16 hospitals, 237 health centers, 13 school health centers, and 93 health stations and 166 Alaska Native village clinics.
- **Urban Organizations:** IHS provides funding for Indian health centers located in 34 urban areas.

American Indians & Alaska Natives

(IHS, 2009-2010)

- **Disparities**
  - Diabetes: Death rate is 195% higher in AI/ANs
  - Suicide rate: 1.9 higher than the national average in AI/ANs ages 15 to 34
- **Workforce Shortage**
  - Vacancy: Dental – 24%, Nurse – 26%, Physicians – 21%
- **Facilities**
  - Average age of IHS facilities is 30 years
  - $476 million worth of maintenance needs backlog
- **Funding -** IHS
  - Average of 52% Level of Need for Funding
  - **IHS is discretionary spending**

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What Health Reform Means for Indian Country

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Health Reform & IHCIA

Path to Passage of IHCIA

- 1999: National effort to revise IHCIA
  - Established National Steering Committee to Reauthorize the IHCIA (NSC)
  - NSC reorganized and rewrote the IHCIA
- 2010: Senate version of IHCIA part of broader health reform bill and enacted
  - Enacted March 23, 2010 (S.1790 in H.R. 3590)

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IHCIA

- IHCIA: Indian Health Care Improvement (Reauthorization and Extension) Act (of 2009)
  - **Permanent reauthorization**, but can be amended (Sec. 825)
  - Over 85 new/revised provisions providing new authority
  - **Authorized programs are subject to annual appropriations process**
- **Sec. 2 Findings** – New provision: "(2) A major national goal of the U.S. is to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity of health care services and opportunities that will eradicate the health disparities between Indians and the general public of the U.S."
- **Sec. 3 Policy –** Acknowledgement of "special trust responsibility and legal obligations to Indians."

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To What End:

Projected Outcomes From Health Reform

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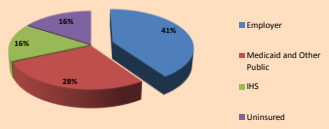
Projected Outcomes

- For AI/AN, 16% have no insurance and another 16% have only IHS

Source of Health Insurance Coverage for Nonelderly American Indians and Alaska Natives, 2006-2007*



* Source: Race, Ethnicity and Health Care, "A Profile of American Indians and Alaska Natives and Their Health Coverage", Kaiser Family Foundation, September 2009. Figures may exceed 100% due to rounding.

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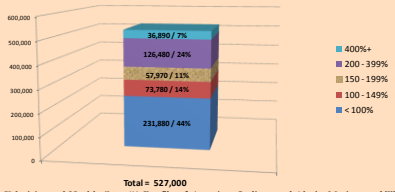
Projected Outcomes

- Uninsured AI/AN are primarily lower-income

Nonelderly American Indians and Alaska Natives Who Are Uninsured or Only Have IHS by Poverty Level, 2006-2007*



Total = 527,000

* Source: Race, Ethnicity and Health Care, "A Profile of American Indians and Alaska Natives and Their Health Coverage", Kaiser Family Foundation, September 2009

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Projected Outcomes

- Federal poverty level thresholds

2010 Poverty Guidelines ("Federal Poverty Level")*

Persons in Family	100% FPL	300% FPL
1	**$10,830**	**$32,490**
2	$14,570	$43,710
3	**$18,310**	**$54,930**
4	$22,050	$66,150
5	$25,790	$77,370
6	$29,530	$88,590
7	$33,270	$99,810
8	$37,010	$111,030
Alaska	**+25%**	
Hawaii	**+15%**	

* http://aspe.hhs.gov/poverty/10poverty.shtml

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Projected Outcomes

Tribal Technical Advisory Group (TTAG) recommendations on desired outcomes

- Significantly increase the rate of health coverage
- Financially strengthen Indian health providers so programs can expand service capacity and access to health care
- Significantly reduce the glaring health disparities that oppress AI/AN
- Ensure that Tribal leaders and Indian health program staff receive training to understand and educate and enroll members

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Projected Outcomes

- Ensure that all Indian communities directly benefit from new funding opportunities
- Implement Indian-specific provisions as effectively and efficiently as possible
- Recognize that the Indian health system is very different from the mainstream health delivery system and, therefore, assure that it is protected from any adverse consequences
- Require all Department of Health and Human Services agencies that have implementation responsibilities to engage in meaningful Tribal Consultation that respects the Federal trust responsibility and Government-to-Government relationship with Tribes

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Major Indian Specific Provisions in Affordable Care Act

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Major Provisions: ACA

Insurance Requirement - Individual Mandate

- By 2014 Most Americans will be required to buy health insurance, if they don't already have some other health coverage.
- Under Sec. 1411(b)(5)(A), Indians may obtain an exemption from tax penalties that may be imposed on people who are otherwise required to be covered.
  - Inclusion of exemption is recognition of trust responsibilities of Federal government.

