

Sonosky, Chambers, Sachse,
Endreson & Perry, LLP

*A national law firm devoted to representing
Native American interests*

Maximizing Third Party Revenues: Tribal Options Under the Affordable Care Act

A Presentation for the National Indian Health Board 2015 Annual Consumer Conference

**Samuel E. Ennis, J.D.
September 22, 2015**

sennis@sonoskysd.com



Washington, DC

Juneau, AK

Anchorage, AK

Albuquerque, NM

San Diego, CA

Section 206 of the Indian Health Care Improvement Act



Sonosky, Chambers, Sachse, Endreson & Perry, LLP

Section 206 - Generally

- **Section 206 of the Indian Health Care Improvement Act (25 U.S.C. § 1621e) gives Tribal health programs the right to recover “from an insurance company, health maintenance organization, employee benefit plan, third-party tortfeasor, or any other responsible or liable third party (including a political subdivision or local governmental entity of a State),” either:**
 - The program’s “reasonable charges billed,” or;
 - If higher than the provider’s reasonable charges, “the highest amount the third party would pay for care and services furnished by providers other than governmental entities, to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive damages, reimbursement, or indemnification for such charges or expenses if such services had been provided by a nongovernmental provider; and such individual had been required to pay such charges or expenses and did pay such charges or expenses.”

Section 206 – “Fuzzy Friends”

- **Numerous ambiguities in the statute:**
 - When is a bill “reasonable?”
 - Are there geographic limitations to the “highest amount” clause?
 - If you’re in Oklahoma and the insurer pays you \$100, pays someone else in Oklahoma \$150, and pays someone in Texas \$300, what do you get?
 - Under the “highest amount clause,” if you can only recover to the “same extent” as the patient, does that mean the insurer can deduct that patient’s copayments and other cost-sharing amounts from payments to your program?

Section 206 – YKHC Litigation

- **First Section 206 case was in 1994: *Yukon-Kuskokwim Health Corp. v. Trust Insurance Plan for Southwest Alaska*.**
- **Federal district judge in Alaska ruled that:**
 - Tribal health program may recover under Section 206 even if patient failed to satisfy insurer's claim submission requirements.
 - Insurers cannot "game" Section 206 by instituting policies like, for example, "we do not reimburse claims made by governments."

Section 206 – *Premera* Litigation

- **In May 2012, the Alaska Native Tribal Health Consortium (ANTHC) sued Premera Blue Cross Blue Shield (Premera) in Alaska federal district court seeking to recover under Section 206.**
 - ANTHC and Premera had a contract that ANTHC terminated in 2011 after Premera unilaterally amended the contract in its own favor.
 - Premera's subsequent payments to ANTHC were anywhere from 0%-60% of its billed charges.
- **Case is currently still active after four rounds of summary judgment, numerous evidentiary challenges, and multiple failed settlement negotiations.**
 - Parties will participate in a judicial settlement conference in October.

Premera – Rulings Thus Far

- **The judge has held:**
 - Section 206 right of recovery *does not apply* if the provider and payor have an active contract.
 - “Highest amount paid” clause refers to geographic area in which provider operates, not the entirety of insurer’s nationwide network (in Alaska, determined according to state regulation setting out minimum payments to non-contracted providers).
 - “Reasonable charges” clause and “highest amount paid” clause represent separate rights of recovery (cannot limit the former with the latter).
 - “Reasonable charges” not limited to what insurer would reimburse individual patient (i.e., Section 206 is not a subrogation clause).
 - Insurer *cannot* deduct cost-sharing (copays, deductibles, coinsurance) from amounts paid under “reasonable charges” clause, but might be allowed to do so under the “highest amount paid” clause.

Premera – Ongoing Disputes

- **What constitutes a “reasonable” billed charge?**
 - ANTHC argues that reasonableness is determined by comparison of billed charges among provider’s peer group (i.e., market forces determine reasonableness).
 - Premera argues that reasonableness is determined by comparing payments made by insurers to providers (i.e., insurers alone determine reasonableness).
- **When evaluating insurer payment rates, what charges to include?**
 - ANTHC says you only examine charges from non-contracted payors since Section 206 does not apply when you have a contract.
 - Premera says you must examine all charges, both contracted and non-contracted.

