White Paper: Native American Health Care

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The Affordable Care Act is a failed effort on the part of the government to provide insurance coverage for all uninsured persons in the United States. Since that was the original premise behind the ACA demonstration project, we now see that it did not provide health insurance for the forty million uninsured Americans identified as the target market in 2008, it is not affordable for those who were pulled into the ACA system, and the out of pocket maximums associated with the plan effectively make access to healthcare unattainable.

However, for Indian Country there were provisions in the law that did make Native American access to affordable healthcare a reality. Specifically, Native Americans are allowed to enroll during any month in the year; Native Americans do not have to pay out of pocket expense associated with the ACA plan they select; Native Americans are not subject to the individual mandate penalty provision; Native American PRC plans can sponsor Tribal Members and pay their respective ACA premium; and IHS funding was permanently re-authorized going forward.

The new administration will present a replacement plan for ACA in the coming months. Healthcare and health insurance will improve for Americans in general under the replacement plan. However, for Native America, there are provisions within ACA that need to be protected.

MUST BE ON DEFENSE FOR THE FOLLOWING ISSUES:

1. Protecting Native provisions within the ACA
    a. Payer of last resort
    b. Out of pocket waiver
    c. Monthly enrollment opportunity
    d. Grants
    e. Medicaid funding
    f. Third party dollars
2. Protecting IHS funding levels currently in place
    a. Congress will be looking for budget cuts to existing programs to pay for the replacement transition. IHS funding will be up for consideration.
    b. Permanent reauthorization needs to be protected as well as funding allocation
3. Protecting Sovereign rights, Self-Determination, and Self-Governance

Implementing a replacement plan also offers an opportunity for Indian Country to implement innovative ideas and concepts that are in keeping with the intent of making affordable health insurance and access to quality healthcare a reality for more Native Americans. Some of these opportunities are outlined herein.

RECOMMENDATIONS AND IDEAS:

1. Exemption for all penalties and assessments if any remain.
    a. All penalties, fees, and reporting requirements within the ACA law should be eliminated immediately. If the individual and group mandates are no longer in place, then there is

no need to complete and file cumbersome reports that are designed to tell the IRS if each employee was offered affordable minimum essential benefits each month of a calendar year.

b. If ACA is repealed then there is no need to require employers to contribute to the PCORI fund, or the re-insurance fund.

2. Access to MLR payment authorization for all Native owned enterprises.
    a. Healthcare is a treaty right for all Native Americans. The method of delivering healthcare for Native Americans is the Indian Health Service system established through the Federal Government. The Federal Government allocates funds to the IHS system each fiscal year. This allocation has been and continues to be inadequate to meet the healthcare needs of Native Americans. Currently it is underfunded by thirty billion dollars annually.
    b. Legislation was passed by Congress in the 70's instituting the provisions that allow Native American Tribes and Nations the ability to self-govern themselves with the goal of making self-determination a reality. A key component of self-governance is the ability to provide for the health and welfare of the Members of a Tribe or Nation. Since enactment, Tribes and Nations have expanded their economic growth and diversified their economic interests with the overriding goal of providing for the health and welfare of their respective Tribal Members.
    c. As stated above, IHS funding has been and will always be far less than what is needed to meet the healthcare needs of Tribal Members. However, Native American Tribes have continuously subsidized this underfunded system by offering various types of health assistance programs for their Members. The effect of these programs is limited because the Tribe must pay healthcare providers more than Medicare Like Rates which are the payment rates approved for PRC programs.
    d. The second highest expense for Tribes and Nations who start companies through their economic development programs is health insurance. If these healthcare plans were able to pay providers using MLR, the Tribe would save up to 40% of their second highest operating expense.
    e. IHS is under-funded. Tribes and Nations are willing to subsidize this underfunding in keeping with their goal of self-governance and self-determination. The money needed to increase this subsidy can come from a drastic reduction in the cost of healthcare for their employee benefit plans. This savings would serve to fund a Tribal Member Health Plan that would be a direct subsidy to the underfunded IHS program.
    f. Native America will commit to assisting the IHS program and will help the government meet its treaty obligation to Indian Country, if MLR pricing is made available to all Tribal owned and Tribal sponsored health insurance plans associated with their enterprises and companies.
3. Exemption from MEWA regulations in order to form state wide association Plans without insurance commissioner oversight.
    a. In the insurance industry, the rule of large numbers is paramount in addressing cost and the spread of risk over a large population. One of the structures that can be implemented that incorporates the rule of large numbers is a MEWA (multiple employer welfare arrangement).