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Major Provisions: ACA

Indian-Specific Exchange Provisions

- Cost Sharing: Indians at or below 300% FPL will have **no** cost-sharing under a plan offered through the Exchange
- Enrollment: All Indians can enroll on a monthly basis, rather than during annual 2 month period

Indian-Specific Provisions under All Plans

- I/T/U Clients: No cost-sharing by AI/AN clients for services provided by IHS, Tribal or urban Indian program, or CHS
- I/T/U Providers: All I/T/U providers are able to bill health plans for reimbursement
  - The amount is the higher of a) reasonable charges billed or b) highest amount plan would pay to other providers

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Cost Sharing

- As with the general population, the cost-sharing protections for AI/AN are available only for AI/AN enrolled in non-employer provided coverage (i.e., individual market) in an exchange
  - Section 1404(d) SPECIAL RULES FOR INDIANS.—
    - (1) INDIANS UNDER 300 PERCENT OF POVERTY.—If ***an individual enrolled in any qualified health plan in the individual market through an Exchange*** is an Indian (as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d))) whose household income is not more than 300 percent of the poverty line for a family of the size involved, then, for purposes of this section— (A) such individual shall be treated as an eligible insured; and (B) the issuer of the plan shall eliminate any cost-sharing under the plan."

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CostSharing

- **If between 300% and 400% of Federal Poverty Level**
  - Subsidies (through advance tax credits paid directly to plans) are available for all Americans
- **Why Should Indians Be Enrolled in a Plan**
  - Can be used to acquire services that the I/T/U cannot provide
  - Insurance payments to the I/T/U for services it does provide
  - Reduces costs to contract health services program

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Medicaid - Enrollment and access

- **There are no Indian specific provisions regarding Medicaid Expansion.**
- But, there is still lots to do! As much as 60% of uninsured AI/AN are or will be eligible for Medicaid
- **DON'T FORGET – The State must consult with Tribes BEFORE making changes to Medicaid.** *See*, Sec. 5006 of ARRA.
- Medicaid is a primary source of third party revenue for Indian Health programs.

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Medicaid: Enrollment and Access

- Other (existing) AI/AN-specific Medicaid provisions
  - States are eligible to receive 100% FMAP for administrative expenditures, including Targeted Case Management Services, for AI/AN populations
  - States are eligible to receive 100% FMAP for services provided by IHS and Tribal government (I/T) to Medicaid recipients
  - Health plans, including Medicaid, required to reimburse I/T/Us for services to AI/AN
  - States must consult with Tribes before making changes to Medicaid (provision contained in Recovery and Reinvestment Act (ARRA))
  - No cost-sharing under Medicaid for AI/AN (ARRA)

Federal Government Actions and NIHB Activities on Implementation

Federal Government Actions and NIHB Interactions on Implementation

- May 12: Tribal Leader Letter: HHS and IHS initiated formal Tribal consultation on the IHCIA and Indian-specific provisions in the ACA
  - NIHB response submitted July 1, 2010
  - TTAG response submitted July 1, 2010
  - Tribal Budget Formulation Workgroup response submitted July 7, 2010

Federal Government Actions and NIHB Interactions on Implementation

- May 11: HHS Notice on Negotiated Rulemaking, Medically Underserved Area and HPSA
  - NIHB response submitted
- July 22: Tribal Leader Letter from IHS on selected provisions
- July 30: HHS/Office of Consumer Information and Insurance Oversight (OCIIO) Request for Comment on Pre-Existing Condition Insurance Plan Program
  - NIHB response submitted September 28, 2010

Federal Government Actions and NIHB Interactions on Implementation

- Aug. 3: OCIIO Request for Comments on Planning and Establishment of State-Level Exchanges
  - **NIHB response submitted October 4, 2010**
    - Require consultation with the Tribal governments.
    - Establish a clear mechanism by which Tribal governments may make premium contributions to an Exchange on behalf of Tribal members.
    - Require Exchanges and health plans offered in an Exchange to notify AI/AN of the option to continue to seek services from I/T/U providers and provide information on the I/T/U providers available in the plan's service area.
    - AI/AN should be able to self-certify that they qualify as an Indian; if not, work with current systems that rely on this identification.

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Federal Government Actions and NIHB Interactions on Implementation

- Oct 5: Tribal Leader Letter from Office of Personnel Management (OPM) and IHS regarding access to FEHBP
  - Nov. 5: Response to OPM/IHS due from Tribes to survey questions on potential participation in FEHBP due
- Nov. 1 and 2: IHS long-term care conference in Washington, DC
- Nov. 8, 9 and 10: TTAG face-to-face meeting in Washington, DC
- Nov. (TBD): Tribal Consultation on Exchange-related provisions in ACA

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The Unfolding Story…

- Now, the tasks at hand are to –
  - Ensure that the law is successfully implemented to meet the needs of AI/AN
  - Work to gain sufficient funding (appropriations) for authorized but-not-yet funded programs

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