Section 206 – What are “Reasonable Charges”?

- **Judge found the following factors relevant to reasonableness:**
 - An analysis of the relevant market for hospital services;
 - The hospital’s internal cost structure;
 - The nature of the services provided;
 - The average payment the provider would have accepted as full payment from third-parties;
 - The usual and customary rate the hospital charges; and
 - The price an average patient would agree to pay for the service at issue.
 - Judge acknowledged that latter two factors are less applicable in the tribal context because Indian patients are not billed and do not pay for services.
- **Judge held that these factors must be established by expert testimony.**

Section 206 – Lessons Learned

- **Know your contract.**
 - Contract terms trump Section 206 (at least in Alaska...).
- **Understand what you're being paid.**
 - Payers cannot apply “allowed amounts” or other cost-sharing deductions to your “reasonable billed charges” when paying you under Section 206.
- **Don't be afraid to press your rights...**
 - Many insurers are unaware of Section 206 or do not understand how it works. Upon being given an explanation, several insurers have changed their payment policies in accordance with the law.
- **...but recognize the risk in doing so.**
 - Some insurers have already issued letters to I/T/U indicating they will immediately comply with Section 206. Premera has litigated the issue for over three years. Be prepared in either case.

Federal Employee Health Benefits Program



Sonosky, Chambers, Sachse, Endreson & Perry, LLP

What is the Federal Employee Health Benefits Program?

- **The United States federal government insures its employees through the Federal Employee Health Benefits Program (FEHB) and Federal Employees' Group Life Insurance Program (FEGLI)**
 - The FEHB program is operated by the federal Office of Personnel Management (OPM).
- **Section 409 of the Indian Health Care Improvement Act authorizes Tribes operating programs under the Indian Self Determination and Education Assistance Act (ISDEAA) to offer their employees FEHB and FEGLI coverage. 25 U.S.C. § 1647b.**
 - FEGLI coverage temporary unavailable pending OPM developing program standards for Tribes.

Who is Eligible for FEHB Coverage?

- **In order to participate in FEHB, at least one Tribal “business unit” that operates ISDEAA programs must offer FEHB coverage to its employees.**
 - OPM refers to a “business unit” as being a distinct “line of business,” which presumably includes each individual Tribal program and commercial entity.
 - So long as one such “business unit” participates in FEHB, every other Tribal business unit may choose whether or not to participate in FEHB on a unit-by-unit basis, regardless of whether or not they also operate ISDEAA programs.
- **Participating business units must exclusively offer FEHB coverage to all of its eligible tribal employees (certain exceptions for unionized employees).**
 - An “eligible employee” is a full-time or part-time tribal employee who is considered a common law tribal employee by the IRS, as well as a seasonal tribal employee who works more than six months in a year. It does not include a contract employee, tribal retiree, or volunteer.
 - An employee’s spouse (including a valid common law or same sex marriage) and children under age 26 are also eligible for enrollment (with some restrictions on foster children).

FEHB Eligibility, Continued

- **Tribal employees are eligible for FEHB coverage regardless of whether they're Tribal members, or even American Indian or Alaska Native.**
- **Tribes can continue to offer its Tribal members coverage under a separate health plan.**
 - But, Tribal member employees working for a FEHB-enrolled business unit are only eligible for FEHB, not the separate plan.
- **There is no minimum employee enrollment percentage.**
 - Employees may independently obtain coverage outside of FEHB if they so choose.
- **Currently two plan types: self only and family. OPM is in the process of creating additional "self plus one" plans.**

How Much Do FEHB Plans Cost?

- Tribal employees may choose among any of the in-state plans offered through FEHB, as well as among any available national plans. Plan costs will vary on a plan-by-plan and state-by-state basis.
- Employer's required payment percentage of employee premium is statutorily set at approximately 72-75% of the total monthly premium, as well as a per-employee administrative fee of approximately \$15-20 per month.
 - Tribal employers may optionally choose to contribute up to 100% of employee premiums.
- Current rates for each State and each plan are available on the OPM FEHB website.
 - Depending on plan options, deductibles, etc., premiums can vary wildly from state to state and plan to plan. Must evaluate your state's specific situation prior to enrolling.