b. Under current insurance law, the insurance commissioner of a state has oversight authority over MEWA's. The requirements to form a MEWA are established by the state insurance commissioner. Those requirements in essence require a MEWA to be licensed by the state and to meet the minimum capital and surplus requirements in place for insurance companies operating in the state.
c. Indian Country could benefit greatly by forming a MEWA that any and all Tribes within a state could participate for the insurance coverage for their employees and Members. The requirements for formation, licensure, and funding are restrictive and prohibit Tribes from forming such an organization.
d. We propose that Tribes and Nations be exempt from these requirements and be allowed to form a MEWA under their own self-governance rules.

4. Consider creating a self-funded Native American risk pool for Tribes and Nations within the state of Oklahoma. Establish Native controlled rules and regulations related to the establishment of the pool. Award an appropriate portion of Medicaid funding available in a state to the Native American sponsored risk pool to help offset some of the claims cost.
    a. If MLR is approved for Tribes and Nations, then it is feasible for Native American Tribes within a state to form their own risk pool for Native Americans who do not otherwise have access to health insurance. This also reinforces the goal of Self Governance and Self Determination.
    b. This pool would be funded by Native American Tribes and Nations and their enterprises with a fee assessed to each Plan that is embedded as part of their overall premium or funding amount for their health benefit plans.
    c. Additional funding could come from block grants to Tribes for this specific program. The government awards millions of dollars in planning projects, feasibility studies, and other healthcare related studies. These monies could be better spent as a funding source for direct delivery of health care to Native Americans through a risk pool that uses MLR as the provider payment schedule. The cost/benefit result of funding direct healthcare to Native Americans is far greater than what is realized from many of the existing grants.
    d. Non-Native statewide pools may not be able to implement MLR pricing due to legal complications, but as Sovereign Nations, MLR may be available to Tribes.
5. Develop state wide Native American purchasing group to leverage buying power in behalf of all Tribes and Nations and their enterprises.
    a. If MLR pricing is not made available to all Tribal sponsored benefit Plans, then an option would be to establish a statewide demonstration project allowing Tribes and Nations to form a purchasing group to leverage buying power with providers.
    b. BCBS and other large insurance companies enjoy a competitive edge over smaller insurance companies and self-funded Plans that do not or cannot access the same provider discount levels afforded BCBS. On its face, this is price discrimination on the part of healthcare providers, but they have successfully lobbied a position that deep discounts are given based on payment volume received from a payer.

c. This position is disingenuous since individual companies who enroll in an insurance plan sold by one of these insurance companies have not given those insurance companies authorization to negotiate in their behalf using their premium dollars.
d. The end result of this practice is a tendency over time to monopolize the insurance market by a relatively few number of payers and forcing employers to purchase their products without the benefit of open competition on a level playing field. President Trump proposes a replacement plan that promotes and supports competition in the insurance market. Current price discrimination and monopolistic practices prohibit that from happening.

6. Use Sovereign Nation status wherever possible to implement these and all other options.
    a. As limited Sovereign Nations, Native American Tribes have special enabling provisions in the Federal law that may allow for new and innovative approaches that will improve access to affordable healthcare for Native Americans. To the extent possible, Sovereign Nation status should be used to facilitate implementation of the ideas presented herein.
7. Implement Tribal Member Health Plans.
    a. As stated earlier, IHS is underfunded. Tribes and Nations have implemented programs that effectively subsidize the IHS program.
    b. If MLR was made available to all Tribal sponsored health insurance plans, then the savings realized could be used to create the long term subsidy solution which is Tribal sponsored Tribal Member Health Plans. There are a few of these plans in operation by Tribes at this time. MLR would be the foundation legislation that would allow all Tribes and Nations to increase IHS subsidies dramatically, and move closer to Self-Governance and Self Determination.

PATHWAY TO MEET THESE CHALLENGES:

1. Unification becomes a reality and all Tribes agree to participate in the resulting programs.
2. Close relationship with Representative Mark Wayne Mullen (and your Federal legislators) to get a seat at the table.
3. Discussion with your state legislative body about state demonstration projects to include self-funded association group, Native American risk pool, and purchasing group.
4. Establish statewide strategic planning groups to identify available planning grants and demonstration project grants and apply for them.
5. Regional legislative committees who go to D.C. and actively lobby for your strategic plan, and MLR pricing for all Native American sponsored health care Plans.