Mastering the Marketplace



Sonosky, Chambers, Sachse, Endreson & Perry, LLP

Cost-Sharing Reductions - Generally

- **Two American Indian and Alaska Native (AI/AN)-specific cost-sharing reductions (CSRs) for Affordable Care Act (ACA) Marketplace plans.**
 - For purposes of rule, “cost-sharing” includes copayments, coinsurance, deductibles, and similar charges, but does not include premium costs.
- **Qualified health plan (QHP) issuers in ACA Marketplaces must offer variations of their QHPs that incorporate the reductions.**
 - Reductions are only available to enrollees in Marketplace plans.
 - QHP issuer cannot withhold CSR amounts from payment to provider, but rather will be reimbursed those amounts by the federal government.
- **Reductions are only available to “Indians” as defined in the ACA:**
 - Members of federally-recognized Indian Tribes and Alaska Native Villages.
 - Alaska Native Claims Settlement Act (ANCSA) corporation shareholders.

Zero Cost-Sharing Variation

- The “zero cost-sharing” plan variation is available to AI/ANs who (1) have a household income between 100% and 300% of the federal poverty level and (2) qualify for premium tax credits in an ACA Marketplace.
- Enrollee does not pay *any* cost-sharing whatsoever when receiving a service deemed to be an “essential health benefit” under the plan.
 - This is true regardless of where the individual received the service.

Limited Cost-Sharing Variation

- The “limited cost-sharing” plan variation applies to any AI/AN who does not qualify for a zero cost-sharing variation due to income level or ineligibility for tax credits.
 - Eligibility applies based solely on AI/AN status, not income.
- Enrollee does not pay any cost-sharing whatsoever when receiving a service deemed to be an “essential health benefit” under the plan so long as the service was provided:
 - By the Indian Health Service, a Tribal health program, or an Urban Indian Organization (I/T/U); or
 - By a non-I/T/U provider through purchased/referred care (formerly contract health services).

Tribal Premium Sponsorship

- **Marketplaces may allow Indian tribes, tribal organizations, and urban Indian organizations to “sponsor” Marketplace premium payments for qualified individuals. If authorized by the Marketplace, QHPs must accept such payments.**
 - 42 C.F.R. § § 155.240(b), .156.1250(b).
 - Marketplace determines whether premium payments may be aggregated (i.e., tribe pays a lump sum for total costs and Marketplace pays all relevant insurers, or if tribe must pay each insurer individually).
- **Such organizations can use funds made available through the Indian Self-Determination and Education Assistance Act (ISDEAA) or programs under the Social Security Act (Medicare, Medicaid, and CHIP) to purchase such health insurance.**
- **Tribes may, but are not required to, apply eligibility criteria for sponsorship such as financial need.**
- **Factoring in tax credits, annual premium costs approximately \$500 to \$3,150 per member, with reported costs averaging between \$1,300 and \$2,500.**

Presenter

Sam Ennis is an associate in the San Diego office of Sonosky, Chambers, Sachse, Endreson & Perry LLP, which specializes in representing Tribal interests throughout the United States. Mr. Ennis works in all areas of the firm's practice, with a focus on health law and Tribal self-governance. Mr. Ennis graduated with honors from the University of Virginia, and then from the UCLA School of Law, where he was Chief Comments Editor of the UCLA Law Review, interned at the United States Commission on Civil Rights, and participated in the UCLA Tribal Legal Development Clinic.

Mr. Ennis is a member of the National Indian Health Board Medicare & Medicaid Policy Committee and has worked in conjunction with the Centers for Medicare and Medicaid Services Tribal Technical Advisory Group. He also serves as a consultant to the National Indian Health Board with regard to training on and implementation of the Affordable Care Act and Indian Health Care Improvement Act. He has authored numerous published articles on various aspects of federal Indian law.